OFFICE OF THE UNDER SECRETARY OF DEFENSE
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PERSONNEL AND
READINESS

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

JUN 12 2024

Dear Mr. Chairman:

The Department's response to House Report 118–125, pages 211-212, accompanying H.R. 2670, the National Defense Authorization Act for Fiscal Year (FY) 2024, "Report on TRICARE Delays," is enclosed. The report addresses four key areas related to access to care for TRICARE Prime beneficiaries over the last three FYs (FYs 2021-2023). It encompasses access metrics within military medical treatment facilities and the private sector, coordination of patient care services, referral processes to civilian providers, and mechanisms for considering patient feedback.

Thank you for your continued strong support for the health and well-being of our Service members, veterans, and their families.

Sincerely,

[redacted]

Ashish S. Vazirani
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

[redacted]

Report to the Committee on Armed Services of the House of Representatives

Report on TRICARE Delays

June 2024

The estimated cost of this report or study for the Department of Defense is approximately $1,712.00 for the 2024 Fiscal Year. This includes $0 in expenses and $1,712.00 in DoD labor.
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SUMMARY

This report is in response to House Report 118–125, pages 211-212, accompanying H.R. 2670, the National Defense Authorization Act for Fiscal Year (FY) 2024, "Report on "TRICARE Delays." The report addresses four key areas related to access to care for TRICARE Prime beneficiaries over the last three FYs (FYs 2021-2023). It encompasses access metrics within military medical treatment facilities (MTFs) and the private sector, coordination of patient care services, referral processes to civilian providers, and mechanisms for considering patient feedback. Data reveals an average wait time for urgent/acute care at 1.6 days, routine care at 14.4 days, and specialty care at 14.4 days. Access to primary care managers (PCMs) or designees via telephone or virtual means averaged 7.6 days. The Managed Care Support Contractors (MCSCs) report average days between referral authorization and service date, with urgent/acute care in the West Region at 2 days and the East Region at 10 days. Routine and specialty care averages vary, with longer wait times noted for both types of care across regions. TRICARE offers a Case Management program accessible to all beneficiaries, focusing on identifying care needs and coordinating appropriate services. No significant changes are proposed for the current system, but a new care coordination pilot project launched in April 2024 to enhance patient care transitions and healthcare delivery. The referral process, guided by TRICARE Operations Manual (TOM) 6010.59-M, involves a structured approach to managing referrals from MTFs to network providers. A potential area for improvement includes revising the Right of First Refusal (ROFR) process to expedite referrals to civilian providers and possibly enhance access to care. The Defense Health Agency (DHA) actively solicits and reviews patient feedback through various channels, including surveys such as the Joint Outpatient Experience Survey (JOES) and the TRICARE Overseas Program Patient Satisfaction Surveys. Insights from these feedback mechanisms are utilized to inform service improvements and address access to care issues.

The Department is providing the requested metrics and information herein.

DISCUSSION

SECTION 1: AN ACCOUNTING OF ACCESS TO CARE METRICS FOR THE LAST THREE FISCAL YEARS FOR BENEFICIARIES ENROLLED IN TRICARE PRIME

Access to Care Metrics for Beneficiaries Enrolled in TRICARE Prime

Direct Care (MTFs):

DHA measures access to care by calculating the average time from appointment booking to the actual appointment for beneficiaries. For TRICARE Prime beneficiaries seeking the following types of care from MTFs in FYs 2021-2023, Table 1 indicates the average, maximum and median of wait time for urgent/acute, routine (non-emergency) and specialty care:

Table 1. Wait Time Given in Number of Days

Type of Care	Average	Maximum	Median
Urgent/Acute Care	1.6	6.1	1.4
Routine Care	14.4	21.3	13.3
Specialty Care	14.4	12.8	12.7

Access to PCMs or designees by telephone or virtual means have an average wait of 7.6 days with a maximum of 18.1 days and a median of 7.5.

Appendix A displays the average, maximum, minimum, and median days to care for all beneficiaries across DHA by MTF for FY 2021-2023. These data are displayed using DHA standard appointment types for primary care, including 24HR appointments (acute care), appointments in the future (FTR) (routine or follow-up care), and virtual (VIRT) appointments (virtual care).

Appendix B displays the average, maximum, minimum, and median days to care for all beneficiaries across DHA, by MTF, for FY 2021-2023. These data are displayed using DHA standard appointment types for specialty care, FTR appointments (routine/non-emergency care or follow-up care) and specialty (SPEC) appointments (specialty care appointments).

Private Sector Care (Network)

The MCSCs are not required to schedule appointments in the network, and beneficiaries make their own appointments. As a result, the MCSCs do not have visibility of when a beneficiary attempts to make an appointment or of any factors that impact the date of an appointment. DHA can provide: 1) data on the date a referral is authorized; and 2) the beneficiary's actual date of service (based on a claim received). Table 2 below indicates the average, maximum and median days between authorization of referrals and date of service.

Table 2. Days between Authorization of Referral and Date of Service

West Region

Type of Care	Average	Maximum	Median
Urgent/Acute Care	2	363	1
Routine Care	34	364	21
Specialty Care	26	364	20

East Region (HGB)

Type of Care	Average	Maximum	Median
Urgent/Acute Care	10	184	4
Routine Care	24	189	14
Specialty Care	23	189	13

This data can be used as a proxy for trending purposes; however, it is only valid for confirming that when days to care is at or less than the standard of 28 days for specialty care and 7 days for routine/non-emergency care, the MCSCs met access to care standards. Lacking visibility on appointing, the MCSCs do not know if factors such as beneficiary scheduling choices or selection of a specific provider may have contributed to an appointment exceeding access to care standards.

TRICARE's 2017 (T-2017) contracts do not require the MCSCs to report on PCMs who provide services by telephone or virtual means. However, DHA may be able to request a one-time report from each MCSC on the number of providers who offer telephonic or telehealth (virtual means). Ongoing reporting would require a modification to the contracts. Given the variances in host nation private sector availability, the TRICARE Overseas Program (TOP) contractor is not contractually required to meet TRICARE Access to Care (ATC) standards. Instead, the TOP contractor is required to make its best effort to ensure the TRICARE standards for access, in terms of beneficiary travel time, appointment wait time, and office wait time, are met.

The TOP contractor is not required to schedule appointments in the network, and beneficiaries make their own appointments (the TOP contractor provides assistance on request). As a result, the TOP contractor does not have visibility of when a beneficiary attempts to make an appointment or of any factors that impact the date of an appointment. DHA can provide: 1) data on the date a referral is authorized; and 2) the beneficiary's actual date of service (based on a claim received). This data can be used as a proxy for trending purposes; however, it is only valid for confirming TOP contractor met ATC standards on a best effort basis. Lacking visibility on appointing, the TOP contractor does not know if factors such as beneficiary scheduling choices or selection of a specific provider may have contributed to an appointment exceeding access to care standards.

There is not a mechanism by which office wait times for non-emergency circumstances are tracked. Tracking office wait times in the overseas private sector is not logistically feasible. There is a grievance process by which beneficiaries can express dissatisfaction with inordinate office wait time.

The TOP contract does not use private sector PCMs in Prime locations (except for Puerto Rico). With respect to Puerto Rico, the TOP contract does not contain a requirement stipulating that the TOP contractor report on PCMs who provide services by telephone or virtual means on a routine basis.

SECTION 2: OUTLINE OF PATIENT CARE COORDINATION SERVICES OFFERED TO THOSE ENROLLED IN TRICARE

All TRICARE beneficiaries have access to the MCSCs Case Management (CM) program. Beneficiaries can be referred or self-refer to the CM program through the MCSCs portal. Care coordination is provided as one component of the CM program. The case manager collaborates with the beneficiary or family to identify specific needs or potential gaps in care. The case manager then coordinates care based on those needs and/or gaps.

Access to the appropriate providers is an integral part of ensuring the beneficiary receives the necessary care. The case manager will work with the beneficiary and their primary care provider to identify specialists in each area or if needed, tertiary care centers providing specialized care, such as transplants or gene therapy for rare diseases.

The MCSCs also have specialized programs within their CM programs. The beneficiaries enrolled in these specialized programs receive help from their case manager to identify providers and assist with arranging appointments during family transitions, such as permanent change of station moves. The case manager will contact the needed provider to assess for available appointments, coordinate with the family to secure an appointment in their new location. These activities help to prevent interruptions in treatment.

MCSCs provide case management to beneficiaries with both medical and behavioral health needs. Behavioral health case managers also work closely with beneficiaries and their providers to identify necessary subspecialties or specific treatment protocols. The case manager will assist the beneficiary in locating providers that may specialize in certain forms of therapy or areas such as eating disorders or trauma. Additionally, they will assist the beneficiary in contacting the provider to establish care if necessary. These steps all enhance access to care by helping to locate specific providers, working with the beneficiary and or the primary care provider and specialist to establish care.

Currently no changes have been recommended as no deficiencies have been identified with the current contract. With the start of the T-5 contract, we will be incorporating new requirements based on industry standards and lessons learned. At the start of healthcare delivery with T-5, the MCSCs shall ensure care coordination programs and services are available for the duration of the contract for both medical and behavioral health conditions and services. The MCSCs shall utilize a multidisciplinary team approach to address the unique needs of each beneficiary.

DHA initiated a pilot project in April 2024 focusing on patient care coordination. This initiative focuses on implementing seamless care coordination processes between direct care and private sector care to enhance the patient experience and facilitate healthcare delivery. Coordination pilot sites will test the ability of data-driven and patient-centered solutions to resolve gaps in care and facilitate referrals and appoint through the implementation of a transparent system for patient movement, as well as support clinical information exchange between the direct and private sector care components of the Military Health System (MHS). Pilot sites will focus on hematology/oncology, behavioral health, obstetrics and gynecology, and medical subspecialties, per the DHA Assistant Director for Health Care Administration's and Director, DHA's guidance. Services provided to patients will include, but not be limited to:

1. Assist patients by booking MTF specialty care appointments based on Referral Management guidance and patient availability.

2. Communicate with patients, once a referral is authorized, to determine the support needed to manage their referral(s).

3. Liaise with TRICARE MCSCs to address authorization issues as needed.

4. Liaise with MTF's product line leads to identify MTF capacity and fill vacant appointments.

SECTION 3: A DESCRIPTION OF BUSINESS RULES FOR REFERRALS TO CIVILIAN PROVIDERS AND ADHERENCE TO THESE GUIDELINES, POTENTIAL OPTIONS FOR INCREASING REFERRALS TO CIVILIAN PROVIDERS TO IMPROVE ACCESS TO CARE, AND THE FEASIBILITY OF THESE MEASURES

The policy TOM 6010.59-M provides comprehensive guidance on the referral and authorization processes within the TRICARE system. It details the procedures for referrals from MTFs to contractors, the use of the MHS GENESIS for managing these referrals, and the specifics of urgent care referrals. Additionally, it covers the requirements for preauthorization and authorizations, including the roles of contractors in reviewing requests to ensure compliance with TRICARE benefits and standards.

All specialty referrals are reviewed and dispositioned by the Integrated Referral Management Center and Appointing Center (IRMAC). IRMAC maintains capability and capacity reports for all specialty clinics that are updated monthly. IRMAC personnel review the access to care in the MTF. If a specialty care appointment is not available within 28 days, the referral is deferred to TRICARE for private sector care authorization. IRMAC personnel review PSC access to care in the TRICARE MCSCs online portal to determine if access can be provided sooner.

MTFs providers submit a referral through Military Health System Referral Management system in MHS GENESIS, the DoD's electronic health record. The narrative descriptions of the referral are translated into standard diagnosis and procedure codes. The referral is reviewed for benefit coverage and medical necessity. The MCSC then chooses the most appropriate provider/specialty outlined in the memorandum of understanding (MOU) between the MCSC and the MTFs:

- MTF (via ROFR process (the process for direct care to recapture care when a referral is sent from a civilian provider to the contractor)) or network provider within access standards.

- Non-network if network provider not available within access standards.

- Closest network or non-network provider outside of access, but within 100 miles.

- Closest network or non-network provider outside 100 miles.

- The only exception will be for continuity of care. Continuity of care is operationally defined as follow-on care from a specific specialist as part of a specific procedure or service that was performed within the previous 6 months.

- Out of Region when the care requested is of such a special nature that it cannot be rendered within the region and medical necessity warrants the care. This is expected to occur rarely.

The MCSC will advise the beneficiary, referring MTF/Defense Health Networks, and receiving provider of all approved referrals.

Adherence to Guidelines

Failure to follow the business rules that are outlined in the TOM and in the MOU would result in multiple missed performance standards and metrics that are evaluated by the Government monthly and are reported in the Performance Analysis and Reporting tool. The Government employs TRICARE Health Plan Referral Management subject matter experts that continually monitor and provide oversight of the MCSCs to ensure they meet the standard and follow the current contract requirements.

Potential Options for Increasing Referrals to Civilian Providers

There is a possible option to increase referrals to the network by modifying the current ROFR process. The current ROFR process is when a MCSC refers a beneficiary to a MTF first, the acceptance or deferment of the referral is based on the MTFs capability and capacity for certain specialties. The MTF has the right to take the referral or refuse it. If they refuse it, then the referral is deferred to a network provider. Decreasing ROFRs acceptance at MTFs, would increase overall referrals to civilian providers in the network. Removing the ROFR step would allow the MCSC to utilize their entire directory to assign a provider reducing time to seek care and potentially improving access to care.

Feasibility of these Measures

Changing the ROFR process would involve a contract modification and would greatly reduce MTF patient workload for its providers, the consequence would be a decrease in MTF provider's military readiness.

SECTION 4: A DESCRIPTION OF HOW DHA REVIEWS AND CONSIDERS PATIENT FEEDBACK OR CONCERNS ON ACCESS TO CARE THAT ARE COLLECTED THROUGH PATIENT SATISFACTION SURVEYS, CUSTOMER SERVICE STAFF, OR OTHER METHODS

The MHS listens to feedback from beneficiaries through multiple channels, including responses to surveys, in-person interactions, and community engagements. DHA continues conducting research and leveraging feedback channels to better understand patient needs and expectations – translating insights into actionable service recovery, program improvements, better care, and improved outcomes.

The goal of MHS outpatient surveys is to monitor and report on the experience and satisfaction of MHS beneficiaries who have received outpatient care in an MTF or civilian

provider office. FY 2023 marks the seventh complete year that the JOES has been fielded to replace the Army Provider Level Satisfaction Survey (APLSS), the Navy Patient Satisfaction Survey (PSS), and the Air Force Service Delivery Assessment (SDA).

The JOES- Consumer Assessment of Healthcare Providers and Systems (CAHPS) or JOES-C is a companion survey to the JOES, measuring outpatient care at military and private sector facilities. Beginning in FY 2016, the JOES-C is based on the Agency for Healthcare Research and Quality CAHPS Clinician & Group Survey, as was the predecessor to the JOES-C: the TRICARE Outpatient Satisfaction Survey. This allows MHS comparison to civilian benchmarks, as well as MHS beneficiary ratings across direct and private sector care facilities.

Approximately 306,000 JOES/JOES-C were returned during FY 2023, including 241,000 JOES and 65,000 JOES-C, providing targeted areas for improvement in outpatient care for MHS beneficiaries. The JOES and JOES-C have improved in efficiency and representation, demonstrated through the collection of web-based surveys by active duty Service members in FY 2019 in response to e-mailed invitations. In FY 2020, a pilot program began to send the JOES via text message to beneficiaries at select MTFs and continued to expand to additional MTFs in 2022. A text was sent to consenting beneficiaries with a link to complete the JOES online. Early analyses found response rates were higher for text message recipients and the data was comparable to mail and e-mail survey responses.

Additionally, more surveys are now being completed by active duty Service members stationed overseas, providing invaluable feedback on their care. The results of the JOES and JOES-C measures are published to the JOES/JOES-C reporting website that allows users to examine the quality of care across the MHS. Some of these measures are routinely reported to senior MHS leadership as core measures on various dashboards and are reported publicly on the transparency website of www.health.mil.

Results from the MHS population survey, the Health Care Survey of DoD Beneficiaries (HCSDB), are also included in the findings reported, where appropriate, as a comparison against outpatient surveys that are administered following receipt of care. The HCSDB, based on the CAHPS Health Plan Survey, is administered quarterly to a sample of the eligible MHS population, irrespective of where they might have received care and uses a 12-month recall period for most questions (i.e., “In the last 12 months...”). Both the HCSDB and CAHPS Health Plan Surveys focus on the performance of the health plan over time from the beneficiary’s perspective. The JOES-C is focused on health care received over the past 6 months following a specific outpatient visit, while the JOES pertains solely to a specifically referenced visit. The comparison of these surveys provides a more comprehensive understanding of the experiences of beneficiaries, regardless of the survey that they are completing or the care that they may or may not have received.

Historically, the measure of Getting Care When Needed has been a common question on the outpatient surveys across each of the Services (APLSS, PSS, SDA) and DHA (TRICARE Inpatient Satisfaction Survey, JOES, JOES-C, HCSDB) since FY 2012. This question allows a patient to provide feedback on his or her ability to access care after care has been received.

In addition to tracking patient access to care using administrative and provider-centric data, the inclusion of patient self-reported information provides a more complete user assessment of the performance of the health care system. The ability to see a doctor reflects one measure of successful access to the health care system. Prime enrollees were asked whether they had at least one outpatient visit during the past year.

The Healthcare Integration Board, which is organized under the flag-level Executive Management Board, evaluates changes in access and other performance across the MHS and identifies MTFs not meeting standards or goals, which would then be addressed by the Defense Health Networks or DHA.

TRICARE Overseas Program Patient Satisfaction Surveys

The TOP contractor also collects Patient Reported Experience Measures (PREMs). PREMs are validated questionnaires that gather information regarding the views of patients and families concerning the care they received. These questionnaires are often used to measure the quality of care. Compared to patient-reported outcome measures, PREMs do not look at the outcome of care received but instead at how the process of receiving care impacted the patient's experience at the facility. Some qualities that can affect this include communication from doctors and timeliness of assistance.

The customer service operation for the TOP Contractor collects and utilizes beneficiary feedback collected by their customer service staff. Modes of customer service communication include beneficiary calls to the Beneficiary Support Center call center as well as calls to their Regional Call Centers. Additional information is obtained via their website, chat function on their web app, social media, and correspondence (routine, priority, grievance, congressional).

When the TOP Contractor receives beneficiary inquiries regarding ATC issues, the goal is first call/contact resolution. Customer service agents use their respective Network Provider Directories to locate providers that can render care needed within ATC standards, including drive time and wait time for an appointment. When this is not possible, outreach is necessary.

The TOP Contractor captures and reviews feedback, concerns, and complaints regarding ATC and identified issues are followed up on by customer service agents. Most inquiries are case-by-case; however, when an ATC trend is identified within a certain specialty or area, an escalation is sent to the provider network management teams. When necessary, corrective action plans (CAPs) for network inadequacies are reviewed and addressed.

The TOP Contractor also identifies beneficiary ATC concerns via routine and priority correspondence, grievances, and congressional correspondence. ATC issues are addressed by the grievance/priority correspondence teams, comprised of staff who specialize in addressing beneficiary outreach that requires a higher-level response. These are generally the same staff who address congressional correspondence.

The TRICARE Overseas Program Office (TOPO) also monitors grievances to include some that are submitted by patients. In addition to reviewing the grievances for timeliness of the

response, the TOPO staff review the accuracy of the information provided to the beneficiary and look for any trends in the data. TOPO also reviews and responds to all DHA and congressional inquiries regarding care overseas and audit 1000 customer service calls annually to ensure first call resolution, as well as accuracy and completeness of the response.

MCSCs Customer Service Staff

The customer service operations for the TRICARE East and West region contractors varies slightly in how they collect and utilize beneficiary feedback collected by customer service staff. Given that TRICARE contracts are performance based, operational details not specified by contractor data requirement lists may differ. Modes of customer service communication include beneficiary calls to the MCSC call centers, website, online chat, secure email, social media, and correspondence (routine, priority, grievance, congressional).

When the MCSCs receive beneficiary inquiries regarding ATC issues, the goal is first call/contact resolution. Customer service agents use their respective Network Provider Directories to locate providers that can render care needed within ATC standards, including drive time and wait time for an appointment. When this is not possible, outreach is necessary.

Both MCSCs capture and review feedback, concerns, and complaints regarding ATC and identified issues are followed up on by customer service agents. Most inquiries are case-by-case; however, when an ATC trend is identified within a certain specialty or area, an escalation is sent to the MCSC provider network management teams. If a trend is observed for a particular provider, MCSCs engage with the provider office and remind them of TRICARE ATC standards (listed in provider handbooks, webinars, and newsletters/bulletins). MCSCs also recruit providers new to a Prime Service Area to determine interest in joining the TRICARE provider network. When necessary, CAPs for network inadequacies are reviewed and addressed.

MCSCs also identify beneficiary ATC concerns via routine and priority correspondence, grievances, and congressional correspondence. ATC issues are addressed by the grievance/priority correspondence MCSC teams, comprised of staff who specialize in addressing beneficiary outreach that requires a higher-level response. These are generally the same staff who address congressional correspondence received by the MCSCs.

CONCLUSION

In summary, DHA utilizes a range of metrics to evaluate access to care for TRICARE Prime beneficiaries, with average wait times for various types of care appointments reported for FYs 2021-2023. DHA acknowledges the need for effective resource allocation and the ongoing challenges in adhering to ATC standards, particularly for network and overseas appointments. Various appointment types are offered within primary and specialty care settings to meet patient demands, including urgent, routine, follow-up, group, procedure-based, virtual, and video visits. Although DHA does not track office wait times, it encourages patient feedback through surveys to improve service quality. MCSCs and the TOP have limited visibility over appointment scheduling and wait times as beneficiaries arrange their own appointments, relying on referral authorization dates and actual service dates as proxy metrics. Presently, DHA has initiated its

new care coordination pilot project, which is expected to assist beneficiaries significantly in securing needed healthcare in a timely fashion. Finally, to ensure standards are met on a best effort basis, DHA actively reviews and considers patient feedback on access to care from various sources.

APPENDIX A: Average Days to Primary Care FYs 2021-2023

Primary Care Appointment Types

Primary care appointments, typically lasting 20 minutes, can vary from 10 to 60 minutes to meet demand. The types include:

1. 24HR: 24HR appointments are used when the patient wants or needs to be seen within 24 hours. These are not solely for acute and urgent medical issues.

2. FTR: FTR appointments are used for follow-up care, wellness care, or when the patient requests care beyond 24 hours in the future.

3. Group (GRP): The GRP appointment type will be used for patients who require follow-up of a similar condition/chronic disease, therapy, counseling, or teaching sessions where a provider will perform the service in a group setting.

4. Procedures (PROC): PROC appointment types are used for procedures delivered in a clinic setting.

5. VIRT: VIRT will be used when clinically appropriate based on the provider's judgment and when agreed upon by the patient.

6. Video Visit: Video visits will be used when clinically appropriate based on the provider's judgment and when agreed upon by the patient.

7. SPEC: SPEC appointment types can be used in Pediatrics and Internal Medicine when a lengthier evaluation is needed beyond that of typical primary care.

Well-patient and preventive care are reflected in the Primary Care access to care appointment types. Clinics balance appointment types within provider schedules to optimize patient demand and make available appointments for well-patient and preventative screenings. DHA currently does not track office wait times. However, patients are encouraged to report satisfaction to include timeliness via the JOES. Patients may request to see a different provider on the patient's team or, if desired, be rescheduled for a more convenient time.

Clinics mix appointment types to meet patient needs and provide well-patient and preventive care. DHA does not track office wait times but invites patients to share their experiences through surveys.

FY 2021 - FY 2023 Primary Care ATC												
MTF	24HR Appointments				FTR Appointments				VIRT Appointments			
	Avg	Max	Min	Med	Avg	Max	Min	Med	Avg	Max	Min	Med
10th MEDGRP-ACADEMY	2.5	1.9	0.2	0.5	12.5	16.3	0.2	13.4	4.9	8.0	2.8	5.0
14th MEDGRP-COLUMBUS	0.7	9.0	0.9	2.9	7.8	11.5	0.9	7.5	4.3	6.8	2.4	4.3
15th MEDGRP JBHP-HICKAM	3.4	1.4	0.2	0.6	17.8	29.3	0.2	18.7	10.7	19.8	0.0	9.0
17th MEDGRP-GOODFELLOW	0.7	5.3	0.5	1.5	8.0	14.9	0.5	7.3	1.8	3.3	1.0	1.8
18th MEDGRP-KADENA	1.4	3.1	0.2	1.3	17.0	25.1	0.2	18.2	-	-	-	-
19th MEDGRP-LITTLE ROCK	1.3	9.3	1.0	5.8	17.4	30.9	1.0	16.3	6.5	9.7	5.0	6.5
1st SPCL OPS MED-HURLBURT	5.9	8.0	0.7	1.6	15.9	24.0	0.7	14.3	6.7	12.3	3.8	6.9
20th MEDGRP-SHAW	2.5	2.3	0.5	1.2	18.6	33.5	0.5	17.6	13.6	20.4	6.8	11.8
21st MEDGRP-PETERSON	1.2	1.4	0.3	0.6	14.6	23.9	0.3	13.9	7.7	10.4	5.4	7.8
22nd MEDGRP-MCCONNELL	0.7	6.8	0.5	1.2	12.3	26.5	0.5	11.0	8.4	11.4	5.6	8.6
23rd MEDGRP-MOODY	1.4	12.1	0.7	3.0	13.7	19.4	0.7	13.1	4.5	6.4	2.1	4.5
27th SPCLOPS MDGRP-CANNON	4.1	5.8	0.4	2.5	21.0	37.7	0.4	19.9	18.1	35.0	4.7	18.2
28th MEDGRP-ELLSWORTH	2.5	7.9	0.4	1.2	12.0	17.1	0.4	11.6	6.6	10.6	3.7	5.9
2nd MEDGRP-BARKSDALE	2.1	4.3	1.0	1.4	13.1	20.4	1.0	13.8	13.9	23.7	7.3	13.6
30th MEDGRP-VANDENBERG	1.8	3.4	0.7	1.1	11.6	15.1	0.7	11.5	4.8	9.9	2.3	4.1
316th MEDGRP-MALCOLM GROW	1.3	5.0	0.1	1.5	13.1	21.7	0.1	13.1	17.1	18.5	15.5	16.9
319th MEDGRP-GRAND FORKS	1.6	3.6	0.4	1.1	11.3	22.6	0.4	10.7	6.1	12.6	1.4	5.7
31st MEDGRP-AVIANO	0.9	2.8	0.3	0.6	11.4	15.6	0.3	10.9	-	-	-	-
325th MEDGRP-TYNDALL	0.7	7.2	0.3	1.3	10.0	13.7	0.3	9.4	5.1	8.0	2.8	4.6
341st MEDGRP-MALMSTROM	1.2	5.5	0.7	1.4	14.6	26.8	0.7	13.5	8.2	20.6	1.8	6.9
354th MEDGRP-EIELSON	1.5	5.8	0.7	2.2	12.0	18.3	0.7	12.2	7.5	23.6	0.0	5.0
355th MEDGRP-DAVIS-MONTHAN	2.5	13.0	0.5	2.3	14.7	24.8	0.5	13.3	11.2	17.2	0.9	10.5
35th MEDGRP-MISAWA	2.5	7.1	0.5	1.9	12.7	16.8	0.5	12.7	-	-	-	-
366th MEDGRP-MOUNTAIN HOME	1.8	5.1	0.7	1.1	16.0	24.9	0.7	15.6	7.3	12.4	2.7	7.0
36th MEDGRP-ANDERSEN	1.5	5.0	0.2	1.2	10.6	14.5	0.2	10.1	-	-	-	-
374th MEDGRP-YOKOTA	1.5	3.3	0.5	1.3	17.5	28.4	0.5	18.3	-	-	-	-
375th MEDGRP-SCOTT	1.5	4.1	0.6	1.8	17.3	23.9	0.6	17.6	11.6	13.3	10.0	10.4
377th MEDGRP-KIRTLAND	1.9	0.9	0.1	0.3	16.8	24.2	0.1	16.7	8.4	14.5	5.5	7.9
39th MEDGRP-INCIRLIK	0.3	1.9	0.2	1.2	7.3	12.1	0.2	6.8	-	-	-	-
412th MEDGRP-EDWARDS	1.3	13.9	0.6	2.7	13.3	25.7	0.6	12.3	6.2	10.1	3.5	5.9
42nd MEDGRP-MAXWELL	3.8	5.9	0.5	1.3	15.4	30.3	0.5	14.5	5.4	7.8	3.8	5.5
436th MEDGRP-DOVER	1.4	8.5	0.7	1.3	15.9	29.0	0.7	15.8	17.5	27.0	7.6	17.8

45th MEDGRP-PATRICK	1.9	5.8	0.7	1.7	11.1	22.9	0.7	11.2	4.2	7.3	1.9	3.1
460th MEDGRP-BUCKLEY	1.8	2.5	0.3	0.7	11.1	20.9	0.3	10.5	7.9	14.9	4.7	7.9
47th MEDGRP-LAUGHLIN	0.8	4.7	0.6	1.5	10.0	15.1	0.6	9.3	3.5	10.2	1.6	3.2
48th MEDGRP-LAKENHEATH	1.8	5.9	0.3	1.5	21.3	27.8	0.3	20.2	-	-	-	-
49th MEDGRP-HOLLOMAN	1.7	3.5	0.4	1.1	18.2	34.3	0.4	18.4	10.9	28.5	5.1	9.9
4th MEDGRP-SEYMOUR JOHNSON	1.3	9.7	0.4	1.7	15.0	28.6	0.4	13.9	8.8	19.0	4.8	7.6
509th MEDGRP-WHITEMAN	2.5	2.6	0.5	1.0	13.5	18.7	0.5	13.5	6.7	12.4	2.6	6.0
51st MEDGRP-OSAN	1.1	1.7	0.4	0.8	12.2	17.0	0.4	12.1	-	-	-	-
52nd MEDGRP-SPANGDAHLEM	0.9	15.5	0.7	1.5	11.8	16.5	0.7	12.0	-	-	-	-
55th MEDGRP-OFFUTT	1.7	3.0	0.4	1.2	13.8	85.5	0.4	13.6	5.2	9.4	2.8	4.5
56th MEDGRP-LUKE	1.1	12.8	1.0	3.2	15.4	20.1	1.0	15.1	7.1	12.6	0.8	7.0
59th MDW-WHASC-LACKLAND	2.9	5.2	0.5	3.2	17.1	27.8	0.5	17.4	8.8	13.4	6.1	8.7
5th MEDGRP-MINOT	2.9	6.1	0.8	2.3	14.5	20.6	0.8	14.0	5.7	9.2	3.3	5.4
60th MEDGRP-TRAVIS	2.4	24.9	0.0	1.2	16.0	21.8	0.0	16.1	8.2	13.7	4.6	8.0
61st MED SQ-LOS ANGELES	1.5	6.9	0.2	0.4	13.9	18.8	0.2	13.1	5.8	11.0	2.5	5.9
628th MEDGRP-CHARLESTON	1.5	4.7	0.6	1.1	12.3	25.9	0.6	11.2	13.4	22.0	7.0	13.1
633rd MEDGRP JB-LANGLEY	1.3	4.7	0.4	1.3	16.6	26.7	0.4	15.6	12.3	13.6	7.9	12.3
66th MEDSQ-HANSCOM	1.4	3.6	1.3	2.1	11.9	34.0	1.3	11.2	8.3	16.8	5.5	6.7
673rd MEDGRP JBER-ELMENDORF	2.2	2.5	0.7	1.5	15.8	27.0	0.7	15.1	7.2	10.4	2.3	7.0
6th MEDGRP-MACDILL	1.3	2.6	0.4	0.8	12.6	18.4	0.4	12.1	7.2	8.3	3.3	7.3
71st MEDGRP-VANCE	1.0	8.3	0.2	0.9	12.4	19.7	0.2	11.1	5.9	11.2	1.6	5.7
72nd MEDGRP-TINKER	1.4	2.3	0.5	1.2	12.8	23.1	0.5	12.0	6.4	9.9	2.9	5.7
75th MEDGRP-HILL	1.1	2.1	0.5	0.8	10.4	20.3	0.5	9.9	5.5	9.0	3.5	5.1
78th MEDGRP-ROBINS	0.9	5.3	0.1	1.4	11.9	16.2	0.1	11.4	15.5	18.8	11.4	15.6
7th MEDGRP-DYESS	1.7	2.5	0.4	0.8	13.9	20.5	0.4	14.5	5.3	8.3	2.6	5.0
81st MEDGRP-KEESLER	1.0	2.6	0.2	0.4	15.1	26.9	0.2	14.5	6.0	10.1	2.1	6.0
82nd MEDGRP-SHEPPARD	0.6	3.2	0.6	0.9	13.4	30.5	0.6	11.8	3.7	4.6	2.9	3.5
86th MEDGRP-RAMSTEIN	1.3	3.6	0.3	0.9	14.7	26.9	0.3	12.1	-	-	-	-
87th MDGRP-MCGUIRE-DIX-LAKHRST	1.3	3.3	0.5	0.7	11.2	24.0	0.5	9.9	6.9	11.7	3.4	7.0
88th MEDGRP-WRIGHT-PAT	0.9	6.0	0.4	1.9	14.6	20.2	0.4	14.3	6.2	6.5	5.8	6.2
8th MEDGRP-KUNSAN	2.1	7.6	0.9	2.2	13.2	24.4	0.9	12.7	-	-	-	-
90th MEDGRP-FE WARREN	2.8	3.4	0.3	1.0	12.7	17.0	0.3	12.5	5.6	10.0	2.4	5.5
92nd MEDGRP-FAIRCHILD	1.0	13.0	0.8	2.0	18.6	26.5	0.8	18.2	4.8	12.2	2.1	4.2
96th MEDGRP-EGLIN	3.2	2.2	0.2	0.6	14.5	25.2	0.2	13.5	7.3	9.0	4.4	7.4
97th MEDGRP-ALTUS	0.8	6.9	0.4	3.6	13.3	18.7	0.4	13.2	7.7	14.1	3.7	6.0
99th MEDGRP-NELLIS	3.5	6.0	0.7	2.4	14.6	19.0	0.7	14.6	5.4	8.7	3.9	5.2
9th MEDGRP-BEALE	2.2	3.3	0.3	1.1	11.8	18.6	0.3	11.7	5.5	12.0	1.2	6.0

ACH BASSETT-WAINWRIGHT	1.1	1.2	0.4	0.8	15.8	21.2	0.4	16.2	7.5	10.5	4.8	7.6
ACH BAYNE-JONES-FT JOHNSON	0.8	2.7	0.7	1.1	12.8	16.7	0.7	12.6	5.5	6.8	3.8	5.5
ACH BLANCHFIELD-FT CAMPBELL	1.1	2.0	0.6	1.0	14.9	24.9	0.6	14.9	8.2	9.7	7.2	7.8
ACH BRIAN D ALLGOOD-PYEONGTAEK	1.0	2.2	0.6	1.0	13.0	16.1	0.6	13.0	-	-	-	-
ACH EVANS-CARSON	1.1	11.4	1.5	6.4	16.0	22.7	1.5	16.4	7.6	11.8	1.1	8.0
ACH IRWIN-RILEY	6.1	2.5	0.4	0.6	14.9	24.2	0.4	15.7	6.5	10.1	4.3	5.6
ACH KELLER-WEST POINT	0.7	2.9	0.2	0.5	13.4	19.3	0.2	13.3	8.5	12.0	5.1	8.1
ACH LEONARD WOOD	0.7	4.0	0.0	1.0	11.9	19.0	0.0	11.6	5.2	10.8	2.8	5.1
ACH MARTIN-FT MOORE	1.1	3.1	0.5	1.2	12.6	18.8	0.5	12.3	5.9	9.0	4.5	5.8
ACH WEED-IRWIN	1.2	3.3	0.8	1.3	13.3	19.4	0.8	12.5	5.3	12.0	2.1	5.4
ACH WINN-FT STEWART	1.6	0.6	0.3	0.4	13.9	22.7	0.3	14.4	2.9	4.9	2.0	2.9
AHC BG CRAWFORD SAMS-CAMP ZAMA	0.4	1.7	0.0	0.2	10.9	16.8	0.0	10.5	-	-	-	-
AHC FOX-REDSTONE ARSENAL	0.6	2.1	0.2	0.5	19.3	24.6	0.2	18.2	3.9	7.3	2.8	3.7
AHC GUTHRIE-DRUM	0.7	2.0	0.3	0.9	18.2	26.0	0.3	17.9	4.9	7.0	4.1	5.0
AHC IRELAND-KNOX	1.0	3.0	0.4	0.8	17.1	26.1	0.4	16.7	9.1	9.7	7.9	9.4
AHC KENNER-GREGG-ADAMS	0.9	2.7	0.3	1.4	12.7	22.5	0.3	13.2	8.2	11.3	6.2	7.9
AHC LYSTER-NOVOSEL	1.1	2.0	0.6	0.9	13.0	20.6	0.6	12.8	2.9	9.1	0.5	3.5
AHC MCDONALD-EUSTIS	1.0	7.9	1.4	3.4	12.6	19.0	1.4	12.7	7.2	9.2	4.6	8.1
AHC MONCRIEF-JACKSON	3.1	3.6	0.4	0.7	11.7	24.9	0.4	10.8	7.4	9.9	5.5	8.0
AHC MUNSON-LEAVENWORTH	1.0	6.7	0.2	0.6	16.2	31.5	0.2	17.7	6.4	9.8	3.8	6.4
AHC R W BLISS-HUACHUCA	1.4	8.3	0.5	1.6	14.3	26.3	0.5	13.1	6.2	11.5	1.5	5.6
AHC REYNOLDS-FT SILL	2.2	3.5	0.7	2.0	14.1	23.1	0.7	14.4	4.8	6.0	2.4	4.9
AMC BAMC-FSH	1.5	1.4	0.4	0.7	14.1	24.8	0.4	16.4	12.6	25.7	2.8	10.5
AMC DARNALL-FT CAVAZOS	0.8	3.0	0.5	1.3	13.6	16.9	0.5	13.3	6.6	10.5	4.0	6.3
AMC EISENHOWER-FT EISENHOWER	1.3	4.6	2.2	3.0	13.3	24.9	2.2	13.6	7.3	12.2	5.2	6.6
AMC MADIGAN-FT LEWIS	3.1	3.1	0.5	1.5	19.1	22.6	0.5	19.3	7.2	11.1	5.4	6.9
AMC TRIPLER-SHAFTER	1.6	4.7	0.8	1.6	14.0	25.4	0.8	13.9	4.1	5.5	0.4	4.3
AMC WILLIAM BEAUMONT-FT BLISS	2.0	2.9	0.7	1.7	14.6	22.4	0.7	13.8	6.9	8.3	5.8	6.8
AMC WOMACK-FT LIBERTY	1.5	2.0	0.8	1.1	16.9	25.1	0.8	17.6	9.0	13.2	6.9	8.5
BAVARIA MEDDAC-VILSECK	1.1	6.6	2.3	3.4	14.4	17.4	2.3	14.5	-	-	-	-
AT AUGUSTA MILITARY MED CENTER	1.1	3.6	1.6	2.6	17.2	28.5	1.6	16.1	10.5	11.9	9.0	10.3
FT MEADE MEDDAC	2.6	2.4	0.4	0.7	14.7	25.5	0.4	14.2	9.7	11.3	7.8	10.3
JAMES A LOVELL FHCC	0.8	2.7	0.7	1.4	8.9	13.0	0.7	8.0	-	-	-	-

LANDSTUHL REGIONAL MEDCEN	1.5	2.1	0.6	1.0	15.1	21.2	0.6	15.0	-	-	-	-
LS-62nd MED FLT-JBLM-MCHORD	1.1	1.8	0.5	1.0	7.5	10.6	0.5	7.1	3.4	7.3	2.2	3.6
NH BEAUFORT	1.0	3.6	0.6	1.1	9.8	15.6	0.6	9.1	3.8	5.1	2.1	4.2
NH BREMERTON	1.3	3.3	1.1	1.6	12.6	18.0	1.1	12.2	5.6	10.7	3.7	5.4
NH CAMP PENDLETON	1.7	4.1	0.5	0.8	9.8	13.3	0.5	9.2	3.6	5.0	2.2	3.6
NH GUAM-AGANA	1.3	7.4	0.5	1.0	15.2	19.5	0.5	15.0	-	-	-	-
NH GUANTANAMO BAY	1.4	5.2	0.5	0.8	9.3	15.9	0.5	9.9	-	-	-	-
NH JACKSONVILLE	1.4	0.8	0.3	0.4	15.7	22.4	0.3	16.0	7.0	8.7	2.9	7.3
NH NAPLES	0.4	1.5	0.4	0.7	12.6	16.2	0.4	12.1	-	-	-	-
NH OKINAWA	0.7	0.8	0.4	0.5	10.0	15.0	0.4	8.9	-	-	-	-
NH ROTA	0.5	0.9	0.3	0.4	10.2	14.3	0.3	9.9	-	-	-	-
NH SIGONELLA	0.5	2.0	0.5	1.0	8.2	12.3	0.5	7.9	-	-	-	-
NH TWENTYNINE PALMS	1.1	1.2	0.4	0.7	13.7	17.7	0.4	13.4	5.4	7.9	2.4	5.3
NH YOKOSUKA	0.7	2.1	0.3	0.8	12.2	15.2	0.3	11.8	-	-	-	-
NHC ANNAPOLIS	0.8	3.9	0.2	0.7	10.6	21.1	0.2	10.4	3.5	5.1	1.8	3.2
NHC CHARLESTON	1.0	3.3	0.3	0.9	10.7	16.7	0.3	10.3	2.7	6.7	1.4	2.1
NHC CHERRY POINT	1.0	7.6	0.5	1.0	12.2	22.2	0.5	11.1	4.7	9.4	2.3	5.0
NHC CORPUS CHRISTI	1.5	5.0	0.5	2.1	10.6	24.5	0.5	11.4	9.0	18.6	3.7	8.0
NHC HAWAII	2.0	4.6	0.4	2.0	14.5	21.4	0.4	15.7	9.7	15.3	0.3	9.1
NHC LEMOORE	2.2	2.8	0.4	0.8	10.4	14.5	0.4	10.0	6.2	9.2	3.5	6.8
NHC NEW ENGLAND	1.2	2.9	0.4	1.3	11.0	16.1	0.4	10.9	4.7	9.1	3.2	4.2
NHC OAK HARBOR	1.4	3.2	0.4	0.9	12.2	21.5	0.4	11.5	5.4	13.7	2.5	4.7
NHC PATUXENT RIVER	1.0	2.3	0.5	1.0	12.0	22.0	0.5	11.6	9.5	13.7	6.5	9.1
NHC PENSACOLA	0.9	4.4	0.6	1.4	11.9	17.0	0.6	12.3	5.5	10.0	2.3	5.6
NHC QUANTICO	1.5	5.4	0.6	1.6	13.8	25.2	0.6	13.4	17.2	23.7	6.3	17.6
NMC CAMP LEJEUNE	1.9	12.4	0.5	1.0	14.3	16.3	0.5	14.1	6.3	11.6	3.7	6.2
NMC PORTSMOUTH	1.6	3.3	0.1	1.9	15.0	24.3	0.1	15.1	14.9	20.8	7.6	13.6
NMC SAN DIEGO	2.0	5.4	1.4	2.8	15.9	23.3	1.4	15.7	4.8	7.5	2.9	4.7
WALTER REED NATL MIL MED CNTR	2.9	-	-	-	18.7	-	-	-	12.8	16.8	7.5	12.9

APPENDIX B: Average Days to Specialty Care FYs 2021-2023

Specialty care templates generally consist of SPEC and FTR appointments. Unlike Primary Care, there is no standard for using GRP and PROC within specialty care schedules and templates. MTFs must actively validate patient demand against SPEC, FTR, GRP, and PROC appointment offerings to ensure the appropriate appointment mix is offered to meet patient demand.

The following appointment types are authorized for use within Specialty Care settings:

1. 24HR: 24HR appointments are used for urgent specialty referrals from other clinics in the MTF or when acutely distressed patients present to the clinic as walk-ins, through messaging or via central appointing.

2. SPEC: SPEC appointments are reserved for a patient's first non-urgent specialty care appointment.

3. FTR: FTR appointments are used for routine or follow-up care for established patients after the first specialty care appointment.

4. GRP: The GRP appointment type will be used for patients who require therapy, counseling, or teaching sessions where a provider will perform the service in a group setting.

5. PROC: PROC appointment types are used for procedures delivered in a clinic setting.

6. VIRT: VIRT leveraged as the patient desires and as is clinically appropriate, to meet patient demand and reduce private sector deferrals.

FY 2021 – FY 2023 Specialty Care ATC								
MTF	FTR Appointments				SPEC Appointments			
	Avg	Max	Min	Med	Avg	Max	Min	Med
10th MEDGRP-ACADEMY	17.0	26.8	6.9	16.7	15.9	24.6	2.7	15.9
14th MEDGRP-COLUMBUS	10.3	16.7	6.5	9.8	7.4	10.9	4.5	7.0
15th MEDGRP JBHP-HICKAM	19.4	26.8	10.7	20.2	11.9	28.4	8.2	12.9
17th MEDGRP-GOODFELLOW	10.7	16.8	7.5	11.6	9.2	19.5	4.8	8.9
18th MEDGRP-KADENA	15.7	21.8	11.2	16.4	7.6	24.7	2.4	8.3
19th MEDGRP-LITTLE ROCK	12.5	21.1	8.0	13.3	9.5	19.7	3.4	15.2
1st SPCL OPS MED-HURLBURT	16.4	27.3	11.6	16.5	7.6	25.2	3.3	13.8
20th MEDGRP-SHAW	17.0	26.9	11.2	18.8	14.0	28.8	5.6	17.2
21st MEDGRP-PETERSON	20.8	26.4	14.4	21.4	12.6	21.2	7.4	14.0
22nd MEDGRP-MCCONNELL	16.6	23.9	11.4	16.6	12.9	23.5	7.9	13.1
23rd MEDGRP-MOODY	21.7	41.4	10.9	22.2	11.3	30.1	5.7	13.6

27th SPCLOPS MDGRP-CANNON	15.1	24.9	11.0	15.9	11.3	24.3	5.7	16.0
28th MEDGRP-ELLSWORTH	15.6	25.5	12.0	17.2	10.8	20.0	4.4	11.3
2nd MEDGRP-BARKSDALE	14.3	22.0	7.2	15.4	11.9	21.6	6.1	15.6
30th MEDGRP-VANDENBERG	14.9	19.8	8.3	14.9	13.4	34.2	5.5	13.9
316th MEDGRP-MALCOLM GROW	16.6	24.1	11.7	18.8	19.4	28.5	15.3	18.9
319th MEDGRP-GRAND FORKS	14.3	22.8	7.3	14.7	10.2	25.0	4.4	12.7
31st MEDGRP-AVIANO	16.6	23.8	8.8	18.2	10.6	17.5	7.2	11.5
325th MEDGRP-TYNDALL	13.6	21.3	9.3	13.9	10.9	25.9	5.4	9.3
341st MEDGRP-MALMSTROM	14.8	29.2	2.3	17.0	13.1	19.5	3.5	13.3
354th MEDGRP-EIELSON	15.7	22.3	1.7	16.6	18.1	39.5	2.7	17.7
355th MEDGRP-DAVIS-MONTHAN	14.1	17.5	2.7	14.6	13.0	18.6	2.8	13.5
35th MEDGRP-MISAWA	17.0	30.6	13.0	16.4	12.5	18.9	8.2	13.2
366th MEDGRP-MOUNTAIN HOME	16.2	22.0	11.9	16.3	12.2	18.3	5.6	12.1
36th MEDGRP-ANDERSEN	13.4	21.1	10.0	12.9	11.9	18.0	4.9	9.9
374th MEDGRP-YOKOTA	16.8	22.6	12.0	17.1	11.0	18.8	6.0	11.7
375th MEDGRP-SCOTT	17.3	25.4	11.8	17.4	12.4	23.1	7.1	15.4
377th MEDGRP-KIRTLAND	19.3	24.8	16.0	19.1	16.8	32.3	7.5	13.6
39th MEDGRP-INCIRLIK	9.2	15.9	4.8	9.1	7.4	15.7	3.7	8.2
412th MEDGRP-EDWARDS	19.9	34.6	8.5	18.6	13.9	26.7	6.2	14.2
42nd MEDGRP-MAXWELL	16.8	22.4	13.1	17.4	15.4	23.1	8.9	13.9
436th MEDGRP-DOVER	21.0	37.0	13.7	23.4	20.1	42.9	10.9	19.5
45th MEDGRP-PATRICK	15.1	21.2	10.9	14.9	8.9	25.8	5.5	8.6
460th MEDGRP-BUCKLEY	18.8	27.2	11.4	19.5	12.8	20.7	6.6	12.6
47th MEDGRP-LAUGHLIN	10.4	20.0	4.3	8.9	7.8	17.0	3.0	6.8
48th MEDGRP-LAKENHEATH	17.5	25.2	12.6	18.2	13.1	23.0	6.8	15.3
49th MEDGRP-HOLLOMAN	19.3	27.5	12.9	19.3	9.1	24.5	4.2	8.8
4th MEDGRP-SEYMOUR JOHNSON	13.1	19.4	7.5	13.4	7.4	18.8	4.6	7.8
509th MEDGRP-WHITEMAN	13.5	17.4	11.2	13.1	10.8	16.5	8.0	10.4
51st MEDGRP-OSAN	16.6	21.6	12.6	16.8	9.8	15.5	5.0	10.5
52nd MEDGRP-SPANGDAHLEM	15.0	21.5	11.2	15.5	10.5	14.2	6.9	10.6
55th MEDGRP-OFFUTT	17.0	51.1	13.1	17.7	16.3	42.6	10.1	17.5
56th MEDGRP-LUKE	14.6	22.5	3.9	14.4	14.5	20.3	2.9	14.4
59th MDW-WHASC-LACKLAND	19.3	30.4	12.1	20.2	13.9	22.8	9.6	14.3
5th MEDGRP-MINOT	12.8	19.0	8.9	14.3	15.0	34.8	4.8	21.8
60th MEDGRP-TRAVIS	20.0	27.6	16.3	20.0	15.5	19.2	11.6	15.6
61st MED SQ-LOS ANGELES	11.5	16.9	4.5	10.8	13.6	26.1	4.3	12.6
628th MEDGRP-CHARLESTON	13.5	19.8	4.0	14.0	8.6	13.4	5.3	8.2
633rd MEDGRP JB-LANGLEY	17.5	27.1	11.8	18.7	18.5	28.3	13.9	17.6
66th MEDSQ-HANSCOM	13.1	19.2	6.6	13.0	7.6	18.4	4.2	7.7
673rd MEDGRP JBER-ELMENDORF	18.3	27.7	0.8	19.1	15.7	23.8	0.0	15.3
6th MEDGRP-MACDILL	20.3	25.3	11.8	20.2	14.0	20.0	9.2	15.0

71st MEDGRP-VANCE	12.1	20.8	5.9	10.9	11.9	24.1	4.0	11.0
72nd MEDGRP-TINKER	19.1	24.6	13.8	18.8	14.1	23.7	7.6	13.5
75th MEDGRP-HILL	14.1	23.5	2.6	15.1	13.4	24.5	1.3	13.1
78th MEDGRP-ROBINS	16.7	23.4	10.6	17.0	12.9	18.1	6.2	12.7
7th MEDGRP-DYESS	16.5	21.1	9.4	16.8	9.3	24.7	3.4	9.6
81st MEDGRP-KEESLER	20.5	27.8	15.6	20.3	15.7	26.3	9.5	16.2
82nd MEDGRP-SHEPPARD	17.3	21.9	11.9	18.4	8.4	19.5	3.9	9.2
86th MEDGRP-RAMSTEIN	16.5	24.3	8.4	18.3	16.9	27.0	6.7	17.5
87th MDGRP-MCGUIRE-DIX-LAKHRST	19.3	28.7	10.4	20.5	14.9	24.9	10.0	13.7
88th MEDGRP-WRIGHT-PAT	22.5	25.9	19.3	22.8	10.5	17.0	5.1	11.1
8th MEDGRP-KUNSAN	13.1	17.9	8.9	12.9	11.7	17.2	4.6	10.3
90th MEDGRP-FE WARREN	16.5	21.6	12.2	16.4	13.5	24.7	8.1	13.5
92nd MEDGRP-FAIRCHILD	14.9	28.0	11.2	15.8	14.2	26.2	8.8	13.5
96th MEDGRP-EGLIN	16.3	23.5	13.1	16.3	14.9	18.6	10.9	14.7
97th MEDGRP-ALTUS	10.7	17.8	4.5	10.7	7.6	16.6	4.7	7.2
99th MEDGRP-NELLIS	21.5	26.7	11.0	23.1	17.3	23.6	10.6	17.2
9th MEDGRP-BEALE	15.6	22.3	9.8	16.4	16.2	23.5	9.3	15.5
ACH BASSETT-WAINWRIGHT	19.5	24.6	0.8	20.2	15.9	20.1	0.2	15.9
ACH BAYNE-JONES-FT JOHNSON	21.3	29.2	14.2	22.2	13.1	20.0	9.3	13.4
ACH BLANCHFIELD-FT CAMPBELL	17.5	20.7	14.8	18.0	12.7	14.8	11.2	12.8
ACH BRIAN D ALLGOOD-PYEONGTAEK	18.8	23.1	15.3	19.2	12.8	15.9	10.7	12.9
ACH EVANS-CARSON	20.6	26.8	4.4	21.9	17.8	22.7	3.8	18.5
ACH IRWIN-RILEY	16.1	18.5	12.0	16.0	14.6	21.8	9.4	13.6
ACH KELLER-WEST POINT	15.0	19.2	7.1	15.8	9.9	14.1	6.4	9.7
ACH LEONARD WOOD	19.4	23.2	14.3	19.7	13.1	20.0	6.8	13.3
ACH MARTIN-FT MOORE	17.9	20.9	9.1	18.0	10.8	14.6	6.7	10.3
ACH WEED-IRWIN	21.0	30.0	15.0	21.1	15.1	20.0	10.8	15.0
ACH WINN-FT STEWART	18.8	26.4	13.3	19.8	12.3	18.9	7.4	12.1
AHC BG CRAWFORD SAMS-CAMP ZAMA	13.6	17.0	9.4	13.5	12.2	19.8	7.0	11.4
AHC FOX-REDSTONE ARSENAL	17.4	23.0	13.6	18.1	14.2	20.2	7.9	14.4
AHC GUTHRIE-DRUM	21.5	26.9	15.3	22.7	14.3	21.1	10.6	13.9
AHC IRELAND-KNOX	21.1	28.5	14.0	22.1	14.2	20.2	8.8	14.8
AHC KENNER-GREGG-ADAMS	16.0	26.2	11.6	15.5	9.6	17.9	7.4	8.8
AHC LYSTER-NOVOSEL	18.8	25.3	13.0	19.5	8.2	13.5	5.8	8.9
AHC MCDONALD-EUSTIS	19.1	28.0	14.3	19.0	15.5	22.3	10.5	16.2
AHC MONCRIEF-JACKSON	19.0	23.5	12.7	19.3	13.1	16.8	8.4	13.0
AHC MUNSON-LEAVENWORTH	25.4	35.9	15.7	25.9	11.7	15.6	6.6	12.3
AHC R W BLISS-HUACHUCA	17.0	20.5	4.3	17.1	10.0	17.9	2.7	9.3
AHC REYNOLDS-FT SILL	16.3	22.2	12.5	16.4	10.1	14.4	7.5	9.5
AMC BAMC-FSH	22.1	31.4	12.5	23.1	17.9	28.0	11.7	17.6
AMC DARNALL-FT CAVAZOS	19.9	26.5	15.0	20.3	15.9	21.3	12.2	16.4

AMC EISENHOWER-FT EISENHOWER	19.1	29.8	14.5	17.8	15.8	43.5	11.8	15.2
AMC MADIGAN-FT LEWIS	22.1	27.5	17.2	22.9	17.6	23.9	14.0	17.0
AMC TRIPLER-SHAFTER	17.3	22.8	11.6	18.3	13.7	16.7	9.7	13.7
AMC WILLIAM BEAUMONT-FT BLISS	18.2	23.2	14.1	18.5	16.1	23.6	12.1	15.8
AMC WOMACK-FORT LIBERTY	17.8	24.2	13.7	18.4	14.5	23.3	10.8	14.1
BAVARIA MEDDAC-VILSECK	21.5	26.3	15.8	21.8	13.4	16.3	10.9	13.7
AT AUGUSTA MIL MED CENTER	23.5	27.9	15.9	25.0	18.8	24.0	14.5	18.8
FT MEADE MEDDAC	20.0	24.0	15.1	20.1	16.2	23.4	12.2	16.2
JAMES A LOVELL FHCC	14.8	17.9	10.8	15.3	8.6	13.4	4.8	9.6
LANDSTUHL REGIONAL MEDCEN	19.8	24.9	14.0	21.1	14.2	19.4	11.8	13.8
LS-62nd MED FLT-JBLM-MCHORD	-	-	-	-	-	-	-	-
NH BEAUFORT	16.2	20.6	10.6	16.9	10.4	14.1	7.7	10.5
NH BREMERTON	18.0	21.5	15.3	18.4	13.4	17.2	10.5	13.3
NH CAMP PENDLETON	15.3	23.6	8.6	16.4	14.6	20.2	6.0	14.0
NH GUAM-AGANA	14.0	18.4	11.9	13.9	12.3	16.4	9.5	11.8
NH GUANTANAMO BAY	14.7	19.3	10.7	14.3	10.8	14.6	7.8	10.6
NH JACKSONVILLE	19.5	25.5	15.0	20.2	14.4	19.6	11.9	14.4
NH NAPLES	17.0	21.3	13.7	17.2	11.9	14.8	8.7	11.4
NH OKINAWA	17.4	20.4	14.5	17.1	15.8	21.6	11.5	15.8
NH ROTA	17.8	23.2	11.9	18.1	11.9	14.6	9.1	12.1
NH SIGONELLA	14.2	17.5	11.8	14.3	10.5	13.5	6.0	10.6
NH TWENTYNINE PALMS	17.4	25.8	13.3	17.8	15.2	19.9	8.6	15.3
NH YOKOSUKA	16.3	22.6	11.3	17.1	12.2	14.2	10.1	12.2
NHC ANNAPOLIS	11.9	24.6	8.1	11.2	9.9	21.6	7.8	10.0
NHC CHARLESTON	24.7	36.5	14.7	26.5	13.5	22.4	8.8	12.2
NHC CHERRY POINT	17.8	25.4	12.0	18.2	12.3	17.7	8.1	12.2
NHC CORPUS CHRISTI	14.4	22.1	8.8	14.4	9.3	17.8	5.4	8.8
NHC HAWAII	21.5	33.7	15.0	20.0	14.0	20.6	10.0	15.8
NHC LEMOORE	16.0	25.4	10.8	19.5	13.1	19.3	6.5	13.1
NHC NEW ENGLAND	17.0	28.0	13.4	18.0	10.1	14.9	7.2	10.3
NHC OAK HARBOR	17.9	36.2	12.7	19.4	13.3	27.3	8.1	12.6
NHC PATUXENT RIVER	19.7	26.0	13.9	20.0	12.8	16.9	8.2	12.8
NHC PENSACOLA	15.9	26.1	11.8	16.6	11.3	19.4	8.8	11.9
NHC QUANTICO	21.6	32.3	11.2	21.5	9.1	14.0	5.7	9.0
NMC CAMP LEJEUNE	17.9	22.2	13.9	17.9	14.1	26.0	10.4	12.9
NMC PORTSMOUTH	21.9	25.4	13.8	22.2	16.6	22.6	12.4	16.4
NMC SAN DIEGO	21.0	30.9	0.2	21.3	17.0	25.7	0.0	17.1
WALTER REED NATL MIL MED CNTR	22.4	25.9	12.7	23.2	16.7	22.2	13.1	16.6