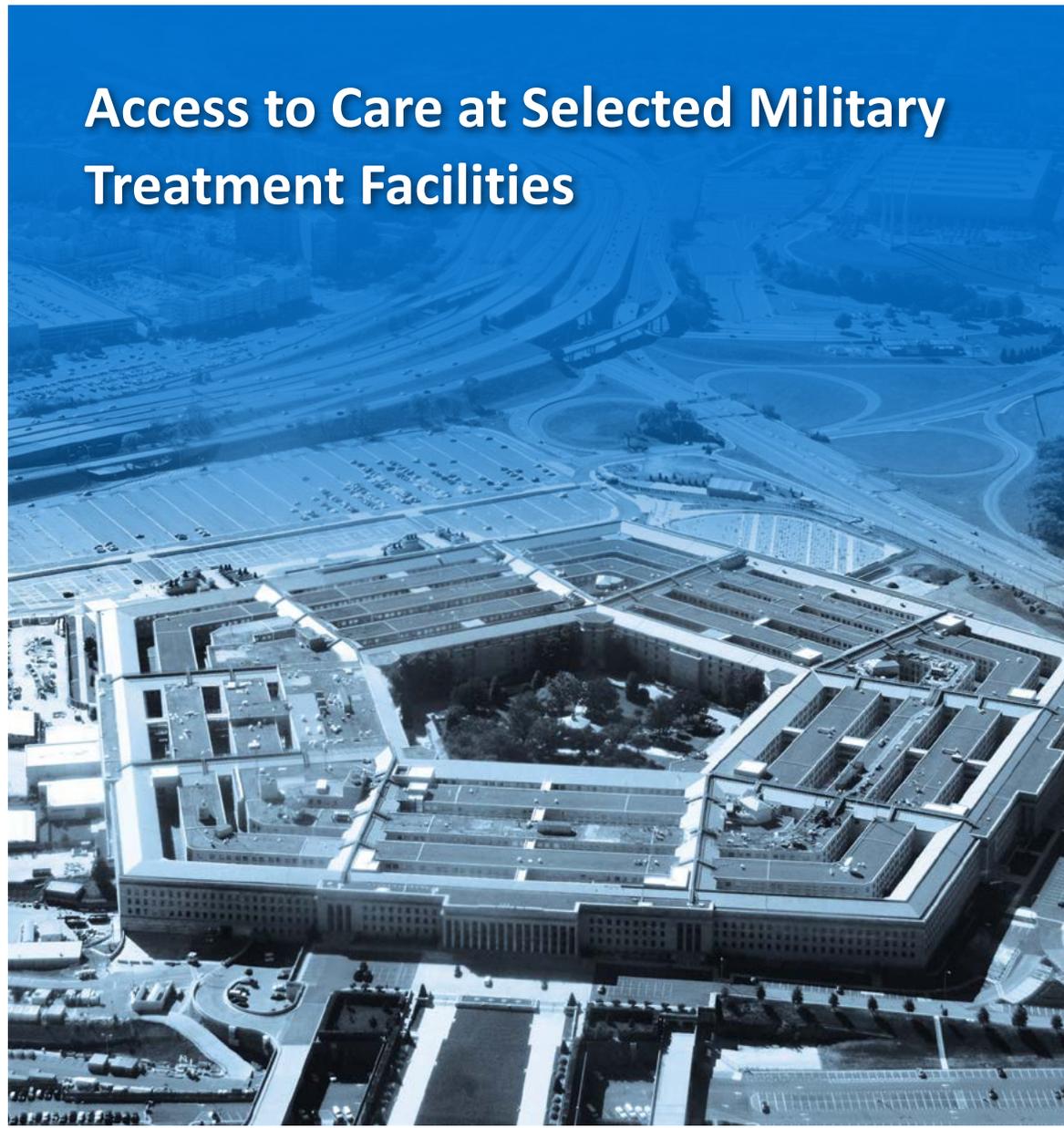




# INSPECTOR GENERAL

*U.S. Department of Defense*

MAY 1, 2018



## Access to Care at Selected Military Treatment Facilities

INTEGRITY ★ EFFICIENCY ★ ACCOUNTABILITY ★ EXCELLENCE

INTEGRITY ★ EFFICIENCY ★ ACCOUNTABILITY ★ EXCELLENCE

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# Results in Brief

## *Access to Care at Selected Military Treatment Facilities*

May 1, 2018

### Objective

Our objective was to determine whether DoD is meeting access to care standards for acute and routine appointments at selected military treatment facilities.

### Background

Federal regulations establish access to care standards for the Military Health System, including providing patients an appointment to visit a provider within 7 days for a routine appointment and 24 hours for an urgent appointment. Assistant Secretary of Defense (Health Affairs) guidance states that DoD beneficiaries must be offered routine and urgent appointments within the established standards. When health care is not available within access to care standards at the MTF, beneficiaries can receive health care outside of the MTF. The Defense Health Agency's (DHA) access to care metrics measure the ability of the MTFs to meet the standard of urgent and routine appointments.

According to DoD guidance, the DHA Director coordinates with the Military Departments regarding administration of MTFs. However, public law changed the DHA's responsibilities regarding the MTFs. Beginning October 1, 2018, the DHA Director will be responsible for the administration of each MTF, and the Secretary of Defense, in consultation with the Secretaries of the Military Departments, will maintain the MTFs.

In the Preliminary Draft Interim Report delivered on March 31, 2017, the DoD confirmed the Secretary of Defense's

decision to implement a new model to address the requirements listed in the law. The Department will submit a final report to Congress by June 30, 2018.

### Finding

The DoD did not consistently meet the access to care standards for urgent and routine appointments at selected MTFs. Based on DHA metrics, three of the seven MTFs we visited, Irwin Army Community Hospital at Fort Riley, Kansas; Naval Hospital Pensacola, Pensacola, Florida; and Naval Health Clinic Hawaii at Joint Base Pearl Harbor, Hickam, Hawaii met access to care standards for routine and urgent appointments and one MTF, Tripler Army Medical Center, Honolulu, Hawaii, met access to care standards for 4 of 5 months between January and May 2017.

However, three Air Force MTFs—U.S. Air Force Hospital Langley at Joint Base Langley-Eustis, Virginia; David Grant U.S. Air Force Medical Center at Travis Air Force Base, California; and MacDill Air Force Base Clinic at MacDill Air Force Base, Florida—did not consistently meet access to care standards. For example, in February 2017, U.S. Air Force Hospital Langley did not meet the 7-day routine appointment metric by 15.8 days (226 percent). Additionally, in March 2017, David Grant U.S. Air Force Medical Center did not meet the 1-day urgent appointment metric by 7.2 days (720 percent).

The Air Force MTFs did not meet beneficiary demand for appointments because the Air Force Surgeon General:

- assigned a higher number of patients per health care provider compared to the Army and Navy;
- did not establish policy to consistently decrease the number of appointments per provider to compensate for their other duties (except for flight commanders);
- did not pay comparable salaries for civilian nursing personnel; and
- did not have authority to direct Air Force medical personnel.



# Results in Brief

## *Access to Care at Selected Military Treatment Facilities*

### **Finding (cont'd)**

As a result, the 105,000 MHS beneficiaries enrolled at the three Air Force MTFs we visited may not have received the care they needed, and may have been at risk of increased health complications due to longer wait times. In March 2017, beneficiaries waited as long as 8.2 days on average for an urgent appointment at David Grant U.S. Air Force Medical Center and, in February 2017, beneficiaries waited as long as 22.8 days on average for a routine appointment at U.S. Air Force Hospital Langley.

Because of the DHA's oversight and assumption of expanded responsibilities for MTFs, we made recommendations to the DHA Director instead of the Air Force Surgeon General.

### **Recommendations**

We recommend that the DHA Director establish a standard method across the Military Departments for calculating the number of patients assigned to each provider and establish a standard method for decreasing the number of appointments per provider based on their additional duties. Additionally, the DHA Director should convene a working group with personnel from the Military Departments' Surgeons General and the Air Force Personnel Center to conduct a review to determine if position descriptions and pay grades for civilian medical personnel assigned to MTFs are consistent, and consider standardizing position descriptions and pay grades across the Military Departments. Finally, we recommend that the DHA Director, in coordination with the Air Force Surgeon General, develop a plan outlining how the DHA will assume authority, direction, and control over Air Force MTFs to make changes necessary to improve access to care and hold MTF commanders accountable when the MTFs do not meet access to care standards.

### **Management Comments and Our Responses**

The DHA Director agreed with our finding and recommendations. The Director agreed to implement additional standard business rules to calculate empanelment sizes to reduce variances at MTFs and establish a standard method for decreasing the number of appointments that are scheduled for certain providers based on those providers' additional assigned duties. Additionally, the Director agreed to convene a working group to review position descriptions and pay grades. Finally, the Director agreed to develop a plan on how the DHA will hold MTF commanders accountable for meeting access to care standards. Therefore, these recommendations are resolved but remain open. We will close the recommendations once we verify that the DHA has implemented the planned corrective actions.

The Air Force Surgeon General provided comments and requested technical changes to the report, some of which we incorporated in the final report and others we did not. See the Finding section for a summary of those comments and our response.

Please see the Recommendations Table on the next page.

## Recommendations Table

Management	Recommendations Unresolved	Recommendations Resolved	Recommendations Closed
Defense Health Agency Director	None	1.a, 1.b, 2,3	None

Note: The following categories are used to describe agency management's comments to individual recommendations.

- **Unresolved** – Management has not agreed to implement the recommendation or has not proposed actions that will address the recommendation.
- **Resolved** – Management agreed to implement the recommendation or has proposed actions that will address the underlying finding that generated the recommendation.
- **Closed** – OIG verified that the agreed upon corrective actions were implemented.





**INSPECTOR GENERAL  
DEPARTMENT OF DEFENSE  
4800 MARK CENTER DRIVE  
ALEXANDRIA, VIRGINIA 22350-1500**

May 1, 2018

**MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)  
DEFENSE HEALTH AGENCY DIRECTOR**

**SUBJECT: Access to Care at Selected Military Treatment Facilities  
(Report No. DODIG-2018-111)**

We are providing this report for review. We conducted this audit in accordance with generally accepted government auditing standards.

We considered comments on the draft of this report when preparing the final report. Comments from the Defense Health Agency Director addressed all specifics of the recommendations and conformed to the requirements of DoD Instruction 7650.03.

We appreciate the cooperation and assistance received during the audit. Please direct questions to me at (703) 604-9187.

A handwritten signature in cursive script, reading "Michael J. Roark", is positioned above the printed name.

Michael J. Roark  
Assistant Inspector General  
Readiness and Global Operations

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# Introduction

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## Objective

We determined whether the DoD is meeting access to care standards for acute (urgent) and routine appointments at selected military treatment facilities (MTFs). See the Appendix for a discussion of the scope, methodology, and prior audit coverage.

## Background

On May 28, 2014, the Secretary of Defense ordered a comprehensive review of the Military Health System (MHS). The review assessed whether access to medical care in the MHS met defined access standards. The DoD issued a final report in August 2014 and concluded that, on average, the DoD met access to care standards; however, performance varied across the MHS.

## Access to Care Standards

Federal regulations establish access to care standards for the MHS, including providing patients an appointment to visit a provider within 7 days for a routine appointment and within 24 hours for an urgent appointment.<sup>1</sup> Assistant Secretary of Defense (Health Affairs) guidance states that DoD beneficiaries must be offered routine and urgent appointments within the established standards.<sup>2</sup>



Federal regulations establish access to care standards for the MHS, including providing patients an appointment to visit a provider within 7 days for a routine appointment and within 24 hours for an urgent appointment.

The Defense Health Agency's (DHA) access to care metrics measure the ability of the MTFs to meet the standards for urgent and routine appointments. Urgent appointments are designed for beneficiaries who request an office visit within 24 consecutive hours for a non-emergency illness or injury.<sup>3</sup> Routine appointments are designed for patients who request an office visit within 7 days for a new health care problem that is not considered urgent. When health care is not available within access to care standards at the MTF, beneficiaries can receive health care outside of the MTF with a referral. As of January 2018, DHA allows non-active duty prime beneficiaries to receive health

<sup>1</sup> Title 32 Code of Federal Regulations section 199.17 (2011).

<sup>2</sup> Assistant Secretary of Defense (Health Affairs) Policy 11-005, "TRICARE Policy for Access to Care," February 23, 2011.

<sup>3</sup> Urgent care is typically needed to treat a condition that does not threaten life, limb, or eyesight, but needs attention before it becomes a serious health risk.

care at network urgent care centers without a referral. However, active duty members are still required to obtain a referral—with the exception of emergency care—when MTFs are not reasonably available.<sup>4</sup>

DHA uses the “third next available appointment,” the standard health care industry metric, to measure how long a patient must wait for an available appointment. At 8:30 a.m. each day, DHA personnel calculate the daily, third next available appointment for each clinic in the MTF. For example, a provider in a family health clinic has the soonest three available appointments, with open appointments at 10:00 a.m. and 1:00 p.m. that day, and an open appointment at 8:30 a.m. the following day. The third next metric for the family health clinic would be 1 day because the third next available appointment is at 8:30 a.m. the following day. Additionally, multiple open appointments at the same time are counted as one appointment.

According to the DHA Chief for Primary Care Access and Patient Experience, beginning in 2012, DHA personnel measured the daily third next available appointment for the provider with the soonest third next available appointment and then averaged the daily metrics for each MTF clinic to report a monthly MTF metric. However, in June 2017, DHA personnel modified the third next calculation to find the third next available appointment within a given clinic’s schedule (versus a single provider) and adopted a weighted average score, which gives more weight to a busier clinic. DHA personnel developed the new third next available appointment methodology to calculate a more representative average for metrics at the MTF level. We reviewed monthly MTF metrics reported by DHA from January to May 2017. In July 2017, after we conducted our site visits, DHA recalculated the January to May 2017 metrics using the new methodology. The change in the metrics for the seven MTFs selected was not significant enough to change our results and conclusions.

Every month, DHA personnel post the access to care metrics on the TRICARE Operations Center website for the Military Departments and DHA to monitor. DHA personnel also post the access to care metrics to the MHS transparency website for the public.

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<sup>4</sup> Defense Health Agency Procedural Instruction 6025.03, “Standard Processes and Criteria for Establishing Urgent Care (UC) Services and Expanded Hours and Appointment Availability in Primary Care in Medical Treatment Facilities (MTFs) to Support an Integrated Health Care System (IHCS),” January 30, 2018.

## ***Changes to Defense Health Agency Responsibilities***

According to DoD guidance, the DHA Director coordinates with the Military Departments regarding administration of MTFs.<sup>5</sup> However, public law changed the DHA's responsibilities regarding the MTFs.<sup>6</sup> Beginning October 1, 2018, the DHA Director will administer the MTFs, and the Secretary of Defense, in consultation with the Secretaries of the Military Departments, will maintain the MTFs.

In the Preliminary Draft Interim Report delivered on March 31, 2017, the DoD confirmed the Secretary of Defense's decision to implement a new model to address the requirements listed in the law. According to the Deputy Secretary of Defense report to Congress, under the new model, the DHA will be a single leader within the DoD and have the authority to manage health care delivery at the enterprise level.<sup>7</sup> The Department will submit a final report to Congress by June 30, 2018.

## ***Sample of MTFs Visited***

We nonstatistically selected 7 of 135 MTFs across the MHS. We selected our sample of MTFs from the access to care metrics reported from April through December 2016 on the MHS Transparency website.<sup>8</sup> To determine if MTFs identified in the 2014 MHS Review improved, we included some of those MTFs in our sample. We also included suggestions from the Military Departments' Surgeons General. We did not review any MTFs where the Service audit agencies were performing access to care audits. After our site selections, access to care metrics for some of the MTFs improved leaving us with MTFs in our sample that met and did not meet access to care standards. The following seven MTFs we selected had approximately 295,000 enrolled beneficiaries:

- 633rd Medical Group, U.S. Air Force Hospital Langley, Joint Base Langley-Eustis, Virginia;
- 60th Medical Group, David Grant U.S. Air Force Medical Center, Travis Air Force Base, California;
- 6th Medical Group, MacDill Air Force Base Clinic, MacDill Air Force Base, Florida;
- Irwin Army Community Hospital, Fort Riley, Kansas;

<sup>5</sup> DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013.

<sup>6</sup> Public Law 114-328, "The National Defense Authorization Act for Fiscal Year 2017," December 23, 2016.

<sup>7</sup> Report to the Armed Services Committees of the Senate and House of Representatives, "Plan to Implement Section 1073c of Title 10, United States Code," June 30, 2017.

<sup>8</sup> The MTF metrics reported on the MHS Transparency website included the branch clinics under the command of the MTF. For example, the 60th Medical Group, David Grant U.S. Air Force Medical Center, also included the McClellan Clinic.

- Naval Hospital Pensacola, Pensacola, Florida;
- Naval Health Clinic Hawaii, Joint Base Pearl Harbor-Hickam, Hawaii; and
- Tripler Army Medical Center, Honolulu, Hawaii.<sup>9</sup>

## Review of Internal Controls

DoD Instruction 5010.40 requires DoD organizations to implement a comprehensive system of internal controls that provides reasonable assurance that programs are operating as intended and to evaluate the effectiveness of the controls.<sup>10</sup>

We identified internal control weaknesses with three Air Force MTFs meeting access to care standards from January to May 2017. We will provide a copy of the report to the senior official responsible for internal controls in the DHA and the Department of the Air Force.

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<sup>9</sup> Eligible DoD beneficiaries are enrolled at an MTF to receive health care.

<sup>10</sup> DoD Instruction 5010.40, "Managers' Internal Control Program Procedures," May 30, 2013.

## Finding

### DoD Did Not Consistently Meet Access to Care Standards at Selected MTFs

The DoD did not consistently meet the access to care standards for urgent and routine appointments at selected MTFs. According to DHA metrics, three of the seven MTFs we visited met access to care standards for routine and urgent appointments, and one MTF met access to care standards for 4 of 5 months between January and May 2017.

However, three Air Force MTFs did not consistently meet access to care standards. For example, in February 2017, U.S. Air Force Hospital Langley did not meet the 7-day routine appointment standard by 15.8 days (226 percent). Additionally, in March 2017, David Grant U.S. Air Force Medical Center did not meet the 1-day urgent appointment standard by 7.2 days (720 percent).

The Air Force MTFs did not meet the beneficiary demand for appointments because the Air Force Surgeon General:

- assigned a higher number of patients per health care provider compared to the Army and Navy;
- did not establish policy to consistently decrease the number of appointments per provider to compensate for their other duties (except for flight commanders);
- did not pay comparable salaries for civilian nursing personnel; and
- did not have authority to direct Air Force medical personnel.

As a result, the 105,000 MHS beneficiaries enrolled at the three Air Force MTFs we visited may not have received the care they needed and may have been at risk of increased health complications due to longer wait times. In March 2017, beneficiaries waited as long as 8.2 days on average for an urgent appointment at David Grant U.S. Air Force Medical Center and, in February 2017, beneficiaries waited as long as 22.8 days on average for a routine appointment at U.S. Air Force Hospital Langley. In addition, longer wait times could negatively affect the health, morale, and readiness of troops. Because of the DHA's oversight and the DHA assuming expanded responsibilities for MTFs, we made recommendations to the DHA Director instead of the Air Force Surgeon General.

## **DoD Did Not Meet Access to Care Standards at Selected MTFs**

Based on DHA metrics, three of the seven MTFs we visited met access to care standards for routine and urgent appointments and one MTF met access to care standards for 4 of 5 months between January and May 2017. Specifically, according to DHA metrics, Naval Hospital Pensacola, Naval Health Clinic Hawaii, and Irwin Army Community Hospital met access to care standards for routine and urgent appointments between January and May 2017. According to DHA metrics, Tripler Army Medical Center met the standards for 4 of the 5 months for urgent and routine appointments.

However, according to DHA metrics, U.S. Air Force Hospital Langley, David Grant U.S. Air Force Medical Center, and MacDill Air Force Base Clinic did not consistently meet access to care standards for routine or urgent appointments between January and May 2017. Table 1 shows that these three Air Force MTFs consistently exceeded access to care metrics for January through May 2017 (as reported on the DHA TRICARE Operations Center website before DHA changed the third next available methodology). For example, according to DHA metrics, during February 2017, U.S. Air Force Hospital Langley did not meet the routine metric by 15.8 days (226 percent), and during March 2017, David Grant U.S. Air Force Medical Center did not meet the urgent metric by 7.2 days (720 percent).

Table 1. MTF Access to Care Metrics for January Through May 2017

Urgent access (Target: <1.0 day)					
	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017
Tripler Army Medical Center	1.3	0.9	0.6	0.7	0.8
Irwin Army Community Hospital	0.8	0.8	0.7	0.7	0.7
U.S. Air Force Hospital Langley	3.6	3.6	2.3	2.1	3.5
David Grant U.S. Air Force Medical Center	7.2	6.0	8.2	3.0	4.4
MacDill Air Force Base Clinic	2.0	2.2	1.5	1.7	1.2
Naval Hospital Pensacola	0.8	0.8	0.6	0.7	0.8
Naval Health Clinic Hawaii	0.8	0.6	0.6	0.6	0.6

Routine access (Target: <7.0 days)					
	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017
Tripler Army Medical Center	6.9	7.0	6.4	5.4	7.8
Irwin Army Community Hospital	3.6	4.9	3.8	4.0	3.8
U.S. Air Force Hospital Langley	6.5	22.8	19.6	15.2	15.4
David Grant U.S. Air Force Medical Center	12.5	9.9	11.7	8.0	11.5
MacDill Air Force Base Clinic	9.1	10.6	10.4	9.7	8.5
Naval Hospital Pensacola	4.5	5.9	4.9	5.0	5.1
Naval Health Clinic Hawaii	4.1	3.1	3.3	3.3	3.3

Source: DHA

## Three Air Force MTFs Did Not Offer Enough Appointments

Three Air Force MTFs did not consistently meet the beneficiary demand for appointments because the Air Force Surgeon General:

- assigned a higher number of patients per health care provider compared to the Army and Navy;
- did not establish policy to consistently decrease the number of appointments per provider to compensate for their other duties (except for flight commanders);
- did not pay comparable salaries for civilian nursing personnel; and
- did not have authority to direct Air Force medical personnel.<sup>11</sup>

<sup>11</sup> Flight commanders are Air Force personnel responsible for management and oversight of an MTF clinic.

## ***Air Force Assigned a Higher Number of Patients per Health Care Provider***

The Air Force assigned a higher number of patients per health care provider (also known as empanelment) compared to the Army and Navy.<sup>12</sup> The Army and Navy calculate their empanelment rates based on the availability of providers assigned to the MTF.<sup>13</sup> However, the Air Force calculates its empanelment based on the number of providers authorized at the MTF, even if not all those positions are filled.<sup>14</sup>

For example, in March 2017, U.S. Air Force Hospital Langley was authorized 21 providers to staff its family health clinic; however, due to unfilled vacancies, the family health clinic had only 17 providers assigned to the MTF. Air Force guidance recommends an empanelment of an average of 1,250 patients per provider for primary care clinics. The MTF calculated provider empanelment for the family health clinic based on the 21 providers authorized instead of the 17 actually on staff. Therefore, the 17 assigned providers had to be available to see the patients empaneled to the 4 provider vacancies, causing 11 of the providers to have more than the 1,250 patients recommended by the Air Force—some providers had as many as 1,600 patients.



Some providers had as many as 1,600 patients.

In contrast, Navy guidance states that empanelment is calculated based on the availability of providers assigned to an MTF, using full-time equivalents.<sup>15</sup> According to the guidance, a full-time equivalent should be empaneled on average with 1,100 patients, but not exceed 1,300 patients. Additionally, the provider cannot exceed this empanelment unless approved by the Navy Medicine Regional Commander.

The Navy can reduce a provider's empanelment based on additional duties. Providers may have additional duties, such as clinic leadership and inpatient workload, that limit their availability to see patients. For example, according to Navy guidance, a provider who is also a department head should receive a 0.1 full-time equivalent decrease for each patient-centered medical home team he is responsible for, resulting in an empanelment of 990 patients.<sup>16</sup>

<sup>12</sup> A health care provider may include a physician, physician assistant, or nurse practitioner.

<sup>13</sup> Operations Order 16-02, "Army Medical Home," October 2015. BUMED Instruction 6300.19, "Primary Care Services in Navy Medicine," May 26, 2010.

<sup>14</sup> Air Force Instruction 44-171, "Patient Centered Medical Home Operations," November 28, 2014.

<sup>15</sup> A full-time equivalent is the amount of time a provider is actually available to see patients on an average per week.

<sup>16</sup> Calculation based on a provider being 1.0 full-time equivalent at 1,100 patients. BUMED Memorandum, "Primary Care Enrollment and Provider Staffing Target," March 12, 2014.

The Army calculates its empanelment based on the availability of providers who are assigned to MTFs and uses the total number of projected annual appointments divided by the number of projected annual appointments per patient. According to Army guidance, a full-time active duty or civilian provider in the pediatric or family medicine clinics should have approximately 4,500 projected annual appointments, resulting in an empanelment of 1,125 patients.<sup>17</sup> The Army also reduces provider empanelment when providers have additional duties that limit their availability. For example, according to Army guidance, an Army provider who is also a department head receives about a 50-percent reduction in empanelment, resulting in approximately 560 patients. Army guidance states that any additional decreases to empanelment should be approved by personnel at the Regional Health Command.<sup>18</sup>

Calculating empanelment based on the number of authorized providers, which may not be available to see patients, rather than the number of assigned providers, caused the family health clinic at U.S. Air Force Hospital Langley to overburden the available providers and be short by at least 80 appointments per day.<sup>19</sup> Establishing too high of an empanelment for providers who are available to treat patients caused an increased demand for the limited number of appointments they can provide, thus limiting a patient's ability to get an appointment within the MTF in a timely manner. When appointments are not available within the MTF, the patient can receive care outside the MTF with a referral. Empaneling patients based on the number of available providers would not overburden the available providers and could improve access to care. Because DHA is responsible for developing technical guidance, regulations, and instructions to manage TRICARE and to support the Assistant Secretary of Defense (Health Affairs) in the management of all medical programs, the DHA Director should establish a standard method across the Military Departments for calculating empanelment sizes for providers.<sup>20</sup>

### ***Air Force Did Not Establish Policy for Consistently Decreasing Appointments to Compensate for Additional Duties***

The Air Force Surgeon General did not establish a policy to consistently decrease the number of appointments for providers—other than flight commanders. Any provider may be assigned additional duties that limit their availability to see patients. In contrast, the Army and Navy have defined methodologies for decreasing the number of appointments for providers who have additional duties.

<sup>17</sup> Operations Order 16-02, "Army Medical Home," October 2015.

<sup>18</sup> Operations Order 16-36, "Optimizing Access to Primary Care," February 2016.

<sup>19</sup> Air Force Memorandum, "Virtual Appointment Guidance & Criteria for the Air Force Medical Service," May 10, 2017, states that family health providers must offer a minimum of 20 appointments per day.

<sup>20</sup> DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013.

Air Force guidance establishes percentages to decrease the number of appointments for flight commanders based on the number of personnel assigned to the department.<sup>21</sup> A flight commander responsible for over 50 personnel has an approved maximum decrease of 75 percent. We found that the Deputy Chief of Staff at David Grant U.S. Air Force Medical Center approved a 75-percent decrease for the Internal Medicine flight commander, resulting in the flight commander seeing patients only 25 percent of the time. For Air Force providers other than flight commanders, decreases to the number of appointments for clinical or non-clinical duties are at the discretion of the MTF Chief of Staff. For example, all providers in the David Grant U.S. Air Force Medical Center's Internal Medicine Clinic requested decreases to their weekly appointments so they could perform their physical training requirements together. According to the Deputy Chief of Staff, David Grant U.S. Air Force Medical Center, he denied the request and suggested staggering clinic starting times to allow physical training without impacting access.

The Army defines decreases to a provider's projected annual number of appointments based on the provider's clinic responsibilities, average number of patient appointments per year, and MTF enrollment.<sup>22</sup> There are standard decreases to the projected annual number of appointments for providers assigned as department chiefs, medical directors, graduate medical education residency directors, faculty, and residents. According to Army guidance, a provider assigned as a medical director with less than 10,000 enrolled beneficiaries and a projected annual demand of 3,600 appointments has a decrease in appointments of 20 percent. For example, a department head at Irwin Army Community Hospital had a decrease in appointments consistent with that guidance. According to guidance, additional decreases to the number of appointments should be approved by personnel at the Regional Health Command.<sup>23</sup>

Navy guidance also establishes percentages for providers assigned additional clinic responsibilities and full-time equivalent availability to decrease the number of appointments.<sup>24</sup> The guidance establishes decreases to the number of appointments for providers assigned as medical directors, department heads, executive committee chairs, technology champions, and specialty leaders and applies the decreases to each full-time equivalent. Furthermore, Navy guidance states that additional decreases are not authorized. The guidance states that providers assigned as department heads have an approved decrease in appointments of

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<sup>21</sup> Air Force Instruction 44-171, "Patient Centered Medical Home Operations," November 28, 2014.

<sup>22</sup> Operations Order 16-02, "Army Medical Home," appendix 11, October 2015.

<sup>23</sup> Operations Order 16-36, "Optimizing Access to Primary Care," February 2016.

<sup>24</sup> BUMED Instruction 6300.19, "Primary Care Services in Navy Medicine," May 26, 2010; BUMED Memorandum, "Primary Care Enrollment and Provider Staffing Target," March 12, 2014.

10 percent for each patient-centered medical home team in their department. For example, we found that a department head at Naval Health Clinic Hawaii responsible for three patient-centered medical home teams had a decrease in appointments of 30 percent consistent with that guidance.

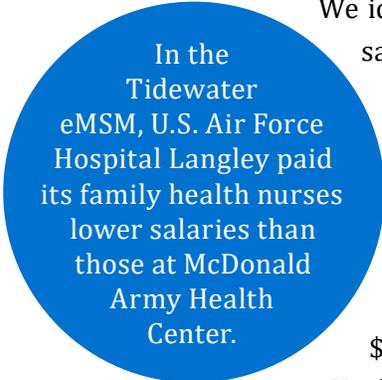
Overall, each of the Military Departments uses different methodologies to reduce the number of appointments per provider. Additionally, the Air Force does not standardize decreases to the number of appointments for providers (other than flight commanders) and leaves the approval for decreasing the number of appointments for other providers to the discretion of the MTF Chief of Staff. Providers should be in clinics to the maximum extent possible for patient care. A provider's absence from the clinic reduces the number of available appointments and decreases access to care at the MTF. To ensure maximum provider availability and clinic coverage, the DHA Director should establish a standard method for decreasing the number of appointments certain providers see based on additional duties as assigned.



A provider's absence from the clinic reduces the number of available appointments and decreases access to care at the MTF.

### ***Air Force MTFs Did Not Pay Comparable Salaries for Civilian Nursing Personnel***

Air Force MTFs did not pay comparable salaries for civilian nursing personnel across the MTFs we reviewed. In the Tidewater, Virginia, enhanced multi-service market (eMSM), an Air Force MTF did not pay the same salary as an Army MTF. An eMSM is an area designated by the Deputy Secretary of Defense that contains multiple MTFs. The eMSM has the authority to move workforce between the MTFs in the market or share personnel within the eMSM.



In the Tidewater eMSM, U.S. Air Force Hospital Langley paid its family health nurses lower salaries than those at McDonald Army Health Center.

We identified two examples in which the MTFs created a salary disparity for the same type of job. For example, in the Tidewater eMSM, U.S. Air Force Hospital Langley paid its family health nurses lower salaries than those at McDonald Army Health Center at Joint Base Langley-Eustis, Virginia. Specifically, U.S. Air Force Hospital Langley paid its family health nurses at a general schedule (GS)-9 pay grade, with a salary ranging from \$69,404 to \$88,139 annually, whereas McDonald Army Health Center paid its family health nurses at a GS-11 pay

grade, with a salary ranging from \$82,315 to \$104,540 annually.<sup>25</sup> The difference between the GS-9 and GS-11 pay was \$12,911 to \$16,401 annually.

In addition, U.S. Air Force Hospital Langley paid its pediatric nurse practitioner one GS pay grade lower than McDonald Army Health Center. Specifically, U.S. Air Force Hospital Langley paid its pediatric nurse practitioner at a GS-12 pay grade, with a salary ranging from \$111,289 to \$139,631 annually, while McDonald Army Health Center paid its pediatric nurse practitioners at a GS-13 pay grade, with a salary ranging from \$117,587 to \$145,930 annually. The difference between the pay grade GS-12 and GS-13 salaries was approximately \$6,300 annually.<sup>26</sup> According to U.S. Air Force Hospital Langley personnel, U.S. Air Force Hospital Langley lost nurses to other MTFs within the eMSM that offered higher GS pay for nurses assigned to perform the same duties.

Nurses and other support staff are essential to operating patient-centered medical home teams. The patient-centered medical home model consists of a provider with nursing and administrative support. Some of the tasks performed by the nursing and administrative staff include handling secure messaging responses, walk-ins, nurse-run clinics, support staff protocols, and phone consults. Without adequate providers and support staff, the team is limited in the number of appointments it can provide to meet patient demand.

While both the Army and Navy medical commands can determine the GS pay grade a position description warrants, the Air Force MTFs must have the Air Force Personnel Center make the determination.<sup>27</sup> The DHA Director should convene a working group with personnel from the Military Departments' Surgeons General and the Air Force Personnel Center to conduct a review to determine if position descriptions and pay grades for civilian medical personnel assigned to MTFs are consistent and consider standardizing position descriptions and pay grades across the Military Departments.

### ***Air Force Surgeon General Does Not Have Authority Over Air Force Medical Personnel***

According to Air Force guidance, the Air Force Surgeon General does not have command authority or direct control over Air Force medical personnel, but provides planning, coordination, and oversight.<sup>28</sup> In comparison, Navy guidance

<sup>25</sup> Annual salaries are based on the DoD Special Salary Rate Authorization for registered nurses, GS-0610, table number D269, issued December 28, 2016.

<sup>26</sup> Annual salaries are based on the DoD Special Salary Rate Authorization for nurse practitioners, GS-0610, table number D315, issued January 19, 2017.

<sup>27</sup> While the U.S. Army Medical Command and the Bureau of Medicine and Surgery are subordinate commands to the Army and Navy Surgeons General, the Air Force Personnel Center is a field agency of Headquarters, U.S. Air Force.

<sup>28</sup> Air Force Annex 4-02, "Medical Operations," September 29, 2015.

establishes the Bureau of Medicine and Surgery as the direct authority over medical personnel assigned to Navy MTFs, and Army guidance establishes U.S. Army Medical Command as the authority over Army medical personnel.<sup>29</sup>

In 2016 and 2017, the Air Force Medical Operations Agency and the Air Force Medical Support Agency performed comprehensive reviews of operations at the Air Force MTFs we visited. These reviews recognized that the Air Force MTFs were not meeting access to care standards and made recommendations to improve access to care metrics, such as increasing the number of appointments. However, according to Air Force Medical Operations Agency personnel, if the MTFs did not make the recommended changes because MTF personnel do not fall under the command and control of the Air Force Surgeon General, they could not enforce the recommendations or hold MTF personnel accountable for not meeting access to care standards.



Air Force MTF personnel do not fall under the command and control of the Air Force Surgeon General.

As the DHA implements changes required by Public Law 114-328, the DHA will be a single leader within the DoD and have the authority, direction, and control over each MTF and its personnel. Until the DHA finalizes implementation, the DHA Director, in coordination with the Air Force Surgeon General, should develop a plan outlining how it will assume authority, direction, and control over Air Force MTFs to make changes necessary to improve access to care and hold MTF commanders accountable when they do not meet access to care standards.

## Longer Wait Times Could Impact Health Care

The three Air Force MTFs did not consistently meet access to care standards because the Air Force MTFs did not meet the beneficiary demand for appointments. The methods the Air Force MTFs used to calculate empanelment and reduce the number of appointments for providers could overburden the available providers. While MHS beneficiaries enrolled to an MTF primarily receive health care at the MTF through their primary care provider, beneficiaries can receive health care outside of the MTF, with a referral, when health care is not available within access to care standards. By properly managing demand for appointments, Air Force MTFs could improve access to care metrics.

<sup>29</sup> Office of the Chief of Naval Operations Instruction 5450.215D "Mission and Functions of the Bureau of Medicine and Surgery," May 14, 2012, and Army Regulation 10-87, "Army Commands, Army Service Component Commands, and Direct Reporting Units," September 4, 2007.

The shortage of available appointments at the Air Force MTFs led to longer wait times. Therefore, the 105,000 MHS beneficiaries enrolled at the three Air Force MTFs we visited may not have received the care they needed, and may have been at risk of increased health complications. In March 2017, beneficiaries waited as long as 8.2 days on average for an urgent appointment at David Grant U.S. Air Force Medical Center and in February 2017, beneficiaries waited as long as 22.8 days on average for a routine appointment at U.S. Air Force Hospital Langley.

## Management Comments on the Finding and Our Response

The Air Force Surgeon General provided the following comments on the finding. For the full text of the Air Force Surgeon General's comments, see the Management Comments section of the report.

### *Air Force Surgeon General Comments*

The Air Force Surgeon General requested the following changes to the report:

- update the report to reflect that a referral is no longer required for an urgent care visit for non-active duty prime enrollees,
- add language to the third next methodology that states multiple open appointments at the same time were counted as one, and
- add language that the Deputy Chief of Staff; David Grant U.S. Air Force Medical Center recommended staggered clinic starting times to allow for physical training and delete the statement that previous leadership approved such requests.

The Air Force Surgeon General also requested that we delete nursing from our discussion on nursing salaries.

### *Our Response*

We made the Air Force Surgeon General's requested changes to the report such as:

- incorporating that, as of January 2018, referrals were no longer required for active duty prime enrollees;
- adding the statement on counting appointments at the same time as one appointment to the third next methodology; and
- adding historical context to the discussion on decrementing appointments at David Grant U.S. Air Force Medical Center.

We did not delete "nursing" from the statement, "Air Force MTFs did not pay comparable salaries for civilian nursing personnel across the MTFs we reviewed," because our review was limited to only nursing personnel salaries.

## Recommendations, Management Comments, and Our Response

### **Recommendation 1**

**We recommend that the Defense Health Agency Director:**

- a. Establish a standard method across the Military Departments for calculating empanelment sizes for providers.**

#### *Defense Health Agency Comments*

The DHA Director agreed with our recommendation, stating that additional standard business rules are required to calculate empanelment sizes to reduce variances at MTFs. She stated that DHA Interim Procedures Memorandum 17-003, "Accounting for Defense Health Program Primary Care Managers," defines a primary care manager and establishes standard MTF empanelment and capacity calculations. However, current business rules allow MTF leadership to empanel beneficiaries based on the primary care manager's additional duties and patient complexity; therefore, variances exist at MTFs. She further stated that the DHA will hold an off-site meeting in April 2018 to develop a standard method for calculating empanelment sizes, and DHA will present the method in a DHA Procedural Instruction that will replace Interim Procedure Memorandum 17-003 by September 30, 2018.

#### *Our Response*

Comments from the Director addressed the specifics of the recommendation; therefore the recommendation is resolved. We will close the recommendation once we verify that the DHA established a standard method for calculating empanelment sizes in the DHA Procedural Instruction.

- b. Establish a standard method for decreasing the number of appointments certain providers see based on additional duties as assigned.**

#### *Defense Health Agency Comments*

The DHA Director agreed with the recommendation, stating that the DHA will establish a standard method for decreasing the number of appointments that are scheduled for certain providers based on those providers' additional assigned duties. She also stated that DHA Interim Procedures Memorandum 18-001, "Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in MTFs," establishes standard processes for primary care

including the number of appointments per primary care manager and adjusts the number of appointments based on the complexity of empaneled beneficiaries. The Director further stated that the DHA will hold an off-site meeting in April 2018 to establish a standard method for decreasing the number of appointments providers see based on additional assigned duties and present the standard method in a DHA Procedural Instruction that will replace Interim Procedure Memorandum 18-001 by September 30, 2018.

### *Our Response*

Comments from the Director addressed the specifics of the recommendation; therefore the recommendation is resolved. We will close the recommendation once we verify that the DHA established a standard method for decreasing the number of appointments providers see based on additional assigned duties in the DHA Procedural Instruction.

## **Recommendation 2**

**We recommend that the Defense Health Agency Director convene a working group with personnel from the Military Departments' Surgeons General and the Air Force Personnel Center to conduct a review to determine if position descriptions and pay grades for civilian medical personnel assigned to military treatment facilities are consistent and consider standardizing position descriptions and pay grades across the Military Departments.**

### *Defense Health Agency Comments*

The DHA Director agreed with the recommendation, stating that the DHA should convene a working group with appropriate representation from the Military Departments' Surgeons General and other subject matter experts to review position descriptions and performance measures to ensure consistent application of classification standards and pay grade setting for civilian medical personnel assigned to MTFs. She further stated that, where feasible, DHA will consider standardization of position descriptions across the MHS. Finally, the Director stated that DHA will determine the most effective composition of the working group members no later than September 30, 2018.

### *Our Response*

Comments from the Director addressed the specifics of the recommendation; therefore the recommendation is resolved. We will close the recommendation once we verify that the DHA established the working group and conducted the review.

### ***Recommendation 3***

**We recommend that the Defense Health Agency, in coordination with the Air Force Surgeon General, develop a plan outlining how the Defense Health Agency will assume authority, direction, and control over the Air Force military treatment facilities to make changes necessary to improve access to care and hold military treatment facility commanders accountable when they do not meet access to care standards.**

#### *Defense Health Agency Comments*

The DHA Director agreed with the recommendation, stating that the DHA is working, in coordination with the Service Medical Department, to develop its transition plan to assume authority, direction, and control of Army, Navy, and Air Force MTFs. The Director stated that the DHA will complete the transition plan in the fourth quarter of FY 2018. She further stated that one component of the transition plan is the development of the Quadruple Aim Performance Plan, which addresses key areas of readiness, health, care, and cost. The Director further stated that access to care is one measure in the performance plan and that the DHA will assess, approve, monitor, and reassess MTF performance on a quarterly basis to hold MTF commanders accountable in meeting access to care standards.

#### *Our Response*

Comments from the Director addressed the specifics of the recommendation; therefore the recommendation is resolved. We will close the recommendation once we review the Quadruple Aim Performance Plan for DHA's access to care accountability measures.

#### *Air Force Surgeon General Comments*

The Air Force Surgeon General stated that leadership accountability impacts access and actions to improve access are multifactorial. He acknowledged that empanelment sizes, additional duties, and salaries contributed to poor access. He also stated that additional factors affecting access include staff availability and challenges with contracting staff. The Air Surgeon General suggested we change Recommendation 3 to state, "DHA, in coordination with the Air Force Surgeon General, develop a plan outlining how the DHA will assume administrative authority over Air Force MTFs, provide necessary resources, and hold MTF commanders accountable when they do not meet access to care standards."

### *Our Response*

We recognize that other factors not addressed in the report may also affect access to care. In a memorandum, the Under Secretary of Defense (Personnel and Readiness) stated that the DoD established a model to transition administration and management responsibilities of the MTFs from the Military Medical Departments to DHA.<sup>30</sup> He further stated that the basic elements of the model to fulfill section 702 of the FY 2017 National Defense Authorization Act include that all MTF clinical and health delivery services and business operations will come under the authority, direction, and control of the DHA. Additionally the memorandum stated that the commander of each MTF will report to DHA. As such, we did not change the recommendation.

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<sup>30</sup> Under Secretary of Defense (Personnel and Readiness), "Authorities and Responsibilities of the Military Treatment Facility Leaders, Service Leaders and the Military Medical Departments," February 21, 2018.

## Appendix

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### Scope and Methodology

We conducted this performance audit from March 2017 through February 2018 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.

### MTF Selection

We nonstatistically selected a sample of 7 of 135 MTFs across the MHS. We selected our initial sample of MTFs from the access to care metrics from April 2016 through December 2016, reported on the MHS Transparency website. We selected MTFs that met and did not meet access to care standards to identify best practices, as well as areas for improvement. To determine if MTFs improved, we also included some MTFs identified in the 2014 MHS Review. We also included suggestions from the Military Departments' Surgeons General. We did not review any MTFs where the Service audit agencies were performing access to care audits. After our site selections, access to care metrics for some of the MTFs improved.

### Documentation and Interviews

To determine roles, responsibilities, and oversight as it pertains to access to care, we conducted site visits and interviewed personnel from the DHA, Office of the Army Surgeon General, U.S. Army Medical Command, Navy Bureau of Medicine and Surgery, Office of the Air Force Surgeon General, Air Force Medical Support Agency, and Air Force Medical Operations Agency.

To determine whether MTFs were meeting access to care standards, we reviewed access to care data reported on the MHS Transparency and TRICARE Operations Center websites. We based our review on monthly MTF metrics reported by DHA from January to May 2017. At the time of our review, the DHA calculated the January to May 2017 metrics using the third next available methodology. In June 2017, the DHA modified the methodology it uses to calculate MTF metrics. We conducted site visits to seven MTFs, including the 633rd Medical Group, U.S. Air Force Hospital Langley; 60th Medical Group, David Grant U.S. Air Force Medical Center; 6th Medical Group, MacDill Air Force Base Clinic; Irwin Army Community Hospital; Naval Hospital Pensacola; Naval Health Clinic Hawaii; and Tripler Army Medical Center.

To determine whether MTFs were meeting access to care standards, we interviewed personnel and reviewed access to care management functions, including policies to reduce appointments for providers; the MTF's day-to-day management of clinics' templates, scheduling and appointing functions; MTF enrollment and provider empanelment; management of access to care metrics; referral management activities; areas that reduce appointment access; challenges providers faced when providing additional access; best practices identified with meeting access to care; and corrective action MTFs took when not meeting access to care standards. In addition, we reviewed MTF access to care reports, briefings, provider templates, and grades and position descriptions for nursing staff.

## Criteria

To determine Federal and Service requirements and policy over access to care, patient centered medical home, and specialty pay we reviewed the following guidance.

- Title 32 Code of Federal Regulations section 199.17 (2011).
- DoD Instruction 1400.25, "DoD Civilian Personnel Management System: Pay Rates and Systems (General)," April 6, 2009.
- DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013.
- Assistant Secretary of Defense (Health Affairs) Policy 11-005, "TRICARE Policy for Access to Care," February 23, 2011.
- Assistant Secretary of Defense (Health Affairs) Policy 09-015, "Policy Memorandum Implementation of the 'Patient-Centered Medical Home' Model of Primary Care in MTFs," September 18, 2009.
- BUMED Instruction 6300.19, "Primary Care Services in Navy Medicine," May 26, 2010.
- BUMED Memorandum, "Primary Care Enrollment and Provider Staffing Target," March 12, 2014.
- Air Force Instruction 44-171, "Patient Centered Medical Home Operations," November 28, 2014.
- Air Force Memorandum, "Air Force Guidance Memorandum to Air Force Instruction (AFI) 44-176, Access to Care Continuum," April 20, 2015.
- Air Force Memorandum, "Virtual Appointment Guidance & Criteria for the Air Force Medical Service (AFMS)," May 10, 2017.
- Operations Order 16-02, "Army Medical Home," October 2015.
- Operations Order 16-36, "Optimizing Access to Primary Care," February 2016.

To determine command and control policy over medical personnel we reviewed the following guidance.

- Public Law 114-328, “The National Defense Authorization Act for Fiscal Year 2017,” section 702, “Reform of Administration of the Defense Health Agency and Military Medical Treatment Facilities,” December 23, 2016.
- Office of the Chief of Naval Operations Instruction 5450.215D, “Mission and Functions of the Bureau of Medicine and Surgery,” May 14, 2012.
- Army Regulation 10-87, “Army Commands, Army Service Component Commands, and Direct Reporting Units,” September 4, 2007.
- Air Force, “Annex 4-02 Medical Operations,” September 29, 2015.

## Use of Computer-Processed Data

We used computer-processed data to perform this audit. Specifically, we used access to care metrics reports from the TRICARE Operations Center and the MHS Transparency websites. The access to care metrics reports are generated daily from the Composite Health Care System’s master appointment and schedulable entity data using a methodology approved by the Medical Deputies Action Group.<sup>31</sup> To assess the reliability of the data, we interviewed subject matter experts about quality control procedures and system certifications for Composite Health Care System and reviewed relevant documentation. In addition, we completed limited testing of the data by comparing self-reported access to care data from selected MTFs to the data on the MHS Transparency website. We determined that the data were sufficiently reliable for the purpose of this report.

## Prior Coverage

During the last 5 years, the Naval Audit Service and Air Force Audit Agency issued two reports discussing access to care. Naval Audit Service reports are not available over the Internet. Unrestricted Air Force Audit Agency reports can be accessed from <https://www.foia.af.mil/palMain.aspx> by clicking on Freedom of Information Act Reading Room and then selecting audit reports.

<sup>31</sup> The Medical Deputies Action Group consists of the Principal Deputy Assistant Secretary of Defense Health Affairs, Service Deputy Surgeons General, and DHA personnel. The Composite Health Care System serves as the foundation for the DoD current electronic health record. Clinicians use the Composite Health Care systems to electronically schedule patient appointments.

## ***Navy***

Report No. N2017-0037, "Wait Time at Navy Military Treatment Facilities," August 2017

Report No. N2017-0037, "Wait Time at Navy Military Treatment Facilities," identified opportunities, using patient encounters from FY 2015, to improve controls over classifying and reporting patient encounters, develop policy on addressing cancelled or changed appointments, and develop procedures to remind patients of their future appointments. Department of Navy organizations took action to address all of the recommendations made in the audit report.

## ***Air Force***

Report No. F2016-0001-RWT000, "Access to Care," October 2015

Report No. F2016-0001-RWT000, "Access to Care," identified opportunities using MTF utilization data from January through April 2015, to improve oversight and controls over monitoring unbooked appointments and procedures for booking appointments. Department of Air Force organizations took action to address all of the recommendations made in the audit report.

# Management Comments

## Defense Health Agency Comments



**DEFENSE HEALTH AGENCY**  
7700 ARLINGTON BOULEVARD, SUITE 5101  
FALLS CHURCH, VIRGINIA 22042-5101

APR 04 2018

MEMORANDUM FOR DEPARTMENT OF DEFENSE, INSPECTOR GENERAL

SUBJECT: Response to Department of Defense Inspector General Draft Report, "Access to Care at Selected Military Treatment Facilities", Project No. (D2017-D000CJ-0104.000), Request for Comments to Draft Report

Thank you for the opportunity to review and comment on the Department of Defense Inspector General's Draft Report, "Access to Care at Selected Military Treatment Facilities" Project No (D2017-D000CJ-0104.000).

As requested, our response to Recommendations 1, 2, and 3 are attached.

My points of contact regarding this matter are [REDACTED], who may be reached at [REDACTED] or via email at [REDACTED], and [REDACTED], who may be reached at [REDACTED] or via email at [REDACTED].

*R. C. Bono*  
FOR  
R. C. BONO  
VADM, MC, USN  
Director

Attachment:  
As stated

## Defense Health Agency Comments (cont'd)

**Defense Health Agency  
Response to Department of Defense Inspector General Draft Report  
“Access to Care at Selected Military Treatment Facilities”  
(D2017-D000CJ-0104.000)**

**Department of Defense Inspector General (DoD IG) Finding:** “The DoD did not consistently meet the access to care standards for urgent and routine appointments at selected MTFs.”

**DHA Response:** DHA concurs with the DoD IG finding.

**DoD IG Recommendation 1:** “The Director, Defense Health Agency: a) establish a standard method across the Military Departments for calculating empanelment sizes for providers; b) establish a standard method for decreasing the number of appointments certain providers see based on additional duties as assigned.”

**DHA Response:** DHA concurs with DoD IG Recommendations 1.a. and 1.b.

**DoD IG Recommendation 1.a.** The DHA concurs that additional standard business rules are required to calculate empanelment sizes for providers to reduce unwarranted variance at medical treatment facilities (MTFs). The DHA Interim Procedures Memorandum (IPM) 17-003 “Accounting for Defense Health Program (DHP) Primary Care Managers (PCMs)”, establishes uniform accountability and business rules for capturing data in standard Military Health System (MHS) information systems on PCMs, defines a PCM and establishes standard MTF empanelment and capacity calculations. Because current business rules allow MTF Commanders and Directors to empanel beneficiaries to specific providers based on PCMs’ additional duties and patient acuity, variance exists at MTF’s in the number of beneficiaries empaneled to each provider. The DHA is holding a Primary Care off-site 2-6 April 2018 to develop a standard method for calculating empanelment sizes for providers and will codify the method in a DHA Procedural Instruction (DHA-PI) to replace DHA-IPM 17-003 no later than 30 September 2018.

**DoD IG Recommendation 1.b.** The DHA concurs with DoD IG Recommendation 1.b. to establish a standard method for decreasing the number of appointments certain providers see based on additional assigned duties. The DHA-IPM 18-001, “Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs)” establishes standard processes for primary care including the number of appointments expected per PCM. DHA-IPM 18-001 also adjusts the expected number of appointments per PCM based on empaneled beneficiaries’ acuity. The DHA is holding a Primary Care off-site 2-6 April 2018 to establish a standard method for decreasing the number of appointments certain providers see based on additional assigned duties. The DHA will codify the standard method in a DHA DHA-PI to replace the DHA-IPM 18-001 no later than 30 September 2018.

**DoD IG Recommendation 2:** “The Director, Defense Health Agency, convene a working group with personnel from the Military Departments’ Surgeons General and the Air Force Personnel Center to conduct a review to determine if position descriptions and pay grades for civilian medical personnel assigned to military treatment facilities are consistent and consider standardizing position descriptions and pay grades across the Military Departments.”

## Defense Health Agency Comments (cont'd)

**DHA Response:** The DHA concurs with the DOD IG Recommendation 2 that the DHA establish a working group with appropriate representation from the Military Departments' Surgeons General and other subject matter experts, as appropriate, to review position description roles and responsibilities, and performance measures to ensure consistent application of classification standards and setting of pay grades for civilian medical personnel assigned to military medical treatment facilities. Where feasible, the standardization of position descriptions should be considered for application across the MHS. The DHA will determine the most effective composition of the work group members no later than 30 September 2018.

**DoD IG Recommendation 3:** "The Director, Defense Health Agency, in coordination with the Air Force Surgeon General, develop a plan outlining how the Defense Health Agency will assume authority, direction and control over the Air Force military treatment facilities to make changes necessary to improve access to care and hold military treatment facility commanders accountable when they do not meet access to care standards."

**DHA Response:** The DHA concurs with DoD IG recommendation 3. The DHA is currently working, in coordination with the Service Medical Department, to develop its transition plan to assume authority, direction, and control of Army, Navy, and Air Force MTF's. The transition plan will be completed in Q4FY18. One component of the transition plan is the development of a Quadruple Aim Performance Plan (QPP) which addresses key areas of readiness, health, care, and cost. Access to care is one of our measures in the QPP. The DHA will assess, approve, monitor, and re-assess MTF performance on a quarterly basis to hold MTF commanders accountable in meeting access to care standards.

## Air Force Surgeon General Comments



DEPARTMENT OF THE AIR FORCE  
HEADQUARTERS UNITED STATES AIR FORCE  
WASHINGTON DC

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL  
ATTN: [REDACTED]

FROM: HQ USAF/SG  
1780 Air Force Pentagon  
Washington, DC 20330-1780

SUBJECT: DoDIG Draft Report, "Access to Care at Selected Military Treatment Facilities",  
Project D2017-D000CJ-0104.000

The Air Force appreciates the opportunity to provide comments on the DoDIG Draft Report, "Access to Care at Selected Military Treatment Facilities," Project D2017-D000CJ-0104.000. The Air Force submits the seven comments at Attachment 1.

As requested, the document was also reviewed by AFMOA/SGAT and it was determined that there were no specific words or sentences that would be applicable to any of the 9 Freedom of Information Act (FOIA) exemptions.

The AF/SG point of contact is [REDACTED], or via email at [REDACTED].

  
MARK A. EDIGER  
Lieutenant General, USAF, MC, CFS  
Surgeon General

Attachment  
Comment Matrix

## Air Force Surgeon General Comments (cont'd)

SELECT A CLASSIFICATION						
CONSOLIDATED DoD ISSUANCE COMMENT MATRIX						
Issuance Type and Number, "Title"						
CLASS	#	PAGE	PARA	BASIS FOR NON-CONCUR?	COMMENTS, JUSTIFICATION, AND ORIGINATOR JUSTIFICATION FOR RESOLUTION	COMPONENT AND POC NAME, PHONE, AND E-MAIL
	1	i	2	<input type="checkbox"/>	<p><b>Coordinator Comment and Justification:</b> Update statement to reflect that a referral is no longer required for an urgent care visit for non-active duty Prime enrollees as a result of a recent DHA publication DHA-PI 6025.03, Standard Process and Criteria for Establishing Urgent Care (UC) Services..." based on NDAA 17, Section 704.</p> <p><b>Coordinator Recommended Change:</b> Change to, "When health care is not available within access to care standards at the MTF, non-active duty beneficiaries are authorized unlimited self-referred network Urgent Care Clinic (UCC) visits outside the MTF within the network. Active Duty Service Members (ADSMs) can receive health care with a referral."</p> <p><b>Originator Response:</b> Choose an item.</p> <p><b>Originator Reasoning:</b></p>	USAF, [REDACTED] (AFMOA/SGHC), [REDACTED] [REDACTED]
	2	i	6	<input type="checkbox"/>	<p><b>Coordinator Comment and Justification:</b> Statement limits civilian personnel comparable salaries to nursing personnel</p> <p><b>Coordinator Recommended Change:</b> delete "nursing" from the statement</p> <p><b>Originator Response:</b> Choose an item.</p> <p><b>Originator Reasoning:</b></p>	USAF, [REDACTED] (AFMOA/SGHC), [REDACTED] [REDACTED]
	3	2	2	<input type="checkbox"/>	<p><b>Coordinator Comment and Justification:</b> Multiple appointments in one time slot only count as one. This is an important detail in the methodology.</p>	USAF, [REDACTED] (AFMOA/SGHC), [REDACTED] [REDACTED]

Final Report Reference

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## Air Force Surgeon General Comments (cont'd)

SELECT A CLASSIFICATION						
CONSOLIDATED DoD ISSUANCE COMMENT MATRIX						
Issuance Type and Number, "Title"						
CLASS	#	PAGE	PARA	BASIS FOR NON-CONCUR?	COMMENTS, JUSTIFICATION, AND ORIGINATOR JUSTIFICATION FOR RESOLUTION	COMPONENT AND POC NAME, PHONE, AND E-MAIL
					<p><b>Coordinator Recommended Change:</b> Add, "Multiple open appointments at the same time are counted as one."</p> <p><b>Originator Response:</b> Choose an item.</p> <p><b>Originator Reasoning:</b></p>	[REDACTED]
	4	9	3	<input type="checkbox"/>	<p><b>Coordinator Comment and Justification:</b> The reference to denying IMC decrement request for physical training is misleading due to missing pertinent historical context.</p> <p><b>Coordinator Recommended Change:</b> Immediately following "For example, all providers...training requirements together.", add "Taking into account the delta comparing all Internal Medicine provider's starting baseline for daily templated available appointments was negative 4 compared to the established Air Force expectation, the decrement request was subsequently denied. Rather, the deputy SGH recommended staggering the clinic starting time to allow Flight physical training without impacting access."</p> <p><b>Originator Response:</b> Choose an item.</p> <p><b>Originator Reasoning:</b></p>	USAF, [REDACTED] (60 MDG), [REDACTED]
	5	9	3	<input type="checkbox"/>	<p><b>Coordinator Comment and Justification:</b> Inaccurate statement based on either misquote or factual misinterpretation.</p> <p><b>Coordinator Recommended Change:</b> Last sentence of paragraph should be deleted or changed to "The decrement request justification provided by the</p>	USAF, [REDACTED] (60 MDG), [REDACTED]

DD FORM 818-1, AUG 2016

SELECT A CLASSIFICATION

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Page 10

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## Air Force Surgeon General Comments (cont'd)

Final Report  
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SELECT A CLASSIFICATION						
CONSOLIDATED DoD ISSUANCE COMMENT MATRIX						
Issuance Type and Number, "Title"						
CLASS	#	PAGE	PARA	BASIS FOR NON-CONCUR?	COMMENTS, JUSTIFICATION, AND ORIGINATOR JUSTIFICATION FOR RESOLUTION	COMPONENT AND POC NAME, PHONE, AND E-MAIL
					Internal Medicine leadership stated that, historically, prior SGHs approved the request; however, no documentation exists to substantiate their claim.  <b>Originator Response:</b> Choose an item.  <b>Originator Reasoning:</b>	
	6	10	4	<input type="checkbox"/>	<b>Coordinator Comment and Justification:</b> Statement limits civilian personnel comparable salaries to nursing personnel  <b>Coordinator Recommended Change:</b> delete "nursing" from further applicable statements. Although the example applied to nursing, the disparity in salaries applies to other medical personnel such as physicians, physician assistants, etc...  <b>Originator Response:</b> Choose an item.  <b>Originator Reasoning:</b>	USAF, [REDACTED] (AFMOA/SGHC), [REDACTED] [REDACTED]
	7	14	1	<input type="checkbox"/>	<b>Coordinator Comment and Justification:</b> Leadership accountability impacts access; however, actions to improve access are multifactorial. As reflected in this report, empanelment sizes, additional duties, and competitive salaries contributed to poor access. Factors such as staff availability and challenges with contracting staff (not addressed in this report) also have a major impact on access. Recent Travis access data over the last several months reflects significant improvements to access can be made by an MTF commander, outside of direct line authority.  <b>Coordinator Recommended Change:</b> Change to Recommendation 3 to read, "We recommend that the Director, Defense Health Agency, in coordination with	USAF, [REDACTED] (AFMOA/SGHC), [REDACTED] [REDACTED]

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## Air Force Surgeon General Comments (cont'd)

**Final Report  
Reference**

SELECT A CLASSIFICATION						
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					the Air Force Surgeon General, develop a plan outlining how the Defense Health Agency will assume administrative authority over Air Force Military Treatment Facilities (MTFs) and provide the necessary resources to improve access to care; and hold MTF commanders accountable when they do not meet access to care standards (where the root cause was not due to external factors beyond their control).  <b>Originator Response:</b> Choose an item.  <b>Originator Reasoning:</b>	

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DD FORM 818-1, AUG 2016
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4

## Air Force Surgeon General Comments (cont'd)

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### HOW TO FILL OUT THE DD 818-1 MATRIX

**GENERAL GUIDANCE:**

- **To sort table** by page/paragraph number, hover your mouse over the top of the first cell in the "page" column until a downward arrow appears; click and drag to the right to select both page and para columns. Under Paragraph on the Home ribbon, select A-Z button, set to sort by Column 3 and then Column 4, and select "OK." **To add new rows**, copy and paste a blank row to keep consistent formatting. **To add automatic numbering to column 2**, select entire column and click on the Numbering button under Paragraph on the Home ribbon.

**OSD COMPONENT (OFFICE OF PRIMARY RESPONSIBILITY):**

- Do **not** use the DD Form 818.
- Consolidate comments from all coordinators and adjudicate them. When **pasting** coordinator's comments from the coordinating Components' DD Form 818s into your consolidated DD Form 818-1, use "Merge Tables" paste option. You do not need to include administrative comments (spelling, paragraph numbering, etc.), in the consolidated DD Form 818-1. Leave columns 3 and 4 blank for general comments that apply to the whole document.
- **Sort comments** by the pages/paragraphs to which they apply using the **General Guidance** sort feature (e.g., all comments from all coordinators that apply to Page 3, Paragraph 1.1.a., should be together; all comments that apply to Page 3, Paragraph 1.1.b., should be next). Set classification header, footer, Column 2, and complete the last two entries in Column 6:

*COLUMN 6* If you rejected or partially accepted a comment, enter your rationale in the originator reasoning area. If any material is **classified**, follow DoDM 5200.01 guidance for marking the document. Leave originator reasoning area blank if you accepted it. Include any related communications with the coordinating Component. You **must** provide convincing support for rejecting nonconurrence comments.

## Acronyms and Abbreviations

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<b>DHA</b>	Defense Health Agency
<b>eMSM</b>	Enhanced Multi-Service Market
<b>GS</b>	General Schedule
<b>MHS</b>	Military Health System
<b>MTF</b>	Military Treatment Facility

# **Whistleblower Protection**

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*The Whistleblower Protection Ombudsman's role is to educate agency employees about prohibitions on retaliation and employees' rights and remedies available for reprisal. The DoD Hotline Director is the designated ombudsman. For more information, please visit the Whistleblower webpage at [www.dodig.mil/Components/Administrative-Investigations/DoD-Hotline/](http://www.dodig.mil/Components/Administrative-Investigations/DoD-Hotline/).*

### **For more information about DoD OIG reports or activities, please contact us:**

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4800 Mark Center Drive  
Alexandria, Virginia 22350-1500  
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