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COMPUTER-BASED PATIENT RECORDS

Sound Planning and Project
Management Are Needed to
Achieve a Two-Way
Exchange of VA and DOD
Health Data

Statement of Linda D. Koontz
Director, Information Management Issues



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Highlights

Highlights of [GAO-04-402T](#), testimony before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs

Why GAO Did This Study

A critical component of the Department of Veterans Affairs' (VA) information technology program is its ongoing work with the Department of Defense (DOD) to achieve the ability to exchange patient health care data and create electronic records for use by veterans, active military personnel, and their health care providers.

GAO testified before the Subcommittee last November that one-way sharing of data, from DOD to VA medical facilities, had been realized. At the Subcommittee's request, GAO assessed, among other matters, VA's and DOD's progress since that time toward defining a detailed strategy for and developing the capability of a two-way exchange of patient health information.

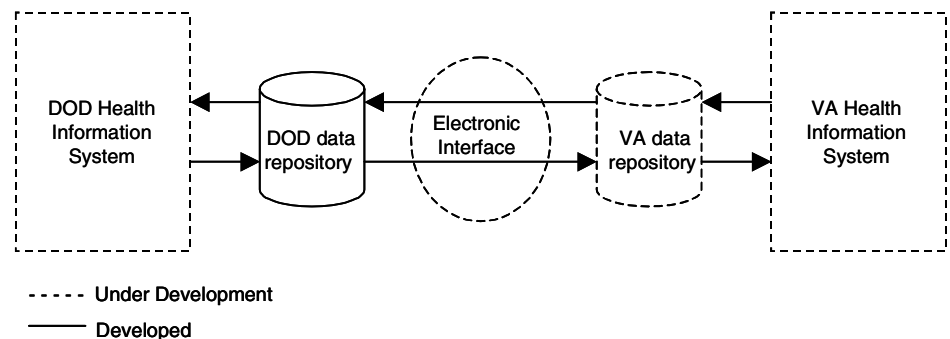
COMPUTER-BASED PATIENT RECORDS

Sound Planning and Project Management Are Needed to Achieve a Two-Way Exchange of VA and DOD Health Data

What GAO Found

Since November, VA and DOD have made little progress in determining their approach for achieving the two-way exchange of patient health data. Department officials recognize the importance of an architecture to articulate how they will electronically interface their health systems, but continue to rely on a nonspecific, high-level strategy—in place since September 2002—to guide their development and implementation of this capability (see figure).

High-Level Strategy Intended To Allow Two-Way Exchange of Health Data



Source: VA and DOD

VA officials stated that an initiative begun this month to satisfy a mandate of the Bob Stump National Defense Authorization Act for Fiscal Year 2003 will be used to better define the electronic interface needed to exchange patient health data. However, this project is at an early stage, and the departments have not yet fully identified the approach or requirements for this undertaking. Given these uncertainties, there is little evidence of how this project will contribute to defining a specific architecture and technological solution for achieving the two-way health data exchange.

These uncertainties are further complicated by the absence of sound project management to guide the departments' actions. At present, neither department has the authority to make final decisions binding on the other, and day-to-day oversight of the joint initiative to develop an electronic interface is limited. Progress toward defining data standards continues, but delays have occurred in the development and deployment of the agencies' individual health information systems.

www.gao.gov/cgi-bin/getrpt?GAO-04-402T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Linda D. Koontz at (202) 512-6240 or koontzl@gao.gov.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to participate in continuing discussions of the Department of Veterans Affairs' (VA) information technology program. My testimony focuses on a critical aspect of that program—VA's work with the Department of Defense (DOD) to achieve the ability to exchange patient health care data and create an electronic medical record for veterans and active duty military personnel. As you are well aware, having readily accessible medical data on these individuals—many of whom are highly mobile and may have health records at multiple medical facilities within and outside of the United States—is important to providing high-quality health care to them and to adjudicating any disability claims that they may have. VA and DOD have been pursuing ways to share data in their health information systems and create electronic records since 1998, yet accomplishing a two-way health data exchange has been elusive.

When we testified on this initiative last November,¹ VA and DOD had achieved a measure of success in sharing data through the one-way transfer of health information from DOD to VA health care facilities.² Yet VA and DOD faced significant challenges and were far from realizing a longer term objective: providing a virtual medical record based on the two-way exchange of data, as part of their Health₂People (Federal) initiative. The departments had not clearly articulated a common health information architecture, and lacked the details and specificity essential to determining how they would achieve this capability.

At your request, my testimony will discuss our review of VA's and DOD's actions since November toward defining a detailed strategy and developing the capability for a two-way exchange of patient health information. In addition, I will provide an update on actions that the departments have taken to address recommendations resulting from prior

¹U.S. General Accounting Office, *Computer-Based Patient Records: Short-Term Progress Made, but Much Work Remains to Achieve a Two-Way Data Exchange Between VA and DOD Health Systems*, [GAO-04-271T](#) (Washington, D.C.: November 19, 2003).

²The one-way transfer of health care data from DOD to VA is being accomplished as part of the Federal Health Information Exchange initiative.

reviews of their efforts to share medical data,³ including those articulated in the May 2003 report of the President's task force on the development of electronic medical records.⁴

In conducting this work, we analyzed key documentation supporting VA's and DOD's strategy for developing and implementing the two-way electronic exchange of health data, including deployment and conversion plans, project schedules, and status reports for their individual health information systems. In addition, we reviewed documentation to identify the costs incurred by VA and DOD in developing technology to support the sharing of health data, including costs associated with the government computer-based patient record and federal health information exchange initiatives, and with VA's and DOD's ongoing projects to develop new health information systems. We supplemented our analyses with interviews of VA and DOD officials responsible for key decisions and actions on the initiatives. Further, we analyzed documentation and interviewed relevant VA and DOD officials to determine actions that have been taken to address our previous recommendations related to the government computer-based patient record initiative and those contained in the President's task force report. We did not verify the departments' reported actions in response to the President's task force recommendations. We performed our work in accordance with generally accepted government auditing standards, from December 2003 through March of this year.

Results in Brief

Since November, VA and DOD have made little progress toward defining how they intend to achieve the two-way exchange of patient health data under the Health@People (Federal) initiative. Although VA officials recognize the importance of having an architecture to describe in detail how they plan to develop an electronic interface between their health information systems, they acknowledged that the departments' actions are continuing to be driven by a less-specific, high-level strategy that has been in place since September 2002. VA and DOD officials stated that they

³U.S. General Accounting Office, *Veterans Affairs: Sustained Management Attention Is Key to Achieving Information Technology Results*, [GAO-02-703](#) (Washington, D.C.: June 12, 2002) and *Computer-Based Patient Records: Better Planning and Oversight By VA, DOD, and IHS Would Enhance Health Data Sharing*, [GAO-01-459](#) (Washington, D.C.: April 30, 2001).

⁴*President's Task Force to Improve Health Care Delivery For Our Nation's Veterans*, Final Report (Washington, D.C.: May 26, 2003).

intend to rely on an initiative being undertaken this month to satisfy a mandate of the Bob Stump National Defense Authorization Act for Fiscal Year 2003⁵ to better define the electronic interface needed to exchange patient health information. However, this project is at an early stage, and the departments have not yet fully determined the approach or requirements for this undertaking. Given these uncertainties, there is little evidence as to whether and how this project will contribute to defining an explicit architecture and technological solution for achieving the two-way exchange of patient health information.

Adding to the challenge and uncertainties of developing the electronic interface is that VA and DOD have not fully established a project management structure to ensure the necessary day-to-day guidance of and accountability for the departments' investment in and implementation of this capability. Although maintaining that they are collaborating on this initiative through a joint working group and receiving oversight from executive-level councils, neither department has had the authority to make final project decisions binding on the other. Further, the departments are operating without a project management plan describing the specific responsibilities of VA and DOD in developing, testing, and deploying the interface. In the absence of an explicit architecture and critical project management, VA and DOD are progressing slowly in their development of this important technology. The departments have continued to define data standards that are essential to facilitating the exchange of data, but have experienced delays in key milestones associated with the development and deployment of their individual health information systems. Such delays call into question the departments' ability to meet their target date for beginning to exchange patient health information in 2005.

Both the President's task force and we have made multiple recommendations aimed at improving VA's and DOD's success in undertaking projects intended to achieve the electronic exchange of patient health records. For example, the task force recommended developing and deploying, by fiscal year 2005, electronic medical records that are interoperable, bidirectional, and standards-based. The departments reported that they are currently in various stages of acting on the specific recommendations that the task force made for providing timely, high-quality care through effective electronic sharing of health information. Beyond this, we previously recommended that, among other

⁵P.L. 107-314, sec. 724 (2002).

actions, VA and DOD designate a lead entity with final decisionmaking authority and establish a clear line of authority for the earlier, near-term government computer-based patient record project. In line with our recommendations, VA and DOD made overall management and accountability enhancements that could provide lessons learned for improving the departments' approach to successfully accomplishing the longer term initiative to develop a two-way health information exchange.

Background

In 1998 VA and DOD, along with the Indian Health Service (IHS), began an initiative to share patient health care data, called the government computer-based patient record (GCPR) project. At that time, each agency collected and maintained patient health information in separate systems, and their health facilities could not electronically share patient health information across agency lines. GCPR was envisioned as an electronic interface that would allow physicians and other authorized users at VA, DOD, and IHS health facilities to access data from any of the other agencies' health facilities. The interface was expected to compile requested patient information in a "virtual" record that could be displayed on a user's computer screen.

In reporting on the initiative in April 2001,⁶ we raised doubts about GCPR's ability to provide expected benefits. We noted that the project was experiencing schedule and cost overruns and was operating without clear goals, objectives, and consistent leadership. We recommended that the participating agencies (1) designate a lead entity with final decisionmaking authority and establish a clear line of authority for the GCPR project, and (2) create comprehensive and coordinated plans that included an agreed-upon mission and clear goals, objectives, and performance measures, to ensure that the agencies could share comprehensive, meaningful, accurate, and secure patient health care data. VA, DOD, and IHS agreed with our findings and recommendations.

In March 2002, however, we again reported that the project was continuing to operate without clear lines of authority or a lead entity responsible for final decisionmaking.⁷ Further, the project continued to move forward

⁶GAO-01-459.

⁷U.S. General Accounting Office, *VA Information Technology: Progress Made, but Continued Management Attention Is Key to Achieving Results*, [GAO-02-369T](#) (Washington, D.C.: March 13, 2002).

without comprehensive and coordinated plans and an agreed-upon mission and clear goals and measures. In addition, the participating agencies had announced a revised strategy that was considerably less encompassing than the project was originally intended to be. For example, rather than serve as an interface to allow data sharing across the three agencies' disparate systems, as originally envisioned, the revised strategy initially called only for a one-way transfer of data from DOD's current health care information system to a separate database that VA hospitals could access. In further reporting on this initiative in June 2002, we recommended that VA, DOD, and IHS revise the original goals and objectives of the project to align with their current strategy, commit the executive support necessary to adequately manage the project, and ensure that it followed sound project management principles.⁸

In September 2002 we reported that VA and DOD had made some progress toward electronically sharing patient health data.⁹ The two departments had renamed the project the Federal Health Information Exchange (FHIE) program and, consistent with our prior recommendation, had finalized a memorandum of agreement designating VA as the lead entity for implementing the program. With this agreement, FHIE became a joint effort between VA and DOD to achieve the exchange of health care information in two phases. The first phase, completed in mid-July 2002, enabled the one-way transfer of data from DOD's existing health information system to a separate database that VA hospitals could access. A second phase, finalized earlier this month, completed VA's and DOD's efforts to add to the base of patient health information available to VA clinicians via this one-way sharing capability. VA and DOD reported total FHIE costs of about \$85 million through fiscal year 2003.

The revised strategy also envisioned VA and DOD pursuing a longer term, two-way exchange of health information. This initiative, known as Health@People (Federal), is premised upon the departments' development of a common health information architecture comprising standardized data, communications, security, and high-performance health information systems. The joint effort is expected to result in the secured sharing of health data required by VA's and DOD's health care providers between

⁸GAO-02-703.

⁹U.S. General Accounting Office, *VA Information Technology: Management Making Important Progress In Addressing Key Challenges*, [GAO-02-1054T](#) (Washington, D.C.: September 26, 2002).

systems that each department is currently developing—DOD’s Composite Health Care System II (CHCS II) and VA’s HealthVet VistA.

DOD began developing CHCS II in 1997 and has completed its associated clinical data repository that is key to achieving an electronic interface. DOD expects to complete deployment of all of its major system capabilities by September 2008.¹⁰ The department reported expenditures of about \$464 million for the system through fiscal year 2003. VA began work on HealthVet VistA and its associated health data repository in 2001, and expects to complete all six initiatives that make up this system in 2012.¹¹ VA reported spending about \$120 million on HealthVet VistA through fiscal year 2003.

Under the HealthPeople (Federal) strategy, VA and DOD envision that, upon entering military service, a health record for the service member will be created and stored in DOD’s CHCS II clinical data repository. The record will remain in the clinical data repository and be updated as the service member receives medical care. When the individual separates from active duty and, if eligible, seeks medical care at a VA facility, VA will then create a medical record for the individual, which will be stored in its health data repository. Upon viewing the medical record, the VA clinician would be alerted and provided access to clinical information on the individual also residing in DOD’s repository. In the same manner, when a veteran seeks medical care at a military treatment facility, the attending DOD clinician would be alerted and provided with access to the health information existing in VA’s repository. According to VA and DOD, the planned approach would make virtual medical records displaying all available patient health information from the two repositories accessible to both departments’ clinicians. VA officials have stated that they anticipate being able to exchange some degree of health information through an interface of their health data repository with DOD’s clinical data repository by the end of calendar year 2005.

¹⁰DOD’s CHCS II capabilities are being deployed in blocks. Block 1 provides a graphical user interface for clinical outpatient processes; block 2 supports general dentistry; block 3 provides pharmacy, laboratory, radiology, and immunizations capabilities; block 4 provides inpatient and scheduling capabilities; and block 5 will provide additional capabilities as defined.

¹¹The six initiatives that make up HealthVet VistA are health data repository, billing replacement, laboratory, pharmacy, imaging, and appointment scheduling replacement.

Lacking A Defined Strategy, VA And DOD Have Made Limited Progress Toward A Common Health Information Exchange

VA's and DOD's ability to exchange data between their separate health information systems is crucial to achieving the goals of *Health@People* (Federal). Yet successfully sharing patient health information via a secure electronic interface between each of their data repositories can be complex and challenging, and depends on their having a clearly articulated architecture, or blueprint, defining how specific technologies will be used to achieve the interface. Developing, maintaining, and using an architecture is a best practice in engineering information systems and other technological solutions. An architecture would articulate, for example, the system requirements and design specifications, database descriptions, and software descriptions that define the manner in which the departments will electronically store, update, and transmit their data.

Equally critical is an established project management structure to guide project development. Industry best practices and information technology project management principles¹² stress the importance of accountability and sound planning for any project, particularly an interagency effort of the magnitude and complexity of this one. Inherent in such planning is the development and use of a project management plan that describes, among other factors, the project's scope, implementation strategy, lines of responsibility, security requirements, resources, and estimated schedule for development and implementation.

As was the situation when we testified last November, VA and DOD continue to lack an explicit architecture detailing how they intend to achieve the data exchange capability, or just what they will be able to exchange by the end of 2005—their projected time frame for putting this capability into operation. VA officials stated that they recognize the importance of a clearly defined architecture, but acknowledged that the departments' actions were continuing to be driven by the less-specific, high-level strategy that has been in place since September 2002.

The officials added that just this month, the departments had taken a first step toward trying to determine how their separate data repositories would interface to enable the two-way exchange of patient health records. Specifically, officials in both departments pointed to a project that they are undertaking in response to requirements of the National Defense Authorization Act for Fiscal Year 2003, which mandated that VA and DOD

¹²Institute of Electrical and Electronics Engineers, *IEEE/EIA Guide for Information Technology* (IEEE/EIA 12207.1- 1997), April 1998.

develop a real-time interface, data exchange, and capability to check prescription drug data for outpatients by October 1, 2004.¹³ VA's Deputy Chief Information Officer for Health stated that they hope to determine from a prototype planned for completion by next September whether the interface technology developed to meet this mandate can be used to facilitate the exchange of data between the health information systems that they are currently developing.

By late February, VA had hired a supporting contractor to develop the planned prototype, but the departments had not yet fully defined their approach or requirements for developing and demonstrating its capabilities. DOD officials stated that the departments would rely on the contractor to more fully define the technical requirements for the prototype. Further, according to VA officials, since the departments' new health information systems that are intended to be used under Health@People (Federal) have not yet been completed, the demonstration may only test the ability to exchange data in VA's and DOD's existing health systems—the Veterans Information Systems and Technology Architecture and the Composite Health Care System, respectively. Thus, given the early stage of the prototype and the uncertainties regarding what capabilities it will demonstrate, there is little evidence and assurance as to how or whether this project will contribute to defining the architecture and technological solution for the two-way exchange of patient health information.

Further compounding the challenges and uncertainty that VA and DOD face is the lack of a fully established project management structure to ensure the necessary day-to-day guidance of and accountability for the departments' investments in and implementation of the electronic interface between their systems. Officials in both departments maintain that they are collaborating on this initiative through a joint working group and with oversight provided by the Joint Executive Council and VA/DOD

¹³Sec. 724 of the act mandates that the Secretaries of Veterans Affairs and Defense seek to ensure that, on or before October 1, 2004, the two departments' pharmacy data systems are interoperable for VA and DOD beneficiaries by achieving real-time interface, data exchange, and checking of prescription drug data of outpatients and using national standards for the exchange of outpatient medication information. The act further states that if the specified interoperability is not achieved by that date, then the Secretary of Veterans Affairs shall adopt DOD's Pharmacy Data Transaction System for VA's use.

Health Executive Council.¹⁴ However, neither department has had the authority to make final project decisions binding on the other, and there has been a visible absence of day-to-day project oversight for the joint initiative to develop an electronic interface between the departments' planned information systems. Further, VA and DOD are operating without a project management plan describing the overall development and implementation of the interface, including the specific roles and responsibilities of each department in developing, testing, and deploying the interface and addressing security requirements. In discussing these matters last week, VA officials stated that the departments had recently designated a program manager for the planned prototype. Further, VA and DOD officials added that they had begun discussions to establish an overall project plan and finalize roles and responsibilities for managing the joint initiative to develop an electronic interface. Until these essential project management elements are fully established, VA and DOD will lack assurance that they can successfully develop and implement an electronic interface and the associated capability for exchanging health information within the time frames that they have established.

Progress Toward Achieving a Two-Way Data Exchange Has Been Limited

In the absence of an architecture and project management structure for the initiative, VA and DOD have continued to make only limited progress toward developing the technological solution essential to interfacing their patient health information. To their credit, the departments have continued essential steps toward standardizing clinical data—important for exchanging health information between disparate systems. The Institute of Medicine's Committee on Data Standards for Patient Safety has reported the lack of common data standards as a key factor preventing information sharing within the health care industry. Over the past 4 months, VA and DOD have agreed to adopt additional data standards¹⁵ for uniformly presenting in any system data related to demographics,

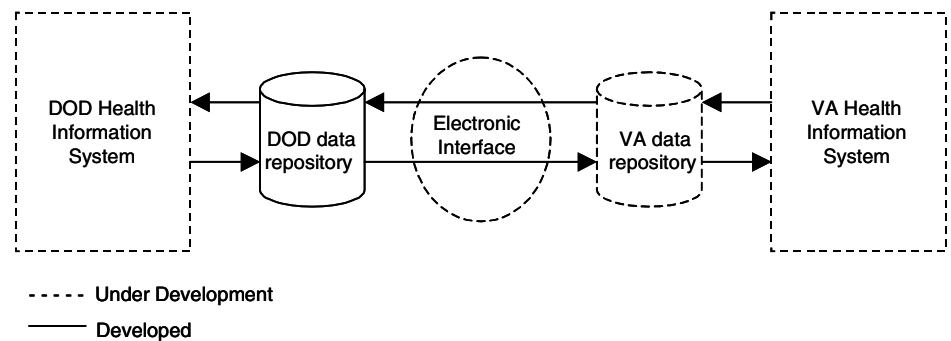
¹⁴The Joint Executive Council is composed of the Deputy Secretary of Veterans Affairs, the Undersecretary of Defense for Personnel and Readiness, and the cochair of joint councils on health, benefits, and capital planning. The council meets on a quarterly basis to recommend strategic direction of joint coordination and sharing efforts. The VA/DOD Health Executive Council is composed of senior leaders from VA and DOD, who work to institutionalize sharing and collaboration of health services and resources. The council is cochaired by the VA Undersecretary for Health and DOD Assistant Secretary of Defense for Health Affairs, and meets on a bimonthly basis.

¹⁵When we testified last November, VA and DOD had agreed to four standards to allow the transmission of messages and one standard allowing laboratory results.

immunizations, medications, names of laboratory tests ordered, and laboratory result contents.

Nonetheless, as reflected in figure 1, the technology needed to achieve a two-way exchange of patient health information remains far from complete, with only DOD's data repository having been fully developed.

Figure 1: VA/DOD High-level Strategy for the Two-Way Exchange of Health Data



Source: VA and DOD.

Since November, both departments have delayed key milestones associated with the development and deployment of their individual health information systems. VA program officials told us that completion of a prototype for the department's health data repository has been delayed approximately a year, until the end of this June. The officials explained that earlier testing of the prototype had slowed clinicians' use of the clinical applications, necessitating a revised approach to populating the repository. In addition, while DOD officials previously stated that the department planned to complete the deployment of its first release of CHCS II functionality (a capability for integrating DOD clinical outpatient processes into a single patient record) in September 2005, the agency has now extended its completion date to June 2006. According to DOD officials, the schedule for completing this deployment was revised because of a later than anticipated decision on when the department could proceed with its worldwide deployment. Collectively, the lack of an architecture and project management structure, coupled with delays in the departments' completion of key projects, places VA and DOD at increased risk of being unable to successfully accomplish the HealthPeople (Federal) initiative and the overall goal of more effectively meeting service members' and veterans' health care and disability needs.

VA and DOD Could Benefit From Current And Past Recommendations On Sharing Electronic Medical Records

Mr. Chairman, as part of our review, you asked that we update the status of VA's and DOD's actions to address prior recommendations related to sharing electronic medical information. In this regard, both the President's task force and we have made a number of recommendations to VA and DOD for improving health care delivery to beneficiaries through better coordination and management of their electronic health sharing initiatives. In its final report of May 2003,¹⁶ the President's task force recommended specific actions for providing timely, high-quality care through effective electronic sharing of health information, such as the development and deployment, by fiscal year 2005, of electronic medical records that are interoperable, bidirectional, and standards-based. The departments reported that they are in various stages of acting on these recommendations, with anticipated completion dates ranging from June of this year to September 2005. Our attachment to this statement summarizes these specific recommendations, and the departments' reported actions to address them. Giving full consideration to these recommendations could provide VA and DOD with relevant information for determining how to proceed with the Health@People (Federal) initiative.

Also, as mentioned earlier, our prior reviews of the departments' project to develop a government computer-based patient record determined that the lack of a lead entity, clear mission, and detailed planning to achieve that mission had made it difficult to monitor progress, identify project risks, and develop appropriate contingency plans. As a result, in reporting on this initiative in April 2001 and again in June 2002, we made several recommendations to help strengthen the management and oversight of this project. VA and DOD have taken specific measures in response to our recommendations for enhancing overall management and accountability of the project, with demonstrated improvements and outcomes. Extending these practices to current activities supporting the development of Health@People (Federal) could strengthen the departments' approach to successfully accomplishing a two-way health information exchange.

In summary, Mr. Chairman, achieving an electronic interface to enable VA and DOD to exchange patient medical records between their health information systems is an important goal, with substantial implications for improving the quality of health care and disability claims processing for our nation's military members and veterans. However, in seeking a virtual

¹⁶President's Task Force, Final Report, May 26, 2003.

medical record based on the two-way exchange of data between their separate health information systems, VA and DOD have chosen an approach that necessitates the highest levels of project discipline, including a well-defined architecture for describing the interface for a common health information exchange and an established project management structure to guide the investment in and implementation of this electronic capability. At this time, the departments lack these critical components, and thus risk investing in a capability that could fall short of their intended goals. The continued absence of a clear approach and sound planning for the design of this new electronic capability elevates concerns and skepticism about exactly what capabilities VA and DOD will achieve as part of HealthPeople (Federal), and in what time frame.

Mr. Chairman, this concludes my statement. I would be pleased to respond to any questions that you or other members of the Subcommittee may have at this time.

Contacts and Acknowledgments

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Appendix: VA's and DOD's Reported Actions to Address Recommendations in the President's Task Force Report of May 26, 2003

Recommendations	Reported Actions	
	Department of Veterans Affairs (VA)	Department of Defense (DOD)
1. VA and DOD should develop and deploy by fiscal year 2005 electronic medical records that are interoperable, bi-directional, and standards-based.	The VA/DOD Joint Strategic Plan and the Joint Electronic Health Records Plan have set September 2005 as the target date by which VA and DOD will achieve interoperability of health data. The VA/DOD Health Executive Council Information Management/ Information Technology Work Group is on track to complete this capability by the end of fiscal year 2005. In March 2004, the departments awarded a contract to develop a bi-directional pharmacy solution that will demonstrate interoperability in a prototype environment. The departments are on track to complete the prototype by October 2004.	Operational interoperability is planned for fiscal year 2005. The pharmacy prototype is the initial effort within the Clinical Health Data Repositories (CHDR) framework. This framework is the effort to develop software component services that will be used by the VA and DOD data repositories. The prototype has a planned completion date of October 2004.
2. The Administration should direct the Department of Health and Human Services to declare the two departments to be a single health care system for purposes of implementing the Health Insurance Portability and Accountability Act (HIPAA) regulations.	This issue remains under review by the Veterans Health Administration's HIPAA Program Office. It is VA's understanding that VA and DOD have concluded that this is not necessary in order to share information on patients that both departments are treating.	DOD believes that it and VA can achieve the appropriate sharing of protected health information within the guidelines of the current regulations. The HIPAA privacy rule has a specific exception authorizing one-way sharing of health data at the time of a service member's separation. This supports the "seamless transition to veteran status."
3. The departments should implement by fiscal year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process. Upon separation, DOD should transmit an electronic Department of Defense (DD) 214 (discharge paperwork) to VA.	The Joint Strategic Plan has set June 2004 as the target date for the departments to develop an implementation plan for the one physical exam protocol. VA and DOD are currently piloting the single separation physical exam that meets DOD needs and VA's rating criteria at 16 Benefits Delivery at Discharge sites.	The departments are currently testing an advanced technological demonstration project that transfers images of paper personnel documents to VA from official military personnel file repositories in the Army, Navy, and Marine Corps, with Air Force integration into the program in process (including the DD214). When fully operational, this system will send digital images of any personnel record to the VA within 48 hours of the request.

Recommendations	Reported Actions	
	Department of Veterans Affairs (VA)	Department of Defense (DOD)
4. By fiscal year 2004, VA and DOD should initiate a process for routine sharing of each service member's assignment history, location, occupational exposure, and injuries information.	Both the Health Executive Council (through the Deployment Health Work Group) and the VA/DOD Benefits Executive Council are currently developing and implementing processes to address these issues.	DOD is already providing VA with daily information on personnel separating from active duty, which includes assignment history, location, and occupational duties through the DD214. DOD's TRICARE On Line provides health care professionals with access to the individual service member's pre- and post-deployment health assessments. The Defense Occupational and Environmental Health Readiness System with CHCS II, is capturing data on occupational exposures and transferring it to the clinical data repository. When these systems are fully operational, appropriate information will be able to be shared via a two-way exchange with VA.

Source: VA and DOD.

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