United States Government Accountability Office

Report to Congressional Committees

July 2017

MILITARY PERSONNEL

Improvements Needed in the Management of Enlistees' Medical Early Separation and Enlistment Information

GAO-17-527

GAO Highlights

Highlights of GAO-17-527, a report to congressional committees

July 2017

MILITARY PERSONNEL

Improvements Needed in the Management of Enlistees' Medical Early Separation and Enlistment Information

Why GAO Did This Study

For fiscal years 2005 through 2015, the military services enlisted over 1.7 million servicemembers at an estimated cost of approximately $75,000 each. Incomplete medical information or inadequate screening of enlistees at MEPS may result in them not fulfilling their initial terms of commitment and the military services losing their investment in them. The House Report accompanying a proposed bill for the Fiscal Year 2017 National Defense Authorization Act included a provision for GAO to review applicant medical screening issues at the MEPS. This report assesses the extent to which (1) enlistees have not completed their initial terms of commitment due to medical reasons; (2) USMEPCOM obtains, analyzes, and uses information about enlistee medical early attrition; and (3) DOD has implemented its new electronic health record system at the MEPS. GAO analyzed accession and attrition data for fiscal years 2005 through 2015 (the most recent available), visited selected MEPS near services' training bases, and reviewed selected DOD, USMEPCOM, and service policies.

What GAO Recommends

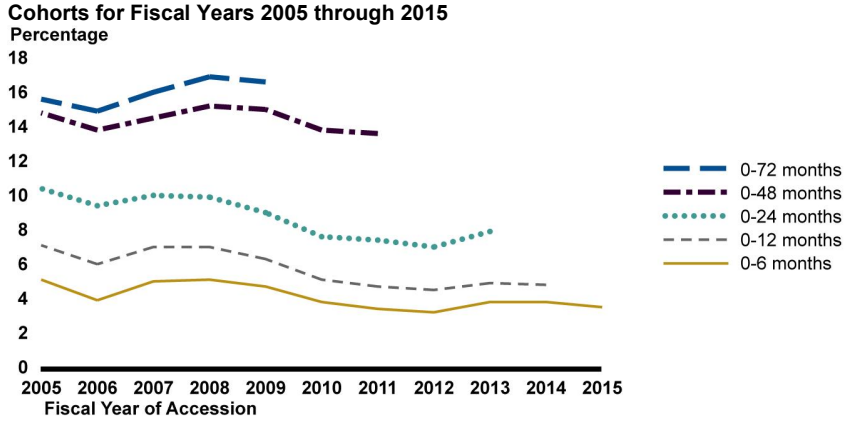
GAO recommends that DOD develop a clear process for USMEPCOM to obtain medical early separation records, a schedule to repair the database used to analyze the records, and a schedule to deploy MHS GENESIS at the MEPS. DOD concurred with the first two recommendations and partially concurred with the third, stating it is already developing such a schedule. GAO continues to believe action is

View GAO-17-527. For more information, contact Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov

What GAO Found

GAO's analysis of Department of Defense (DOD) accession and attrition data found that early attrition rates due to medical reasons during an enlistee's initial term of commitment were generally stable for fiscal years 2005 through 2015. As shown in the figure, the medical early attrition rate at the 48-month point was an estimated 14.9 percent in fiscal year 2005 and an estimated 13.7 percent in fiscal year 2011—the most recent year for which 48 months of data were available. The leading category for early attrition was "unqualified for active duty, other," which DOD defines as a nondisability condition such as obesity.

Figure: Cumulative Medical Early Attrition Rates by Selected Intervals by Accession Year Cohorts for Fiscal Years 2005 through 2015



Source: GAO analysis of Defense Manpower Data Center (DMDC) data. | GAO-17-527

Note: Medical early attrition rates for all time periods are not available as enlistees in later accession years have not been in military service long enough to determine longer-term early attrition rates.

U.S. Military Entrance Processing Command (USMEPCOM), DOD's organization responsible for medically qualifying applicants for military service, does not fully obtain, analyze and use information about enlistees who separate early due to medical reasons. This is because DOD does not have a clearly defined process for the military services to provide USMEPCOM with all relevant medical records. Further, the database that USMEPCOM relies on to analyze these records is inoperable and no schedule has been developed to repair it. As a result, USMEPCOM has provided limited feedback to chief medical officers—responsible for the medical qualification decisions—that they could use to improve screening outcomes. Without addressing these issues, DOD has limited assurance that medically disqualifying conditions among new enlistees will be identified before the services invest substantial resources in their initial training.

DOD has not implemented its new electronic health record system at the Military Entrance Processing Stations (MEPS) and its schedule to do so is uncertain. Known as MHS GENESIS, this new system is intended to give DOD the capability to electronically share more complete medical data with and between both federal and private sector medical facilities that are similarly equipped. Without a clear and complete schedule for implementation of MHS GENESIS, DOD has limited assurance that the system will support the MEPS as planned.

Contents

Tables

Figures

Abbreviations

DOD	Department of Defense
DMDC	Defense Manpower Data Center
HIV	Human Immunodeficiency Virus
EPTS	Existed Prior to Service
MEPS	Military Entrance Processing Station
USMEPCOM	U.S. Military Entrance Processing Command

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

July 14, 2017

The Honorable John McCain
Chairman
The Honorable Jack Reed
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Mac Thornberry
Chairman
The Honorable Adam Smith
Ranking Member
Committee on Armed Services
House of Representatives

From fiscal year 2005 through fiscal year 2015, the military services enlisted over 1.7 million servicemembers at an estimated cost of approximately $75,000 per enlistee, according to the Department of Defense (DOD).[1] However, incomplete medical information or inadequate medical screening of these enlistees may result in them not fulfilling their initial terms of commitment, which often ranges from 4 and 6 years of active duty. When early separation occurs, the military services lose their investment in the enlistees and must recruit additional applicants to replace them.

In January 1997, we reported that DOD could save millions of dollars by employing better screening procedures of enlistees.[2] Specifically, we reported that DOD did not have consistent and complete data to allow it to assess attrition trends and the factors behind changes in the trends. Additionally, we reported that applicants often conceal their medical

[1]This is an estimated cost to recruit, screen, and train an enlistee as reported by the Accession Medical Standards Analysis and Research Activity (AMSARA). AMSARA's primary activities are managing efforts in support of evidence-based DOD medical standards and developing collaborations to conduct epidemiologic research using unique military resources to benefit the health of military and civilian populations. These numbers do not include the Coast Guard, which we excluded from our review. We also did not consider the accession or early separation of commissioned officers from the military services.

[2]GAO, *Military Attrition: DOD Could Save Millions by Better Screening Enlisted Personnel,* GAO/NSIAD-97-39 (Washington, D.C.: Jan. 9, 1997).

histories and that the military services were waiving[3] medical conditions that, according to DOD directives, were disqualifying. In the1997 report, we made seven recommendations to DOD to help reduce the attrition of enlistees during the first 180 days of their initial terms of commitment. Of these seven recommendations, DOD concurred with and implemented changes that addressed all but one—moving the review of the medical early separation records away from the U.S. Military Entrance Processing Command (USMEPCOM), which still requests and analyzes those records. USMEPCOM operates under the direction of the Deputy Assistant Secretary of Defense for Military Personnel Policy-Accession Policy within the Office of the Under Secretary of Defense for Personnel and Readiness. Its mission is to evaluate applicants by applying established DOD standards during applicant processing for the military service at 65 Military Entrance Processing Station (MEPS) locations across the United States. To further address several of the recommendations we made in our 1997 report, Congress enacted changes in November 1997 to Title 10, the law governing the armed forces, aimed at improving recruit quality and reducing recruit attrition.[4]

House Report 114-537,[5] which accompanied a proposed bill for the National Defense Authorization Act for Fiscal Year 2017, included a provision for us to conduct a review of applicant medical screening issues at the MEPS. This report assesses the extent to which (1) enlistees have been unable to complete their initial terms of commitment due to medical reasons for fiscal years 2005 through 2015; (2) USMEPCOM obtains, analyzes, and uses information about enlistee early attrition due to medical reasons; and (3) DOD has implemented its new electronic health record system at the MEPS to obtain and document applicants' medical information.

[3]A waiver is a formal request to consider the suitability for service of an applicant who because of inappropriate conduct, dependency status, current or past medical conditions, or drug use may not be qualified to serve. Upon the completion of a thorough examination using a whole person review, the applicant may be granted a waiver. The applicant must have displayed sufficient mitigating circumstances that clearly justify waiver consideration. The Secretaries of the military departments are the final approval authority for all waivers.

[4]National Defense Authorization Act for Fiscal Year 1998, Pub. L. 105-85, div. A, title V, subtitle D, §531-533 (Nov. 18, 1997), (codified at 10 U.S.C. §503 note).

[5]H.R. Rep. No. 114-537, at 147 (2016).

For the first objective, we analyzed data from the Defense Manpower Data Center (DMDC)[6] on accessions and the early attrition of active-duty enlistees from the four military services during their first terms of commitment, often between four and six years of active duty service, for fiscal years 2005 through 2015. Fiscal year 2015 is the most recent year for which an entire year's worth of attrition data are available and, for relevancy purposes, we obtained data not more than 10 years old, beginning in fiscal year 2005. We analyzed these data to show early attrition due to medical reasons and overall early attrition over selected intervals by military service for each fiscal year as well as for the leading causes of early attrition. We assessed the reliability of these data by reviewing the data files and relevant data documentation and interviewing knowledgeable officials, and found that the data were sufficiently reliable for reporting the estimated number of accessions and attritions by military service and time periods. We also interviewed DOD, USMEPCOM, and military service officials to obtain their perspectives on early attrition rates.

For the second objective, we reviewed DOD memorandums and USMEPCOM regulations related to obtaining, analyzing, and using information about enlistee early attrition due to medical reasons. We evaluated USMEPCOM practices for obtaining, analyzing, and using information from enlistees' medical records of enlistees who separated within the first 180 days of service because of medical conditions that existed prior to their service against requirements from our *Schedule Assessment Guide* and *the Standards for Internal Control in the Federal Government.*[7] This included the importance of designing control activities to achieve objectives and respond to risks and using quality information by identifying information requirements, obtaining relevant data from reliable internal and external sources in a timely manner, and processing the obtained data into quality information. Additionally, we interviewed officials at USMEPCOM and officials from basic training bases to further understand the collection and reporting of early medical attrition

[6]DMDC is DOD's repository for department-wide data and is a key support organization that, among other things, generates reports for decision makers in the Office of the Secretary of Defense, the military services, and the Joint Staff. External organizations such as GAO and federally funded research and development centers also rely on DMDC for quantitative data and analyses pertaining to a wide variety of issues, such as the number of DOD personnel in specified occupations or demographic groups.

[7]GAO, *Schedule Assessment Guide: Best Practices for Project Schedules*, GAO-16-89G (Washington, D.C.: December 2015), and *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014).

information. These bases were selected on the basis of geographical dispersion and included one from each of the military services.

For the third objective, we reviewed selected DOD, USMEPCOM, and military instructions and regulations related applicant medical screening processes. Additionally, we selected a convenience sample of four MEPS that were located in large geographically dispersed U.S. cities that were also near a military service recruiting office and a basic training base to observe medical-related MEPS operations and to interview officials. During our visits to the selected MEPS locations, we interviewed officials from nearby military service recruiting organizations to discuss their perspectives on challenges with medically screening applicants. We supplemented our visits to the large MEPS locations with questionnaires sent to MEPS command officials, chief medical officers, and military service recruiting liaisons of a nongeneralizable sample of eight small or medium-sized MEPS as determined first by workload level, then sorted randomly, and then chosen to ensure distribution across all MEPS battalions. Further, regarding DOD's effort to implement an electronic health record system into MEPS locations, we interviewed officials from Accession Policy within the Office of the Under Secretary of Defense for Personnel and Readiness and USMEPCOM as well as contacted the Program Executive Office Defense Healthcare Management System to obtain information regarding the implementation status of DOD's new electronic health record within USMEPCOM at the MEPSs locations. We compared their efforts against selected information technology project management practices for developing well-planned schedules.[8]

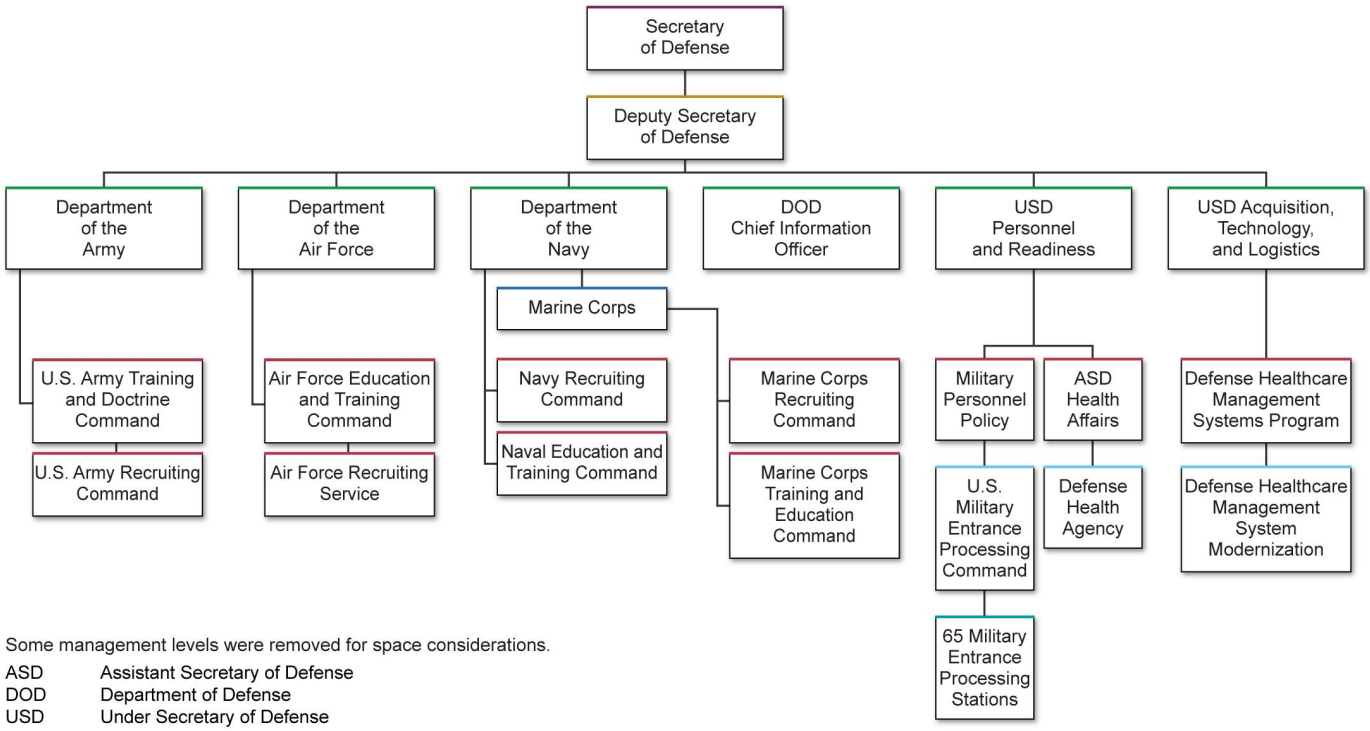
We conducted this performance audit from July 2016 to July 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Further details regarding our scope and methodology are presented in appendix I.

[8]GAO, *Schedule Assessment Guide: Best Practices for Project Schedules*, GAO-16-89G (Washington, D.C.: December 2015) and *Information Technology Investment Management: A Framework for Assessing and Improving Process Maturity,* GAO-04-394G (Washington, D.C.: Mar.1, 2004).

Background

Various organizations across DOD perform functions related to the recruiting, accessions, and training of active-duty enlistees as shown in figure 1.

Figure 1: Selected Department of Defense Organizations Involved in the Recruiting, Accessions, and Training of Active-Duty Enlistees



Some management levels were removed for space considerations.

ASD Assistant Secretary of Defense
DOD Department of Defense
USD Under Secretary of Defense

Source: GAO analysis of DOD information. | GAO-17-527

Each Military Service's Recruiters Conduct Preliminary Screens of Applicants

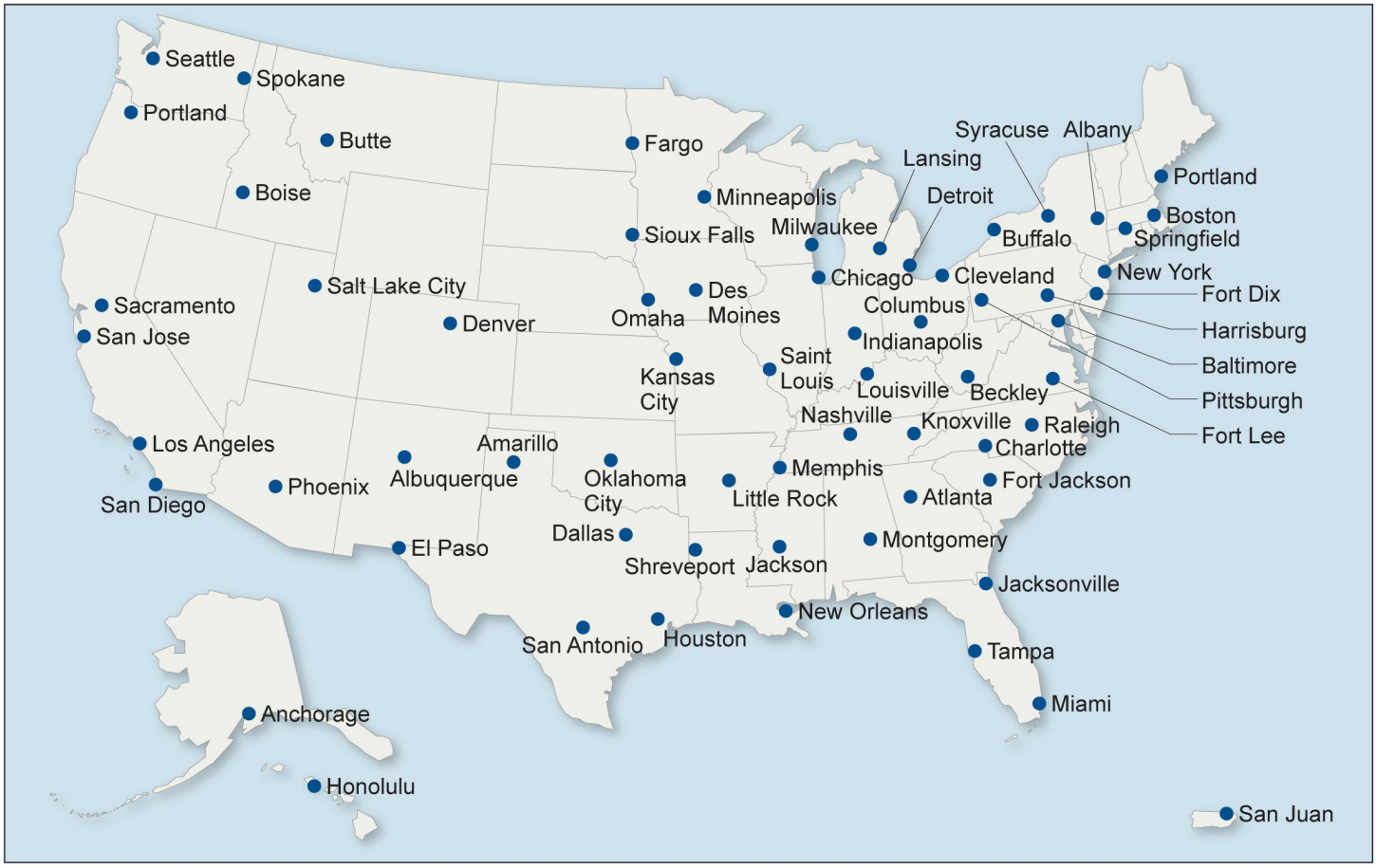
Enlistment processing and qualification determinations for age, citizenship, education, dependency status, and moral character are made by each military service. Their respective recruiting entities conduct preliminary screening of applicants to determine if they meet overall and medical DOD enlistment requirements. Among other things, recruiters also, for example, conduct a background review to screen an applicant for potentially disqualifying moral factors, review the applicant's education credentials, and assist in completing a medical history report. When an applicant answers any question on the preliminary medical screening form affirmatively, they are expected to obtain, or authorize others within DOD, which could be their recruiter who is assisting them, to obtain additional documentation regarding that medical condition to include with the medical prescreen questionnaire. Once completed, recruiters forward the medical prescreening report and any other documentation collected to military service recruiting liaisons located at a MEPS location to schedule the applicant for further review prior to scheduling the applicant for a medical examination.

USMEPCOM Provides More Detailed Medical Screening to Help Determine an Applicant's Enlistment Eligibility

USMEPCOM officials perform various functions, which include verifying personal identity; performing medical exams; documenting, reviewing, and updating applicant medical history; determining the extent to which applicants meet DOD's medical qualification standards; supporting the military service medical waiver review process; administering the Armed Services Vocational Aptitude Battery[9] and special purpose tests; conducting pre-enlistment interviews; conducting the oath of enlistment; and verifying signed enlistment contracts. The locations of the MEPS are displayed in figure 2.

[9]The Armed Services Vocational Aptitude Battery is a multiple-aptitude battery test that which measures developed abilities and helps to predict future success in the military.

Figure 2: U.S. Military Entrance Processing Command's Military Entrance Processing Station Locations



Source: Department of Defense; Map Resources (map). | GAO-17-527

Each MEPS location is staffed with military and civilian personnel, including a chief medical officer, with additional medical personnel and recruiting liaisons representing each military service. MEPS medical personnel collect blood and urine specimens to send for Human Immunodeficiency Virus (HIV) and drug testing and examine applicants in physical and behavioral health areas in accordance with DOD's medical qualification standards for enlistment.[10] Finally, a MEPS physician will make a final determination as to whether an applicant does or does not meet accession medical standards based on applicant's medical history,

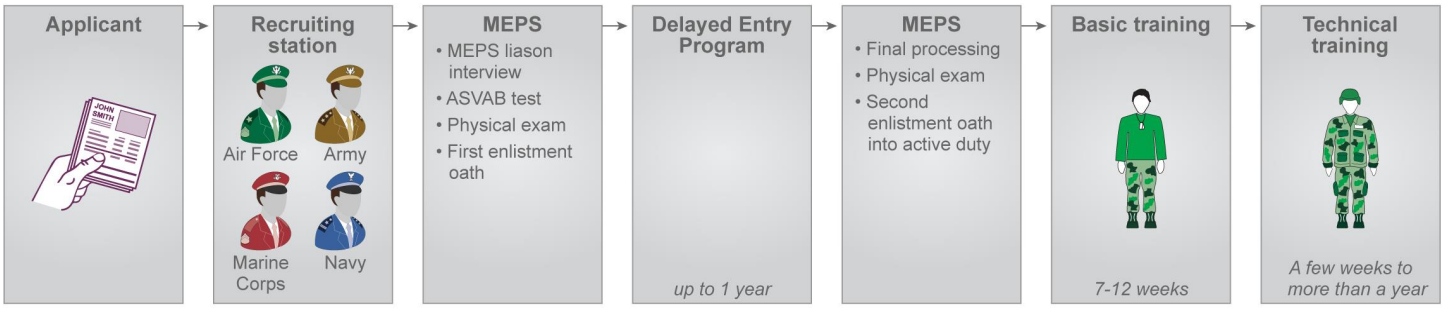
[10]The medical qualification standards are set out in DOD Instruction 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services* (Apr. 28, 2010) (incorporating change 1, Sept. 12, 2011).

a physical examination, and test results. USMEPCOM designated physicians are the DOD medical authority for applicants processing with USMEPCOM for determining if an applicant medically meets the requirements of Title 10 to be qualified, effective, and able-bodied prior to enlistment. For those found to have disqualifying conditions, the MEPS physician will recommend for or against pursuing a medical waiver to the military services' medical waiver authorities, who are authorized to grant medical waivers. Only applicants who are medically qualified are allowed to go to basic training. Some enlistees leave for basic training from their home towns and some return to the MEPS to undergo a brief follow-up physical inspection to determine whether they continue to meet the medical qualification standards for military service. For information on selected DOD and military service instructions, policies and guidance regarding medical screening of applicants, see appendix II.

Military Service Training Commands Receive New Enlistees for Basic Training

New enlistee basic training varies between 7 to 12 weeks depending on the military service. The Air Force basic training program lasts 7.5 weeks and is given at one training site located at Joint Base San Antonio-Lackland in San Antonio, Texas. Navy recruits remain in basic training for approximately 7 weeks at one training site, located at the Naval Station Great Lakes in North Chicago, Illinois. The Marine Corps' basic training is 12 weeks and recruits are trained in San Diego, California, or Parris Island, South Carolina. The Army's basic training is 10 weeks and recruits are trained at Fort Benning, Georgia; Fort Jackson, South Carolina; Fort Sill, Oklahoma; or Fort Leonard Wood, Missouri. After completing basic training, most enlistees complete follow-on training in technical skills, though the length of such training can vary widely by military service from a few weeks to a year or more. Figure 3 summarizes the most common recruiting, screening, and training process for new enlistees.

Figure 3: The Most Common Recruiting, Screening, and Training Process for New Enlistees



MEPS Military Entrance Processing Station
ASVAB Armed Services Vocational Aptitude Battery

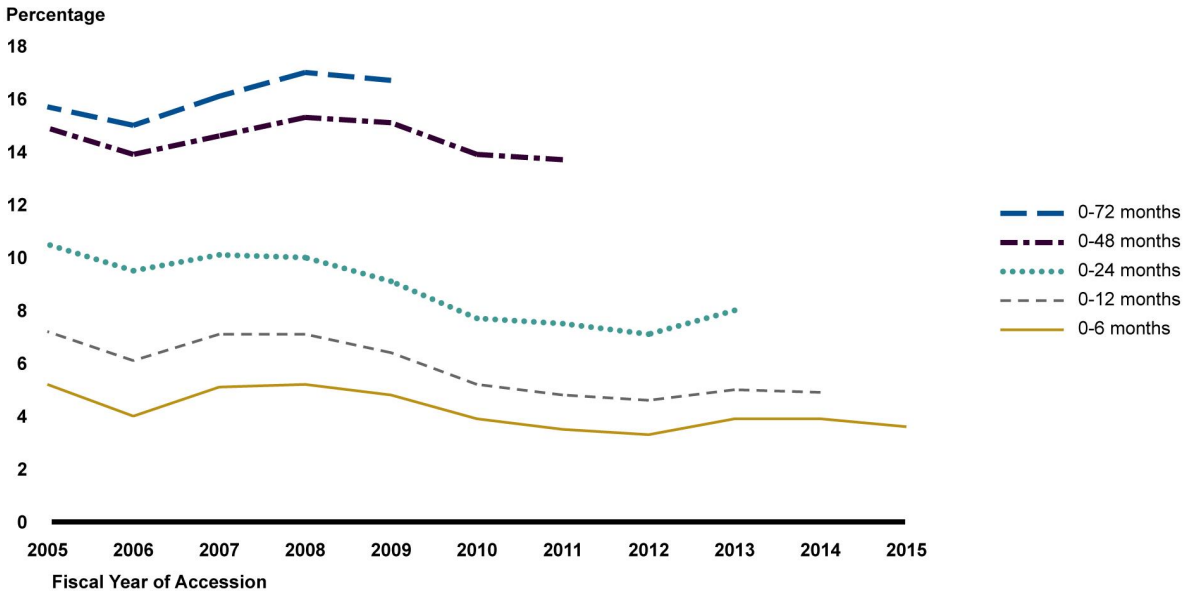
Source: GAO analysis of DOD information. | GAO-17-527

DOD's Yearly Medical Early and Overall Attrition Rates Were Generally Stable for Fiscal Years 2005 through 2015

Medical Early Attrition Rates during Enlistees' Initial Terms of Commitment Were Generally Stable for Fiscal Years 2005 through 2015

Based on our analysis of DOD accession and attrition data, early attrition rates due to medical reasons during an enlistee's initial term of commitment were generally stable for fiscal years 2005 through 2015. Although there were some increases and some decreases across the years for each of the time intervals we assessed, these changes were relatively small, with an average change of just over 1 percentage point. Figure 4 shows the estimated cumulative medical early attrition rates at the 6-month, 12-month, 24-month, 48-month, and 72-month points for servicemembers who separated prior to fulfilling their first term of commitment by accession year cohorts for fiscal years 2005 through 2015. For example, the medical early attrition rate at the 48-month point of enlistees' initial term of commitment was an estimated 14.9 percent in fiscal year 2005 and an estimated 13.7 percent in fiscal year 2011—the most recent year for which 48 months of data were available—with fluctuations between these years. Additionally, the medical early attrition rate at the 6-month point of enlistees' initial term of commitment was an estimated 5.2 percent in fiscal year 2005 and 3.6 percent in fiscal year 2015, with fluctuations between these years.

Figure 4: Cumulative Medical Early Attrition Rates by Selected Intervals by Accession Year Cohorts for Fiscal Years 2005 through 2015

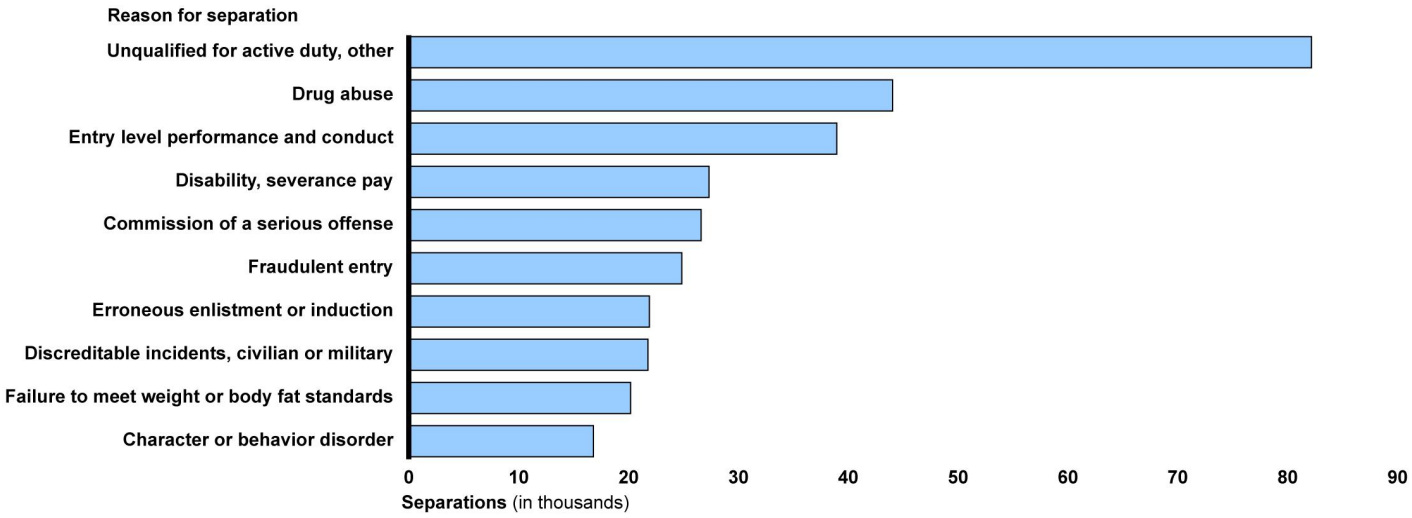


Source: GAO analysis of Defense Manpower Data Center (DMDC) data. | GAO-17-527

Note: Medical early attrition rates for all time periods are not available as enlistees in later accession year cohorts may have not been in military service long enough to determine longer term early attrition rates.

Based on our analysis of DOD separation categories that were explicitly of a medical nature, we identified the leading categories of early attrition due to medical reasons, as shown in figure 5. According to this analysis, the leading category of early attrition due to medical reasons is "Unqualified for active duty, other" which DOD defines as a nondisability medical condition, such as obesity, motion sickness or allergies, that interferes with the performance of duties and contributes to the failure to meet physical readiness standards. Other leading categories of early attrition due to medical reasons include drug abuse, disability with severance pay, and failure to meet weight or body fat standards.

Figure 5: Estimated Leading Medical Categories of Early Attrition for Enlistees for Fiscal Years 2005 through 2015



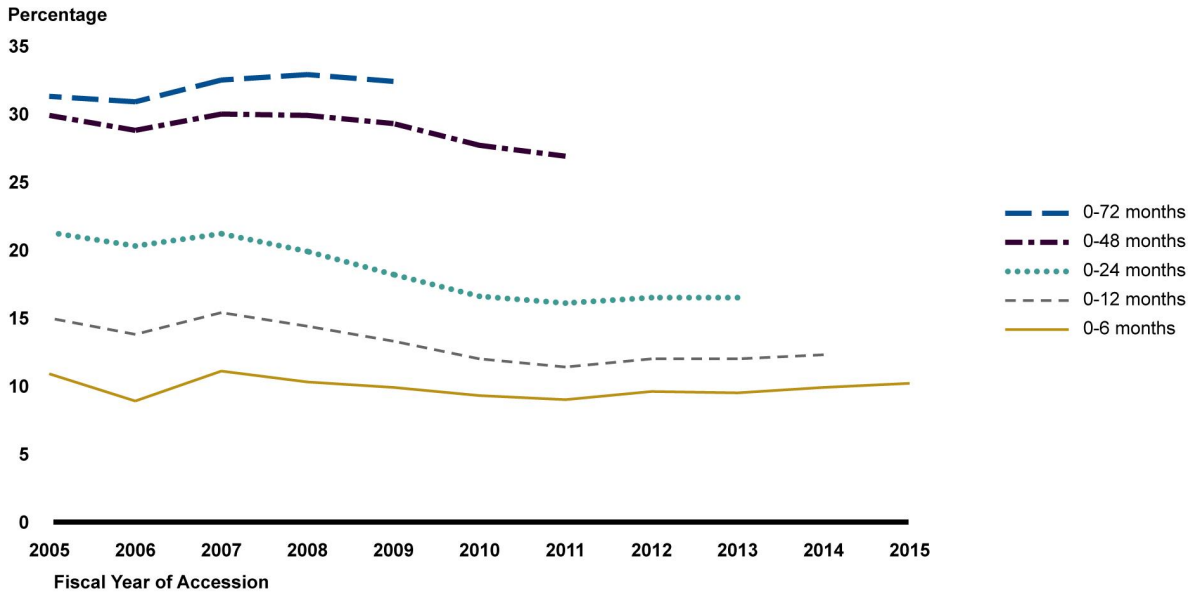
Source: GAO analysis of Defense Manpower Data Center (DMDC) data. | GAO-17-527

Military service officials stated they have taken numerous steps to decrease early attrition due to medical reasons by taking steps to help improve the new enlistees' physical and mental condition while in basic training. For example, Army officials at Fort Benning stated that they are piloting a program called the Initial Entry Training Physical Resiliency Enhancement Program. This program trains enlistees who may be prone to injury for 3-5 weeks before shipping them to basic training in an attempt to improve physical fitness and reduce injuries. Air Force officials at Joint Base San Antonio-Lackland stated that they are piloting a program to embed sports medicine experts throughout basic training to identify poor physical fitness practices and intervene before injuries occur. Moreover, Air Force officials also are piloting the use of a questionnaire called the Lackland Behavioral Questionnaire. Under this pilot, Air Force enlistees complete a questionnaire with over 70 questions on mental and behavioral health in an attempt to identify recruits with potential mental or behavioral issues so they can be interviewed by medical professionals and provided any necessary help or counseling early. Marine Corps officials stated that they place enlistees who fail the Marine Corps' initial strength test into a physical conditioning platoon for further physical conditioning before they begin basic training to help improve physical fitness and reduce injuries. Further, a Navy official stated that a specialized machine is used to measure enlistees' feet to select the proper shoes in an attempt to reduce injuries.

Overall Early Attrition Rates during Enlistees' Initial Terms of Commitment Were Generally Stable Overall for Fiscal Years 2005 through 2015

For comparison purposes, we also analyzed overall early attrition rates during enlistees' initial terms of commitment. Analyzing DOD accession and attrition data, we found that, similar to early attrition rates for medical reasons, overall early attrition rates during enlistees' initial terms of commitment were generally stable for fiscal years 2005 through 2015. Although there were some increases and some decreases across years for each of the time intervals we assessed, these changes were relatively small, with an average change 2 percentage points. Figure 6 shows the estimated cumulative overall early attrition rates at the 6-month, 12-month, 24-month, 48-month, and 72-month points of enlistees' initial terms of commitment by accession year cohorts for fiscal years 2005 through 2015. For example, the overall early attrition rate at the 48-month point of enlistees' initial terms of commitment was an estimated 29.9 percent in fiscal year 2005 and an estimated 26.9 percent in fiscal year 2011—the most recent year for which 48 months of data were available—with fluctuations between these years. Additionally, the 6-month overall early attrition rate was an estimated 10.9 percent in fiscal year 2005 and an estimated 10.2 percent in fiscal year 2015, with fluctuations between these years.

Figure 6: Cumulative Overall Early Attrition Rates by Selected Intervals by Accession Year Cohorts for Fiscal Years 2005 through 2015

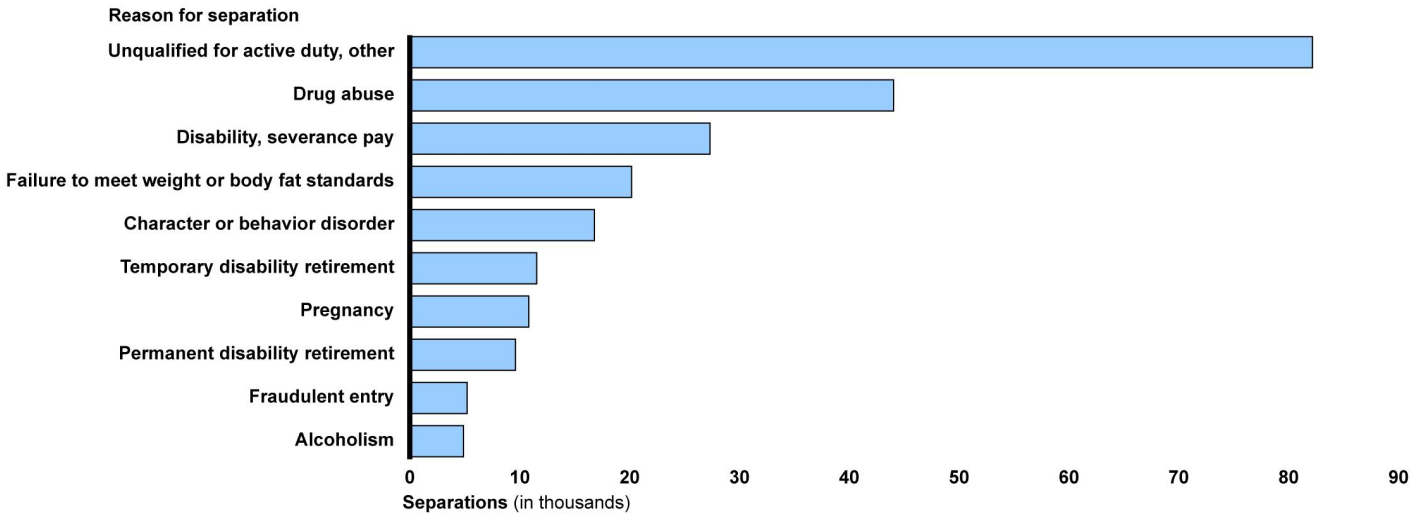


GAO analysis of Defense Manpower Data Center (DMDC) data. | GAO-17-527

Note: Early attrition rates for all time periods are not available as enlistees in later accession year cohorts may have not been in military service long enough to determine longer term early attrition rates.

Our analysis of DOD separation categories for overall early attrition indicated that, as with our analysis of early attrition due to medical reasons, the leading category of overall early attrition is again "Unqualified for active duty, other." Other leading categories of overall early attrition include drug abuse, poor entry level performance and conduct, and commissions of serious offenses. Figure 7 shows the reported leading categories of overall early attrition for enlistees by accession year for fiscal year 2005 through fiscal year 2015.

Figure 7: Estimated Leading Overall Categories of Early Attrition for Enlistees for Fiscal Years 2005 through 2015



Source: GAO analysis of Defense Manpower Data Center (DMDC) data. | GAO-17-527

USMEPCOM Does Not Fully Obtain, Analyze, and Use Information about Enlistees' Early Attrition Due to Medical Reasons

USMEPCOM does not fully obtain, analyze, or use information for early attrition due to medical reasons within enlistees' first 180 days of service. This is because DOD does not have a process for the military services' training bases to provide USMEPCOM all of the medical records of enlistees who separate early due to medical reasons. Additionally, the database that USMEPCOM uses to perform complete statistical analyses on the early separation medical records it does receive is inoperable, impacting its ability to conduct such analyses. Finally, USMEPCOM does not use the information from these medical records to provide regular and specific feedback regarding early separations to MEPS medical personnel to improve the quality of applicant screening.

The Military Services' Training Bases Do Not Provide Complete Medical Records to USMEPCOM

A 2001 memorandum from the Assistant Secretary of Defense for Force Management Policy requests that basic training bases send medical records of enlistees who separated within the first 180 days of their

military career for disqualifying medical conditions determined to have existed before the enlistee began military service (separations commonly known as Existed Prior to Service or EPTS discharges) to USMEPCOM for review and analysis. However, not all basic training bases provide medical records in accordance with the memorandum.[11] In fact, for fiscal year 2015, the latest full fiscal year of data available, USMEPCOM reported receiving medical records for only 2,017 of 8,592 EPTS separations, a rate of 23 percent.

USMEPCOM officials and basic training site officials we met with provided four reasons as to why all EPTS medical records are not provided to USMEPCOM. First, USMEPCOM officials stated that no uniform, standardized process to collect the necessary documentation from basic training sites has been established by any higher level headquarters. *Standards for Internal Control in the Federal Government* state that management, in order to achieve its objectives, should design control activities to achieve objectives and respond to risks. Moreover, the standards state that management should document—in policies for each unit—its responsibilities for all operational processes. Management should also review related policies, procedures, and related control activities for continued relevance and effectiveness in achieving the entity's objectives.[12] Officials stated that no specific process or instructions have been developed that clearly lay out the roles and responsibilities of USMEPCOM and the military services as well as the specific information that the services should provide to USMEPCOM. As such, inconsistent information is sent to USMEPCOM, and in some cases, certain medical records may not be sent at all, making analysis difficult, if not impossible. For example, USMEPCOM officials told us that Air Force officials were not sending medical records for psychological EPTS separations and were told it was due to Air Force officials' confusion as to whether these cases were considered medical separations because of their interpretation of DOD separation classifications and coding.

Second, language used in the 2001 memorandum has led to some confusion by the military services as to whether the memorandum is simply a request or a requirement for them to send medical records of

[11]Assistant Secretary of Defense for Force Management Policy Memorandum, *Medical Records of Military Trainees with Existed Prior to Service Discharges* (Nov. 30, 2001).

[12]GAO-14-704G.

enlistees with EPTS separations at their training bases. Third, military service officials stated that since the memorandum was very old, they were unsure if it was still active or who was specifically responsible at the training bases for sending the medical records to USMEPCOM—personnel officials or medical professionals. Fourth, USMEPCOM officials stated that some military service officials cited Privacy Act and concerns regarding their responsibilities for handling personal health information and the ability of USMEPCOM to safeguard the information adequately as reasons for their failure to send USMEPCOM the medical records for EPTS separations.[13] USMEPCOM officials acknowledge the reluctance to send medical records because of the personal health information contained. As such, they believe the use of electronic health records would be useful in providing stronger safeguards that they believe should mitigate concerns about the handling of enlistees' medical records to USMEPCOM. For example, recent discussions between USMEPCOM and Navy training base officials have led the Navy to draft a memorandum of understanding to clarify responsibilities regarding sending EPTS records and handling medical information. As of April 2017, the Navy had not completed this memorandum of understanding with USMEPCOM, and USMEPCOM was still not receiving the Navy EPTS separation medical records.

DOD is planning to reissue a DOD instruction in July 2017 with changes that would require basic training sites to forward EPTS medical information to USMEPCOM, according to DOD officials. We obtained and reviewed the draft instruction and noted that it does require the submission of the medical records to USMEPCOM, but the draft instruction does not contain specific instructions aimed at addressing many of the reasons USMEPCOM and military service officials gave for the current failure to provide records. Specifically, the draft instruction does not identify a clear process with defined roles and responsibilities. As a result, we were unable to determine if the draft instruction will resolve any of the issues noted above, other than eliminating doubts about the currency and mandatory nature of the direction to provide the

[13]For example, the Privacy Act of 1974 (5 U.S.C. §552a) places restrictions on the federal government's collection, maintenance, use, and dissemination of personal information and The Privacy Rule (45 C.F.R. §§160, Subparts A and E) of the Health Insurance Portability and Accountability Act of 1996 (Pub.L. 104–191 (Aug. 21, 1996), *codified in scattered titles and sections, United States Code*) calls for the protection of all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper or oral. The Privacy Rule calls this information protected health information.

records to USMEPCOM. Without a clear process with defined roles and responsibilities, USMEPCOM may continue to not receive the majority of EPTS medical records for its review and analysis.

USMEPCOM's Nonoperational Database Limits the Ability to Fully Analyze Medical Records for EPTS Separations

USMEPCOM has been unable to fully analyze the medical records it does receive because its internal EPTS database has been nonoperational since September 2015 due to technical issues. Prior to September 2015, USMEPCOM officials told us that they scanned the paper medical records for EPTS separations that they received from basic training bases into this internal database. This allowed them to use information from these medical records to analyze specific data points, such as the cause of the separation and the MEPS location where the enlistee was medically qualified. This analysis allowed them to examine trends over time, such as a trend in separations due to errors related to a specific medical diagnosis or trends in processing errors to gain insight into problem areas. Without an operational EPTS database, USMEPCOM officials said that they can only conduct a limited, manual analysis of EPTS separation medical records, and are not able to fully analyze and utilize this information.

Additionally, officials stated that the dependence on hard-copy medical records requires a large amount of resources to perform the manual analysis of these records and incurs large administrative costs associated with organizing medical records as they arrive, scanning them, manually coding results, and then repackaging the records. USMEPCOM officials stated that they are currently in the process of repairing the database, but they could not provide a schedule for its completion. We have previously reported that having a well-planned schedule is a fundamental management tool.[14] In addition, the 2001 memorandum we previously discussed states that the findings from EPTS analysis form an important part of USMEPCOM's quality control process, particularly in identifying and correcting physician errors and reducing the number of erroneous enlistments. Analyzing these particular separations provides insight into medical conditions that were not detected during the medical qualification process at a MEPS, allows USMEPCOM officials to identify trends in

[14]GAO, *Schedule Assessment Guide: Best Practices for Project Schedules*, GAO-16-89G (Washington, D.C.: December 2015).

errors related to specific diagnoses, and provides information to improve the medical qualification process. According to USMEPCOM's analysis of the limited number of EPTS medical records it received for fiscal year 2015, 47 percent of all such separations occurred due to enlistees concealing their medical history and 29 percent occurred due to the enlistee being unaware of the medical condition. For the same year, only 3 percent of such separations occurred due to an error on the part of MEPS personnel during the medical qualification process.

Given the importance of the database to the analyses that USMEPCOM conducts, as long as it is unavailable, USMEPCOM will be hampered in its ability to conduct these analyses. The lack of a schedule for implementing the repairs to the database raises concerns about the timeliness of these repairs. As we have previously noted, a well-planned schedule is important for ensuring that projects, such as the database repair, are completed on time. Without a schedule for these database repairs, USMEPCOM has limited assurance that this tool will be available to it expeditiously.

USMEPCOM Does Not Use EPTS Separation Information to Provide Regular Feedback to MEPS Medical Personnel

USMEPCOM's regulation for its Medical Qualification Program states that USMEPCOM will provide feedback to MEPS chief medical officers regarding EPTS separations, but the feedback that USMEPCOM gives them is limited due to the small number of EPTS separation medical records received from the training bases and the partial manual analysis being done on those received.[15] *Standards for Internal Control in the Federal Government* states that management, in order to achieve its objectives, should use quality information by identifying information requirements, obtaining relevant data from reliable internal and external sources in a timely manner, and processing the obtained data into quality information.[16] However, USMEPCOM officials stated individual feedback regarding EPTS separations has been limited to cases in which USMEPCOM alerted chief medical officers to an obvious error at their MEPS location during the medical qualification process. For example, two

[15]USMEPCOM Regulation 40-1, *Medical Qualification Program* (Feb. 27, 2017).

[16]GAO-14-704G.

chief medical officers we contacted reported receiving feedback at least once regarding EPTS separations that were classified as “MEPS errors.”

While MEPS chief medical officers do receive feedback through other methods, none of these methods are individually tailored to the performance of MEPS chief medical officers as it relates to EPTS separations. Specifically, USMEPCOM officials stated that feedback regarding EPTS separations occurs during more general forums such as the annual MEPS chief medical officer conference or during monthly conference calls where USMEPCOM can discuss questions or concerns that could affect all MEPS. Additionally, USMEPCOM has implemented its Peer Review Program where physicians at each MEPS review each other’s medical qualification decisions on a daily basis, if possible, as a local means of quality control. USMEPCOM officials also stated that they can provide feedback if a MEPS chief medical officer contacts USMEPCOM requesting clarification on an EPTS issue. However, these methods of feedback, while useful, do not provide individual feedback to MEPS chief medical officers regarding their specific decisions to medically qualify applicants who ultimately separated from military service within 180 days due to a medical reason. Six of the twelve MEPS medical officers that we contacted stated that they receive very limited to no feedback regarding EPTS cases specific to their MEPS and each said it would be helpful if they did. USMEPCOM officials acknowledge that it has been difficult for them to provide a large amount of feedback to the MEPS because of having to rely on paper medical records from the training bases and because of the technical difficulties they have had in analyzing what records they have received. The USMEPCOM officials believe that if they had an electronic medical record rather than the voluminous paper medical records, it would be easier to analyze information and share the results.

Receiving feedback on EPTS separations could allow MEPS chief medical officers to refine and improve their performance during the medical qualification process, thereby disqualifying applicants at the MEPS rather than after the military services have invested significant resources in enlistees at the basic training sites. As previously noted, DOD’s Accession Medical Standards Analysis and Research Activity estimates that the average cost to recruit, screen, and train each enlistee is approximately $75,000. However, until USMEPCOM uses EPTS separation information to provide regular and specific feedback to MEPS chief medical officers, USMEPCOM may not be assured that it is adequately identifying medically disqualifying conditions among

applicants for military service before the military services invest substantial resources in the applicants' initial training.

DOD Has Not Implemented Its New Electronic Health Record at MEPS Locations

DOD has not implemented its new electronic health record system at the MEPS and its schedule to do so is uncertain. As a result, the MEPS rely largely on self-disclosed medical conditions, history, and records from the applicants to make their medical qualification decisions, and they use a paper-based system for recording and processing applicant medical information. DOD recognizes the need to upgrade the enlistee accession process; however, its schedule for implementing a new electronic health record system to support this process is uncertain.

The MEPS' Medical Screening of Enlisted Applicants Relies on Self-Disclosure and the Processing of Paper Files

Without an electronic health record system that enables MEPS chief medical officers to electronically obtain the medical history of applicants and document health conditions in an electronic health record, MEPS officials rely on applicant self-disclosure and a paper-based process to evaluate the array of information related to each applicant's medical history and current condition to determine if an applicant is medically qualified to join the military. At the beginning of the accession process, an applicant must self-disclose personal medical information by answering a medical prescreening questionnaire with over 160 questions covering major body systems along with sleep disorders; learning, psychiatric, and behavioral issues; and medicine usage.[17] When an applicant answers any of these questions affirmatively, they are expected to obtain—or authorize others, such as their recruiter, to obtain—additional documentation regarding that medical condition to include with the medical prescreen questionnaire. While current medical processing provides valuable information, reliance is placed heavily upon applicant self-disclosure of his/her medical history, leaving a potential void in details if the applicant does not disclose any known medical conditions. This creates the

[17]DD Form 2807-2, *Accessions Medical Prescreen Report* (March 2015).

possibility that an applicant could conceal a potentially disqualifying medical condition that should be considered during the medical qualification process. According to a DOD review, reliance on applicants' self-disclosed material limits information for review, constrains analysis and hampers efforts to identify applicants who do not meet standards early in the military recruiting and accession process.[18] As mentioned previously, USMEPCOM analysis shows that, in 2015, about 75 percent of early attrition due to medical reasons within the first 180 days of service was attributed to either applicant concealment of known medical conditions or due to the enlistee being unaware of the medical condition.

Even if an applicant self-discloses that they have or previously had a medical condition to either a recruiter or later to MEPS medical physicians and provides their medical records for further review, the MEPS use a largely paper-based documentation system that requires manual processing of the medical information collected on applicants. DOD has noted that enlistment across the military force requires processing 70 to 80 million pieces of paper every year—a slow, duplicative, and expensive process.[19] Throughout the accession process for enlistees, paper is still mailed, faxed, hand-carried, and scanned, often multiple times, to the MEPS for use in processing the applicant for further review. In addition to the applicants' hard copy medical prescreen questionnaire and any supporting medical documents that are submitted to the MEPS, MEPS medical personnel record on paper forms the additional medical history and physical examination results and comments they obtain during their evaluation of the applicant.[20] Additionally, there may be numerous other forms used during an applicant's medical processing that are not captured electronically, including authorizations for medical testing, consultation requests and results, and chain of custody documents. Officials at each of the MEPS locations we visited or contacted characterized the volume of paper they deal with on a daily basis as being challenging, overwhelming, an administrative burden, or time-consuming. Further, they said that handling, transferring, and manual processing of the paper records is often done multiple times in order to advance an applicant through the medical qualification process. Figure 8

[18]Office of the Under Secretary of Defense (Personnel and Readiness Information Management) White Paper, *Military Accession* (Feb. 26, 2015).

[19]Secretary of Defense Memorandum, *The Next Two Links to the Force of the Future* (June 9, 2016).

[20]DD Form 2808, *Report of Medical Examination* (October 2005).

illustrates examples of the possible paper forms and documentation that may be used for enlisted applicants and accession processing activities.

Figure 8: Paper Forms and Documentation That May Be Used for Enlisted Applicants and Accession Processing Activities

Source: Department of Defense. | GAO-17-527

DOD's Schedule for Deploying the New Electronic Health Record System to Support Enlistee Accessions at MEPS Locations Is Uncertain

DOD is in the process of implementing a new integrated electronic health record system, but DOD's schedule for deploying this system at MEPs to assist with the medical screening of enlisted applicants is uncertain. In July 2015, the Program Executive Office, DOD Healthcare Management System, under the authority and direction of the Under Secretary of Defense for Acquisition, Technology, and Logistics, awarded a $4.3 billion contract for a new integrated electronic health record system known as MHS GENESIS. This new system is intended to give DOD the capability to electronically share more complete medical data with and between both federal and private sector medical facilities that are similarly equipped.[21] More specifically, currently USMEPCOM has no electronic interfaces to electronic medical information holders for it to independently obtain medical history information on applicants including information held by other DOD (e.g., Military Health System), government (e.g. Veterans Affairs, Social Security Administration, etc.), and public/private sector (e.g., medical insurance, pharmacy beneficiary, etc.) entities. If implemented within USMEPCOM, this new electronic health record system could provide this electronic interface as well as other capabilities to improve USMEPCOM's ability to access data and share medical information.

A USMEPCOM concept of operations paper discusses how USMEPCOM believes the use of an electronic health record system could reduce both its reliance on applicant self-disclosure and its paper-based process of recording applicant medical information.[22] For example, with MHS GENESIS' planned interoperability and data exchange capabilities, USMEPCOM officials could reduce their reliance on applicant self-disclosure and improve the medical qualification decision-making process by interfacing with and accessing applicant electronic medical records that may exist to independently obtain and verify applicant medical history information. Additionally, the ability to electronically exchange information would allow USMEPCOM to share the information more quickly with other

[21]Fiscal Year 2018 Defense Health Program Budget Hearing Before the S. Comm. on Appropriations, 115th Congress, 2,4,7 (2017) (statement of Stacy A. Cummings, Program Executive Officer Defense Healthcare Management Systems).

[22]USMEPCOM Concept of Operations, *Medical Entrance Processing* (Oct. 7, 2012).

accession stakeholders like service medical waiver review authorities. Further, a transition to an electronic health record system would begin to reduce the use of the paper-based system—and its associated costs and challenges—for recording the medical information obtained or generated during the accession process. Thus, integration of an electronic health record system into the accession community could enhance DOD's ability to obtain and document complete, accurate, detailed medical information that is fully accessible, could be used to improve USMEPCOM officials' medical qualification decisions, and perhaps affect early attrition rates.

Recognizing the potential for MHS GENESIS to support the MEPS, in June 2016 the Acting Principal Deputy Under Secretary of Defense for Personnel and Readiness emphasized that the modernization of accession processes is a priority and requested that the MHS GENESIS program management office coordinate with the accession community to include the MEPS in the deployment schedule for the new system.[23] In response to this request, in August 2016 the program management office issued a memorandum stating it fully intends to work with USMEPCOM to ensure MEPS locations are included in the implementation of MHS GENESIS.[24] Subsequently, officials from Accession Policy within the Office of the Under Secretary of Defense for Personnel and Readiness and USMEPCOM stated that they had initial coordination meetings in January and April 2017 with MHS GENESIS program management officials to discuss the inclusion of MEPS locations into the system deployment plans. According to USMEPCOM officials, the latest meeting produced an expectation that MHS GENESIS will meet its initial operating capability at one MEPS location in the fall of 2018. However, according to a MHS GENESIS program management official, detailed plans for deploying MHS GENESIS to the MEPS are in the earliest stages of development and no deployment decisions or timelines have been established. Thus, DOD's schedule for deploying MHS GENESIS at MEPS locations and ensuring that the system supports its accession programs is uncertain.

[23]Acting Principal Deputy Under Secretary of Defense for Personnel and Readiness Memorandum, *Inclusion of Accession Organizations into the Defense Healthcare Management System Modernization Program* (June 15, 2016).

[24]Defense Healthcare Management Systems Program Executive Office Memorandum, *Inclusion of Accession Organizations into the Defense Healthcare Management System Modernization Program* (Aug. 31, 2016).

We have previously reported that projects such as MHS GENESIS can benefit from the effective use of project planning and management practices.[25] These practices can significantly increase the likelihood of delivering promised capabilities on time and within budget. Additionally, we and others have issued guidance calling for the development of essential documentation needed for project planning execution and management.[26] According to this guidance, project planning involves, among other things, establishing a schedule of actions required to attain project objectives. We have also reported that a well-planned schedule is a fundamental management tool that can help government programs use public funds effectively by specifying when work will be performed in the future and measuring program performance against an approved plan. Moreover, an integrated and reliable schedule can show when major events are expected as well as the completion dates for all activities leading up to them, which can help determine if the program's parameters are realistic and achievable.[27] Further, a reliable schedule can contribute to an understanding of the cost impact if the program does not finish on time.

Until DOD completes development of a schedule that includes dates for MHS GENESIS' deployment to MEPS locations, the department will not have assurance that its efforts to modernize the department's medical screening process through reducing its reliance on self-disclosure and the processing of paper files is moving forward expeditiously and as planned.

[25]GAO, *Information Technology: HUD Needs to Improve Key Project Management Practices for Its Modernization Efforts*, GAO-13-455 (Washington, D.C.: June 12, 2013); *Information Technology: FDA Needs to Fully Implement Key Management Practices to Lessen Modernization Risks*, GAO-12-346 (Washington, D.C.: Mar. 15, 2012); *USDA Systems Modernization: Management and Oversight Improvements Are Needed*, GAO-11-586 (Washington, D.C.: July 20, 2011); and *Office of Personnel Management: Retirement Modernization Planning and Management Shortcomings Need to Be Addressed*, GAO-09-529 (Washington, D.C.: Apr. 21, 2009).

[26]Project Management Institute: *A Guide to the Project Management Body of Knowledge (PMBOK® Guide)*, Fifth Edition, 2013. *PMBOK®* is a mark of the Project Management Institute, Inc.*;* Software Engineering Institute/Carnegie Mellon, *Capability Maturity Model® Integration (CMMI®) for Development*, Version 1.3, CMU/SEI-2010-TR-033 (Hanscom AFB, Massachusetts: November 2010) and *CMMI® for Acquisition*, Version 1.3, CMU/SEI-2010-TR-032 (Pittsburgh, Pennsylvania.: November 2010); and GAO, *Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs*, GAO-09-3SP (Washington D.C.: Mar. 2, 2009).

[27]GAO, *Schedule Assessment Guide: Best Practices for Project Schedules*, GAO-16-89G (Washington, D.C.: December 2015).

Conclusions

The military services enlist thousands of new servicemembers each year, but if incomplete medical information is gathered or if inadequate medical screening is performed, the military services may increase the likelihood that some of these enlistees may leave the military before their initial terms of commitment are fulfilled. Early separation is costly, and enlistee early attrition during their initial term of commitment due to medical reasons—many of which may be either not disclosed or unknown—constitutes a significant loss to the military services. Even when an enlistee separates from military service within the first 180 days due to a medical reason, DOD can use information from those cases to improve its accession medical qualification process; however, DOD does not have a clear process to ensure that complete medical information is available about early separation cases from the military services. Moreover, it has not set a schedule to repair a key database at USMEPCOM to analyze this information. As a result, DOD may not be able to review and analyze information that could help improve the medical qualification decision process and ensure that MEPS are adequately identifying medically disqualifying conditions among applicants for military service.

Further, DOD primarily relies on the self-disclosure of medical information by enlisted applicants and a paper-based system to process and obtain medical information for new enlistees. As DOD begins its planning efforts for integrating a new multibillion dollar electronic health record system and transforming the current manual accession medical process to an automated one, it is important that DOD have a clear and complete schedule and plan in place to effectively manage this effort. Without a clear and complete schedule for implementation of its new system, DOD has limited assurance that the system will be support the MEPS as planned.

Recommendations for Executive Action

We recommend that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness to take the following three actions:

- In coordination with the Director, USMEPCOM, and the military services develop a clear process with defined roles and responsibilities to ensure that complete EPTS separation medical

records for enlistees who separated within 180 days of service from the military services' basic training sites are provided to USMEPCOM.

- In coordination with the Director, USMEPCOM, establish a schedule to repair the internal EPTS database so that USMEPCOM can provide more regular and specific feedback to MEPS chief medical officers.
- In coordination with the Under Secretary of Defense for Acquisition, Technology, and Logistics and the DOD Healthcare Management Systems Program Executive Office, develop a schedule of actions for deploying its new electronic health record system, MHS GENESIS, within USMEPCOM that includes key activities such as the major actions required to accomplish this effort, completion dates for all actions leading up to these events, and dates for the system's deployment to MEPS locations.

Agency Comments and Our Evaluation

We provided a draft of this report to DOD for review and comment. In written comments, reproduced in appendix III, DOD concurred with two recommendations; partially concurred with one recommendation; and separately provided technical comments, which we incorporated as appropriate.

DOD concurred with our first recommendation to develop a clear process with defined roles and responsibilities to ensure that complete EPTS separation medical records are provided to USMEPCOM and described actions that the department plans to take to implement this recommendation.

DOD concurred with our second recommendation to establish a schedule to repair the internal database it uses to analyze medical records for EPTS separations so that USMEPCOM can provide more regular and specific feedback to MEPS chief medical officers. In its comments, DOD stated that the database is being reviewed as part of a multi-year information technology modernization effort that includes the use of business intelligence tools found within DOD's new electronic health record system known as MHS GENESIS. DOD stated that once these tools are available, USMEPCOM will be able to conduct the EPTS medical record reviews and provide detailed feedback to the MEPS chief medical officers. We believe that having access to MHS GENESIS' business intelligence tools should improve USMEPCOM's ability to conduct a more thorough analysis of EPTS separation medical records.

However, the MHS GENESIS implementation schedule within USMEPCOM has not been finalized and is not expected to be approved until a Full Deployment Decision certification is issued some time in 2018. This means that the phased implementation of MHS GENESIS at the MEPS is likely to be several years away at a minimum. Therefore, we continue to believe that in the interim it would be beneficial for USMEPCOM to establish a schedule specific to repairing its current database that will allow for a more thorough analysis of EPTS separation medical records.

DOD partially concurred with our recommendation to develop a schedule for deploying the new electronic health record system, MHS GENESIS, within USMEPCOM. After receiving our draft report, DOD officials expressed concerns regarding the office to which this recommendation was directed. DOD officials stated that since the Under Secretary of Defense for Personnel and Readiness is the functional owner of the new electronic health record system, the recommendation should be directed to that office, instead of to the Under Secretary of Defense for Acquisition, Technology and Logistics. After consideration of this information and a discussion with these officials, we agreed to revise the recommendation to be directed to the Under Secretary of Defense for Personnel and Readiness in conjunction with officials from the Office of the Under Secretary of Defense for Acquisition, Technology and Logistics.

Further, in its comments, DOD stated that it has already taken actions to implement our recommendation, as the Program Executive Office for DOD Healthcare Management Systems has developed proposed schedules for incorporating MHS GENESIS into the MEPS. DOD also stated that because these schedules were unofficial and unapproved, it could not share them with us. We are very concerned with DOD's statement that the department is unable to share this unapproved information with us. Throughout the audit, we were repeatedly told by the Program Executive Office that details for the MHS GENESIS deployment to MEPS facilities did not exist. When we asked for clarification about whether schedules really did not exist or rather if officials were refusing to provide any existing schedules to us, we received no response.

Our access authority under 31 U.S.C. § 716 provides us authority to obtain documents that may be "pre-decisional" in nature. Absent our ability to review these schedules, we continue to believe that our recommendation remains valid and we will continue to monitor DOD's actions in this area related to the development, approval and

implementation of a schedule for deploying the department's new electronic health record system, MHS GENESIS, within USMEPCOM.

We are sending copies of this report to the appropriate congressional committees; the Secretary of Defense; the Under Secretary of Defense for Personnel and Readiness; the Under Secretary of Defense for Acquisition, Technology, and Logistics; the Commander, U.S. Military Entrance Processing Command; the Secretaries of the Army, the Navy, and the Air Force; and the Commandant of the Marine Corps. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-3604 or farrellb@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

Brenda S. Farrell
Director, Defense Capabilities and Management

Appendix I: Scope and Methodology

The scope of our review included Department of Defense (DOD) offices involved in the accession, training, or separation of enlisted active-duty servicemembers in the Army, the Air Force, the Navy, and the Marine Corps.[1] Table 1 contains a list of the organizations, offices, and military installations that we visited or contacted during the course of our review.

Table 1: Organizations, Offices, and Military Installations That We Visited or Contacted

Department of Defense	• Office of the Under Secretary of Defense for Personnel and Readiness, Washington, D.C. • U.S. Military Entrance Processing Command (USMEPCOM), North Chicago, Illinois • Chicago Military Entrance Processing Station (MEPS), Chicago, Illinois • Atlanta MEPS, Forest Park, Georgia • San Diego MEPS, San Diego, California • San Antonio MEPS, Fort Sam Houston, Texas • Jackson MEPS, Jackson, Mississippi • Salt Lake City MEPS, Salt Lake City, Utah • Springfield MEPS, Chicopee, Massachusetts • Little Rock MEPS, Little Rock, Arkansas • Charlotte MEPS, Charlotte, North Carolina • Shreveport MEPS, Shreveport, Louisiana • Honolulu MEPS, Pearl Harbor, Hawaii • Buffalo MEPS, Niagara Falls Air Reserve Station, New York • Minneapolis MEPS, Fort Snelling, Minnesota • Fort Dix MEPS, Fort Dix, New Jersey • Accession Medical Standards Analysis and Research Activity, Silver Spring, Maryland • Defense Manpower Data Center, Seaside, California • Defense Health Agency, Falls Church, Virginia
Army	• Assistant Secretary of the Army - Manpower and Reserve Affairs, Washington, D.C. • Maneuver Center of Excellence, Fort Benning, Georgia • U.S. Army Atlanta Recruiting Battalion, Atlanta, Georgia • U.S. Army Training and Doctrine Command, Fort Eustis, Virginia • U.S. Army Recruiting Command, Fort Knox, Kentucky • U.S. Army Audit Agency, Fort Eustis, Virginia • U.S. Army Human Resources Command, Fort Knox, Kentucky

[1]We did not consider the accession or early separation of commissioned officers from the military services and we did not include the Coast Guard.

Air Force	• Headquarters, U.S. Air Force, Washington, D.C. • Lackland Air Force Base, San Antonio, Texas • Air Force Recruiting Service, Joint Base San Antonio-Randolph, Texas
Navy	• Bureau of Medicine and Surgery, Falls Church, Virginia • Bureau of Naval Personnel, Millington, Tennessee • Navy Recruit Training Command, North Chicago, Illinois • Navy Service Training Command, Great Lakes, Illinois • Navy Recruiting District Chicago, Great Lakes, Illinois
Marine Corps	• Headquarters, U.S. Marine Corps, Quantico, Virginia • Marine Corps Recruit Depot, San Diego, California • Marine Corps Recruiting Command, 12th Marine Corps District, San Diego, California

Source: GAO. | GAO-17-527

To determine the extent to which servicemembers are unable to complete their initial terms of commitment because of medical reasons, we analyzed data from the Defense Manpower Data Center (DMDC) on accessions and early attrition of active-duty enlistees from the four military services during their first terms of commitment, often between 4 and 6 years of active-duty service, for fiscal years 2005 through 2015. Fiscal year 2015 is the most recent year for which an entire year's worth of attrition data are available and, for relevancy purposes, we obtained data not more than 10 years old, beginning in fiscal year 2005. We analyzed these data to show overall early attrition and early attrition due to medical reasons over selected intervals by military service for each fiscal year. We also analyzed DOD separation codes assigned to each separation to examine the leading categories of early attrition. We reviewed the data to check for their completeness and for obvious errors such as out-of-range date values. We also interviewed a knowledgeable official from DMDC regarding data quality and reliability. We determined that the data were sufficiently reliable for reporting historical early attrition trends. We also interviewed DOD, USMEPCOM, and military service officials to obtain their perspectives on early attrition rates.

To determine the extent to which USMEPCOM obtains, analyzes, and uses information about enlistee early attrition due to medical reasons, we reviewed DOD memorandums and USMEPCOM regulations related to obtaining, analyzing, and using information about enlistee early attrition due to medical reasons. We also compared USMEPCOM practices for obtaining, analyzing, and using information from medical records for enlistees who separated within the first 180 days of their service due to medical conditions that existed prior to their service with the *Standards for*

Internal Control in the Federal Government.[2] This included the importance of designing control activities to achieve objectives and respond to risks and using quality information by identifying information requirements, obtaining relevant data from reliable internal and external sources in a timely manner, and processing the obtained data into quality information. Additionally, we interviewed officials at USMEPCOM and officials from four of the military services' training bases to further understand the collection and reporting of early medical attrition information. These bases were selected on the basis of geographical dispersion and included one from each of the military services.

To determine the extent to which DOD has implemented its new electronic health record system at the MEPS to obtain and document applicants' medical information, we reviewed selected DOD, USMEPCOM, and military regulations related to applicant medical screening processes. Additionally, we selected a convenience sample of four MEPS that were located in large geographically dispersed U.S. cities that were also near a military service recruiting office and a basic training base to observe medical-related MEPS operations and interview officials. During our visits to the selected MEPS locations, we also interviewed officials from nearby military service recruiting organizations to discuss their perspectives on recruiting potential applicants and the process and challenges associated with medically screening applicants. We supplemented our visits to the large MEPS locations with questionnaires sent to MEPS command officials, chief medical officers, and military service recruiting liaisons of a nongeneralizable selection of eight small or medium-sized MEPS as determined first by workload level, then sorted randomly, and then chosen to ensure distribution across all MEPS battalions. Further, regarding DOD's efforts to implement an electronic health record into MEPS locations, we interviewed officials from Accession Policy within the Office of the Under Secretary of Defense for Personnel and Readiness and USMEPCOM as well as contacted the Program Executive Office Defense Healthcare Management System to obtain information regarding the implementation status of DOD's new electronic health record within USMEPCOM at the MEPS locations. We

[2]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014).

compared their efforts against selected information technology project management practices for developing well-planned schedules.[3]

We conducted this performance audit from July 2016 to July 2017 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.

[3]GAO, *Schedule Assessment Guide: Best Practices for Project Schedules*, GAO-16-89G (Washington, D.C.: December 2015); and *Information Technology Investment Management: A Framework for Assessing and Improving Process Maturity*, GAO-04-394G (Washington, D.C.: March 2004).

Appendix II: Selected Policies for Medically Screening and Processing Military Applicants

Table 2 provides a selected list of DOD and military service instructions, guidance, and policies regarding the medical screening and processing of military applicants.

Table 2: Selected Department of Defense (DOD) and Military Service Instructions, Guidance, and Policies Regarding the Medical Screening and Processing of Military Applicants

Reference	Source	Description	Publication date
DOD Directive 1145.02E, *United States Military Entrance Processing Command (USMEPCOM)*	DOD	Prescribes USMEPCOM policies and responsibilities for processing military applicants and inductees.	October 18, 2012
DOD Instruction 1304.26, *Qualification Standards for Enlistment, Appointment, and Induction*	DOD	Prescribes policies and responsibilities for basic entrance qualification standards for enlistment, appointment, and induction into the military services and delegates the authority to specify certain standards to the Secretaries of the military departments.	March 23, 2015 (incorporating change 2, Apr. 11, 2017)
DOD Instruction 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*	DOD	Establishes policy, assigns responsibilities, and prescribes procedures for physical and medical standards for appointment, enlistment, or induction in the military services.	April 28, 2010 (incorporating change 1, Sept. 13, 2011)
USMEPCOM Regulation 40-1, *Medical Qualification Program*	USMEPCOM	Prescribes policy and procedures for the administration of the United States Military Entrance Processing Command (USMEPCOM) Medical Qualification Program.	February 27, 2017
USMEPCOM Regulation 40-2, *Provider Quality Management Program*	USMEPCOM	Establishes policy and regulatory guidance for the Provider Quality Management Program.	March 21, 2017
USMEPCOM Regulation 601-23, *Enlistment Processing*	USMEPCOM	Establishes policy and regulatory guidance for the operations of Military Entrance Processing Stations (MEPS).	April 26, 2017 (incorporating immediate revision of June 19, 2017)

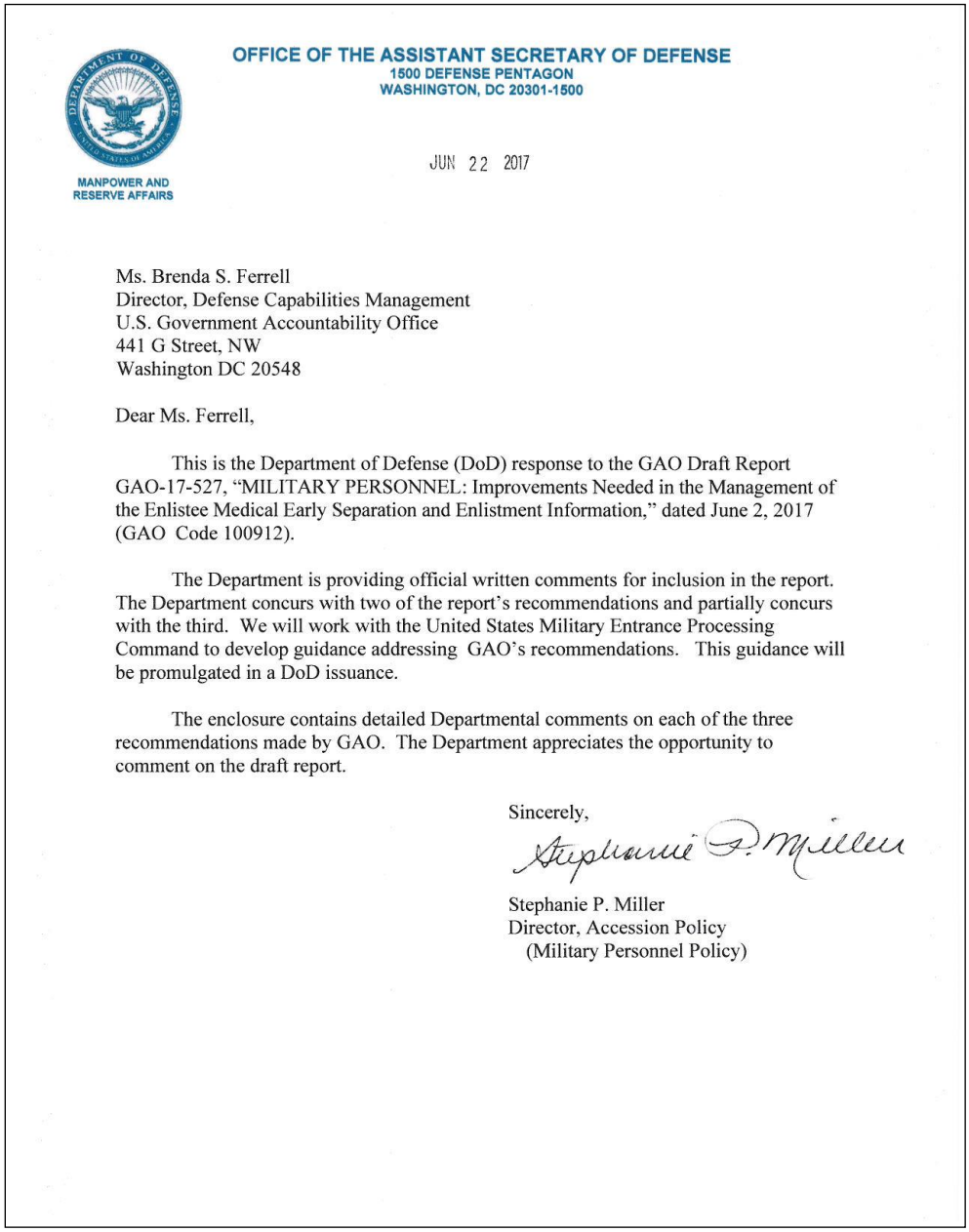
Reference	Source	Description	Publication date
Army Regulation 40-501, *Standards of Medical Fitness*	Army	Provides information on medical fitness standards and related policies and procedures for induction, enlistment, appointment, and retention.	June 14, 2017
U.S. Army Recruiting Command Regulation 601-210, *Enlistment and Accessions Processing*	Army	Establishes the policies and procedures for processing applicants for enlistment into the Army.	January 3, 2017

Reference	Source	Description	Publication date
Army Regulation 601-270, Military Entrance Processing Station (MEPS)	Army	Establishes Military Entrance Processing Station (MEPS) operational policies and procedures applicable to recruiting activities of the military services and contains agency and command tasks for the operation and support of the MEPS.	March 23, 2007 (incorporating Rapid Action Revision, Sept. 13, 2011)
Manual of the Medical Department, U.S. Navy NAVMED P-117 Chapter 15	Navy	Provides guidance on performing, recording, and interpreting the results of physical examinations conducted for a wide variety of screening and qualifying purposes.	August 12, 2005 (incorporating change 160, Feb. 3, 2017)
Navy Recruiting Manual-Enlisted COMNAVCRUITCOMINST 1130.8K, *Volumes I – V*	Navy	Prescribes enlistment eligibility requirements, provide information on various enlistment programs available to applicants for naval service, prescribes procedures for the enlistment and processing of men and women into the United States Navy Active and Reserve Components, and to govern the actions and conduct of all personnel connected with the recruitment and enlistment processing of Navy applicants.	July 2016
Air Force Instruction 36-1901, *Recruiting Programs*	Air Force	Provides guidance and procedures necessary for the Air Force recruiting programs throughout the Air Force.	June 20, 2017
Air Force Instruction 48-123, *Medical Examinations and Standards*	Air Force	Establishes procedures, requirements, and recording and medical standards for medical examinations conducted by the Air Force.	November 5, 2013 (incorporating Guidance Memorandum, September 19, 2016)

Reference	Source	Description	Publication date
Marine Corps Recruiting Command Order 1100.1, *Marine Corps Recruiting Command Enlistment Processing Manua*l	Marine Corps	Establishes the criteria for enlistment as directed by the Commandant of the Marine Corps, the processing of applicants and summarizes recruiting support programs to be used in accomplishing the enlisted recruiting mission.	November 9, 2011

Source: DOD, the U.S. Military Entrance Processing Command, the Army, the Navy, the Air Force, and the Marine Corps. |GAO-17-527

Appendix III: Comments from the Department of Defense



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
1500 DEFENSE PENTAGON
WASHINGTON, DC 20301-1500

MANPOWER AND RESERVE AFFAIRS

JUN 22 2017

Ms. Brenda S. Ferrell
Director, Defense Capabilities Management
U.S. Government Accountability Office
441 G Street, NW
Washington DC 20548

Dear Ms. Ferrell,

This is the Department of Defense (DoD) response to the GAO Draft Report GAO-17-527, "MILITARY PERSONNEL: Improvements Needed in the Management of the Enlistee Medical Early Separation and Enlistment Information," dated June 2, 2017 (GAO Code 100912).

The Department is providing official written comments for inclusion in the report. The Department concurs with two of the report's recommendations and partially concurs with the third. We will work with the United States Military Entrance Processing Command to develop guidance addressing GAO's recommendations. This guidance will be promulgated in a DoD issuance.

The enclosure contains detailed Departmental comments on each of the three recommendations made by GAO. The Department appreciates the opportunity to comment on the draft report.

Sincerely,

Stephanie P. Miller
Director, Accession Policy
(Military Personnel Policy)

GAO DRAFT REPORT DATED JUNE 2, 2017
GAO-17-527 (GAO CODE 100912)

"MILITARY PERSONNEL: IMPROVEMENTS NEEDED IN THE MANAGEMENT OF THE ENLISTEE MEDICAL EARLY SEPARATION AND ENLISTMENT INFORMATION"

DEPARTMENT OF DEFENSE COMMENTS TO THE GAO RECOMMENDATION

RECOMMENDATION # 1: The GAO recommends that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness to take the following action in coordination with the Director, USMEPCOM, and the military services: develop a clear process with defined roles and responsibilities to ensure that complete EPTS separation medical records for enlistees who separated within 180 days of service from the military services' basic training sites is provided to USMEPCOM.

DoD RESPONSE: Concur

The Department agrees with the GAO's recommendation. As noted in the GAO's report, the Department is currently working a Department of Defense Instruction update that formalizes the requirement in policy as well as updated medical release forms that give consent from the individual for this process analysis. Once the instruction and updated medical forms are published, the Office of the Under Secretary of Defense for Personnel and Readiness will direct USMEPCOM to establish Memorandum of Understandings with the military services' basic training sites outlining procedures for providing EPTS separation medical records. Additionally, USMEPCOM is researching the capabilities of the new medical record system, MHS GENESIS, to be able to electronically gain access to all EPTS medical records.

RECOMMENDATION # 2: The GAO recommends that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness to take the following action in coordination with the Director, USMEPCOM: establish a schedule to repair the internal EPTS database so that USMEPCOM can provide more regular and specific feedback to MEPS Chief Medical Officers.

DoD RESPONSE: Concur

The Department agrees with the GAO's recommendation. The USMEPCOM EPTS database is inoperable but being reviewed as part of a multi-year information technology modernization effort. In the near future, this capability will be available in the Business intelligence tools within MHS GENESIS allowing USMEPCOM to conduct the EPTS medical reviews and provide detailed feedback to the MEPS Chief Medical Officers.

RECOMMENDATION # 3: The GAO recommends that the Secretary of Defense direct the Under Secretary of Defense for Acquisition, Technology, and Logistics to direct the DOD Healthcare Management Systems Program Executive Office to develop a schedule for deploying its new electronic health record system, MHS GENESIS, within USMEPCOM.

DoD RESPONSE: Partially Concur

The Department agrees with this recommendation in broad terms, and at the direction of the Under Secretary of Defense for Personnel and Readiness, in coordination with the Under Secretary of Defense for Acquisition, Technology, and Logistics (USD (AT&L)), these actions are already occurring. Program Executive Office DoD Healthcare Management Systems (PEO DHMS) began MHS GENESIS fielding to Initial Operating Capability (IOC) sites in February 2017 and will continue until the end Fiscal Year 2017. Thereafter, USD (AT&L) will issue a Full Deployment Decision (FDD) certification in 2018 to proceed to the remaining sites using a wave model.

While PEO DHMS has developed proposed schedules post-IOC, they are unofficial and unapproved until the FDD. This would include any proposed schedule that incorporates MEPS. We are unable to share unapproved information with the GAO. The PEO DHMS is fully committed to transforming the delivery and documentation of healthcare for service members, veterans, and their families, including service members processing into military service, and look forward to sharing additional information on this topic with the GAO in the future.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Brenda S. Farrell, (202) 512-3604 or farrellb@gao.gov

Staff Acknowledgments

In addition to the contact named above, Kimberly C. Seay (Assistant Director), Vijay Barnabas, Rebecca Beale, Vincent Buquicchio, Cynthia Grant, Mae Jones, Amie Lesser, Josh Ormond, Amber Sinclair, Rachel Stoiko, Wade Tanner, and Sabrina Willard made major contributions to this report.

Appendix V: Accessible Data

Data Tables

Data Table for Highlights Figure: Cumulative Medical Early Attrition Rates by Selected Intervals by Accession Year Cohorts for Fiscal Years 2005 through 2015

Months	0 – 6	0 – 12	0 - 24	0 - 48	0 - 72
2005	5.2	7.2	10.5	14.9	15.7
2006	4	6.1	9.5	13.9	15
2007	5.1	7.1	10.1	14.6	16.1
2008	5.2	7.1	10	15.3	17
2009	4.8	6.4	9.1	15.1	16.7
2010	3.9	5.2	7.7	13.9	NA
2011	3.5	4.8	7.5	13.7	NA
2012	3.3	4.6	7.1	NA	NA
2013	3.9	5	8	NA	NA
2014	3.9	4.9	NA	NA	NA
2015	3.6	NA	NA	NA	NA

Data Table for Figure 4: Cumulative Medical Early Attrition Rates by Selected Intervals by Accession Year Cohorts for Fiscal Years 2005 through 2015

Months	0 – 6	0 – 12	0 - 24	0 - 48	0 - 72
2005	5.2	7.2	10.5	14.9	15.7
2006	4	6.1	9.5	13.9	15
2007	5.1	7.1	10.1	14.6	16.1
2008	5.2	7.1	10	15.3	17
2009	4.8	6.4	9.1	15.1	16.7
2010	3.9	5.2	7.7	13.9	NA
2011	3.5	4.8	7.5	13.7	NA
2012	3.3	4.6	7.1	NA	NA
2013	3.9	5	8	NA	NA
2014	3.9	4.9	NA	NA	NA
2015	3.6	NA	NA	NA	NA

Data Table for Figure 5: Estimated Leading Medical Categories of Early Attrition for Enlistees for Fiscal Years 2005 through 2015

Reason for separation	Separations
Unqualified for active duty, other	82,179
Drugs	44,038
Entry level performance and conduct	38,958
Disability, severance pay	27,327
Commission of a serious offense	26,599
Fraudulent entry	24,856
Erroneous enlistment or induction	21,897
Discreditable incidents, civilian or military	21,768
Failure to meet weight or body fat standards	20,178
Character or behavior disorder	16,798

Data Table Figure 6: Cumulative Overall Early Attrition Rates by Selected Intervals by Accession Year Cohorts for Fiscal Years 2005 through 2015

Months	0 – 6	0 – 12	0 - 24	0 - 48	0 - 72
2005	10.9	15	21.3	29.9	31.3
2006	8.9	13.8	20.3	28.8	30.9
2007	11.1	15.4	21.2	30	32.5
2008	10.3	14.4	19.9	29.9	32.9
2009	9.9	13.3	18.2	29.3	32.4
2010	9.3	12	16.6	27.7	NA
2011	9	11.4	16.1	26.9	NA
2012	9.6	12	16.5	NA	NA
2013	9.5	12	16.5	NA	NA
2014	9.9	12.3	NA	NA	NA
2015	10.2	NA	NA	NA	NA

Data Table Figure 7: Estimated Leading Overall Categories of Early Attrition for Enlistees for Fiscal Years 2005 through 2015

Reason for separation	Separations
Unqualified for active duty, other	82,179
Drugs	44,038
Disability, severance pay	27,327

Reason for separation	Separations
Failure to meet weight or body fat standards	20,178
Character or behavior disorder	16,798
Temporary disability retirement	11,540
Pregnancy	10,823
Permanent disability retirement	9,622
Fraudulent entry	5,211
Alcoholism	4,883

Agency Comment Letter

Text of Appendix III: Comments from the Department of Defense

Page 1

Ms. Brenda S. Ferrell

Director, Defense Capabilities Management

U.S. Government Accountability Office 441 G Street, NW

Washington DC 20548

Dear Ms. Ferrell,

This is the Department of Defense (DoD) response to the GAO Draft Report

GA0-17-527, "MILITARY PERSONNEL: Improvements Needed in the Management of the Enlistee Medical Early Separation and Enlistment Information," dated June 2, 2017 (GAO Code 100912).

The Department is providing official written comments for inclusion in the report. The Department concurs with two of the report's recommendations and partially concurs with the third. We will work with the United States Military Entrance Processing Command to develop guidance addressing GAO's recommendations. This guidance will be promulgated in a DoD issuance.

The enclosure contains detailed Departmental comments on each of the three recommendations made by GAO. The Department appreciates the opportunity to comment on the draft report.

Sincerely,

Stephanie P. Miller Director, Accession Policy

(Military Personnel Policy)

Page 2

DEPARTMENT OF DEFENSE COMMENTS TO THE GAO RECOMMENDATION

RECOMMENDATION # 1:

The GAO recommends that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness to take the following action in coordination with the Director, USMEPCOM, and the military services: develop a clear process with defined roles and responsibilities to ensure that complete EPTS separation medical records for enlistees who separated within 180 days of service from the military services' basic training sites is provided to USMEPCOM .

DoD RESPONSE: Concur

The Department agrees with the GAO's recommendation. As noted in the GAO's report, the Department is currently working a Department of Defense Instruction update that formalizes the requirement in policy as well as updated medical release forms that give consent from the individual for this process analysis. Once the instruction and updated medical forms are published , the Office of the Under Secretary of Defense for Personnel and Readiness will direct USMEPCOM to establish Memorandum of Understandings with the military services' basic training sites outlining procedures for providing EPTS separation medical records. Additionally, USMEPCOM is researching the capabilities of the new medical record system, MHS GENESIS, to be able to electronically gain access to all EPTS medical records.

RECOMMENDATION # 2:

The GAO recommends that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness to take the following action in coordination with the Director, USMEPCOM: establish a schedule to repair the internal EPTS database so that USMEPCOM can provide more regular and specific feedback to MEPS Chief Medical Officers.

DoD RESPONSE: Concur

The Department agrees with the GAO's recommendation. The USMEPCOM EPTS database is inoperable but being reviewed as part of a multi-year information technology modernization effort. In the near future, this capability will be available in the Business intelligence tools within MHS GENESIS allowing USMEPCOM to conduct the EPTS medical reviews and provide detailed feedback to the MEPS Chief Medical Officers.

Page 3

RECOMMENDATION # 3:

The GAO recommends that the Secretary of Defense direct the Under Secretary of Defense for Acquisition , Technology, and Logistics to direct the DOD Healthcare Management Systems Program Executive Office to develop a schedule for deploying its new electronic health record system, MI-IS GENESIS, within USMEPCOM.

DoD RESPONSE: Partially Concur

The Department agrees with this recommendation in broad terms, and at the direction of the Under Secretary of Defense for Personnel and Readiness, in coordination with the Under Secretary of Defense for Acquisition, Technology, and Logistics (USD (AT&L)), these actions are already occurring. Program Executive Office DoD Healthcare Management Systems (PEO DHMS) began MHS GENESIS fielding to Initial Operating Capability (IOC) sites in February 2017 and will continue until the end Fiscal Year 2017. Thereafter, USD (AT&L) will issue a Full Deployment Decision (FDD) certification in 2018 to proceed to the remaining sites using a wave model.

While PEO OHMS has developed proposed schedules post-IOC, they are unofficial and unapproved until the FDD. This would include any proposed schedule that incorporates MBPS. We are unable to share unapproved information with the GAO. The PEO DI-IMS is fully committed to transforming the delivery and documentation of healthcare for service members, veterans, and their families, including service members processing into military service, and look forward to sharing additional information on this topic with the GAO in the future.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (http://www.gao.gov). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to http://www.gao.gov and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, http://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, LinkedIn, Twitter, and YouTube. Subscribe to our RSS Feeds or E-mail Updates. Listen to our Podcasts. Visit GAO on the web at www.gao.gov and read The Watchblog.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: http://www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400,
U.S. Government Accountability Office, 441 G Street NW, Room 7125,
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Strategic Planning and External Liaison

James-Christian Blockwood, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548