OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 22 2017

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

I am pleased to provide you with a follow-up to the Department of Defense's (DoD) Fiscal Year (FY) 2016 Evaluation of the TRICARE Program report to Congress. The original report, submitted April 6, 2016, responded to the requirements in section 717 of the National Defense Authorization Act (NDAA) for FY 1996 (Public Law 104–106), as amended by section 713 of the NDAA for FY 2016 (Public Law 114–92), which requires an assessment of information on the accreditation status, relevant policies and procedures, and data on patient safety, access to care and quality of care including data on appointment wait times and surgical and maternity outcomes, with respect to each military medical treatment facility (MTF). This follow-up report presents progress in Military Health System (MHS) performance management with respect to initiatives to assess and improve access, quality, and safety. Finally, this report presents the MHS strategy for public reporting on the MHS transparency website (www.health.mil) and the 2017 Evaluation of the TRICARE Program report to Congress, due March 1, 2017.

As noted in the FY 2016 report, the evaluation was expanded from prior year submissions to partially meet the requirements of section 713, within the limited time available to meet the legislated annual due date, and given the extensive amount of detail not previously required. The report addressed each of the requirements of section 713, by reporting an assessment of the data at the MHS enterprise level, but not with respect to each MTF worldwide. The report also presented our strategy for subsequently complying with section 713 in FY 2016, by complying with the requirements of section 712—publishing on a publically available Internet website (within 180 days of enactment of the NDAA) data at the MTF level pertaining to the accreditation status and findings, Service policies or procedures, and on patient safety, quality of care, satisfaction, and health outcomes. The Office of the Assistant Secretary of Defense for Health Affairs (ASD(HA)) public-facing Web portal went live on May 20, 2016, ahead of the section 712 required deadline.

The ASD(HA) portal at www.health.mil includes a hyperlink titled "MHS Transparency" (http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Patient-Portal-for-MHS-Quality-Patient-Safety-and-Access-Information), which leads visitors to an extensive menu to select "Patient Satisfaction and Access to Care," "Health Outcomes," "Patient Safety," or "Quality of Care." Within each of these sections, the visitor is offered further options to examine our assessment of the accreditation status of each MTF, and the data on each MTF over

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A similar letter has been sent to the President of the Senate, the Speaker of the House, and the other congressional defense committees. Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 22 2017

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

I am pleased to provide you with a follow-up to the Department of Defense's (DoD) Fiscal Year (FY) 2016 Evaluation of the TRICARE Program report to Congress. The original report, submitted April 6, 2016, responded to the requirements in section 717 of the National Defense Authorization Act (NDAA) for FY 1996 (Public Law 104–106), as amended by section 713 of the NDAA for FY 2016 (Public Law 114–92), which requires an assessment of information on the accreditation status, relevant policies and procedures, and data on patient safety, access to care and quality of care including data on appointment wait times and surgical and maternity outcomes, with respect to each military medical treatment facility (MTF). This follow-up report presents progress in Military Health System (MHS) performance management with respect to initiatives to assess and improve access, quality, and safety. Finally, this report presents the MHS strategy for public reporting on the MHS transparency website (www.health.mil) and the 2017 Evaluation of the TRICARE Program report to Congress, due March 1, 2017.

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Sincerely,

A. M. Kurta
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 22 2017

The Honorable Thad Cochran
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

I am pleased to provide you with a follow-up to the Department of Defense's (DoD) Fiscal Year (FY) 2016 Evaluation of the TRICARE Program report to Congress. The original report, submitted April 6, 2016, responded to the requirements in section 717 of the National Defense Authorization Act (NDAA) for FY 1996 (Public Law 104–106), as amended by section 713 of the NDAA for FY 2016 (Public Law 114–92), which requires an assessment of information on the accreditation status, relevant policies and procedures, and data on patient safety, access to care and quality of care including data on appointment wait times and surgical and maternity outcomes, with respect to each military medical treatment facility (MTF). This follow-up report presents progress in Military Health System (MHS) performance management with respect to initiatives to assess and improve access, quality, and safety. Finally, this report presents the MHS strategy for public reporting on the MHS transparency website (www.health.mil) and the 2017 Evaluation of the TRICARE Program report to Congress, due March 1, 2017.

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Sincerely,

A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Patrick J. Leahy
Vice Chairman

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 22 2017

The Honorable Rodney P. Frelinghuysen
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

I am pleased to provide you with a follow-up to the Department of Defense's (DoD) Fiscal Year (FY) 2016 Evaluation of the TRICARE Program report to Congress. The original report, submitted April 6, 2016, responded to the requirements in section 717 of the National Defense Authorization Act (NDAA) for FY 1996 (Public Law 104–106), as amended by section 713 of the NDAA for FY 2016 (Public Law 114–92), which requires an assessment of information on the accreditation status, relevant policies and procedures, and data on patient safety, access to care and quality of care including data on appointment wait times and surgical and maternity outcomes, with respect to each military medical treatment facility (MTF). This follow-up report presents progress in Military Health System (MHS) performance management with respect to initiatives to assess and improve access, quality, and safety. Finally, this report presents the MHS strategy for public reporting on the MHS transparency website (www.health.mil) and the 2017 Evaluation of the TRICARE Program report to Congress, due March 1, 2017.

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Sincerely,

A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 22 2017

The Honorable Michael R. Pence
President of the Senate
United States Senate
Washington, DC 20510

Dear Mr. President:

I am pleased to provide you with a follow-up to the Department of Defense's (DoD) Fiscal Year (FY) 2016 Evaluation of the TRICARE Program report to Congress. The original report, submitted April 6, 2016, responded to the requirements in section 717 of the National Defense Authorization Act (NDAA) for FY 1996 (Public Law 104–106), as amended by section 713 of the NDAA for FY 2016 (Public Law 114–92), which requires an assessment of information on the accreditation status, relevant policies and procedures, and data on patient safety, access to care and quality of care including data on appointment wait times and surgical and maternity outcomes, with respect to each military medical treatment facility (MTF). This follow-up report presents progress in Military Health System (MHS) performance management with respect to initiatives to assess and improve access, quality, and safety. Finally, this report presents the MHS strategy for public reporting on the MHS transparency website (www.health.mil) and the 2017 Evaluation of the TRICARE Program report to Congress, due March 1, 2017.

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Sincerely,

A. M. Kurta
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 22 2017

The Honorable Paul D. Ryan
Speaker of the House
U.S. House of Representatives
H-209, The Capitol
Washington, DC 20515

Dear Mr. Speaker:

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Sincerely,

A. M. Kurta
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

Response to Section 713 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114–92)

Expansion of Evaluation of Effectiveness of the TRICARE Program to Include Information on Patient Safety, Quality of Care, and Access to Care at Military Treatment Facilities

The estimated cost of this report or study for the Department of Defense is approximately $20,000 for the FY2016-2017. This includes $100 in expenses and $20,000 in DoD labor.

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Executive Summary

The Department of Defense's (DoD) Fiscal Year (FY) 2016 Evaluation of the TRICARE Program Report to Congress was submitted April 6, 2016. The report responded to the requirements in section 717 of the National Defense Authorization Act (NDAA) for FY 1996 (Public Law 104–106), and was expanded to partially respond to section 713 of the NDAA for FY 2016 (Public Law 114–92) requiring an assessment of, with respect to each military medical treatment facility (MTF), information on the accreditation status, relevant policies and procedures, and data on patient safety, quality of care, and access to care including surgical and maternity outcomes.

This supplemental report summarizes Military Health System (MHS) initiatives since 2015 consistent with the requirements of section 713. The MHS began the journey of transforming into a high reliability organization (HRO) by developing or refining internal processes and structures; and collaborating with, and learning from, noted civilian health systems leaders who have progressed in their own HRO journeys. This journey resulted in a governance structure for leadership and execution; established a performance management system to assess and improve MHS performance at all levels and improved public transparency of many of these measures.

As noted in the submission of the FY 2016 report, the evaluation was expanded from prior year submissions to partially meet the requirements of section 713, within the limited time available to meet the legislated annual due date, and given the extensive amount of detail not previously required. The submitted report addressed each of the requirements of section 713 by reporting an assessment of the data at the MHS enterprise-level, but not with respect to each MTF worldwide. The report also presented our strategy for complying with section 713 in FY 2016 by also complying with the requirements of section 712—publishing on a publically available Internet website (within 180 days of enactment of the NDAA) data at the MTF-level pertaining to the accreditation status and findings, Service policies or procedures, and on patient safety, quality of care, satisfaction and health outcomes.

The requirements of section 713 and MHS compliance to date are:

a) An identification of the number of practitioners providing health care in military MTFs reported to the NCBD during the year. Response: This information was provided on page 47 of the FY 2016 Report and will be updated in the FY 2017 report.

b) With respect to each military MTF, an assessment of:
   1) The current accreditation status of each facility including recommendations for corrective action. Response: This information was partially provided on page 47 of the FY 2016 report by summarizing the number of accredited facilities in each Service Department. Also, with deployment of the public-facing health.mil website that became operational in May 2016, the accreditation status of each MTF, type of accreditation and survey dates, and summary of the requirements for improvement before accreditation status would be granted are provided at www.health.mil/AccreditationandPolicy. The accreditation status of each MTF is often displayed at the MTF's website as well (e.g., Walter Reed National Military

Medical Center's site reflects over 19 program accreditations at http://www.wrnmmc.capmed.mil/about%20us/QSPR/SitePages/Home.aspx).

2) Any policies or procedures implemented during the year by the Secretary of the military department concerned, designed to improve patient safety, quality of care, and access to care. Response: A consolidated summary of relevant HA and Service Polices is provided at www.health.mil/AccreditationandPolicy. Appropriate HA and Military Department level policies are also provided in their associated subject areas related to access, patient safety, and quality of care at the public facing www.health.mil.

3) Data on surgical and maternity care outcomes during the year. Response: MHS-level data were presented on pages 47, 50, and 51 of this year's report. MTF-level data over time are publically available at www.health.mil in the "Health Outcomes" section showing number of deliveries, percentage of deliveries to full term, and complications related to surgery. Complications related to surgery are compared to the top 10 percent of NSQIP rates among 600 leading hospitals in the U.S.

4) Data on appointment wait times during the year. Response: MHS-level data were presented in the Access section of this year's report, from pages 37 to 46. MTF-level data over time are publically available at www.health.mil in the "Patient Satisfaction and Access" section showing more detailed results for PCM continuity, access to acute and primary care appointments, and patient engagement and self-reported access to care data. Data presented for each MTF on the public website depict unique measures of access, and are compared to the MHS-stated established standards.

5) Data on patient safety, quality of care, and access to care as compared with standards established by DoD. Response: The MHS performance management system and the MHS Dashboard present data at the MTF level aggregated upwards to the levels relevant for leadership review (e.g., MTF level for local commanders and their subject matter expert staff, or Service Intermediate Command-level (e.g., Army's Regional Health Command-C, or Navy Medicine- East), or the multi service market area level, all the way to the Service and MHS levels. These data are routinely monitored and assessed by the Service staff and their MTF leadership, as well as in relevant Tri-Service working groups for assessment of policies or processes of high performing MTFs that might be shared across the Services and/or standardized across the MHS. Measures have established expected targets of performance based on relevant and applicable civilian standards (e.g.,, comparing MHS results of the Outcomes measure of complications related to surgery compared to top 10 percent of the NSQIP-reporting hospitals in the nation, or MHS beneficiary ratings of their willingness to recommend a hospital to others compared to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) 50th percentile). Where there are no relevant external benchmarks or standards, the MHS either uses legislated standards (such as appointment availability) or targets based on improvement from prior year results (such as patient reports of their ability to get care when needed). Data are presented on the health.mil pubic-facing website to help our

beneficiaries and constituency understand their health care capability in their local areas.

Finally, this report presents our strategy for improving the data quality and analyses in the forthcoming year. This includes public reporting on the MHS transparency website on health.mil and the 2017 Evaluation of the TRICARE Program.

The MHS established, followed, and improved on a comprehensive set of enterprise-wide performance measures that are aligned to the core MHS strategy of the Quadruple Aim: Improved Readiness, Better Health, Better Care, and Lower Cost. The performance management system--Partnership for Improvement, or P4I, was operational in January 2015. Within the P4I performance management system, the MHS Core Dashboard was developed in January 2015 with 30 core measures reported at the MTF-level and aggregated upwards to the Services and across the MHS enterprise. These measures are now formally reviewed by the Assistant Secretary of Defense for Health Affairs (ASD(HA)), Surgeons General, and supporting leaders on a quarterly basis. In March 2016, the Defense Health Agency (DHA) responded to a Service leadership challenge to enhance visibility of P4I results enabling MTF leadership to quickly view their overall performance on the dashboard core measures and to compare their progress relative to their Service and to the enterprise overall, as well as to benchmarks or targets established by MHS senior leaders. This performance management system revealed improvements in performance in several of the measures supporting the Quadruple Aim; showed progress in reducing variance, particularly in primary care access; and identified further opportunities to reduce variance within the Services and National Capital Region Medical Directorate (henceforth called the Services), and across the system. The P4I dashboard, and related dashboards for higher levels of leadership, with support from senior leadership, established both accountability for performance improvement at every level of the organization and identified those areas where continued improvements are needed. In addition to assessing MTF and aggregate performance through the dashboards, results of these and other measures are presented on the ASD(HA) public-facing website, with respect to each MTF, the MHS collaborative assessment of data on accreditation and findings, patient safety, quality of care, satisfaction, health outcome measures, and relevant Service policies. Publication of these data complied with the NDAA 2016 section 712 requirements and supported compliance with section 713 as promised would happen in the FY 2016 Evaluation of the TRICARE Program report.

This supplement to the published FY 2016 Evaluation of the TRICARE Program reviews the MHS Enterprise efforts to-date since the MHS Review. It specifically addresses the MHS enterprise, Services, and MTF-level measures routinely monitored and assessed by the Services and DoD leadership, as well as those measures and data at the MTF level posted on the health.mil public website determined to be "appropriate" metrics of MTF performance on safety, quality, and access helpful to our MHS beneficiaries. The FY 2017 Evaluation of the TRICARE Program, due March 1, 2017, presents additional data on variability of measures at the MTF level and specific assessment of MTF performance to-date by each of the Services.

Introduction

The Department of Defense (DoD) Fiscal Year (FY) 2016 Evaluation of the TRICARE Program Report was submitted April 6, 2016, responding to the requirements of section 717 of the National Defense Authorization Act (NDAA) for FY 1996 (Public Law 104-106), and expanded to partially respond to section 713 of the NDAA for FY 2016 (Public Law 114-92) requiring information on patient safety, quality of care, and access to care at MTFs. Section 713 (provided in Appendix A) required:

a) An identification of the number of practitioners providing health care in military medical treatment facilities reported to the National Practitioner Data Bank during the year.

b) With respect to each MTF, an assessment of:
   1) the current accreditation status of each facility and recommendations for corrective action
   2) any policies or procedures implemented during the year by the Secretary of the military department concerned designed to improve patient safety, quality of care, and access to care
   3) data on surgical and maternity care outcomes during the year
   4) data on appointment wait times during the year
   5) data on patient safety, quality of care, and access to care as compared with standards established by DoD

The April 2016 submission of the FY 2016 Evaluation of the TRICARE Program sought to partially meet the intent of Congress by addressing each of the requirements of Section 713, by reporting results at the MHS enterprise-level, but not with respect to MTF-level data. The April 2016 report was limited due to the extensive amount of detail associated with the new requirements of section 713, the limited time available to meet the legislated due date, and the limited amount of MTF-level data that had been collected at that time.

This supplemental report summarizes the MHS initiatives since 2015 consistent with the requirements of section 713. MHS has begun the journey of transforming into a HRO by developing internal processes and structures, collaborating with, and learning from, noted civilian health systems leaders who have progressed in their own HRO journeys, and emphasizing transparency of information with visibility internally and externally, especially to DoD beneficiaries.

MHS Review

In May 2014, the Secretary of Defense (SECDEF) ordered a 90-Day comprehensive review of the Military MHS. A working group chartered by the Deputy Secretary of Defense conducted the review and summarized its findings in a final report (*Military Health System Review*, August 2014), which contained 82 action items. The Review focused on access to care, quality of care, and patient safety within the MHS. In this review, key staff from all three Services and the DHA conducted site visits at selected military hospitals in the U.S. and one overseas. The review examined existing measures used to assess access, quality, and patient safety in MTFs. Data were also provided by three top-performing civilian health care medical centers to establish a

benchmark for what great performance looks like. The report concluded that, although the MHS provides high quality care that is safe and timely and is comparable to that found in the civilian sector, the MHS demonstrates wide performance variability with some areas better than civilian counterparts and other areas below national benchmarks.

After examining the MHS Review, the SECDEF issued a follow-on memorandum in October 2014 ("Military Health System (MHS) Action Plan to Improve Access, Quality of Care and Patient Safety", October 1, 2014). This memorandum established clear expectations and explicit milestones for implementing his directed actions. Specifically, his memorandum mandated the development of a plan for implementing changes necessary to becoming a top performing health system and addressing all recommendations in the MHS Review. In addition, The Secretary directed the Services and DHA to develop action plans to improve the performance of MTFs identified during the MHS Review as outliers and for the MHS to take action to improve transparency of performance data and to enhance patient engagement. He directed the MHS to develop a plan to "provide all currently available aggregated statistical access, quality and safety information for all MTFs on health.mil" and to "develop a mechanism through which patients and stakeholders are engaged for ongoing and enduring input for access, quality and safety issues." The Secretary mandated three specific deliverables: (1) an MHS HRO Plan; (2) a performance management system; and (3) a plan for a more comprehensive assessment of quality and safety within purchased care.

Beginning the Journey to a High Reliability Organization

In response to the Secretary's memo, staff from each of the Services, the DHA, and Health Affairs was tasked to review the action items identified in the MHS Review and establish a method for addressing them. The Action Officers established 41 Action Plans to accomplish the 82 action items in the areas of access, quality, safety, performance improvement, and purchased care. These Action Plans were detailed in an Integrated Deliverable Document (December 30, 2014).

The MHS has made progress since the 2014 SECDEF-directed Review in establishing organizational structure and codified processes to improve access, quality, patient safety and patient experience. The following paragraphs describe two major initiatives in response to the Review and implementation of the Action Plans, consistent with the requirements found in section 713. This established the beginning of the long journey to becoming a HRO.

MHS Performance Management System - Partnership for Improvement (P4I)

While the MHS has been committed to the Quadruple Aim (Improved Readiness, Better Health, Better Care, and Lower Cost) as its strategic framework since 2010, consistent with the Secretary's direction, an effort began in 2014 to develop an enterprise strategy with clear objectives for each of the system-level aims. In October 2014, the MHS formed a DHA-TRICARE Service P4I Steering Committee (P4I-SC) and began development of an enterprise

performance dashboard allowing senior medical leaders to track progress toward achieving the Quadruple Aim.

On December 10, 2014, a P4I operating concept was approved by leadership at the MHS Strategy Review and Analysis (R&A) meeting.[1] The overarching principle of this operating concept is that DHA supports the Services and MHS Governance. DHA gathers performance data, provides enterprise-level analysis, and supports improvement. Execution is the responsibility of the Services, except for the National Capital Region Medical Directorate (NCR MD), where DHA is responsible for execution.

The MHS also developed a set of leadership commitment statements for each area of responsibility. These were approved at the December 2014 R&A meeting and emphasize transparency, accountability, knowledge sharing, and continuous improvement.

In January 2015, the MHS developed a tool enabling users to view the measures at the MHS, Service, and MTF-level of detail. Thirty core measures were preliminarily identified as being the best initial enterprise-level measures, resulting in the P4I MHS Core Dashboard. Each measure was developed to have performance thresholds enabling the system to have clear performance targets. The P4I dashboard provides leadership with enterprise-wide information on our system's progress in showing improvement. Today, most of these measures can be viewed at an enterprise, Service, Service Intermediate Command, and MTF level. Continued efforts will ensure that all measures, at all levels, are visible to all levels of management. As reflected in the Core MHS Dashboard, shown in Figure 1 below, measures are grouped by Quadruple Aim domains (Improved Readiness, Better Care, Better Health and Lower Cost), and by key objectives (including safety, quality of care and patient engagement). Each measure is classified by its developmental status relating to MHS experience with the measure and maturity in application as follows:

1. **Accountability (A):** Mature and stable measure with identified targets. MHS Enterprise commits to reaching a numeric target by a specific date.
2. **Improvement (I):** MHS has experience with measure, trusts algorithm for calculating measure, and commits to improvement over baseline.
3. **Exploratory (E):** Organization has little experience with measure and/or is not confident that measure is sound; learns about usefulness of measure then decides whether it should be included as an accountability or improvement measure.

[1] MHS senior leaders attending the R&A meeting include the Assistant Secretary of Defense for Health Affairs; Principal Deputy Assistant Secretary of Defense for Health Affairs; Army, Navy, and Air Force Surgeons General and Deputy Surgeons General, Director of the Defense Health Agency, Joint Staff Surgeon, and President of the Uniformed Services University of the Health Sciences.

Figure 1. MHS Enterprise Performance Management System- Partnership for Improvement (P4I) Core Dashboard (May 2015)

Strategic Alignment						Thresholds			Component Performance						
Aim	Objective		Performance Measure	Dev. Status	MHS Performance	Red	Green	Blue	A	N	AF	NCR MD	PSC	As Of	Data Entry
Readiness	Medically Ready Force (PLS1)		Individual Medical Readiness (IMR)	A	87%	TBD	>85%	TBD	83%	92%	89%		N/A	Dec 14	Mar 15
	Ready Medical Force (PLS2)		TBD	---	---	---	---	---	---	---	---	---	---	---	
Better Health	Healthy People (PLS3)		TBD	---	---	---	---	---	---	---	---	---	---	---	
	Improve Healthy Behaviors (IP5)		HEDIS Cancer Screening Index	E	66%	50%	70%	90%	93%	93%	73%	80%	40%	Dec 14	Mar 15
Better Care	Improve Clinical Outcomes and Consistent Patient Experience (PLS4)	▼	Risk Adjusted Mortality (All Cases)	E	0.62	TBD	TBD	TBD	0.87	0.75	1	0.57	N/A	Dec 13	Mar 15
			Inpatient: Recommend Hospital (Satisfaction)	A	71%	≤73%	73%	≥75%	71%	74%	78%	84%	72%	Dec 14	May 15
			Overall Satisfaction w/Healthcare (Outpatient)	I	N/A	Service Specific	Service Specific	Service Specific	92%	96%	96%	92%	92%	Dec 14	May 15
	Improve Safety (IP9)	▼	**HAI (CLABSI)**	E	27	N/A	N/A	0	13	7	4	3	N/A	Mar 15	May 15
		▼	**PSI 5 - Foreign Body Retention (Per Year)**	I	9	N/A	N/A	0	7	1	1	0	N/A	2014 Q3	Mar 15
		▼	National Surgical Quality Improvement Program (NSQIP) (30 Day) All Case Morbidity Index	E	N/A	10th percentile	11th - 89th percentile	90th percentile	Multiple scores per service				N/A	Mar 14	Mar 15
			CAUTI												
			Wrong Site Surgery												
	Improve Condition-Based Quality Care (IP7)		**HEDIS Diabetes Index**	E	54%	50%	70%	90%	71%	83%	75%	82%	20%	Feb 15	May 15
			HEDIS Appropriate Care Index (Low Back Pain, Pharyngitis, URI)	E	45%	50%	70%	90%	40%	64%	63%	60%	30%	Feb 15	May 15
		▼	NPIC Post-Partum Hemorrhage	E	5.3%	2σ above NPIC avg.(3.4%)	within 2σ of NPIC avg. (3.4%)	2σ below NPIC avg.(3.4%)	4.3%	6.1%	6.1%	3.2%	N/A	2014Q2	Mar 15
		▼	NPIC Vaginal Deliveries w/Coded Shoulder Dystocia Linked to a Newborn ≥ 2500 grams w/Birth Trauma	E	14.1.%	2σ above NPIC avg.(11.8%)	within 2σ of NPIC avg. (11.8%)	2σ below NPIC avg.(11.8%)	17.9%	11.5%	12.0%	0%	N/A	2014Q2	Mar 15
			HEDIS (30-Day) Mental Health Follow-Up	E	79% (~68th percentile)	50th percentile (74%)	75th percentile (81%)	90th percentile (85%)	80%	80%	60%	80%	60%	Nov 14	Mar 15
		▼	HEDIS All Cause Readmission	E	1.33 (<50th percentile)	50th percentile (0.79)	75th percentile (0.73)	90th percentile (0.68)	1.36	1.27	1.24	1.43	N/A	Jun 14	Mar 15
			ORYX Transition of Care Index (Asthma, VTE, Inpt Psy(2))	E	44%	60%	75%	100%	38%	50%	56%	50%	N/A	2014 Q2	Mar 15
			AHRQ Prevention Quality Indicator (PQI) Index	E	94%	70%	80%	90%	94.2%	94.2%	100%	98%	N/A	2014 Q1	Mar 15
	Improve Comprehensive Primary Care (IP8)		PCM Continuity	A	64%	55%	65%	81%	60%	61%	60%	51%	N/A	Feb 15	Mar 15
			PCM Empanelment	E	1,046	<1,100:1	1,100:1	>TBD	1,027	992	1,101	1,117	N/A	Jan 15	Mar 15
		▼	Primary Care Leakage	I	23.9%	>24%	24% to > 20%	≤ 20%	21.5%	25.0%	26.4%	25.3%	N/A	Dec 14	Mar 15
		▼	**Avg. No. of Days to Third Next Available Future Appointment (Primary Care)**	I	6.6d	>7d	7.0d	2.2d	6.5d	6.6d	6.5d	11.3d	N/A	Mar 15	May 15
		▼	**Avg. No. of Days to Third Next Available 24 Hour Appointment (Primary Care)**	I	1.5d	>1d	1.0d	0.8d	1.5d	1.0d	1.7d	2.1d	N/A	Apr 15	May 15
	Optimize & Standardize Access & Other Care Support Processes (IP10)		**Percent of Direct Care Enrollees in Secure Messaging**	TBD	34%	TBD	TBD	TBD	26%	40%	40%	37%	N/A	Apr 15	May 15
			Satisfaction with Getting Care When Needed (Service Surveys)	I	N/A	Service Specific	Service Specific	Service Specific	82%	90%	90%	80%	85%	Dec 14	May 15
Lower Cost	Improve Stewardship (PLS5)	▼	PMPM	I	$338 3.3%	>2% yearly growth	2% to > 0% yearly growth	≤ 0% yearly growth	0.3%	0.5%	4.6%	-6.9%	4.1%	Jun 14	Mar 15
		▼	Total Purchased Care Cost	E	$-47.7M -2.5%	Service Specific	Service Specific	Service Specific	-7.0%	-0.8%	0.3%	-3.6%	N/A	Dec 14	Mar 15
		▼	Private Sector Care Cost per Prime Enrollee	I	$167 1.3%	>2% yearly growth	2% to > 0% yearly growth	≤ 0% yearly growth	4.3%	3.6%	2.7%	-0.7%	4.3%	Dec 14	Mar 15
			OR Utilization	E		TBD	TBD	TBD	N/A	N/A	N/A	N/A	N/A	N/A	Mar 15
			Total Enrollment	I	3.59M 0.1%	<0% yrly growth	0% to < 5% yrly growth	≥ 5% yrly growth	-0.3%	2.1%	-1.3%	1.0%	N/A	Mar 15	May 15
		▼	Pharmacy Percent Retail Spend	I	56.3%	>40%	40% to > 35%	≤35%	58.5%	59.8%	52.3%	42.1%	N/A	Feb 15	May 15
			Productivity Targets	I	88%	Service Specific	Service Specific	Service Specific	91%	89%	86%	69%	N/A	Dec 14	Mar 15

The first review of these uniformly reported enterprise measures was presented to MHS senior leadership at the March 18, 2015 R&A meeting and have continued on a quarterly basis. This infrastructure for leadership reviews and ongoing monitoring fosters organizational learning as senior leaders have more shared experience reviewing enterprise performance. It will also help to answer system wide questions such as:

- How are we doing as a system?
- Are we improving fast enough?
- How do we compare to external benchmarks?
- Are there any areas of risk that top management needs to understand and be assured that an appropriate action plan has been set in place?

In the March 18, 2015, quarterly R&A leadership identified four Process Improvement Priorities (PIP) for focus: Improve Access; Increase Direct Care Primary Care Capacity; Improve Quality Outcomes for Condition-Based Care; and Reduce Patient Harm.[2] Subsequently, nine measures from the MHS Core Dashboard were associated with the four process improvement areas. These areas are reviewed on a monthly basis with the Principal Deputy ASD(HA) and Service Deputy

[2] Woodson, J. (2015). Military Health System Strategy Review and Analysis – 18 March 2015.

Surgeons General to enhance knowledge sharing with regard to process improvement efforts (Figure 2 below).

Figure 2. P4I Performance Management Process Improvement Priorities

Report as of 3 MAR 2016

Performance Summary – Process Improvement Priorities

In March 2015, we committed to 4 Process Improvement Priorities which encompass 9 measures; how are we are doing?

Improvement Priority	Measure	Green Threshold	Prior Perf.	Current Performance					
			Aug 2014	MHS	A	N	AF	NCR	MCSC
Improve Outcomes For Condition Based Quality Care	HEDIS Diabetes In[…]			79% (Dec 15)	72% (63%)	86% (77%)	83% (70%)	84% (76%)	20%* (20%)
	MHS Acute Conditi[…] Composite			49% (Dec 15)	41% (40%)	71% (53%)	65% (60%)	65% (53%)	39% (27%)
Reduce Patient Harm	CLABSI	Location Specific**	32 (Sept 14)	39 (Dec 15)				4 (5)	---
	URFOs	Based on current quarter against previous performance	3 (Sept 14)	5 (Sep 15)	(2)	(1)	(0)	0 (0)	---
Improve Access	% Enrolled in Secure Messaging	50%	36% (May 15)	40.6% (Jan 16)	33%	48%	43%	46%	---
	Third Next Available Hour			1.5d (Jan 16)	1.5d (2.3d)	0.9d (1.1d)	1.9d (2.6d)	1.5d (4.0d)	---
	Third Next Available – Future	7.0d	7.69d	5.9d (Jan 16)	5.6d (7.2d)	4.9d (6.9d)	6.4d (8.6d)	9.1d (11.4d)	---
	Satisfaction with Getting Care When Needed	Service Specific	84% (Sept 14)	86% (Sept 15)	83% (82%)	90% (90%)	90% (89%)	82% (79%)	
Increase Direct Care Primary Care Capacity	Total Enrollment (annual growth)	0-5%	3.59M +1.3%	3.57M -0.4% (Nov 15)				+1.5% (+2.0%)	---

MHS has achieved green threshold, should we set a higher threshold?

Do opportunities exist to standardize policies and procedures (i.e. OB)?

Do we believe that this target is achievable by the end of the year?

Do opportunities exist to recapture prime enrollees from the network?

Current Performance is equated to date in MHS columns
Prior Performance ( ) is equated to Aug 2014

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* Only 1 of 2 components of index available
** Thresholds designated using CDC risk adjusted criteria; not able to calculate a Component color because measure is reported by location type

The P4I operating concept has three interdependent parts: P4I Support, Execution, and Governance.

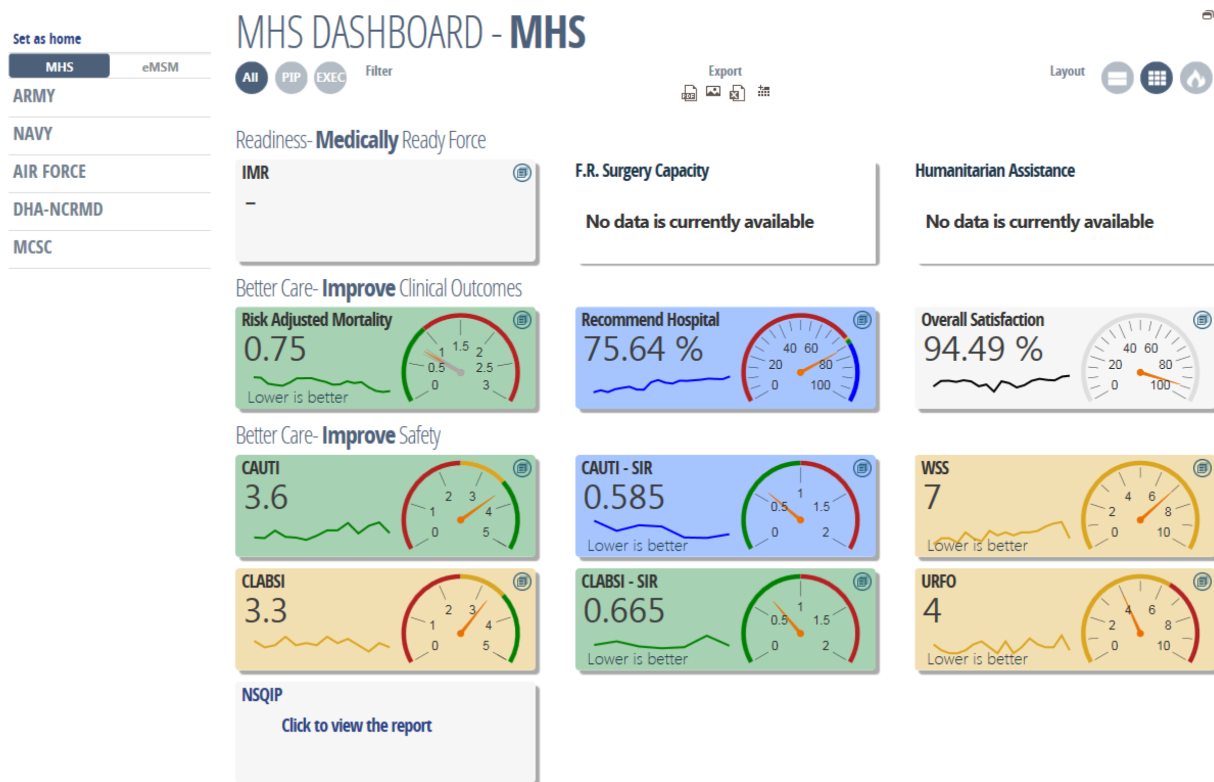
P4I Support (DHA): DHA is responsible for supporting the performance management processes and develops standard performance measures as directed by MHS Governance. It collects, validates, and distributes performance information to the Services and DHA. In addition, DHA provides analysis on enterprise trends and risks to MHS Governance.

Execution (Services and DHA): The Services and DHA (for the NCR MTFs) are responsible for using the information provided by DHA to analyze and review performance, develop strategies (to include resource allocation), and improve the performance of MTFs, along with other operations under their authority, direction, and control. The Services also develop Service-specific and local measures, which they can propose through Governance for inclusion in the set of common refined or enterprise core measures.

Governance (MHS): MHS Governance uses the information provided by DHA and other sources to set the MHS enterprise strategy, provide oversight of MHS performance, and to allocate resources.

As noted previously, in January 2015, the MHS developed a tool, which enabled users to view the core measures at the MHS, Service, and MTF level of detail as requested by the Secretary. This tool was developed in 60 days and was limited in its capability, not allowing an MTF or Service the ability to see an aggregate view of all the measures on one screen. In November 2015, leaders challenged the DHA to develop an easy-to-use tool at the MTF level of detail for each measure with the capability to aggregate the measures at the MHS, Service, Command, MTF and enhanced Multi-Service Markets (eMSM) level of detail. In March 2016, working with the Services to improve the tool's functionality, the DHA deployed an improved Dashboard with the ability for MTFs to select a view of their overall performance on the core measures without having to navigate various screens. Figure 3 reflects a screen shot of the MHS dashboard at the enterprise-level, providing the status of various measures supporting Increased Readiness and Better Care, the general trending of the measure over time, and current state of the measure against targeted performance. Users of the dashboard can hover over each measure depiction to understand how the measure is defined, and the currency of the data represented on the dashboard.

Figure 3. MHS Core Dashboard Updated Appearance with Visibility of All Measures and Status, with Drill-down capability for Each Service Intermediate Command, eMSM Area and MTF



Dashboard users can drill down into each measure, as shown in the examples in Appendix B. Appendix B-1 presents the overall Dashboard view, then an example of two "drill down" views of the Access to Care measure "Getting Care When Needed" based on patient self-assessments of their ability to get care when they feel they need it (B-2); and the flexibility in the Dashboard by selecting a depiction of the variability in ratings across MTFs (B-3) using a box-and-whisker trend chart showing change in the median of all MTFs, their interquartile range (difference between the 25th and 75th percentiles), and extreme outliers.

As the MHS began to conduct performance reviews within all levels of governance, it became apparent that depending upon the audience there was a need for different types of dashboards. The measures chosen for these different dashboards all came from the existing core measures set. In March 2016, leaders expressed a desire to have a tool that looked at readiness, access to care, patient safety, outpatient clinical quality and cost in aggregate as well. The MHS Executive Dashboard (Figure 4 below) was developed, creating roll-up or composite views where appropriate. The details for each of the individual measures that make up the composites are still viewable to the leaders as required.

Figure 4. MHS Executive Dashboard

MHS Executive Dashboard — As of 12 Sept

MEASURE	DATA AS OF	THRESHOLDS: RED	THRESHOLDS: GREEN	THRESHOLDS: BLUE	PERFORMANCE: MHS	ARMY	NAVY	AIR FORCE	DHA-NCRMD	MARINE	CG	MCSC
IMR	6/1/2016	<75%	≥85%	90%	-	83.5 %	90.1 %	88.8 %	-	90.2%	81.9%	-
Forward Resuscitative Surgery Capacity		<65%	≥75%	85%		65%	78%	84.2%	-	-	-	-
Humanitarian Assistance/ Disaster Relief Capacity		<65%	≥75%	85%		75%	76%	77.3%	-	-	-	-
Health Related Quality of Life (HRQOL)					Pending Data Submission							
Risk Adjusted Mortality	3/1/2016	-	-	-	0.74	0.74	0.60	0.62	1.24	-	-	-
Inpatient: Recommend Hospital	12/1/2015	<71%	≥73%	≥75%	75.64 %	73.33 %	74.29 %	79.41 %	84.84 %	-	-	-
Overall Satisfaction with Healthcare: Outpatient	3/1/2016	Component Specific			94.39 %	92.92 %	95.06 %	96.25 %	92.55 %	-	-	-
Safety Composite	3/1/2016	< 5 pts	≥7pts	≥9 pts	3.7	3.3	4.0	8.9	4.3	-	-	-
Quality (Outpatient) Composite	6/1/2016	<50%	70%	90%	66.67 %	73.33%	93.33 %	80 %	86.67 %	-	-	26.67 %
Access Composite		<10 pts	≥15 pts	20 pts	10	11	11	7	10	-	-	-
PMPM	3/1/2016	>3.2% yearly growth	3.2%-0% Yearly growth	≤0% yearly growth	4.34 %	6.03 %	5.52 %	4.54 %	2.14 %	-	-	0.61 %
Total Enrollment	7/1/2016	<0% growth	0%-5% growth	≥5% growth	-0.5 %	-1.0 %	0.3 %	-0.7 %	0.7 %	-	-	-5.2 %
Pharmacy Percent Retail Spend	6/1/2016	>35%	35%	≤30%	27.4 %	25.9 %	29.0 %	28.3 %	22.3 %	-	-	-
Productivity Targets	6/1/2016	Component Specific			92 %	94 %	90 %	88 %	91%	-	-	-

NOTE: This Dashboard was developed from the Core set of MHS measures with the intention of enabling senior leadership to focus on a smaller number of measures that are key to the overall performance improvement efforts of the enterprise

ASD(HA), DHA Director and Service Surgeons General have been conducting performance reviews on a quarterly basis since March 2015, having discussions surrounding policy, resource implications and enterprise risk related to improvement efforts. Tri-Service working groups of subject matter experts in each of the domains of access, quality, safety, patient satisfaction,

readiness and cost continuously monitor the core measures as well as many others to assess performance and advise on changes to process or policy. The first annual in-depth review of these measures took place during the summer of 2016. In June 2016, leadership set a target date of June 2017, for "going to green" on the PIP measures. If already "green," on a particular measure, a 30 percent reduction for those MTFs identified as "amber" or "red" was targeted. Setting this additional threshold further illustrates MHS leadership commitment to reducing variance and not being satisfied with just getting to "green". Leadership requested a risk analysis be presented at the December 2016 R&A identifying potential risks which could impede the MHS in reaching the June 2017 green targets for each of the PIP measures. An annual review was conducted of all the MHS Core measures, to include recommending new measures where gaps were identified and removing some that were no longer relevant. At the September 28, 2016, Senior Military Medical Advisory Council Review and Analysis session, leaders approved the FY 2017 Core Measure Set which now consists of 38 measures. Barring any unforeseen issues, these measures will remain in place without changes until FY 2018.

Using the Performance Management System to Manage Performance

The accountability for the direct care system execution and improvement efforts continues to rest with the Services. The DHA supports the Services by providing access to strategic partnerships such as the Institute for Healthcare Improvement (IHI). In September 2016, the MHS embarked on a collaborative regarding access to care and surgical quality to accelerate improvement through learning, knowledge sharing, and spread of proven practices. These learning collaboratives will take place over the course of the next year. MTF teams identified by the Services will work with IHI faculty to solve problems, improve performance and increase the spread of proven practices.

Knowledge Sharing

The R&A meetings have taken on a new dimension by engaging leading health system executives to come and share their journey towards becoming a HRO. September 2016 was the first such opportunity with a focus on improving patient safety. Leaders from Cincinnati Children's Hospital and each of the Services shared what each was doing to advance a culture of safety and then discussed shared learnings from successes and failures.

Future Plans

The MHS is closely coordinating with the Centers for Medicare and Medicaid Services (CMS) to add DoD MTFs to the Hospital Compare website, which will provide MHS staff and beneficiaries with the ability to compare institutional performance between DoD and civilian hospitals at a local level. With CMS support, MHS will introduce this capability in FY 2017. Efforts will continue in FY 2017 and FY 2018 to align direct and purchased care data and align with standard industry measures. The visibility of MHS MTF performance through Hospital Compare complements the MHS performance management system, and supplements ongoing efforts toward increased transparency of MHS performance.

Transparency

A major directive stemming from the 2014 MHS Review was to emphasize transparency of information, including from both the direct and purchased care venues, with visibility internally, externally, and to DoD beneficiaries. Greater alignment of measures for purchased care with the direct care should be incorporated into TRICARE regional contracts. To address transparency in support of the journey to high reliability, the MHS Transparency Initiative Group (TIG) was chartered to establish an MHS framework for transparency in the four domains identified by the National Patient Safety Foundation: 1) between clinicians and patients, 2) among clinicians within an organization, 3) between organizations and, 4) between organizations and the public.

To date, the MHS emphasizes transparency through at least the following actions:

- Quality, patient safety and access to care data, as deemed appropriate, was consolidated and published on the TRICARE.mil website in December 2014. To improve availability and optimize content management, the information was moved and published to the health.mil website (http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Patient-Portal-for-MHS-Quality-Patient-Safety-and-Access-Information) in May 2016 with links to this information placed on every MTF website. Information on the website includes MTF accreditation status, inpatient hospital quality measures (The Joint Commission's (TJC) ORYX® initiative), outpatient preventive care measures (e.g.,, Health Effectiveness Data and Information Set (HEDIS)), CMS Hospital Compare data for purchased care facilities, patient-centered medical home practices, and beneficiary survey data.
- The MHS shares information for quality and patient safety improvement by obtaining accreditation by TJC (ORYX data) and participating in professional collaboratives (e.g.,, the American College of Surgeons' National Surgical Quality Improvement Program).
- The P4I, as noted previously, was established as the MHS performance management system, fostering internal discussions on achieving improved processes and outcomes.
- A "Healthcare Resolutions" initiative to engage patients after unexpected outcomes met with success in eight MTFs.

The current focus of the TIG includes meeting the NDAA FY 2016 section 712 requirements, publishing on a publically available Internet website of the DoD data on all measures the Secretary considers appropriate that are used by the Department to assess patient safety, quality of care, patient satisfaction, and health outcomes for healthcare provided under the TRICARE program at each MTF. The April 6, 2016, submission of the annual Evaluation of the TRICARE Program sought to partially meet the intent of Congress by addressing each of the requirements of section 713, reporting results at the MHS enterprise level. The report summarized the enterprise-level results on page 47 and provided greater detail on subsequent pages. The report also presented the strategy for complying with section 713 by noting we would substantially meet it by also responding to the requirements of section 712; that is, by publishing on a publically available Internet website data pertaining to the accreditation status and findings, Service policies or procedures, patient safety, quality of care, satisfaction and health outcomes at the MTF level. Section 712 required publication on a public-facing website within 180 days of enactment of the NDAA (see Appendix C for section 712 requirements). The health.mil public-facing website went live on May 20, 2016, less than 180 days following enactment. Figure 5 presents the 24 MHS measures available on the www.health.mil website as of May 20, 2016.

These 24 measures cover the domains of access, patient experience (satisfaction), health outcomes, safety and quality of care (including accreditation status and major findings of all MTFs, and appropriate Joint Commission Oryx and HEDIS measures). Data for the measures are updated quarterly, semi-annually or annually, depending on the measure.

Figure 5. Transparency measures on www.health.mil May 2016

Category	Measures/information	Level	Published	Last Updated	Data As Of	Frequency
Access and Satisfaction	1. Appointment primary care 24h	**MTF**	20 May '16	23 Jun '16	21 Jun '16	Quarterly
	2. Appointment for primary care Future	**MTF**	20 May '16	23 Jun '16	23 Jun '16	Quarterly
	3. Get Care When Needed	**MTF**	20 May '16	23 Jun '16	09 Jun '16	Quarterly
	4. Provider Continuity	**MTF**	20 May '16	23 Jun '16	17 Jun '16	Quarterly
	5. Recommend Hospital	**MTF**	20 May '16	13 Jul '16	09 Jun '16	Quarterly
	6. Health Care Survey of DoD Beneficiaries	**MHS** (MTF via drilldown)	20 May '16	-	-	Annually
Health Outcomes	1. Number of Deliveries	**MTF**	20 May '16	23 Jun '16	22 Jun '16	Quarterly
	2. Elective Deliveries <39 weeks	**MTF**	20 May '16	23 Jun '16	10 Jun '16	Quarterly
	3. Complications from Surgery (NSQIP Morbidity)	**MTF**	20 May '16	13 Jul '16	13 Jul '16	Semi-annually
Safety	1. Patient Safety Event Reporting	**MHS**	20 May '16	23 May '16	19 Apr '16	Annually
	2. Sentinel Events (MHS and by MTF)	**MTF&MHS**	20 May '16	23 May '16	19 Apr '16	Annually
	3. Catheter Associated Urinary Tract Infections Adult ICU	**MTF**	20 May '16	23 May '16	18 Apr '16	Semi-annually
	4. Central Line Associated Blood Stream Infections Adult ICU	**MTF**	20 May '16	23 May '16	18 Apr '16	Semi-annually
Quality of Care	1. Accreditation Status of MTFs	**MTF**	20 May '16	23 May '16	31 Dec '15	Annually
	2. Inpatient Quality measures (sel by MTF) ORYX	**MTF**	20 May '16	23 Jun '16	10 May '16	Quarterly
	3. Outpatient Quality Measures - HEDIS	**MTF**	20 May '16	23 Jun '16	20 Jun '16	Quarterly
	1) Well-Child Visits in First 15 Months					
	2) Children's common cold					
	3) Children's sore throat					
	4) Breast Cancer Screening					
	5) Cervical Cancer Screening					
	6) Colorectal Cancer Screening					
	7) Low Back Pain Imaging					
	8) Diabetes Testing and Control					
	9) Follow-up after Mental Health Hosp (7/30d)					

The Office of the Assistant Secretary of Defense for Health Affairs portal at www.health.mil, offers a hyperlink titled "MHS Transparency" (http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Patient-Portal-for-MHS-Quality-Patient-Safety-and-Access-Information). This link opens a menu for visitors to select "Patient Satisfaction and Access to Care", "Health Outcomes", "Patient Safety", or "Quality of Care." Within each of these sections, the visitor is offered text explaining "What do we measure?", "How do I read the results?" and the ability to download the explanatory text and MTF-level data in two different software versions to facilitate compatibility with various Internet readers or software. These data are available at individual MTF websites as well, under the same or similar titles. The April 6, 2016 report, combined with the public-facing health affairs website and links to MTFs, extends our efforts to comply with the requirements of section 713 of the NDAA 2016.
Screen shots from the www.health.mil public website are presented in Appendix D, providing examples of the detail presented down to the MTF level for these 24 areas. Each access, quality, safety and patient satisfaction measure presented on the website is accompanied by an explanation to help our beneficiaries understand the data, the benchmark or the standard used for

comparing results (e.g., national 90th percentile among civilian institutions, or MTF averages or the MHS standard such as in third available acute and future appointments) as well as to offer suggestions on how best to engage the MHS to improve their health and care. Also, the DHA and Services will gather stakeholder input by soliciting from subject matter experts and stakeholders their input in shaping priorities for transparency.

MHS Achievements since the 2014 MHS Review

In summary, the MHS Review provided impetus for envisioning and codifying an enterprise strategy to achieve the Quadruple Aim by embarking on the journey toward becoming a HRO dedicated to vigilance in preventing medical errors; accountability for performance; and continuous improvement in structure, process, and outcomes of access, quality and safety. Critical achievements have been in:

Access to Care: Primary care access has been uniformly enhanced by:

> (1) expanding the 24 hour/7 days per week Nurse Advice line (NAL) for after-hours health care expertise;
> (2) simplifying appointment types across the MHS from 15 standard types to two;
> (3) integrating the NAL with Patient Centered Medical Home clinics with ability to schedule MTF appointments, transferring the caller to the MTF via telephone, or providing information about MTF Urgent Care (UC) and Emergency Room (ER) Fast Track options.

Access has been further enhanced by requiring first call resolution from MTF appointment systems and monitoring patient access and satisfaction through a standardized outpatient survey called the Joint Outpatient Experience Survey, consolidating disparate Service surveys while capitalizing on the extensive depth of those surveys, allowing MTF management to assess their providers' performance on a routine basis from their beneficiary's perspective. The MHS is evaluating an Urgent Care Pilot across the US allowing expanded access for urgent care other than through an emergency room and expanded policies governing more effective referrals for specialty care as well as mandating standards of access. Expanding and promoting TRICARE On Line has enhanced patient-provider communications via secure messaging, allowing flexibility in making or cancelling MTF appointments by selecting preferred date and time parameters and setting prescription reminders for themselves or family members to refill prescriptions or check prescription status.

The three Services and the DHA have jointly aligned Tri-Service Telehealth initiatives to focus current efforts on Telehealth to the Patient Location, Teleconsultations, and Remote Health Monitoring. In May 2014, MHS leadership approved Project ECHO® (Extension for Community Healthcare Outcomes), developed by the University of New Mexico, as a direct care telehealth initiative. Project ECHO® uses a hub and spoke model to link a team of expert clinicians with multiple Patient Centered Medical Home teams to consult on care for direct care system enrollees. A recent focus for this initiative is Pain Management. Each of these telehealth initiatives are deployed at varying levels across the MHS, but are centered on the goal of providing access to quality care to direct care system enrollees. Telehealth, in many cases, is a covered benefit in purchased care as well. Also, under the provisional coverage authority in the

NDAA 2015, section 704, TRICARE can now review and cover emerging health care services and supplies that do not meet TRICARE's reliable evidence criteria, which will provide greater uniformity in the availability of emerging healthcare services across direct and private sector care.

Quality of Care: The MHS continues to capitalize on the availability of standardized health care measures for internal measurement of quality and safety, as well as for benchmarking. MHS takes advantage of and emulates industry measures to mirror those of the industry at large. The MHS must learn from, and be vigilant to emerging industry measures, and be flexible in IT and clinical infrastructure capability to capture comparable data streams and produce reliable and auditable measures for comparing to industry benchmarks. The MHS has developed and reported a number of measures which, over time, have been retired or suspended at the national level. For example, the FY 2014 TRICARE Evaluation Report reported several MHS enterprise measures produced at the MTF level from 2009 to 2012, which were suspended in 2012 by CMS and Hospital Compare (e.g., Acute Myocardial Infarction-AMI, measures 1, 3 and 5) and subsequently retired by CMS and TJC (e.g., AMI 4, Pneumonia measures PN-2, 4, 5c and 7).

For many years, the MHS has been dedicated to external assessment of the quality and safety of MTFs consistent with the health care industry standards. One mechanism relied on by both civilian institutions and DoD treatment facilities to assess the performance is through onsite surveys by nationally recognized accreditation organizations. MTFs are surveyed every three years. These surveys look at our sites and deliver recommendations for improvement of the delivery of healthcare at our facilities. MTFs address those recommendations to ensure sustained compliance with standards. The accreditation process consists of an onsite survey, accreditation body report, report to the facility, (including identifying areas for improvement) and MTF documentation of compliance with requirements for improvement. The 2016 Evaluation of the TRICARE Program (page 47) noted all inpatient (hospital) MTFs were accredited by TJC, an independent, not-for-profit organization that accredits and certifies more than 20,500 health care organizations and programs in the United States. Their accreditation and certifications are recognized nationwide as symbols of quality. The report also noted that all uniquely governed, free-standing ambulatory clinic MTFs (that are not subordinate to MTF hospitals) are accredited separately by either TJC (Army and Navy clinics) or the Accreditation Association for Ambulatory Health Care (AAAHC, for Air Force clinics that have not yet transitioned to TJC accreditation).

Patient Safety: The direct care system deployed Essentris® 2.0 (Partnership for Improvement requirements) and Essentris Newborn Note 1.0, prioritized DoD/Veterans Administration clinical practice guidelines for MHS direct care, and contracted the Joint Commission "High Reliability Self-Assessment Tool" (HRST) pilot (at four MTFs). The direct care system is expanding its participation in the National Surgical Quality Improvement Program (NSQIP) from 17 to 48 MTFs performing inpatient surgery. NSQIP is now available at 36 MTFs and expansion will be complete by the end of calendar year 2016. NSQIP will provide MTFs with data on the quality of surgical care delivered and help identify areas for improvement. The NSQIP Work Group has aligned American College of Surgeons NSQIP resources to support the IHI Surgical Quality collaborative and established the Tri-Service Ambulatory collaborative in November 2015 with nine ambulatory surgery centers (ASCs). An ASC Benchmarking contract is in procurement, pending award, to make quality data on ambulatory surgical care available to

help identify areas for improvement in the ambulatory surgery setting. The MHS has published and deployed the sentinel event policy; developed the Root Cause Analysis (RCA) Toolkit and Web-based repository of RCA lessons learned; acquired a clinical obstetric (OB) emergency simulator, standardizing OB simulation training across MHS; identified role-based competencies and education for patient safety, quality, and process improvement (S/Q/PI); and acquired and deployed the IHI Global Trigger Tool (GTT).

With respect to Infection Prevention and Control, an Infection Prevention Community of Practice has been established, promoting continuing education and sharing best practices. Also, the Infection Prevention and Control Work Group has expanded device-associated event reporting to inpatient wards in the Centers for Disease Control & Prevention National Healthcare Safety Network, while a DHA Procedural Instruction is in coordination with the Services to implement a comprehensive infection prevention program at each MTF. The Institute for Healthcare Improvement Industry's benchmark GTT is in the process of being deployed, and will provide a more intensive review of MTF safety concerns. The Learning Organization Integrated Product Team (IPT) has validated a gap analysis in available patient safety, quality, and Process Improvement learning resources. It is in the process of disseminating the Leadership Engagement Toolkit and will support MTF implementation of the toolkit with coaching resources. The IPT has started developing a roadmap for an MHS Learning Organization.

MHS HRO Way Forward-Key Initiatives for 2017

Pursuant to the HRO strategy, infrastructure changes have been approved and are being implemented across the Services and NCR-MD. The MHS will:

- Continue HRO program implementation, support MHS Review Action Plan Initiatives, and measure the effectiveness of these efforts;
- Continue Service-specific training, while overall working toward MHS synchronization;
- Capitalize on the experience of strategic partners to build improvement capability and capacity such as through the IHI Improvement Collaborative and educational opportunities. Learn from and leverage Service/NCR- MD successes in the journey to high reliability and share best practices;
- Continue to mature the P4I to drive system-wide improvements; and
- Continue to promote transparency with beneficiary input to refine health info on a public website. Develop Strategies for Patient Safety/Quality/Process Improvement (PS/Q/PI) education as a learning organization.

In furtherance of the above HRO strategy, the MHS has engaged the IHI in a collaborative partnership involving all three Services, the NCR MD, and multiple MTFs to improve primary and specialty care access and patient safety. These best practices will be shared across the MHS, and the partnership offers the enterprise acceleration in engaging with strategic partner health systems from around the world, setting up the framework to be a learning health system, training to support improvement capability, and rapid cycle innovation.

a) The MHS is rolling out two collaborative Learning Partnerships: Surgical Quality and Access to Care, with 22 and 25 participating MTF teams, respectively, across the MHS enterprise.

b) Team leads met with IHI faculty, including leading civilian health system executives, at the end of September 2016 to kick-off the year-long Learning Partnerships in these two improvement areas.

With respect to streamlining and enhancing further MTF primary and specialty care access, the MHS will deploy the Direct Access Reporting Tool to allow MTFs to measure and address unmet demand, fully leverage virtual health (Primary Care Manager (PCM) phone visits, the NAL and secure messaging), and streamline specialty appointing and referral management.

In addition to engaging the Institute for Healthcare Improvement Surgical Quality collaborative activities with key MTFs, MHS accountability for quality will be reinforced with development of a perinatal dashboard of relevant metrics; while the P4I will be used to target areas to enhance performance and expand and refine patient safety, quality, satisfaction, and health outcomes data, as well as increase transparency on Health.mil.

Safety: Develop strategies for PS/Q/PI education as a learning organization; support MTF leadership teams, implementing and sustaining leadership engagement practices; and roll-out OB Emergency Simulators with standardized training across the MHS, and a GTT to monitor for adverse events and improve safety.

Summary and Conclusions

The FY 2016 Evaluation of the TRICARE Program was more extensive than prior annual reports to partially meet the intent of Congress by addressing each of the requirements of section 713, and reporting results at the MHS enterprise level, but not at the detailed level of each MTF worldwide. The report summarized the enterprise-level results on page 47 with greater detail on subsequent pages and presented our strategy for subsequently complying with section 713 in FY 2016 by also complying with the requirements of section 712—publishing on a publically available Internet website (within 180 days of enactment of the NDAA) data on patient safety, quality of care, satisfaction and health outcomes at the MTF level. Our public-facing website went live on May 20, 2016, ahead of the section 712 required deadline, and added additional information required of section 713, pertaining to the accreditation status and findings of each MTF, and relevant Service policies or procedures supporting access, quality, and safety. The Office of the ASD(HA) portal at www.health.mil includes a hyperlink titled "MHS Transparency" (http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Patient-Portal-for-MHS-Quality-Patient-Safety-and-Access-Information). These data are available at individual MTF websites as well, under the same or similar titles. Therefore, in response to section 713, requiring the Department to assess in the annual report, with respect to each military MTF, patient safety, quality of care, and access to care, combined, the two sources provided:

a) An identification of the number of practitioners providing health care in military MTFs reported to the NCBD during the year. Response: This information was provided on page 47 of the FY 2016 Report and will be updated in the FY 2017 report.

b) With respect to each military MTF, an assessment of:
   1) The current accreditation status of each facility including recommendations for corrective action. Response: This information was partially provided on page 47 of the FY 2016 report by summarizing the number of accredited facilities in each Service Department. Also, the accreditation status of each MTF, type of accreditation and survey dates, and summary of the requirements for improvement before accreditation status would be granted are provided at www.health.mil/AccreditationandPolicy. The accreditation status of each MTF is often displayed at the MTF's website (e.g., Walter Reed National Military Medical Center's site reflects over 19 program accreditations at http://www.wrnmmc.capmed.mil/about%20us/QSPR/SitePages/Home.aspx.)

   2) Any policies or procedures implemented during the year by the Secretary of the military department concerned, designed to improve patient safety, quality of care, and access to care. Response: A consolidated summary of relevant HA and Service Polices is provided at www.health.mil/AccreditationandPolicy. Appropriate HA and Military Department level policies are also provided in their associated subject areas related to access, patient safety, and quality of care at the public facing www.health.mil.

   3) Data on surgical and maternity care outcomes during the year. Response: MHS-level data were presented on pages 47, 50, and 51 of this year's report. MTF-level data over time are publically available at www.health.mil in the "Health Outcomes" section showing number of deliveries, percentage of deliveries to full term, and complications related to surgery. Complications related to surgery are compared to the top 10 percent of NSQIP rates among 600 leading hospitals in the U.S.

   4) Data on appointment wait times during the year. Response: MHS-level data were presented in the Access section of this year's report, from pages 37 to 46. MTF-level data over time are publically available at www.health.mil in the "Patient Satisfaction and Access" section showing more detailed results for PCM continuity, access to acute and primary care appointments, and patient engagement and self-reported access to care data. Data presented for each MTF on the public website depict unique measures of access, and are compared to the MHS-stated established standards.

   5) Data on patient safety, quality of care, and access to care as compared with standards established by DoD. Response: As noted previously, the MHS performance management system, P4I, and the MHS Dashboard, present data at the MTF level aggregated upwards to the levels relevant for leadership review (e.g.,, MTF level for local commanders and their subject matter expert staff, or Service Intermediate Command-level (e.g., Army's Regional Health Command-C, or Navy Medicine-East), or the multi service market area level, all the way to the Service and MHS levels. These data are routinely monitored and assessed by the Service staff and their

MTF leadership, as well as in relevant Tri-Service working groups for assessment of policies or processes of high performing MTFs that might be shared across the Services and/or standardized across the MHS. Measures have established expected targets of performance based on relevant and applicable civilian standards (e.g.,, comparing MHS results of the Outcomes measure of complications related to surgery compared to top 10 percent of the NSQIP-reporting hospitals in the nation, or MHS beneficiary ratings of their willingness to recommend a hospital to others compared to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) 50th percentile). Where there are no relevant external benchmarks or standards, the MHS either uses legislated standards (such as appointment availability) or targets based on improvement from prior year results (such as patient reports of their ability to get care when needed). Data are presented on the health.mil pubic-facing website to help our beneficiaries and constituency understand their health care capability in their local areas.

The FY 2017 Evaluation of the TRICARE Program, due March 1, 2017, includes a supplement from each of the Services and the NCR MD addressing all assessments required of section 713 of the 2016 NDAA with respect to each MTF. These assessments will present the progress by each Service's MTFs in improving access, quality and safety since the MHS review. The core report will again present an assessment of related measures required of section 713 at the enterprise-level, including additional data on MTF variability.

APPENDICES

APPENDIX A – SECTION 713. NDAA 2016

EXPANSION OF EVALUATION OF EFFECTIVENESS OF THE TRICARE PROGRAM TO INCLUDE INFORMATION ON PATIENT SAFETY, QUALITY OF CARE, AND ACCESS TO CARE AT MILITARY MEDICAL TREATMENT FACILITIES.

Section 717(a) of the National Defense Authorization Act for Fiscal Year 1996 (Public Law 104–106; 10 U.S.C. 1073 note) is amended—

(3) in paragraph (2), by striking the period at the end and inserting ''; and''; and

(4) by adding at the end the following new paragraph: ''(3) address patient safety, quality of care, and access to care at military medical treatment facilities, including—

> (A) an identification of the number of practitioners providing health care in military medical treatment facilities that were reported to the National Practitioner Data Bank during the year preceding the evaluation; and
>
> (B) with respect to each military medical treatment facility, an assessment of—
>
> > (i) the current accreditation status of such facility, including any recommendations for corrective action made by the relevant accrediting body;
> >
> > (ii) any policies or procedures implemented during such year by the Secretary of the military department concerned that were designed to improve patient safety, quality of care, and access to care at such facility;
> >
> > (iii) data on surgical and maternity care outcomes during such year; ''(iv) data on appointment wait times during such year; and ''(v) data on patient safety, quality of care, and access to care as compared to standards established by the Department of Defense with respect to patient safety, quality of care, and access to care.''

APPENDIX B - MHS Dashboard

Figure B-1. Enterprise View of Core Measures & Status

Figure B-2. MHS Dashboard- Drill-Down View to "Getting Care When Needed" Patient Survey-Based Measures- Service Comparison View

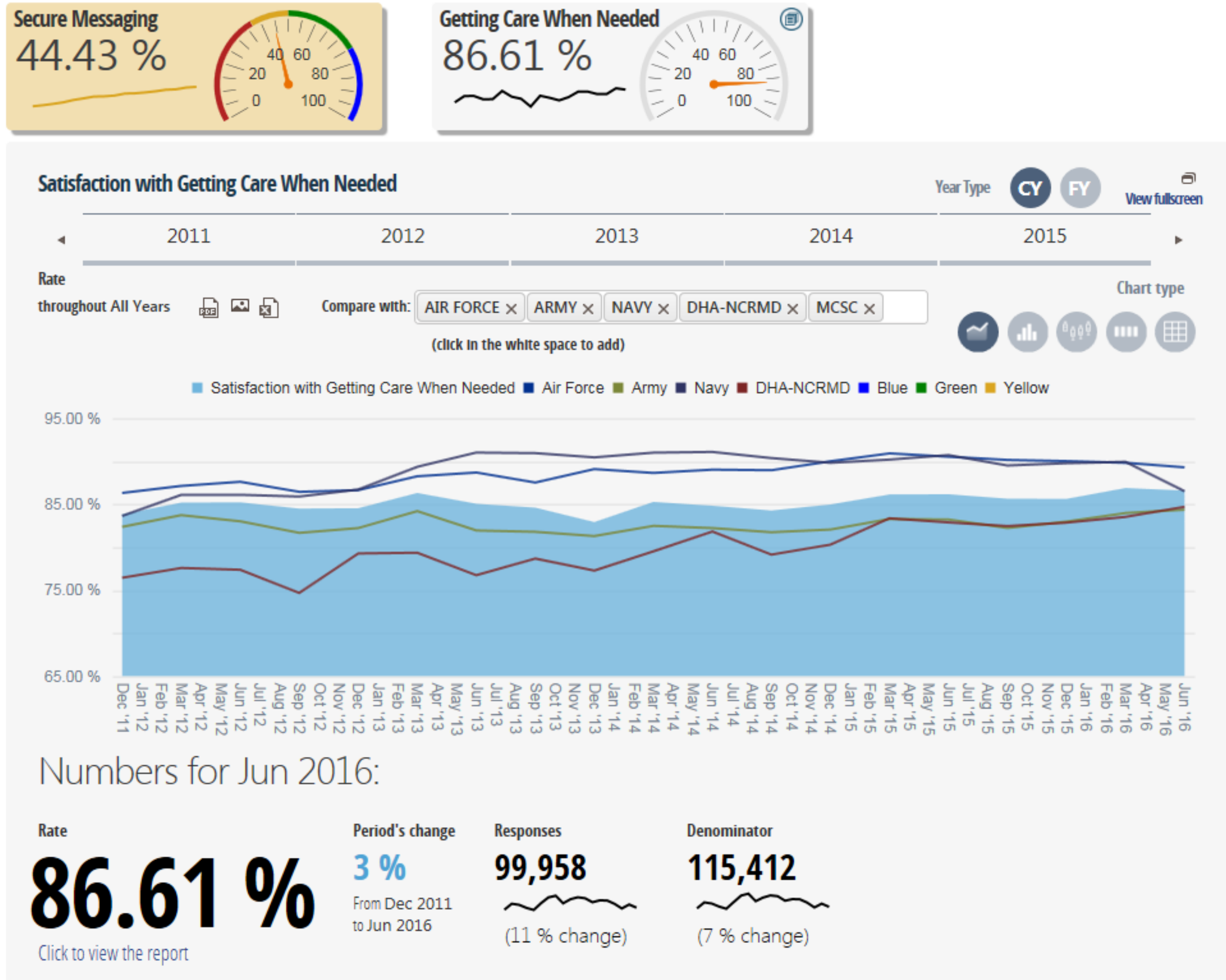
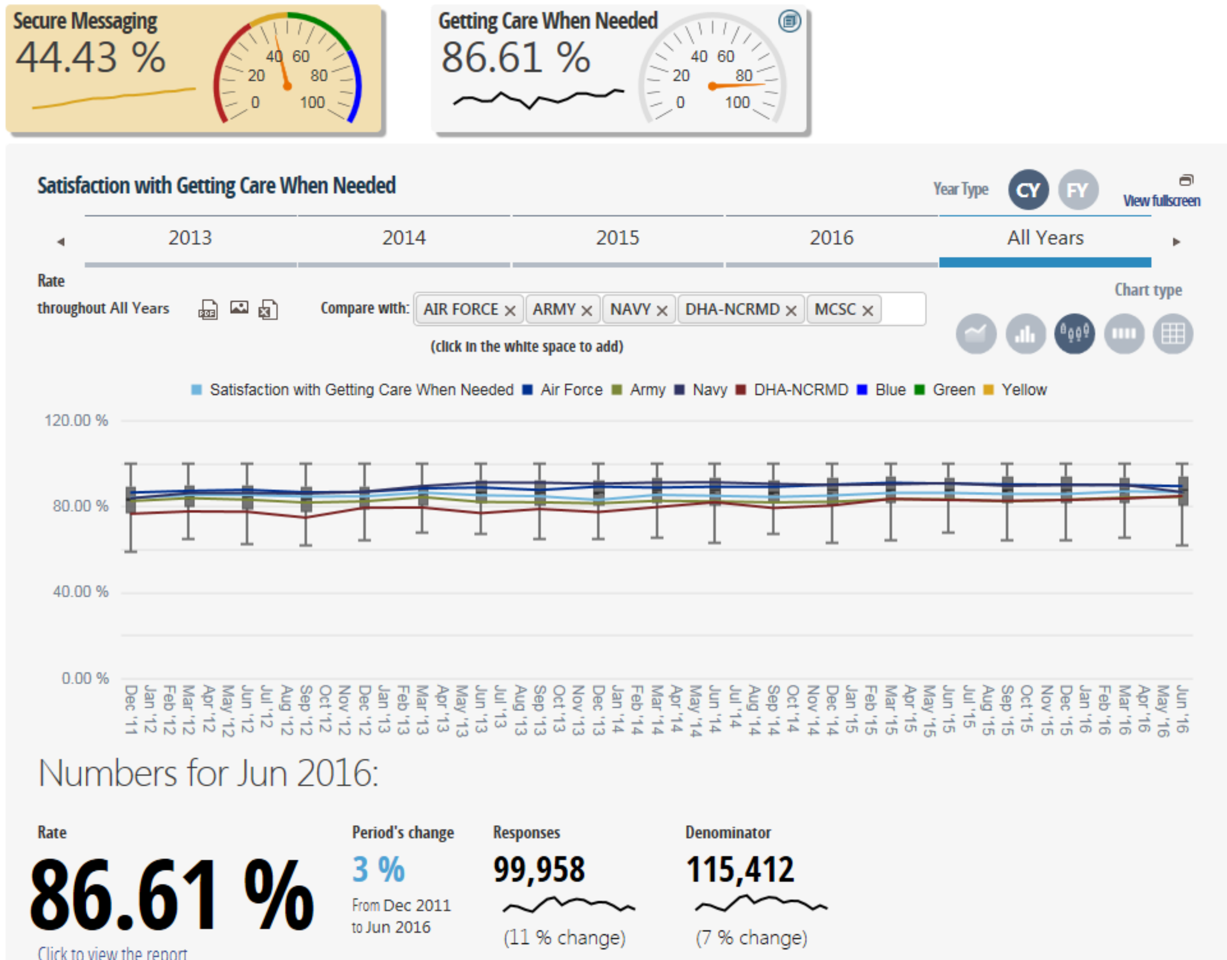


Figure B-3. MHS Dashboard- Drill-Down View to "Getting Care When Needed" Patient Survey-Based Measures- Service Comparison View With Box-and-Whisker Chart showing Variability in Service MTF Results over Time



APPENDIX C - SECTION 712 OF NDAA 2016

SEC. 712. PUBLICATION OF DATA ON PATIENT SAFETY, QUALITY OF CARE, SATISFACTION, AND HEALTH OUTCOME MEASURES UNDER THE TRICARE PROGRAM.

Section 1073b of title 10, United States Code, is amended by adding at the end the following:
''(c) PUBLICATION OF DATA ON PATIENT SAFETY, QUALITY OF CARE, SATISFACTION, AND HEALTH OUTCOME MEASURES.—(1) Not later than 180 days after the date of the enactment of the National Defense Authorization Act for Fiscal Year 2016, the Secretary of Defense shall publish on a publically available Internet website of the Department of Defense data on all measures that the Secretary considers appropriate that are used by the Department to assess patient safety, quality of care, patient satisfaction, and health outcomes for health care provided under the TRICARE program at each military medical treatment facility.
''(2) The Secretary shall publish an update to the data published under paragraph (1) not less frequently than once each quarter during each fiscal year.
''(3) The Secretary may not include data relating to risk management activities of the Department in any publication under paragraph (1) or update under paragraph (2).
''(4) The Secretary shall ensure that the data published under paragraph (1) and updated under paragraph (2) is accessible to the public through the primary Internet website of the Department and the primary Internet website of the military medical treatment facility with respect to which such data applies.''

APPENDIX D - TRANSPARENCY

Figure D-1. MHS Public Facing Transparency Portal (www.health.mil)

Figure D-2. MHS Transparency page (www.health.mil)

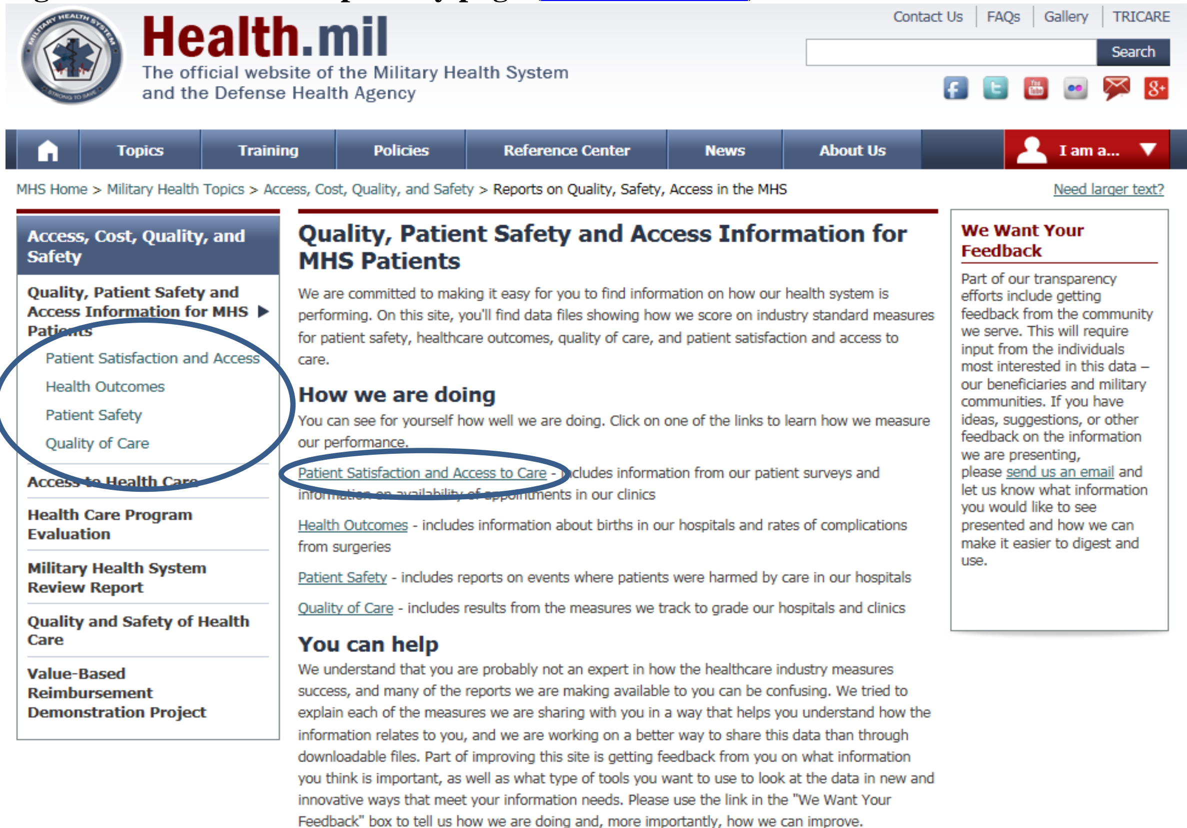


Figure D-3. MHS Transparency- Patient Satisfaction and Access (www.health.mil)

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MHS Home > Military Health Topics > Access, Cost, Quality, and Safety > Reports on Quality, Safety, Access in the MHS > Patient Satisfaction and Access

Need larger text?

Access, Cost, Quality, and Safety

Quality, Patient Safety and Access Information for MHS Patients

- Patient Satisfaction and Access
- Health Outcomes
- Patient Safety
- Quality of Care

Access to Health Care

Health Care Program Evaluation

Military Health System Review Report

Quality and Safety of Health Care

Value-Based Reimbursement Demonstration Project

Patient Satisfaction and Access

There are many factors the MHS tracks related to Patient Satisfaction and Access. For your convenience we have categorized these in the below sections:

- Primary Care Manager Continuity
- Access to Acute and Primary Care Appointments
- Service Survey—Satisfaction with Seeing a Provider When Needed
- Do patients recommend their hospital?
- Health Care Survey of DoD Beneficiaries

Primary Care Manager Continuity

When your provider team is familiar with your medical history, it is good for you, especially if you have more complex medical issues. Our Patient Centered Medical Homes (PCMHs) help you see the same provider team. Your PCMH team will work to keep you healthy by suggesting preventive services that may prevent more complex problems later. We track this measure to find out how often you are seen by the same medical team. *Last Updated October 7, 2016*

Download in Excel | Download in PDF

What do we measure?

How do I read the results?

Military Health System Access to Care Standards

Our goals for access to care

Our goal is to ensure you receive the right level of care, at the right time, by the right provider. The MHS access to care standard for patients to receive an appointment for acute care is within 24 hours (1 day) and to receive an appointment for routine care is within 7 days. If the military hospital or clinic cannot meet these standards with your primary care manager, the facility will schedule an appointment with another provider. We aim to increase the number of primary care appointments per day and have the right number of appointments available at the right time of day to meet our patient

Figure D-4. MHS Transparency- Primary Care Manager Continuity Data (www.health.mil)

Military Treatment Facility	Number of Appointments where the Patient saw their own Provider	Total Number of Appointments	Percent of Appointments where the Patient saw their own provider
April 2016			
Army			
Army Community Hospital BASSETT-WAINWRIGHT	3174	6501	48.8%
Army Community Hospital BAYNE-JONES-POLK	3417	5155	66.3%
Army Community Hospital BLANCHFIELD-CAMPBELL	10725	17685	60.6%
Army Community Hospital BRIAN ALLGOOD-SEOUL	3549	6877	51.6%
Army Community Hospital EVANS-CARSON	10256	16908	60.7%
Army Community Hospital IRELAND-KNOX	4109	6510	63.1%
Army Community Hospital IRWIN-RILEY	5761	8387	68.7%
Army Community Hospital KELLER-WEST POINT	2427	3280	74.0%
Army Community Hospital LEONARD WOOD	2805	5156	54.4%
Army Community Hospital MARTIN-BENNING	8560	13785	62.1%
Army Community Hospital MONCRIEF-JACKSON	3709	4964	74.7%
Army Community Hospital R W BLISS-HUACHUCA	1962	2838	69.1%
Army Community Hospital REYNOLDS-SILL	4947	7594	65.1%
Army Community Hospital WEED-IRWIN	2139	2753	77.7%
Army Community Hospital WINN-STEWART	7123	11824	60.2%
Army Health Clinic BG CRAWFORD F SAMS-CAMP ZAMA	369	682	54.1%
Army Health Clinic FOX-REDSTONE ARSENAL	1201	2522	47.6%

To improve your healthcare, we want you to be able to see your own provider when you need care. Our goal is 65%.

Figure D-5. MHS Transparency- Access to Acute and Primary Care Appointments (www.health.mil)

Average days to be seen for an acute medical condition (Goal < 1 day)*					
Army					
Military Treatment Facility	**April 2016**	**May 2016**	**June 2016**	**July 2016**	**August 2016**
Army Community Hospital BASSETT-WAINWRIGHT	0.99	1.03	0.87	0.93	0.87
Army Community Hospital BAYNE-JONES-POLK	0.55	0.92	0.50	0.80	0.82
Army Community Hospital BLANCHFIELD-CAMPBELL	1.32	1.12	1.40	1.94	1.26
Army Community Hospital BRIAN ALLGOOD-SEOUL	1.91	2.07	2.16	1.19	0.81
Army Community Hospital EVANS-CARSON	0.66	1.03	0.90	1.14	0.82
Army Community Hospital IRELAND-KNOX	1.17	1.30	1.33	1.42	1.07
Army Community Hospital IRWIN-RILEY	1.52	1.10	1.82	1.38	2.45
Army Community Hospital KELLER-WEST POINT	0.89	0.85	0.88	0.84	0.61
Army Community Hospital LEONARD WOOD	0.82	0.73	0.75	0.83	0.54
Army Community Hospital MARTIN-BENNING	0.85	0.88	0.85	1.34	0.82
Army Community Hospital MONCRIEF-JACKSON	1.48	0.92	0.82	1.07	0.77
Army Community Hospital R W BLISS-HUACHUCA	0.98	0.95	1.11	1.30	1.09
Army Community Hospital REYNOLDS-SILL	1.36	3.11	1.52	1.19	1.33
Army Community Hospital WEED-IRWIN	0.63	0.72	0.53	0.84	0.80
Army Community Hospital WINN-STEWART	0.80	1.11	2.89	3.08	2.41
Army Health Clinic BG CRAWFORD F SAMS-CAMP ZAMA	0.54	0.70	0.46	0.79	0.46
Army Health Clinic FOX-REDSTONE ARSENAL	1.27	1.13	1.14	3.73	0.93
Army Health Clinic GUTHRIE-DRUM	3.64	3.57	1.37	1.84	1.12
Army Health Clinic KENNER-LEE	1.20	1.72	1.75	1.63	1.16
Army Health Clinic LYSTER-RUCKER	0.53	0.57	0.45	0.75	0.51
Army Health Clinic MCDONALD-EUSTIS	0.67	0.91	1.02	1.53	0.89
Army Health Clinic MUNSON-LEAVENWORTH	0.54	0.60	0.51	0.66	0.56
Army Medical Activity BAVARIA-VILSECK	1.67	1.58	1.13	1.10	1.22
Army Medical Center Brooke Army Medical Center-FSH	1.12	1.26	1.09	1.26	0.97
Army Medical Center DARNALL-HOOD	1.17	1.42	1.29	1.41	1.12
Army Medical Center EISENHOWER-GORDON	1.05	0.97	0.96	1.00	0.88
Army Medical Center MADIGAN-LEWIS	1.70	2.19	2.17	1.93	2.04
Army Medical Center TRIPLER-SHAFTER	0.92	1.34	2.14	1.56	1.20
Army Medical Center WILLIAM BEAUMONT-BLISS	1.04	1.53	0.99	1.20	1.34
Army Medical Center WOMACK-BRAGG	1.34	1.41	1.12	1.35	1.11
KIMBROUGH AMBULATORY CARE CENTER-MEADE	1.22	1.39	1.59	2.16	2.00
LANDSTUHL Regional Medical Center	1.68	1.82	1.74	1.37	1.03
Air Force					
Military Treatment Facility	**April 2016**	**May 2016**	**June 2016**	**July 2016**	**August 2016**
10th MED GRP-ACADEMY	1.54	1.06	2.91	2.69	1.73
14th MED GRP-COLUMBUS	0.63	0.75	0.53	1.02	0.91
15th MED GRP-JB HICKAM-PEARL HARBOR	1.11	1.39	1.08	1.21	0.89
17th MED GRP-GOODFELLOW	0.79	1.24	0.90	7.29	3.83
18th MED GRP-KADENA	1.48	6.11	2.24	2.59	3.83
19th MED GRP-LITTLE ROCK	0.85	1.00	0.88	0.92	0.87
1st SPCL OPS MED-HURLBURT	1.03	1.04	1.01	1.39	0.73
20th MED GRP-SHAW	0.94	0.98	0.77	0.95	0.69
21st MED GRP-PETERSON	1.07	1.93	1.30	1.80	2.04
22nd MED GRP-MCCONNELL	1.48	1.25	1.58	2.19	1.96
23rd MED GRP-MOODY	1.63	5.85	2.28	1.78	1.59
27th SPCLOPS MDGRP-CANNON	1.86	2.56	1.12	2.79	2.42
28th MED GRP-ELLSWORTH	0.61	1.02	2.69	1.59	0.72

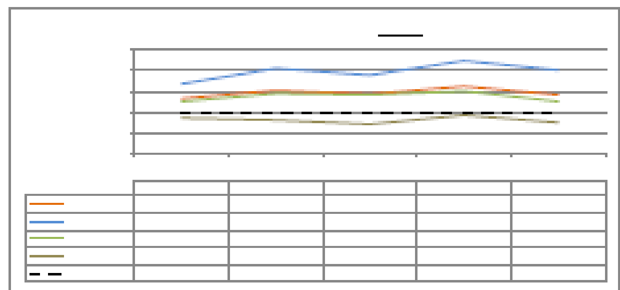
This table displays Primary Care Access

*The MHS appreciates that patients want a variety of appointments to choose from and measures access by how many days into our schedule we have 3 available appointments for a patient to choose from.

Examples with hours:
0.7 days = 16 hours

Figure D-5. (Continued) MHS Transparency- Access to Acute and Primary Care Appointments (www.health.mil)

Average days to be seen for an acute medical condition (Goal < 1 day)*					
	Apr-16	May-16	Jun-16	Jul-16	Aug-16
MHS Overall	1.32	1.52	1.43	1.63	1.41
Air Force	1.68	2.05	1.89	2.34	2.01
Army	1.25	1.44	1.41	1.50	1.35
Navy	0.85	0.80	0.70	0.92	0.74
Target	1.00	1.00	1.00	1.00	1.00



Average days to be seen for a routine or follow up appointment (Goal < 7 days)*					
	Apr-16	May-16	Jun-16	Jul-16	Aug-16
MHS Overall	6.42	7.25	7.48	7.54	7.62
Air Force	6.94	8.11	8.40	8.66	8.80
Army	5.25	6.08	6.25	6.35	6.51
Navy	4.20	4.55	5.13	5.34	5.35
Target	7.00	7.00	7.00	7.00	7.00

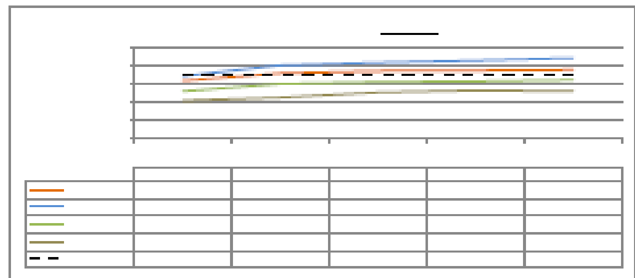


Figure D-6. MHS Transparency- Transparency- Able to See Provider When Needed (Get Care) (www.health.mil)

Facility Name	Rating		
*Note: For these ratings, do not compare facility ratings *across* Services. Individiual facilities can be compared within a Service.*			
Army - Getting Care When Needed			
	FY15Q4	FY16Q1	FY16Q2
Army FY15 Totals	83%		
Army Totals	**82%**	**83%**	**84%**
ACH BASSETT-WAINWRIGHT	81%	77%	83%
ACH BAYNE-JONES-POLK	86%	82%	87%
ACH BLANCHFIELD-CAMPBELL	81%	82%	82%
ACH BRIAN ALLGOOD-SEOUL	86%	81%	88%
ACH EVANS-CARSON	81%	78%	80%
ACH IRELAND-KNOX	76%	75%	79%
ACH IRWIN-RILEY	83%	84%	86%
ACH KELLER-WEST POINT	92%	92%	93%
ACH LEONARD WOOD	82%	80%	81%
ACH MARTIN-BENNING	83%	85%	86%
ACH MONCRIEF-JACKSON	76%	82%	82%
ACH REYNOLDS-SILL	80%	85%	88%
ACH WEED-IRWIN	87%	86%	90%
ACH WINN-STEWART	80%	82%	81%
AHC ANDREW RADER-MYER-HENDERSON	85%	85%	89%
AHC ANSBACH	91%	88%	92%
AHC AP HILL	**	100%**	**
AHC BARQUIST-DETRICK	93%	94%	92%
AHC BAUMHOLDER	79%	83%	85%
AHC BG CRAWFORD F SAMS-CAMP ZAMA	89%	95%	91%
AHC BRUSSELS	91%	100%	97%
AHC CAMP CASEY-TONGDUCHON	87%	77%	80%
AHC CAMP HUMPHREYS-PYONGTAEK	74%	73%	76%
AHC CAMP STANLEY	83%	80%	100%**

Figure D-7. MHS Transparency- Patient Engagement- Do Patients Recommend Their Hospital (www.health.mil)

- Patient Satisfaction and Access
- Health Outcomes
- Patient Safety
- Quality of Care

Access to Health Care

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- Service Survey—Satisfaction with Seeing a Provider When Needed
- Do patients recommend their hospital?
- Health Care Survey of DoD Beneficiaries

Primary Care Manager Continuity

When your provider team is familiar with your medical history, it is good for you, especially if you have more complex medical issues. Our Patient Centered Medical Homes (PCMHs) help you see the same provider team. Your PCMH team will work to keep you healthy by suggesting preventive services that may prevent more complex problems later. We track this measure to find out how often you are seen by the same medical team. *Last Updated October 7, 2016*

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What do we measure?

How do I read the results?

Access to Acute and Primary Care Appointments

Seeing your provider in a timely manner is important to you – and to us. Our goal is to ensure you receive the right level of care, at the right time, by the right provider. This measure is used across the health care industry and lets us know if we are meeting our access to care standards. If the military hospital or clinic can't get you an appointment with your Primary Care Manager within the standards, they will get you an appointment with another provider. We monitor this metric on a monthly basis and make more appointments available when the measure shows we need to. *Last Updated October 7, 2016*

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What do we measure?

How do I read the report?

Service Survey—Satisfaction with Seeing a Provider When Needed

Seeing your provider when you need to is important to you – and to us. We want to ensure that you get the care you need when you need it. This measure lets us know if you think we responded appropriately to your appointment request. *Last Updated October 7, 2016*

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What do we Measure?

How do I read the results?

Do patients recommend their hospital?

We value your opinion on your hospital stay. We want to see how we're doing over time, and how we compare to civilian hospitals. *Last Updated October 7, 2016*

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receive the right level of care, at the right time, by the right provider. The MHS access to care standard for patients to receive an appointment for acute care is within 24 hours (1 day) and to receive an appointment for routine care is within 7 days. If the military hospital or clinic cannot meet these standards with your primary care manager, the facility will schedule an appointment with another provider. We aim to increase the number of primary care appointments per day and have the right number of appointments available at the right time of day to meet our patient demand.

What are we doing to improve access to care?

The MHS has standardized our primary care appointments across the enterprise, matching appointment availability based on patient demand. The military hospitals and clinics have transitioned their primary care templates to offer only two types of appointments, primary care appointments available within 24 hours, and primary care appointments available in the future. This simplified approach to primary care appointing is based on national Institute of Medicine best practices.

What if I have questions about access to care?

If your experience does not match our standards, please contact your patient advocate. You can also check your military hospital or clinic's webpage or visit your facility's Facebook page for ways to provide feedback.

Figure D-8. MHS Transparency- Patient Engagement- Do Patients Recommend Their Hospital, Detail Data (www.health.mil)

Facility Name	Rating	Benchmark
Army Overall FY2016Q2	74%	National Civilian Benchmark Average is 71%
Navy Overall FY2016Q2	77%	
Air Force Overall FY2016Q2	80%	
NCR Overall FY2016Q2	85%	

Navy - Recommend Hospital	FY15Q4	FY16Q1	FY16Q2
Navy - FY15 Total		74%	
NH BEAUFORT	75%*	100%*	67%*
NH BREMERTON	75%	69%	74%
NH CAMP LEJEUNE	69%	68%	71%
NH CAMP PENDLETON	69%	76%	72%
NH GUAM	87%	85%	82%
NH GUANTANAMO BAY	*	80%*	100%*
NH JACKSONVILLE	74%	76%	82%
NH NAPLES	63%*	88%	92%
NH OAK HARBOR	55%	63%	71%
NH OKINAWA	83%	86%	82%
NH PENSACOLA	83%	82%	84%
NH ROTA	100%*	85%	83%
NH SIGONELLA	100%*	100%*	89%*
NH TWENTYNINE PALMS	62%	69%	67%
NH YOKOSUKA	68%	89%	76%
NMC PORTSMOUTH	72%	72%	73%
NMC SAN DIEGO	75%	73%	80%

Facility Name	Rating	Benchmark
Army Overall FY2016Q2	74%	National Civilian Benchmark Average is 71%
Navy Overall FY2016Q2	77%	
Air Force Overall FY2016Q2	80%	
NCR Overall FY2016Q2	85%	

Air Force - Recommend Hospital	FY15Q4	FY16Q1	FY16Q2
Air Force - FY15 Total		79%	
AF-H-31st MED GRP-AVIANO	75%	83%	90%
AF-H-35th MED GRP-MISAWA	100%*	57%*	80%*
AF-H-366th MED GRP-MOUNTAIN HOME	67%*	100%*	67%*
AF-H-374th MED GRP-YOKOTA AB	83%*	62%	60%*
AF-H-48th MED GRP-LAKENHEATH	79%	91%	83%
AF-H-51st MED GRP-OSAN AB	*	*	100%*
AF-H-633rd MED GRP-JB LANGLEY-EUSTIS	75%	73%	76%
AF-H-673rd MED GRP-JB ELMNDRF-RICHARDSON	75%	77%	73%
AF-H-96th MED GRP-EGLIN	79%	80%	79%
AF-MC-60th MED GRP-TRAVIS	78%	77%	79%
AF-MC-81st MED GRP-KEESLER	89%	86%	87%
AF-MC-88th MEDICAL GROUP	78%	80%	85%
AF-MC-99th MED GRP-NELLIS	81%	80%	77%

Figure D-9. MHS Transparency- Health Care Survey of DoD Beneficiaries Page (www.health.mil)

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- **Value-Based Reimbursement Demonstration Project**

Patient Satisfaction and Access

There are many factors the MHS tracks related to Patient Satisfaction and Access. For your convenience we have categorized these in the below sections:

- Primary Care Manager Continuity
- Access to Acute and Primary Care Appointments
- Service Survey—Satisfaction with Seeing a Provider When Needed
- Do patients recommend their hospital?
- Health Care Survey of DoD Beneficiaries

Primary Care Manager Continuity

When your provider team is familiar with your medical history, it is good for you, especially if you have more complex medical issues. Our Patient Centered Medical Homes (PCMHs) help you see the same provider team. Your PCMH team will work to keep you healthy by suggesting preventive services that may prevent more complex problems later. We track this measure to find out how often you are seen by the same medical team. *Last Updated October 7, 2016*

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What do we measure?

How do I read the results?

Military Health System Access to Care Standards

Our goals for access to care

Our goal is to ensure you receive the right level of care, at the right time, by the right provider. The MHS access to care standard for patients to receive an appointment for acute care is within 24 hours (1 day) and to receive an appointment for routine care is within 7 days. If the military hospital or clinic cannot meet these standards with your primary care manager, the facility will schedule an appointment with another provider. We aim to increase the number of primary care appointments per day and have the right number of appointments available at the right time of day to meet our patient

Figure D-10. MHS Transparency- Health Care Survey of DoD Beneficiaries- 2016 All Users Army Regional Summary (www.health.mil)

Adult Annual Beneficiary Reports

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2016 | West Army | All Users

Composite Scores	Ease of Access		Communication and Customer Service			Ratings				Prevention	Behaviors
Region	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Claims Processing	Health Plan Rating	Health Care Rating	Personal Doctor Rating	Specialty Care Rating	Preventive Care	Healthy Behaviors
Trends	Trend	Trend	Trend	Trend	Trend	Trend	Trend	Trend	Trend	Trend	Trend
Benchmark	86	84	95	85	86	57	74	82	81	92	78
USA MHS	77[b]	76[b]	91[b]	79[b]	87	63[a]	64[b]	74[b]	77[b]	89[b]	83[a]
Army	76[b]	72[b]	90[b]	77[b]	84	64[a]	62[b]	73[b]	73[b]	89[b]	83[a]
West	76[b]	75[b]	90[b]	76[b]	84[b]	62[a]	62[b]	74[b]	76[b]	89[b]	83[a]
West Army	74[b]	71[b]	89[b]	76[b]	83	63[a]	61[b]	73[b]	71[b]	89[b]	84[a]
Evans ACH-Ft. Carson	78	62[b]	91	70[b]	87	58	65	68[b]	77	87	87[a]
Irwin ACH-Ft. Riley	70[b]	74	84	***	89	58	58[b]	65	56[b]	85	68
L. Wood ACH-Ft. Leonard Wood	74[b]	64[b]	87	***	***	74[a]	71	68	78	91	69[b]
Madigan AMC-Ft. Lewis	67[b]	71	82[b]	72	79	58	53[b]	73	70	90	84[a]
Munson AHC-Ft. Leavenworth	85	90	95	79	86	70[a]	76	77	84	92	84
R W Bliss AHC-Ft. Huachuca	80	77	91	82	89	57	57[b]	71[b]	77	92	85[a]

Figure D-11. MHS Transparency- Patient Safety (www.health.mil)

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Patient Safety

There are many factors the MHS tracks related to Patient Safety. For your convenience we have categorized these in the below sections:

- Sentinel Events in the Military Health System
- Sentinel Events by Military Hospital
- Patient Safety Event Reporting
- Catheter-Associated Urinary Tract Infection in the ICU
- Central Line Associated Blood Stream Infection in the ICU

Sentinel Events in the Military Health System

We encourage our medical staffs to report all types of patient safety events – injuries, illnesses and especially deaths. Sentinel events are those that result in harm to a patient and that require immediate reporting, response and investigation. More reported events don't necessarily mean more events have occurred. It could mean that more providers have reported events. This measure is a system-wide one that gives you a snapshot of what kind of sentinel events the entire system reported in 2014 and 2015. *File Updated May 23*

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What do we measure?

How do I read the results?

Sentinel Events by Military Hospital

Figure D-12. MHS Transparency- Patient Safety, MTF-level Sentinel Events Notification (www.health.mil)

Sentinel Events Notifications Submitted by MTFs 2014 and 2015	2014 Total	2015 Total
Anesthesia Complications	*	*
Delay in Treatment: Lab, Path, Radiology, Referral, TX Order	19	22
Elopement: Disappearance, AMA	*	0
Environmental Events: Electronic Shock, Oxygen/Other Gas, Burn Incurred, Physical Restraints, Bed Rails	*	5
Fall: Accidental, Anticipated Physiological, Unanticipated Physiological	7	*
Fetal: No Signs of Life	4	5
Healthcare Associated Infection (Not Surgery/Procedure-Related; Ventilator, Other)	*	*
Intraoperative or Immediate Post-Op/ Post-Procedure or Surgery	18	18
Irretrievable Loss of an Irreplaceable Biological Specimen	*	*
Maternal (>= 20 WGA - 42 Days PP): Hemorrhage, Hysterectomy	5	35
Medication/Biological/Nutritional	5	11
Neonatal (APGAR >= 1; Birth 28 Days): Unexpected Death, Injury/Trauma, Hyperbilirubinemia	6	15
Potential Criminal Events: Impersonation, Abduction, Physical Assault, Sexual Assault, Homicide, Rape	0	*
Pressure Ulcers acquired After Admission/Presentation	0	*
Product or Device Events: Contaminated Drug/Devices/Biologics Not Used as Intended, Intravascular Air Embolism	*	*
Radiologic Events: Radiation Overdose, Prolonged Fluoroscopy, MRI	0	*
Suicide, Attempted Suicide or Self Harm	4	4
Surgical Site Infection	0	*
Unintended Retained Foreign Object	14	20
Unsafe Administration of Blood or Blood Products	*	0
Wrong Site Surgery: Wrong-Patient, Wrong-Site, Wrong-Procedure	20	25
Military Health System Reported Total	**111**	**174**

Source: Defense Health Agency Patient Safety Analysis Center; retrieved on 04/19/2016

SE data shown are based on event-occurred date and include all events that The Joint Commission considers reportable.

Some cells have an asterisk to comply with 10 U.S.C 1102 (Protection of individual event healthcare quality assurance data) and do not meet the definition of aggregate statistical data.

* = there was at least one event but too few to allow reporting without endangering patient privacy

YOUR MILITARY HEALTH SYSTEM INTENDS TO BE A LEADER IN TRANSPARENCY. SHARING INFORMATION WITH OUR PATIENTS WILL HELP US PARTNER TOGETHER IN THEIR CARE.

Figure D-13. MHS Transparency Tab, Patient Safety, Catheter-Associated Urinary Tract Infection in the ICU (CAUTI) (www.health.mil)

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- Patient Safety Event Reporting
- Catheter-Associated Urinary Tract Infection in the ICU
- Central Line Associated Blood Stream Infection in the ICU

Sentinel Events in the Military Health System

We encourage our medical staffs to report all types of patient safety events – injuries, illnesses and especially deaths. Sentinel events are those that result in harm to a patient and that require immediate reporting, response and investigation. More reported events don't necessarily mean more events have occurred. It could mean that more providers have reported events. This measure is a system-wide one that gives you a snapshot of what kind of sentinel events the entire system reported in 2014 and 2015. *File Updated May 23*

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What do we measure?

How do I read the results?

Sentinel Events by Military Hospital

We encourage our medical staffs to report all types of patient safety events – injuries, illnesses and especially deaths. Sentinel events are those that result in harm to a patient and that require immediate reporting, response and investigation. More reported events don't necessarily mean more events have occurred. It could mean that more providers have reported events. This measure is a facility-specific one that shows you what sentinel events occurred in individual hospitals or clinics. *File Updated May 23*

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What do we measure?

How do I read the results?

Patient Safety Event Reporting

You expect us to keep you safe when you are in one of our hospitals or clinics. One way we do that is by reporting and reviewing Patient Safety Events so we can identify and fix potentially unsafe conditions in our hospitals and clinics. Patient Safety Events are any avoidable event that could result in harm to a patient. This includes what we call "near miss" events where a patient isn't harmed, but could have been. Visit the Patient Safety Reporting page for the report.

What do we measure?

How do I read the results?

Catheter-Associated Urinary Tract Infection in the ICU

A catheter is a drainage tube that is inserted by a doctor into a patient's urinary bladder through the urethra and is left in place to collect urine while a patient is immobile or incontinent. When not put in correctly or kept clean, or if left in place for long periods of time, catheters can become an easy way for germs to enter the body and cause serious infections in the urinary tract. These infections are called catheter-associated urinary tract infections (CAUTIs), and they can cause additional illness or be deadly. CAUTIs are mostly preventable when healthcare providers use infection control steps recommended by the Centers for Disease Control and Prevention (CDC). *Last Updated October 7, 2016*

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Figure D-14. MHS Transparency- Patient Safety, Catheter-Associated Urinary Tract Infection in the ICU (CAUTI) Detail Report (www.health.mil)

MTFs	Central Line Associated Blood Stream Infections (ICU)		
	2014	2015	2016Q1 Q2
Air Force			
673rd Medical Group DoD/VA Joint Venture Hospital	*	0 Events *	0 Events *
96th Medical Group	*	0 Events *	0 Events *
David Grant Medical Center	No Different Than The National Benchmark	No Different Than The National Benchmark	No Different Than The National Benchmark
Keesler Medical Center	No Different Than The National Benchmark	No Different Than The National Benchmark	0 Events *
Langley AFB Hospital	0 Events *	0 Events *	0 Events *
Mike O'Callaghan Federal Hospital	0 Events *	0 Events *	0 Events *
Wright-Patterson Medical Center	*	0 Events *	0 Events *
Army			
Blanchfield Army Hospital	0 Events *	0 Events *	0 Events *
Brooke Army Medical Center	Better Than The National Benchmark	No Different Than The National Benchmark	Better Than The National Benchmark
Carl R. Darnall Army Medical Center	**	*	0 Events *
D.D. Eisenhower Army Medical Center	No Different Than The National Benchmark	No Different Than The National Benchmark	*
Evans Army Community Hospital	0 Events *	*	0 Events *
Landstuhl Regional Medical Center	**	0 Events *	0 Events *
Madigan Army Medical Center	Better Than The National Benchmark	Better Than The National Benchmark	No Different Than The National Benchmark
Tripler Army Medical Center	No Different Than The National Benchmark	Worse Than The National Benchmark	No Different Than The National Benchmark
William Beaumont Army Medical Center	No Different Than The National Benchmark	No Different Than The National Benchmark	*
Womack Army Medical Center	No Different Than National Benchmark	0 Events *	*
Navy			
Naval Hospital Bremerton	**	**	**
Naval Hospital Camp Lejeune	0 Events *	0 Events *	0 Events *
Naval Hospital Camp Pendleton	0 Events *	0 Events *	0 Events *
Naval Hospital Jacksonville	0 Events *	0 Events *	0 Events *
Naval Medical Center Portsmouth	No Different Than The National Benchmark	No Different Than The National Benchmark	No Different Than The National Benchmark
Naval Medical Center San Diego	No Different Than The National Benchmark	No Different Than The National Benchmark	No Different Than The National Benchmark
USNH OKINAWA	**	**	0 Events *
USNH Yokosuka	**	**	**
NCRMD			
Fort Belvoir Community Hospital	0 Events *	0 Events *	0 Events *
Walter Reed National Military Medical Center	No Different Than The National Benchmark	No Different Than The National Benchmark	No Different Than The National Benchmark

Figure D-15. MHS Transparency- Quality of Care Opening Page (www.health.mil)

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MHS Home > Military Health Topics > Access, Cost, Quality, and Safety > Reports on Quality, Safety, Access in the MHS

Need larger text?

Access, Cost, Quality, and Safety

- **Quality, Patient Safety and Access Information for MHS Patients**
  - Patient Satisfaction and Access
  - Health Outcomes
  - Patient Safety
  - Quality of Care
- **Access to Health Care**
- **Health Care Program Evaluation**
- **Military Health System Review Report**
- **Quality and Safety of Health Care**
- **Value-Based Reimbursement Demonstration Project**

Quality, Patient Safety and Access Information for MHS Patients

We are committed to making it easy for you to find information on how our health system is performing. On this site, you'll find data files showing how we score on industry standard measures for patient safety, healthcare outcomes, quality of care, and patient satisfaction and access to care.

How we are doing

You can see for yourself how well we are doing. Click on one of the links to learn how we measure our performance.

Patient Satisfaction and Access to Care - includes information from our patient surveys and information on availability of appointments in our clinics

Health Outcomes - includes information about births in our hospitals and rates of complications from surgeries

Patient Safety - includes reports on events where patients were harmed by care in our hospitals

Quality of Care - includes results from the measures we track to grade our hospitals and clinics

You can help

We understand that you are probably not an expert in how the healthcare industry measures success, and many of the reports we are making available to you can be confusing. We tried to explain each of the measures we are sharing with you in a way that helps you understand how the information relates to you, and we are working on a better way to share this data than through downloadable files. Part of improving this site is getting feedback from you on what information you think is important, as well as what type of tools you want to use to look at the data in new and innovative ways that meet your information needs. Please use the link in the "We Want Your Feedback" box to tell us how we are doing and, more importantly, how we can improve.

We Want Your Feedback

Part of our transparency efforts include getting feedback from the community we serve. This will require input from the individuals most interested in this data – our beneficiaries and military communities. If you have ideas, suggestions, or other feedback on the information we are presenting, please send us an email and let us know what information you would like to see presented and how we can make it easier to digest and use.

Figure D-16. MHS Transparency- Quality of Care Page (www.health.mil)

Access, Cost, Quality, and Safety

Quality, Patient Safety and Access Information for MHS Patients

- Patient Satisfaction and Access
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Access to Health Care

Health Care Program Evaluation

Military Health System Review Report

Quality and Safety of Health Care

Value-Based Reimbursement Demonstration Project

Quality of Care

There are many factors the MHS tracks related to Quality of Care. For your convenience we have categorized these in the below sections:

- Accreditation Measures
    - Inpatient Quality Measures Chosen by Military Hospitals for Accreditation
    - Accreditation Status of Military Hospitals and Clinics
- HEDIS® Outpatient Quality Measures
- HEDIS Outpatient Pediatric Measures
    - Well-Child Visits in the first 15 Months of Life
    - Upper Respiratory Infection (children's cough, cold and flu)
    - Pharyngitis Pain (children's sore throat)
- Other HEDIS Outpatient Quality Measures
    - Breast Cancer Screening
    - Cervical Cancer Screening
    - Colorectal Cancer Screening
    - Low Back Pain Imaging
    - Diabetes Testing and Control
    - Follow-up after Hospitalization for Mental Health (within 7 and 30 days)

You can also view VA/DoD Clinical Practice Guidelines.

Accreditation Measures

Inpatient Quality Measures Chosen by Military Hospitals for Accreditation

You expect your military hospital or clinic will provide you with quality care. One of the ways the Military Health System guarantees that we deliver you that care is by requiring all of our military hospitals and clinics be accredited by an outside agency. Most military hospitals and clinics use Joint Commission for accreditation, and all will eventually move to Joint Commission accreditation in the next few years. The measures in this report show how the military hospitals and clinics are graded using the Joint Commission standards. *File Updated June 23*

Download in Excel | Download as PDF

What do we measure?

How do I read the results?

Accreditation Status of Military Hospitals and Clinics

Because you expect your hospital or clinic to provide quality care, we require our clinics and hospitals to undergo on-site surveys by nationally-recognized accreditation organizations every three years. *File Updated May 23*

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Compare Civilian Hospitals

Hospital Compare

Hospital Compare is a national website, operated separately from the Military Health System (MHS). Hospital Compare has information about the quality of care at over 4,000 Medicare-certified hospitals across the country. You can use Hospital Compare to find hospitals and compare the quality of their care. All civilian facilities in the TRICARE network can be found on Hospital Compare. In the coming year, DoD facilities will be added to the Hospital Compare website.

Why is Hospital Compare important to me?

The intent is to help improve hospitals' quality of care by distributing objective, easy to understand data on hospital performance, and quality information from consumer perspectives.

Take a look at the data shown on this site, and compare it to other hospitals in the local community— whether they are in the TRICARE network or outside of it. You can discuss with your provider the information you find on Hospital Compare and decide which hospital may be best for you. If you have any concerns, please call the TRICARE contractor nearest you.

Compare

Figure D-17. MHS Transparency- Quality of Care, Accreditation Page (www.health.mil)

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MHS Home > Military Health Topics > Access, Cost, Quality, and Safety > Reports on Quality, Safety, Access in the MHS > Quality of Care

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Access, Cost, Quality, and Safety

Quality, Patient Safety and Access Information for MHS Patients

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Figure D-18. MHS Transparency- Quality of Care, Status of MTF Accreditation (www.health.mil)

Military Treatment Facility	Location	Accreditation Organization	Survey Month/ Year	Accreditation Status
AIR FORCE				
Aviano AB/31 MDG	Italy	The Joint Commission	Jan-14	Fully Accredited
Eglin AFB/96 MDG	Destin, FL	The Joint Commission	Jul-15	Fully Accredited
Elmendorf AFB/673 MDG	Anchorage, AK	The Joint Commission	Jun-14	Fully Accredited
JB Langley Eustis/633 MDG	Hampton, VA	The Joint Commission	Oct-14	Fully Accredited
Keesler AFB/81 MDG	Biloxi, MS	The Joint Commission	Feb-13	Fully Accredited
RAF Lakenheath AFB/48 MDG	UK	The Joint Commission	Nov-13	Fully Accredited
Misawa AB/35 MDG	Japan	The Joint Commission	Jun-15	Fully Accredited
Mt Home AFB/366 MDG	Mt Home AFB, ID	The Joint Commission	Aug-15	Fully Accredited
Nellis AFB/99 MDG	Las Vegas, NV	The Joint Commission	Jan-15	Fully Accredited
Osan AB/51 MDG	Korea	The Joint Commission	Mar-14	Fully Accredited
Travis AFB/60 MDG	Vacaville, CA	The Joint Commission	Dec-13	Fully Accredited
Wright Patterson AFB/88 MDG	Dayton, OH	The Joint Commission	Mar-15	Fully Accredited
Yokota AB/374 MDG	Japan	The Joint Commission	Jun-15	Fully Accredited
RAF Alconbury/423 ABS	UK	Accreditation Association for Ambulatory Health Care	Aug-14	Fully Accredited
Altus AFB/97 MDG	Altus, OK	Accreditation Association for Ambulatory Health Care	Jun-14	Fully Accredited
Andersen AB/36 MDG	Yigo, Guam	Accreditation Association for Ambulatory Health Care	May-14	Fully Accredited
Andrews AFB/779 MDG	Camp Springs, MD	Accreditation Association for Ambulatory Health Care	Aug-14	Fully Accredited
Barksdale AFB/2 MDG	Bossier City, LA	Accreditation Association for Ambulatory Health Care	Dec-13	Fully Accredited
Beale AFB/9 MDG	Marysville, CA	The Joint Commission	Dec-15	Fully Accredited
JB Anacostia-Bolling/579 MDG	Washington DC	Accreditation Association for Ambulatory Health Care	Feb-14	Fully Accredited
Buckley AFB/460 MDG	Aurora, CO	Accreditation Association for Ambulatory Health Care	Feb-14	Fully Accredited
Cannon AFB/27 SOMDG	Clovis, NM	Accreditation Association for Ambulatory Health Care	Apr-15	Fully Accredited
Charleston AFB/628 MDG	Charleston, SC	Accreditation Association for Ambulatory Health Care	Sep-14	Fully Accredited
Columbus AFB/14 MDG	Columbus, MS	Accreditation Association for Ambulatory Health Care	Apr-13	Fully Accredited
RAF Croughton/422 ABS	UK	Accreditation Association for Ambulatory Health Care	Aug-14	Fully Accredited
Davis–Monthan AFB/355 MDG	Tucson, AZ	Accreditation Association for Ambulatory Health Care	Mar-14	Fully Accredited
Dover AFB/436 MDG	Dover, DE	The Joint Commission	Dec-15	Fully Accredited
Dyess AFB/7 MDG	Abilene, TX	Accreditation Association for Ambulatory Health Care	Apr-13	Fully Accredited
Edwards AFB/412 MDG	Edwards AFB, CA	The Joint Commission	Jan-13	Fully Accredited
Eielson AFB/354 MDG	Eielson AFB, AK	Accreditation Association for Ambulatory Health Care	May-15	Fully Accredited
Ellsworth AFB/28 MDG	Rapid City, SD	The Joint Commission	Mar-13	Fully Accredited
F.E. Warren AFB/90 MDG	Cheyenne, WY	The Joint Commission	Nov-15	Fully Accredited
Fairchild AFB/92 MDG	Spokane, WA	The Joint Commission	Dec-15	Fully Accredited
Goodfellow AFB/17 MDG	San Angelo, TX	Accreditation Association for Ambulatory Health Care	Feb-14	Fully Accredited
Grand Forks AFB/319 MDG	Grand Forks, ND	Accreditation Association for Ambulatory Health Care	Aug-13	Fully Accredited
Hanscom AFB/66 MDS	Hanscom AFB, MA	The Joint Commission	Dec-15	Fully Accredited
JB Pearl Harbor-Hickam/15 MDG	Oahu, HI	Accreditation Association for Ambulatory Health Care	Aug-14	Fully Accredited
Hill AFB/75 MDG	Ogden, UT	Accreditation Association for Ambulatory Health Care	Oct-14	Fully Accredited
Holloman AFB/49 MDG	Holloman AFB, NM	Accreditation Association for Ambulatory Health Care	Mar-13	Fully Accredited
Hurlburt Field/1 SOMDG	Ft. Walton Beach, FL	The Joint Commission	Dec-15	Fully Accredited
Incirlik AB/39 MDG	Turkey	Accreditation Association for Ambulatory Health Care	Feb-13	Fully Accredited
Kadena AB/18 MDG	Japan	Accreditation Association for Ambulatory Health Care	Jan-13	Fully Accredited
Kirtland AFB/377 MDG	Albuquerque, NM	Accreditation Association for Ambulatory Health Care	Feb-13	Fully Accredited
Kunsan AB/8 MDG	Korea	Accreditation Association for Ambulatory Health Care	Mar-14	Fully Accredited
Laughlin AFB/47 MDG	Del Rio, TX	Accreditation Association for Ambulatory Health Care	Nov-13	Fully Accredited
Little Rock AFB/19 MDG	Little Rock, AR	Accreditation Association for Ambulatory Health Care	Sep-13	Fully Accredited
Los Angeles AFB/61 MDS	El Segundo, CA	Accreditation Association for Ambulatory Health Care	May-15	Fully Accredited
Luke AFB/56 MDG	Glendale, AZ	Accreditation Association for Ambulatory Health Care	Oct-14	Fully Accredited

The Military Health System is dedicated to providing quality of care to our beneficiaries.

Our clinics and hospitals undergo on-site surveys by nationally-recognized accreditation organizations every three years.

Figure D-19. MHS Transparency- Quality of Care, Accreditation, Inpatient Quality Measures (ORYX- Air Force MTFs (www.health.mil)

Inpatient Hospital Quality Measures - Joint Commission National Hospital Quality Measures (ORYX®)

These inpatient measures are composites...the individual measures that make up the composites are available on The Joint Commission Website at www.qualitycheck.org

MTF	Measure	3Q15	4Q15	1Q16
Air Force				
31 MDG - Aviano AB	Venous Thromboembolism (clots)	100%	100%	100%
	Substance Use	100%	100%	0%
	Perinatal Care	100%	100%	100%
	Tobacco Treatment	100%	100%	100%
	Immunization	ND	47%	61%
96 MDG - Eglin AFB	Perinatal Care	100%	100%	100%
	Tobacco Treatment	62%	83%	82%
	Venous Thromboembolism	100%	95%	ND
	Immunization	ND	63%	66%
673 MDG - Joint Base Elmendorf-Richardson	Venous Thromboembolism	94%	94%	0%
	Tobacco Treatment	80%	75%	59%
	Perinatal Care	100%	100%	100%
	Immunization	ND	83%	86%
81 MDG - Keesler AFB	Children's Asthma Care	100%	0%	ND
	Tobacco Treatment	70%	88%	88%
	Venous Thromboembolism	100%	100%	ND
	Perinatal Care	100%	100%	100%
	Immunization	ND	46%	64%
48 MDG - RAF Lakenheath	Perinatal Care	100%	100%	100%
	Venous Thromboembolism	100%	92%	ND
	Tobacco Treatment	100%	80%	64%
	Immunization	ND	54%	87%
	Venous Thromboembolism	96%	100%	ND
	Tobacco Treatment	79%	100%	93%
	Perinatal Care	75%	100%	0%

The Military Health System provides quality care and is committed to continuous improvement.

These measures help us focus our improvement efforts.

Figure D-20. MHS Transparency-Quality of Care, HEDIS Outpatient Quality Measures (www.health.mil)

HEDIS® Outpatient Quality Measures

We track 11 outpatient quality measures for our military hospitals and clinics, all of which we are providing for you in one report. Below this report are nine descriptions of the types of measures we are sharing (there are two measures for diabetes control and two for mental health follow up appointments to make up the total of 11 measures). Click the link to open the file. Look for your military hospital or clinic in the facility name column. You will see the 11 quality measure scores in the following columns. We measure scores as a percentage, and show the average score for health plans across the nation for comparison. Please remember that all of the outpatient quality measures are in this one file, and the descriptions are listed below the download button for the nine categories, so you won't need to download multiple files for the outpatient quality measures.

Last Updated October 7, 2016

HEDIS Outpatient Pediatric Measures

Well-Child Visits in the first 15 Months of Life

In the first 15 months of a child's life, there are a number of preventive and monitoring services. These early services may lead to lifelong health and wellness.

What do we measure?

Upper Respiratory Infection (children's cough, cold and flu)

The common cold or upper respiratory infection (URI) is a common reason children visit their provider. Most of these infections are viral and an antibiotic won't help. There's a national effort to reduce overuse of antibiotics. Overuse is contributing to an increase in organisms that are resistant to popular antibiotics.

What do we measure?

Pharyngitis Pain (children's sore throat)

Pharyngitis, or inflammation of the throat, is the only condition among URIs where your provider may determine that antibiotic use is appropriate. U.S. medical leaders recommend that only children diagnosed with group A streptococcus (strep) pharyngitis be treated with antibiotics. A strep test is the definitive test of group A strep pharyngitis.

What do we measure?

Other HEDIS Outpatient Quality Measures

Breast Cancer Screening

Breast cancer is the second cause of cancer death for women, behind only lung cancer. Breast cancer screening through mammography can help detect cancer at an early and more treatable stage. By the time symptoms appear, cancer may have begun to spread, so early and regular screening is very important.

What do we measure?

Figure D-21. MHS Transparency- Quality of Care, HEDIS Outpatient Quality Measures, Detail Report (www.health.mil)

Outpatient Quality Measures (Health Effectiveness Data Information Set) HEDIS®																																	
	Pediatric Measures									Other Measures																							
Facility Name	Well Child Visits in first 15			Child Strep Test if			Child Common Cold - No			Breast Cancer Screen			Cervical Cancer Screen			Colon Cancer Screen			Diabetes A1c Test			Diabetes A1C Control <8			Low Back Pain			Admission for Mental			Admission for Mental		
Average for healthplans nationwide (HEDIS 50th percentile)	81%			85%			89%			74%			77%			66%			91%			60%			76%			53%			73%		
ARMY	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1
BASSETT ACH-FT. WAINWRIGHT	85%	86%	85%	83%	84%	82%	96%	96%	96%	86%	87%	88%	86%	85%	84%	81%	80%	79%	94%	95%	94%	68%	66%	66%	70%	70%	72%	88%	86%	87%	95%	94%	93%
BAYNE-JONES ACH-FT. POLK	90%	92%	93%	64%	59%	60%	90%	90%	89%	86%	86%	87%	84%	84%	86%	78%	77%	78%	97%	97%	95%	67%	67%	66%	53%	56%	58%	73%	73%	70%	80%	81%	76%
BLANCHFIELD ACH-FT. CAMPBELL	83%	85%	85%	79%	76%	76%	93%	93%	92%	86%	86%	86%	84%	83%	83%	81%	81%	80%	96%	97%	97%	73%	73%	70%	69%	71%	73%	75%	77%	77%	87%	87%	87%
BRIAN ALLGOOD ACH-SEOUL	82%	85%	84%	81%	87%	88%	96%	97%	97%	82%	86%	86%	86%	86%	85%	85%	87%	87%	92%	88%	88%	65%	63%	67%	76%	77%	78%	98%	98%	99%	99%	99%	99%
EVANS ACH-FT. CARSON	82%	82%	82%	58%	58%	60%	95%	95%	95%	79%	78%	76%	78%	78%	78%	82%	82%	81%	89%	89%	90%	66%	65%	62%	70%	72%	76%	77%	79%	80%	85%	86%	87%
IRELAND ACH-FT. KNOX	89%	91%	92%	86%	85%	85%	88%	89%	88%	81%	82%	82%	74%	74%	75%	75%	75%	75%	92%	91%	91%	68%	69%	68%	66%	71%	75%	67%	67%	71%	86%	82%	85%
IRWIN ACH-FT. RILEY	85%	85%	86%	64%	66%	66%	94%	94%	95%	87%	87%	86%	87%	87%	86%	81%	81%	81%	94%	95%	95%	70%	70%	72%	66%	66%	69%	82%	81%	82%	91%	91%	92%
KELLER ACH-WEST POINT	92%	91%	91%	92%	90%	89%	91%	91%	91%	77%	79%	80%	80%	80%	81%	75%	76%	76%	92%	90%	90%	67%	69%	72%	74%	78%	83%	81%	82%	88%	89%	92%	95%
KIMBROUGH AMB CAR CEN-FT MEADE	89%	88%	89%	88%	89%	89%	94%	94%	93%	80%	80%	80%	78%	79%	79%	72%	73%	73%	91%	91%	92%	69%	69%	68%	65%	66%	68%	73%	76%	72%	83%	84%	81%
L. WOOD ACH-FT. LEONARD WOOD	90%	89%	89%	68%	65%	65%	85%	86%	87%	81%	82%	81%	78%	79%	78%	85%	85%	84%	93%	92%	90%	75%	74%	71%	66%	61%	62%	79%	82%	84%	88%	90%	92%
MARTIN ACH-FT. BENNING	86%	87%	86%	71%	68%	69%	77%	78%	78%	81%	81%	80%	77%	78%	78%	79%	79%	79%	89%	89%	89%	65%	63%	63%	61%	62%	66%	78%	80%	80%	91%	91%	91%
MONCRIEF ACH-FT. JACKSON	85%	85%	83%	70%	69%	69%	91%	91%	91%	83%	83%	84%	80%	80%	80%	80%	80%	79%	91%	91%	88%	67%	66%	64%	68%	67%	68%	61%	61%	62%	74%	75%	75%
REYNOLDS ACH-FT. SILL	92%	94%	94%	75%	73%	76%	83%	83%	83%	84%	83%	83%	82%	83%	83%	79%	80%	80%	93%	93%	93%	69%	67%	63%	65%	66%	71%	77%	76%	74%	86%	86%	85%
WEED ACH-FT. IRWIN	89%	87%	89%	79%	74%	74%	96%	96%	96%	81%	83%	84%	81%	80%	80%	80%	78%	78%	98%	96%	96%	76%	75%	71%	70%	70%	73%	72%	68%	67%	85%	83%	84%
WINN ACH-FT. STEWART	86%	86%	87%	68%	67%	71%	87%	87%	86%	83%	82%	83%	81%	81%	82%	80%	81%	81%	93%	94%	94%	72%	74%	72%	71%	72%	76%	71%	75%	74%	84%	85%	86%
BG CRAWFORD SAMS AHC-CAMP ZAMA	84%	82%	82%	100%	80%	82%	99%	100%	100%	80%	80%	81%	83%	82%	80%	75%	77%	81%	72%	100%	100%	56%	57%	48%	79%	85%	88%	ND	ND	ND	ND	ND	ND
FOX AHC-REDSTONE ARSENAL	94%	89%	90%	82%	79%	78%	84%	83%	81%	84%	84%	85%	79%	78%	77%	77%	77%	77%	94%	94%	92%	70%	71%	67%	63%	62%	65%	41%	42%	49%	52%	57%	65%
GUTHRIE AHC-FT. DRUM	85%	86%	86%	67%	68%	68%	90%	90%	91%	79%	79%	79%	85%	85%	85%	74%	74%	74%	93%	91%	88%	68%	64%	61%	62%	63%	70%	91%	91%	92%	96%	97%	96%
KENNER AHC-FT. LEE	88%	87%	84%	84%	81%	80%	93%	94%	94%	75%	75%	76%	79%	79%	79%	77%	77%	77%	91%	91%	91%	71%	72%	69%	55%	55%	58%	71%	69%	67%	86%	83%	81%
LYSTER AHC-FT. RUCKER	85%	86%	84%	70%	68%	68%	81%	83%	84%	85%	87%	87%	84%	84%	84%	82%	82%	82%	95%	95%	95%	71%	72%	70%	72%	72%	70%	67%	74%	74%	89%	91%	92%
MCDONALD AHC-FT. EUSTIS	90%	89%	88%	82%	81%	82%	95%	95%	95%	83%	82%	81%	81%	81%	80%	79%	78%	78%	94%	94%	93%	75%	72%	71%	73%	71%	71%	66%	65%	72%	85%	82%	87%
MUNSON AHC-FT. LEAVENWORTH	83%	83%	86%	78%	78%	82%	92%	92%	91%	87%	86%	86%	84%	84%	85%	80%	80%	80%	95%	95%	94%	76%	76%	72%	68%	71%	76%	84%	85%	85%	93%	96%	97%
R W BLISS AHC-FT. HUACHUCA	77%	78%	82%	67%	70%	77%	93%	92%	94%	74%	74%	73%	76%	76%	75%	72%	72%	73%	85%	86%	83%	62%	60%	61%	68%	71%	71%	74%	77%	79%	86%	83%	84%
BAMC-SAMMC JBSA FSH	82%	82%	83%	71%	73%	72%	95%	95%	95%	72%	73%	73%	74%	75%	75%	79%	79%	79%	88%	88%	89%	63%	64%	65%	65%	66%	68%	63%	63%	64%	80%	80%	79%
DARNALL AMC-FT. HOOD	87%	88%	88%	62%	64%	65%	89%	88%	88%	72%	71%	72%	77%	77%	76%	74%	73%	73%	84%	85%	83%	56%	54%	52%	68%	68%	70%	77%	78%	78%	90%	90%	90%
EISENHOWER AMC-FT. GORDON	85%	86%	86%	72%	70%	69%	89%	88%	88%	86%	86%	86%	83%	84%	84%	82%	83%	84%	92%	94%	94%	71%	73%	72%	70%	70%	72%	72%	73%	76%	85%	86%	87%
MADIGAN AMC-FT. LEWIS	88%	90%	91%	70%	68%	69%	96%	96%	96%	79%	79%	78%	82%	83%	82%	79%	78%	78%	87%	88%	88%	61%	61%	63%	69%	70%	72%	82%	84%	86%	90%	92%	92%
TRIPLER AMC-FT SHAFTER	86%	87%	88%	80%	77%	78%	96%	97%	97%	78%	80%	80%	85%	86%	86%	77%	78%	78%	91%	91%	90%	70%	70%	68%	74%	75%	77%	88%	87%	87%	94%	93%	94%
WILLIAM BEAUMONT AMC-FT. BLISS	83%	86%	88%	63%	68%	70%	86%	86%	87%	80%	81%	80%	83%	84%	84%	75%	75%	76%	87%	87%	85%	67%	68%	65%	58%	59%	62%	77%	77%	80%	87%	87%	88%
WOMACK AMC-FT. BRAGG	83%	83%	83%	64%	65%	67%	93%	93%	92%	78%	78%	78%	79%	79%	80%	81%	80%	81%	90%	91%	91%	61%	65%	68%	61%	61%	62%	77%	76%	73%	86%	86%	85%
BAVARIA MEDDAC	88%	88%	88%	71%	73%	75%	97%	98%	98%	75%	80%	77%	84%	85%	84%	78%	80%	78%	90%	87%	87%	63%	68%	68%	79%	80%	79%	92%	91%	89%	97%	97%	98%
LANDSTUHL REGIONAL MEDCEN	83%	84%	86%	84%	78%	79%	97%	97%	97%	79%	84%	83%	81%	83%	82%	74%	73%	74%	82%	83%	85%	62%	63%	64%	75%	75%	76%	93%	95%	95%	95%	97%	97%
AIR FORCE	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1	CY15Q3	CY15Q4	CY16Q1
10th MED GROUP-USAF ACADEMY CO	88%	90%	89%	79%	79%	77%	92%	92%	94%	78%	79%	80%	77%	75%	76%	81%	82%	82%	94%	95%	94%	78%	76%	73%	64%	67%	74%	73%	76%	73%	83%	88%	86%
14th MED GRP-COLUMBUS	ND	ND	ND	81%	77%	74%	98%	100%	100%	72%	71%	71%	82%	82%	81%	78%	78%	77%	96%	97%	97%	79%	79%	79%	63%	72%	79%	75%	70%	61%	86%	85%	78%
15th MED GRP-HICKAM	91%	92%	93%	86%	86%	82%	98%	98%	97%	80%	83%	83%	84%	88%	87%	77%	79%	80%	93%	95%	95%	72%	73%	68%	86%	87%	89%	86%	91%	95%	92%	96%	98%
17th MED GRP-GOODFELLOW	84%	84%	86%	74%	81%	83%	79%	80%	83%	76%	76%	74%	83%	81%	80%	70%	70%	70%	92%	91%	92%	70%	66%	66%	85%	86%	88%	54%	56%	53%	65%	64%	66%
18th MED GRP-KADENA AB	82%	82%	81%	82%	82%	84%	97%	97%	97%	89%	98%	95%	81%	81%	81%	76%	75%	76%	84%	82%	91%	67%	66%	78%	80%	81%	80%	96%	100%	100%	96%	100%	100%
19th MEDICAL GRP-LITTLE ROCK	81%	82%	85%	80%	78%	80%	94%	94%	95%	70%	72%	74%	80%	79%	77%	75%	76%	76%	95%	95%	94%	80%	78%	71%	72%	72%	73%	59%	55%	55%	79%	85%	83%
1st SPEC OPS MED GRP-HURLBURT	88%	90%	91%	64%	59%	60%	92%	93%	92%	83%	84%	88%	83%	82%	83%	76%	77%	78%	88%	89%	91%	72%	77%	75%	75%	75%	79%	75%	72%	66%	88%	83%	76%
20th MED GRP-SHAW	88%	87%	88%	73%	69%	63%	92%	94%	95%	79%	80%	81%	83%	82%	82%	80%	79%	79%	94%	95%	95%	76%	76%	75%	77%	73%	73%	74%	76%	72%	88%	89%	89%
21st MED GRP-PETERSON	84%	86%	86%	68%	71%	75%	93%	94%	94%	79%	82%	81%	78%	80%	80%	79%	80%	80%	98%	98%	98%	75%	75%	70%	77%	79%	82%	70%	73%	72%	85%	88%	88%
22nd MED GRP-MCCONNELL	81%	85%	87%	79%	76%	76%	90%	89%	90%	75%	78%	76%	79%	77%	77%	74%	75%	75%	92%	90%	90%	69%	73%	72%	58%	57%	63%	77%	78%	81%	84%	86%	91%
23rd MED GRP-MOODY	83%	85%	89%	80%	80%	85%	94%	96%	96%	77%	74%	73%	84%	84%	85%	77%	77%	78%	98%	98%	99%	80%	83%	83%	74%	81%	87%	82%	85%	83%	90%	88%	87%
27th SPEC OPS MED GRP-CANNON	76%	75%	76%	76%	80%	79%	87%	88%	89%	73%	73%	74%	76%	75%	76%	64%	68%	71%	96%	97%	96%	77%	78%	75%	74%	77%	74%	84%	80%	76%	94%	92%	91%
28th MED GRP-ELLSWORTH	86%	89%	91%	84%	87%	89%	90%	92%	93%	79%	79%	80%	86%	87%	86%	79%	78%	78%	96%	97%	98%	83%	85%	83%	78%	78%	82%	48%	51%	53%	71%	74%	71%