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Report to Congressional Committees

November 2012

RECOVERING SERVICEMEMBERS AND VETERANS

Sustained Leadership Attention and Systematic Oversight Needed to Resolve Persistent Problems Affecting Care and Benefits

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GAO-13-5

November 2012

RECOVERING SERVICEMEMBERS AND VETERANS

Sustained Leadership Attention and Systematic Oversight Needed to Resolve Persistent Problems Affecting Care and Benefits

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Highlights

Highlights of GAO-13-5, a report to congressional committees

Why GAO Did This Study

The National Defense Authorization Act for Fiscal Year 2008 required DOD and VA to jointly develop and implement policy on the care, management, and transition of recovering servicemembers. It also required GAO to report on DOD's and VA's progress in addressing these requirements. This report specifically examines (1) the extent to which DOD and VA have resolved persistent problems facing recovering servicemembers and veterans as they navigate the recovery care continuum, and (2) the reasons DOD and VA leadership have not been able to fully resolve any remaining problems. To address these objectives, GAO visited 11 DOD and VA medical facilities selected for population size and range of available resources and met with servicemembers and veterans to identify problems they continue to face. GAO also reviewed documents related to specific DOD and VA programs that assist recovering servicemembers and veterans and interviewed the leadership and staff of these programs to determine why problems have not been fully resolved.

What GAO Recommends

GAO recommends that DOD provide central oversight of the military services' wounded warrior programs and that DOD and VA sustain high-level leadership attention and collaboration to fully resolve identified problems. DOD partially concurred with the recommendation for central oversight of the wounded warrior programs, citing issues with common eligibility criteria and systematic monitoring. DOD and VA both concurred with the recommendation for sustained leadership attention.

View GAO-13-5. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

Deficiencies exposed at Walter Reed Army Medical Center in 2007 served as a catalyst compelling the Departments of Defense (DOD) and Veterans Affairs (VA) to address a host of problems for wounded, ill, and injured servicemembers and veterans as they navigate through the recovery care continuum. This continuum extends from acute medical treatment and stabilization, through rehabilitation to reintegration, either back to active duty or to the civilian community as a veteran. In spite of 5 years of departmental efforts, recovering servicemembers and veterans are still facing problems with this process and may not be getting the services they need. Key departmental efforts included the creation or modification of various care coordination and case management programs, including the military services' wounded warrior programs. However, these programs are not always accessible to those who need them due to the inconsistent methods, such as referrals, used to identify potentially eligible servicemembers, as well as inconsistent eligibility criteria across the military services' wounded warrior programs. The departments also jointly established an integrated disability evaluation system to expedite the delivery of benefits to servicemembers. However, processing times for disability determinations under the new system have increased since 2007, resulting in lengthy wait times that limit servicemembers' ability to plan for their future. Finally, despite years of incremental efforts, DOD and VA have yet to develop sufficient capabilities for electronically sharing complete health records, which potentially delays servicemembers' receipt of coordinated care and benefits as they transition from DOD's to VA's health care system.

Collectively, a lack of leadership, oversight, resources, and collaboration has contributed to the departments' inability to fully resolve problems facing recovering servicemembers and veterans. Initially, departmental leadership exhibited focus and commitment—through the Senior Oversight Committee—to addressing problems related to case management and care coordination, disability evaluation systems, and data sharing between DOD and VA. However, the committee's oversight waned over time, and in January 2012, it was merged with the VA/DOD Joint Executive Council. Whether this council—which has primarily focused on long-term strategic planning—can effectively address the shorter-term policy focused issues once managed by the Senior Oversight Committee remains to be seen. Furthermore, DOD does not provide central oversight of the military services' wounded warrior programs, preventing it from determining how well these programs are working across the department. However, despite these shortcomings, the departments continue to take steps to resolve identified problems, such as increasing the number of staff involved with the electronic sharing of health records and the integrated disability evaluation process. Additionally, while the departments' previous attempts to collaborate on how to resolve case management and care coordination problems have largely been unsuccessful, a joint task force established in May 2012 is focused on resolving long-standing areas of disagreement between VA, DOD, and the military services. However, without more robust oversight and military service compliance, consistent implementation of policies that result in more effective case management and care coordination programs may be unattainable.

Contents

Tables

Figures

Abbreviations

DOD	Department of Defense
Dole-Shalala Commission	President's Commission on Care for America's Returning Wounded Warriors
FRCP	Federal Recovery Coordination Program
IDES	Integrated disability evaluation system
LOA	Line of Action
MTF	military treatment facility
NDAA 2008	National Defense Authorization Act for Fiscal Year 2008
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OND	Operation New Dawn
PTSD	posttraumatic stress disorder
RCP	Recovery Coordination Program
Recovering Warrior Task Force	Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces
Senior Oversight Committee	Wounded, Ill, and Injured Senior Oversight Committee
TBI	traumatic brain injury
VA	Department of Veterans Affairs
VAMC	Department of Veterans Affairs Medical Center
WWCTP	Office of Wounded Warrior Care and Transition Policy

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Congressional Committees

A series of media reports in early 2007 disclosed troublesome deficiencies in the provision of outpatient services at Walter Reed Army Medical Center in Washington, D.C.[1] These reports prompted broader questions about whether the Departments of Defense (DOD) and Veterans Affairs (VA) were fully prepared to meet the needs of the growing number of servicemembers and veterans returning from recent conflicts. Several review groups were subsequently tasked with investigating the reported problems and identifying recommendations.[2] These groups identified common areas of concern including: inadequate case management to ensure continuity of care,[3] confusing disability evaluation systems, and insufficient sharing of servicemembers' health records and other data between DOD and VA—all long-standing problems that we have reported on extensively.[4]

To elevate the response to concerns raised by these review groups, DOD and VA established the Wounded, Ill, and Injured Senior Oversight Committee (Senior Oversight Committee) in May 2007. The committee was intended to operate on a short-term basis to review and implement

[1]"Soldiers Face Neglect, Frustration at Army's Top Medical Facility," *Washington Post* (Washington, D.C.: Feb. 18, 2007); "The Other Walter Reed: The Hotel Aftermath," *Washington Post* (Washington, D.C.: Feb. 19, 2007); and "Hospital Investigates Former Aid Chief," *Washington Post* (Washington, D.C.: Feb. 20, 2007).

[2]Independent Review Group, *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* (Arlington, Va.: April 2007); Task Force on Returning Global War on Terror Heroes, *Report to the President* (April 2007); President's Commission on Care for America's Returning Wounded Warriors, *Serve, Support, Simplify* (July 2007); Veterans' Disability Benefits Commission, *Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century* (October 2007); and Department of Defense Office of the Inspector General, Department of Veterans Affairs Office of the Inspector General, *DOD/VA Care Transition Process for Service Members Injured in OIF/OEF* (June 2008).

[3]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 high quality, cost-effective outcomes.

[4]See list of related GAO products at the end of this report.

the recommendations made by the various review groups and improve seamlessness in the provision of care for recovering servicemembers and veterans.[5] It was cochaired by the Deputy Secretaries of Defense and Veterans Affairs and included the military service Secretaries and other high-ranking officials within the departments. Congress subsequently passed the National Defense Authorization Act for Fiscal Year 2008 (NDAA 2008) requiring the Secretary of Defense and the Secretary of Veterans Affairs to jointly develop and implement policy, to the extent feasible, to improve the care, management, and transition of recovering servicemembers.[6] Because of its related ongoing work, the Senior Oversight Committee also assumed responsibility for addressing these requirements.

Despite actions taken by DOD and VA to address the problems identified at Walter Reed in 2007, concerns remain that recovering servicemembers and veterans continue to face many of the same problems as they did in 2007 navigating the recovery care continuum, from acute medical treatment and stabilization, through rehabilitation, to reintegration—either back to active duty or to the civilian community as a veteran. In 2009, Congress required DOD to establish a task force to assess the effectiveness of DOD programs and policies developed to assist recovering servicemembers and to make recommendations for continuous improvements of such policies and programs.[7] The DOD Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces—referred to as the Recovering Warrior Task Force—issued its first report in September 2011;[8] it contained 21 recommendations on a variety of issues affecting recovering servicemembers.[9] Additionally, congressional committees held

[5]In this report, we will use the term "recovering servicemembers" to denote wounded, ill, and injured servicemembers.

[6]Pub. L. No. 110-181, § 1611, 122 Stat. 3, 433 (2008).

[7]National Defense Authorization Act for Fiscal Year 2010, Pub. L. No. 111-84, § 724, 123 Stat. 2190, 2389 (2009).

[8]Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces, *Department of Defense* Recovering *Warrior Task Force 2010-2011 Annual Report* (September 2011).

[9]To understand how VA interacts with servicemembers, the Recovering Warrior Task Force reviewed VA programs, including those that assist servicemembers with the transition from DOD's to VA's health care system.

multiple hearings in 2010 and 2011 that highlighted ongoing difficulties facing these servicemembers and veterans, including issues with duplication and poor coordination among case management and care coordination programs,[10] delays in completing the disability evaluation process, and the lack of full interoperability between DOD's and VA's computer systems.[11]

The NDAA 2008 required that we report on DOD's and VA's progress in developing and implementing joint policy on issues related to the care, management, and transition of recovering servicemembers.[12] As discussed with the committees of jurisdiction, we have reviewed and reported on the departments' progress with respect to various topic areas. This review, which is focused on the continuity of care for recovering servicemembers and veterans, is the latest in our body of work.[13] In this review, we are reporting on

1. the extent to which DOD and VA have resolved persistent problems facing recovering servicemembers and veterans as they navigate the recovery care continuum and
2. the reasons DOD and VA leadership have not been able to fully resolve any remaining problems.

[10]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.

[11]See *Hearing on the Federal Recovery Coordination Program: From Concept to Reality, Subcommittee on Health, Committee on Veterans' Affairs*, House of Representatives (May 13, 2011); and *Review of the VA and DOD Integrated Disability Evaluation System*, Hearing before the Committee on Veterans' Affairs, United States Senate (Nov. 18, 2010).

[12]Pub. L. No. 110-181, § 1615(d), 122 Stat. 2, 447.

[13]GAO has produced a body of work assessing progress made to improve care, management, and transition of recovering servicemembers, including: *Recovering Servicemembers: DOD and VA Have Made Progress to Jointly Develop Required Polices but Additional Challenges Remain,* GAO-09-540T (Washington, D.C.: Apr. 29, 2009); *Recovering Servicemembers: DOD and VA Have Jointly Developed the Majority of Required Policies but Challenges Remain*, GAO-09-728 (Washington, D.C.: July 8, 2009); *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); *DOD and VA Health Care: Action Needed to Strengthen Integration across Care Coordination and Case Management Programs*, GAO-12-129T (Washington, D.C.: Oct. 6, 2011).

To respond to these objectives, we interviewed the directors of the following case management and care coordination programs,[14] including

- the Army Warrior Care and Transition Command's Warrior Transition Units and the Army Wounded Warrior Program,
- the Navy Safe Harbor Program,
- the Air Force Recovery Care Program and the Air Force Wounded Warrior Program,
- the Marine Corps Wounded Warrior Regiment,
- the United States Special Operations Command's Care Coalition,
- the Federal Recovery Coordination Program, and
- VA's Operation Enduring Freedom/Operation Iraqi Freedom/ Operation New Dawn (OEF/OIF/OND) Care Management Program.

We collected data for each of these programs, such as the number of enrollees over time. (See app. I for data on enrollment and population characteristics for these programs.) We also reviewed documents describing the scope, mission, and leadership of these selected programs.

In addition, we took the following steps to determine the extent to which DOD and VA have resolved persistent problems affecting recovering servicemembers and veterans along the recovery care continuum:

- We visited a judgmental sample of 11 DOD military treatment facilities (MTF) and VA Medical Centers (VAMC) to identify variations in how care coordination and case management programs are being operated at the local level. We focused on Army and Marine Corps MTFs because, collectively, the wounded warrior programs for these military services serve more than 70 percent of the wounded, ill, and injured servicemember and veteran population. We selected facilities

[14]We selected key care coordination and case management programs that provide assistance to recovering servicemembers and veterans—many of which were created or modified after Walter Reed media reports. These programs have also been the subject of prior reviews by GAO and others.

that provide or have access to significant medical and rehabilitation resources as well as facilities that have fewer medical or rehabilitation resources. The sites we visited included MTFs at Fort Bragg (N.C.), Fort Knox (Ky.), Fort Carson (Colo.), Fort Belvoir (Va.), Fort Meade (Md.), Walter Reed National Military Medical Center (Md.), Camp Lejeune (N.C.), and Quantico (Va.), and VAMCs in Richmond, Virginia; Denver, Colorado; and the District of Columbia. At these facilities, we met with local leadership officials and the officials responsible for managing the facilities' case management and care coordination programs, and we obtained information on how these programs were working as well as the types of problems that recovering servicemembers and veterans continue to face. While at these facilities, we met with recovering servicemembers and veterans to obtain information about their experiences.

- We interviewed officials from military and veteran advocacy groups to obtain their members' perspective on any problems that persist in navigating the recovery care continuum.

- We interviewed the director of the VA Liaison for Healthcare Program to understand VA's role in assisting recovering servicemembers' transition from DOD's to VA's health care system.

- We met with members of the Recovering Warrior Task Force, reviewed relevant task force documentation, and attended its public meetings to obtain information about problems they identified that affect recovering servicemembers and veterans.

- We reviewed published and ongoing studies and GAO reports[15] describing problems that recovering servicemembers and veterans face, including issues related to the disability evaluation system and the electronic sharing of health records between DOD and VA.

To identify the reasons why DOD and VA leadership have not fully resolved any remaining problems facing recovering servicemembers and veterans, we reviewed relevant documentation to identify the roles of DOD and VA offices that coordinate or oversee case management or care coordination programs, their placement within their respective departments, and whether and how these offices monitor the

[15]See list of related GAO products.

performance of the programs we reviewed. We also obtained information about organizational and program changes, including officials' views about the potential impact of these changes. We also interviewed key DOD and VA leadership officials, such as the Deputy Assistant Secretary of Defense for Wounded Warrior Care and Transition Policy, VA's Chief of Staff, and former and current officials from the departments' coordinating and oversight offices, including the Senior Oversight Committee, DOD's Office of Wounded Warrior Care and Transition Policy, the Interagency Program Office, and the VA/DOD Collaboration Service, which is an office within VA. To obtain information about recent efforts DOD and VA have initiated to address problems facing servicemembers and veterans, we interviewed DOD and VA officials participating in these activities, including officials involved in the DOD and VA Warrior Care and Coordination Taskforce. We also reviewed the documentation available regarding the departments' recent efforts; however, we predominately relied on testimonial evidence provided by these officials.

The NDAA 2008 also requires us to certify whether we had timely access to sufficient information to make informed judgments on the matters covered by our report. We were provided sufficient information in a timely manner to assess the extent to which DOD and VA have resolved persistent problems facing recovering servicemembers and veterans as they navigate the recovery care continuum and the reasons DOD and VA leadership have not been able to fully resolve any remaining problems.

We conducted this performance audit from July 2011 through September 2012 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

Review groups identified significant problems after the media reports concerning Walter Reed. Initial efforts to respond to these problems were primarily coordinated through the Senior Oversight Committee, and DOD and VA undertook additional efforts to respond to these problems.

Review Groups Identified Problems across the Recovery Care Continuum

Following the revelations at Walter Reed, several review groups noted significant problems that may arise during servicemembers' recovery from wounds, illnesses, and injuries.[16] Some of these problems involve the provision of appropriate medical care, while others involve the acquisition of needed DOD and VA benefits. In 2007, one of the review groups, the President's Commission on Care for America's Returning Wounded Warriors—commonly referred to as the Dole-Shalala Commission—noted that recovering servicemembers depend on the effective and efficient provision of medical services and benefits across the recovery care continuum,[17] which is separated into three phases:

- *recovery*, when wounded, ill, and injured servicemembers are stabilized and receive acute inpatient medical treatment at an MTF, VAMC, or private medical facility;
- *rehabilitation*, when recovering servicemembers with complex trauma, such as missing limbs, receive medical and rehabilitative care; and
- *reintegration*, when servicemembers either return to active duty or to the civilian community as veterans.

A recovering servicemember or veteran may not experience the recovery care continuum as a linear process, and may move back and forth across the continuum over time, depending on his or her medical needs. For example, a servicemember who has transitioned to the rehabilitation phase may go back to the recovery phase if there is a need to return to an MTF to obtain acute medical care, such as a surgical procedure.

Initial Efforts to Address Problems Were Coordinated by the Senior Oversight Committee

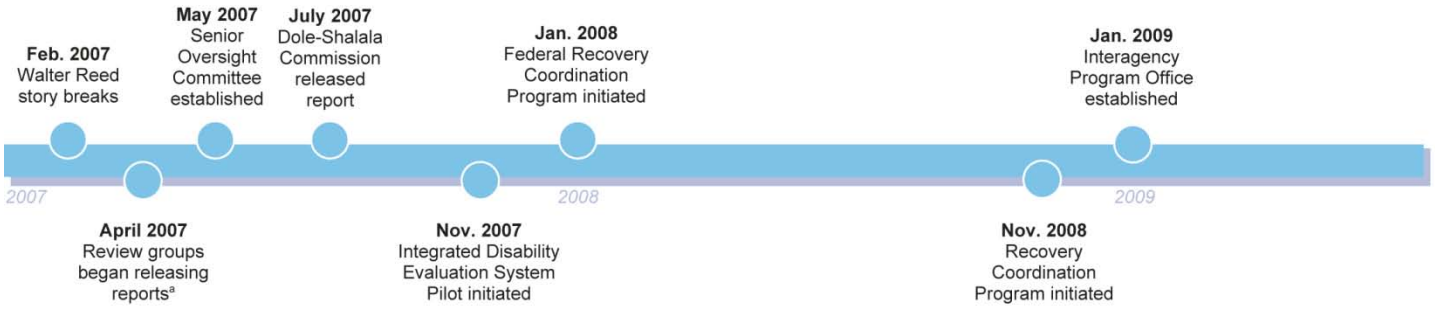
DOD and VA took a number of steps to address the problems identified by the review groups that investigated the issues raised by the Walter Reed media reports. As an initial step, the departments established the

[16]The terms "wounded, ill, and injured" are used by DOD and VA as general classifications of servicemembers or veterans with regard to their medical condition. "Wounded" generally means any injury inflicted by an external force during combat. "Ill and injured" refers to any illness or injury in the line of duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

[17]President's Commission on Care for America's Returning Wounded Warriors, *Serve, Support, Simplify*.

Senior Oversight Committee to coordinate and oversee DOD's and VA's efforts to jointly resolve these problems. Through this committee, DOD and VA created programs and initiatives to assist recovering servicemembers and veterans as they navigate the recovery care continuum. Key efforts included the establishment of the integrated disability evaluation system (IDES), the Federal Recovery Coordination Program (FRCP), the Recovery Coordination Program (RCP), and the Interagency Program Office. (See fig. 1.)

Figure 1: Timeline of Key Events in the 2-Year Period Following the Walter Reed Army Medical Center Media Reports

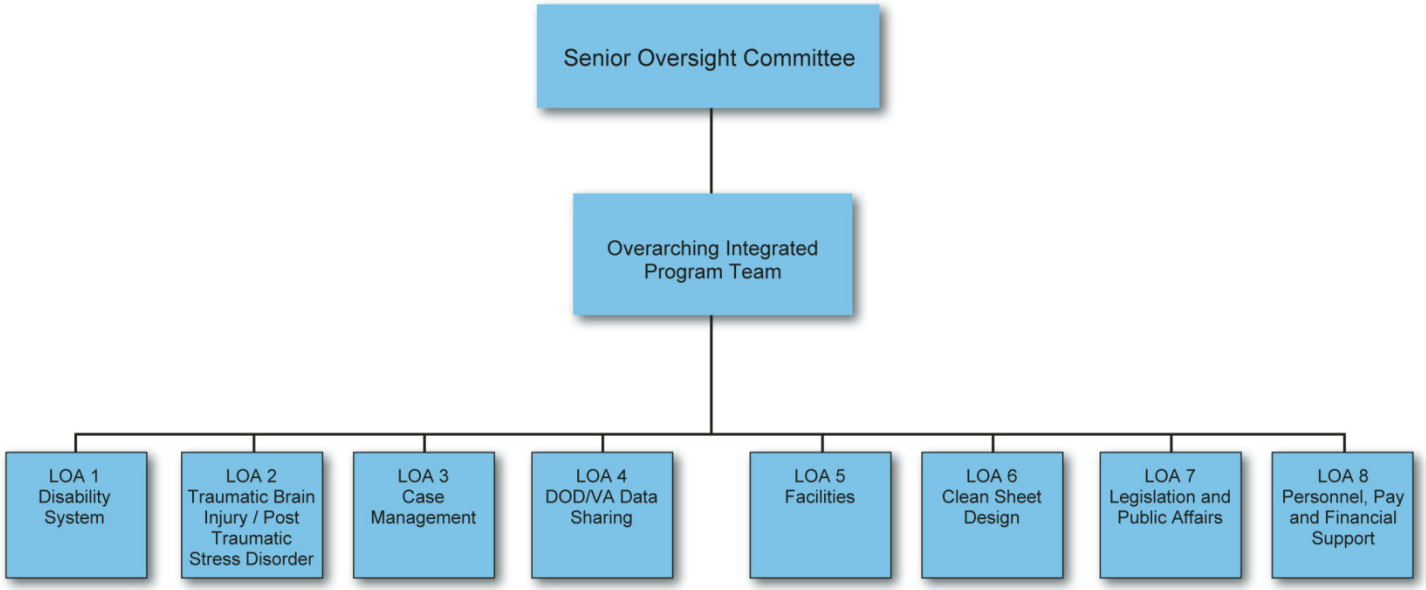


Source: Department of Defense.

[a]Several review groups, including the Dole-Shalala Commission, were tasked with investigating the problems reported at Walter Reed Army Medical Center in Washington, D.C., and identifying recommendations. The other review groups included the Independent Review Group, *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* (Arlington, Va.: April 2007); Task Force on Returning Global War on Terror Heroes, *Report to the President* (April 2007); Veterans' Disability Benefits Commission, *Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century* (October 2007); and Department of Defense Office of the Inspector General, Department of Veterans Affairs Office of the Inspector General, *DOD/VA Care Transition Process for Service Members Injured in OIF/OEF* (June 2008).

Senior Oversight Committee. The Senior Oversight Committee was responsible for ensuring that the recommendations—which totaled more than 600 from the various review groups—were properly reviewed, coordinated, implemented, and resourced. Supporting the Senior Oversight Committee was an Overarching Integrated Product Team, the membership of which included the Assistant Secretaries of Defense, the military departments' Assistant Secretaries for Manpower and Reserve Affairs, and various senior officials from DOD and VA. This team coordinated, integrated, and synchronized the work of the eight "Lines of Action" (LOA) that focused on specific issues, including case management, disability evaluation systems, and data sharing between DOD and VA. (See fig. 2.)

Figure 2: Original Senior Oversight Committee Organizational Chart, including the Lines of Action (LOA) Workgroups



Source: Senior Oversight Committee.

Each LOA included representation from DOD, including each military service, and VA. They performed the bulk of the work to address the issues and recommendations of the various review groups, including establishing plans, setting and tracking milestones, and identifying and enacting early and short-term solutions. More specifically, the LOAs were as follows:

- **LOA 1**—Disability Evaluation: Responsible for addressing efforts to reform the DOD and VA disability evaluation systems.
- **LOA 2**—Traumatic Brain Injury (TBI)/Post Traumatic Stress Disorder (PTSD): Responsible for addressing issues related to TBI/PTSD.
- **LOA 3**—Case Management: Responsible for addressing issues related to the care, management, and transition of recovering servicemembers from recovery to rehabilitation and reintegration.
- **LOA 4**—DOD/VA Data Sharing: Responsible for addressing issues regarding the electronic exchange of DOD and VA health records.
- **LOA 5**—Facilities: Responsible for addressing issues relating to military and VA medical facilities.

- **LOA 6**—"Clean Sheet" Review: Developed recommendations to improve care and benefits without the constraints of existing laws, regulations, organizational roles, personnel constraints, or budgets.

- **LOA 7**—Legislation and Public Affairs: Responsible for addressing legal and other issues for policy development.

- **LOA 8**—Personnel, Pay, and Financial Support: Responsible for addressing compensation and benefit issues.

Some of the key efforts initiated out of the LOAs included the establishment of an integrated disability evaluation system, care coordination programs, and steps towards the electronic exchange of DOD and VA health records—a responsibility that was later assumed by the Interagency Program Office.

DOD/VA Integrated Disability Evaluation System. Through LOA 1, DOD and VA jointly began to develop and pilot IDES to improve the disability evaluation process by eliminating duplication in DOD's and VA's separate evaluation systems and expediting the receipt of VA benefits. Specifically, IDES merges DOD's and VA's separate medical exams for servicemembers into a single exam process; consolidates DOD's and VA's separate disability rating decisions into a single VA rating decision; and provides staff to perform outreach and nonclinical case management and explain VA results and processes to servicemembers. By October 2011, DOD and VA had fully deployed IDES at 139 MTFs in the United States and several other countries.

Care Coordination Programs. LOA 3 took the lead role in addressing problems with uncoordinated case management for recovering servicemembers and veterans through the establishment of two care coordination programs—the FRCP and the RCP. The FRCP was based on a recommendation from the Dole-Shalala Commission that a single individual—a recovery coordinator—would work with existing DOD and VA case managers to ensure that servicemembers had the resources needed for their care. LOA 3 designed the FRCP to assist "severely" wounded, ill, and injured OEF and OIF[18] servicemembers, veterans, and

[18]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 (OND).

their families with access to care, services, and benefits. This population includes servicemembers and veterans who suffer from traumatic brain injuries, amputations, burns, spinal cord injuries, visual impairment, and PTSD. The program uses federal recovery coordinators to monitor and coordinate clinical services, including facilitating and coordinating medical appointments, and nonclinical services, such as providing assistance with obtaining financial benefits or special accommodations, needed by program enrollees and their families. Federal recovery coordinators, who are senior-level registered nurses and licensed clinical social workers, were intended to serve as the single point of contact among all of the case managers of DOD, VA, and other governmental and nongovernmental programs[19] that provide services directly to servicemembers and veterans. Although the FRCP was designed as a joint program, it is administered by VA, and the federal recovery coordinators are VA employees.

LOA 3 subsequently developed the RCP in response to a requirement in the NDAA 2008. The RCP is a DOD-specific program that uses recovery care coordinators to coordinate nonclinical services and resources for "seriously" wounded, ill, and injured servicemembers who may return to active duty, unlike those categorized as "severely" wounded, ill, and injured, who are not likely to return to duty and would be served by the FRCP. The military services were responsible for separately implementing the RCP through each of their existing wounded warrior programs as a means of providing care coordination services to program enrollees.

Electronic Sharing of Health Records. LOA 4 was focused on addressing issues related to the electronic exchange of DOD and VA health records. However, this effort was superseded by the NDAA 2008,[20] which required the establishment of the Interagency Program Office to serve as a single point of accountability for both departments in the development and implementation of interoperable electronic health records.[21] Although DOD and VA retained the responsibility for the development and

[19]Federal Recovery Coordinators are intended to coordinate all care and benefits for their enrollees, including coordinating assistance from private sector programs.

[20]Pub. L. No. 110-181, § 1635, 122 Stat. 3, 460-63.

[21]Interoperability is the ability of two or more systems or components to exchange information and to use the information that has been exchanged.

management of the information technology systems, the Interagency Program Office was responsible for ensuring the implementation of an electronic health records system or capabilities that allowed for the complete sharing of health care information for the provision of clinical care. In October 2011, the Interagency Program Office also became accountable for DOD's and VA's work on developing an integrated electronic health records system that both departments would use for their beneficiaries.

Additional Efforts by DOD and VA to Address Problems Facing Recovering Servicemembers and Veterans

In addition to the Senior Oversight Committee's efforts, DOD, its military services, and VA developed or modified a number of programs and initiatives to assist recovering servicemembers and veterans in navigating the recovery care continuum.

Military Services' Wounded Warrior Programs. The military services' wounded warrior programs were established to assist recovering servicemembers[22] during their recovery, rehabilitation, and initial reintegration back to active duty or to civilian life. Most of these programs provide nonclinical case management services to the recovering servicemembers; that is, they help to resolve issues related to finances, benefits and compensation, administrative and personnel paperwork, housing, and transportation. In addition, the wounded warrior programs serve as the central point of access to other types of services or resources that support recovering servicemembers, such as clinical case management, care coordination, and career, education, and readiness services. (See table 1.) If a wounded warrior program does not directly provide a service or resource, it can facilitate servicemembers' access to that service or resource. Although the wounded warrior programs were intended mainly to provide services to recovering servicemembers, all but one of the programs continue to assist individuals after they have transitioned to veteran status.

[22]Recovering servicemembers include those who are wounded, ill, or injured in a combat zone or due to an incident that occurred in the United States or overseas while in active status.

Table 1: Military Services' Wounded Warrior Programs: Types of Services Provided

Military services' wounded warrior program	Types of services provided			
	Clinical case management	Nonclinical case management	Care coordination	Career, education, and readiness[a]
Army				
Army Warrior Care and Transition Program: Warrior Transition Units and Community-Based Warrior Transition Units[b]	●	●		●
Army Warrior Care and Transition Program: Army Wounded Warrior Program			●	●
Navy/Coast Guard				
Navy Safe Harbor Program			●	●
Air Force				
Air Force Wounded Warrior Program		●		●
Air Force Recovery Care Program			●	●
Marine Corps				
Marine Corps Wounded Warrior Regiment		●	●	●
United States Special Operations Command				
United States Special Operations Command's Care Coalition		●	●	●

Source: GAO analysis of military services' wounded warrior program information.

Notes: The characteristics listed in this table are general characteristics of each program; individual circumstances may affect the services provided by specific programs. For the purposes of this report, clinical case management services include services such as scheduling medical appointments and providing outreach education about medical conditions such as PTSD. Nonclinical case management services include services such as assisting servicemembers with financial benefits and accessing accommodations for families.

[a]Career, education, and readiness services are provided through programs such as the Warrior Athlete Reconditioning Program and DOD's Operation Warfighter Program and Education and Employment Initiative. The Warrior Athlete Reconditioning Program enhances recovery by engaging wounded, ill, and injured servicemembers in individualized physical and cognitive activities outside of traditional therapy settings. Operation Warfighter is a federal internship program for wounded, ill, and injured servicemembers that places them in supportive work settings to prepare them to return to active duty or to transition into jobs in the government or private sector. To access the Operation Warfighter Program a recovering servicemember has to be enrolled in a military service wounded warrior program. In addition, the military services' wounded warrior programs facilitate access to other programs such as the Warrior Athlete Reconditioning Program.

[b]A warrior transition unit is technically an Army brigade, battalion, or company that provides command and control, administrative support, primary care and case management and other services to support soldiers and their families during recovery, rehabilitation, and transition back to active duty or to civilian life. For the purposes of this report, we are categorizing it as a wounded warrior program.

VA Transition Programs. VA's Liaison for Healthcare Program and its OEF/OIF/OND Care Management Program assist recovering servicemembers with transitioning from DOD's to VA's health care system. As of August 2012, the Liaison for Healthcare Program employed 33 liaisons at 18 MTFs nationwide.[23] After a DOD or VA treatment team determines that a recovering servicemember is medically ready to transition to a VAMC, a VA liaison facilitates the transfer from an MTF to a VAMC closest to their homes or to the most appropriate locations for the specialized services their medical condition requires. VA liaisons follow recovering servicemembers as they enter the VA health care system, ensuring that their first VA appointments are scheduled. Thereafter, the VA OEF/OIF/OND Care Management Program team assigned to each recovering individual coordinates the individual's care at the VAMC and provides ongoing follow-up.[24] Each VAMC has an OEF/OIF/OND Care Management Program team in place to coordinate patient care activities.

[23]According to a VA official, in fiscal year 2013, VA will hire 10 additional liaisons and expand the number of MTFs where liaisons will be located to 21.

[24]The VA OEF/OIF/OND Care Management Program screens all returning combat veterans to determine if case management services are required.

DOD and VA Have Not Fully Resolved Persistent Problems with Case Management and Care Coordination, Disability Evaluation Systems, and Electronic Sharing of Health Records

Recovering Servicemembers and Veterans Do Not Always Have Access to the Case Management and Care Coordination Programs Designed to Assist Them

Recovering servicemembers' access to case management and care coordination programs has been impeded by two main factors—(1) the limited ability to identify and refer those servicemembers who could benefit from enrollment in the programs along with officials' reluctance to refer them, and (2) variations in eligibility criteria among the military services' wounded warrior programs, resulting in access disparities for similarly situated recovering servicemembers.[25]

Recovering Servicemembers Are Not Always Identified and Referred to Programs That May Benefit Them

We found that referrals may be lacking or delayed (1) from military service unit commanders to wounded warrior programs; (2) from wounded warrior programs to the FRCP; and (3) for certain groups of servicemembers, such as those with "invisible injuries" as well as members of the National Guard and Reserve.

Referral to the military services' wounded warrior programs. The military services' wounded warrior programs primarily use referrals to identify recovering servicemembers that might be eligible for enrollment. However, we found that the methods for referral, which include casualty reports and direct referrals, are imprecise, such that all servicemembers

[25]Not all wounded, ill, and injured servicemembers and veterans are eligible for access to these programs. Most military service wounded warrior programs only serve those who are "seriously" and "severely" wounded, ill, and injured.

who could benefit from being enrolled in these programs are not necessarily identified and referred.

Officials from three wounded warrior programs told us that casualty reports are the primary method for receiving referrals.[26] Casualty reports are initial alerts to military personnel, including wounded warrior program officials, that a servicemember has been injured. These reports can be initiated by unit commands or other military personnel as a method of referral to the wounded warrior programs. However, wounded warrior program officials from four wounded warrior programs told us that casualty reports are not created after every injury or may be created late in a servicemember's recovery. In particular, some of these officials said that military service unit command staff may delay or not create casualty reports for servicemembers not injured in combat, such as for injuries that occur stateside or while on leave, because servicemembers' units may not find out about such incidents immediately.

According to wounded warrior program officials, referrals to wounded warrior programs also can be made directly from unit command staff and other sources, including staff at the MTF where a recovering servicemember is receiving treatment or through self-referrals.[27] These referrals also may not be made in a timely manner. Specifically, unit command staff may not refer potentially eligible servicemembers to wounded warrior programs because either they want to "take care of their own" or because they are not well informed about the programs and the services they provide, according to wounded warrior program officials. For example, a wounded warrior program official told us that he identified a servicemember who had sustained a gunshot wound to the head but was still assigned to his combat unit. This official explained that even though the servicemember was receiving treatment, he could have benefited from being enrolled in the wounded warrior program because of the additional assistance it provides, including nonclinical case management and care coordination services. Additionally, several recovering servicemembers told us that they encountered difficulties in

[26]Casualty reports, including personnel casualty reports, are electronic messages that contain casualty information including type of injury, where the injury occurred, and location of the injured servicemember.

[27]We found that referrals by unit command staff are most likely, because they have the most knowledge about servicemembers' conditions, injuries, and treatment locations.

their recovery as a result of staying in their units and not being referred to a wounded warrior program earlier. For example, a recovering servicemember told us that despite having been recently discharged from a hospital for arm injuries, he was required to operate a floor buffing machine in his unit, which was difficult for him as a result of his injuries. He did not receive rehabilitative treatment for his injuries until he was assigned to a wounded warrior program. Furthermore, we found that most of the military services' wounded warrior programs do not always track the number of referrals to their programs, including data on whether or not servicemembers referred to the programs were actually enrolled. (See table 14 in app. I for additional information about referral data.) Without this information, it is not clear whether all those who could benefit from a wounded warrior program are being enrolled.

Referral to the FRCP. In addition to problems with referrals to wounded warrior programs, wounded warrior program officials sometimes delay or fail to make referrals of potentially eligible servicemembers to the FRCP, which coordinates care across the departments and throughout the recovery care continuum. As we have previously reported, the FRCP relies predominantly on referrals from other sources, including wounded warrior program officials and clinical treatment teams, because it does not have a systematic way to identify potential enrollees.[28] Referrals to the FRCP are important because federal recovery coordinators are intended to provide continuity of care throughout servicemembers' recovery, starting with their initial treatment at an MTF and throughout the recovery care continuum. They can also assist in facilitating recovering servicemembers' access to VA services and benefits while servicemembers are still on active duty, according to VA officials.[29] However, we found that officials from wounded warrior programs view the jointly created and established FRCP as a VA program and, therefore, delay their referrals until it is certain that the servicemember will become a veteran.

Referrals for certain servicemember populations. We found that certain servicemember populations may be at greater risk for not being identified for DOD and VA case management and care coordination programs.

[28]GAO-11-250.

[29]Servicemembers are eligible for certain VA benefits while still on active duty, including access to treatment at specialized VA facilities and grants for home and car modifications.

Specifically, according to wounded warrior program officials, servicemembers who have undiagnosed, "invisible" wounds, such as PTSD and TBI, may be at greater risk of not being referred to a wounded warrior program or the FRCP until it becomes apparent that the servicemember cannot be deployed. For example, a servicemember told us that although he was experiencing anxiety every time he put on his uniform, it was not until he had a severe anxiety attack, as a result of his PTSD, that he was hospitalized and then referred to a wounded warrior program. According to officials representing military advocacy organizations, National Guard and Reserve servicemembers may be particularly reluctant to identify injuries and illnesses because they are eager to return home and do not want to be delayed at the installation for an evaluation of any conditions they may have. However, these officials said that when these servicemembers have been deactivated and problems manifest themselves later on, they may experience difficulties establishing that their injuries or illnesses are a result of their service in the military, which could make it difficult for them to access services and programs provided by DOD and VA.

Recovering Servicemembers' Access to the Military Services' Wounded Warrior Programs Is Likely to Be Inequitable Due to Variations in Their Eligibility Criteria

Because of variations in eligibility criteria among the military services' wounded warrior programs, DOD cannot assure that similarly situated servicemembers have equitable access to these programs, leading to disparities in the level of assistance provided across the military services. (See table 2.) For example, servicemembers can only be eligible for the Air Force Wounded Warrior Program if they have a combat-related injury or illness, whereas servicemembers with combat or non-combat-related injuries or illnesses can be eligible for the Army's Warrior Transition Units.

Table 2: Eligibility Criteria for Military Services' Wounded Warrior Programs

Military services' wounded warrior program	Eligibility criteria
Army	
Army Warrior Care and Transition Program: Warrior Transition Units and Community-Based Warrior Transition Units	Serves servicemembers who require at least 6 months of rehabilitative care and complex medical management[a]
Army Warrior Care and Transition Program: Army Wounded Warrior Program	Serves "severely" wounded, ill, and injured servicemembers in the warrior transition units who have, or are expected to receive, a physical evaluation disability rating[b] of 30 percent or greater in one or more specific categories or a combined rating of 50 percent or greater for conditions that are combat-related
Navy/Coast Guard	
Navy Safe Harbor Program	Serves "seriously" wounded, ill, and injured sailors and coast guardsmen not likely to return to duty in 180 days and likely to be medically retired, as well as high-risk wounded, ill, and injured sailors that have less serious health concerns
Air Force	
Air Force Wounded Warrior Program	Serves servicemembers with a combat-related injury or illness that requires long-term care[c] as well as examinations to determine fitness for duty
Air Force Recovery Care Program	Serves all servicemembers who are "seriously"[d] ill and injured either in a combat-related incident or in a non-combat-related incident
Marine Corps	
Marine Corps Wounded Warrior Regiment	Serves wounded, ill, and injured servicemembers who require more than 90 days of medical treatment or rehabilitation. A recovering servicemember also may be assigned to the Wounded Warrior Regiment when: • the unit command cannot support transportation requirements to the military treatment facility, • the Marine cannot serve a function in the unit command due to his/her injuries or illness, or • the Marine has three or more medical appointments per week.
United States Special Operations Command	
United States Special Operations Command's Care Coalition	Assists Special Forces servicemembers who are • wounded, injured, or ill evacuated from a combat area; • wounded, injured, or ill returned to duty or redeployed; or • injured or ill whose injury or illness is not combat-related.

Source: GAO analysis of military services' wounded warrior program information.

[a]Reservists in need of definitive medical treatment for conditions caused or aggravated while on active duty or training status are also eligible.

[b]After medical examinations are conducted to determine a servicemember's ability to continue to serve in the military, decisions are made about the servicemember's fitness for duty and about a servicemember's disability rating, which determines the DOD and VA benefits he or she can receive.

[c]According to an Air Force Wounded Warrior Program official, the program does not define long-term care or provide criteria related to the time needed for recovery.

[d]According to an Air Force Recovery Care Program official, a servicemember is designated as "seriously' ill or injured on the basis of a medical diagnosis made by Air Force medical staff when referred to the program; the program does not make this designation.

As a result of these differences in eligibility criteria, recovering servicemembers in one military service may qualify for entry in their wounded warrior program while similarly situated servicemembers in another military service do not have access to their program. Consequently, according to wounded warrior program officials, some recovering servicemembers do not have access to services that would otherwise be available to them, including the RCP and Operation Warfighter.[30] Additionally, because wounded warrior programs facilitate access to other programs and services, including the VA Liaison for Healthcare Program and the Warrior Athlete Reconditioning Program,[31] not being eligible for a particular wounded warrior program could preclude a servicemember from receiving the services of these other programs.[32] Military coalition officials who advocate for recovering servicemembers and their families told us the lack of standardization across similar programs, such as the military services' wounded warrior programs, is one of the main reasons recovering servicemembers "fall through the cracks" or do not get the services that they need when they are navigating the recovery care continuum.

DOD is aware of inconsistencies in eligibility criteria among the military services' wounded warrior programs and the potential for disparities in the provision of services and assistance that may result. DOD has not taken action to correct this, however, despite the identification of this issue as a potential problem for recovering servicemembers by a congressionally mandated DOD task force. Specifically, in its 2011 annual report to

[30]Operation Warfighter is a DOD-sponsored internship program for wounded, ill, and injured servicemembers who are at MTFs. Operation Warfighter is designed to provide recuperating servicemembers with meaningful activity outside of the hospital environment that assists in their wellness and offers a formal means of transition back to the civilian workforce. Open to active duty, National Guard and Reserve components, Operation Warfighter represents an opportunity for servicemembers in a medical hold status to build their resumes, explore employment interests, develop job skills, and gain valuable work experience that will prepare them for the future (see www.militaryhomefront.dod.mil).

[31]The Warrior Athlete Reconditioning program provides recreational activities and competitive athletic opportunities to recovering servicemembers to improve their physical and mental quality of life throughout the continuum of recovery and transition. The program is designed to enhance recovery by engaging recovering servicemembers in physical and cognitive activities outside of traditional therapy settings.

[32]Servicemembers do not have to be enrolled in or attached to a wounded warrior program to participate in the VA Liaison for Healthcare Program or the Warrior Athlete Reconditioning Program.

congressional committees, the Recovering Warrior Task Force noted that as a result of differences in eligibility criteria among the military services, certain subpopulations of recovering servicemembers may be at a disadvantage.[33] In response to this report, DOD stated that although there are no DOD-wide criteria for entry into wounded warrior programs, the individual military services already have policies in place as a result of the flexibility given to them by DOD.

Delays in DOD's and VA's Integrated Disability Evaluation System Persist, Limiting Recovering Servicemembers' Ability to Plan for Their Future

Although IDES provides improved timeliness over the separate DOD and VA disability evaluation systems, processing times have continued to increase since its implementation in November 2007, resulting in frustration and uncertainty for servicemembers going through the process. In a May 2012 hearing,[34] we testified that the average number of days for servicemembers to complete the IDES process and receive VA benefits increased from 283 in fiscal year 2008 to 394 in fiscal year 2011 for active duty cases (compared to the goal of 295 days) and from 297 to 420 for reserve cases, respectively (compared to the goal of 305 days).[35]

While there are many reasons for increases in processing times,[36] recovering servicemembers and wounded warrior program officials told us that extended timelines in the IDES process and the lack of a firm completion date limits recovering servicemembers' ability to plan for their future. Several recovering servicemembers said that not being given a timeframe for completion of the IDES process is frustrating, particularly when their own providers are unable to obtain additional information on

[33]Recovering Warrior Task Force, Department of Defense Recovering Warrior Task Force 2010-2011 Annual Report.

[34]GAO, *Military Disability System: Preliminary Observations on Efforts to Improve Performance*, GAO-12-718T (Washington, D.C.: May 23, 2012). For additional information about IDES, see reports listed on the related products page.

[35]The fiscal year 2008 and 2011 averages include only those servicemembers who completed IDES and received VA benefits. The averages do not include other outcomes, such as servicemembers who were found fit and returned to duty. Not all reservists complete the VA benefit phase and thus DOD does not apply the 30-day goal for this phase to reservists. For those reservists who do go through the VA benefits phase, this time is reflected in the overall time in IDES.

[36]As we have previously testified, other reasons that could impact the increase in IDES processing times include large case loads and insufficient staff to complete a stage of IDES in a timely manner.

the status of their case. For example, a servicemember told us that after going through the IDES process, receiving a rating, and filing an appeal over a year ago, he still did not know the status of his case, negatively affecting his ability to plan for his future. Similarly, a wounded warrior program official also told us that her program has had several servicemembers lose job opportunities because they applied for positions thinking that they would be through the IDES process by a certain date, but when that date was pushed back, the employers rescinded their offers.

Wounded warrior program officials from some of the sites we visited told us that extended waiting periods resulting from the disability process also may lead to some recovering servicemembers engaging in negative behavior, including drug use. Wounded warrior program officials told us that after waiting for so long in the wounded warrior barracks due to the lengthy disability process, servicemembers can get depressed, resist or just stop going to medical appointments, and stop working on their recovery. Similarly, the DOD Inspector General has reported that lengthy IDES processing times has contributed to a negative and even counterproductive environment, which was not conducive to servicemembers' recovery and transition.[37] To prevent these problems, we found that two wounded warrior programs require recovering servicemembers to participate in programs such as the Warrior Athlete Reconditioning Program and Operation Warfighter. A recovering servicemember told us that soon after being assigned to the wounded warrior program, he was referred to the Warrior Athlete Reconditioning Program, which gave him something to do other than "sitting around." Another recovering servicemember told us that the Warrior Athlete Reconditioning Program is an effective motivator for recovery.

Conversely, the servicemembers could take actions that may impact their own processing times in IDES and, therefore, their length of stay in a wounded warrior program. We found that some servicemembers may appeal their disability decisions to prolong their own recovery and transition out of the military. According to wounded warrior program

[37]Department of Defense Office of the Inspector General, Special Plans and Operations, *Assessment of DOD Wounded Warrior Matters-Camp Lejeune* (March 2012) and Department of Defense Office of the Inspector General, Special Plans and Operations, *Assessment of DOD Wounded Warrior Matters-Wounded Warrior Battalion-West Headquarters and Southern California Units* (August 2012).

officials from some of the sites we visited, some servicemembers resist their transfer out of the wounded warrior program and the military because they want to continue to take advantage of the opportunities and services available to them, including the financial security of a regular paycheck. For example, a wounded warrior program official and a VA official told us that some servicemembers will purposefully miss appointments to delay the IDES process because they feel that they are not ready to leave the program.

DOD and VA Have Yet to Develop Sufficient Capability to Electronically Share Health Records, Potentially Delaying Servicemembers' Receipt of Coordinated Care and Benefits

The departments have not yet developed sufficient capability to electronically share servicemembers' and veterans' complete health records, which can delay the receipt of care and benefits for recovering servicemembers and veterans. As we have previously reported, for over a decade DOD and VA have undertaken several efforts to improve the ability of their information technology systems to electronically share health records.[38] For example, the Federal Health Information Exchange, which was started in 2001 and completed in 2004, allows DOD to electronically transfer servicemembers' health information to VA when they leave active duty. In addition, the departments' Bidirectional Health Information Exchange was established in 2004 to allow clinicians in both departments to view limited health information on patients who receive care from both departments. More recently, the departments have undertaken two new joint initiatives, the Virtual Lifetime Electronic Record and an integrated electronic health records system, in an effort to increase electronic health record interoperability and modernize their systems.

We found that although DOD and VA care providers were expected to have access to some electronic health record information across the departments, the DOD and VA care providers that we spoke to still did not have the ability to electronically share complete health records for recovering servicemembers who were transferring between DOD's and VA's health care systems, and therefore they had to use other methods.

[38]See, for example, GAO, *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); *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 Should Remove Barriers and Improve Efforts to Meet Their Common System Needs*, GAO-11-265 (Washington, D.C.: Feb. 2, 2011).

For example, wounded warrior program and VA officials told us that they had to resort to copying and faxing recovering servicemembers' health records to VAMC staff in preparation for a servicemember's transition from DOD's to VA's health care system because there was not an automatic, electronic way to transfer them. In addition to copying and faxing health records, according to VA officials we spoke with, DOD and VA staff may hold a video-teleconference between the transferring MTF and receiving VA health care facilities to exchange information.

In addition, wounded warrior program and VA officials who help servicemembers transition from DOD to VA told us that they only share with VA facilities the health records necessary for the treatment of a recovering servicemember's current condition. As a result, servicemembers' and veterans' complete health records are not always shared between departments when transferring facilities, and ultimately, the responsibility to collect and provide a complete health record to the VA facility can fall on the recovering servicemember and veteran.[39] A VA official told us that this process can be complicated because DOD separately maintains servicemembers' inpatient, outpatient, and behavioral health records and does not have a single database that can identify all of the medical facilities where a servicemember received treatment. Further, according to VA and DOD officials, delaying the collection and assembly of a servicemember's complete medical history until the start of the disability process could result in servicemembers having to be reexamined when they are demobilized, needing to establish that their injuries were connected to their time in the military, thus possibly delaying a servicemember's or veteran's receipt of VA benefits.

Both departments have needed to create programs and provide staff to assist recovering servicemembers during their transition from a DOD MTF to a VAMC. For example, VA Liaisons and DOD nurse case managers help recovering servicemembers transition from DOD to VA by assembling their health records and sharing them with the VAMC where the servicemember will be receiving treatment. According to DOD and VA

[39]DOD policy requires that, upon retirement, discharge, or end of active obligated service, records be transferred to the VA Records Management Center if the servicemember is not applying for VA benefits or the appropriate VA Regional Office if the servicemember has applied or plans to apply for VA benefits. Department of Defense, *Service Treatment Record* (*STR*) and *Non-Service Treatment Record* (*NSTR*) *Life Cycle Management*, DOD Instruction 6040.45, Enclosure 3, (Oct. 28, 2010). The transfer of records from DOD to a VA medical facility is achieved under different procedures.

staff that assist servicemembers in their transition from one system to another, DOD nurse case managers at installations that do not have VA Liaisons do not always have the same knowledge of VA services and benefits, and may not be informed of the appropriate referral methods or contacts used by VA Liaisons to provide a servicemember with a seamless transition to a VAMC. A DOD official told us that at locations where the VA Liaison program is not available, the transition process for recovering servicemembers from DOD to VA is more difficult. This official understood how to properly transfer servicemembers' records from the DOD facility to the receiving VA facility only because of past VA experience.

DOD and VA Have Not Fully Resolved Long-standing Problems Due to Deficiencies in Leadership and Oversight, Resources, and Collaboration

Lack of Leadership and Oversight Has Limited DOD's and VA's Ability to Effectively Manage Programs for Recovering Servicemembers and Veterans

The lack of leadership and program oversight has limited DOD's and VA's ability to effectively manage programs created to serve recovering servicemembers and veterans. Two bodies established to oversee these programs, the Senior Oversight Committee and the Office of Wounded Warrior Care and Transition Policy (WWCTP),[40] lacked consistent leadership attention and oversight capabilities. In addition, DOD does not have a central office that oversees or collects common data on the military services' wounded warrior programs.

Strength of Senior Oversight Committee Leadership Waned

Before the Senior Oversight Committee was consolidated into the Joint Executive Council[41] in early 2012, it had already lost many of the characteristics that had made it a strong decision making and oversight body for the programs and initiatives created to assist recovering servicemembers and veterans. What had originally made it strong were

[40]In 2008, DOD established the Office of Transition Policy and Care Coordination which was renamed the Office of Wounded Warrior Care and Transition Policy (WWCTP). Reporting to the Under Secretary of Defense for Personnel and Readiness, up until June 2012, WWCTP served as a single, centralized office for developing policy, coordinating interagency collaboration, and conducting outreach to address the broad set of issues confronted by wounded, ill and injured service members and their families. WWCTP also provided program oversight for the integrated disability evaluation system process and care coordination.

[41]The Joint Executive Council was established by law in November 2003 to provide senior leadership for collaboration and resource sharing between DOD and VA. Through a joint strategic planning process, the Joint Executive Council recommends to the Secretaries the strategic direction for the joint coordination and sharing efforts between the two departments and oversees the implementation of those efforts.

- high-level leadership participation without substitution of lower-ranking officials,
- rapid policy development and quick decision making, and
- rigorous monitoring to hold the military services and the two departments accountable for needed actions.

Sustaining the Senior Oversight Committee's original momentum over time became difficult, and its waning influence and effectiveness became evident in a number of ways:

- Starting in December 2008, the Senior Oversight Committee experienced leadership changes, including the departure of its cochairs, the Deputy Secretaries,[42] as well as turnover in some of its key staff. According to a former Senior Oversight Committee executive, the personal commitment and strong relationship between the Deputy Secretaries who initially cochaired the Senior Oversight Committee served as a unifying and confidence building force that was not replicated by subsequent leadership, while leadership turnover in the DOD offices supporting the Senior Oversight Committee negatively impacted its ability to function effectively.
- As we have previously reported, the Senior Oversight Committee also began to encounter challenges when DOD "disrupted the unity of command" by changing the organizational structure of the committee and realigning and incorporating the committee's staff and responsibilities into existing or newly created DOD and VA offices, such as WWCTP.[43] Officials formerly involved with the committee told us that the new staffing arrangement did not adequately support the committee's efforts, and VA did not provide full-time staff members to support the committee, as it had in the past. Later in October 2008, VA established the Office of VA/DOD Collaboration Services, and VA supported Senior Oversight Committee efforts, along with broader collaboration efforts, through this separate office.

[42]With the change of presidential administration in January 2009, the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs were replaced.

[43]GAO-09-728.

- The committee began meeting less frequently. For example, in contrast to weekly meetings held during its initial year of operation, in fiscal year 2011, the committee met less than 11 hours in total.

- Top DOD leadership no longer consistently attended Senior Oversight Committee meetings. According to a former Senior Oversight Committee official, the second Deputy Secretary of Defense to cochair the committee sent the Deputy Undersecretary of Defense for Personnel and Readiness to represent DOD in his place.

- The Senior Oversight Committee no longer made relatively quick decisions. According to former Senior Oversight Committee executive and support staff, frequent substitutions by lower-ranking officials at Senior Oversight Committee meetings no longer allowed for quick decision making and transformed Senior Oversight Committee meetings into informational briefings.

- The Senior Oversight Committee no longer tracked or monitored progress of its policy initiatives or assigned tasks. According to a former LOA cochair and a cognizant support staff member, by 2011 the Senior Oversight Committee was no longer routinely using a tracking mechanism to hold the departments accountable for completing appointed tasks. Later that year, the Recovering Warrior Task Force reported that the Senior Oversight Committee no longer had a formal mechanism for assessing the status of the committee's initiatives and goals, leaving no way to determine whether initiatives or goals had been partially or fully implemented or met.

In its September 2011 report, the Recovering Warrior Task Force recommended combining the Senior Oversight Committee and Joint Executive Council to improve effectiveness and reduce redundancies as both entities had similar membership and operating structures. In January 2012, the Joint Executive Council cochairs agreed to consolidate the two groups. The Senior Oversight Committee's working groups for care coordination and the integrated disability evaluation system were realigned within the Joint Executive Council, and a Wounded, Ill, and Injured Council was established under the Joint Executive Council to oversee emerging issues for recovering servicemembers and veterans.

Whether the Joint Executive Council can effectively address the issues once managed by the Senior Oversight Committee has yet to be seen. Several DOD and VA officials expressed concern to us about the ability of the Joint Executive Council to focus on rapid, short-term policy decision

making rather than the longer-term strategic planning role that it has traditionally played. For example, according to a DOD official, historically, the Joint Executive Council has not been able to drive policy decision making, and therefore, issues that should have been decided by the Joint Executive Council were taken directly to the Secretaries for resolution, raising doubts about the ability of the Joint Executive Council to function effectively. A former Senior Oversight Committee executive noted that the Joint Executive Council cochairs are not of equivalent rank, another challenge that may serve as a barrier to the council's ability to make decisions and drive policy changes. Specifically, the VA cochair is the Deputy Secretary, who has control over all relevant offices within VA, while the DOD cochair is the Deputy Undersecretary of Defense for Personnel and Readiness, whose responsibilities include establishing health and benefit policies affecting recovering servicemembers and directing the military services to comply with such policies but lacks authority in enforcing the military services' implementation of these policies. The Recovering Warrior Task Force also cited concerns about the rank of the DOD cochair of the Joint Executive Council, stating that a higher level of leadership is needed to sustain departmental attention on key initiatives such as IDES and electronic health records.[44] Furthermore, as of August 2012, DOD officials told us that the Joint Executive Council is operating under the original procedures that were in place prior to the entities merging. As a result, it is unclear at this time how the Joint Executive Council will provide oversight and accountability for issues once addressed by the Senior Oversight Committee.

WWCTP Lacks Authority and Leadership to Provide Oversight for Care Coordination

In 2008, WWCTP became responsible for overseeing the RCP among other programs that provide assistance to recovering servicemembers. However, WWCTP's ability to oversee the RCP, including its ability to monitor program performance and ensure compliance with DOD policy, is limited by its lack of operational authority, such as budget and tasking authority, over the military services that implement the program. According to WWCTP officials, this lack of operational authority challenges WWCTP's ability to direct the military services on their implementation of the program. For example, although WWCTP has been responsible for RCP oversight since 2008, the office was not able to collect basic program data, such as monthly enrollment numbers, on a

[44]Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces, *Department of Defense Recovering Warrior Task Force 2011-2012 Annual Report* (August 2012).

consistent basis until October 2011. According to a WWCTP official, although WWCTP requested monthly data submissions from the military services, the information was provided on an ad hoc basis; sometimes the services would submit it, and other times they would not. Data-collection efforts still remain a challenge for WWCTP. For example, the Army's Wounded Warrior Program, which serves as the Army's care coordination program, only agrees to share partial data with WWCTP, arguing that the Army is only obligated to share data on servicemembers served by WWCTP-contracted personnel.

Getting the military services to implement consistent care coordination policies also poses a challenge for WWCTP. WWCTP officials said that while WWCTP can develop policy to guide the military services, the military services may interpret that policy and implement their programs differently. Consequently, some DOD officials assert that the military services have not consistently implemented the RCP in accordance with DOD policy—an observation that is shared by the Recovering Warrior Task Force.[45] DOD policy requires that care coordination should be provided to those who are "seriously" and "severely" wounded, ill, and injured, but the Army only provides care coordination to recovering servicemembers who are "severely" wounded, ill, and injured.[46] As a result, some servicemembers who could benefit from having someone coordinate their care and benefits as they navigate the recovery care continuum do not have access to those services.

Some WWCTP officials with whom we spoke expressed the view that the military services have been inconsistent in their cooperation with WWCTP, with cooperation being better on issues that represent priorities of top leadership. Specifically, WWCTP officials told us that top DOD leadership has not been pressured to resolve lingering care coordination issues as much as other more visible issues, such as IDES and electronic medical record interoperability problems confronting the departments. Consequently, WWCTP officials said that the military services cooperate with WWCTP's efforts to oversee IDES and to monitor whether the military services achieve their goals for timely completion of the IDES

[45]Recovering Warrior Task Force, *Department of Defense Recovering Warrior Task Force 2011-2012 Annual Report*.

[46]Department of Defense, *Recovery Coordination Program*, DOD Instruction 1300.24, (Dec. 1, 2009).

process. Although these goals have not consistently been achieved,[47] the officials told us that military service cooperation has not been an impediment to overseeing IDES as it has been for overseeing care coordination. Conversely, the military services have not been as inclined to cooperate with WWCTP on its oversight of the RCP relative to these other issues.

In addition to limited operational authority over the military services, turnover in leadership and other staffing changes have also limited WWCTP's ability to provide consistent direction and oversight for the RCP, according to WWCTP officials. Specifically:

- Three different DOD officials have led WWCTP since its inception in 2008. According to WWCTP staff, each of these officials had different visions and priorities for the office, which led to disruptions in RCP oversight. For example, a major oversight initiative—to collect satisfaction survey data across the RCP—was abandoned when a new official was appointed. In addition, the RCP has been led by three different directors, with the most recent director leaving in June 2012.

- In September through December 2011, WWCTP's contracted staffing was temporarily reduced by 70 percent when a contract expired and was not immediately renewed, according to DOD. Staff reductions primarily impacted WWCTP's ability to oversee the RCP, since many RCP support staff members were lost. For example, according to a WWCTP official, the office was no longer able to make monitoring visits to the RCP program sites. However, in July 2012 a contract was awarded that allowed WWCTP to engage additional staff to support the RCP, according to a WWCTP official.

- In June 2012, DOD changed the name of the WWCTP office to the Office of Warrior Care Policy and moved it under the Assistant Secretary of Defense for Health Affairs. According to a DOD official, the change was made as part of a realignment of DOD's organizational structure in response to statutory requirements.[48] An

[47]See GAO, *Military and Veterans Disability System: Pilot Has Achieved Some Goals, but Further Planning and Monitoring Needed*, GAO-11-69 (Washington, D.C.: Dec . 6, 2010); *Military and Veterans Disability System: Worldwide Deployment of Integrated System Warrants Careful Monitoring*, GAO-11-633T (Washington, D.C.: May 4, 2011); and GAO-12-718T.

[48]See Pub. L. No. 111-84, § 906, 123 Stat. 2190, 2425 (2009).

official in Health Affairs said that the move will be beneficial because it will provide greater access to resources, including human resources and information technology, among others. However, it is too early to determine the full effect of this change.

Wounded Warrior Programs Lack Central Oversight

There is currently no central office or authority that oversees or collects common data on the military services' wounded warrior programs, preventing DOD from both assessing how well the programs are working across the department and leveraging the strengths of each program by sharing proven best practices across the military services.

Each of the military service Secretaries created their own wounded warrior programs to meet their military service's unique needs. Because each service developed its own policy to govern its wounded warrior programs and no central, unified DOD policy exists to govern these programs, no central DOD office—such as WWCTP—may direct how these programs operate. This lack of central oversight over the wounded warrior programs has been one of the main reasons for the large discrepancies between these programs. The 2011 Recovering Warrior Task Force report recommended that the Secretary of Defense enforce the existing policy guidance regarding the Army's and Marines' wounded warrior transition units' entrance criteria. However, in its response to this recommendation, DOD supported the military service Secretaries' discretion in establishing their own policies in this regard, saying that there is no central DOD policy on the establishment of transition units and entrance criteria, and that the policies were established by the Secretaries for their specific populations.

While no common data are collected on the performance of wounded warrior programs across the military services, each individual program has initiated internal efforts to collect and analyze performance data. The type and quality of data vary by program, however. For example, the largest of the wounded warrior programs, the Army Warrior Care and Transition Program, has collected wounded warrior program performance survey data on a continuous basis since March 2007 and has developed outcome measures to determine the impact of its services. However, smaller programs, such as the Air Force Wounded Warrior Program and the United States Special Operations Command's Care Coalition have measured baseline program satisfaction levels, but they do not have additional years of survey data to monitor any changes over time. (See table 3 for information about the types of performance data collected by each of the wounded warrior programs.)

Table 3: Military Services' Wounded Warrior Program Efforts to Measure Program Performance

Military services' wounded warrior program	Satisfaction surveys: Measures customer satisfaction with program	Performance metrics: Measures whether program meets target output goals	Outcome measures: Measures whether program achieves desired impact
Army			
Army Warrior Care and Transition Program	●	●	●
Army Wounded Warrior Program	●	●	●
Navy/Coast Guard			
Navy Safe Harbor Program	●	●	
Air Force			
Air Force Wounded Warrior Program	●[a]		
Air Force Recovery Care Program	●[a]	●	
Marine Corps			
Marine Corps Wounded Warrior Regiment	●	●	●
United States Special Operations Command			
United States Special Operations Command's Care Coalition	●	●[b]	

Source: GAO analysis of interviews with military services' wounded warrior program officials and program documentation.

[a]Although the Air Force Wounded Warrior and Recovery Care Programs' initial satisfaction survey was completed in October 2011, the survey results have not been released as of August 9, 2012.

[b]The United States Special Operations Command's Care Coalition has performance metrics for its Recovery Program.

Some DOD officials with whom we spoke questioned why common measures have not been developed. For example, a DOD official in charge of wounded warrior care at an MTF suggested developing a measurement tool to determine what aspects of the programs help recovering servicemembers. Another DOD official involved with wounded warrior program performance measurement commented that it is common practice for DOD to share performance measurement practices and standard metrics across the military services.

In September 2011, citing wide disparity across the military services in their implementation of wounded warrior programs and policies, the Recovering Warrior Task Force made four recommendations for creating

common standards to ensure parity in the programs and services provided to recovering servicemembers across DOD.[49] For example, the first recommendation called for a common nomenclature, or consistent definitions to be used in DOD policy to identify recovering servicemembers who may require and be eligible for assistance. The task force concluded that common definitions are needed to promote consistent levels of care among the military services and would better enable DOD to compare across programs and identify best practices. In its response to the task force, DOD acknowledged that some of these recommendations were valid and that DOD should take actions to address them. However, at the time of the Recovering Warrior Task Force's 2012 report, these recommendations had not been implemented, and the task force is continuing to follow DOD's efforts to implement them.[50] Moreover, even if DOD decided to take some actions in this regard, it is unclear who would have responsibility for addressing them, since there is no central oversight office or authority for these programs.

Insufficient Staffing and Budget Control Have Contributed to DOD's and VA's Inability to Resolve Delays with Disability Determinations and Electronically Share Health Records

In addition to problems with leadership and oversight of care coordination and case management programs, DOD and VA have a longstanding track record of insufficient staffing to address delays in disability determinations and insufficient staffing and control over the budget to oversee the development of systems with improved capabilities for electronically sharing health records.[51]

[49]Recovering Warrior Task Force, *Department of Defense Recovering Warrior Task Force 2010-2011 Annual Report.*

[50]Recovering Warrior Task Force, *Department of Defense Recovering Warrior Task Force 2011-2012 Annual Report*.

[51]See GAO-11-69; GAO-11-633T; GAO-12-718T; *Electronic Health Records: DOD and VA Have Increased Their Sharing of Health Information, but More Work Remains*, GAO-08-954 (Washington, D.C.: July 28, 2008); *Electronic Health Records: DOD's and VA's Sharing of Information Could Benefit from Improved Management*, GAO-09-268 (Washington, D.C.: Jan. 28, 2009); *Information Technology: Challenges Remain for VA's Sharing of Electronic Health Records with DOD*, GAO-09-427T (Washington, D.C.: Mar. 12, 2009); GAO-09-775; and GAO-10-332.

Insufficient Staffing Contributed to Delays in Disability Determinations

Insufficient staffing across both departments has affected DOD's and VA's ability to reduce disability determination delays and meet their IDES timeliness goals. We raised concerns about staffing in 2010, when we reported that DOD and VA did not sufficiently staff many key positions in the IDES process, including DOD board liaisons, who counsel servicemembers and ensure that documentation submitted for consideration is complete and accurate, and medical evaluation board physicians, who review medical and service records to identify conditions that limit a servicemember's ability to serve in the military.[52] In 2012, we continued to report evidence of staffing shortages, including high caseloads for DOD board liaisons and VA case managers as well as insufficient numbers of physicians to write narrative summaries needed to complete the medical evaluation board stage of the IDES process in a timely manner.[53] Some recovering servicemembers told us they do not receive sufficient support from their DOD board liaisons, and that there are not enough liaisons to efficiently meet the needs of all the recovering servicemembers going through the IDES process.

Delays in the disability determination process are expected to continue. VA anticipates a much larger caseload of all disability and other benefit claims in the near future, not just those claims associated with IDES cases. Specifically, a high-level VA official told us that new laws, such as the Veterans Opportunity to Work Act,[54] will encourage all transitioning servicemembers—not just those going through the IDES process—to claim VA benefits. This official also told us that DOD and VA have a much larger problem to address as a surge of 300,000 servicemembers begin to transition into the VA system as troops return home from Iraq and Afghanistan. Without adequate planning and adequate resources, these servicemembers may experience much longer processing times in the disability benefits systems.

DOD and VA are working to address staffing challenges in some of the IDES processes that are most delayed. We have previously reported that the Army, for example, is in the midst of a major hiring initiative to increase staffing dedicated to its medical evaluation boards, which will

[52]GAO-11-69.

[53]GAO-12-718T.

[54]Veterans Opportunity to Work (VOW) to Hire Heroes Act, Pub. L. No. 112-56, tit. II, 125 Stat. 712 (2011).

include additional DOD board liaisons and medical evaluation board physician positions.[55] Additionally, VA officials said that the agency has added staffing to its IDES rating sites to handle the demand for preliminary disability ratings, rating reconsiderations, and final benefit decisions, which has increased the number of preliminary VA ratings completed and slightly improved processing times. But it is too early to tell the extent to which VA's efforts will continue to improve processing times.

Lack of Staffing and Budget Control Limited Progress on Electronic Health Records Sharing

The Interagency Program Office was established by law[56] to serve as a single point of accountability for joint DOD and VA efforts to implement fully interoperable electronic health record systems or capabilities, but this office was not given sufficient staffing or budget control by DOD and VA to effectively facilitate the departments' efforts. According to an Interagency Program Office official, the office was never fully staffed and was challenged by a high degree of turnover in staffing and leadership that served in a temporary or acting capacity.

The Interagency Program Office's initial charter limited its ability to exercise authority over DOD and VA. Specifically, the charter stated that control of the budget, contracts, and technical development remained wholly within the two departments' program offices. The charter conveyed no authority in these areas to the Interagency Program Office. As a former Interagency Program Office official testified in July 2011, the office lacked control of budgeting and contracting necessary to achieve its intended purpose, and without this, it could not sufficiently oversee the departments' efforts and compliance with the requirements in NDAA 2008.[57] As a result, each department continued to pursue separate strategies, rather than a unified interoperable approach, according to this former official.

[55]GAO, *Military System: Improved Monitoring Needed to Better Track and Manage Performance*. GAO-12-676 (Washington, D.C.: Aug. 28, 2012).

[56]See Pub. L. No. 110-181, § 1635, 122 Stat. 3, 460-63 (2008).

[57]Legislative Hearing on H.R. 2383, H.R. 2388, H.R. 2243 and H.R. 2470, Before the Subcommittee on Oversight and Investigations of the Committee on Veterans Affairs, 112th Cong. (July 20, 2011) (statement of Debra M. Filippi, former Director, U.S. Department of Defense/U.S. Department of Veterans Affairs Interagency Program Office).

The Interagency Program Office was rechartered in October 2011 and provided an expanded staff and new authorities under the charter, including control over the budget. According to Interagency Program Office officials, when hiring under the new charter is completed, the office will have a staff of 236 personnel, more than seven times the number of staff originally allotted to the office by DOD and VA.[58] In addition, the charter provides the Interagency Program Office with the authority to lead, oversee, and manage budget and contracting for electronic health record sharing efforts. According to Interagency Program Office officials, budget control is the essential component for overseeing progress and ensuring accountability for the departments' efforts.

With the enhanced charter, as well as plans for an expanded staff to oversee the implementation of a single joint electronic health record system, the Interagency Program Office will have more resources to draw upon and support department interoperability initiatives. However, it is still too early to determine whether this investment of resources will be sufficient to meet the office's goals for 2017.[59] For example, despite the provision of additional resources, Interagency Program Office officials told us that as of July 2012, the office is staffed at approximately 48 percent and that hiring additional staff in time to meet appointed implementation deadlines remains one of its biggest challenges.

Despite Repeated Attempts, DOD and VA Have Failed to Effectively Collaborate to Align Their Care Coordination Programs; New Efforts Are Under Way

Since the inception of the RCP in 2008, the FRCP and RCP care coordination programs have conflicted with one another and with other case management programs that provide services to recovering servicemembers and veterans. Conflicting issues have arisen as to what populations they serve, the specific services each would provide, and when each program would get involved in the servicemembers' recovery process. Aligning and integrating these programs with one another—especially the FRCP with the RCP—has proven to be a major challenge for DOD and VA. While the departments are developing an interagency strategy for minimizing duplication between DOD's and VA's care coordination and case management programs, the success of this effort

[58]As we reported in 2008, the Interagency Program Office was in the process of recruiting about 30 permanent staff members (see GAO-08-954).

[59]According to DOD and VA officials, the departments have identified 54 joint capabilities that will be implemented by the end of fiscal year 2017.

will depend upon achieving cooperation between the departments—which has been elusive for many years—as well as with the military services.

With the creation of the RCP, the FRCP was no longer the single point of contact with respect to servicemembers' care coordination, and early on, there were concerns and some confusion about how the FRCP and the RCP would align without creating overlapping and duplicative services. Shortly after the RCP was established, DOD sent a report to congressional committees outlining a medical category assignment process that was based on the severity of each servicemember's medical condition, along with input from the servicemember and his or her unit commander, to determine whether servicemembers would be directed to either the FRCP or to the RCP for care coordination services. In concept, the medical category assignment process would have resulted in wounded, ill, and injured servicemembers being assigned to one of three categories: "mild," "serious," or "severe." Under this approach, the FRCP would provide care coordination services for "severely" wounded, ill, and injured servicemembers and the RCP would serve those who were "seriously" wounded, ill, and injured. (See app. II for additional information on the intended medical category assignment process for DOD and VA care coordination programs.)

Despite DOD's attempt to define the populations served by the FRCP and the RCP, neither the military services' wounded warrior programs, which implement the RCP, nor VA, which administers the FRCP, implemented DOD's assignment process. Instead, these programs expanded their enrollment to include both "seriously" and "severely" recovering servicemembers and veterans, which resulted in both programs serving the same populations, thereby setting up the likelihood of overlap and duplication of services. As we have previously reported, this duplication issue is compounded by the numerous other programs that also provide services to recovering servicemembers and veterans and have overlapping roles as well. It is not uncommon for recovering servicemembers to be enrolled in more than one case management or care coordination program and end up with multiple care coordinators and case managers—each of whom develop different care plans for the same servicemember. The care plans may even conflict with one another, which could conceivably adversely affect the servicemember's recovery process. In fact, in the course of previous work, we found instances where inadequate information exchange and poor coordination between

these programs resulted not only in duplication of effort and overlap of services, but also confusion and frustration for servicemembers and their families.[60] In addition, DOD and VA officials acknowledge that the multiplicity of care coordination and case management programs causes confusion even among members of care coordination teams. In October 2011, we recommended that the Secretaries of Defense and Veterans Affairs 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 to reduce redundancy and overlap.

Although DOD and VA have not yet aligned care coordination policy for the FRCP and RCP, we have found indications that care coordinators and case managers at some locations have been cooperating to some degree and trying to work more closely with one another. In the course of our visits to 11 DOD and VA facilities during this review, we found that care coordinators and case managers in many locations had attempted—with some success—to clarify their roles and to limit the degree of overlap and duplication in the services they provide to recovering servicemembers and veterans. However, such local attempts to improve the degree of cooperation and coordination among the programs are not systemic and depend on individual personalities and circumstances. They may not be sustainable without agreement by DOD and VA and the alignment of policy governing case management and care coordination programs.

Another critical issue on which DOD and VA have disagreed pertains to the stage in a servicemember's recovery when the FRCP should get involved in the coordination of services. Because the FRCP depends on referrals from other programs as a basis for becoming involved with recovering servicemembers, this can be a significant issue. Currently, neither DOD nor VA policy clearly defines when referrals are to be made; consequently, most wounded warrior programs delay referrals to the FRCP until it becomes clear that the servicemember will be separated from the military. Senior DOD officials stated that wounded warrior program officials justify this practice on the basis that referring a recently wounded servicemember to the FRCP—a VA-operated program—sends a negative message to a recovering servicemember that his or her military career has ended, even though the FRCP was designed as a joint

[60] GAO-12-129T.

program. Additionally, the belief among the military that they should "take care of their own," contributes to the reluctance to involve the FRCP. On their part, VA maintains that its point of engagement should be in the early stage of medical treatment to build rapport and trust and to begin coordinating the services needed by severely wounded servicemembers.

Despite multiple efforts over the last several years to align their care coordination and case management programs, DOD and VA have failed to implement lasting measures to resolve underlying problems concerning the aligning of roles and responsibilities of the FRCP, RCP, and case management programs. Previous attempts include the following:

- December 2010. The Senior Oversight Committee directed its case management work group to perform a feasibility study of recommendations on the governance, roles, and mission of DOD and VA care coordination. However, no action was taken by the committee and care coordination was subsequently removed from the Senior Oversight Committee's agenda as other issues were given higher priority.

- March 2011. WWCTP sponsored a joint summit that included officials from VA and the military services to review DOD and VA care coordination issues. Although this collaboration resulted in the development of five recommendations related to care coordination, no agreement was reached by the departments to jointly implement them. A DOD participant told us that VA did not agree with the recommendations, and a VA official involved in the summit concurred, alleging that the recommendations appeared to suggest eliminating overlap and duplication between the FRCP and RCP by ending the FRCP.

- May 2011. Concerned with overlap and duplication between the DOD and VA care coordination programs, the House Committee on Veterans Affairs, Subcommittee on Health directed the Deputy Secretaries of DOD and VA to provide an analysis of how the FRCP and RCP could be integrated under a "single umbrella" by June 20, 2011. In the absence of such a response, the subcommittee scheduled a congressional hearing and requested that options for addressing this issue be presented. Following the notification of the hearing, the departments developed a joint letter and submitted it to the subcommittee in September 2011. This letter, however, did not identify or outline options for aligning the FRCP and the RCP. In a hearing held by the subcommittee in early October 2011, neither VA nor DOD outlined definitive plans to address this issue.

- September 2011. The Recovering Warrior Task Force issued the first of four annual reports that included 21 recommendations, including a recommendation that the roles of care coordinators be clarified. In DOD's official response to congressional committees, the Under Secretary of Defense stated that the department would implement the Recovering Warrior Task Force's recommendations. However, a Recovering Warrior Task Force member stated that the Recovering Warrior Task Force concluded that in most cases DOD has not made significant changes to its programs to achieve the outcomes intended by the recommendations. In August 2012, the Recovering Warrior Task Force reported that DOD has fully implemented only 2 of the 21 recommendations.[61] However, a DOD official whose office is responsible for coordinating DOD's responses to the Recovering Warrior Task Force's recommendations stated that DOD is in the process of addressing several more of the 2011 Recovering Warrior Task Force recommendations.

- October 2011–April 2012. VA declined DOD's requests to discuss care coordination and case management policy issues during this period, according to DOD and VA senior officials, because VA had established its own task force to conduct an internal review of its care coordination and case management activities, including the FRCP.[62] After completing its initial assessment, VA briefed WWCTP officials on the process it was using to review its care coordination and case management activities, but chose not to discuss realignment of the FRCP and RCP at that time, according to DOD officials who attended this briefing. Instead, the VA Chief of Staff said that he approached the Army's Warrior Transition Command—which has the largest number of recovering servicemembers—to propose developing guidelines for better integrating Army's wounded warrior program with the FRCP, including identifying when the Army's wounded warrior programs should refer a recovering servicemember to the FRCP, and replacing multiple care coordination plans with a single, comprehensive planning document. However, a high-level DOD official criticized this initiative as a tactic to minimize central input from

[61]The Recovery Warrior Task Force also reported that DOD has partially addressed an additional 6 recommendations and noted that 13 recommendations remain open.

[62]Responding to a recommendation of a consulting firm that advised VA on its care coordination and case management policy, the VA Chief of Staff directed that VA conduct a department-wide inventory and review of its existing care coordination and case management programs and personnel.

the Office of the Secretary of Defense and pointed out that this effort would result in an agreement with only a single military branch. In contrast, VA's Chief of Staff told us that VA took this approach in the hope that if an agreement could be reached with Army, the other military branches would follow suit.

More recently, in May 2012, VA and DOD developed a new task force, the VA/DOD Warrior Care and Coordination Task Force, which represents an effort to comprehensively address problems caused by the lack of integration between DOD's and VA's care coordination and case management programs. The task force has developed recommendations that are intended to achieve a coordinated, interdepartmental approach to care coordination and case management programs, according to a task force official. On August 10, 2012, the task force presented the following recommendations to the Joint Executive Council for its consideration:

- establish and charter an interagency governance structure responsible for coordinating VA and DOD policy,
- establish and charter an interagency care coordination community of practice,[63]
- align the FRCP to function in a consultant and resource-facilitator role,
- clarify the lead coordinator role and responsibilities for executing a recovering servicemember's comprehensive plan,
- identify the business requirements for technical tools to support the interagency comprehensive plan, and
- accelerate existing information-sharing efforts for care coordination.

The Joint Executive Council provisionally approved the six recommendations, but withheld final approval pending receipt of additional information from the task force, such as an estimate of resources required to implement the recommendations, as well as details of the proposed interagency governance structure. The Joint

[63]Communities of practice are groups of people who engage, through regular interaction with one another, in a process of collective learning in a shared domain of human endeavor.

Executive Council instructed the task force to present the additional information to them in another decision briefing, which was scheduled for September 20, 2012. Absent final approval from the Joint Executive Council, the task force's next step was to hold a status briefing for the DOD and VA Secretaries on September 10, 2012, to discuss the task force's recommended course of action for care coordination.

Given the inability of past task forces to effect changes that better align DOD and VA care coordination and case management policies, it is too soon to determine the full effect of the departments' efforts to manage care coordination services regarding outcomes for recovering servicemembers and veterans. Although VA and DOD appear to be moving in a positive direction on care coordination, notable barriers remain:

- There is concern as to whether the Joint Executive Council can effectively lead the effort to realign VA's and DOD's care coordination policy. Some high-ranking and cognizant DOD officials we talked with expressed concerns that the recently merged Joint Executive Council may not have the capability to effectively monitor the actions taken by DOD and VA to implement the task force's recommendations. Some officials we talked with viewed the council as taking too long to resolve issues due to both the infrequency of its meetings[64] and the difficulties DOD and VA members have in agreeing with one another.

- Following approval of its recommended course of action, task force documents indicate that a detailed plan will be completed by July 2013. VA's task force cochair stated that some aspects of the planned changes could take years to implement, particularly as they transition existing enrollees of programs affected by significant revisions. For example, VA intends to conduct a case-by-case review of every FRCP enrollee before modifying the FRCP to function in a consultant and resource-facilitator role, according to VA's Task Force cochair.

- One of the most fundamental challenges to resolving care coordination problems is the issue of obtaining the cooperation of the military services to implement a new approach to care coordination and case management, especially in light of past difficulties of working in concert with DOD and VA programs and policies. DOD and VA

[64]The Joint Executive Council meets on a bimonthly basis.

leadership officials stated that even if new solutions and policies were to be approved by the departments, changes would be made only if the individual military services implement the new policies as directed by the Secretary of Defense. Several DOD and VA officials identified concurrence and support of the military services as the most difficult element to achieve. Ultimately, the military services' compliance with the departments' agreed-upon strategy for care coordination and case management programs will determine how seamlessly recovering servicemembers and veterans will be able to navigate the recovery care continuum.

Conclusions

The deficiencies exposed at Walter Reed in 2007 served as a catalyst compelling DOD and VA to address a host of problems that complicate the course of a wounded, ill, and injured servicemember's recovery, rehabilitation, and return to active duty or civilian life. We believe strongly and have reported already that fixing the long-standing and complex problems highlighted in the wake of the Walter Reed media accounts as expeditiously as possible is critical to ensuring high-quality care for returning servicemembers and veterans. We continue to believe that the departments' success ultimately depends on sustained attention, systematic oversight, and sufficient resources from both DOD and VA. However, this has not yet occurred, and as a result, after 5 years, recovering servicemembers and veterans are still facing problems as they navigate the recovery care continuum, including access to some of the programs designed to assist them. The transition period from DOD's to VA's health care system is particularly critical, as servicemembers continue to experience delays in the disability evaluation system and the departments continue to use methods other than a common information technology system to share servicemembers' health information. Until these problems are resolved, recovering servicemembers and veterans may still face difficulties getting the services they need to maximize their potential when they return to active duty or transition to civilian life.

Initially, departmental leadership exhibited focus and commitment—through the Senior Oversight Committee—to addressing problems related to case management and care coordination, disability evaluation systems, and data sharing between DOD and VA. However, over time, waning leadership attention, a failure to oversee critical wounded warrior functions and programs, limited resources, and the inability to achieve a collaborative environment— particularly with care coordination—have impeded the departments' ability to fully resolve these problems. A key element in resolving current care coordination issues in particular is

eliciting the cooperation of the military services, which are responsible for implementing various wounded warrior programs and ensuring that these programs operate as intended—which has sometimes not been the case, as with the RCP. Also, absent clear direction and central oversight and accountability among the military services' wounded warrior programs, true cooperation and program effectiveness may be in jeopardy.

We believe that at the heart of the problem is the need for strong and unwavering leadership to bring about changes that best serve our nation's recovering servicemembers and veterans. This leadership should be united across both DOD and VA and centered on the individual servicemember's or veteran's recovery. Many task forces—including the VA/DOD Warrior Care and Coordination Task Force and the Recovering Warrior Task Force—have already attempted to bring a spirit of cooperativeness and clear direction and purpose among the different programs providing services to this population. However, to date, these efforts have not fully resolved key issues, and our nation's recovering servicemembers and veterans continue to face obstacles and challenges, especially as they transition from DOD's to VA's health care system. Certainly, the fluidity and focus of the departments' leadership over the last several years, especially related to care coordination, have added to the challenges of developing consistent policy, effective oversight, and mechanisms to monitor progress and hold programs accountable. The departments have recently taken steps to improve problems related to care coordination, disability evaluations, and the electronic sharing of health records, through concerted efforts to coordinate on policy, increase staffing resources, and provide control over the budget, respectively. However, it is too early to determine the effectiveness of these efforts, and sustained leadership attention will be critical to their success. The need to fully resolve remaining problems is urgent as there will be an increasing demand for services from both DOD and VA as the current conflicts come to an end. If not resolved now, these same problems will persist into the future for recovering servicemembers and veterans.

Recommendations for Executive Action

To ensure that servicemembers have equitable access to the military services' wounded warrior programs, including the RCP, and to establish central accountability for these programs, we recommend that the Secretary of Defense establish or designate an office to centrally oversee and monitor the activities of the military services' wounded warrior programs to include the following:

- Develop consistent eligibility criteria to ensure that similarly situated recovering servicemembers from different military services have uniform access to these programs.

- Direct the military services' wounded warrior programs to fully comply with the policies governing care coordination and case management programs and any future changes to these policies.

- Develop a common mechanism to systematically monitor the performance of the wounded warrior programs—to include the establishment of common terms and definitions—and report this information on a biannual basis to the Armed Services Committees of the House of Representatives and the Senate.

To ensure that persistent challenges with care coordination, disability evaluation, and the electronic sharing of health records are fully resolved, we recommend that the Secretaries of Defense and Veterans Affairs ensure that these issues receive sustained leadership attention and collaboration at the highest levels with a singular focus on what is best for the individual servicemember or veteran to ensure continuity of care and a seamless transition from DOD to VA. This should include holding the Joint Executive Council accountable for

- ensuring that key issues affecting recovering servicemembers and veterans get sufficient consideration, including recommendations made by the Warrior Care and Coordination Task Force and the Recovering Warrior Task Force;

- developing mechanisms for making joint policy decisions;

- involving the appropriate decision-makers for timely implementation of policy; and

- establishing mechanisms to systematically oversee joint initiatives and ensure that outcomes and goals are identified and achieved.

Agency Comments and Our Evaluation

DOD and VA reviewed a draft of this report and provided comments, which are reprinted in appendixes III and IV. DOD and VA also provided technical comments, which we incorporated as appropriate.

DOD concurred with specific components of our first recommendation regarding the establishment of central accountability for the military services' wounded warrior programs. In particular, DOD agreed that a single office should have oversight responsibility for the military services' wounded warrior programs and that these programs should fully comply with the policies governing care coordination and case management programs and any future changes to these policies.

However, DOD only partially concurred with other components of our first recommendation—that DOD develop consistent eligibility criteria for enrollment in wounded warrior programs and that DOD establish a common mechanism to systematically monitor the performance of these programs. In its comments, DOD explained that the three military service Secretaries should have the ability to control entrance criteria into their wounded warrior programs and added that it does not believe that differences in eligibility criteria for these programs results in noticeable differences in access to these programs by recovering servicemembers or their families. DOD did not offer a rationale, however, as to why the military service Secretaries should unilaterally determine eligibility criteria for their wounded warrior programs, other than to suggest that flexibility is important and necessary. Moreover, as we have reported, DOD does not systematically assess or monitor these programs across the department, and as a result, we believe that DOD has no basis to assert that there are no noticeable differences in access to these programs. Overall, we believe that similarly situated wounded, ill, and injured servicemembers should be given the same access to wounded warrior programs and the assistance these programs provide, regardless of their branch of military service.

With respect to developing a common mechanism to systematically monitor the performance of the wounded warrior programs, DOD responded that the Interagency Care and Coordination Committee will conduct an inventory of all wounded warrior programs to identify duplication and areas for gaining efficiencies. In commenting on our recommendation to also report its performance information on the wounded warrior programs to the Armed Services Committees on a biannual basis, DOD stated that the department reports progress through the Joint Executive Council's annual strategic planning report and any additional reporting would be redundant and of limited value. We disagree. The Joint Executive Council's strategic planning and annual reports focus on joint efforts between the departments and do not report on the performance of the military services' wounded warrior programs. Therefore, we do not believe that the performance information on the

wounded warrior programs would be redundant or of limited value given that the department itself is currently unable to systematically determine how well these programs are functioning. As we reported, one of the key problems hindering a department-wide assessment of these programs is the lack of common terms and definitions used by the military services. Although DOD acknowledges that this is an issue, it asserts that it has instituted some common definitions through the Senior Oversight Committee and through its instruction for the RCP and that it will work towards a common understanding and use of these approved definitions. Although we are aware of efforts to define some terms, on the basis of our work, it does not appear that the military services are using them consistently. Therefore, substantial progress towards a common understanding and use will be critical to the department's ability to oversee these programs.

DOD did not respond directly to our recommendation for developing a common mechanism for performance measurement, which we found is not systematically conducted across the wounded warrior programs. During our collection of performance data from the wounded warrior programs, we found that the programs vary in their ability to report performance outcome measures on the basis of what each program chooses to track. In addition, we found that some of the programs had difficulty reporting basic data, such as enrollment numbers, and only compiled these data following our request—sometimes taking about 5 months to do so. Lastly, our recommendation is consistent with the call of the Interagency Care and Coordination Committee that the military programs develop more useful quantitative and qualitative metrics that would effectively demonstrate their performance. Until DOD takes the necessary steps to assess these programs department-wide, it will never know with certitude whether these programs are meeting the needs of its recovering servicemember population.

DOD and VA both concurred with our second recommendation that the departments ensure that care coordination, disability evaluation, and electronic health record sharing receive sustained leadership attention and collaboration at the highest levels, with a singular focus on what is best for the individual servicemember or veteran to ensure continuity of care and a seamless transition from DOD to VA.

In addition to its comments on our recommendation, VA asserted that the care coordination challenges facing both departments are broader and more complex than issues concerning just the FRCP and RCP and that our overall analysis and conclusions are over simplified. VA stated that through its recently formed task force, both departments identified over 40 programs that provide some level of coordination or management of care and services across the continuum of care and acknowledged that there is no common operational picture that facilitates collaborative planning or situational awareness. We agree that the care coordination challenges are broader and more complex than the FRCP and RCP. Specifically, in October 2011, we recommended that the departments strengthen functional integration across all care coordination and case management programs to reduce redundancy and overlap.[65] Similarly, our current recommendation is broad and does not focus exclusively on these two programs as our review also included other programs, such as the military services' wounded warrior programs, VA's Liaison for Healthcare Program, and VA's OEF/OIF/OND Care Management Program. The scope of our review was directed by Congress, who required us to report on the progress DOD and VA in implementing the programs involved with the care, management, and transition of wounded, ill, and injured servicemembers that they established. Our specific discussion of the FRCP and RCP served to illustrate, until recently, a continued lack of collaboration between the departments to better align these programs and better serve recovering servicemembers and veterans. Furthermore, during detailed discussions with top-level VA and DOD officials, they focused on the FRCP and RCP issue as the main sticking point in achieving coordination and cooperation among the two departments with respect to care coordination and case management. We are encouraged that the departments are now taking steps to identify all programs that need better alignment and integration. However, as we have stated, the key to resolving this and other problems is the need for strong and unwavering leadership that is united across both departments and focused on the individual servicemember's or veteran's recovery.

[65] GAO-12-129T.

VA also suggested further clarifications to our report.

- VA suggested that we clarify that while the VA Liaison for Healthcare Program facilitates the transfer of recovering servicemembers from DOD's to VA's health care system, it is a DOD or VA treatment team that determines if the servicemember is medically ready to begin the transition process. VA also suggested that we add that that the OEF/OIF/OND Care Management Program screens all returning combat veterans for case management services. We incorporated VA's suggested changes.

- VA disagrees with a DOD-attributed statement that the Joint Executive Council historically has not driven policy decision making and that, at times, decisions were taken directly to the DOD and VA Secretaries for resolution. The statement that we attribute to the DOD official relates to the period prior to the integration of the Senior Oversight Committee with the Joint Executive Council. As mentioned in the report, it is too early to ascertain whether the newly merged Joint Executive Council will be able to make decisions and drive policy changes in DOD and VA.

- VA provided clarification about how the Joint Executive Council is currently providing oversight and accountability for wounded warrior issues that were once addressed by the Senior Oversight Committee. We recognize the effort that the Joint Executive Council is now making to track wounded warrior issues, including the integrated disability evaluation system and care coordination. However, we have not had the opportunity to review this tracking mechanism now in place to comment on its effectiveness.

- VA asserts that the size of the overlap between the FRCP and RCP population is fairly small. Although the number of seriously injured servicemembers may be comparatively small, this situation has been and continues to be a major concern in that these individuals and their families represent a highly vulnerable population. Further, during our review, one high-level DOD official we spoke with characterized the FRCP/RCP overlap as the most difficult policy issue to resolve. While we understand that DOD and VA now intend to harmonize care coordination policies within a broader context of interdepartmental care coordination and case management practice, many of the proposed revisions—including the role to be played by the FRCP—are neither fully developed nor implemented by the separate DOD and VA programs at this time.

- In our report, we explain that VA declined DOD's requests to discuss care coordination and case management policy issues—for the better part of 1 year—on the basis that VA was conducting an internal review of its care coordination and case management activities. In its comments, VA stated that the use of the word "decline" is misleading, and suggested that we change our text to state that VA asked DOD to defer collaboration until the internal review was conducted. Despite VA's characterization that our statement is misleading, we maintain that this finding was based on remarks made by high-level DOD officials that were subsequently corroborated by senior VA officials.

We are sending copies of this report to appropriate congressional committees, the Secretary of Defense, the Secretary of Veterans Affairs, and other interested parties. The report also is available at no charge on GAO's website 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 V.

Randall B. Williamson
Director, Health Care

List of Committees

The Honorable Carl Levin
Chairman
The Honorable John McCain
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Patty Murray
Chairman
The Honorable Richard Burr
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable Daniel Inouye
Chairman
The Honorable Thad Cochran
Ranking Member
Subcommittee on Defense
Committee on Appropriations
United States Senate

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The Honorable Mark Kirk
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Subcommittee on Military Construction, Veterans Affairs,
and Related Agencies
Committee on Appropriations
United States Senate

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The Honorable Norman Dicks
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Subcommittee on Defense
Committee on Appropriations
House of Representatives

The Honorable John Culberson
Chairman
The Honorable Sanford Bishop
Ranking Member
Subcommittee on Military Construction, Veterans Affairs,
and Related Agencies
Committee on Appropriations
House of Representatives

Appendix I: Enrollment and Populations for Select Department of Defense and Department of Veterans Affairs Programs

Both the Department of Defense (DOD) and the Department of Veterans Affairs (VA) operate care coordination[1] and case management[2] programs designed to assist servicemembers and veterans as they navigate the recovery care continuum, from acute medical treatment and stabilization, through rehabilitation, to reintegration—either back to active duty or to the civilian community as a veteran. This appendix describes selected DOD and VA programs and includes data on enrollment and population characteristics as well as the type of information each program tracks on referrals.

DOD Wounded Warrior Programs

Within DOD, each military service has established its own wounded warrior program or a complement of programs[3] to assist wounded, ill, and injured servicemembers during their recovery and rehabilitation, and to help with the transition back to active duty or to civilian life.[4] Wounded warrior programs range in size from the largest, the Army's Warrior Transition Units and Community-Based Warrior Transition Units, with 18,762 enrollees served in fiscal year 2011, to the smallest, the Navy Safe Harbor Program, with 784 enrollees served in fiscal year 2011. (See table 4 for a list of the DOD wounded warrior programs and enrollment for fiscal year 2011.)

[1]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.

[2]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 high quality, cost-effective outcomes.

[3]Military services operate multiple programs that are specialized to serve different populations, such as the severely wounded or surviving family members. For example, within the Air Force's Warrior and Survivor Care Program, the Air Force operates three distinct programs: (1) the Air Force Wounded Warrior Program to serve those who were injured in combat; (2) the Air Force Recovery Care Program to serve other seriously and severely wounded, ill, and injured; and (3) the Air Force Survivor Assistance Program, to serve surviving family members or caregivers of wounded, ill, and injured servicemembers.

[4]For the purpose of this appendix we will be discussing seven of the case management and care coordination programs established by the military services to assist recovering servicemembers and veterans with recovery, rehabilitation, and transition either back to military service or to civilian life.

Table 4: Military Services' Wounded Warrior Programs: Enrollment for Fiscal Year 2011

Military services' wounded warrior program	Number enrolled, as of fiscal year 2011
Army	
Army Warrior Care and Transition Program: Warrior Transition Units and Community-Based Warrior Transition Units[a,b]	18,762
Army Warrior Care and Transition Program: Army Wounded Warrior Program[b]	9,738
Navy/Coast Guard	
Navy Safe Harbor Program[c]	784
Air Force	
Air Force Wounded Warrior Program[d]	1,386
Air Force Recovery Care Program	1,804
Marine Corps	
Marine Corps Wounded Warrior Regiment[e,f]	2,155
United States Special Operations Command[g]	
United States Special Operations Command's Care Coalition	4,570

Source: GAO analysis of military services' wounded warrior program information.

[a]Enrollment data include servicemembers who were in the Army Warrior Care and Transition Program at any point during the fiscal year, not the population on a specific date.

[b]Enrollees may include servicemembers who are dually enrolled in the Army Warrior Care and Transition Program and Army Wounded Warrior Program.

[c]Enrollment numbers represent all enrollees being served by the program as of December 31, rather than as of the end of each fiscal year.

[d]Servicemembers may be dually enrolled in the Air Force Wounded Warrior Program and the Air Force Recovery Care Program. The enrollment data presented here only reflect servicemembers who are enrolled in the Air Force Wounded Warrior Program.

[e]According to a Wounded Warrior Regiment official, the Wounded Warrior Regiment does not have "enrollees," rather the program assigns and attaches Marines to the program.

[f]Total enrollment does not include Wounded Warrior Regiment enrollees who are not assigned or attached to a Wounded Warrior Regiment site. Many wounded, ill, and injured Marines are supported by the Wounded Warrior Regiment while remaining with their parent unit.

[g]Enrollees of the United States Special Operations Command's Care Coalition Recovery Program may also be enrolled in a military service's wounded warrior program on the basis of their branch of service, but the United States Special Operations Command's Care Coalition Recovery Program takes the lead for providing nonclinical case management.

Programs differ in their organization and function. For example, two of the wounded warrior programs—the Army's Warrior Transition Units and the Marine Corps Wounded Warrior Regiment—are organized under separate military commands, which means that wounded, ill, and injured servicemembers enrolled in these programs may be removed from their parent units or commands and assigned or attached to a separate unit or

regiment that provides command and control[5] over the recovering servicemember as well as administrative support. These servicemembers may be housed in separate barracks while receiving medical care and waiting to transition back to active duty or civilian life. The other wounded warrior programs do not assign or attach servicemembers to a separate command structure, but provide services while recovering servicemembers remain with their parent units. The services provided by the wounded warrior programs also vary. A servicemember may receive either case management or care coordination services or both, depending on how the military service's wounded warrior program is structured. For example, the Navy Safe Harbor Program only provides care coordination services and does not have a case management component, whereas the Marine Corps Wounded Warrior Regiment provides all servicemembers with both case management and care coordination services. A further distinction is whether or not a program serves veterans as well as servicemembers. For example, the Army Warrior Transition Units do not serve veterans, but eligible veterans are served through the Army Wounded Warrior Program. The remainder of the wounded warrior programs continue to provide support to any enrollee who needs services even after the enrollee has transitioned to veteran status.

Army Warrior Care and Transition Program

The Army's Warrior Care and Transition Program, which was established in May 2007,[6] consists of two components that support the recovery process for wounded, ill, and injured servicemembers—the Warrior Transition Units[7] and the Army Wounded Warrior Program. The Army operates a number of warrior transition units located at Army installations across the country. Recovering servicemembers who are attached or assigned to a warrior transition unit generally are housed in barracks and receive medical care, rehabilitative services, professional development and clinical and nonclinical case management services in order to help

[5]DOD defines command and control as the exercise of authority and direction by a properly designated commander over assigned and attached forces in the accomplishment of the mission.

[6]The program was originally named the Army Medical Action Plan.

[7]Warrior Transition Units are technically an Army brigade, battalion, or company that provides command and control, administrative support, primary care and case management and other services to promote readiness of soldiers and family to transition back to active duty or to civilian life. For the purposes of this report, we are categorizing it as a wounded warrior program.

them in their transition back to active duty or to the civilian community. Army Warrior Transition Units vary in size and functionality, including community-based warrior transition units,[8] which primarily serve Reserve Component servicemembers.[9] In fiscal year 2011, there were a total of 14,906 recovering servicemembers assigned or attached to 29 warrior transition units and 3,856 recovering servicemembers assigned or attached to 10 community-based warrior transition units. (See table 5.) According to Army policy, recovering servicemembers assigned or attached to the units are expected to require 6 months or more of rehabilitative care or require complex medical management.

The Army Wounded Warrior Program[10] was established in April 2004 to assist severely wounded, ill, and injured servicemembers, their families, and caregivers. Army Wounded Warrior Program enrollees are assigned an Advocate who provides nonclinical care coordination services, which include assisting enrollees with benefit information, career guidance, finances, and the integrated disability evaluation system (IDES) process. Recovering servicemembers are eligible for Army Wounded Warrior Program services if they have, or are expected to receive, an Army disability rating of 30 percent or greater in one or more specific categories or a combined rating of 50 percent or greater for conditions that are the result of combat or are combat-related. The most severely wounded, ill, or injured servicemembers who are assigned to warrior transition units are also enrolled in the Army Wounded Warrior Program. The Army Wounded Warrior Program also provides services to veterans. In fiscal year 2011, nearly three-fourths of the population (6,953) were veterans. (See table 6.)

[8]The Community-based Warrior Transition Unit Program allows servicemembers to live at home and perform duty at a location near home while receiving medical care.

[9]Warrior transition units and community-based warrior transition units serve Active Component servicemembers as well as servicemembers in National Guard and Reserve Components, but do not serve veterans.

[10]The Army Wounded Warrior Program was originally named the Disabled Soldier Support System.

Table 5: Army Warrior Care and Transition Program Enrollment Populations and Characteristics, Fiscal Years 2008 through 2011

	Fiscal year			
	2008	**2009**	**2010**	**2011**
Program enrollment for Warrior Transition Units and Community-Based Warrior Transition Units				
Total enrollment[a,b]	**20,878**	**19,238**	**18,647**	**18,762**
Active Duty	13,558	11,771	9,560	9,160
National Guard[c]	4,761	4,839	5,860	5,857
Reservists[c]	2,559	2,628	3,227	3,745
Population characteristics				
Enrollees with combat-related conditions[d]	2,523	2,033	1,788	1,984
Enrollees with non-combat-related conditions[e]	18,355	17,205	16,859	16,778
Enrollees who left the program				
Returned to active duty[f]	4,366	4,279	4,664	5,349
Transitioned to veteran status[g]	5,125	5,938	4,027	3,448
Left for other reasons[h]	146	200	159	148
Referrals				
Total number of servicemembers referred to the program[i]	**20,878**	**19,238**	**18,647**	**18,762**
Warrior Transition Unit enrollment				
Total enrollment in Warrior Transition Units[a,b]	**18,038**	**16,203**	**14,921**	**14,906**
Active Duty	13,511	11,686	9,456	9,058
National Guard[c]	2,864	2,807	3,336	3,354
Reservists[c]	1,663	1,710	2,129	2,494
Population characteristics				
Enrollees with combat-related conditions[d]	2,231	1,798	1,569	1,760
Enrollees with non-combat-related conditions[e]	15,807	14,405	13,352	13,146
Enrollees who left the program				
Returned to active duty[f]	3,613	3,653	3,803	4,259
Transitioned to veteran status[g]	4,706	5,445	3,700	3,167
Left for other reasons[h]	139	184	146	135
Community-Based Warrior Transition Unit enrollment				
Total enrollment in Community-Based Warrior Transition Units[a,b,j]	**2,840**	**3,035**	**3,726**	**3,856**
Active Duty	47	85	104	102
National Guard[c]	1,897	2,032	2,524	2,503
Reservists[c]	896	918	1,098	1,251

	Fiscal year			
	2008	2009	2010	2011
Population characteristics				
Enrollees with combat-related conditions[d]	292	235	219	224
Enrollees with non-combat-related conditions[e]	2,548	2,800	3,507	3,632
Enrollees who left the program				
Returned to active duty[f]	753	626	861	1,090
Transitioned to veteran status[g]	419	493	327	281
Left for other reasons[h]	7	16	13	13

Source: GAO analysis of Army Warrior Care and Transition Program data.

Notes: The Army Warrior Care and Transition Program's Warrior Transition Units and Community-Based Warrior Transition Units serve Active, Guard, and Reserve Component servicemembers. The program does not serve veterans.

[a]Enrollment data include servicemembers who were in the Army Warrior Care and Transition Program at any point during the fiscal year, not the population on a specific date.

[b]Enrollees may include servicemembers who are dually enrolled in the Army Warrior Care and Transition Program and the Army Wounded Warrior Program.

[c]National Guard and Reservists enrolled in the Army Warrior Care and Transition Program must be on active-duty orders in order to participate in the program.

[d]Enrollees with combat-related conditions only include those enrollees medically evacuated from a combat zone with identified battle injuries. Other combat-related conditions, such as posttraumatic stress disorder, may not have required medical evacuation from a combat zone and therefore would not be captured in the data provided. In addition, prior battle injuries not related to the servicemember's current medical diagnosis would also be excluded from the data. Battle injury is defined as damage or harm sustained by personnel during or as a result of battle conditions.

[e]Enrollees with non-combat-related conditions include all enrollees who were not medically evacuated from a combat zone and those who are identified as having nonbattle injuries.

[f]Enrollees who exit the program by returning to duty also include Guard or Reserve Components who are released from active duty, but not medically separated from military service.

[g]Enrollees who transition to veteran status include only enrollees who are medically separated from military service.

[h]Enrollees are considered to have left the Army Warrior Care and Transition Program's Warrior Transition Units for "other" reasons, including death or as a result of military legal actions. This category also includes those enrollees with incomplete information about why they left the program.

[i]According to Army Warrior Care and Transition Program officials, the program only tracks referral information for program enrollees. Therefore, the program does not have data on servicemembers who were referred, but never enrolled into the program.

[j]The Army's Community-Based Warrior Transition Units are populated only by servicemembers who transfer to the Community-Based Units from their original assignment to a Warrior Transition Unit. According to Army Warrior Care and Transition Program officials, the first 60 days of recovery are typically spent in a Warrior Transition Unit. After the initial recovery period, a decision is made about whether the servicemember should be transferred to a community-based unit. Data provided in the table reflect the most recent location recorded for each enrollee.

Table 6: Army Wounded Warrior Program Enrollment Populations and Characteristics, Fiscal Years 2008 through 2011

	Fiscal year			
	2008	**2009**	**2010**	**2011**
Program enrollment for Army Wounded Warrior Program				
Total enrollment[a,b]	**3,813**	**6,473**	**8,454**	**9,738**
Servicemembers	2,037	3,377	3,354	2,785
Active Duty	1,249	2,252	1,954	1,210
National Guard[c]	562	794	985	1,091
Reservists[c]	226	331	415	484
Veterans	1,776	3,096	5,100	6,953
Population characteristics				
Enrollees with combat-related conditions	3,233	5,503	7,082	8,001
Enrollees with non-combat-related conditions	544	875	1,104	1,184
Enrollees with conditions not classified as either combat- or non-combat-related[d]	36	95	268	553
Enrollees who changed duty status or left the program				
Returned to active duty[e]	117	80	59	47
Transitioned to veteran status[f]	958	1,574	1,539	1,100
Left for other reasons[g]	10	24	21	3
Referrals and assists				
Total number of servicemembers referred to the program	**3,106**	**4,199**	**3,993**	**3,364**
Servicemembers referred and enrolled in the program	2,037	3,377	3,354	2,785
Servicemembers referred and assisted, but not enrolled in the program[h]	969	822	639	579
Total number of veterans referred to the program	**2,568**	**3,617**	**5,554**	**7,291**
Veterans referred and enrolled in the program	1,776	3,096	5,100	6,953
Veterans referred and assisted, but not enrolled in the program	792	521	454	338

Source: GAO analysis of Army Wounded Warrior Program data.

[a]Enrollment data include servicemembers and veterans who were served by the program at any point during the fiscal year, not the population being served on a specific date.

[b]Enrollees also may be enrolled in the Army's Warrior Transition Units or Community-Based Warrior Transition Units.

[c]Enrollment is counted in this category only for National Guard and Reservists who were on active duty orders during the designated fiscal year. According to Army Wounded Warrior Program officials, National Guard and Reservists who were demobilized previous to the designated fiscal year are considered veterans.

[d]Enrollees considered to have "conditions not classified as either combat- or non-combat-related" include enrollees who have yet to complete the physical disability evaluation process and therefore do not have verification of whether or not their conditions are combat-related.

[e]Army Wounded Warrior Program officials said that the program does not specifically track whether or when an enrollee returns to active duty. However, data on duty status are available for those enrollees who are also enrolled in the Army's Warrior Transition Units or Community-Based Warrior Transition Unit, as provided in the table.

[f]Army Wounded Warrior Program officials said that the program does not specifically track whether or when an enrollee transitions to veteran status because it has no impact on enrollees' eligibility for the program and whether they leave the program. Rather, these data have been derived by the program by counting the number of enrolled servicemembers who received a certificate of release or discharge from active duty within each fiscal year.

[g]Enrollees considered to have "left for other reasons" include those who died while enrolled in the Army Wounded Warrior Program.

[h]The data include those enrollees who were later found ineligible for the program and were disenrolled, but assisted during their initial period of enrollment. These ineligible enrollees were not included in the program's count of total enrollees. Additionally, some servicemembers who were referred to the Wounded Warrior Program and provided short-term, informal assistance are not included in the data because they are not tracked by the program.

Navy Safe Harbor Program

The Navy Safe Harbor Program office was established in 2005. Over time, this office expanded its reach and mission, and in 2008 the program became responsible for nonclinical care coordination and oversight of all severely (and high-risk nonseverely) wounded, ill, and injured Sailors and Coast Guardsmen.[11] Recovering servicemembers enrolled in the program are assigned to nonmedical care managers who are geographically dispersed at major military treatment facilities and Veterans Affairs polytrauma medical centers. The program's nonmedical care managers assist enrollees with services such as pay and personnel, legal, housing, as well as education and training benefits. In addition, enrollees obtain support from centrally located experts in transition and benefits assistance, such as a liaison to the Department of Labor and a Navy Staff Judge Advocate. Recovering servicemembers enrolled in the program are enrolled for life and, if desired, receive support from Navy Safe Harbor personnel after they transition to veteran status. (See table 7.)

[11]According to Navy Safe Harbor Program officials, the program evolved from the Navy's preexisting Military Severely Injured Center & Casualty Office.

Table 7: Navy Safe Harbor Program Enrollment Populations and Characteristics, Fiscal Years 2008 through 2011

	Fiscal year			
	2008	**2009**	**2010**	**2011**
Program enrollment for Navy Safe Harbor Program				
Total enrollment[a]	**255**	**434**	**576**	**784**
Servicemembers	144	236	271	391
Active Duty	77	129	152	254
Reservists	67	107	119	137
Veterans	111	198	305	393
Population characteristics				
Enrollees with combat-related conditions	130	166	193	239
Enrollees with non-combat-related conditions	125	268	383	545
Enrollees who changed duty status or left the program				
Returned to active duty	ND	ND	ND	113
Transitioned to veteran status	ND	91[b]	338[b]	142
Left for other reasons	0	0	0	1
Referrals and assists				
Total number of servicemembers and veterans referred to the program[c]	**304**	**296**	**370**	**475**
Servicemembers and veterans referred and enrolled in the program	255	179	142	208
Servicemembers and veterans referred and assisted, but not enrolled in the program	74	417	330	199
Servicemembers and veterans referred but not enrolled in or assisted by the program	0	0	2	73

Legend: ND indicates that no data are available.

Source: GAO analysis of Navy Safe Harbor Program data.

[a]Enrollment numbers represent all enrollees being served by the program as of December 31, rather than as of the end of each fiscal year.

[b]According to a Navy Safe Harbor Program official, the database used to capture information about the duty status of enrollees did not have the ability to track dates when servicemembers transitioned to veteran status until the system was upgraded in 2010. At that point, the program moved all enrollees who had previously medically retired to a veteran status. Therefore, the number of enrollees who transitioned to veteran status in fiscal year 2010 includes both servicemembers who transitioned to veteran status within the fiscal year and servicemembers who transitioned to veteran status during the previous fiscal years.

[c]The database used to capture referral information for the Navy Safe Harbor Program does not distinguish servicemembers from veterans referred to the program. Rather, the referral information provided for servicemembers also includes any veterans who were referred to the program.

Air Force Warrior and Survivor Care Program

The Air Force Warrior and Survivor Care Program supports wounded, ill, and injured servicemembers through its Air Force Wounded Warrior Program and the Air Force Recovery Care Program.[12] The Air Force Wounded Warrior Program was established in June 2005 to provide nonclinical case management to Airmen, Air National Guard, and Reserve Component servicemembers who have combat-related illnesses or injuries. Each enrolled servicemember is assigned a nonmedical care manager, who serves as an advocate for enrollees to obtain services from agencies and organizations that support the needs of enrolled servicemembers, their families and caregivers. The Air Force Wounded Warrior Program continues to provide services to enrollees once they transition to veteran status. (See table 8.)

The Air Force Recovery Care Program was established in November 2008 to provide nonclinical care coordination services for seriously ill and injured Airmen, Air National Guard, and Reserve Component servicemembers. Each enrolled servicemember is assigned a care coordinator who oversees the coordination of services and assists enrollees' with nonclinical needs, such as employment and benefits. These care coordinators also work with enrolled servicemembers to develop their recovery plans and career goals. Enrollees who have combat-related illness or injuries are concurrently enrolled in the Air Force Wounded Warrior Program. For example, in fiscal year 2011, almost 300 Air Force Recovery Care Program enrollees were also either tracked or actively assisted by the Air Force Wounded Warrior Program. (See table 9.)

[12]The Air Force Warrior and Survivor Care Program's Survivor Assistance Program primarily provides services to the families of wounded, ill, and injured servicemembers.

Table 8: Air Force Wounded Warrior Program Enrollment Populations and Characteristics, Fiscal Years 2008 through 2011

	Fiscal year			
	2008	**2009**	**2010**	**2011**
Program enrollment for Air Force Wounded Warrior Program				
Total enrollment[a]	**194**	**451**	**836**	**1,386**
Servicemembers	160	388	703	1,143
Active Duty	103	256	463	783
National Guard	32	60	123	194
Reservists	25	72	117	166
Veterans	34	63	133	243
Population characteristics				
Enrollees with combat-related conditions	187	442	804	1,327
Enrollees with non-combat-related conditions	7	9	32	59
Enrollees who changed duty status or left the program				
Returned to active duty	4	22	65	128
Transitioned to veteran status	157	329	532	786
Referrals and assists				
Total number of servicemembers referred to the program	**146**	**357**	**724**	**1,176**
Servicemembers referred and enrolled in the program	145	337	645	1,071
Servicemembers referred and assisted, but not enrolled in the program[b]	1	20	79	105
Servicemembers referred but not enrolled in or assisted by the program	0	0	0	0
Total number of veterans referred to the program	**34**	**63**	**133**	**243**
Veterans referred and enrolled in the program	34	63	133	243
Veterans referred and assisted, but not enrolled in the program	NA	NA	NA	NA
Veterans referred but not enrolled in or assisted by the program	0	0	0	0

Legend: NA indicates that the category is not applicable to the program.

Source: GAO analysis of Air Force Wounded Warrior Program data.

[a]Servicemembers may be dually enrolled in the Air Force Recovery Care Program and the Air Force Wounded Warrior Program. The enrollment data presented here only reflect servicemembers who are enrolled in the Air Force Wounded Warrior Program.

[b]According to Air Force Wounded Warrior Program officials, because the program only serves servicemembers with combat-related conditions, most referrals come from casualty reports and the disability evaluation process, where it is determined whether a servicemember's wound, illness, and injury are combat-related. Once the determination is made, servicemembers are enrolled into the program.

Table 9: Air Force Recovery Care Program Enrollment Populations and Characteristics, Fiscal Years 2008 through 2011

	Fiscal year			
	2008	**2009**	**2010**	**2011**
Program enrollment for Air Force Recovery Care Program				
Total enrollment[a]	**ND**	**ND**	**ND**	**1,804**
Servicemembers	ND	ND	ND	ND
National Guard	ND	ND	ND	ND
Reservists	ND	ND	ND	ND
Veterans	ND	ND	ND	ND
Others[b]	ND	ND	ND	251
Population characteristics				
Enrollees with combat-related conditions	ND	ND	ND	316
Enrollees with non-combat-related conditions	ND	ND	ND	782
Enrollees who changed duty status or left the program				
Returned to active duty	ND	ND	ND	288
Transitioned to veteran status	ND	ND	ND	394
Left for other reasons	ND	ND	ND	ND
Referrals and assists				
Total number of servicemembers referred to the program	**ND**	**ND**	**ND**	**1,804**

Legend: ND indicates that no data are available.

Source: GAO analysis of Air Force Recovery Care Program data.

Notes: According to Air Force Recovery Care Program officials, the program did not routinely track certain data about the program, because these data were not required to be collected by the DOD policy that governs the program. In addition, the original Air Force Recovery Care program requirements did not include provisions for data collection. The officials told us that a data-collection tool is being developed and that requirements for data collection would be finalized by the beginning of July 2012. The officials anticipate the new tool will be operational by January 2013.

[a]Enrollees may also be enrolled in the Air Force's Wounded Warrior Program.

[b]The Air Force Recovery Care Program serves some servicemembers from other military services.

Marine Corps Wounded Warrior Regiment

The Marine Corps established the Wounded Warrior Regiment in May 2007 to provide and facilitate assistance to wounded, ill, and injured Marines and their family members throughout the recovery process. The Wounded Warrior Regiment is a single command that oversees nonmedical care for the total Marine force, including Active Duty, Reserve, retired, and veteran Marines. The regiment enrolls Marines regardless of whether they have combat- or non-combat-related conditions. The regiment commands the operation of two wounded warrior battalions and 14 detachments located at 12 principal military treatment facilities and four Veterans Affairs polytrauma medical centers

across the United States and overseas. A Marine enrolled in the regiment can either stay with his or her parent unit and be supported by the regiment, or be assigned or attached to one of the regiment's battalions and detachments, depending on their specific needs. Generally, Marines who require more than 90 days of medical treatment or rehabilitation are assigned or attached to a battalion or detachment. The District Injured Support Cells Program is the component of the Wounded Warrior Regiment that provides services to veterans.[13] District Injured Support Coordinators are located at 30 sites across the United States to provide support, including nonmedical care management to its enrollees. In fiscal year 2011, the District Injured Support Coordinators provided support to 1,488 veterans. (See table 10.)

[13]District Injured Support Coordinators may also provide support to Reserve and Active Duty Marines in remote locations away from military or other federal resources.

Table 10: Marine Corps Wounded Warrior Regiment Enrollment Populations and Characteristics, Fiscal Years 2008 through 2011

	Fiscal year			
	2008	**2009**	**2010**	**2011**
Program enrollment for Marine Corps Wounded Warrior Regiment				
Total enrollment[a,b]	**810**	**725**	**634**	**2,155**
Servicemembers	810	725	634	667
Active Duty	712	633	494	517
Reservists	98	92	140	150
Veterans served through District Injured Support Coordinators[c]	ND	ND	ND	1,488
Population characteristics				
Enrollees with combat-related conditions[d]	216	105	115	224
Enrollees with non-combat-related conditions[e]	594	620	519	443
Enrollees who changed duty status or left the program				
Returned to active duty	35	38	84	94
Transitioned to veteran status	149	266	311	366
Left for other reasons[e]	ND	ND	ND	ND
Referrals				
Total number of servicemembers referred to the program[f]	**ND**	**ND**	**ND**	**ND**
Total number of veterans referred to District Injured Support Coordinators[g]	**ND**	**ND**	**ND**	**ND**

Legend: ND indicates that no data are available.

Source: GAO analysis of Marine Corps Wounded Warrior Regiment data.

[a]According to a Wounded Warrior Regiment official, the Wounded Warrior Regiment does not have "enrollees," rather the program assigns and attaches Marines to the program.

[b]Total enrollment does not include Wounded Warrior Regiment enrollees who are not assigned or attached to a Wounded Warrior Regiment site. Many wounded, ill, and injured Marines are supported by the Wounded Warrior Regiment while remaining with their parent unit.

[c]The District Injured Support Coordinators provide outreach and services to Reserve and veteran Marines located across the country.

[d]The data in this category do not include Marines attached to the Wounded Warrior Regiment who may have been wounded, fallen ill, or injured in a combat zone, but who were not medically evacuated from a combat zone.

[e]Although the Wounded Warrior Regiment was not able to provide data on the number of enrollees who left the Wounded Warrior Regiment for reasons other than returning to duty or transitioning to veteran status, according to a Wounded Warrior Regiment official, Marines attached to the Wounded Warrior Regiment have left the program for other reasons such as death or as a result of military legal actions taken against the Marine.

[f]According to a Marine Corps Wounded Warrior Regiment official, although a policy exists requiring referral information to be collected, the policy was not always enforced. According to this official, as of fiscal year 2012, the data are routinely collected.

[g]According to a Marine Corps Wounded Warrior Regiment official, the District Injured Support Coordinators initially served veterans on an ad hoc basis, so referral information was not collected.

United States Special Operations Command's Care Coalition

The United States Special Operations Command established the Care Coalition in August 2005 to track, support, and advocate for Special Operations Force's wounded, ill, and injured servicemembers regardless of their duty status or whether their conditions are combat-related. (See table 11.) All enrollees are assigned an Advocate and are entitled to advocate services for life. Advocates assist enrollees with health care and financial benefits, transition processes, and link enrollees with needed government and nongovernment resources. Because the United States Special Operations Command's Care Coalition serves servicemembers from across the military services, it serves as a liaison with, and complements, the military services' wounded warrior programs. United States Special Operations Command's Care Coalition enrollees are often concurrently enrolled in their own military service's wounded warrior program. However, according to a Care Coalition official, the Care Coalition serves as the lead program for case management and care coordination for dually enrolled servicemembers.

Table 11: United States Special Operations Command's Care Coalition Enrollment Populations and Characteristics, Fiscal Years 2008 through 2011

	Fiscal year			
	2008	**2009**	**2010**	**2011**
Program enrollment for United States Special Operations Command's Care Coalition				
Total enrollment[a]	**2,277**[b]	**2,532**[b]	**3,447**	**4,570**
Servicemembers	1,594	1,741	2,475	3,518
National Guard	113	127	154	228
Reservists	193	196	206	232
Veterans	654	722	838	893
Others[c]	152	192	262	287
Population characteristics				
Enrollees with combat-related conditions[d]	1,693	1,803	2,415	2,879
Enrollees with non-combat-related conditions[d]	736	839	1,256	1,859
Enrollees who changed duty status				
Returned to active duty[e]	31	32	38	46
Transitioned to veteran status[e]	4	23	24	48
Referrals				
Total number of servicemembers referred to the program[f]	**ND**	**ND**	**ND**	**ND**
Total number of veterans referred to the program[f]	**ND**	**ND**	**ND**	**ND**

Legend: ND indicates that no data are available.

Source: GAO analysis of United States Special Operations Command's Care Coalition data.

[a]Enrollees of the United States Special Operations Command's Care Coalition Recovery Program may also be enrolled in a military service's wounded warrior program on the basis of their branch of service, but the United States Special Operations Command's Care Coalition Recovery Program takes the lead for providing nonclinical case management.

[b]According to a United States Special Operations Command's Care Coalition official, because of a change in the data system used to track enrollment, enrollment numbers provided for fiscal year 2008 include enrollees served by the program between October 1, 2007, and May 28, 2009. Enrollment numbers provided for fiscal year 2009 include an additional 255 servicemembers and veterans who enrolled in the program between May 28, 2009, and September 30, 2009.

[c]Others enrolled include civilians, surviving family members, and records with unknown information. According to a United States Special Operations Command's Care Coalition official, the program continues to provide and track services to surviving family members after an enrolled servicemember or veteran has died.

[d]According to a United States Special Operations Command's Care Coalition official, data provided on enrollees with either combat- or non-combat-related conditions also include some servicemembers who were either killed in action or died while enrolled in the program, and therefore were excluded from the total enrollment data. In addition, officials stated that the exact count for non-combat-related conditions may not be accurate, due to inaccuracies in record keeping.

[e]According to a United States Special Operations Command's Care Coalition official, the program did not begin tracking enrollee transition status and transition dates in an accessible format until January 2012. Therefore, information about the duty status and transition status is being updated by hand as an individual record is reviewed by program personnel, and the information provided may not be accurate.

[f]According to a United States Special Operations Command's Care Coalition official, the program has several methods of receiving referrals, but its primary source of referrals comes from casualty reports. The program does not track referral information because the Care Coalition does not have a field in its database to track this information. However, this official said that the Care Coalition could access this information by contacting the military services.

VA Case Management and Care Coordination Programs

VA operates a number of case management and care coordination programs that provide assistance to recovering servicemembers and veterans, including the Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Care Management Program and the Federal Recovery Coordination Program (FRCP).[14] These two programs assist wounded servicemembers and veterans to navigate the recovery care continuum.

OEF/OIF/OND Care Management Program

The OEF/OIF/OND Care Management Program was established in March 2007 to provide case management to wounded, ill, and injured servicemembers and veterans who screen positive for the need for case management or request case management services. (See table 12). Each of VA's 152 Medical Centers (VAMC) has an OEF/OIF/OND Care Management team in place to manage patient care activities and ensure that servicemembers and veterans are receiving patient-centered, integrated care and benefits. Members of the OEF/OIF/OND Care Management team include: a Program Manager, Clinical Case Managers, and a Transition Patient Advocate.

[14]In addition, the Department of Veterans Affairs operates other dedicated programs and systems of care including Polytrauma/Traumatic Brain Injury, Spinal Cord Injury and Diseases, Visual Impairment, and Mental Health that provide specialized lifelong clinical care and care management for these special cohorts of veterans.

Table 12: Operation Enduring Freedom/Operation Iraqi Freedom/ Operation New Dawn (OEF/OIF/OND) Care Management Program Enrollment Populations and Characteristics, Fiscal Years 2008 through 2011

	Fiscal year			
	2008[a]	2009[a]	2010	2011
Total enrollment[b]	**2,463**	**7,048**	**49,145**	**50,255**
Servicemembers[c]	152	590	2,069	2,505
Veterans	1,136	4,212	31,831	29,848
Others[d]	1,175	2,246	15,245	17,902
Population characteristics				
Enrollees with combat-related conditions[e]	1,214	2, 470	7,165	6,898
Enrollees with non-combat-related conditions[f]	212	676	3,115	3,188
Enrollees with conditions not classified as either combat- or non-combat-related[g]	200	880	4,820	4,072
Referrals				
Total number of servicemembers and veterans referred to the program by military treatment facilities[h]	**2,130**	**4,474**	**7,172**	**6,686**

Source: GAO analysis of OEF/OIF/OND Care Management Program data.

[a]According to OEF/OIF/OND Care Management Program officials, 2008 and 2009 data only include severely wounded, ill, and injured because the database only tracked this subpopulation of the program, which was the initial focus of the program's efforts. This population included, for example, those with severe burns, amputations, spinal cord injuries, or blindness, or more than one of these. Soon after the program was initiated, the Department of Veterans Affairs found that people returning from the conflicts in Iraq and Afghanistan required additional support, regardless of the severity of their injuries or illnesses. Therefore, policy was changed and the OEF/OIF/OND Care Management Program began tracking data on all those receiving case management services through their program.

[b]Total enrollment includes those who serve or served in National Guard and Reserve Components.

[c]The OEF/OIF/OND Care Management Program primarily serves veterans. Some servicemembers who are receiving treatment through a VA facility may also be enrolled in the program.

[d]Others include enrollees with unknown military status.

[e]Includes enrollees with battle injuries. According to OEF/OIF/OND Care Management Program officials, battle injuries are injuries sustained while in combat, such as a wound from an improvised explosive device.

[f]Includes enrollees with nonbattle injuries. According to OEF/OIF/OND Care Management Program officials, nonbattle injuries can include injuries sustained in a combat zone that are not directly related to combat.

[g]Includes enrollees with illnesses that may be classified as either combat-related or non-combat-related. According to OEF/OIF/OND Care Management Program officials, the program tracks whether an enrollee's condition is a battle injury or a nonbattle injury, but not whether an illness is related to combat.

[h]According to OEF/OIF/OND Care Management Program officials, servicemembers and veterans are either referred to the program by a military treatment facility or are screened into the program when a servicemember or veteran initially seeks VA services at a VA treatment facility.

FRCP

The FRCP was established in January 2008. Developed as a joint program by DOD and VA, but administered by VA, the program was designed to provide care coordination services to servicemembers and veterans who were "severely" wounded, ill, and injured after September 11, 2001. (See table 13.) The program uses federal recovery coordinators to monitor and coordinate clinical services, including facilitating and coordinating medical appointments, and nonclinical services, such as providing assistance with obtaining financial benefits or special accommodations, needed by program enrollees and their families. Federal recovery coordinators serve as the single point of contact among all of the case managers of DOD, VA, and other governmental and private case management programs that provide services directly to servicemembers and veterans.

Table 13: Federal Recovery Coordination Program (FRCP) Enrollment Populations and Characteristics, Fiscal Years 2008 through 2011

	Fiscal year			
	2008	**2009**	**2010**	**2011**
Program enrollment for the FRCP				
Total enrollment	**177**	**522**	**823**	**1,022**
Servicemembers	132	325	394	573
National Guard[a]	11	51	84	87
Reservists[a]	7	30	45	63
Veterans	43	194	429	449
Others	2	3	0	0
Population characteristics				
Enrollees with combat-related conditions	ND	ND	ND	ND
Enrollees with non-combat-related conditions	ND	ND	ND	ND
Enrollees with conditions not classified as either combat- or non-combat-related	ND	ND	ND	ND
Referrals and assists				
Total number of servicemembers referred to the program	**179**	**257**	**268**	**362**
Servicemembers referred and enrolled in the program	132	194	222	293
Servicemembers referred and assisted, but not enrolled in the program	ND	ND	ND	ND
Servicemembers referred but not enrolled in or assisted by the program	47	63	46	68
Total number of veterans referred to the program	**44**	**171**	**165**	**119**
Veterans referred and enrolled in the program	43	155	150	66
Veterans referred and assisted, but not enrolled in the program	ND	ND	ND	ND
Veterans referred but not enrolled in or assisted by the program	1	16	15	53

Legend: ND indicates that no data are available.

Source: GAO analysis of FRCP data.

[a]According to an FRCP official, the total number of servicemembers who are active duty cannot be delineated because the National Guard and Reservist numbers are descriptive data points and do not designate whether the enrollee is active duty or veteran. In addition, not all National Guard and Reservists are included in the data due to database limitations that have since been resolved.

Referral Information Tracked by DOD and VA Case Management and Care Coordination Programs

DOD and VA case management and care coordination programs primarily identify servicemembers and veterans who may be eligible for enrollment through referrals. Tracking referral information, including the number of those who were referred and enrolled or not enrolled in the program, may indicate whether the programs are identifying those who could benefit from their services. However, fewer than half of the DOD and VA case management and care coordination programs that we reviewed track this type of referral information. (See table 14.)

Table 14: Referral Information Routinely Tracked by DOD and VA Case Management and Care Coordination Programs

Program	Referral information routinely tracked	Types of referral information tracked, if any
Army		
Army Warrior Care and Transition Program: Warrior Transition Units and Community-Based Warrior Transition Units	√	Referral sources for program enrollees
Army Warrior Care and Transition Program: Army Wounded Warrior Program	√	Total number of referrals made to the program Number of those referred to the program who were enrolled into the program Number of those referred to the program who were enrolled and provided short-term assistance by the program, but who were later found ineligible for the program and disenrolled Number of those referred to the program who were not enrolled into the program
Navy/Coast Guard		
Navy Safe Harbor Program	√[a]	Total number of referrals made to the program Number of those referred to the program who were enrolled into the program Number of those referred to the program who were provided short-term assistance by the program, but not enrolled Number of those referred to the program who were not enrolled into the program or provided short-term assistance by the program
Air Force		
Air Force Wounded Warrior Program		According to Air Force Wounded Warrior Program officials, since the program only serves servicemembers with combat-related conditions, most referrals come from casualty reports and the disability evaluation process, where it is determined whether a servicemember's wound, illness, or injury is combat-related.
Air Force Recovery Care Program		None
Marine Corps		
Marine Corps Wounded Warrior Regiment		According to a Marine Corps Wounded Warrior Regiment official, although a policy exists requiring referral information to be collected, the policy was not always enforced.[b]
United States Special Operations Command		

Program	Referral information routinely tracked	Types of referral information tracked, if any
United States Special Operations Command's Care Coalition		According to a United States Special Operations Command's Care Coalition official, the program does not track referral information because there is no field in its database to track this information. However, according to this official, the program is able to access this information from the individual military services.
Department of Veterans Affairs		
Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Care Management Program	√	Total number of referrals made to the program from military treatment facilities
Federal Recovery Coordination Program	√	Total number of referrals made to the program Number of those referred to the program who were enrolled into the program Number of those referred to the program who were provided short-term assistance by the program, but not enrolled Number of those referred to the program who are not enrolled into the program or provided short-term assistance by the program

Source: GAO analysis of DOD and VA data.

[a]According to a Navy Safe Harbor Program official, the database used to track referral information did not capture accurate data until it was upgraded in 2010.

[b]According to a Marine Corps Wounded Warrior Program official, as of fiscal year 2012, data on referral information are routinely collected.

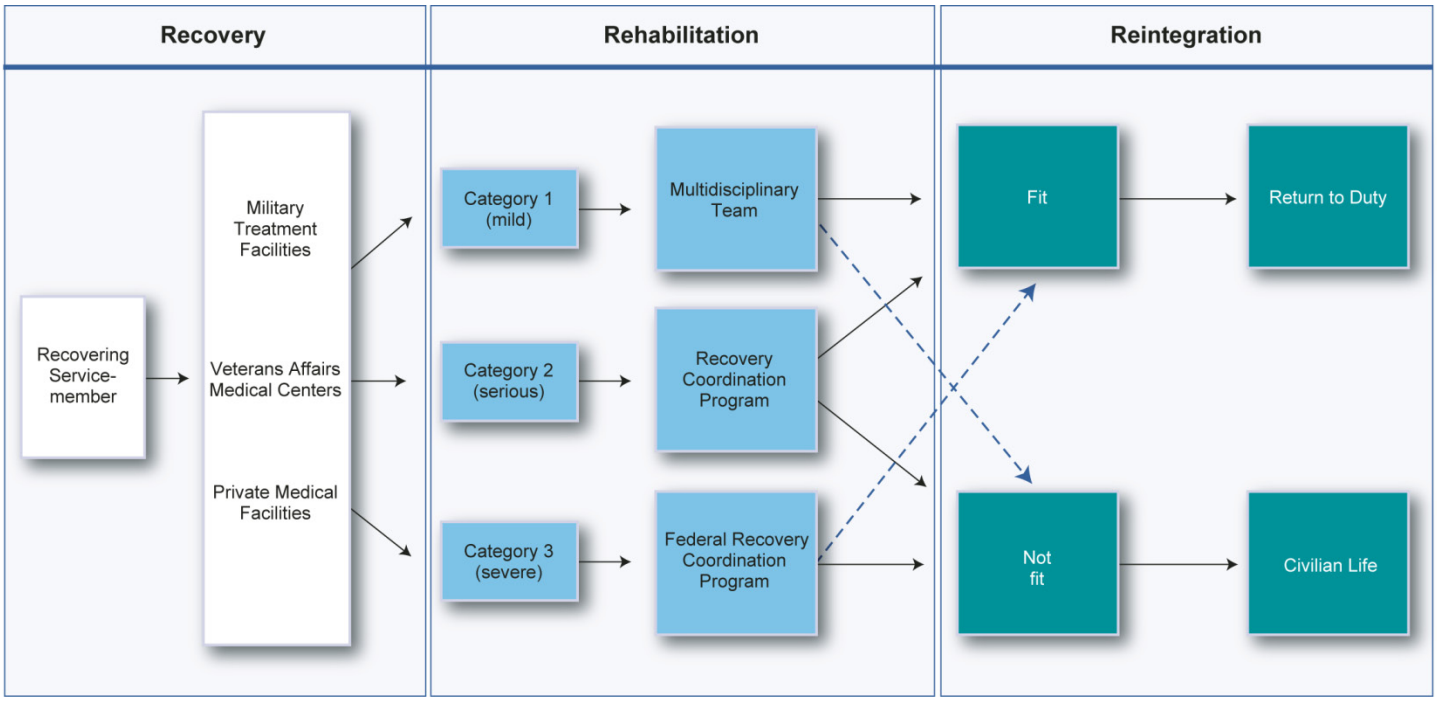
Appendix II: Medical Category Assignment Process for Care Coordination Programs

The Senior Oversight Committee intended for the Federal Recovery Coordination Program (FRCP) and the Recovery Coordination Program (RCP) to be complementary programs, specifically identifying which population of wounded, ill, and injured servicemembers would be assigned to the two programs. On the basis of work done for the committee, the Department of Defense (DOD) sent a report to congressional committees in 2008 outlining a medical category assignment process based on the severity of each servicemember's medical condition, along with input from the servicemember and his or her unit commander, to determine whether servicemembers would be directed either to the FRCP or to the RCP programs for care coordination services.

In concept, the medical category assignment process would have resulted in wounded, injured, or ill servicemembers being assigned to one of three categories. Servicemembers designated as Category 1 were those who were found to have mild injury or illness, who were expected to return to duty in less than 180 days of medical treatment, and primarily received local outpatient and short-term inpatient treatment and rehabilitation. Servicemembers designated as Category 2 were those with serious injury or illness, who were unlikely to return to duty in less than 180 days, and may be medically separated from the military.[1] Servicemembers designated as Category 3 were those with severe injury or illness, who were highly unlikely to return to duty, and were most likely to be medically separated from the military. The category designation was intended to be used to determine whether the recovering servicemember was subsequently referred to a care coordination program, in that Category 1 servicemembers would not be referred to a care coordination program, unless their medical or psychological conditions worsen; Category 2 servicemembers would be referred to the RCP; and Category 3 servicemembers would be referred to the FRCP. (See fig. 3.)

[1]DOD subsequently modified the 180-day criteria to "within a time specified by his or her military department" to accommodate different standards used by the Marine Corps and the Army.

Figure 3: The Department of Defense's Vision of the Assignment Process for the Recovery Coordination Program and the Federal Recovery Coordination Program



Source: GAO analysis of Senior Oversight Committee data.

Note: In this figure, solid arrows indicate typical or expected results and dashed arrows indicate alternative, but possible, outcomes.

Appendix III: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

October 23, 2012

Mr. Randall B. 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's (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-13-5, "RECOVERING SERVICEMEMBERS AND VETERANS: Sustained Leadership Attention and Systematic Oversight Needed to Resolve Persistent Problems Affecting Care and Benefits," dated September 11, 2012 (GAO Code 20934). Thank you for the opportunity to review the draft report.

The report makes specific recommendations to DoD. We offer the enclosed comments and suggestions to make the report more technically accurate; also attached are the responses to the two recommendations.

The points of contact are Ms. Sandra Mason (Functional) and Mr. Gunther Zimmerman (Audit Liaison). Ms. Mason may be reached at (703) 428-7630, or Sandra.Mason@osd.mil. Mr. Zimmerman may be reached at (703) 681-4350, or Gunther.Zimmerman@tma.osd.mil.

Sincerely,

Jonathan Woodson, M.D.

Enclosures:
1. Overall Comments

GAO DRAFT REPORT DATED SEPTEMBER 11, 2012
GAO-13-5 (GAO CODE 290934)

"RECOVERING SERVICEMEMBERS AND VETERANS: SUSTAINED LEADERSHIP ATTENTION AND SYSTEMATIC OVERSIGHT NEEDED TO RESOLVE PERSISTENT PROBLEMS AFFECTING CARE AND BENEFITS"

DEPARTMENT OF DEFENSE COMMENTS TO THE GAO RECOMMENDATION

RECOMMENDATION 1:

- The GAO recommends that the Secretary of Defense establish or designate an office to centrally oversee and monitor the activities of the military Services' Wounded Warrior Programs to include the following:

DoD Response: DoD concurs.

  - The Under Secretary of Defense for Personnel and Readiness has the authority to establish policies affecting Service Members and Wounded Warrior disability matters and to direct the services to comply with such policies. The Deputy Assistant Secretary of Defense for Warrior Care Policy is the executive office for policy and oversight of Wounded Warrior matters, including the Military Services' Wounded Warrior Programs.

- Developing consistent eligibility criteria to ensure that similarly situated recovering Service members from different military Services have uniform access to these programs.

DoD Response: DoD partially concurs.

  - In their 2011 report, the Recovering Warrior Task Force recommended "Enforce the existing policy guidance regarding transition unit entrance criteria." In our response to that recommendation, we noted, "There is no DoD policy on the establishment of transition units and entrance criteria. These policies have been established by the Secretaries of the Military Departments for their specific populations."
  - The Department continues to believe that the three Service Secretaries should control and maintain entrance criteria in to their transition units (Wounded Warrior units.) This flexibility is both important and

necessary and we do not believe results in noticeable differences in access to programs by the Wounded or their families.
- The Department agrees that the Services need to effectively communicate the current eligibility criteria and to ensure that they are delivering consistent programs to their eligible wounded, ill, and injured Service Members.

- Direct the military Services' Wounded Warrior Programs to fully comply with the policies governing care coordination and case management programs and any future changes to these policies.

DoD Response: DoD concurs:

- The cornerstone document governing the Recovery Coordination Program is DoDI 1300.24. It was published in December 2009 and it outlines expected standards across the continuum of care. DoD will take further steps to ensure that Wounded Warrior Programs are in compliance with this doctrine. The Warrior Care Policy office will reinstitute evaluation and compliance oversight to ensure adherence with policies as outlined using a multiple source approach, specifically staff assistance visits, interviews, and documentation.

- Develop a common mechanism to systematically monitor the performance of the Wounded Warrior Programs-to include the establishment of common terms and definitions-and report this information on a biannual basis to the Armed Services Committees of the House of Representatives and the Senate.

DoD Response: DoD partially concurs:

- The Interagency Care and Coordination Committee (IC3) will conduct an inventory of all Wounded Warrior programs to identify duplication and areas for gaining efficiencies. The Department reports progress in these areas via the JEC Annual Report, which is provided to the Congress and the public annually. The Department believes additional reporting to be redundant and of limited value.
- The Department agrees that the Services have defined the wounded, ill, and injured populations in varied ways. Wherever possible, the Department has instituted common definitions and terms relating to our wounded, ill, and injured populations. Many of these common terms were published by the Wounded, Ill, and Injured Senior Oversight Committee in 2008. Many more were codified and defined in the Recovery Care Coordination Instruction from 2009. We will continue to

review these terms and make any necessary policy adjustments as necessary. We will also work towards driving all in this community to a common understanding and use of these approved definitions.

RECOMMENDATION 2:

- The GAO recommends that the Secretaries of Defense and Veterans Affairs ensure that these issues receive sustained leadership attention and collaboration at the highest levels with a singular focus on what is best for the individual Service member or Veteran to ensure continuity of care and a seamless transition from the DoD to VA.

DoD Response: DoD concurs:

- For the past five years, joint DoD-VA priorities were overseen by two different governance bodies, the Joint Executive Committee (JEC) and the Senior Oversight Committee (SOC). On January 19, 2012, the Departments agreed to consolidate the SOC and JEC forums, based on a recommendation from DoD's Recovering Warrior Task Force. Both Departments feel that the JEC provides the appropriate high level exposure for the critical issues facing the wounded, ill, and injured.
- DoD and VA leaders are actively involved in the development of joint policy decisions, timely implementation and oversight. To provide sustained senior leadership attention and systematic oversight for issues involving recovering Service members and Veterans, the Secretaries of Defense and Veterans Affairs rely on the Co-Chairs of the JEC, the Deputy Secretary of VA and the Under Secretary of Defense for Personnel and Readiness to drive progress on joint issues.
- The purpose of merging the SOC and JEC forums was to ensure that all Wounded Warrior care and benefit issues received the same level of senior leadership attention as the rest of DoD and VA's collaborative efforts, including an annual report to Congress and comprehensive Joint Strategic Planning process. In addition, the JEC relies on its sub councils and working groups, such as the Health Executive Council and Benefits Executive Council, within the JEC structure to provide the subject matter expertise to implement leadership's direction.
- Since the consolidation, the frequency of JEC meetings increased from quarterly to bi-monthly and now receives strategic and specific direction from the Secretary of Defense and Secretary of Veterans Affairs, who meet quarterly to discuss and oversee issues facing both Departments. A few of the items that are now receiving the highest levels of attention at the Secretary-level are: the transitioning of our Service members to civilian life; the Disability Evaluation System; Electronic Health

Records; VA disability claims backlog; and care coordination for recovering Service members.

This should include holding the Joint Executive Council accountable for the following:

- Ensuring that key issues affecting recovering Service members and Veterans get sufficient consideration, including recommendations made by the Warrior Care and Coordination Task Force and Recovering Warrior Task Force.

DoD Response: DoD concurs:

- The Warrior Care and Coordination Task Force was created by the JEC in the summer of 2012 to develop recommendations for a more synchronized process to deliver care, benefits, and services to wounded, ill, and injured Warriors, Veterans and their families. At the 27 Sep 2012 JEC, the co-chairs approved the transition of the Task Force to the Interagency Care and Coordination Committee (IC3), establishing formal governance structure that reports directly to the JEC and which is responsible for implementing the recommendations of the Task Force.
- With the consolidation of the Senior Oversight Committee with the Joint Executive Committee, the Wounded, Ill and Injured Committee (WIIC) was specifically created to focus on issues impacting wounded, ill and injured Service members. The WIIC will report their progress to the Joint Executive Committee (JEC), as does the Health Executive Committee (HEC), the Benefits Executive Committee (BEC) and the Interagency Care and Coordination Committee (IC3). Additionally, each of the subgroups provides updates on the Joint Strategic Plan goals and objectives. For instance the IC3 is defining and standardizing the roles and responsibilities of care coordinators in addition to standardizing and providing oversight on the Comprehensive Recovery Plan/Comprehensive Transition Plan. This was specifically briefed to the JEC at the September 27, 2012 meeting.
- The Departments have taken a similar and effective approach with regards to the Recovering Warrior Task Force (RWTF) recommendations. The Department has implemented 8 of the 21 recommendations made by the RWTF in its FY2011 report and continues to work the remaining 13 recommendations. In the FY2012 report, the RWTF made 35 recommendations.

- Developing mechanisms for making joint policy decisions, involving the appropriate decision makers for timely implementation of policy.

DoD Response: DoD concurs:

- The DoD and VA make joint policy decisions via the JEC on matters affecting both departments. Since the consolidation with the SOC, the frequency of JEC meetings increased from quarterly to bi-monthly and now receives specific strategic direction from the Secretary of Defense and Secretary of Veterans Affairs, who meet quarterly to discuss and oversee issues which face both Departments.

- Establishing mechanisms to systematically oversee joint initiatives and ensure that outcomes and goals are identified and achieved.

DoD Response: DoD concurs:

- The overarching purpose of the consolidation of the SOC into the JEC, is to make the JEC accountable for all key issues affecting recovering Service members and to ensure the senior DoD and VA leaders are involved in the development of policy decisions, as well as timely implementation and oversight of related actions. The DoD/VA Joint Strategic Plan and JEC Annual Report identify interagency goals and accomplishments to all stakeholders.

Appendix IV: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

October 16, 2012

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) in close coordination with the Department of Defense (DoD), has reviewed the Government Accountability Office's (GAO) draft report, ***"RECOVERING SERVICEMEMBERS AND VETERANS: Sustained Leadership Attention and Systematic Oversight Needed to Resolve Persistent Problems Affecting Care and Benefits"*** (GAO-13-5). VA concurs with GAO's specific recommendation to the Department. We agree with GAO that resolving the challenges facing recovering Servicemembers and Veterans is a leadership issue.

VA and DoD have collaborated intensively on improving care coordination. We appreciated your team's understanding of the dynamic issues surrounding this topic and their openness to a joint exit brief. As you can appreciate, these not only support our common interests, but are a visual display that both our staffs are serious about collaboration and integration.

Despite this concurrence with the report, the Departments are concerned with the overall analysis and conclusions reached by GAO. In particular, much of the report's conclusions lead to an over-simplified portrayal of the recovery care continuum in place for the transition of recovering Servicemembers and Veterans. Simply put, the challenges the Departments face are broader and more complex than the two programs the report focuses on, namely the Federal Recovery Coordination Program (FRCP) and the Recovery Coordination Program (RCP).

Last spring, VA and DoD, including Administration and Service level leaders, initiated a task force to take a more detailed look at how we execute case management and care coordination within and between the two Departments. Formed in May 2012, this task force was co-chaired by VA's Chief of Staff, and Principal Deputy Assistant Secretary of Defense, Health Affairs.

We reviewed previous internal and external studies on Warrior care programs including the series of GAO audits and reports on Wounded Warrior care coordination and case management as well as materials created by other high level task force efforts. One prevailing theme we identified in these previous efforts was the need to better integrate and synchronize delivery of DoD and VA care, benefits, and services to the population of Warriors we are privileged to serve.

As you too have noted, there are thousands of dedicated and exceptional military personnel, civil servants, and contractors providing vital clinical and non-clinical case management and care coordination services to Warriors and their families – people who need the substantial services that both Departments provide. These caring professionals strive to provide patient-centric care and services and timely delivery of benefits; they attend to the needs of families; and they work tirelessly to ensure the interests of their Warriors are met. Across the Departments, we identified over 40 programs that provide some level of coordination/management of care, benefits, and services across the continuum of recovery. Today, there is no common operational picture that facilitates collaborative planning and assists all to achieve situational awareness. In summary, DoD and VA recognize the challenge is more broad and deep than overlap of FRCP and RCPs and those receiving their services; we must address this across the Departments for all vital contributors to this important work.

On September 27, 2012, the DoD/VA Joint Executive Council (JEC) received the second of two briefings from this task force. Based upon the recommendation of the task force, the JEC created an Interagency Care and Coordination Committee, reporting to the JEC, responsible for developing interagency guidance that will drive DoD and VA policy. This governing body will provide policy and oversight to a community of practice composed of the programs with a role in executing the transitioning Warrior's comprehensive plan. The comprehensive plan will be patient/family-centric and will help the care coordinators and case managers manage a Servicemember/Veteran's goals for recovery, rehabilitation, and reintegration.

To maintain momentum and purpose, all of the task force leaders are transitioning into positions in the newly established formal governance structure. These leaders have begun working on a series of immediate, near-term, and long-term recommendations to correct perceived redundancies, and establish a model for the Nation in the coordination of care for ill and injured individuals. Ultimately, this effort is expected to create a long-term, sustainable model for the two Departments.

The essential challenge we are now organized to address is the comprehensive overhaul of the care coordination process to meet the needs of today's recovering Warrior. We intend to address all of the providers who work to manage and coordinate the delivery of care, benefits, and services to this population. We must improve communications and support to field personnel. There are opportunities to improve and simplify the process to ensure services are neither duplicated, nor erroneously

eliminated. We recognize that we must be clear to our patients and families, and to the team of care coordinators and case managers, as to who has the lead.

The enclosure specifically addresses one of the GAO recommendations and provides comments on the draft report. VA urges full incorporation of the recommended changes.

VA appreciates your continued interest in the coordination and management of care, service and benefits of our recovering Servicemembers and Veterans and 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
"RECOVERING SERVICEMEMBERS AND VETERANS: Sustained Leadership Attention and Systematic Oversight Needed to Resolve Persistent Problems Affecting Care and Benefits"
(GAO-13-5)

GAO Recommendation: To ensure that persistent challenges with care coordination, disability evaluation, and the electronic sharing of health records are fully resolved, we recommend that the Secretaries of Defense and Veterans Affairs ensure that these issues receive sustained leadership attention and collaboration at the highest levels with a singular focus on what is best for the individual servicemember or veteran to ensure continuity of care and a seamless transition from DOD to VA. This should include holding the Joint Executive Committee (JEC) accountable for

- ensuring that key issues affecting recovering servicemembers and veterans get sufficient consideration, including recommendations made by the Warrior Care and Coordination Task Force and the Recovering Warrior Task Force,
- developing mechanisms for making joint policy decisions,
- involving the appropriate decision-makers for timely implementation of policy, and
- establishing mechanisms to systematically oversee joint initiatives and ensure that outcomes and goals are identified and achieved.

VA Response: Concur. VA and DoD have mechanisms currently in place to systematically oversee issues of joint interest such as the recommendations made by the DoD-VA Warrior Care and Coordination Task Force and relevant joint recommendations of the DoD Recovering Warrior Task Force. There are several layers of oversight currently built into the VA-DoD governance structure that includes: quarterly meetings of the VA and DoD Secretaries; bimonthly meetings of the Joint Executive Committee (JEC); and the regular meetings of the Health Executive Committee (HEC); Interagency Care and Coordination Committee (IC3); the Benefits Executive Committee (BEC); the Interagency Program Office (IPO); and the Independent Working Groups (IWG). The Secretaries of VA and DoD are committed to ensuring that key wounded, ill, and injured issues such as care coordination, disability evaluation, and the electronic sharing of health records receive sustained leadership attention. To work the details and drive progress on these joint issues, the Secretaries rely on the co-chairs of the JEC, the Deputy Secretary of VA and the Under Secretary of Defense for Personnel and Readiness. In addition, the JEC relies on the HEC, BEC, IPO, IC3 and the IWG within the JEC structure to provide the subject matter expertise to implement leadership's direction.

The JEC has mechanisms in place for making joint decisions and regularly makes joint policy decisions that are initially developed by the HEC, BEC, IPO, IC3, IWG, and brought to the JEC for resolution and decisions. The co-chairs of the JEC work closely together to provide leadership for VA-DoD governance. Since its consolidation with the Senior Oversight Committee (SOC) in January 2012, the membership of the JEC was

1

Enclosure

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(GAO-13-5)

enhanced to include key decision-makers from VA, DoD, and the Services. This high level of leadership participation in JEC meetings helps to ensure that key issues including those affecting recovering Servicemembers and Veterans receive sufficient leadership attention.

The JEC has mechanisms in place to systematically oversee joint initiatives and to ensure outcomes and goals are identified and achieved. The JEC establishes goals and objectives with identified outcome oriented performance metrics in the VA/DoD Joint Strategic Plan (JSP). The JSP documents key objectives from all the organizations within the JEC governance structure, including the HEC, BEC, IPO, IC3, and IWGs. (Note: JEC IWGs include the Construction Planning Committee, Strategic Communications Working Group, Separation Health Assessment Working Group, and the Wounded Ill and Injured Committee.) In addition to the JSP, the JEC co-chairs also distribute additional written guidance for each fiscal year designed to ensure all JEC stakeholders are aware of joint priorities and objectives. At the end of each fiscal year, the JEC assesses the progress made towards reaching its goals as reported in the VA/DoD JEC Annual Report to Congress. The JEC also continually evaluates progress and drives outcomes in its bimonthly meetings.

The JEC is supported by the efforts of the HEC, BEC, IPO, IC3, and IWGs, which all meet on a bimonthly or more frequent basis to facilitate collaboration and progress at the subject matter expert level. The HEC, BEC, IPO, and IC3 each have multiple sub working groups that maintain regular VA-DoD collaboration and communication on key issues at the staff level. This formal structure within the JEC helps to organize and maintain leadership attention on the wide range of VA-DoD issues. The co-chairs of the HEC, BEC, IPO, IC3, and IWGs are responsible for identifying and raising to the JEC any issues under their oversight that require higher level attention.

Enclosure

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(GAO-13-5)

Additional Comments:

Page 14, "Recovering Servicemembers Are Not Always Identified and Referred to Programs that May Benefit From Them" section: It is DoD and/or VA treatment teams that determine when the Servicemember and family are medically and psychologically ready to begin the transition process. VA Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) clinical case managers screen all returning combat Veterans for the need for case management services.

Page 26, 2nd paragraph, line 5: GAO states that according to a DoD source, historically the JEC has not been able to drive policy decision-making, and therefore issues that should have been decided by the JEC were taken directly to the Secretaries for resolution.

VA Response: It is unclear as to what decisions GAO is referring that have been taken directly to the Secretaries. It is true that since February 2011, the Secretaries of DoD and VA have met 10 times. In reality, these meeting have served to reinforce VA-DoD collaboration efforts and to show their support for ongoing policy issues being worked by the JEC. With the exception of the decision to create an integrated VA-DoD electronic health record (iEHR), the Secretaries have deferred joint policy decisions to the JEC.

Page 27, line 7: GAO states that it is unclear how the JEC will provide oversight and accountability for issues once addressed by the SOC.

VA Response: Resolution and tracking of former SOC issues such as Integrated Disability Evaluation System (IDES), Integrated Mental Health Strategy, Care Coordination, iEHR, and Virtual Lifetime Electronic Records implementation, and Wounded, Ill, and Injured Strategic Communications are now being actively tracked and reviewed by the JEC leadership.

Page 38, 1st paragraph: The size of the overlap in the Federal Recovery Coordination Program (FRCP)/Recovery Coordination Program (RCP) population is fairly small, we need to look more broadly at the overall DoD and VA Wounded, Ill, and Injured population that could benefit from care coordination.

3

Enclosure

Department of Veterans Affairs (VA) Comments to
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(GAO-13-5)

Page 39, 2nd bullet, 1st sentence: This is an inaccurate and misleading statement.

Requested change: VA asked DoD to defer discussion of care coordination and case management policy issues during this period of time, because VA had established...."

4

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact name above, Bonnie Anderson, Assistant Director; Mark Bird, Assistant Director; Michele Grgich, Assistant Director; Jennie Apter; Frederick Caison; Heather Collins; Dan Concepcion; Melissa Jaynes; Deitra Lee; Mariel Lifshitz; Lisa Motley; Elise Pressma; and Greg Whitney made key contributions to this report.

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