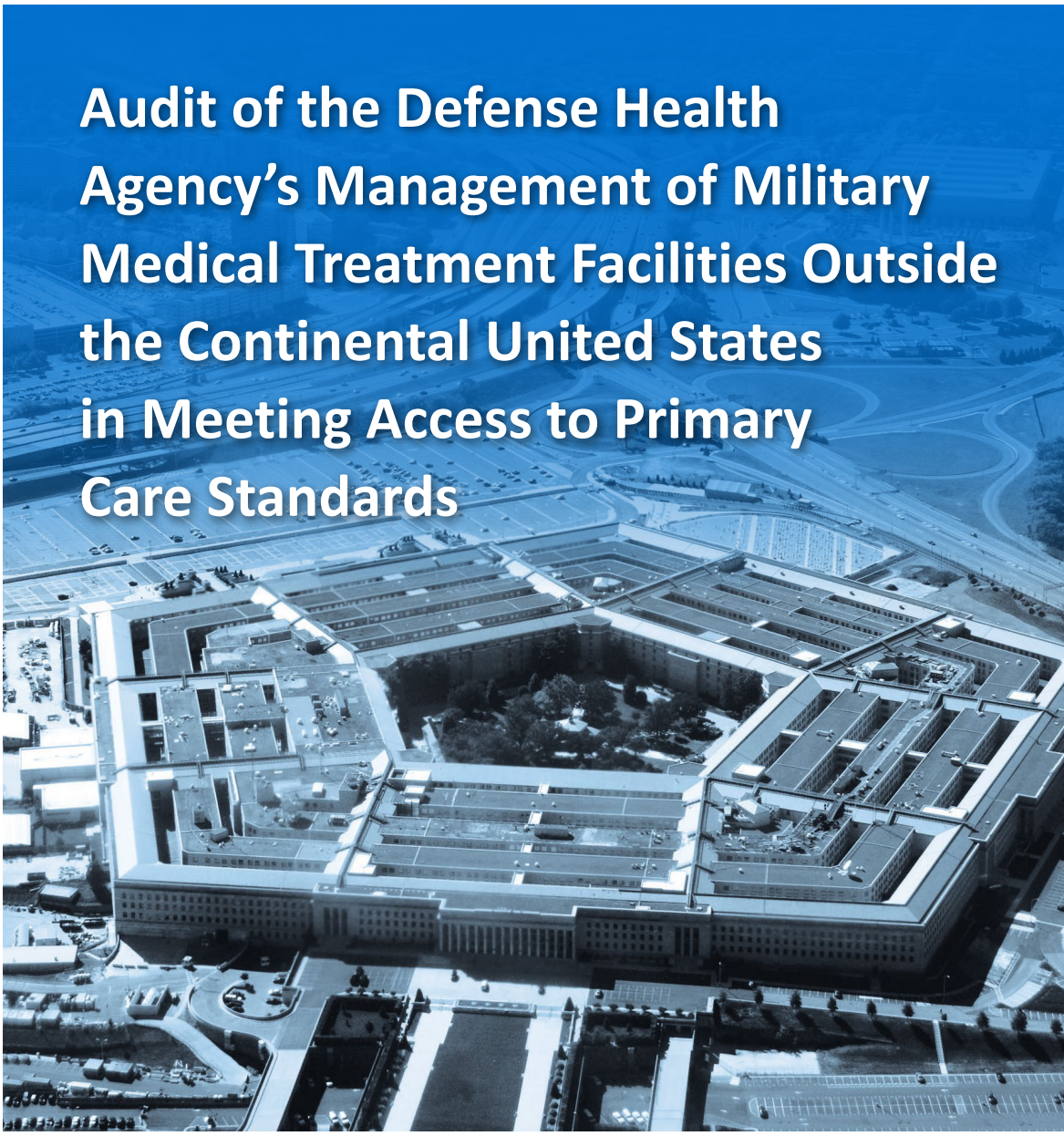
Report No. DODIG-2026-025

INSPECTOR GENERAL

U.S. Department of Defense

DECEMBER 8, 2025

Audit of the Defense Health Agency's Management of Military Medical Treatment Facilities Outside the Continental United States in Meeting Access to Primary Care Standards



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Results in Brief

Audit of the Defense Health Agency's Management of Military Medical Treatment Facilities Outside the Continental United States in Meeting Access to Primary Care Standards

December 8, 2025

Objective

The objective of this audit was to assess the effectiveness of the Defense Health Agency's (DHA) management of military medical treatment facilities (MTFs) outside the continental United States (OCONUS) in meeting access to primary care standards for DoD beneficiaries.

Background

Federal and DoD guidance requires the Military Healthcare System (MHS) to provide DoD beneficiaries an appointment to visit a provider either at an MTF or TRICARE network facility within 24 hours for urgent care, or 7 days for routine care. While MTFs can refer patients to a TRICARE network facility to receive health care if the MTF cannot meet access to care standards, obtaining health care services from providers outside of the MTF in OCONUS locations can present various challenges, including language barriers between the patients and providers, a different patient experience with health care services, and countries that do not accept U.S. health insurance.

Finding

The DHA updated its organizational structure and developed tools to assist OCONUS MTFs in meeting access to care standards; however, the DHA could manage access to care more effectively at OCONUS MTFs. We selected a nonstatistical sample of 15 out of 79 MTFs located OCONUS, including Hawaii and Alaska. Specifically,

Finding (cont'd)

personnel at the 15 OCONUS MTFs we sampled operated inconsistently using different access to care guidance; spent significant time researching and resolving or developing workarounds for inaccurate or unreliable data within the DHA access to care dashboards; and did not have sufficient staff to meet the access to primary care standards. This occurred because the DHA did not:

- issue finalized guidance to the MTF personnel establishing roles, responsibilities, and access to care requirements that reflected the DHA's updated structure, operations, and performance goals;
- analyze data discrepancies within the DHA access to care dashboards or consistently update MTF personnel on data corrections; or
- manage staffing to meet the DHA's mission of delivering timely health care to DoD beneficiaries in the MTF or to support a ready medical force for the DoD.

As a result, according to the DHA Near Real Time dashboard data, Service members and their families faced delays in access to care during the timeframe of our audit, ranging on average from 1.2 days to 21.1 days for urgent appointments and from 7.2 days to 36.8 days for future appointments, which increased the risk for negative outcomes and preventable complications, and decreased patient satisfaction. Lastly, MTF personnel were at risk of decreased readiness, had decreased morale, and experienced burnout.

Recommendations

We made 11 recommendations to the DHA Director to improve access to care management, including to finalize and implement guidance and to analyze and remediate data quality issues. Regarding staffing, we recommend that the DHA Director track data on why personnel are leaving MTFs, perform a comprehensive review of the authorized staffing at OCONUS MTFs, and track support staff availability. Further, we recommend that the DHA Director, in coordination with the Military Departments, determine the time spent on tasks for the DHA health care and DoD readiness missions and make adjustments to balance the workforce.

Management Comments and Our Response

The DHA Acting Deputy Director, responding for the DHA Director, addressed the specifics of two recommendations to track support staff availability and implement guidance to provide appropriate FTE deductions for collateral duties. Therefore, the two recommendations are resolved but will remain open. We will close the recommendations when we verify that the information provided and actions taken by the DHA Director fully address the recommendations.

The DHA Acting Deputy Director did not fully address the specifics of nine recommendations. Therefore, the nine recommendations are unresolved. We request that the DHA Acting Deputy Director provide additional comments within 30 days in response to the final report for the nine recommendations. Please see the Recommendations Table on the next page for the status of recommendations.

Recommendations Table

Management	Recommendations Unresolved	Recommendations Resolved	Recommendations Closed
Director, Defense Health Agency	1.a, 1.b, 1.c, 1.d, 1.e, 1.f, 1.g, 2.a, 2.c.	1.h, 2.b.	

Please provide Management Comments by January 8, 2026.

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** – The DoD OIG verified that the agreed-upon corrective actions were implemented.


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December 8, 2025

MEMORANDUM FOR DIRECTOR, DEFENSE HEALTH AGENCY

SUBJECT: Audit of the Defense Health Agency's Management of Military Medical Treatment Facilities Outside the Continental United States in Meeting Access to Primary Care Standards (Report No. DODIG-2026-025)

This final report provides the results of the DoD Office of Inspector General's audit. We previously provided copies of the draft report and requested written comments on the recommendations. We considered management's comments on the draft report when preparing the final report. These comments are included in the report.

The Defense Health Agency Acting Deputy Director, responding for the DHA Director, proposed actions that satisfy the intent of two recommendations. Therefore, we consider the recommendations resolved and open. We will close the recommendations when you provide us documentation showing that all agreed-upon actions to implement the recommendations are completed. Therefore, please provide us within 90 days your response concerning specific actions in process or completed on the recommendations. Send your response to either [redacted] if unclassified or [redacted] if classified SECRET.

This report also contains recommendations that are considered unresolved because the Defense Health Agency Acting Deputy Director did not agree with one recommendation and did not fully address eight recommendations. Therefore, the recommendations remain open. We will track them until management has agreed to take actions that we determine to be sufficient to meet the intent of the recommendations and management officials submit adequate documentation showing that all agreed-upon actions are completed.

DoD Instruction 7650.03 requires that recommendations be resolved promptly. Therefore, please provide us within 30 days your response concerning specific actions in process or alternative corrective actions proposed on the recommendations. Send your response to [redacted].

If you have any questions, please contact [redacted].

Carmen J. Malone
Assistant Inspector General for Audit
Acquisition, Contracting, and Sustainment

Contents

Introduction

Objective

The objective of this audit was to assess the effectiveness of the Defense Health Agency's (DHA) management of military medical treatment facilities (MTFs) outside the continental United States (OCONUS) in meeting access to primary care standards for DoD beneficiaries.

Background

The Military Health System (MHS) is responsible for providing a medically ready force, a ready medical force, and health care to 9.6 million beneficiaries, including Service members, military retirees, and their families. Health care services are delivered through the two following systems.

- **Direct Care System** – Consists of DoD MTFs located worldwide.
- **Purchased Care System** – Consists of partnerships with civilian health care provider facilities operated through TRICARE contracts.

MTFs, or military hospitals and clinics, are the core of military medicine, where military, civilian, and contractor personnel provide care for beneficiaries and gain the skills and training to support operational units.

Defense Health Agency Roles and Responsibilities

The DHA is responsible for the management and administration of the MTFs as required by the National Defense Authorization Act of FY 2017.[1] The Act also requires the commander of each MTF to ensure the medical readiness of the armed forces at the facility and provide health care and treatment at the facility.

In October 2022, the MHS completed the transition of the authority, direction, and control of all continental United States (CONUS) and OCONUS MTFs from the Military Departments to the DHA. Then, in October 2023, the DHA established nine Defense Health Networks (DHN) with the intent to strengthen the management of health care delivery, combat support, and support to the military health enterprise worldwide. Of the nine DHNs, six networks oversee OCONUS MTFs. See Figure 1 for a description of some of the leadership and responsibilities within the DHA, the DHNs, and MTFs.

[1] Public Law 114-328, "National Defense Authorization Act for Fiscal Year 2017," December 23, 2016.

Figure 1. Leadership and Responsibilities Within the DHA

Source: The DoD OIG.

Access to Care Standards

Federal and DoD guidance requires the MHS to provide DoD beneficiaries an appointment to visit a provider at either an MTF or TRICARE network facility within 24 hours for urgent care, or 7 days for routine care.[2] Urgent care includes non-emergency illnesses or injuries that "will not result in further disability or death if not treated immediately, such as high fevers or sprained ankles."[3] Routine care includes general office visits for the treatment of symptoms, chronic or acute diseases, and follow-up care for ongoing medical conditions. The DHA manages access for urgent and routine care through the use of 24HR and FTR appointments.

Federal and DoD guidance requires the MHS to provide DoD beneficiaries an appointment within 24 hours for urgent care, or 7 days for routine care.

[2] Civilian Health and Medical Program of the Uniformed Services, title 32 Code of Federal Regulations (CFR) section 199.17; Health Affairs Policy 11-005, "TRICARE Policy for Access to Care," February 23, 2011.
A TRICARE network facility is an authorized provider with a TRICARE regional contract that offers health care services and support beyond what is available at the MTF.

[3] Health Affairs Policy 11-005, "TRICARE Policy for Access to Care," February 23, 2011.

Health Care Obtained Outside of an OCONUS MTF

While MTFs may refer patients to a TRICARE network facility to receive health care if the MTF cannot meet access to care standards, obtaining health care services from providers outside of the MTF in OCONUS locations can present various challenges. Reports published by the Government Accountability Office in 1990 and 2000, and the DoD OIG in 2023 identified concerns with obtaining health care outside of the MTF in an OCONUS environment, including language barriers between the patients and providers, a different patient experience with health care services, and lack of continuity of care with a primary care manager.[4]

Obtaining health care services from providers outside of the MTF in OCONUS locations can present various challenges.

Further, according to the U.S. Department of State, most hospitals and doctors in countries, such as Germany, Italy, Japan, and South Korea, do not accept U.S. health insurance and expect payment for services up front, pay in cash, or both. Additionally, most OCONUS locations that we visited did not have urgent care or emergency department facilities available on or near the installations, placing further demand on health care services obtained within the MTF.

MTFs at OCONUS Locations

MTFs at OCONUS military installations provide routine health care to their beneficiary populations and are essential in supporting DoD operations, such as evacuating and treating injured Service members in contingency locations and maintaining and providing oversight of war reserve and medical materiel. Figure 2 shows Airmen at the 51st Medical Group at Osan Air Base, South Korea, participating in an operation readiness exercise responding to a simulated attack.

[4] GAO/T-HRD-90-20, Access to Medical Care at Overseas Military Hospitals, March 29, 1990; GAO/HEHS-00-172, Defense Health Care: Resources, Patient Access, and Challenges in Europe and the Pacific, August 2000; Report No. DODIG 2024-033, Management Advisory: Concerns with Access to Care and Staffing Shortages in the Military Health System, November 29, 2023.

Figure 2. Airmen at Osan Air Base Respond to a Simulated Attack
Source: The U.S. Air Force.

MTFs in OCONUS locations experience constant turnover with Service members. DoD Instruction 1315.18 provides Military Services with the ability to assign and reassign Service members for tours of duty to enhance their careers and professional development while maintaining a high degree of combat capability and readiness.[5] In general, Service members stationed in OCONUS locations have standard tour lengths of 36 months with their families and 24 months without their families. However, there are exceptions including Alaska and Hawaii where Service members serve a minimum tour length of 36 months with or without their families, and South Korea where Service members have tour lengths of 12 months and families are permitted in only limited cases.

Access to Care Monitoring

DHA guidance requires the DHA Healthcare Operations and DHNs to recommend and track measures to assess access to care, capacity and appointing performance, and compliance with the DHA business rules.[6] Additionally, the DHNs are

[5] DoD Instruction 1315.18, "Procedures for Military Personnel Assignments," October 28, 2015 (Incorporating Change 3, June 24, 2019).

[6] 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 Medical Treatment Facilities (MTFs)," February 4, 2020.

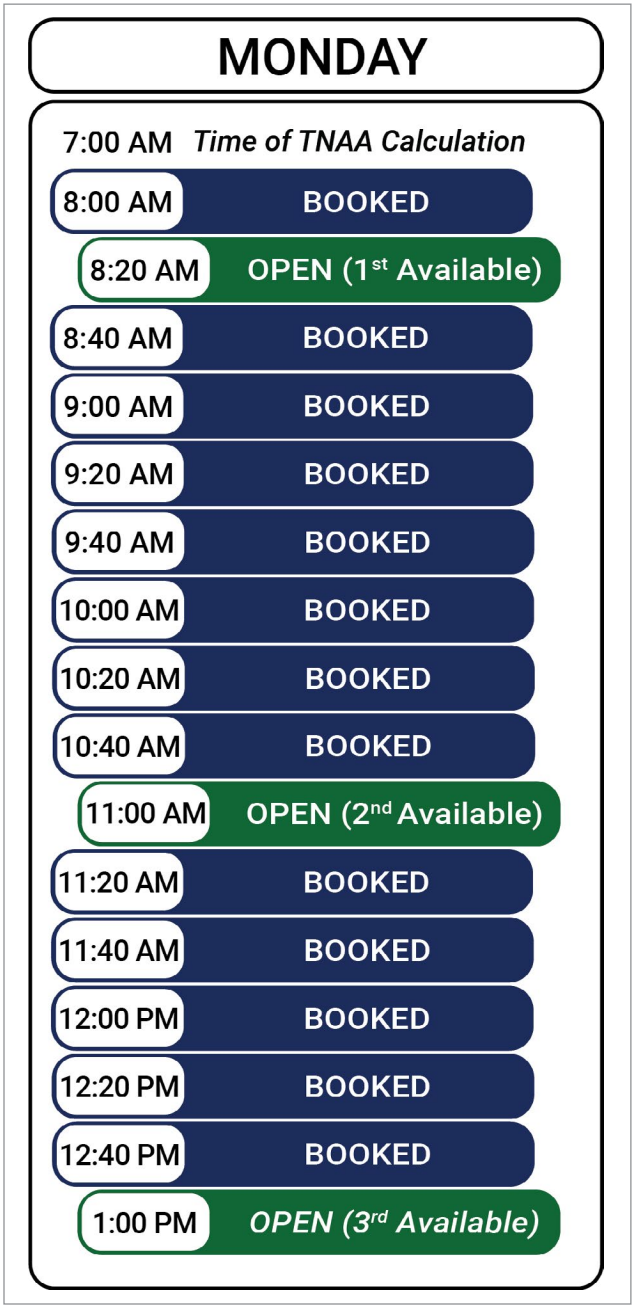
required to ensure the MTFs implement standardized processes, procedures, and appointment types. In the direct care system, the DHA measures access to care in a variety of ways, including tracking metrics, such as average days to appointments and average days to the third next available appointment (TNAA). The average days to appointments provides a retrospective look at how long it took for a patient's appointment to occur, whereas the TNAA metric provides a prospective look at future appointments available to patients.

DHA measures access to care in a variety of ways, such as average days to appointments and average days to the third next available appointment.

To ensure MTFs are providing timely care, the DHA uses the TNAA metric, a standard health care industry practice, to calculate when MTFs have appointments available for urgent and future appointment types. The DHA calculates a daily TNAA metric by finding the third available appointment for each primary care clinic, regardless of provider.[7] Multiple open appointments at the same time are counted as one appointment. For example, a family health clinic has an open appointment at 8:20 a.m., three open appointments at 11:00 a.m., and another open appointment at 1:00 p.m. In this example, the time until the third next available appointment for the family health clinic for this date of observation would be 6 hours (7:00 a.m. until 1:00 p.m.), or a TNAA metric of 0.25 days (6 hours / 24 hours). Figure 3 shows the open appointments at the family health clinic.

[7] Primary care includes clinics for family medicine, pediatrics, internal medicine, and operational medicine. DHA queries appointment data used to calculate TNAA centrally at 8:00 UTC every day for all MTFs.

Figure 3. Example of Third Next Available Appointment at a Family Health Clinic



Source: The DoD OIG.

The DHA uses the daily TNAA for each MTF clinic to then calculate and report an average monthly TNAA metric for each MTF in the DHA dashboards. Because clinics within the MTF offer varying numbers of appointments, the DHA calculates a weighted monthly average TNAA metric for an MTF by comparing the clinic's total appointments with the total appointments offered at the MTF. For example, if the family medicine clinic in Table 1 had 100 monthly appointments in comparison to

the MTFs total monthly appointments of 750, the DHA would apply a 0.13 adjustment ratio (100/750 appointments) to the clinic's monthly average TNAA. Therefore, if the family medicine clinic had a monthly TNAA metric of 3 days, the weighted monthly TNAA for that clinic would be 0.39 days (3 days × 0.13). Lastly, the DHA adds the weighted values for all of the MTF's clinics to determine the monthly average TNAA value for the MTF. For example, a patient would have to wait an average of 1.43 days to see a provider at an MTF based on the data in Table 1. See Table 1 to determine how the DHA calculated the MTF monthly average TNAA metric.

Table 1. Calculation of an MTF's Monthly Average TNAA Metric

Clinic	Clinic Monthly Average TNAA Metric	Clinic Appointments	Adjustment Ratio (Clinic Appointments / MTF Appointments)	Clinic Weighted TNAA (Clinic TNAA × Adjustment Ratio)
Family Medicine	3.0	100	0.13*	0.39
Pediatrics	2.0	200	0.27*	0.54
Internal Medicine	1.5	150	0.20	0.30
Operational Medicine	0.5	300	0.40	0.20
MTF Totals		**750**	**1.00**	**1.43**

Source: The DoD OIG.

* The result does not equal the actual calculation because of rounding.

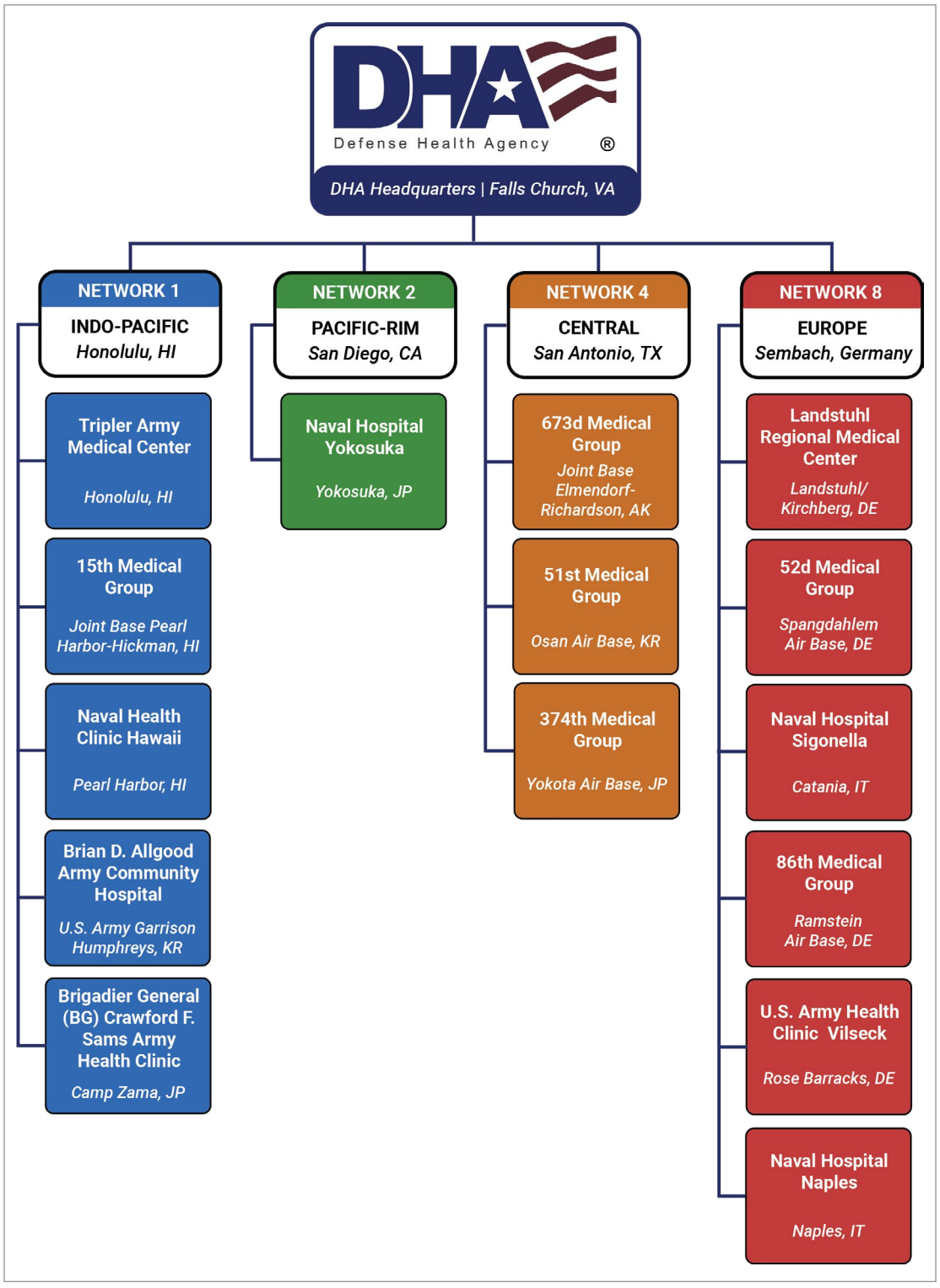
Sample of DHA Networks and DoD MTFs

To evaluate the DHA's management of primary care appointments available in OCONUS MTFs, we met with personnel from the DHA headquarters and four of the six DHA networks that oversee OCONUS MTFs. In 2024, the MHS had 28 parent (primary) MTFs that reported for a total of 51 children (subordinate) MTFs in an OCONUS environment.[8]

We selected a nonstatistical sample of 15 parent OCONUS MTFs located within different geographical areas to understand the relationship between the MTFs and the DHA and challenges that the MTFs face in meeting access to primary care standards. Figure 4 shows the DHNs and OCONUS MTFs from which we interviewed personnel.

[8] Parent MTFs are the primary MTFs assigned to report data for their facility and for other facilities under them (child or subordinate facilities).

Figure 4. Organization Structure of Defense Health Networks and DoD MTFs from Our Sample



Source: The DoD OIG.

We focused our review on access to care provided for Service members, retirees, and their families as DoD beneficiaries. We did not evaluate access to care for DoD civilians or contractor care as Section 726 of the FY 2024 National Defense Authorization Act tasked the Government Accountability Office to review the availability of health care services for these covered individuals.[9] Additionally, we focused on access to direct care in the DoD MTFs managed by the DHA, not access to purchased care managed by the TRICARE managed care support contractors.

[9] Public Law 118-31,"National Defense Authorization Act for Fiscal Year 2024," section 726, "GAO study on health care available to certain individuals supporting the missions of United States Forces Japan and Joint Region Marianas," December 22, 2023.

GAO-25-107453, "Civilian Workforce: DoD is Implementing Actions to Address Challenges with Accessing Health Care in Japan and Guam," April 2025.

Finding

The DHA Could Manage Access to Care More Effectively at OCONUS MTFs

The DHA updated its organizational structure and developed tools to assist OCONUS MTFs in meeting access to care standards; however, the DHA could manage access to care more effectively at OCONUS MTFs. Specifically, personnel at the 15 OCONUS MTFs we sampled operated inconsistently using different access to care guidance; spent significant time researching and resolving or developing workarounds for inaccurate or unreliable data within the DHA access to care dashboards; and did not have sufficient staff to meet the access to primary care standards. This occurred because the DHA did not:

- issue finalized guidance to the MTF personnel to establish roles, responsibilities, and access to care requirements that reflected the DHA's updated structure, operations, and performance goals;
- analyze data discrepancies within the DHA access to care dashboards or consistently update MTF personnel on data corrections; or
- manage staffing to meet the DHA's mission of delivering timely health care to DoD beneficiaries in the MTF or to support a ready medical force for the DoD.

As a result, according to the DHA Near Real Time (NRT) dashboard data, Service members and their families faced delays in access to care during the timeframe of our audit, ranging on average from 1.2 days to 21.1 days for urgent appointments and from 7.2 days to 36.8 days for future appointments, which increased the risk for negative outcomes and preventable complications, and decreased patient satisfaction.[10] Lastly, MTF personnel were at risk of decreased readiness, had decreased morale, and experienced burnout.

The DHA Made Progress in Managing Access to Care Overseas

Since the transition of the authority, direction, and control of the MTFs from the Military Departments to the DHA, the DHA updated its organizational structure from a highly decentralized and complex market structure, to nine DHNs led by all dual-hatted flag or general officers, and developed new tools to assist

[10] Although the DHA and MTFs acknowledged issues with the quality of the data, we used the DHA NRT dashboard data for the delays in access from February through July 2024 because it was what the DHA used to measure MTF performance against the DHA's access to care goals.

OCONUS MTFs in meeting access to care standards. During the period of our review, the DHA was working to expand the functions of its newly established DHNs and defined its access to care positions. In October 2023, the DHA established the DHNs with a dual-hatted flag officer, or general officer, to oversee the MTFs and aligned most MTFs with their affiliated Services rather than by geographical proximity.

The DHA updated its organizational structure to nine DHNs and developed new tools to assist OCONUS MTFs in meeting access to care standards.

For example, a one-star general officer serves as Commander of the Naval Medical Forces Pacific and DHN Director for Pacific Rim with oversight of nine Navy MTFs located in California, Washington, Guam, and Japan. DHN Directors stated that the alignment with their respective Services in most cases provided the flexibility to meet the missions for both health care delivery and readiness, as well as the ability to shift manpower needs across the Services.

During interviews that we conducted from May to November 2024, personnel at the DHNs expressed that they were not adequately resourced to perform oversight of their MTFs or to respond to the challenges that MTFs experienced meeting access measures. However, throughout the period of our review, the DHNs were working with the DHA to increase staffing at the networks to provide adequate oversight of the MTFs, as DHN personnel were the first line of support for MTFs in obtaining assistance on access to care. For example, the DHNs assisted MTFs with providing strategic expertise and arranging temporary personnel support.

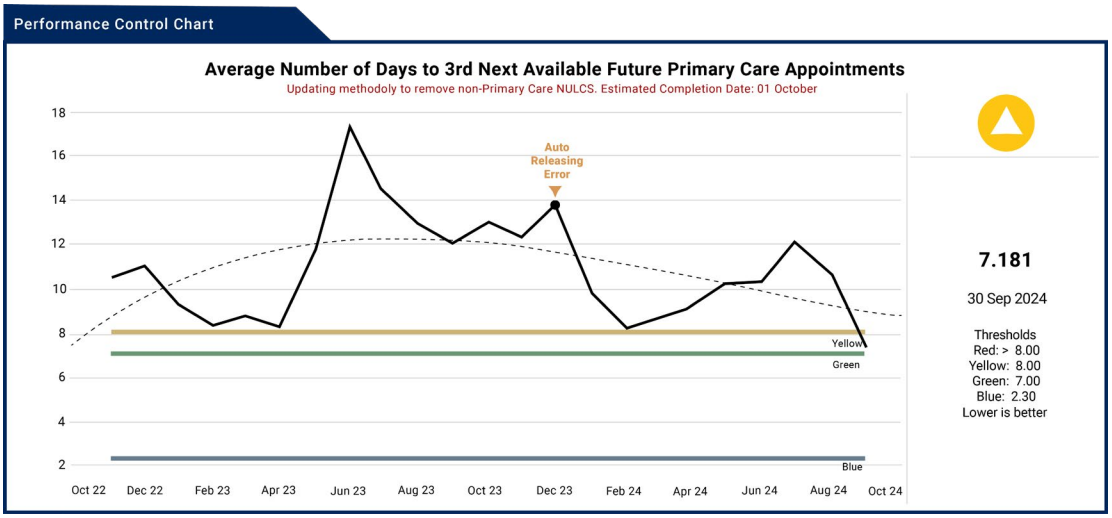
In addition to expanding the DHNs to support its MTFs in meeting access to care, the DHA also required each MTF to have at least one group practice manager (GPM). The GPM is a critical position for access to care and is responsible for reviewing appointment availability and use, analyzing appointment schedules for meeting patient demand, and recommending access to care improvement strategies to MTF leadership.

The DHA also created new tools to allow MTF personnel to analyze different aspects of access to care and identify areas of concern.[11] For example, the DHA Analytics and Evaluation Division developed the Near Real Time (NRT) dashboard on access to care with the intent of providing more timely, accurate, and detailed data to support decisions at the DHA headquarters, DHN, and MTF levels. The NRT dashboard included measures such as the average number of days

[11] Some tools created by the DHA included dashboards within their systems to research factors that affect access to care and an Excel tool to calculate provider decrements and availability.

to TNAA for urgent and future appointment types. Figure 5 shows an example of the NRT dashboard for the average number of days to TNAAs for the future appointment type.

Figure 5. NRT Dashboard for Defense Health Network Indo-Pacific for September 2024



Source: The DHA.

MTF Directors and their clinical operations teams met with DHA leadership monthly using the NRT and other data to discuss the MTFs' access to care performance measures. The monthly meetings also included concerns that impacted access to care, such as staffing shortfalls or vacancies; rotational units that arrived within an MTF's area of responsibility for care, which could increase demand for care at that MTF; and other ongoing priorities.

In addition to the NRT dashboard, MTF personnel have access to the following dashboards and reports to perform further analysis for specific access to care measures.

- **HealtheAnalytics** – Provides operational management reports on provider and patient encounter information, provider schedules, and access to care measures.
- **Financial Management Information System (FMIS)** – A financial management platform that allows the DHA to allocate resources, forecast budgets, and analyze data for appointments and schedules.
- **Discern Reporting Portal** – Provides various reports, including productivity, safety, patient engagement data, personnel details, appointment slot use, and scheduling blocks.
- **TRICARE Operations Center** – Provides reports on appointment data used in the analysis of access to care.

The DHA Could Improve Its Access to Care Management

Although the DHA made organizational changes and developed tools to assist the MTFs in meeting access to care standards, it could more effectively manage access to care at OCONUS MTFs. Specifically, the DHA did not issue finalized guidance to the MTFs detailing DHA expectations for access to care. Additionally, the DHA dashboards provided to MTFs contained inaccurate or unreliable data limiting MTFs ability to implement corrective actions. Finally, the MTFs did not have sufficient staff to meet the access to care standards.

Although the DHA made organizational changes and developed tools to assist the MTFs, it could more effectively manage access to care at OCONUS MTFs.

MTFs Inconsistently Implemented Different Guidance

Personnel at the MTFs inconsistently implemented different guidance for access to care. The DHA managed access to care using several policies and instructions published between 2008 and 2018, as well as an interim DHA procedure for standard appointing processes, procedures, and appointment times that expired in June 2020.[12] However, in October 2022, the DHA assumed authority, direction, and control of DoD MTFs, and subsequently established a new DHN structure and roles responsible for managing access to care.

Prior to the organizational changes at the DHA, the DHA stated in a memorandum that it intended to release a new instruction in spring 2022.[13] However, as of May 2025, the DHA had not published the guidance. The DHA has provided MTFs multiple versions of draft access to care guidance, including four different versions provided by MTFs during our site visits. The drafts conflicted with current guidance or previous Service guidance on access to care, and included updates to operating practices, such as applying provider deductions for non-clinical duties and creating provider templates to plan for the providers'

The DHA has provided MTFs multiple versions of draft access to care guidance, including four different versions provided during our site visits.

[12] Assistant Secretary of Defense (Health Affairs) Policy 11-005, "TRICARE Policy for Access to Care," February 23, 2011; "Military Health System's Guide to Access Success," December 15, 2008; DHA Procedural Instruction (PI) 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; DHA PI 6025.11, "Processes and Standards for Primary Care Empanelment and Capacity in Medical Treatment Facilities (MTFs)," October 9, 2018.

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 Medical Treatment Facilities (MTFs)," February 4, 2020.

[13] DHA Memorandum, "New Standardized Deductions for Primary Care, Specialty Care, Graduate Medical Education, Graduate Health Education, and Inpatient Care," March 25, 2022.

schedules. Additionally, the draft guidance included new performance goals, such as 90 completed encounters per week for each 1.0 full time equivalent (FTE) primary care provider. Further, the draft guidance established the GPM position as a key role that was responsible for managing access to care at the MTFs.

Personnel at some MTFs stated that they started implementing parts of the draft guidance in anticipation of its release, while other MTF personnel stated that they would not implement the guidance because it was not published, resulting in MTFs inconsistently implementing guidance. One GPM stated that their MTF personnel followed a mix of access to care guidance, generally those that were signed, but in other instances where there was no signed guidance, MTF personnel referred to the DHA's draft access to care guidance. An official from one MTF stated that when they asked the DHA whether to implement the draft guidance, the DHA official stated that they could not direct the MTF to follow guidance that had not been signed. However, MTF personnel stated that they were being held accountable by the DHA for some measures in the draft guidance, such as achieving a target of 90 completed encounters per week per one FTE primary care provider.

MTF Personnel Spent Significant Time Researching and Correcting DHA Dashboard Errors

Personnel at the MTFs spent a significant amount of time researching and resolving or developing workarounds for inaccurate or unreliable data on DHA access to care dashboards. Although the DHA created dashboards to help monitor and remediate access to care metrics, MTF personnel experienced challenges validating the data. For example, MTF personnel presented an example in which the TNAA methodology in the dashboards did not identify all the primary care providers at their MTF. MTF personnel followed up with the DHA for over 2 months on a resolution before the DHA acknowledged and corrected the discrepancy.

Although the DHA created dashboards to help monitor and remediate access to care metrics, MTF personnel experienced challenges validating the data.

Another MTF provided an example where the third next available appointment data was skipping their open appointments. MTF personnel stated that the issue was ongoing for 8 months prior to our site visit. The MTF personnel stated that the DHA was responsive to tickets submitted by the MTFs but that the errors took a long time to correct, and that it was difficult to make data-based decisions when the data was not correct. The MTF was maintaining an internal daily tracker to calculate the third next available appointment data to compare to the DHA's data.

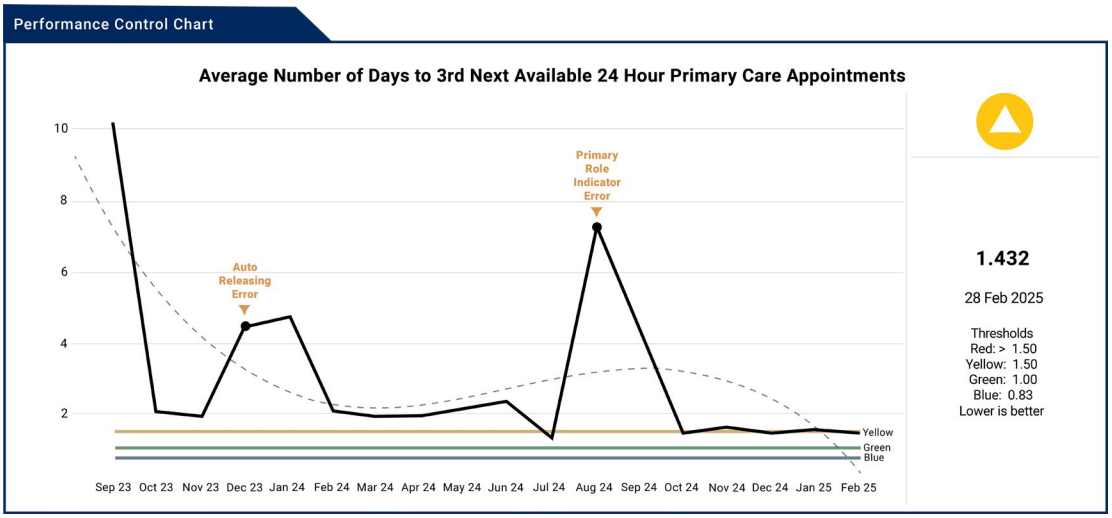
Personnel at another MTF identified inaccuracies with the MTF's template utilization rate, a metric that the DHA used to measure access to care. The template utilization rate provides the percentage of scheduled appointments out of the total appointments made available to patients at the MTF, helping to ensure that an appropriate number of appointments are available to provide timely access to care. For example, an MTF clinic has two providers with 50 templated appointments each, for 100 total appointments available to patients. If 75 appointments are booked, the clinic's template utilization rate with the two providers is 75 percent, which determines how well the planned appointments are used at a clinic. However, if the data inaccurately shows three providers for an MTF clinic with 150 total appointments available to patients, the clinic's template utilization rate would decrease to 50 percent. MTF personnel stated that they found providers listed under their MTFs who were no longer there or new providers who the DHA did not include under their MTFs, which affected their template utilization rate. For example, a GPM at one MTF showed us that the DHA was inaccurately reporting a nurse practitioner under the primary care clinic, decreasing the MTFs utilization rate because the DHA was inappropriately including the nurse practitioner's appointments. A low template utilization rate reflects poorly on the MTFs performance, indicating that an MTF is not efficiently using resources. The GPM stated that there were multiple systems with dashboards to pull information from but when comparing dashboards they all had different information.

MTF personnel stated that the access to care metrics the DHA reported on its dashboard did not match data the MTF was using from other systems, even though the DHA reported that the systems were pulling data from the same source data and should only have negligible differences because of latency or timing issues. A GPM at one OCONUS MTF explained that their MTF showed an average of 4 days for urgent appointments from HealtheAnalytics, a joint DoD, Veterans Health Administration, and Coast Guard system, while the DHA NRT dashboard reported a high average of 28.9 days. Personnel from at least four MTFs developed their own tracking spreadsheets to compare to DHA data. For example, personnel at one MTF created a spreadsheet for daily tracking because they felt it was more accurate and timely than the DHA dashboard and helped them determine the reasons behind the access to care metrics. MTF personnel explained that it was difficult to answer DHA questions when DHA's data was much different than data at the local level, and internal processes to monitor and track the access to care data took a significant amount of time.

MTF personnel explained that it was difficult to answer DHA questions when DHA's data was much different than data at the local level.

The DHA has acknowledged and reported to MTF personnel issues with the data on its dashboards. For example, the DHA reported a spike in TNAA metrics on its dashboard from December 2023 to January 2024, as well as August 2024. See Figure 6 for examples of the spikes in metrics because of errors reported on DHA's dashboard for the average number of days to TNAA for 24HR appointments in primary care.

Figure 6. Examples of Errors the DHA Reported for the Average Number of Days to Third Next Available Appointment for 24HR in Primary Care at DHN Europe



Source: The DHA.

In May 2024, we met with a Branch Chief in DHA's Healthcare Optimization Division to discuss the data abnormalities. When discussing the auto-releasing error, the Branch Chief explained that the DHA encouraged MTF personnel to use a setting in MHS Genesis that automatically converted reserved appointment slots that were not scheduled by the clinic within a specified timeframe to available appointments for patients, but the setting had an auto-releasing error that led to the appearance of a worsened access to care metric for urgent appointment types. Specifically, MTFs had appointments available for patients even though the access metric did not account for all the urgent appointment types that should have populated with the conversion of unscheduled future appointments. According to the DHA dashboard, as of January 6, 2024, the DHA had addressed the issue, but it stated that historical data could not be retroactively corrected.

MTFs Did Not Have Sufficient Staff to Meet Access to Care Standards

MTFs did not have sufficient staff to meet the access to primary care standards. The DHA Director, in coordination with the Secretaries of the Military Departments, is responsible for planning and accommodating for the absence

of military medical personnel from the MTFs. Additionally, the DHA Director "is responsible for the absence or lack of availability of the civilian workforce" at the DHA and its MTFs, and for making effective and efficient use of Service members, civilian employees, and contractor personnel.[14] While the Military Departments retain administrative control of its Service members, the Military Departments also support the DHA Director's staffing plan by providing feedback on the availability of military medical personnel. DHA personnel stated that the requirements between the DHA and Military Departments may not always align but that the DHA collaborated with the Military Departments to address personnel gaps and to leverage available resources.

According to MTF personnel, although OCONUS MTFs are filled with higher rates of military personnel than MTFs within the continental United States, the Services could not fully staff the MTFs with the military personnel authorized on the staffing documents because of shortages of medical personnel within the Military Departments. A memorandum by the Deputy Secretary of Defense stated that the "realignment of medical personnel, coupled with a challenging health care economy and ambitious private sector capacity assumptions, led to chronically understaffed MTFs."[15]

According to MTF personnel, the Services could not fully staff the MTFs because of shortages of medical personnel within the Military Departments.

MTF staffing data showed shortages in personnel at OCONUS MTFs. For example, in September 2024, one MTF reported that they had only 27 (75 percent) of the 36 civilian personnel and 27 (73 percent) of the 37 contractor personnel that they were authorized across the clinics for their MTF. Staffing data for another MTF showed that for the years 2019 through 2024 in the primary care clinic, active duty doctors decreased 53 percent (43 to 20 personnel) and active duty technicians, medics, and licensed practical nurses decreased 20 percent (152 to 122 personnel), although there were no significant decreases to patient enrollment. Further, personnel from the same MTF highlighted that family medicine physicians were one of the top 10 military occupational specialties tasked for deployments and other duties in FY 2023.

MTF personnel stated that they struggled to hire civilian staff to augment the military personnel because of budgetary constraints. In an October 2023 newsletter, the DHA reported that FY 2024 presented a unique challenge for the

[14] Office of the Under Secretary of Defense for Personnel and Readiness, Directive-Type Memorandum 24-003, "Military Health System Manpower Requirements Determination, Resourcing, and Assignment," June 28, 2024.

[15] Deputy Secretary of Defense memorandum, "Stabilizing and Improving the Military Health System," December 6, 2023.

direct care system, as flatline funding had not kept pace with inflation.[16] Because of budgetary constraints, the DHA removed funding from ongoing civilian hiring actions for positions that the Civilian Human Resources Agency had not filled and any vacancies that did not have active hiring actions for their MTFs. MTF personnel expressed concerns that lengthy civilian hiring actions led to the vacant civilian billet issues at their MTFs. According to the DHA's dashboard data for civilian hiring at DHNs Indo-Pacific, Pacific Rim, Central, and Europe in November 2024, the average total days to hire ranged from 155 to 213 days.

In 2021, the DoD OIG performed an audit to examine whether the DoD conducted strategic planning when hiring its overseas civilian workforce. The report issued recommendations on the DoD's strategy to hire its overseas civilian workforce in support of the DoD's global mission and ongoing operations. As of May 2025, there were two open recommendations related to collecting and disseminating best practices to improve the DoD's ability to establish hiring timeline guidance, and to develop practical hiring policies that minimize vacancies, where possible.[17]

MTF personnel encountered challenges with obtaining temporary staff from other MTFs due to a lack of funding to support personnel and an overall shortage of providers. In 2023, one DHN received 282 requests for military personnel from its MTFs but was able to support only 88 of the requests from within its network. For example, MTF personnel requested a temporary provider for 3 months because they had a provider on maternity leave and two other provider shortages. In the request justification, MTF personnel stated that the current staffing would result in an unsatisfactory number of shifts for remaining personnel potentially leading to provider fatigue, the potential for poor patient outcomes, and no flexibility for staff injury or illness. DHN personnel denied the request for temporary personnel, stating that the position was not a high priority for hiring. According to an Assistant Director for Medical Services at the MTF, the DHN stated that the provider could use their maternity leave in increments, starting with an initial request of 30 days of leave, to allow the clinic to continue seeing patients.

One DHN received 282 requests for military personnel from its MTFs but was able to support only 88 of the requests.

[16] DHA Assistant Director, Resources and Personnel Integration Newsletter, FY2024, Issue 1, Volume 1, October 17, 2023.

[17] Report No. DODIG 2022-036, Audit of the Department of Defense Strategic Planning for Overseas Civilian Positions, November 16, 2021.

The DHA Did Not Issue Finalized Guidance

The DHA did not effectively manage access to care because it did not issue finalized guidance to establish access to care requirements that reflected the DHA's updated structure, operations, and performance goals. As of May 20, 2025, the DHA had not issued finalized guidance. DHA officials stated that the delays were caused by reviews from the DHA's Office of General Counsel, a new Labor and Management Employee Relations Office requirement to have the policy reviewed by a union, and the approval of draft guidance on a new model of care.[18] Effective formal policies and procedures are essential for the DHA to communicate its expectations and standard business practices to MTF personnel to implement consistent practices to meet access to care standards, as well as to establish the roles and responsibilities of positions that are key to monitoring and remediating access to care metrics.

Issuing a finalized DHA policy would provide MTF personnel clearly documented roles, responsibilities, and access to care requirements, helping to improve access to care. Therefore, we recommend that the DHA Director finalize and implement guidance that establishes the DHA's expectations and roles and responsibilities for access to care, incorporating the DHA's new structure and positions, and updated practices. If the DHA cannot finalize and implement guidance within 90 days of the final report, we recommend that the DHA Director issue formal interim guidance to the MTFs to establish access to care requirements until the DHA implements the finalized guidance.

The DHA Did Not Analyze Data Discrepancies or Consistently Update Users

The DHA did not effectively manage MTFs in meeting access to care standards because it did not conduct a comprehensive analysis of the MTF-reported data discrepancies within the DHA dashboards to identify trends or determine potential system issues. Additionally, the DHA did not consistently provide MTF personnel with updates on the status or expected timelines for data corrections.

To address MTF concerns with the dashboard data, the DHA scheduled weekly and bi-weekly meetings with the DHNs and MTFs to discuss data discrepancies. A Branch Chief in DHA's Healthcare Optimization Division also explained that MTF personnel could report data discrepancies through the DHA Analytics and Evaluation Division portal. Regarding whether the DHA tested for data reliability, DHA personnel stated that a team worked with the MTFs to identify peculiarities with the data or provide training for workflow issues. However, beyond the

[18] In 2024, the DHA launched "My Military Health," a new model of care that provides patients the flexibility and convenience of receiving care through scheduled virtual visits. The DHA deployed this platform in 2025.

data-related issues with MHS GENESIS, such as auto-release issues that affected the methodology calculation for the access to care metrics, DHA personnel stated that they could not provide themes of the issues found in the MTF data.

In addition, MTF personnel responses varied on whether the DHA corrected the data issues the MTFs identified and the timeliness of those corrections. At one MTF, personnel followed up with the DHA multiple times from April 25, 2024, through July 10, 2024, for resolution related to data discrepancies with their primary care providers. A health systems analyst at the DHA reviewed the methodology document and acknowledged the discrepancy so that the MTF could include the additional health care provider in primary care to accurately calculate the TNAA metric. Personnel at another MTF provided an example of data discrepancies with their primary care clinic from February through July 2024. Specifically, the data that they were tracking did not match the TNAA metric for future appointments on the dashboard, which MTF personnel attributed to the MTF's transition over to MHS GENESIS in October 2023. According to MTF personnel, the DHA could not explain the cause for the issue.

Although the dashboards had known issues, many MTF personnel stated that the DHA continued to use the access to care dashboards to make decisions, such as instances in which the DHA needed to increase access or where to move resources.

Although the dashboards had known issues, many MTF personnel stated that the DHA continued to use the access to care dashboards to make decisions.

Reliable and accurate data ensures that personnel managing access to care across the DHA can make well-informed decisions to identify areas for improvement and optimize operations. Conducting a comprehensive analysis of reported data discrepancies is important because it helps identify trends, root causes, and potential data issues that could impact the accuracy, reliability, and effectiveness of the dashboards. Finally, communicating the status and estimated timelines for completing data corrections to users would promote transparency, allow users to make informed decisions based on estimated timelines, and enhance confidence for users in the DHA dashboard data. Therefore, we recommend that the DHA Director (1) perform a comprehensive analysis to determine consistent themes across MTFs' concerns with the reliability, accuracy, and completeness of data used to monitor and remediate issues with the access to care metrics; (2) designate a centralized location accessible to the DHNs and MTF personnel that communicate whether data issues are widespread or localized, and the status of resolution; and (3) develop and implement a remediation plan to prioritize and fix data issues with the Defense Health Agency Near Real Time dashboard data on access to care.

The DHA Did Not Effectively Manage Staffing

While the DHA faced challenges with limited military personnel and budgetary constraints, the DHA did not effectively manage staffing at the OCONUS MTFs to meet the DHA mission of delivering timely health care to DoD beneficiaries in the MTF or to support a ready medical force for the DoD. Specifically, the DHA did not have a process to identify reasons why medical personnel left the MTFs, establish a primary care staffing model, establish deductions that appropriately reflect the workload of providers, or supplement the MTFs with the appropriate level of civilian personnel to assist MTFs in meeting access to care standards. The DoD OIG previously reported that DoD MTFs experienced shortages in health care personnel before and during the COVID-19 pandemic. Specifically, shortages existed because the DoD needed to improve its competitive pay rates and qualification requirements for health care personnel, hiring process for appointing retired Service members to civilian health care positions, and extension process for civilian personnel working overseas.[19] Maintaining appropriate personnel in health care facilities is essential to providing timely access to care.

The DHA Did Not Identify Why Personnel Left the MTFs

The DHA did not effectively manage MTF staffing to meet access to care metrics because the DHA did not have a process to identify reasons why medical personnel left the MTFs. While some MTFs had informal discussions or exit interviews, the MTFs did not capture data to identify trends and determine why personnel left the MTFs to develop tools to retain staff in OCONUS MTFs. A Director of Medical Services at one MTF stated that no one outside of their command asked why a provider wanted to leave. The Director also stated that if an organization wanted to keep personnel, the organization should try to understand the reasons why providers are leaving.

The MTFs did not capture data to identify trends and determine why personnel left the MTFs to develop tools to retain staff.

By systematically collecting and analyzing data from exit surveys or interviews, the DHA could better understand why employees are leaving to identify recurring issues and improve retention strategies. Further, retaining experienced staff can help maintain timely, high-quality patient care, and operational stability, as well as support the effective management of the DHA's workforce. The DHA acknowledged the importance of workforce retention in its FY 2023-2028 Strategic Plan, stating that it planned to enable the best patient-centered outcomes for its beneficiaries and stakeholders by strengthening the agency's workforce, in part, by retaining

[19] Report No. DODIG-2024-086, Audit of DoD Health Care Personnel Shortages During the Coronavirus Disease–2019 Pandemic, May 23, 2024.

and developing its staff. Therefore, we recommend that the DHA Director: (1) develop and implement a standardized process that collects data identifying why MTF personnel left their position, and (2) develop and implement a process to analyze and track trends to ensure that the DHA has mitigation strategies for common reasons that personnel leave the MTFs.

The DHA Did Not Establish a Primary Care Staffing Model

The DHA did not effectively manage staffing at the MTFs because it did not establish a primary care staffing model to determine the appropriate staffing for the MTFs to meet access to care standards. In its draft guidance, the DHA referred to a team of health care personnel as a Patient-Centered Medical Home (PCMH) model consisting of a primary care manager and support team; however, the draft guidance did not identify the composition of the primary care manager support team. MTF personnel stated that the DHA introduced draft guidance with a PCMH model years prior; however, the guidance was never published.

During our audit, the acting Under Secretary of Defense for Personnel and Readiness issued a June 2024 memorandum identifying the need for a staffing model by directing the DHA Director to program the balance of its human resource requirements using civilian and contractor personnel against validated staffing model requirements at each MTF.[20] In October 2024, the DHA shared draft PCMH staffing models with DHN Directors for feedback. For primary care, the DHA developed staffing models for operational medicine, internal medicine, pediatrics, and family medicine. Within the PCMH model, the DHA established a staffing model for each PCMH team, as well as ancillary staff. For example, for family medicine, each PCMH team should have one nurse per 2,000 enrollees, and each provider should have two clinical support staff and a 0.5 FTE medical support assistant.

We followed up with DHN and MTF personnel following the release of the DHA's draft staffing models, and DHN and MTF personnel stated the MTFs were not staffed to support the models. For example, personnel at one MTF stated that the DHA could not support the number of staff needed for a primary care staffing model because their MTF had six pediatricians and seven technicians, even though the draft staffing model requires two clinical support staff per provider. DHA personnel stated they did not have enough funding or

DHA personnel stated they did not have enough funding or personnel working within the DHA system to fulfill primary care requirements at the MTFs.

[20] Directive-Type Memorandum 24-003, "Military Health System Manpower Requirements Determination, Resourcing, and Assignment," June 28, 2024.

personnel working within the DHA system to fulfill primary care requirements at the MTFs. They further stated that they mitigated risks the best that they could given the reduced availability of military personnel working in the MTFs and the services that they must provide within certain MTFs.

On May 19, 2025, the DHA stated that it incorporated updates to the models based on user feedback, provided another draft of the staffing models to the DHNs and MTFs, and continued to provide training weekly. On July 2, 2025, the DHA finalized its staffing models. Therefore, we recommend that the DHA Director perform a comprehensive review of the staffing at OCONUS MTFs to ensure MTFs are authorized the staffing necessary to support the primary care staffing models.

The DHA Deductions Did Not Appropriately Reflect the Workload of Providers

The DHA did not effectively manage MTF staffing to meet access to care metrics because its standardized deductions to providers' empanelment and appointment goals did not appropriately reflect the workload of providers.[21] Specifically, provider workload was unrealistic because the DHA limited applying multiple standardized deductions to providers' empanelment and appointment goals and did not recognize any non-standardized deductions for MTF providers.

The DHA established standardized deductions to adjust provider empanelment and appointment goals to account for time worked outside of the clinic, including completing administrative duties, Graduate Medical Education requirements, and caring for inpatients. Additionally, the standards are used to create manpower standards in support of the Human Capital Distribution Plan. The DHA's guidance issued in October 2018 and a subsequent deductions memorandum issued in March 2022 did not specify limitations on stacking deductions for MTF leadership roles.[22] However, under the DHA's draft guidance, which MTFs began implementing during our audit, MTF personnel could apply multiple deductions to providers only performing peer review or inpatient responsibilities and providers who were breastfeeding. Therefore, MTF personnel had to claim a single role that provided the highest deduction amount. This limitation led providers to work long hours, balancing patient care with military duties.

[21] Empanelment refers to beneficiaries registered to an MTF's provider.

[22] DHA PI 6025.11, "Processes and Standards for Primary Care Empanelment and Capacity in Medical Treatment Facilities (MTFs)," October 9, 2018.
DHA Memorandum, "New Standardized Deductions for Primary Care, Specialty Care, Graduate Medical Education, Graduate Health Education, and Inpatient Care," March 25, 2022.

OCONUS MTF officials expressed concerns that the DHA's draft deduction guidance on FTE deductions did not accurately reflect the workload of providers when they were assigned to more than one collateral duty. Active duty providers who have leadership positions face competing demands between their management responsibilities, patient care duties, and readiness and clinical currency requirements. For example, under the current guidance, an Air Force active duty provider who serves as a Flight Commander, a Primary Care Pain Management Champion, and an MTF Committee Chair is allowed a collective 0.35 FTE deduction to the provider's empanelment and appointment goals. The provider would receive a 0.1 FTE deduction for their active duty status, a 0.1 FTE deduction for the Flight Commander role, a 0.1 FTE deduction for being a Primary Care Pain Champion, and a 0.05 FTE deduction as an MTF Committee Chair. However, under the DHA's draft deduction guidance, the provider would receive only a 0.1 FTE deduction for their active duty status, and the larger 0.1 FTE deduction for either a Flight Commander role or a Primary Care Champion role. The results of the reduced FTE deductions would lead to the provider having an additional 80 appointments per month compared to the full FTE deduction. See Table 2 for a comparison of the current and draft guidance provider deductions for an example of the effects on the provider's empanelment and appointment goals in an active duty clinic.

Active duty providers who have leadership positions face competing demands between their management responsibilities, patient care duties, and readiness and clinical currency requirements.

Table 2. Comparison of Current and Draft Guidance on Provider Deductions Available for an Air Force Active Duty Provider Serving as a Flight Commander, Primary Care Pain Champion, and MTF Committee Chair

	Current Guidance	Draft Guidance
FTE Total Deductions	0.35	0.2
Adjusted Empanelment	715	891
Adjusted Appointment Goal (Monthly)	208	288

Source: The DoD OIG.

Additionally, MTF personnel expressed concerns that the DHA's draft guidance did not recognize all types of collateral duties to accurately reflect the availability of providers for patient care. For example, multiple MTF officials expressed concerns with work performed in support of the Exceptional Family Member Program (EFMP). MTF staff review EFMP packages to verify whether the MTF has required

medical services available before authorizing families with special needs to travel at the Government's expense. However, an official at one MTF stated that they were not adequately staffed with personnel to handle medical readiness and administrative tasks, so the responsibility of reviewing these packages was assigned to their PCMH providers. The MTF official stated that each EFMP package for their region took 40 to 60 minutes to review to determine patient suitability, although the DHA guidance did not provide an appointment deduction for the EFMP workload.

We followed up with DHN officials regarding the EFMP deduction and they stated that the DHA Healthcare Optimization Division acknowledged that the EFMP deductions should be reviewed. However, according to DHA personnel, as of May 2025, the DHA had not made changes to the draft deduction guidance.

In another example, one MTF was located on an installation with a brig (military jail) that had prisoners who required medical care. An MTF official stated that family medicine providers rotated 1 day a week for half a day to care for brig patients, which equated to 10 clinical appointments lost weekly. The MTF official stated that the providers who cared for patients in the brig did not receive a deduction for these collateral duties. Therefore, the MTF scheduled brig patients into appointments to capture the provider's workload. The MTF official stated that having the provider out of the clinic affected their access to care and that having a deduction would significantly improve resource allocation and efficiency.

The DHA's draft guidance permitted the DHNs to approve non-standardized deductions for providers; however, the draft guidance specified that the deductions would not be recognized in the deduction system. Therefore, although the MTF and DHN recognized that the provider was unavailable for patient care while they were performing collateral duties, the DHA did not recognize the reduction in the providers appointment goals. Further, DHN officials stated that any workload lost to a non-standardized deduction must be re-distributed among available personnel.

If a provider does not have sufficient support staff, then the provider is left to complete the workload of unavailable support staff.

The DHA developed and implemented a provider deduction tool in September 2024, during our audit, to forecast and track the clinical availability and workload of providers based on the authorized deductions in the DHA's draft guidance. The tool uses data input by MTF personnel and calculates impacts on clinic capacity, empanelment, and appointment metrics. While the provider deduction tool identified reductions to a provider's empanelment and appointment targets, an MTF official stated that it did not consider whether the provider had any support

staff. If a provider does not have sufficient support staff, then the provider is left to complete the workload of unavailable support staff and is unlikely to meet the appointment goals set by the DHA, or the provider risks increased burnout while trying to provide timely access to care for patients. By accurately assessing provider and support staff availability when filling FTEs, MTFs can better ensure timely access to health care, as well as completion of readiness, clinical currency, and other collateral duty requirements.

The DHA placed limitations on "stacking" deductions to provider empanelment and appointment goals to prevent providers from taking too many deductions. Additionally, the limitations discourage MTFs from assigning too many collateral duties to individual providers. While controls are necessary to ensure the availability of providers in meeting their empanelment and appointment goals, having an accurate reflection of provider workload and support staff availability is imperative to ensure MTFs have sufficient staff to provide patients adequate access to care. Therefore, we recommend that the DHA Director, in coordination with the Military Departments, conduct a workload analysis study in primary care to observe and measure the time that primary care providers spend on supporting the DHA health care and DoD readiness missions; implement guidance to provide appropriate FTE deductions for collateral duties such as supporting the Exceptional Family Member Program; and develop and implement a plan to balance the workforce, considering the providers' reduced FTEs, to ensure sufficient staffing to fulfill patients' requirements. Finally, the DHA Director should expand the provider deduction tool to include tracking of support staff availability to ensure a comprehensive picture of overall clinic availability in meeting access to care standards.

The DHA Did Not Supplement MTFs With an Appropriate Level of Civilian Personnel

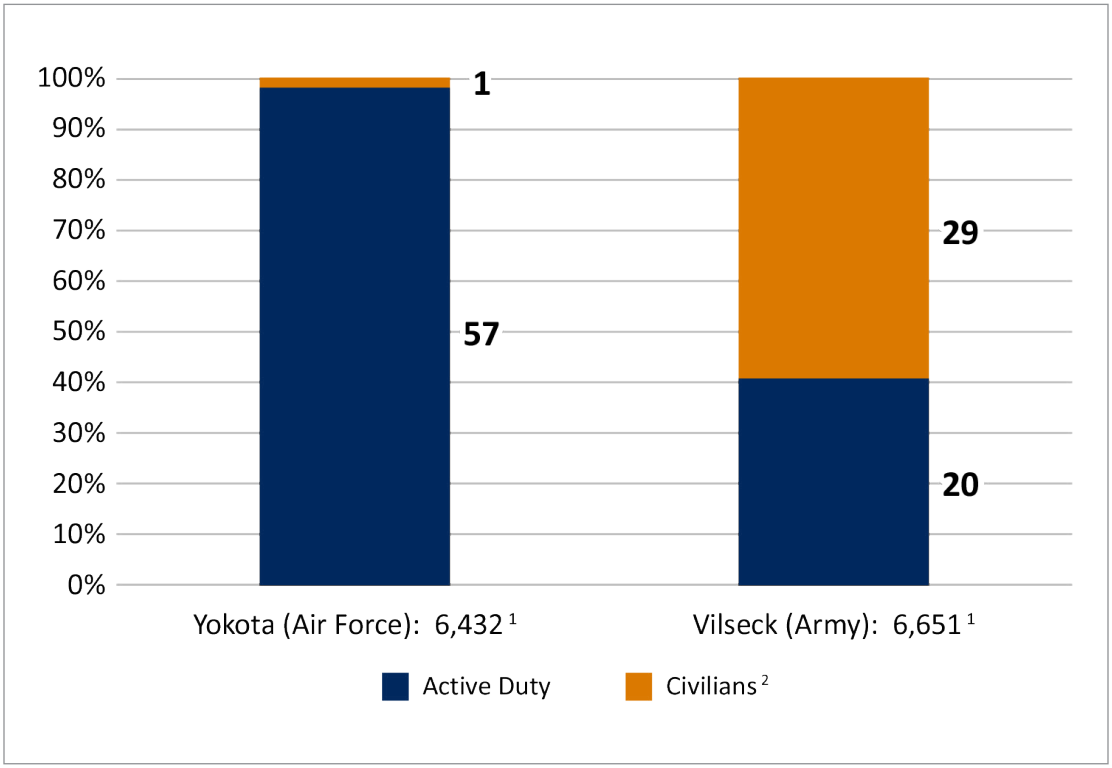
The DHA did not effectively manage staffing at the OCONUS MTFs because it did not supplement the MTFs with an appropriate level of civilian personnel to assist in meeting access to care standards. DHN and MTF personnel were concerned with the disproportionate percentage of military to civilian personnel across the MTFs operated by different Military Services and its effect on access to care.

Army MTFs in our sample were staffed with 56 percent while the Navy and Air Force MTFs were staffed with only 6 percent civilian personnel.

According to DHA staffing data, on average the Army MTFs in our sample were staffed with 56 percent civilian personnel, while the Navy and Air Force MTFs in our sample were staffed

with only 6 percent civilian personnel. See Figure 7 for a staffing composition comparison of primary care personnel at two similarly empaneled OCONUS MTFs we sampled as of August 2024.

Figure 7. Number of Active Duty and Civilian Personnel at Two Similarly Empaneled OCONUS MTFs, August 2024.



[1] Denotes clinic average enrollment from May to July 2024.

[2] The civilian staffing data include U.S. civilians and local national hires for skill types 1-4 (provides direct patient care); skill type 5 (administrative, logistics, or clerical) were excluded from our analysis. Local national hires are a segment of the DoD MTF civilian workforce who are citizens of the host nations. They are hired to serve multiple clinic roles such as health aid and technician positions. These supporting positions help with continuity of care between patients and their providers.

Source: The DoD OIG.

When we asked DHN Directors, who also served as the leaders of their respective Service Medical Commands, why the Army MTFs tended to have more civilians than the Navy and Air Force facilities, the directors stated that the Army historically had more civilians and one director explained that the DHA inherited the staffing composition that the Services had in place before the MTFs transferred to the DHA.

Military personnel are necessary in OCONUS MTFs to respond to unexpected events, such as treating battlefield injuries, mass casualty incidents, natural disasters, and humanitarian assistance missions. However, relying heavily on

military personnel can leave an MTF at a disadvantage because of frequent personnel rotations, readiness training exercises, and other collateral duties that remove military providers and support staff from clinical care. For example, an MTF official provided data supporting that the MTF's pediatric clinic lost 138 weeks of personnel time over 14 months because of military personnel rotations and taskings outside of the MTF. Specifically, the MTF official attributed 118 weeks of lost personnel time to military personnel turnovers, in-processing requirements, and competency training required for incoming active duty personnel, and an additional 20 weeks to loaning active duty personnel for military taskings.

Frequent personnel rotations, readiness training exercises, and other collateral duties remove military providers and support staff from clinical care.

Military personnel assigned in OCONUS locations typically rotate every 1 to 3 years, compared to civilian personnel who can be employed in foreign areas initially for up to 5 years, with options to extend in 2-year increments if supported by a business case analysis and approved by the head of the DoD component.[23] Further, because of the logistics of overseas moves, leave approved in conjunction with personnel rotations, and acclimating a provider with the MTF and systems, there is a staffing shortage between the out-processing and in-processing providers. Having civilian staff can help provide continuity of care in MTFs; however, some OCONUS locations have difficulties hiring civilians, and the MTFs must have available funding.

Having civilian staff can help provide continuity of care in MTFs; however, some OCONUS locations have difficulties hiring civilians, and the MTFs must have available funding.

Temporary departures of military personnel during operational missions and readiness training exercises further affect access to care. A DHA official stated that in MTFs where military personnel must leave for an operational mission, "back-fill" contracts were available to cover shortages. However, the official stated that hiring and training a replacement could be a slow process, leading to situations in which the military personnel return by the time a replacement was hired and trained.

An Air Force MTF official stated that during exercises, they have difficulty staffing their clinic because their personnel were primarily active duty who were participating in the exercises. Readiness training exercises are scenario-driven,

[23] DoD Instruction 1400.25, Volume 1230, "DOD Civilian Personnel Management System: Employment in Foreign Areas and Employee Return Rights," July 26, 2012 (Incorporating Change 1, July 29, 2022).

large-scale training events necessary to prepare and assess military personnel's ability to respond during contingency operations. The Air Force official also stated that it was easier for Army facilities to remain open because they had a higher percentage of civilian personnel who did not participate in Service-related readiness exercises. A DHN Director stated that while the DHA and the Services acknowledged a need to increase the civilian workforce, an appropriation was needed to make the changes. Further, DHA personnel stated that while the DHA would like to cross-level civilians across the MTFs operated by different Services, it would require the Military Departments to agree with shifting military billets to offset the move of civilians by the DHA.

A DHN and MTF Director stated that MTF leaders were constantly balancing their readiness and health care delivery missions. The MTF Director stated that they had to make difficult decisions, such as determining whether to keep the MTF open and have personnel participate in the training exercises in shifts or to close the clinic so that all MTF personnel could participate in the training exercises together. The DHN Director stated that the senior leaders worked to minimize risks to the greatest extent possible, but sometimes they accepted a certain level of risk. The DHN Director stated that if a conflict existed between the two needs, they would honor the readiness mission and curtail the delivery of the benefit.

In August 2023, a GAO report recommended that the Secretary of Defense reevaluate the organizational approach for DHA's market-based management structure and use the conclusions from the reevaluation to study and validate workloads and personnel requirements.[24] The DoD expects to complete the study and validation of workloads and personnel requirements for its management structure in September 2026. Another GAO report issued in November 2018 examined how the DoD determined the composition of military, civilian, and contractor personnel working at their MTFs. The report included a recommendation that the Secretary of Defense ensure that the DHA Director develops a strategic total workforce plan to ensure the execution of an appropriate workforce composition at its MTFs.[25]

As of March 2025, all recommendations from the November 2018 GAO report remained open. While the DHA establishes its workload, personnel requirements, and workforce plan, the DHA needs to ensure a workforce composition that allows OCONUS MTFs to adapt and respond to emerging crises, enable maximum participation in readiness exercises, and deliver high quality, timely health care

[24] GAO-23-105441, "Defense Health Care: DoD Should Reevaluate Market Structure for Military Medical Treatment Facility Management," August 2023.

[25] GAO-19-102, Defense Health Care: Additional Assessments Needed to Better Ensure an Efficient Total Workforce, November 2018.

DHA needs to ensure a workforce composition that allows OCONUS MTFs to respond to emerging crises, enable maximum participation in readiness exercises, and deliver health care.

to DoD beneficiaries. Because the GAO already made recommendations to the DHA on determining a workforce plan with an appropriate workforce composition, we are not making a recommendation.

The DHA's Management of Access to Care Impacted Patients and MTF Personnel

As a result of the DHA's management of access to care at OCONUS MTFs, Service members and their families faced delays in access to care, which increased the risk for negative outcomes and preventable complications. Additionally, Service members and their beneficiaries experienced a decrease in satisfaction because they did not receive care when needed. Finally, MTF personnel were at risk of decreased readiness, had decreased morale, and experienced burnout.

Patients Experienced Delays in Care

Service members and their families encountered delays in access to care. According to the DHA NRT dashboard data, Service members and their families faced delays in access to care from February through July 2024, ranging on average from 1.2 days to 21.1 days for urgent appointments. Additionally, according to the DHA NRT dashboard data for the same timeframe, the TNAA metric for urgent appointments for the 15 MTFs in our sample showed that 14 MTFs (93 percent) consistently did not meet the urgent appointment standard.[26] Figure 8 shows the average number of days reported for the TNAA for urgent appointments (24HR) from February to July 2024 for the 15 OCONUS MTFs we sampled.

According to the DHA NRT dashboard data, Service members and their families faced delays in access to care from 1.2 days to 21.1 days for urgent appointments.

[26] We analyzed a 6-month period that the dashboards did not have DHA-reported system errors.

Figure 8. Average Number of Days to Obtain the Third Next Available Appointment for 24HR Appointments from February Through July 2024

<1 Third Next Available Appointment for 24HR (Target : <1.0 day)						
	FEB 2024	MAR 2024	APR 2024	MAY 2024	JUN 2024	JUL 2024
Landstuhl Regional Medical Center	6.8	2.5	5.1	2.8	3.5	1.9
86th Medical Group	19.5	18.7	12.3	14.9	13.8	2.1
52d Medical Group	2.8	4.0	4.1	5.3	5.5	2.6
U.S. Army Health Clinic Vilseck	10.3	6.4	10.5	7.5	6.4	2.2
Naval Hospital Naples	1.3	1.4	1.6	1.5	1.5	1.3
Naval Hospital Sigonella	2.0	2.0	1.2	13.0	1.4	0.7
673d Medical Group	2.9	3.3	1.4	2.6	7.8	4.5
374th Medical Group	5.5	7.5	6.0	17.1	18.4	2.8
51st Medical Group	2.8	2.3	2.5	4.2	3.8	1.2
Naval Hospital Yokosuka	2.3	2.0	2.2	7.0	2.7	1.4
Tripler Army Medical Center	1.6	1.6	1.3	1.9	2.4	2.2
Naval Health Clinic Hawaii	5.2	13.2	8.7	9.0	6.0	8.0
15th Medical Group	21.1	8.2	7.1	9.5	7.6	8.5
BG Crawford F. Sams Army Health Clinic	2.4	2.8	2.5	3.2	3.8	1.8
Brian D. Allgood Army Community Hospital	17.1	2.4	3.5	3.6	11.3	1.3

Note: The metrics reported are an average of all the parent MTFs' primary care clinics and their reporting of their children facilities. The averages are not weighted based on the number of appointments for each MTF or clinic.

Source: The DoD OIG.

Service members and their families also faced delays in access to care according to the DHA NRT dashboard data, from February through July 2024, ranging on average from 7.2 days to 36.8 days for future appointments. According to the DHA NRT dashboard data for the same timeframe, the TNAA metric for future appointments for the 15 MTFs in our sample showed that 8 MTFs (53 percent) consistently did not meet the future appointment standard of access within 7 days. See Figure 9 for the average number of days reported for the TNAA for future appointments from February through July 2024 for the 15 OCONUS MTFs we sampled.

Service members and their families also faced delays according to the DHA NRT dashboard data, from 7.2 days to 36.8 days for future appointments.

Figure 9. Average Number of Days to Obtain the Third Next Available Appointment for FTR Appointments from February Through July 2024

<7 Third Next Available Appointment for FTR (Target <7.0 days)						
	FEB 2024	MAR 2024	APR 2024	MAY 2024	JUN 2024	JUL 2024
Landstuhl Regional Medical Center	10.8	8.7	7.2	8.8	12.8	12.0
86th Medical Group	15.7	27.1	33.2	27.6	25.2	36.8
52d Medical Group	13.5	12	14.2	8.9	16.7	13.0
U.S. Army Health Clinic Vilseck	6.2	4.8	4.8	5.8	8.0	11.1
Naval Hospital Naples	3.7	4.5	6.2	7.4	7.9	12
Naval Hospital Sigonella	5.8	5.7	5.3	5.1	5.0	6.0
673d Medical Group	20.7	21.2	19.3	18.3	22.6	24.3
374th Medical Group	8.3	12.2	12.5	13.8	9.3	10.6
51st Medical Group	5.6	4.6	3.5	6.7	7.2	5.8
Naval Hospital Yokosuka	6.8	6.9	8.5	12.3	10.6	14.0
Tripler Army Medical Center	6.7	8.8	7.4	11.0	12.0	14.2
Naval Health Clinic Hawaii	9.9	10.5	15.2	13.8	12.3	11.8
15th Medical Group	9.6	18.3	17.6	13.2	15.4	9.6
BG Crawford F. Sams Army Health Clinic	4.4	6.8	8.4	12.7	12.1	9.6
Brian D. Allgood Army Community Hospital	13.7	8.6	12.5	14.0	14.9	11.7

Note: The metrics reported are an average of all the parent MTFs' primary care clinics and their reporting of their children facilities. The averages are not weighted based on the number of appointments for each MTF or clinic.

Source: The DoD OIG.

Service members and their families had an increased risk for negative outcomes because of DHA's management of staffing at OCONUS MTFs, affecting access to care. For example, one option for patients to obtain access to care was through messaging their providers. However, MTF personnel stated that the workload to review patient messages was extensive and required many hours, which impacted access for follow-up care. MTF personnel stated that the clinics were not always fully staffed, particularly in nursing, and that nurses received and triaged patient messages. MTF personnel stated they had difficulty managing the volumes of messages they received from the online patient portal, and sometimes messages could be missed, putting patient safety at risk. For example, at one clinic, providers did not see a prescription refill message in the online portal, and the patient did not follow up with another request to refill their medicine. According to MTF personnel, the patient did not take their antidepressant medication for 2 to 3 weeks, which caused the patient distress. At another MTF, personnel stated that they had shortages in medical technicians, which led to canceled ultrasound appointments, and this impacted access to care because patients could not proceed to the next step for medical care, leading to an increased risk of preventable complications.

Patients Experienced a Decrease in Satisfaction

Service members and their beneficiaries experienced a decrease in patient satisfaction based on the timeliness of their care. According to the patient advocate at one OCONUS MTF, the top trends for negative feedback they received included long wait times for the appointment call center, staff attitude and behavior, and extended wait times for access to care. An MTF Director of Quality and Safety and a patient advocate at the MTF reported observing an increase in workplace violence where patients have been verbally abusive towards clinic staff due to a lack of access or long wait times.

The top trends for negative feedback included long wait times for the appointment call center, staff attitude and behavior, and extended wait times for access to care.

Between March and July 2024, personnel at one MTF stated that they received 186 submissions through the Interactive Customer Evaluations, with 60 percent of beneficiaries reporting that they were dissatisfied and at least 50 percent reporting that they had to wait too long when scheduling or obtaining appointments. A GPM at another MTF stated that they typically receive responses to their Joint Outpatient Experience Surveys only when patients experience something problematic. For example, Joint Outpatient Experience Survey data showed a large decrease in patient satisfaction in April 2024 where patients were not able to see their provider when needed, which the GPM stated was during their permanent change of station season when the clinic had a provider turnover rate of 86 percent.

MTF Personnel Experienced Burnout, Decreased Morale, and Risks to Readiness

Because the DHA did not sufficiently staff the MTFs to provide adequate access to care, MTF personnel experienced burnout, had decreased morale, and were at risk of decreased readiness. MTF officials stated that because of staffing shortages, providers often assumed the workload of the support staff, impacting their morale and creating burnout, and making it difficult for them to meet the 100 appointments per week requirement.

According to the providers, they did not have the appropriate number of support staff to function efficiently but were expected to complete the number of DHA-established daily appointments. Providers also stated that they worked into their lunch breaks and worked after the clinic closed to enter patient notes into their electronic health record, further impacting their morale and causing burnout.

Military personnel assigned to the MTFs expressed concerns that they were at risk for decreased readiness because their clinics focused on meeting the access to care measures and productivity required by the DHA rather than the operational readiness mission. Mass casualty exercises are important to evaluate the readiness of the MTF personnel to respond to mass casualty events. DHA guidance prohibits the MTFs from closing clinics for more than 3 consecutive days to ensure access to care.[27] MTF officials stated that the staff did not perform readiness exercises together, although an official stated that it would be beneficial to have everyone participate because there are a lot of critical individual tasks that every Service member should be proficient to perform. Further, MTF personnel expressed concerns for patient safety when providers worked extended shifts to cover both clinical and readiness requirements. In Figure 10, Airmen from the 51st Medical Group at Osan Air Base decontaminated a simulated patient during a mass casualty training event.

MTFs expressed concerns that they were at risk for decreased readiness because their clinics focused on meeting the access to care measures and productivity required by the DHA.

Figure 10. Osan Airmen Decontaminate a Patient During a Mass Casualty Training Event
Source: The U.S. Air Force.

[27] 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 Medical Treatment Facilities (MTFs)," February 4, 2020.

Some MTF commanders closed their MTFs to conduct readiness training against DHA's policy and accepted this calculated risk to support their combat mission. This risk is also supported by an Air Force Medical Command memorandum that states in order to support Service members, leaders must ensure medics have necessary training to maintain wartime medical skills and that maintaining "ready medics" includes the cost of reduced clinical productivity and access to care.[28] Additionally, the memorandum acknowledged that while access to care was an important peacetime mission, the wartime mission was priority and leadership should understand that impacts to access will occur because of required training.

While DHN Directors worked to balance the requirements for readiness and health care, personnel from multiple MTFs stated that they did not believe senior leadership at the DHA fully understood the operational mission and needs of OCONUS MTFs. One MTF provider who had multiple combat deployments stated that a DHA leader told him that providers could get the deployable medical skills that they needed for war at the MTF clinic because most of the patient requirements for the previous 20 years were disease non-battle injuries. However, the provider stated that while this was true for previous wars, providers needed readiness time to train and retain trauma and critical care skills for future conflicts.

Conclusion

Personnel at the OCONUS MTFs operated inconsistently using different access to care guidance, spent significant time researching and resolving or developing workarounds for inaccurate or unreliable data within the DHA access to care dashboards, and did not have sufficient staff to meet the access to primary care standards. This negatively impacted Service members and their families in receiving timely and satisfactory care, as well as MTF staff productivity, morale, and readiness. Improving the DHA's management of the OCONUS MTFs in meeting access to care standards will help ensure it meets the National Defense Strategy to support the health, safety, and welfare of Service members and their families.

[28] Air Force Medical Command memorandum, "Family Medicine (44F) Comprehensive Medical Readiness Program Checklist Implementation Guidance," August 12, 2024.

Recommendations, Management Comments, and Our Response

Recommendation 1

We recommend that the Defense Health Agency Director:

a. Finalize and implement guidance that establishes the Defense Health Agency's expectations and roles and responsibilities for access to care, incorporating the Defense Health Agency's new structure and positions and updated practices. If the Defense Health Agency cannot finalize and implement guidance within 90 days of the final report, then it should issue formal interim guidance to the military medical treatment facilities to establish access to care requirements until the Defense Health Agency implements the finalized guidance.

Defense Health Agency Acting Deputy Director Comments

The DHA Acting Deputy Director, responding for the DHA Director, agreed with the recommendation, stating that the DHA concurs.

Our Response

Although the Acting Deputy Director agreed, the comments did not provide specific actions to address the recommendation. Therefore, the recommendation is unresolved. We request that the Acting Deputy Director describe the actions that the DHA plans to take to finalize guidance.

b. Perform a comprehensive analysis to determine consistent themes across military medical treatment facilities' concerns with the reliability, accuracy, and completeness of data used to monitor and remediate issues with the access to care metrics.

Defense Health Agency Acting Deputy Director Comments

The DHA Acting Deputy Director, responding for the DHA Director, agreed with the recommendation, stating that the DHA concurs.

Our Response

Although the Acting Deputy Director agreed, the comments did not provide specific actions to address the recommendation. Therefore, the recommendation is unresolved. We request that the Acting Deputy Director describe the actions that the DHA plans to take to analyze and remediate concerns with the access to care metrics.

c. Designate a centralized location accessible to the defense health networks and military medical treatment facilities personnel that communicate whether data issues are widespread or localized, and the status of resolution.

Defense Health Agency Acting Deputy Director Comments

The DHA Acting Deputy Director, responding for the DHA Director, agreed with the recommendation, stating that the DHA concurs.

Our Response

Although the Acting Deputy Director agreed, the comments did not provide specific actions to address the recommendation. Therefore, the recommendation is unresolved. We request that the Acting Deputy Director describe the actions that the DHA plans to take to designate a centralized location that communicates data issues and resolution status.

d. Develop and implement a remediation plan to prioritize and fix data issues with the Defense Health Agency Near Real Time dashboard data on access to care.

Defense Health Agency Acting Deputy Director Comments

The DHA Acting Deputy Director, responding for the DHA Director, agreed with the recommendation, stating that the DHA concurs.

Our Response

Although the Acting Deputy Director agreed, the comments did not provide specific actions to address the recommendation. Therefore, the recommendation is unresolved. We request that the Acting Deputy Director describe the actions that the DHA plans to take to prioritize and fix data issues with access to care.

e. Develop and implement a standardized process that collects data identifying why military medical treatment facility personnel left their position.

Defense Health Agency Acting Deputy Director Comments

The DHA Acting Deputy Director, responding for the DHA Director, agreed with the recommendation, stating that the DHA concurs.

Our Response

Although the Acting Deputy Director agreed, the comments did not provide specific actions to address the recommendation. Therefore, the recommendation is unresolved. We request that the Acting Deputy Director describe the actions that the DHA plans to take to collect data that identifies why military medical treatment facility personnel left their position.

f. Develop and implement a process to analyze and track trends to ensure that the Defense Health Agency has mitigation strategies for common reasons that personnel leave the military medical treatment facilities.

Defense Health Agency Acting Deputy Director Comments

The DHA Acting Deputy Director, responding for the DHA Director, agreed with the recommendation, stating that the DHA concurs.

Our Response

Although the Acting Deputy Director agreed, the comments did not provide specific actions to address the recommendation. Therefore, the recommendation is unresolved. We request that the Acting Deputy Director describe the actions that the DHA plans to take to analyze and track trends for common reasons that personnel leave the military medical treatment facilities.

g. Perform a comprehensive review of the staffing at military medical treatment facilities outside the continental United States to ensure military medical treatment facilities are authorized the staffing necessary to support the primary care staffing models.

Defense Health Agency Acting Deputy Director Comments

The DHA Acting Deputy Director, responding for the DHA Director, agreed with the recommendation, stating that the DHA concurs.

Our Response

Although the Acting Deputy Director agreed, the comments did not provide specific actions to address the recommendation. Therefore, the recommendation is unresolved. We request that the Acting Deputy Director describe the actions that the DHA plans to take to complete a comprehensive review of staffing at military medical treatment facilities outside the continental United States to ensure military medical treatment facilities are authorized the staffing necessary to support the primary care staffing models.

h. Expand the provider deduction tool to include tracking of support staff availability to ensure a comprehensive picture of overall clinic availability in meeting access to care standards.

Defense Health Agency Acting Deputy Director Comments

The DHA Acting Deputy Director, responding for the DHA Director, partially agreed with the recommendation, stating that the DHA would track support staff availability in a tool that was complementary to the provider deduction tool.

Our Response

Although the Acting Deputy Director partially agreed, the comments addressed the specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation when we receive documentation of the tool that tracks support staff availability.

Recommendation 2

We recommend that the Defense Health Agency Director, in coordination with the Military Departments:

a. Conduct a workload analysis study in primary care to observe and measure the time that primary care providers spend on supporting the DHA health care and DoD readiness missions.

Defense Health Agency Acting Deputy Director Comments

The DHA Acting Deputy Director, responding for the DHA Director, disagreed with the recommendation, stating that a workload analysis would require substantial time and resources when data and tools were available to collect and understand readiness and health care delivery requirements. The Acting Deputy Director stated that the Defense Medical Human Resources System-internet reporting tool is the primary platform for measuring time spent on readiness and health care delivery and that the information is reported, trended, and analyzed within the reporting tool in the Financial Management Information System.

Our Response

Comments from the Acting Deputy Director did not address the specifics of the recommendation; therefore, the recommendation is unresolved. While we acknowledge that the Defense Medical Human Resources System-internet (DMHRSi) reporting tool captures clinical and readiness time for primary care providers, the Government Accountability Office made recommendations to the DHA in July 2025 on data quality issues with the timecard system, which remain open (GAO-25-106988, "Defense Health Care: Information Needed to Improve Monitoring

of Military Personnel Staffing at Medical Facilities," July 21, 2025). We ask that the Acting Deputy Director reconsider their position and provide comments in response to the final report on what actions the DHA plans to take to conduct a workload analysis, or to resolve the open GAO recommendations on DMHRSi.

b. Implement guidance to provide appropriate FTE deductions for collateral duties such as supporting the Exceptional Family Member Program.

Defense Health Agency Acting Deputy Director Comments

The DHA Acting Deputy Director, responding for the DHA Director, partially agreed with the recommendation, stating that EFMP deductions have not historically been included because these reviews are part of the primary care managers' responsibilities and that EFMP support resources are assumed to be in place for program management. The Acting Deputy Director stated that the DHA would assess the feasibility of this recommendation.

Our Response

Although the Acting Deputy Director partially agreed, the comments addressed the specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation when we receive documentation of the DHA's assessment for implementing guidance to provide appropriate FTE deductions for collateral duties, such as EFMP.

c. Develop and implement a plan to balance the workforce, considering the providers' reduced FTEs.

Defense Health Agency Acting Deputy Director Comments

The DHA Acting Deputy Director, responding for the DHA Director, agreed with the recommendation, stating that the DHA concurs.

Our Response

Although the Acting Deputy Director agreed, the comments did not provide specific actions to address the recommendation. Therefore, the recommendation is unresolved. We request that the Acting Deputy Director describe the actions that the DHA plans to take to balance the workforce, considering the providers' reduced FTEs.

Appendix

Scope and Methodology

We conducted this performance audit from April 2024 through August 2025 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.

To determine roles, responsibilities, and oversight as it pertains to the access to care program, we conducted site visits and interviewed personnel from the DHA headquarters, four of the six DHNs that oversee OCONUS MTFs, and 15 OCONUS MTFs. We selected a nonstatistical sample of 15 OCONUS MTFs based on a universe of 79 MTFs located OCONUS, including Hawaii and Alaska. We selected 14 of the 15 OCONUS MTFs based on their proximity to DHNs Indo-Pacific, Pacific Rim, Central, and Europe and added one OCONUS MTF in Alaska for geographical coverage.

Additionally, we chose a variety of MTFs representing each of the Military Services. All 15 MTFs in our sample were primary MTFs that reported data for subordinate MTFs as well. Table 3 shows the DHA entities that we interviewed, including divisions within the DHA headquarters, the DHNs, and their respective OCONUS MTFs.

Table 3. DHA Entities That We Interviewed

DHA Headquarters
• Health Care Operations • Resources and Personnel Integration • Analytics and Evaluation Division
DHN Indo-Pacific
• Tripler Army Medical Center (Honolulu, Hawaii) • 15th Medical Group (Joint Base Pearl Harbor-Hickam, Hawaii) • Naval Health Clinic Hawaii (Pearl Harbor, Hawaii) • Brian D. Allgood Army Community Hospital (U.S. Army Garrison Humphreys, South Korea) • BG Crawford F. Sams Army Health Clinic (Camp Zama, Japan)
DHN Pacific Rim
• Naval Hospital Yokosuka (Yokosuka, Japan)
DHN Central
• 673d Medical Group (Joint Base Elmendorf-Richardson, Alaska) • 51st Medical Group (Osan Air Base, South Korea) • 374th Medical Group (Yokota Air Base, Japan)
DHN Europe
• Landstuhl Regional Medical Center (Landstuhl/Kirchberg, Germany) • 52d Medical Group (Spangdahlem Air Base, Germany) • Naval Hospital Sigonella (Catania, Sicily) • 86th Medical Group (Ramstein Air Base, Germany) • U.S. Army Health Clinic Vilseck (Rose Barracks, Germany) • Naval Hospital Naples (Naples, Italy)

Source: The DoD OIG.

Our review focused on access to care management and data during CY 2024, as well as follow-up we performed with the DHA and MTFs in January through May 2025, to identify any updated DHA initiatives. For staffing assist requests, we used data from 2023 because the 2024 data had only 5 months of complete data at the time of our site visit.

To determine whether the DHA effectively managed OCONUS MTFs in meeting the access to primary care standards, we met with officials to understand DHA's management of the access to care program. We conducted site visits to understand the guidance, training, and resources (such as funds and staffing) provided by the DHA that impacted the MTFs ability to meet access to care standards.

We determined the systems used to monitor and track access to care metrics. We also obtained an understanding of the data used by DHA and MTF personnel when calculating access to care. We discussed challenges in meeting access to care standards and any strategies to remediate access to care at the MTFs.

To determine whether MTFs were meeting access to care standards, we reviewed access to care data reported on the DHA NRT dashboard. Specifically, we reviewed access to care reports and metrics with 6 months of data from February through July 2024. We analyzed TNAA measures for primary care for 24HR and FTR appointment types to summarize whether the 15 OCONUS MTFs in our sample met access to care standards. We interviewed personnel in access to care management functions, such as DHN Directors, MTF Directors, GPMs, access template managers, access maintenance managers, and resource managers. Finally, we reviewed MTF access to care reports, briefings, provider templates, statements of operation, training schedules, personnel trackers, and the provider deduction tool.

To determine Federal, DoD, and DHA requirements and policy over access to care and the management of direct care, we reviewed the following guidance.

- Title 32 Code of Federal Regulations section 199.17
- Assistant Secretary of Defense for Health Affairs Policy 11-005, "TRICARE Policy for Access to Care," February 23, 2011
- DoD Directive 5136.13, "Defense Health Agency," September 30, 2013 (Incorporating Change 2, September 12, 2023)
- 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 Medical Treatment Facilities," February 4, 2020
- DHA 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 to Support an Integrated Health Care System," January 30, 2018
- DHA Procedural Instruction 6025.11, "Processes and Standards for Primary Care Empanelment and Capacity in Medical Treatment Facilities," October 9, 2018
- DHA Memorandum, "Access to Care Eligibility and Priorities for Care in Overseas Military Medical Treatment Facilities and Appointment Capacity Standards," October 6, 2022
- Draft versions of DHA Procedures Manual 6025.15/XX, "Standard Processes and Procedures for Optimizing Healthcare within the Military Health System (MHS)"

To determine DoD and DHA requirements over workload and staffing as it relates to access to care, we reviewed the following guidance.

- Office of the Under Secretary of Defense for Personnel and Readiness Directive-type Memorandum 24-003, "Military Health System Manpower Requirements Determination, Resourcing, and Assignment," June 28, 2024
- DoD Instruction 1100.22, "Policy and Procedures for Determining Workforce Mix," April 12, 2010 (Incorporating Change 1, December 1, 2017)
- DoD Instruction 1315.18, "Procedures for Military Personnel Assignments," October 28, 2015 (Incorporating Change 3, June 24, 2019)
- DoD Instruction 1400.25, Volume 250, "DoD Civilian Personnel Management System: Civilian Strategic Human Capital Planning (SHCP)," June 7, 2016
- DHA Procedural Instruction 1100.01, "Guidance for Manpower Program," May 16, 2019
- DHA Memorandum, "New Standardized Deductions for Primary Care, Specialty Care, Graduate Medical Education, Graduate Health Education, and Inpatient Care," March 25, 2022

Internal Control Assessment and Compliance

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. In particular, we assessed the internal control components and underlying principles related to the control environment, control activities, and information and communication. The assessment included the establishment of access to care guidance, the use of quality data when analyzing access to care, and staffing managed by the DHA to meet access to care standards. However, because our review was limited to these internal control components and underlying principles, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

Use of Computer-Processed Data

We used computer-processed data to perform this audit. Specifically, we used computer-processed data from the Integrated Manpower and Personnel Resourcing Tool in FMIS, the Defense Medical Human Resources System internet, and the DHA's NRT Dashboard. To assess the reliability of the data we obtained corroborating testimonial evidence from MTF staff, MTF-level reports from multiple systems (such as HealtheAnalytics and FMIS), and interviewed subject matter experts about their quality control procedures and the technical methodologies for calculated data. We determined the data to be sufficient to support our overall findings, conclusions, and recommendations to improve DHA's management of the access to care program.

Prior Coverage

During the last 7 years, the DoD Office of Inspector General (DoD OIG) issued three reports, and the Government Accountability Office (GAO) issued four reports discussing areas related to the management of access to care at the DHA.

Unrestricted DoD OIG reports can be accessed at http://www.dodig.mil/reports.html/. Unrestricted GAO reports can be accessed at http://www.gao.gov.

DoD OIG

Report No. DODIG-2024-033, "Management Advisory: Concerns with Access to Care and Staffing Shortages in the Military Health System," November 29, 2023

> The DoD OIG summarized challenges with beneficiary access to health care overseas, such as the unavailability of some specialty care services. Other significant challenges associated with civilians using off-base medical care, included language barriers, differences in how medical care is provided overseas compared to the United States, and the lack of availability for some U.S. prescription medications.

Report No. DODIG-2020-112, "Evaluation of Access to Mental Health Care in the Department of Defense," August 10, 2020

> The DoD OIG determined that the DoD did not consistently meet outpatient mental health access to care standards because the DHA did not have an MHS-wide model to identify appropriate levels of staffing and published inconsistent and unclear access to mental health care policies.

Report No. DODIG-2018-111, "Access to Care at Selected Military Treatment Facilities," May 1, 2018

> The DoD OIG determined that the DoD did not consistently meet the access to care standards at three Air Force MTFs 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; did not pay comparable salaries for civilian nursing personnel; and did not have authority to direct Air Force medical personnel.

GAO

Report No. GAO-25-107453, "Civilian Workforce: DoD is Implementing Actions to Address Challenges with Accessing Health Care in Japan and Guam," April 2025

The GAO addressed how often DoD-affiliated civilians and families access health care at military medical facilities in Japan and Guam, the challenges these individuals face accessing health care through local providers in Japan and Guam, and the extent DoD addressed any challenges.

Report No. GAO-23-105441, "Defense Health Care: DoD Should Reevaluate Market Structure for Military Medical Treatment Facility Management," August 2023

The GAO addressed the transition of MTFs to the DHA and highlighted ongoing support from the Military Departments for certain functions. The GAO also described challenges DHA faced in staffing MTFs, including shortfalls in military medical personnel due to deployments and reassignments.

Report No. GAO-20-371, "Additional Information and Monitoring Needed to Better Position DoD for Restructuring Medical Treatment Facilities," May 2020

The GAO addressed DoD's methodology to determine MTF restructuring actions in its implementation plan and found that the DoD based part of its methodology on incomplete and inaccurate information, along with limited assessments of MTFs support to the readiness of military primary care and nonphysician medical providers.

Report No. GAO-19-102, "Defense Health Care: Additional Assessments Needed to Better Ensure an Efficient Total Workforce," November 2018

The GAO addressed workforce challenges within the DoD's Military Health System, highlighting the impact of hiring freezes and lengthy contracting processes to staff MTFs. The report described how the military branches primarily rely on military personnel and that the DoD has not assessed the suitability of federal civilians and contractors to meet operational medical personnel requirements.

Management Comments

Defense Health Agency

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

MEMORANDUM FOR THE DEPARTMENT OF DEFENSE INSPECTOR GENERAL

SUBJECT: Response to Department of Defense Office of Inspection General Draft Report, "Audit of the Defense Health Agency's Management of DoD Medical Treatment Facilities Outside the Continental United States in Meeting Access to Primary Care Standards" (Project Number: D2024-D000AW-0110.000)

The Defense Health Agency (DHA) response to the Department of Defense Inspector General draft report, project number D2024-D000AW-0110.000, is attached. The DHA concurs with eight of the recommendations, partially concurs with two, and non-concurs with one.

The DHA would be remiss to not raise to your attention a few points as it relates to the report itself:

1) The report indicates that the head of a military medical treatment facility is a commander or commanding officer, with respect to its operations. However, that term is imprecise. Section 713 in the National Defense Authorization Act for Fiscal Year 2018 modified section 1073c(a) of Title 10, U.S. Code, such that the head of the military medical treatment facility (MTF) is a "military commander or director." Within DoD Directive 5136.13, *Defense Health Agency*, September 30, 2013, as amended, DoD policy identifies that the dual-hatted individual, when performing duties and functions associated with MTF operations, including the delivery of clinical/health care services and MTF business operations is doing so as a director. Thus, throughout this audit, it should reflect that it's the MTF director's role, vice commander. This is an important distinction.

2) The report refers to MTFs as "medical treatment facilities." However, section 1073c of Title 10, U.S. Code, identifies them as "military medical treatment facilities."

My point of contact is [redacted], Chief, Healthcare Optimization Division, who can be reached at [redacted] or [redacted].

[redacted]
Glendon B. Diehl, PhD
Acting Deputy Director

Attachment:
As stated

Defense Health Agency (cont'd)

DEFENSE HEALTH AGENCY RESPONSE
TO
DEPARTMENT OF DEFENSE OFFICE OF THE INSPECTOR GENERAL
DRAFT REPORT DATED AUGUST 19, 2025
PROJECT NO. D2024-D000AW-0110.000

Audit of the Defense Health Agency's Management of DoD Medical Treatment Facilities Outside the Continental United States in Meeting Access to Primary Care Standards

RECOMMENDATION 1: We recommend that the Defense Health Agency (DHA) Director:

1a: Finalize and implement guidance that establishes the DHA expectations and roles and responsibilities for access to care, incorporating the DHA new structure and positions and updated practices. If the DHA cannot finalize and implement guidance within 90 days of the final report, then it should issue formal interim guidance to the military medical treatment facilities (MTF) to establish access to care requirements until the DHA implements the finalized guidance.

DHA RESPONSE: Concur.

1b: Perform a comprehensive analysis to determine consistent themes across MTF concerns with the reliability, accuracy, and completeness of data used to monitor and remediate issues with the access to care metrics.

DHA RESPONSE: Concur.

1c: Designate a centralized location accessible to the Defense Health Networks (DHN) and MTF personnel that communicate whether data issues are widespread or localized, and the status of resolution.

DHA RESPONSE: Concur.

1d: Develop and implement a remediation plan to prioritize and fix data issues with the DHA Near Real Time (NRT) dashboard data on access to care.

DHA RESPONSE: Concur.

1e: Develop and implement a standardized process that collects data identifying why MTF personnel left their position.

DHA RESPONSE: Concur.

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1f: Develop and implement a process to analyze and track trends to ensure that the DHA has mitigation strategies for common reasons that personnel leave the MTF.

DHA RESPONSE: Concur.

1g: Perform a comprehensive review of the staffing at MTF outside the continental United States to ensure MTF are authorized the staffing necessary to support the primary care staffing models.

DHA RESPONSE: Concur.

1h: Expand the provider deduction tool to include tracking of support staff availability to ensure a comprehensive picture of overall clinic availability in meeting access to care standards.

DHA RESPONSE: Partially concur. DHA will track support staff availability in a tool that is complementary to the Provider Deduction Tool (PDT).

RECOMMENDATION 2: We recommend that the DHA Director, in coordination with the Military Departments:

2a: Conduct a workload analysis study in primary care to observe and measure the time that primary care providers spend on supporting the DHA healthcare and DoD readiness missions.

DHA RESPONSE: Non-concur. A workload analysis would require substantial time and resources when data and tools are already available to collect and understand readiness and healthcare delivery requirements. The Defense Medical Human Resources System-internet (DMHRSi) reporting tool is the primary platform for measuring time spent in readiness and healthcare delivery. This information is reported, trended, and analyzed within the DMHRSi reporting tool in the Financial Management Information System.

2b: Implement guidance to provide appropriate Full Time Equivalent (FTE) deductions for collateral duties such as supporting the Exceptional Family Member Program (EFMP).

DHA RESPONSE: Partially Concur. EFMP deductions have not historically been included because records reviews/documentation are part of primary care managers' responsibilities, and assumed EFMP support resources are in place for program management. DHA leadership will assess the feasibility of this recommendation.

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2c: Develop and implement a plan to balance the workforce, considering the providers' reduced FTEs.

DHA RESPONSE: Concur.

Acronyms and Abbreviations

BG	Brigadier General
CONUS	Continental United States
DHA	Defense Health Agency
DHN	Defense Health Network
EFMP	Exceptional Family Member Program
FMIS	Financial Management Information System
FTE	Full Time Equivalent
GPM	Group Practice Manager
MTF	Military Medical Treatment Facility
MHS	Military Health System
NRT	Near Real Time
OCONUS	Outside the Continental United States
PCMH	Patient Centered Medical Home
TNAA	Third Next Available Appointment


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