Defense Health Agency

PROCEDURAL INSTRUCTION

NUMBER 6025.15
April 16, 2019

J-9 Research and Development

SUBJECT: Management of Problematic Substance Use by DoD Personnel

References: See Enclosure 1.

1. PURPOSE. This Defense Health Agency-Procedural Instruction (DHA-PI), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (aa), establishes the Defense Health Agency's (DHA) procedures to assign responsibilities for problematic alcohol and drug use identification, diagnosis, and treatment for DoD military personnel.

2. APPLICABILITY. This DHA-PI applies to the DHA, Military Departments, medical treatment facilities (MTFs), and all other organizational entities within the DHA (referred to collectively in this DHA-PI as the "DHA Components").

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (d) through (aa), that DoD Components have the responsibility to ensure adherence and maintenance of prescribed procedures and standard practice for treating problematic substance use by DoD personnel.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. RELEASABILITY. **Cleared for public release**. This DHA-PI is available on the Internet from the Health.mil site at: www.health.mil/DHAPublications.

7. EFFECTIVE DATE. This DHA-PI:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with DHA-PI 5025.01 (Reference (c)).

R. C. BONO
VADM, MC, USN
Director

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1. References
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ENCLOSURE 1

REFERENCES

(a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
(b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
(c) DHA-Procedural Instruction 5025.01, "Publication System," August 24, 2018
(d) DoD Instruction 1010.04, "Problematic Substance Use by DoD Personnel," February 20, 2014
(e) Code of Federal Regulations, Title 32, Part 199
(f) DoD Addictive Misuse Advisory Committee, "Charter," December 13, 2016
(g) DoD Instruction 6490.08, "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members," August 17, 2011
(h) DoD Instruction 1332.14, "Enlisted Administration Separations," January 27, 2014, as amended
(i) DoD Instruction 1332.30, "Commissioned Officer Administrative Separations," May 11, 2018, as amended
(j) DoD Instruction 1322.31, "Common Military Training (CMT)," February 26, 2015, as amended
(k) VA/DoD Clinical Practice Guidelines, "Management of Substance Use Disorder," Version 3.0-2015
(l) United States Code, Title 10
(m) Healthcare Common Procedure Coding System[1]
(n) The American Society of Addiction Medicine (ASAM) Criteria, current edition
(o) American Psychiatric Association, "Diagnostic and Statistical Manual of Mental Health Disorders (DSM 5)," current edition
(p) United States Code, Title 5, Chapter 75
(q) DoD Instruction 4515.13, "Air Transportation Eligibility," January 22, 2016, as amended
(r) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health Systems (MHS),"February 17, 2013, as amended and
(s) DoD Manual 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health Systems (MHS)," October 29, 2013
(t) United States Code, Title 42, Section 290dd-2
(u) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 2003
(v) Code of Federal Regulations, Title 42, Part 2
(w) Code of Federal Regulations, Title 32, Part 2
(x) Public Law 96-22, "Veterans Health Care Amendments of 1979," June 13, 1979
(y) Public Law 97-174, "Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," May 4, 1982
(z) DoD 5400.11, "DoD Privacy Program," October 29, 2014
(aa) DoD 5400.11R, "Department of Defense Privacy Program," May 14, 2007

[1] This reference can be found at: https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness and the Assistant Secretary of Defense for Health Affairs, (ASD(HA)), and in accordance with DoD policies and issuances, the Director, DHA, will:

a. Oversee the implementation of this DHA-PI to ensure consistent application across the Military Health System (MHS).

b. Provide management of policy implementation for DHA operations developed by the ASD(HA) pursuant to DoD Instruction 1010.04 (Reference (d)), in the administration and management of all authorized MTF substance use prevention and treatment programs.

c. Provide strategic guidance for the development and implementation of MTF clinical treatment programs. In collaboration with local prevention services, provide strategic guidance for the development of substance misuse prevention programs.

d. Ensure the implementation of TRICARE regulations, contracts, and regulatory guidance appropriate standards for quality assurance in TRICARE provider networks in accordance with Part 199 of Title 32, Code of Federal Regulations (CFR) (Reference (e)).

e. Coordinate with the DoD Addictive Substance Misuse Advisory Committee (ASMAC) to ensure DoD Component substance misuse program/treatment needs and goals are met according to DoD Instruction 1010.04 (Reference (d)) and DoD Addictive Misuse Advisory Committee (Reference (f)).

2. ASSISTANT DIRECTOR, HEALTHCARE ADMINISTRATION. The Assistant Director, Healthcare Administration will:

a. Report directly to the Director, DHA.

b. Establish priorities for healthcare administration and management.

c. Establish policies, procedures, and direction for the provision of direct care at MTFs.

d. Establish priorities for budgeting matters with respect to the provision of direct care at MTFs.

e. Establish policies, procedures, and direction for clinic management and operations at MTFs.

f. Establish priorities for information technology at and between the MTFs.

3. SECRETARIES OF THE MILDEPS. The Secretaries of the MILDEPs will:

a. Dispel the stigma of seeking services for concerns related to problematic substance use by implementing notification practices that are consistent with DoD Instruction 6490.08 (Reference (g)), including the limitations on the amount of information provided to command when command notification is appropriate and encouraging the use of self-referral for education, evaluation, or routine outpatient treatment when appropriate.

b. Ensure personnel are trained on DoD and Service substance misuse policies.

c. Initiate administrative actions against Service members who do not comply with the retention established by the Military Services for substance use disorders (SUDs).

d. Ensure separation of Service members who do not comply with the retention standards established by the Military Services must be in accordance with DoD Instruction 1332.14 (Reference (h)) and DoD Instruction 1332.30 (Reference (i)).

e. Ensure policies differentiate between disciplinary actions resulting from violations of the law and treatment related administrative actions, such as compliance with treatment plans or adherence to retention standards. Administrative separation of Active Duty and Reserve component Service members need not be delayed as a result of their participation in treatment. However, when determining the date of discharge, commanders should weigh the benefits of the Service member completing treatment prior to discharge against any disruption to the good order and discipline of the unit.

f. Ensure Service members diagnosed with an SUD who do not adequately engage in treatment services as medically prescribed, or who persistently fail to attend appropriate follow-up or aftercare services and continue to be impaired by an SUD, or who despite involvement in medically prescribed treatment continue to demonstrate a level of impairment are processed for separation in accordance with Service-separation policies.

g. Coordinate treatment and referral services with other Military programs serving populations at high risk for problematic substance use, such as programs for child and spouse maltreatment, exceptional family member programs, and hospitals' medical and surgical services.

h. Maximize the coordination of care between SUD treatment and other forms of mental health care.

4. SURGEONS GENERAL OF THE MILDEPs. Under the authority, direction, and control of the Secretaries of the MILDEPs, the Surgeons General of the MILDEPs will:

a. Ensure MTF Commanders/Directors implement the developed procedures for Clinical Operations in Enclosure 3 of this DHA-PI.

b. Function as the Chief Medical Advisor to the Director, DHA, on matters pertaining to military health readiness requirements and safety of Service members.

c. Provide direction and guidance to leadership to recruit, organize, train, and equip military medical personnel for substance use care.

d. Develop direction and guidance for military medical personnel for substance use care.

5. MTF DIRECTORS/COMMANDEDS. Under the authority, direction, and control of the Secretaries of the MILDEPs and respective Medical Commands, the MTF Directors/ Commanders will:

a. Comply with instructions outlined in this DHA-PI.

b. Disseminate this DHA-PI to all MTF level healthcare personnel, ensuring that all providers follow the guidance and procedures in Enclosure 3 of this DHA-PI.

c. Coordinate with the Installation Commander for prevention service delivery by local prevention services.

d. Train all medical providers to recognize signs and symptoms of problematic substance use and the available services for providing treatment.

ENCLOSURE 3

PROCEDURES

1. OVERVIEW. The DoD recognizes SUDs are preventable and treatable. While self- referral is preferred, commanders and supervisors at all levels are also responsible for identifying Service members at risk for a SUD, and referring them for screening and evaluation, actively supporting prevention, intervention, and treatment. This DHA-PI provides general guidance on SUD levels of care, clinical practice guidelines and evidence-based treatment and treatment outcomes. Service members receiving treatment for SUDs are subject to policies and regulations of their respective Service.

2. SUBSTANCE USE PREVENTION AND EARLY INTERVENTION. DoD substance abuse programs are command and medical programs that emphasize readiness and personal responsibility. Substance use prevention and early intervention activities provide information intended to prevent or reduce problematic substance use in accordance with best clinical practices. Universal approaches to prevention and early intervention activities aim to reduce community level substance use trends. In collaboration with local prevention services, personnel and MTFs will implement universal strategies based on the emergent need of the community or address trending substance misuse topics. Targeted activities provide all DoD personnel prevention education, including those who have been identified as using substances problematically, but who do not meet the criteria for having a SUD, with information intended to reduce problematic substance use. The program goals are to:

a. Foster the recognition of problematic substance use and its harmful effects.

b. Encourage early identification of personnel engaged in problematic substance use through comprehensive prevention strategies and education.

c. Support personnel, who self–refer or were referred by command, who have used substances problematically, but do not meet the diagnostic criteria for having an SUD, receive education and prevention services from local substance abuse prevention personnel.

d. Ensure compliance with Common Military Training core curriculum requirements in accordance with DoD Instruction 1010.04 (Reference (d)), and DoD Instruction 1322.31 (Reference (j)).

3. METHODS OF IDENTIFICATION AND REFERRAL. The SUD treatment process reflects a logical approach that can be applied to solving challenges (e.g., interpersonal and work relationships, housing, etc.), in any area. Solving these challenges begins with the preliminary identification of the general issues followed by a more detailed determination of the specifics. All healthcare providers are responsible for identifying and referring any personnel whose performance is impaired by use of alcohol, other substances or non-substance related addictive

disorders to the MTFs. One critical aspect of the SUD evaluation process is early identification. Early identification can occur through a variety of methods:

a. Voluntary/self-referral. Individuals are encouraged to refer themselves or be referred for evaluation and treatment services. Command notification is not required for Service members who self-refer for substance misuse education services, evaluation, or routine outpatient treatment unless command notifications requirements are met in accordance with DoD Instruction 6490.08 (Reference (g)).

b. Commander/supervisor identification occurs when a commander or supervisor observes, suspects, or otherwise becomes aware of an individual whose job performance, interpersonal relations, physical or mental readiness, or health appears to be affected adversely by suspected problematic substance use, to include alcohol or substance related incidents.

c. Medical identification can occur when healthcare providers identify problematic substance use during routine or emergency medical treatment. If a healthcare provider notes problematic substance use during routine or emergency medical screening of a Service member or authorized beneficiary, the healthcare provider will recommend the individual be referred for a SUD evaluation and will provide information about the Service member's alleged problematic substance use immediately to the Service member's commander in accordance with DoD Instruction 6490.08 (Reference (g)).

4. ALCOHOL USE SCREENING

a. Annual adult screening for problematic alcohol use for Service members and beneficiaries enrolled in MTF for primary care is an essential component of educating and identifying personnel who may be at risk for developing problems related to their alcohol use.

b. Primary Care Medical Setting Goals

(1) Promote health and readiness through the early identification of problematic alcohol use.

(2) Provide early opportunities for MTF healthcare providers to intervene with beneficiaries who are at-risk for an alcohol use disorder, as clinically indicated.

c. Program

(1) Screening and intervention for at-risk alcohol use in adults will be performed at least annually in primary care settings as published in VA/DoD Clinical Practice Guidelines (Reference (k)).

(2) Medical providers or licensed independent practitioners, including behavioral health (BH) personnel assigned to primary care settings, will receive annual education and training on:

(a) Current trends and practices in the identification, assessment, and referral of personnel at risk for substance use related problems, including the interpretation and use of the alcohol screening instrument Alcohol Use Disorders Identification Test, Alcohol Consumption Questions (AUDIT-C).

(b) Intervention strategies that are consistent with the level of risk identified by the AUDIT-C or other assessments.

(3) The AUDIT-C will be incorporated into the annual Periodic Health Assessment for all Active Duty and Reserve Component personnel.

(4) Other Substances. All Service members, under Title 10, United States Code (USC) (Reference (l)), who are identified by commanding officer/supervisor or another medical service (emergency services, primary care behavioral health, etc.), as suspected or exhibiting signs of substance misuse, without exception, will be referred for a SUD evaluation.

(5) Internal Control Measure(s). The AUDIT-C will be used for Monitoring, Reporting, and Annual Evaluation of the SUD.

d. Program Guidelines

(1) MTF Director will ensure that adult beneficiaries who are enrolled to an MTF for care are screened annually for problematic substance use using the AUDIT-C screening tool.

(2) Providers must inquire further about any suspect screening results and take appropriate actions, as clinically indicated. Actions may include patient education about problematic substance use, health risks, recommended alcohol consumption guidelines, brief intervention, such as screening, brief intervention, referral, and treatment, and referral to BH or SUD treatment personnel for further assessment, as indicated by VA/DoD clinical practice guidelines.

(3) Medical encounters that include the screening and, when necessary, brief interventions should be coded in accordance with Healthcare Common Procedure Coding System (Reference (m)).

5. EVALUATION FOR TREATMENT SERVICES

a. Service members may self-refer for evaluation and treatment services. Service members who are referred by their command for a SUD related incident to an MTF will undergo evaluation to determine treatment needs. Matching personnel to the most appropriate level of care in accordance with The American Society of Addiction Medicine (ASAM) Criteria (Reference (n)), requires a thorough biopsychosocial diagnostic assessment using criteria for SUDs as defined in the current Diagnostic and Statistical Manual of Mental Health Disorders American Psychiatric Association, “Diagnostic and Statistical Manual of Mental Health Disorders” (DSM 5) (Reference (o)). The disclosure of problematic substance use by a Service

member to a healthcare provider, by itself, will not subject the individual to adverse administrative action.

b. Evaluation. A biopsychosocial evaluation of personnel being considered for treatment is essential to prescribing the appropriate level of care. The evaluation will assess:

(1) Level of acute intoxication and withdrawal potential.

(2) Medical conditions and complications, including a history of past and current medical conditions that may complicate treatment or contribute to the patient's condition.

(3) Additional medical or psychological conditions that are either diagnosable or sub-clinical that complicate treatment or require separate medical treatment.

(4) Readiness to change, including resistance to treatment and willingness to accept the current diagnosis and treatment strategy.

(5) Risk of harm to self or others, including additional risks associated with delayed treatment.

(6) The nature of the recovery environment, such as family members, significant others, and living situations that poses a threat to the patient's safety, the safety of others, or their treatment.

(7) The evaluation will also educate the Service member on the limits of confidentiality and required notification of commanders per the applicable DoD policy, evaluation and treatment process, Limited Use Policy, and information about SUD services.

c. Baseline Laboratory Evaluation. Initial baseline laboratory evaluation, including biomarkers, may be ordered by supporting medical providers, typically a psychiatrist/nurse practitioner involved in the patient's SUD treatment. Clinical indications for baseline laboratory evaluation may include but not be limited to Service members who report having physical health symptoms, or who are receiving medical treatment for a physical condition. A baseline laboratory evaluation may be obtained through MTF or comparable civilian medical laboratory services facility. Medical providers will refer to the appropriate DoD/VA Clinical Practice Guidelines for recommended baseline and follow up laboratory evaluations. This will support treatment and better characterize patterns of substance use, recurrent use, and relapse. Routine testing can also support abstinence-based recovery efforts.

6. LEVELS OF CARE

a. The level of substance use intervention/treatment is based upon the severity of the individual's symptoms related to the SUD, as well as a variety of environmental factors and other criteria. For a person diagnosed with a SUD, treatment may consist of individual, group, and/or Family counseling as Early Intervention (Level 0.5), Outpatient Services (Level 1),

Intensive Outpatient/Partial Hospitalization Services (Level 2), or Residential Services (Level 3). Not all MTFs or Service-specific SUD programs will offer every level of care. Modalities are structured within the scope of individualized, short-term treatment. Patient placement is based upon American Society of Addiction Medicine criteria regarding the severity of impairment. If clinically advisable, personnel who have used a substance problematically and meet the diagnostic criteria for having SUD will receive education and prevention services from local substance abuse prevention personnel.

(1) Level 0.5 - Early Intervention: typically, psychoeducation for those at-risk of developing substance-related or addictive behavioral problems.

(2) Level 1 - Outpatient care: typically, a combination of individual and group therapy modalities delivered less than 9 hours per week.

(3) Level 2 - Intensive Outpatient Care/Partial Hospitalization Services:

(a) Level 2.1 - Intensive Outpatient Care: a combination of group and individual care delivered a minimum of 9 hours per week.

(b) Level 2.5 - Partial Hospitalization Programs: a combination of group and individual care delivered a minimum of 20 hours per week.

(4) Level 3 - Residential Inpatient Treatment: residential inpatient treatment is an organized, interdisciplinary, clinical service in which qualified healthcare professionals provide 24 hours a day, 7 days a week, medically monitored assessment, evaluation, and treatment.

(5) Level 4 - Medically Managed Intensive Inpatient Services: this level of care offers 24-hour nursing care and daily physician care for severe, unstable problems. Full resources of general acute medical or psychiatric care available.

b. When clinically indicated, a Service member or beneficiary diagnosed with a SUD will receive substance misuse treatment/care at an appropriate care facility. The substance misuse treatment/care will include: withdrawal management care, medical treatment, and transition counseling, if indicated, within the appropriate level of care facility. Service members who fail to participate adequately in substance misuse programs or to respond successfully to rehabilitation, may be faced with administrative separation from the military.

7. SUD TREATMENT

a. SUD treatments address and seek to alleviate factors and issues that cause individuals to become depended or addicted to drugs and/or alcohol. SUD treatment will be patient-centered, using a multi-disciplinary integrated team approach to provide a full continuum of behavioral and pharmacological therapies to treat SUD and comorbid behavioral health disorders. Treatment planning should be assessed continually and modified as necessary to ensure that the plan meets the patient's changing needs. Individual and/or group counseling and other

behavioral therapies are critical components of effective treatment. As part of treatment, providers may encourage patients to attend and participate in community support self-help/peer support groups.

b. Pharmacotherapies

(1) In addition to the psychosocial treatments provided in SUD treatment, all MHS beneficiaries receiving SUD treatment in an MTF will be evaluated for appropriate adjunctive pharmacotherapy, as clinically indicated, as part of a comprehensive treatment plan.

(2) Long-term drug replacement therapies may be made available VA/DoD Clinical Practice Guidelines (Reference (k)).

c. Command Notification. Service members in SUD Treatment suspected of substance misuse are subject to command notification policies and regulations of their respective Service or Agency in accordance with DoD Instruction 6490.08 (Reference (g)).

8. COMMAND, SUPERVISOR, AND FAMILY INVOLVEMENT IN CARE

a. Command or Supervisor Involvement. The commanding officer for Service members or supervisor in conjunction with the treatment staff, should be involved in the individual's treatment program and engaged in their recovery support whenever necessary in accordance with Chapter 75 of Title 5, U.S.C. (Reference (p)).

(1) Commanders and supervisors must receive written or verbal communication documented by the provider in the medical record stating that inpatient rehabilitation admission is only the initial stage of treatment to be followed by step-down and/or aftercare treatment.

(2) It is the responsibility of the Command to confer with the SUD clinic to determine if a referral for evaluation is made when a commander/supervisor suspects substance misuse is related to adverse impact on: individual job performance, interpersonal relations, physical or mental readiness, or health.

(3) Commanders who refer personnel for evaluation will be informed of the results of the assessment, as permitted by regulation. For those not covered by the Uniform Code of Military Justice, a consent form must be obtained.

b. Family Involvement. When appropriate, family involvement should be encouraged and authorization from the patient obtained. Initial patient assessment must include family data and an initial plan for family involvement in treatment and recovery support; which must be made known to the patient before entry into treatment. Lack of participation by family members will not preclude treatment for personnel affected with an SUD. Within the limitations of existing regulations, the family member will receive administrative support and assistance when being air transported for treatment, consistent with DoD Instruction 4515.13 (Reference (q)).

9. TREATMENT PROGRAM STAFFING AND TRAINING. Individual provider credentials and qualifications will be carefully evaluated before allowing involvement in patient care.

a. The Military Services must use a data-driven, risk adjustment model to set staffing levels for trained professionals, treatment personnel, and support staff required to ensure program effectiveness.

b. Staff members must be under the direct supervision of personnel qualified to evaluate their clinical performance in accordance with DoD Instruction 1010.04 (Reference d)).

(1) A licensed, privileged BH provider must be responsible for all care provided by the Alcohol and Drug Counselor (ADC) and, in addition to the required "eyes on" supervision, the provider must provide sufficient additional supervision and direction of care to ensure the quality of services.

(2) Certified ADCs must practice within the scope of the four domains as specified by the International Certification and Reciprocity Consortium for ADCs, and as directed by a privileged healthcare provider.

(a) The initial assessment, any changes to the treatment plan, or crisis intervention requires "eyes on" supervision of the ADC by a licensed and privileged healthcare provider. In treatment situations, "eyes on" supervision must be provided by observation of direct patient contact and review of the patient's electronic medical and other appropriate treatment records. All supervision must be documented in the medical record.

(b) An SUD diagnosis can only be made by a licensed and privileged healthcare provider.

(3) MTF Directors will ensure that medical providers or licensed independent practitioners will receive annual education on current trends and practices in the identification, assessment and referral of personnel at risk for substance use related problems, including the interpretation and use of the alcohol screening instrument, AUDIT-C.

10. QUALITY ASSURANCE

a. MTF SUD treatment services must adhere to the MHS medical quality assurance standards related to the credentialing and privileging of providers, risk management, reporting of adverse medical events, and performance measurement and improvement in accordance with DoD Instruction 6025.13 (Reference (r)) and Section 290dd-2 of Title 42, U.S.C. (Reference (t)).

b. MTF SUD treatment services must maintain accreditation by the Joint Commission or other authority approved by the Director, DHA.

c. MTF SUD treatment services must satisfy the requirements of DoD clinical quality oversight activities. Program performance improvement activities must be linked to MHS strategic goals and SUD treatment evidenced-based best practices and clinical outcomes.

d. Case evaluations and reviews must be in compliance with the confidentiality requirements set forth in Section 290dd-2 of Title 42, U.S.C. (Reference (t)).

11. DOCUMENTATION, CONFIDENTIALITY, CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

a. Documentation. The DoD Electronic Health Record (EHR) will be used to document care, including all SUD treatment regardless of the level of care provided to Service members and beneficiaries. All clinical contacts will be documented, as soon as possible, no later than 72 hours following the encounter.

b. Confidentiality. Confidentiality is respected and maintained at all times. The limitations of confidentiality in accordance with relevant regulations should be clearly stated at the initial meeting with the Service member and beneficiaries. The Service member completes the most current Limits of Confidentiality and Consent for treatment prior to being seen. Any paper forms will be scanned into the DoD EHR. Providers will review the Limited Use Policy with Service members and annotate within the DoD EHR that this policy was discussed with the Service member.

c. Consent for Release of Information. Special rules for alcohol and drug abuse program patient record is outlined in DoD 6025.18-R (Reference (u)). Covered entities will comply with the special rules protecting the confidentiality of alcohol and drug abuse patient records in federally assisted alcohol and drug abuse programs, Part 2 of Title 42, CFR (Reference (v)). Covered alcohol and drug abuse patient records may only be used or disclosed if the requirements of both regulations and Part 2 of Title 32, CFR (Reference (w)) are satisfied.

12. MONITORING, MEASURES, REPORTING, AND ANNUAL EVALUATION

a. Monitoring. Compliance with annual screening using the AUDIT-C will be monitored through information in the MHS Data Repository and other administrative databases, where applicable and/or as access becomes available.

b. Measures. The following measures will serve as internal control mechanisms related to policy implementation: percent of patient encounters across the MHS in compliance with annual AUDIT-C screening requirement. Baseline for AUDIT-C screening will be established in 2018. Then the annual screening rates and trends can be calculated (by the same measure and measurement period) and identified for reporting in all subsequent years. Each installation and region will serve as its own benchmark for comparison.

c. Reporting. The Psychological Health Center of Excellence will collect and analyze AUDIT-C screening data, then report to the Behavioral Health Clinical Community on compliance with and trends in AUDIT-C screening across the MHS at least annually or as requested.

d. Annual Evaluation of Measures. By practice, when the AUDIT-C is administered, screening data is entered at each encounter using the electronic record management system. Administrative data will be utilized to establish appropriate thresholds and cut points for meaningful change.

13. RESOURCE SHARING. The DoD, in concert with the VA, must share resources in accordance with Public Law 96-22 (Reference (x)), and Public Law 97-174 (Reference (y)), when beneficial and feasible. Service members in transition between facilities, services, or from the DoD healthcare system to the VA healthcare system or the TRICARE purchased care system; should include a transition plan that ensures continuity of care and coordination among providers. Healthcare teams should work jointly to provide assessment and services to patients within this transitioning population. Management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care. If a clear transition process is lacking, then an effort should be made to construct a functional transition process that supports patient-centered care.

a. Residential VA Treatment. When mutually agreeable and authorized by law, the DoD Components may choose to use VA residential programs for DoD Service members and authorized beneficiaries via a Memorandum of Understanding between MHS and specific VA facilities.

b. Outpatient (Nonresidential) VA Treatment. Criteria for entry is described in Enclosure 3, Section 6, of this DHA-PI.

c. Treatment for DoD Members Who Are Being Discharged. Personnel who are to be discharged for an SUD may be referred for treatment to a VA facility when mutually agreed upon by the referring agency and the VA facility. In accordance with DoD 5400.11 (Reference (z)) and DoD 5400.11R (Reference (aa)), the VA facility will be provided appropriate records, such as a copy of the Service member's Military Service record, and the nature of the Service member's discharge. The Service member must be informed of this opportunity for treatment. Service members who are evaluated as not having potential for further Military Service, if discharged, are to be evaluated by a physician, physician assistant and/or nurse practitioner provided with appropriate care and referred to a VA facility for further services in accordance with the provisions of Part 199 of Title 32, CFR (Reference (e)).

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ADC	Alcohol and Drug Counselor
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASMAC	Addictive Substance Misuse Advisory Committee
AUDIT-C	Alcohol Use Disorders Identification Test, Alcohol-Consumption Questions
BH	behavioral health
CFR	Code of Federal Regulations
DHA	Defense Health Agency
DHA-PI	Defense Health Agency-Procedural Instruction
EHR	Electronic Health Record
MHS	Military Health System
MILDEP	Military Department
MTF	medical treatment facility
SUD	substance use disorder
U.S.C.	United States Code
VA	Department of Veterans Affairs

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purposes of this DHA-PI.

Aftercare. Provides support for patients in early or sustained remission, usually in an individual or group setting.

ASMAC. The Committee is a standing advisory committee to the Medical Personnel Executive Steering Committee, which reports to Under Secretary of Defense for Personnel and Readiness, as necessary. Under the authority, direction, and control of the ASD(HA), and in accordance with DoD Instruction 1010.04 (Reference (d)) and DoD Instruction 6490.08 (Reference (g)), the ASMAC will comply with committee functions and responsibilities as established in DoD Instruction 6490.08 (Reference (g)). The Committee will serve as a central point for information analysis and integration, program coordination, identification of policy needs and problem

solving on Military Service issues involving policies and programs with regard to legal and illegal addictive substance use and SUDs in those served by the MHS.

AUDIT-C. The AUDIT-C is a three-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the ten question AUDIT instrument.

beneficiary. An individual who has been determined to be eligible for TRICARE benefits, as defined in Part 199, Title 32, CFR (Reference (e)).

commander. Any commissioned officer who exercises command authority over a Service member. The term includes a military member designated in accordance with this instruction to carry out any activity of a commander.

detoxification. Process of withdrawing a person from a specific psychoactive substance in a safe and effective manner. Medical detoxification generally is accomplished on an inpatient basis and includes withdrawing alcohol and other drugs of misuse from the individual and providing medical and psychological support.

documentation. The DoD EHR or other approved EHR system used to document care, including all SUD treatment, regardless of the level of care provided to Service members and beneficiaries. All clinical contacts will be documented, no later than 72 hours following the encounter.

DoD personnel. Members of the Military Services under the authority of the DoD and subject to the Uniform Code of Military Justice.

drug. Any substance that a person inhales, injects, consumes, or introduces into their body in any manner, to alter mood or function.

drug misuse. The use of substance(s) with the intent to alter one's mental physiological state (e.g., to alter one's mood, emotion, or state of consciousness). May include medications, illicit drugs, or use of a commercial product outside its intended purpose (such as inhalants or synthetic cannabinoids).

early intervention. Services that explore and address any problems or risk factors that appear to be related to use of alcohol, tobacco, and/or other drugs and addictive behaviors and that may help an individual to recognize the harmful consequences of high-risk use or behavior. Such individuals may not appear to meet the diagnostic criteria for substance misuse or addictive disorder but require early intervention for education and further assessment.

"eyes on" supervision. Direct contact with the patient of sufficient length and interaction to validate the assessment and recommendation.

illegal drug use. The use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act. Such a term does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled

Substances Act or other provisions of Federal law as defined in DoD Instruction 1010.04 (Reference (d)).

illicit drug. A drug or other substance that is prohibited by law or DoD policy.

inpatient treatment. A patient who has been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care for the active medical treatment of the acute phases of substance withdrawal (detoxification), for stabilization and for treatment of medical complications for SUD, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation. If the patient has been received at the hospital, but death occurs before the actual admission occurs, an inpatient admission exists as if the patient had lived and had been formally admitted.

Intensive Outpatient Program. A treatment setting capable of providing an organized day or evening program that includes assessment, treatment, case management and rehabilitation for individuals not requiring 24-hour care for mental disorders, to include SUDs, as appropriate for the individual patient. Treatment is a minimum of 9 hours (or more) of treatment per week. Intensive Outpatient Programs are diverse and flexible with respect to the spectrum, intensity and duration of settings in which services are delivered. The program structure is regularly scheduled, individualized and shares monitoring and support with the patient's family and support system.

license. A grant of permission by an official agency of a State; the District of Columbia; or a commonwealth, territory, or possession of the United States to provide healthcare within the scope of practice for a discipline. A current license is one that is active, not revoked, suspended, or lapsed in registration. A valid license is one in which the issuing authority accepts, investigates, and acts upon Quality Assurance information, such as provider professional performance, conduct, and ethics of practice, regardless of the provider's military status or residency. An unrestricted license is one that is not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction. An unrestricted license must allow the provider unabridged permission to practice in any civilian community in the jurisdiction of licensure without having to take any additional action on her or his license.

medically managed treatment. Services that involve daily medical care, where diagnostic and treatment services are directly provided and/or managed by an appropriately trained and licensed physician. Such treatment is provided in an acute care hospital or psychiatric hospital or treatment unit.

medically monitored treatment. Services provided by an interdisciplinary staff of nurses, counselors, social workers, SUD specialists, and other health and technical personnel under the direction of a licensed physician. Medical monitoring is provided through an appropriate mix of direct patient contact, review of records, treatment team meetings, 24-hour coverage by a physician, and quality assurance programs.

MTF. A military facility established for the purpose of furnishing medical and dental care to eligible individuals.

outpatient treatment. Non-residential treatment delivered in an outpatient setting, typically 9 or less contact hours per week, in which treatment staff provide professionally directed evaluations and treatment for substance-related, addictive, and/or BH disorders.

partial hospitalization program. A treatment setting capable of providing an interdisciplinary program of medically monitored therapeutic services, to include management of withdrawal symptoms, as medically indicated. Services may include day, evening, night and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. Partial hospitalization is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. Partial hospitalization is an appropriate setting for crisis stabilization, treatment of partially stabilized mental disorders, to include substance disorders, and a transition from an inpatient program when medically necessary.

pharmacotherapy. The treatment of disease with prescribed medication.

prescription drug misuse. Taking a medication in a manner or dose other than prescribed; taking someone else's prescription, even if for a legitimate medical compliant such as pain; or taking a medication to feel euphoria (e.g., to get high).

prevention programs. Activities designed to influence participants to avoid problematic substance use or to encourage individuals to seek early assistance.

privileged health care provider. A behavior health provider or other healthcare provider whose credentials for practice have been verified and have been granted permission to practice within the scope and defined limits of their current licensure, relevant education and clinical training.

problematic alcohol use. The consumption of alcohol in daily or weekly amounts greater than those defined as safe by the U.S. Preventive Task Force. Drinking at levels above the recommended amounts places an individual at greater risk for illness, injury, or social or legal problems.

problematic substance use. The use of any substance in a manner that puts the user at risk of failing in their responsibilities to mission or family, or that is considered unlawful by regulation, policy, or law. This includes substance use that results in negative consequences to the health and/or well-being of the user or others; or meets the criteria for an SUD.

psychoeducation. The use of information or training that is intended to increase awareness or improve skills of persons with a psychological disturbance.

recovery support. Social support services, linkages to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life.

rehabilitation. The process of restoring a person who is impaired by the use of alcohol or other drugs to an effective functioning level.

relapse. The resumption of a pattern of substance use in an individual seeking abstinence that was previously identified as problematic.

residential inpatient treatment. Residential treatment that provides medically monitored, interdisciplinary addiction-focused treatment. Qualified professionals provide 24-hour, 7 days-per-week, medically monitored assessment, evaluation, and treatment.

substance or drug misuse. The use of any substance with or without a prescription with the primary goal to alter one's mental state (i.e., to alter mood, emotion, or state of consciousness), outside of its medically prescribed purpose. May include medications, illicit drugs, or use of a commercial product outside its intended purpose (such as inhalants or synthetic cannabinoids).

SUD. As defined in American Psychiatric Association (Reference (o)).

supervision. The process of reviewing, observing, and accepting responsibility for assigned personnel. The types of supervision are:

indirect. The supervisor performs retrospective review of selected records. Criteria used for review relate to quality of care, quality of documentation, and the authorized scope of practice.

direct. The supervisor is involved in the decision-making process.

verbal. The supervisor is contacted by phone or informal consultation before implementing or changing a regimen of care.

supervisor. A commissioned officer within or out of a Service member's official chain of command, or civilian employee in a grade level comparable to a commissioned officer, who:

Exercises supervisory authority over the Service member owing to the Service member's current or temporary duty assignment or other circumstances of the Service member's duty assignment; and

Is authorized due to the impracticality of involving an actual commanding officer in the member's chain of command to direct a Mental Health Evaluation.

support staff. Members of a SUD treatment team whose primary work activities involve nursing, clinical, and administrative in order to provide support for patients with substance-related and other addictive disorders.

treatment personnel. Trained members of the SUD treatment program staff qualified to provide consultative, treatment, or referral services.

voluntary self-referral. The process of seeking information about or obtaining an appointment for SUD screening, evaluation or treatment initiated by a Service member without being ordered or directed by a commander or supervisor.