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DOD AND VA HEALTH CARE

Challenges Encountered by Injured Servicemembers during Their Recovery Process

Statement of Cynthia A. Bascetta
Director, Health Care





Highlights of [GAO-07-589T](#), a testimony before the Subcommittee on National Security and Foreign Affairs, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

As of March 1, 2007, over 24,000 servicemembers have been wounded in action since the onset of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), according to the Department of Defense (DOD). GAO work has shown that servicemembers injured in combat face an array of significant medical and financial challenges as they begin their recovery process in the health care systems of DOD and the Department of Veterans Affairs (VA).

GAO was asked to discuss concerns regarding DOD and VA efforts to provide medical care and rehabilitative services for servicemembers who have been injured during OEF and OIF. This testimony addresses (1) the transition of care for seriously injured servicemembers who are transferred between DOD and VA medical facilities, (2) DOD's and VA's efforts to provide early intervention for rehabilitation for seriously injured servicemembers, (3) DOD's efforts to screen servicemembers at risk for post-traumatic stress disorder (PTSD) and whether VA can meet the demand for PTSD services, and (4) the impact of problems related to military pay on injured servicemembers and their families.

This testimony is based on GAO work issued from 2004 through 2006 on the conditions facing OEF/OIF servicemembers at the time the audit work was completed.

www.gao.gov/cgi-bin/getrpt?GAO-07-589T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101 or bascettac@gao.gov.

DOD AND VA HEALTH CARE

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What GAO Found

Despite coordinated efforts, DOD and VA have had problems sharing medical records for servicemembers transferred from DOD to VA medical facilities. GAO reported in 2006 that two VA facilities lacked real-time access to electronic medical records at DOD facilities. To obtain additional medical information, facilities exchanged information by means of a time-consuming process resulting in multiple faxes and phone calls.

In 2005, GAO reported that VA and DOD collaboration is important for providing early intervention for rehabilitation. VA has taken steps to initiate early intervention efforts, which could facilitate servicemembers' return to duty or to a civilian occupation if the servicemembers were unable to remain in the military. However, according to DOD, VA's outreach process may overlap with DOD's process for evaluating servicemembers for a possible return to duty. DOD was also concerned that VA's efforts may conflict with the military's retention goals. In this regard, DOD and VA face both a challenge and an opportunity to collaborate to provide better outcomes for seriously injured servicemembers.

DOD screens servicemembers for PTSD but, as GAO reported in 2006, it cannot ensure that further mental health evaluations occur. DOD health care providers review questionnaires, interview servicemembers, and use clinical judgment in determining the need for further mental health evaluations. However, GAO found that 22 percent of the OEF/OIF servicemembers in GAO's review who may have been at risk for developing PTSD were referred by DOD health care providers for further evaluations. According to DOD officials, not all of the servicemembers at risk will need referrals. However, at the time of GAO's review DOD had not identified the factors its health care providers used to determine which OEF/OIF servicemembers needed referrals. Although OEF/OIF servicemembers may obtain mental health evaluations or treatment for PTSD through VA, VA may face a challenge in meeting the demand for PTSD services. VA officials estimated that follow-up appointments for veterans receiving care for PTSD may be delayed up to 90 days.

GAO's 2006 testimony pointed out problems related to military pay have resulted in debt and other hardships for hundreds of sick and injured servicemembers. Some servicemembers were pursued for repayment of military debts through no fault of their own. As a result, servicemembers have been reported to credit bureaus and private collections agencies, been prevented from getting loans, gone months without paychecks, and sent into financial crisis. In a 2005 testimony GAO reported that poorly defined requirements and processes for extending the active duty of injured and ill reserve component servicemembers have caused them to be inappropriately dropped from active duty, leading to significant gaps in pay and health insurance for some servicemembers and their families.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss health care and other services for U.S. military servicemembers wounded during Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF).¹ On March 1, 2007, the Department of Defense (DOD) reported that over 24,000 servicemembers have been wounded in action since the onset of the two conflicts. In 2005, DOD reported that about 65 percent of the OEF and OIF servicemembers wounded in action were injured by blasts and fragments from improvised explosive devices, land mines, and other explosive devices. More recently, DOD estimated in 2006 that as many as 28 percent of those injured by blasts and fragments have some degree of trauma to the brain. These injuries often require comprehensive inpatient rehabilitation services to address complex cognitive and physical impairments. In addition to their physical injuries, OEF/OIF servicemembers who have been injured in combat may also be at risk for developing mental health impairments, such as post-traumatic stress disorder (PTSD), which research has shown to be strongly associated with experiencing intense and prolonged combat.²

While servicemembers are on active duty, DOD decides where they receive their care—at a military treatment facility (MTF), from a TRICARE civilian provider,³ or at a Department of Veterans Affairs (VA) medical facility. From the OEF and OIF conflict areas, seriously injured servicemembers are usually brought to Landstuhl Regional Medical Center in Germany for treatment. From there, they are usually transported to MTFs located in the United States, with most of the seriously injured admitted to Walter Reed Army Medical Center or the National Naval

¹OEF, which began in October 2001, supports combat operations in Afghanistan and other locations, and OIF, which began in March 2003, supports combat operations in Iraq and other locations.

²Charles W. Hoge et al., “Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care,” *The New England Journal of Medicine*, 351 (2004): 13-22.

³DOD provides health care through TRICARE—a regionally structured program that uses civilian contractors to maintain provider networks to complement health care services provided at MTFs.

Medical Center, both of which are in the Washington, D.C., area.⁴ Once the servicemembers are medically stabilized, DOD can elect to send those with traumatic brain injuries and other complex trauma, such as missing limbs, to one of the four polytrauma rehabilitation centers (PRC)⁵ operated by VA for medical and rehabilitative care. The PRCs are located at VA medical centers in Palo Alto, California; Tampa, Florida; Minneapolis, Minnesota; and Richmond, Virginia. While many servicemembers who receive such rehabilitative services return to active duty after they are treated, others who are more seriously injured are likely to be discharged from their military obligations and return to civilian life with disabilities.

Our work has shown that servicemembers injured in combat face an array of significant medical and financial challenges as they begin their recovery process in the DOD and VA health care systems. In light of these challenges and recent media reports that have highlighted unsanitary and decrepit living conditions at the Walter Reed Army Medical Center,⁶ you asked us to discuss concerns we have identified regarding DOD and VA efforts to provide medical care and rehabilitative services for servicemembers who have been injured during OEF and OIF. Specifically, my remarks today will focus on (1) the transition of care for seriously injured OEF/OIF servicemembers—those with traumatic brain injuries or other complex trauma, such as missing limbs—who are transferred between DOD and VA medical facilities; (2) DOD’s and VA’s efforts to provide early intervention for rehabilitation services as soon as possible after the onset of a disability for seriously injured servicemembers; (3) DOD’s efforts to screen OEF/OIF servicemembers at risk for PTSD and

⁴Other MTFs that received OEF/OIF servicemembers include Brooke Army Medical Center (San Antonio, Texas), Dwight David Eisenhower Army Medical Center (Augusta, Georgia), Madigan Army Medical Center (Tacoma, Washington), Darnall Army Community Hospital (Fort Hood, Texas), Evans Army Community Hospital (Fort Carson, Colorado), and the Naval Hospital Camp Pendleton (Camp Pendleton, California).

⁵The Veterans Health Programs Improvement Act of 2004, Pub. L. No. 108-422, § 302, 118 Stat. 2379, 2383-86, mandated that VA establish centers for research, education, and clinical activities related to complex multiple trauma associated with combat injuries. In response to that mandate, VA established PRCs at four VA medical facilities with expertise in traumatic amputation, spinal cord injury, traumatic brain injury, and blind rehabilitation. A PRC addresses the rehabilitation needs of the combat injured in one setting and in a coordinated manner.

⁶See, for instance, Dana Priest and Anne Hull, “Soldiers Face Neglect, Frustration at Army’s Top Medical Facility,” *The Washington Post* (Feb. 18, 2007).

whether VA can meet the demand for PTSD services; and (4) the impact of problems related to military pay on injured servicemembers and their families.

My testimony is based on issued GAO work.⁷ The information I am reporting today reflects the conditions facing OEF/OIF servicemembers at the time the audit work was completed and illustrates the types of problems injured servicemembers encountered during their healing and rehabilitation process. To complete the work for these products, we visited DOD and VA facilities, reviewed relevant documents, analyzed DOD data, and interviewed DOD and VA officials. Our work was performed in accordance with generally accepted government auditing standards.

In summary, DOD and VA have made various efforts to provide medical care and rehabilitative services for OEF/OIF servicemembers. The departments established joint programs to facilitate the transfer of injured servicemembers from DOD facilities to VA medical facilities, assess whether servicemembers will be able to remain in the military, and assign VA social workers to selected MTFs to coordinate the transfers. DOD has also established a program to screen servicemembers after their deployment outside of the United States has ended to assess whether they are at risk for PTSD. However, we found several problems in the efforts to provide health care and rehabilitative services for OEF/OIF servicemembers. For example, DOD and VA had problems sharing medical records and questions arose about the timing of VA's outreach to servicemembers whose discharge from military service was not certain. Furthermore, we found that DOD cannot provide reasonable assurance that OEF/OIF servicemembers who need referrals for mental health evaluations receive them. Finally, problems related to military pay have resulted in overpayments and debt for hundreds of sick and injured servicemembers.

⁷See Related GAO Products at the end of this statement.

DOD and VA Have Taken Actions to Facilitate the Transfer of Servicemembers but Experienced Problems in Exchanging Health Care Information

In our June 2006 report, we found that DOD and VA had taken actions to facilitate the transition of medical and rehabilitative care for seriously injured servicemembers who were being transferred from MTFs to PRCs.⁸ For example, in April 2004, DOD and VA signed a memorandum of agreement that established referral procedures for transferring injured servicemembers from DOD to VA medical facilities. DOD and VA also established joint programs to facilitate the transfer to VA medical facilities, including a program that assigned VA social workers to selected MTFs to coordinate transfers.

Despite these coordination efforts, we found that DOD and VA were having problems sharing the medical records VA needed to determine whether servicemembers' medical conditions allowed participation in VA's vigorous rehabilitation activities. DOD and VA reported that as of December 2005 two of the four PRCs had real-time access to the electronic medical records maintained at Walter Reed Army Medical Center and only one of the two also had access to the records at the National Naval Medical Center. In cases where medical records could not be accessed electronically, the MTF faxed copies of some medical information, such as the patient's medical history and progress notes, to the PRC. Because this information did not always provide enough data for the PRC provider to determine if the servicemember was medically stable enough to be admitted to the PRC, VA developed a standardized list of the minimum types of health care information needed about each servicemember transferring to a PRC. Even with this information, PRC providers frequently needed additional information and had to ask for it specifically. For example, if the PRC provider notices that the servicemember is on a particular antibiotic therapy, the provider may request the results of the most recent blood and urine cultures to determine if the servicemember is medically stable enough to participate in strenuous rehabilitation activities. According to PRC officials, obtaining additional medical information in this way, rather than electronically, is very time consuming and often requires multiple phone calls and faxes. VA officials told us that the transfer could be more efficient if PRC medical personnel had real-time access to the servicemembers' complete DOD electronic medical records from the referring MTFs. However, problems existed even for the two PRCs that had been granted electronic access. During a visit to those

⁸GAO, *VA and DOD Health Care: Efforts to Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans*, [GAO-06-794R](#) (Washington, D.C.: June 30, 2006).

PRCs in April 2006, we found that neither facility could access the records at Walter Reed Army Medical Center because of technical difficulties.

DOD and VA Collaboration Is Important for Early Intervention for Rehabilitation

As discussed in our January 2005 report, the importance of early intervention for returning individuals with disabilities to the workforce is well documented in vocational rehabilitation literature.⁹ In 1996, we reported that early intervention significantly facilitates the return to work but that challenges exist in providing services early.¹⁰ For example, determining the best time to approach recently injured servicemembers and gauge their personal receptivity to considering employment in the civilian sector is inherently difficult. The nature of the recovery process is highly individualized and requires professional judgment to determine the appropriate time to begin vocational rehabilitation. Our 2007 *High-Risk Series: An Update* designates federal disability programs as “high risk” because they lack emphasis on the potential for vocational rehabilitation to return people to work.¹¹

In our January 2005 report, we found that servicemembers whose disabilities are definitely or likely to result in military separation may not be able to benefit from early intervention because DOD and VA could work at cross purposes. In particular, DOD was concerned about the timing of VA’s outreach to servicemembers whose discharge from military service is not yet certain. DOD was concerned that VA’s efforts may conflict with the military’s retention goals. When servicemembers are treated as outpatients at a VA or military hospital, DOD generally begins to assess whether the servicemember will be able to remain in the military. This process can take months. For its part, VA took steps to make seriously injured servicemembers a high priority for all VA assistance. Noting the importance of early intervention, VA instructed its regional offices in 2003 to assign a case manager to each seriously injured servicemember who applies for disability compensation. VA had detailed

⁹GAO, *Vocational Rehabilitation: More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers*, [GAO-05-167](#) (Washington, D.C.: Jan. 14, 2005).

¹⁰We also reported on early intervention in GAO, *SSA Disability: Return-to-Work Strategies from Other Systems May Improve Federal Programs*, [GAO/HEHS-96-133](#) (Washington, D.C.: July 11, 1996).

¹¹GAO, *High-Risk Series: An Update*, [GAO-07-310](#) (Washington, D.C.: January 2007).

staff to MTFs to provide information on all veterans' benefits, including vocational rehabilitation, and reminded staff that they can initiate evaluation and counseling, and, in some cases, authorize training before a servicemember is discharged. While VA tries to prepare servicemembers for a transition to civilian life, VA's outreach process may overlap with DOD's process for evaluating servicemembers for a possible return to duty.

In our report, we concluded that instead of working at cross purposes to DOD goals, VA's early intervention efforts could facilitate servicemembers' return to the same or a different military occupation, or to a civilian occupation if the servicemembers were not able to remain in the military. In this regard, the prospect for early intervention with vocational rehabilitation presents both a challenge and an opportunity for DOD and VA to collaborate to provide better outcomes for seriously injured servicemembers.

DOD Screens Servicemembers for PTSD after Deployment, but DOD and VA Face Challenges Ensuring Further PTSD Services

In our May 2006 report, we described DOD's efforts to identify and facilitate care for OEF/OIF servicemembers who may be at risk for PTSD.¹² To identify such servicemembers, DOD uses a questionnaire, the DD 2796, to screen OEF/OIF servicemembers after their deployment outside of the United States has ended. The DD 2796 is used to assess servicemembers' physical and mental health and includes four questions to identify those who may be at risk for developing PTSD. We reported that according to a clinical practice guideline jointly developed by DOD and VA, servicemembers who responded positively to at least three of the four PTSD screening questions may be at risk for developing PTSD. DOD health care providers review completed questionnaires, conduct face-to-face interviews with servicemembers, and use their clinical judgment in determining which servicemembers need referrals for further mental health evaluations.^{13,14} OEF/OIF servicemembers can obtain the mental

¹²GAO, *Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers*, [GAO-06-397](#) (Washington, D.C.: May 11, 2006).

¹³Health care providers that review the DD 2796 may include physicians, physician assistants, nurse practitioners, or independent duty medical technicians—enlisted personnel who receive advanced training to provide treatment and administer medications.

¹⁴DOD's referrals are used to document DOD's assessment that servicemembers are in need of further mental health evaluations.

health evaluations, as well as any necessary treatment for PTSD, while they are servicemembers—that is, on active duty—or when they transition to veteran status if they are discharged or released from active duty.

Despite DOD's efforts to identify OEF/OIF servicemembers who may need referrals for further mental health evaluations, we reported that DOD cannot provide reasonable assurance that OEF/OIF servicemembers who need the referrals receive them. Using data provided by DOD,¹⁵ we found that 22 percent, or 2,029, of the 9,145 OEF/OIF servicemembers in our review who may have been at risk for developing PTSD were referred by DOD health care providers for further mental health evaluations. Across the military service branches, DOD health care providers varied in the frequency with which they issued referrals to OEF/OIF servicemembers with three or more positive responses to the PTSD screening questions—the Army referred 23 percent, the Air Force about 23 percent, the Navy 18 percent, and the Marines about 15 percent. According to DOD officials, not all of the OEF/OIF servicemembers with three or four positive responses on the screening questionnaire need referrals. As directed by DOD's guidance for using the DD 2796, DOD health care providers are to rely on their clinical judgment to decide which of these servicemembers need further mental health evaluations. However, at the time of our review DOD had not identified the factors its health care providers used to determine which OEF/OIF servicemembers needed referrals. Knowing these factors could explain the variation in referral rates and allow DOD to provide reasonable assurance that such judgments are being exercised appropriately.¹⁶ We recommended that DOD identify the factors that DOD health care providers used in issuing referrals for further mental health evaluations to explain provider variation in issuing referrals. DOD concurred with the recommendation.

¹⁵In our review we analyzed computerized data provided by DOD to identify 178,664 OEF/OIF servicemembers who were deployed in support of OEF/OIF from October 1, 2001, through September 30, 2004, and who have since been discharged or released from active duty. These servicemembers had answered the four PTSD screening questions on the DD 2796 and had a record of their completed questionnaire available in a DOD computerized database. We found that DOD data indicated 9,145 of the 178,664 servicemembers in our review may have been at risk for developing PTSD.

¹⁶The John Warner National Defense Authorization Act for Fiscal Year 2007 required DOD to develop guidelines for mental health referrals, as well as mechanisms to ensure proper training and oversight, by April 2007. Pub. L. No. 109-364, § 738, 120 Stat. 2083, 2303-4.

Although OEF/OIF servicemembers may obtain mental health evaluations or treatment for PTSD through VA when they transition to veteran status, VA may face a challenge in meeting the demand for PTSD services. In September 2004 we reported that VA had intensified its efforts to inform new veterans from the Iraq and Afghanistan conflicts about the health care services—including treatment for PTSD—VA offers to eligible veterans.¹⁷ We observed that these efforts, along with expanded availability of VA health care services for Reserve and National Guard members, could result in an increased percentage of veterans from Iraq and Afghanistan seeking PTSD services through VA. However, at the time of our review officials at six of seven VA medical facilities we visited explained that while they were able to keep up with the current number of veterans seeking PTSD services, they may not be able to meet an increase in demand for these services. In addition, some of the officials expressed concern because facilities had been directed by VA to give veterans from the Iraq and Afghanistan conflicts priority appointments for health care services, including PTSD services. As a result, VA medical facility officials estimated that follow-up appointments for veterans receiving care for PTSD could be delayed. VA officials estimated the delays to be up to 90 days.

Problems Related to Military Pay Have Resulted in Debt and Other Hardships for Hundreds of Sick and Injured Servicemembers

As discussed in our April 2006 testimony, problems related to military pay have resulted in overpayments and debt for hundreds of sick and injured servicemembers.¹⁸ These pay problems resulted in significant frustration for the servicemembers and their families. We found that hundreds of battle-injured servicemembers were pursued for repayment of military debts through no fault of their own, including at least 74 servicemembers whose debts had been reported to credit bureaus and private collections agencies. In response to our audit, DOD officials said collection actions on these servicemembers' debts had been suspended until a determination could be made as to whether these servicemembers' debts were eligible for relief.

¹⁷GAO, *VA and Defense Health Care: More Information Needed to Determine If VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services*, [GAO-04-1069](#) (Washington, D.C.: Sept. 20, 2004).

¹⁸GAO, *Military Pay: Military Debts Present Significant Hardships to Hundreds of Sick and Injured GWOT Soldiers*, [GAO-06-657T](#) (Washington, D.C.: April 27, 2006).

Debt collection actions created additional hardships on servicemembers by preventing them from getting loans to buy houses or automobiles or pay off other debt, and sending several servicemembers into financial crisis. Some battle-injured servicemembers forfeited their final separation pay to cover part of their military debt, and they left the service with no funds to cover immediate expenses while facing collection actions on their remaining debt.

We also found that sick and injured servicemembers sometimes went months without paychecks because debts caused by overpayments of combat pay and other errors were offset against their military pay.¹⁹ Furthermore, the longer it took DOD to stop the overpayments, the greater the amount of debt that accumulated for the servicemember and the greater the financial impact, since more money would eventually be withheld from the servicemember's pay or sought through debt collection action after the servicemember had separated from the service.

In our 2005 testimony about Army National Guard and Reserve servicemembers, we found that poorly defined requirements and processes for extending injured and ill reserve component servicemembers on active duty have caused servicemembers to be inappropriately dropped from active duty.²⁰ For some, this has led to significant gaps in pay and health insurance, which has created financial hardships for these servicemembers and their families.

Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other members of the subcommittee may have at this time.

¹⁹We found that after voluntary allotments and other required deductions, many times there was no net pay due the servicemember.

²⁰GAO, *Military Pay: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers*, [GAO-05-322T](#) (Washington, D.C.: Feb. 17, 2005).

Contacts and Acknowledgments

For further information about this testimony, please contact Cynthia A. Bascetta at (202) 512-7101 or bascettac@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Michael T. Blair, Jr., Assistant Director; Cynthia Forbes; Krister Friday; Roseanne Price; Cherie' Starck; and Timothy Walker made key contributions to this statement.

Related GAO Products

High-Risk Series: An Update. [GAO-07-310](#). Washington, D.C.: January 2007.

VA and DOD Health Care: Efforts to Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans. [GAO-06-794R](#). Washington, D.C.: June 30, 2006.

Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers. [GAO-06-397](#). Washington, D.C.: May 11, 2006.

Military Pay: Military Debts Present Significant Hardships to Hundreds of Sick and Injured GWOT Soldiers. [GAO-06-657T](#). Washington, D.C.: April 27, 2006.

Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members. [GAO-06-362](#). Washington, D.C.: March 31, 2006.

Military Pay: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers. [GAO-05-322T](#). Washington, D.C.: February 17, 2005.

Vocational Rehabilitation: More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers. [GAO-05-167](#). Washington, D.C.: January 14, 2005.

VA and Defense Health Care: More Information Needed to Determine If VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services. [GAO-04-1069](#). Washington, D.C.: September 20, 2004.

SSA Disability: Return-to-Work Strategies from Other Systems May Improve Federal Programs. [GAO/HEHS-96-133](#). Washington, D.C.: July 11, 1996.

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