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

PERSONNEL AND
READINESS

APR 15 2016

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

Dear Mr. Chairman:

The enclosed report is in response to House Report 114–139, Page 279, which accompanied H.R. 2685, the Department of Defense (DoD) Appropriations Bill, 2016, that requests a report on current DoD programs offered to educate Service members about the risks of prescription medication; the current treatment options for Service members suffering from addiction; the estimated number of Service members that participated in education and/or treatment programs in fiscal years 2012, 2013, and 2014; and specific recommendations for improving education and treatment programs.

The report provides an overview of DoD education and treatment programs for prescription drug abuse and substance use disorder, as well as data on Service member participation in those programs. Within the military, data indicate that overall prescription drug misuse is low and on the decline. While it is difficult to ascertain the exact reason(s) for this decline, the data suggest DoD's strong focus in recent years on education and screening requirements for prescription drug abuse and addiction risk is having a positive impact. In addition, DoD is committed to provider training on evidence-based guidance for the prevention, screening, evaluation, and treatment of prescription drug abuse and substance use disorders. The report also includes the Department's ongoing efforts for continued advancement of prescription drug abuse education and treatment.

Thank you for your interest in the health and well-being of our Service members, Veterans, and their families. A similar letter is being sent to the other congressional defense committees.

Sincerely,

Peter Levine
Acting

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

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

PERSONNEL AND
READINESS

APR 15 2016

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

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Peter Levine
Acting

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

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

PERSONNEL AND
READINESS

APR 15 2016

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

Dear Mr. Chairman:

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Sincerely,

Peter Levine
Acting

Enclosure:
As stated

cc:
The Honorable Richard J. Durbin
Ranking Member

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

PERSONNEL AND
READINESS

APR 15 2016

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

Dear Mr. Chairman:

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Sincerely,

Peter Levine
Acting

Enclosure:
As stated

cc:
The Honorable Peter J. Visclosky
Ranking Member

Report to Congress on Prescription Drug Abuse

Requested by: House Report 114-139, accompanying the Department of Defense Appropriations Bill, 2016, on Prescription Drug Abuse (page 279-280)

Office of the Secretary of Defense
March 2016

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $2,800.00 for the Fiscal Year (FY) 2016. This includes $0.00 in expenses and $2,800.00 in DoD labor.
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EXECUTIVE SUMMARY

This report is in response to the House Report 114-139, accompanying the Department of Defense (DoD) Appropriations Bill, 2016, requesting a summary of DoD substance use education and treatment programs for Service members. Key elements include an overview of DoD education and treatment programs for prescription drug abuse and substance use disorder (SUD), a summary of Service education and treatment strategies, data on Service member participation in education and treatment programs, and recommended actions for continued advancement of prescription drug abuse education and treatment.

Overall prescription drug misuse is low in the military and on the decline. Between fiscal year (FY) 2010 and 2015, there was a 29% decrease in the number of Service members receiving a primary diagnosis of Opioid Drug Dependence and/or Opioid Abuse, with an overall prevalence rate of 0.2% (Military Health System (MHS) Data Repository, extracted February 24, 2016). Opiate positive drug tests among Service members also declined by 42% between FY 2013 and FY 2014. Furthermore, FY 2015 data reveal a decline in overall drug abuse, including prescription opiates, benzodiazepines, and synthetic cannabinoid (also known as "Spice"). The Active Duty drug positive rate was 0.60% in FY 2015, down from 0.72% in FY 2013, and the total DoD drug positive rate, which includes Active Duty, Guard, and Reserve, was 0.84% in FY 2015, down from 0.93% in FY 2013.

While it is difficult to ascertain the exact reason(s) for this dramatic decrease, the data suggest the DoD's strong focus in recent years on education and screening requirements for prescription drug abuse and addiction risk is having a positive impact. In addition, the DoD is committed to provider training on evidence-based guidance for the prevention, screening, evaluation, and treatment of prescription drug abuse and SUDs. In an effort to continue this trend, the DoD's ongoing efforts to improve prescription drug and SUD education and treatment programs include:

1. **Update TRICARE coverage to expand access to Medication-Assisted Treatment (MAT) and provide parity for substance use benefits:** A new Proposed Rule, titled, "TRICARE: Mental Health and Substance Use Disorder Treatment," was published in the Federal Register (FR) (FR Vol. 81, No. 20) on February 1, 2016, for public comment. It proposes to revise TRICARE coverage to expand treatment options for opioid use disorder (OUD) and to cover SUD treatment without imposing co-payments, benefit limitations, and other restrictions that are more stringent than those imposed on medical and surgical benefits.

2. **Update MAT policy for Active Duty Service members:** MAT is widely available to Service members with an OUD in the direct care system. However, personnel and medical policies and procedures associated with MAT are not uniform across the MHS. The DoD is evaluating Service and Defense Health Agency (DHA) policies and procedures with the goal of issuing consolidated

guidance regarding MAT that will have Tri-Service Surgeon General (SG) endorsement.

3. **Increase availability of Drug Enforcement Administration (DEA) waiver trained providers:** The DoD is committed to further expanding the number of military treatment facility (MTF) providers eligible to apply for DEA waivers to prescribe buprenorphine. The DHA is coordinating quarterly trainings that will include instruction on managing buprenorphine prescriptions as well as oral/injectable naltrexone prescriptions with the goal of training an additional 100 providers in FY 2016.

4. **Update the Clinical Practice Guideline (CPG) on the Management of Opioid Therapy for Chronic Pain:** The DoD continues to improve utilization and review of the existing pain-related CPGs that provide prescribing guidance and help providers mitigate the risks of opioid misuse. In October 2015, the Department of Veterans Affairs (VA)/DoD initiated the formal process for revising the CPG for the Management of Opioid Therapy for Chronic Pain.

5. **Update pain management and prescription drug abuse training:** The DoD is developing a standardized pain management curriculum for widespread use in education and training programs to improve the pain management competencies of the combined federal clinical workforce. The Defense and Veterans Center for Integrative Pain Management (DVCIPM) has coordinated the Joint (DoD & VA) Pain Education Project (JPEP) which focuses on the needs of providers and patients in primary care, and provides a holistic, multi-modal, and multi-disciplinary pain care model that supports the balanced use of medications, procedures, specialty care, and self-care approaches for pain management. The JPEP curriculum meets and exceeds recently released criteria in the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain. The curriculum not only includes the essentials of quality pain management, but also provides information on appropriate use, risks, and contraindications for opioids and other prescription pain medications as well as other treatment approaches.

6. **Provide tools and infrastructure to support clinical practice and research advancements in pain management:** The DoD is working to ensure providers use validated, patient reported, pain-related outcomes data to monitor the efficacy of the appropriate opioid utilization and use of non-opioid treatment options.

7. **Uniformed Services University (USU) School of Medicine (SOM) Training:** It is the first medical school in the nation to formally and fully incorporate DVCIPM's JPEP curriculum into its medical education program. This instruction provides a solid foundation for educating emerging physicians in the benefits of utilizing a multi-faceted approach to the management of acute and chronic pain, conditions which all too frequently result in an increased reliance on narcotic analgesics, and which may subsequently lead to the development of one or more substance abuse disorders.

8. **Drug Take-Back (DTB) Program:** The DoD will continue to partner with the DEA on Prescription DTB Events in 2016 and is working to publish a Department of Defense Instruction (DoDI) in April 2016. The companion procedures document, the DHA Interim Procedures Memorandum (IPM), is in formal coordination and outlines standard processes and tasks to be completed by MTFs to ensure successful implementation of the DTB Program.

INTRODUCTION

Prescription drug abuse is a threat to the health and welfare of Service personnel. It is also incompatible with the military and public service. The abuse of prescription drugs can impair performance and negatively impact readiness in the hazardous conditions unique to the military work environment.

Service members were prescribed pain medication at a rate four times higher in 2009 than in 2001 (Institute of Medicine (IOM), 2012). Chronic pain medication and opioid use rates in the military, specifically in Service members returning from Afghanistan, were estimated at approximately 44% and 15%, respectively (Toblin, Quartana, Riviere, Walper, & Hoge, 2014). Most of the prescription drugs misused by Service members are opiate pain medications, which include codeine, morphine, oxycodone, oxymorphone, hydrocodone, and hydromorphone.

Combat-related injuries may help explain the increase in prescriptions and the corresponding increase in self-reported misuse of prescription drugs. Post-traumatic stress and other mental health disorders are associated with substance misuse, as are other problems experienced by returning military personnel, including sleep disturbances, traumatic brain injury, and unemployment (National Institute on Drug Abuse, 2013).

Overall prescription drug misuse is low in the military. Between FY 2010 and 2015, there was a 29% decrease in the number of Service members receiving a primary diagnosis of Opioid Drug Dependence and/or Opioid Abuse, with an overall prevalence rate of 0.2% (MHS Data Repository, extracted February 24, 2016). According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2014, an estimated 1.73 million people aged 18 and older had an OUD related to prescription pain relievers (Center for Behavioral Health Statistics and Quality, 2015). This equates to a national prevalence of 0.7%, which is three and a half times greater than the 0.2% prevalence in the military.

Further, FY 2014 data indicate that the number of Service members identified as opiate (e.g., pain medications) abusers within the DoD declined 42% compared to FY 2013. The percent reduction was greatest for the hydrocodone/hydromorphone and the oxycodone/oxymorphone drug classes. Moreover, FY 2015 data from the Drug Demand Reduction Program (DDRP) revealed a decline in overall drug abuse, including prescription opiates, benzodiazepines, and synthetic cannabinoid (also known as "Spice"). The FY 2015 Active Duty drug positive rate was 0.60%, down from 0.72% in FY 2013, and the total DoD drug positive rate, which includes Active Duty, Guard, and Reserve, was 0.84% down from 0.93% in FY 2013.

While it is difficult to ascertain the exact reason(s) for this dramatic decrease, it suggests the DoD's strong focus in recent years on education and screening requirements for prescription drug abuse and addiction risk is having a positive impact. Military health care providers and pharmacists have become more alert to the signs of prescription drug abuse. In addition, the DoD continues to improve the flexibility of information

technology platforms that track prescription medications in an effort to inhibit the diversion and misuse of prescribed medications. Several programs have been implemented to encourage minimally effective dosing, restrain "medication shopping" with multiple doctors and pharmacies, limit refills for Schedule III-V medications, and restrict Schedule II medication to a 30-day prescription with no refills. In combination, these programs are used to monitor, both actively and through data mining processes, controlled substance utilization for the entire TRICARE eligible population for prescriptions filled in MTFs worldwide, the TRICARE retail network, the TRICARE mail order program, and paper claims submitted by beneficiaries.

More recently, the DoD has engaged in a number of efforts to improve SUD education and treatment. These efforts include the removal of the ban on substitution therapies for the treatment of SUDs, implementation of a DoD-level committee to coordinate SUD services (formed in 2011), revision of policy, and proposed changes to TRICARE coverage of SUD care. Education has expanded through a number of campaigns and training programs, including mental health awareness and anti-stigma campaigns, provider mandated prescription drug misuse training, and patient education during medical encounters (e.g., annual Periodic Health Assessments (PHAs)).

Screening and early intervention activities have strengthened as well, to include expanded access to behavioral health providers in primary care, substance misuse screening activities included in the Deployment Health Assessments and Reassessments, and drug testing programs to identify and evaluate potential substance use issues and facilitate access to treatment programs for recovery. Additionally, the DoD has revised the drug testing panel for Active Duty personnel to include the detection of a broader range of drugs with the potential for abuse. As a result of these educational efforts and procedural tightening, the percentage of Active Duty Service members prescribed narcotics is currently down nearly 17%.

Background

This report addresses a request in House Report 114-139, accompanying the Department of Defense Appropriations Bill, 2016, to provide a summary of education and treatment programs for prescription drug abuse and addiction, to include an overview of: "the current programs offered to educate Service members about the risks of prescription medication; the current treatment options for Service members suffering from addiction; the estimated number of Service members that participated in education and/or treatment programs in FYs 2012, 2013, and 2014; and specific recommendations for improving education and treatment programs."

The DoD has focused in recent years on addressing findings uncovered in IOM and DoD reviews of SUDs in the military. The National Defense Authorization Act (NDAA) for FY 2010, section 596, required the DoD to conduct a review of policies and programs for the prevention, diagnosis, and treatment of SUD in members of the Armed Forces (July 2011). The NDAA concurrently required the DoD to solicit an independent review of similar parameters, conducted by the IOM. In September 2012, the IOM

released a report on "Substance Use Disorders in the U.S. Armed Forces" that presented 20 broad findings on SUD in the military. The report identified a number of barriers that limit access to SUD care—including availability, gaps in insurance coverage, stigma, fear of negative consequences, and lack of confidential services—and made several recommendations to increase access to care; strengthen the SUD workforce; increase emphasis on prevention efforts; and develop strategies for identifying, adopting, implementing, and disseminating evidence-based programs and best practices for SUD care.

In a July 2013 Report to Congress titled, "Update to the Comprehensive Plan on Prevention, Diagnosis, and Treatment of SUDs and Disposition of Substance Use Offenders in the Armed Forces," the DoD outlined 21 actions to address the IOM recommendations. The 2013 Report to Congress summarized DoD activities to re-energize SUD prevention efforts and the implementation of provider education, evidence-based practices (EBPs), and treatments to enhance early recognition and intervention for individuals that may have an emerging SUD and prescription drug misuse. Below is an overview of DoD guidance, programs, and policies that have been developed or expanded in recent years to promote enterprise use of EBPs and increase quality and safety, while decreasing variation in SUD and prescription drug misuse education, screening, and treatment.

VA/DoD CPGs. CPGs provide guidance on the diagnosis, treatment, and management of patients based upon clinical evidence obtained from an intensive and comprehensive review and analysis of published medical literature. CPGs and the supporting toolkits give clinicians a standard to guide their clinical decisions. To foster adoption of best practices for SUD and prescription drug misuse, the DoD requires provider adherence to the VA/DoD CPGs for the Management of SUDs, Assessment and Management of Low Back Pain, and Management of Opioid Therapy for Chronic Pain.

The CPG on the Management of SUDs encourages all providers to use evidence-based methods across the continuum of care including: outpatient, intensive outpatient, partial hospitalization, and inpatient hospitalization programs. In 2014, a joint work group comprised of SUD research and treatment experts was established to review and revise current policies, guidelines, and practices related to the promotion of EBPs for SUD screening, treatment, and prevention. One of the key questions considered during the literature review was related to reviewing outcomes for adults with an OUD and the comparative effectiveness of treatment management strategies, including length of stay, treatment adherence, and adverse events in primary and specialty care settings. The work group reviewed the evidence for management of opioid disorders and renewed the recommendation of MAT as an evidence-based treatment option. A revised CPG for the Management of SUDs was published in December 2015. In October 2015, the VA/DoD began updates to the CPG for Management of Opioid Therapy for Chronic Pain.

Credentialing and Peer Review. A peer review process is required as part of the credentialing process for individual providers in all MTFs. The credentialing process for MTF providers contains safeguards to ensure that individual prescribing practices meet the standard of care for safe and effective medical care. MTFs are accredited by the Joint

Commission, and for certain facilities, the Commission on Accreditation of Rehabilitation Facilities. Both accrediting agencies require peer review as part of the credentialing process for independent providers.

Peer review involves the routine clinical quality monitoring performed by a peer in the same profession and clinical area of expertise as the provider under review. This ensures that each privileged provider meets the standard of care. Compliance with CPGs is often part of the peer review process. Results of peer review are summarized in the credentials package submitted every 24 months as part of periodic review for renewal of privileges for individual providers. Concerns about prescribing practices related to polypharmacy are identified and addressed within the peer review process.

DoDI 1010.04: "Problematic Substance Use by DoD Personnel." DoDI 1010.04, dated February 20, 2014, establishes policies, assigns responsibilities, and prescribes procedures for problematic alcohol and drug use prevention, identification, diagnosis, and treatment for DoD military and civilian personnel, as well as describes the relationship between the DoD and VA with regard to drug and alcohol use treatment. The goal of this instruction is to maintain high standards of performance by preventing and eliminating problematic substance use affecting readiness. The instruction also mandates education for DoD personnel about health and other risks to military readiness associated with problematic substance use. Providers are required to offer education about SUDs and the potential negative consequences associated with substance misuse. Further, Commanders and health care personnel are required to participate in an annual training on the identification, assessment, and referral of personnel displaying signs of problematic substance use. Presently, "Do No Harm" training fulfills the criterion for healthcare personnel. Services have been tracking the percentage of completion of required healthcare personnel. Services have been tracking the percentage of completion of required personnel. DoDI 1010.04 also outlines provisions for identification of beneficiaries who exhibit signs of problematic substance use and recommendations for the provision of treatment, consultation, or psychoeducational services.

Service-Specific Guidance. DoD Components have created Service-specific detailed guidance and have made available evidence-based SUD services that adhere to CPGs as published by a VA/DoD EBP Work Group (EBPWG) and accredited professional organizations specializing in the treatment of SUDs. Examples of Service-specific guidance include Air Force Instruction 44-121: "Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program" (July 8, 2014); Army Regulation (AR) 600–85: "The Army Substance Abuse Program Headquarters Department of the Army Washington, DC" (December 28, 2012); and Bureau of Medicine and Surgery (BUMED) Instruction 5353.4B: "Standards for Provision of Substance Related Disorder Treatment Services" (July 6, 2015).

DoDI 6490.12: "Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation." DoDI 6490.12, dated February 26, 2013, establishes the policy for person-to-person mental health assessments (MHAs) for each Service member deployed in connection with a contingency operation, as required in section 1074m of title 10, United States Code. Per the policy, Service members who

deploy in connection with a contingency operation will receive person-to-person, privately-administered MHAs before deployment, and three times after return from deployment to determine whether treatment is needed for mental health conditions. During the MHA, medical providers must inquire about any elevated screening scores and provide a brief intervention to Service members who may be at risk for unhealthy substance use. The brief intervention may be educational only, or it may generate a referral to specialty care for further evaluation. Those at significant risk receive a referral for more intensive evaluation, and possibly intervention and treatment through the specialty care clinic. Building on this DoDI, section 701 of the NDAA for FY 2015 added a requirement for deployment MHAs to be administered once during each 180-day period during which a member is deployed.

MAT. Service members access MAT through the DoD direct care system. Providers work closely with the patient and Command to address readiness and deployability while treating the Service member for OUD. In recent years, the DoD has expanded the availability of MAT to MHS beneficiaries by updating the TRICARE benefit; expanded education and training to MTF physicians on EBPs for provision of MAT (See "Do No Harm" training below); and revised medical and personnel policies regarding Service members requiring MAT.

Since 2013, the DoD has collaborated with the Services, Walter Reed National Military Medical Center (WRNMMC), and SAMHSA to offer a required DEA-hosted waiver training that providers must obtain in order to prescribe buprenorphine. The waiver requires an 8-hour training designed to enable a diverse audience of physicians to treat patients with OUD in a variety of settings, including family practice, internal medicine, and psychiatry. In the last 12 months, 100 providers have completed the required training, and the DoD has increased the number of providers holding a current DEA waiver by 15%.

In addition, the Assistant Secretary of Defense for Health Affairs has taken the lead in coordinating efforts to ensure that opiate overdose reversal kits (e.g., naloxone) and training are available to every first responder (e.g., Emergency Medical Services, Fire, and Police) on military bases or other areas under DoD control. This is an important safeguard to combat MAT-related overdose.

"Do No Harm" Training. The Services, in collaboration with the DHA, require all credentialed and privileged prescribing providers to complete an interactive training entitled "Do No Harm" that provides education on identifying patterns of prescription drug misuse and proposes potential interventions via interactive clinical scenarios. Since implementation in 2013, 20,688 prescribing providers, or 96% of eligible DoD providers, have completed the "Do No Harm" training. The training fulfills Chapter 2, Section D of the Office of National Drug Control Policy's (ONDCP's) FY 2014 National Drug Control Strategy and participant numbers are reported regularly to the ONDCP.

Pharmacy Drug Monitoring Programs. The DHA Pharmacy Operations Division (POD) has several tools that enable monitoring of opioid prescriptions. Overall, these monitoring tools focus on capturing all beneficiaries' prescription information and

alerting MTF healthcare providers of prescription trends through actionable reports that can be utilized to address concerns. Details on each of the tools to monitor opioid-based prescriptions are provided below.

Pharmacy Data Transaction Service (PDTS). Since 2002, the DoD has managed pharmacy transaction data through a contracted service. Historically, this function was performed by PDTS, which recorded prescription data from MTFs, TRICARE Retail Network Pharmacies, and the Mail Order Pharmacy (MOP) program, nationwide for our 9.5 million beneficiaries. After May 1, 2015, the responsibility transitioned to the Pharmacy Benefit Contractor. The Pharmacy Benefit Contractor conducts on-line, real-time prospective drug utilization review (clinical screening) against a patient's complete medication history for each new or refilled prescription prior to dispensing. Clinical screenings identify potential medication issues, which are immediately resolved to ensure the patient receives safe and quality care. Real-time tracking and messaging back to the submitting MTF provider (using Computerized Provider Order Entry) and pharmacist facilitate timely resolution of potential drug-drug interactions, therapeutic duplication, incorrect dosing, and over/under utilization. The Pharmacy Contractor currently aggregates all DoD prescription claims on its system and provides a daily update to PDTS which serves primarily as the DoD's data repository.

PDTS and the Pharmacy Contractor serve as a prescription drug monitoring program for the DoD, by providing real-time access to a patient's medication profiles and interactive alerts to DoD providers and pharmacies via the integrated medical information systems. PDTS and the Pharmacy Contractor monitor, both actively and through data mining processes, utilization of controlled substances among the entire TRICARE eligible population for prescriptions transmitted from all points of service (TRICARE retail network, MOP, MTFs, and paper claims). Prescription transactions for dual eligible beneficiaries at VA facilities are also captured real-time, and prescriptions filled in forward deployed theaters are captured in the PDTS weekly feed.

Controlled Drug Medication Analysis and Reporting Tool (CD-MART). The DHA POD developed the CD-MART, an automated, customizable tool to assist military healthcare providers in the review of controlled substance usage by their enrolled patients. The tool's objective is to assist these providers in analyzing the data and identifying patients who have received controlled substance prescriptions. The CD-MART report is compiled from the data in PDTS.

Polypharmacy Medication Analysis and Reporting Tool (Poly-MART). The DHA POD developed the Poly-MART to aid health care providers and pharmacy personnel to identify Active Duty and TRICARE enrolled members who are on multiple medications, and at risk for adverse events. The Poly-MART meets the requirements of the Office of the SG/U.S. Army Medical Command Policy Memo 15-039: "Guidance for Managing Polypharmacy and Preventing Medication Overdose in Patients Prescribed Psychotropic Medications and Central Nervous System Depressants." The Poly-MART report is compiled from the data in PDTS.

DHA Prescription Monitoring Program (PMP). The PMP, formerly known as the 1-1-1 or lock-in program, is a quarterly review of all TRICARE beneficiaries who received prescriptions using the TRICARE pharmacy benefit. The Pharmacy Contractor identifies beneficiaries that have demonstrated a high use of controlled substances, such as, medications used for pain management. Actionable results are sent to the appropriate medical, dental, and MTF reviewers to validate the beneficiary's appropriate use with a medical diagnosis. Any inconsistencies identified with utilization and/or medical diagnosis prompt the reviewer to develop a coordination of care plan for the beneficiary. A coordination of care plan may include case management, pain management, or other available services, with or without assigning restrictions to a specific provider and pharmacy. The goal is to identify beneficiaries who may be at risk and in need of additional medical assistance.

DoD DDRP. The DoD DDRP components include compulsory random drug testing with punitive consequences, anti-drug education, and outreach programs. The DoD DDRP is aligned with DoD policies that pertain to readiness within the Office of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)). Specifically, the DDRP policy for Service members is promulgated in DoDI 1010.01: "Military Personnel Drug Abuse and Testing Program," with detailed guidance concerning drug testing procedures contained in DoDI 1010.16: "DoD Civilian Employee Drug Abuse Testing Program," and drug and alcohol abuse policy in DoD Directive 1010.4: "Drug and Alcohol Abuse by DoD Personnel." The DoD DDRP policy for civilian personnel is contained in DoDI 1010.09: "DoD Civilian Employee Drug Abuse Testing Program." In 2012, the DoD expanded Service member drug testing requirements to include some of the most abused prescription drugs containing hydrocodone and benzodiazepine. Service members with prescriptions for these drugs are not subject to disciplinary action when they are taken within the prescribed dosage and time limits.

DTB Program. The MHS DTB Program is an enterprise-wide program that will provide beneficiaries with a way to properly and safely remove unused and expired medications from circulation that can be used for suicide or suicide attempts and have the potential for misuse, diversion, or accidental poisoning. The DoDI from the USD(P&R) was formally coordinated and concurred upon by the Services and is being coordinated for the Deputy Secretary of Defense's signature. The DoDI is expected to be published in April 2016. Its companion procedures document, the DHA IPM, which outlines a standardized process and details tasks to be completed by MTFs to ensure successful implementation of the DTB Program, is in formal coordination. In addition, the DTB IPM addresses provider and beneficiary training and education on the proper disposal of prescription medications. The Communications Plan section details the educational components of this program and all educational materials will be in compliance with existing DEA, U.S. Food and Drug Administration (FDA), and U.S. Environmental Protection Agency (EPA) regulations

In the interim, the Services have participated in all DEA-hosted Prescription DTB Days since 2010. During the last DTB Event on September 26, 2015, 62 participating MTFs collected approximately 11,000 pounds of unwanted, unused, or expired medications. For each of the DEA DTB Events, the DHA has done an outreach to beneficiaries

informing them of DTB Day at MTFs. These events help reduce the risk of prescription drug diversion and abuse, while also increasing awareness of this critical public safety and public health issue.

Prescription Drug Abuse Education

The DoD recognizes that the availability of medications that provide relief to those who suffer also creates opportunistic avenues for drug diversion. It is incumbent on Service medical departments to educate practitioners on these risks and to ensure that all methods of pain control are employed as part of a comprehensive pain management plan. Whether personnel use greater amounts of prescription medication than prescribed due to poor pain control or due to drug diversion for abuse, prescribing practitioners must be sensitized to the potential for prescription drug misuse and the risks associated with it. Below are strategies implemented by the DoD and each Service to educate Service members, family members, and providers about prescription drug abuse.

Army

Installation Army Substance Abuse Program (ASAP) personnel are responsible for executing awareness campaigns and training based on the needs of their respective installations. The Army's universal prevention training includes information regarding laws, regulations and definitions of use, misuse and abuse of substances, and information on how to refer for treatment. In addition, the Army's Alcohol and Other Drug Abuse Prevention Training is a 12-hour prevention educational/motivational intervention which focuses on the adverse effects and consequences of prescription drug use and misuse, alcohol, and other drug abuse.

The Army's "It's a Thin Line" is an evidence-based marketing and prevention campaign designed to educate Soldiers, their friends and families, and the provider community about the dangers of prescription drug misuse and abuse. The campaign, accessed through www.imcom.army.mil/ASAP/ArmyThinLine.aspx, encourages safe and responsible decisions when using prescription drugs, with the goal of reducing the prevalence of prescription drug misuse and abuse in the Army community. Educational information includes definitions of misuse, abuse, and addiction, as well as consequences for Soldiers and the referral process for treatment.

Service members and beneficiaries assigned to Army Medical Homes also receive personalized medication patient-centered care plans from clinical pharmacists, including education about mitigating medication risk. The Army Warrior Transition Units which provide personalized support to wounded, ill, and injured Soldiers, who require at least 6 months of rehabilitative care and complex medical management, receive targeted education about prescription medication risks from the Warrior Transition Units care management team. In addition, Service members and beneficiaries receive polypharmacy education from several sources, to include hospital services orientation, Family Readiness Group training, and other community outreach events.

The Army National Guard (ARNG) Traditional Soldiers are required to complete 2 hours of annual drug and alcohol prevention training. The ARNG Active Guard/Reserve and Active Duty Operational Support Soldiers are required to complete 4 hours of annual drug and alcohol prevention training. The ARNG preferred prevention training curriculum is Strong Choices, a research-based drug and alcohol prevention program that features information about the risks associated with taking prescription medication other than as prescribed and/or using another person's prescriptions. Modules include education about the ways drugs and alcohol affect the brain, standard drink guidelines, low-risk drinking guidelines, biological vs. behavioral risk for alcohol dependence, changes in stress vulnerabilities as a result of alcohol or drug use, real-life examples of how drugs and alcohol can affect the balance of stress, and resources for seeking help. The training is facilitated by each state's Prevention Coordinator and provides standardized content that is specific to the ARNG Substance Abuse Prevention Program, meets the needs of the ARNG's geographically dispersed units, and complies with the requirements for training in AR 600-85, with a particular emphasis on making responsible drinking choices.

Building on the Strong Choices prevention training curriculum, the Army Resiliency Directorate is developing an integrated universal prevention training package that will be implemented Army-wide. This training will focus on personal readiness and is designed to induce bystander intervention by individuals across a spectrum of risk behaviors, including substance abuse.

Navy/U.S. Marine Corps (USMC)

The Navy offers several programs to educate Service members about the risks of prescription medication. Many of these programs target the misuse of prescription medication and other substances. The Annual General Military Training includes a curriculum that provides guidance on prescription medication use and potential risks. Guidance includes: only taking medications for the period of time and as they are prescribed; not buying, selling, sharing, or borrowing prescription drugs; properly disposing extra medication; and ensuring all prescribed drugs, including those from civilian doctors, are entered into military medical records. Training also covers negative impacts of prescription drug misuse such as addiction, dependence, performance issues, and sleep cycle disruption. Service members also receive training on the use of alcohol, drugs, and tobacco, and the negative effects of substance abuse. The programs facilitate recognition and deterrence of addictive behavior, impaired decision-making, and other potentially detrimental factors to force readiness and the well-being of Service members.

Since August 2012, Navy Service members have received additional prescription drug use education through programs such as Drug Aware, Alcohol and Drug Abuse Management Seminar (ADAMS) for Leaders, ADAMS for Supervisors, and Drug and Alcohol Program Advisor (DAPA) training. Drug Aware is a Command level awareness training on drugs of abuse and risks involved in abusing legal and illegal drugs to include prescription medications. ADAMS for Leaders provides information for Command leadership on substance abuse and managing local prevention education efforts, whereas ADAMS for Supervisors provides first line supervisor training for E-5 and above Sailors

on the impact of drug policy and programs. DAPA is a 5-day course that prepares participants to assist Command leaders with developing prevention plans and programs to reduce substance abuse.

The Navy's Prescription for Discharge program, launched in April 2014, focuses on educating Sailors and their families on Navy policies, health and safety risks, and proper use of prescription drugs. The campaign's key messages for prescription medication are: take medications correctly by following doctor's orders and prescription instructions; report promptly to ensure Navy Medicine and Command are aware of current prescriptions; dispose of unused medications in such a way they are unusable by others; and never share prescription medication with a friend, shipmate, or family member. Service members are encouraged to engage with their DAPAs and to self-refer at the earliest signs of trouble. The campaign is flexible, allowing implementation by Commands worldwide based on priorities and resources. Messaging is delivered through posters, banners, flyers, table tents, fact sheets, social media messages, medical provider toolkits, Command level presentations, an implementation guide, and a Flickr account.

In FY 2015, the Navy rolled out Bystander Intervention to the Fleet training for all hands. The training is designed to empower Sailors to intervene to stop behaviors not aligned with Navy Ethos and Core Values; provide Sailors with techniques to safely and effectively step up and step in; and promote a culture in which bystander intervention is widely accepted, expected, implemented, and supported by all Sailors from E-1 to O-10. Training facilitators use realistic scenarios to demonstrate the right course of action can be challenging, but Sailors must remember they are acting in the best interests of their shipmates, and Navy Ethos and Core Values can help navigate difficult situations.

The USMC also offers several programs to educate Service members about the risks of prescription medication. The USMC Substance Abuse Program provides education and awareness training to all Marines, Sailors, and their family members on the dangers of misusing prescription drugs via public service announcements, educational materials, and informational briefings. Service members and their family members are educated on the proper disposal of unused and expired medications. The USMC Substance Abuse Program also educates Marine leaders on the dangers of abusing prescription medication via annual Substance Abuse Supervisory Level Training and Command briefs provided by Drug Demand Reduction (DDR) Coordinators located at each USMC installation. The program promotes information sharing across the continuum of care while continuing to work with the Navy in increasing monitoring and surveillance of prescription drug urinalysis testing and positives.

The USMC relies on Substance Abuse Counseling Centers (SACCs) to educate Marines about SUDs. Marines come to the SACC and receive screenings, assessments, and outpatient/intensive outpatient counseling services. This process allows counselors to help individuals recognize their illnesses and develop programs of recovery. The USMC currently offers education about SUDs through three primary programs: the DDRP, the Alcohol Abuse Prevention Program (AAPP), and the Clinical Services Program. The Behavioral Health Continuum of Care Model – introduced by IOM – serves as a framework for the USMC's comprehensive approach to prevention.

Each installation has a DDRP that helps prevent the misuse of prescription medication and other drugs through awareness, education, and training. The USMC assigns DDR Coordinators to each major installation in support of these education, outreach, and training initiatives. Each installation also has an AAPP and the USMC assigns Alcohol Abuse Prevention Specialists to each major installation to provide Marines with education and awareness training on the misuse of alcohol. The AAPP conducts community outreach events aimed at increasing substance abuse awareness. The AAPP also provides units with evidence-based tools that they can use to implement their own initiatives.

In addition to these primary programs, the Unit Marine Awareness and Prevention Integrated Training (UMAPIT) is an integrative universal annual training that educates all Marines at the unit level about behavioral health risk factors and warning signs, including alcohol use and misuse. UMAPIT incorporates protective factors and skill-building techniques that can protect against behavioral health issues. This training ensures Marines understand their responsibility to intervene when a fellow Marine shows signs or symptoms of alcohol misuse and behavioral health concerns. UMAPIT also strives to increase acceptance and practice of help-seeking behaviors as well as willingness to refer and/or report behavioral health incidents. Additional training reinforces UMAPIT concepts during a Marine's career, including the Marine Awareness and Prevention Integrated Training Dashboard. The Dashboard provides selective training based on the unit's needs through 30- to 45-minute topic-specific guided discussions in PDF format, which can be led by anyone in any situation.

The USMC implemented PRIME for Life® (PFL) in 2012. PFL is included in the National Registry of Evidence-based Programs and Practices. Participants must take self-assessments along with individual and group activities. A workbook is provided to each participant and is essential to student learning. It includes activities completed in class and an easy-to-read summary of the information taught in class. The USMC offers PFL 16.0, which is a 16-hour early "indicated" prevention intervention strategy designed to target Marines who are actively making high-risk substance misuse choices and who may have incurred legal consequences (i.e., alcohol- or drug-related incidents). PFL 16.0 is an evidence-based curriculum facilitated by trained and certified prevention specialists. In 2013, the USMC implemented PFL 4.5, which is a 4.5-hour early intervention course offered by prevention specialists for Marines, ages 17-25, at high risk for alcohol- and drug-related incidents.

United States Air Force (USAF)

The USAF provides briefings to Service members and their families in various settings to educate about the risks of all forms of substance abuse, treatment options available, and referral information. Air Force Alcohol and Drug Abuse Prevention and Treatment (ADAPT) and DDR programs/offices are located at all USAF bases and head up both education and prevention efforts, which are each aimed at targeting every Airman and their dependents at multiple points throughout their careers.

Current practices and programs designed to prevent and monitor for prescription drug abuse include: urinalysis testing, screening controlled substance prescriptions, 100% accountability of all controlled substances, ADAPT and DDR programs, and the "Sole Provider" prescription restriction program. Urinalysis testing provides deterrence via random drug testing for both illicit drugs and unauthorized use of prescription drugs. The program has evolved over time to cover even more substances as the threat environment changes.

Briefings are provided at base newcomer's orientation, during First Term Airman orientation training, and at various leadership academies illustrating the hazards of drugs of abuse and risks involved with the misuse of alcohol, prescription medications, and illegal/illicit drugs. Commanders and First Sergeants receive focused briefings and units are briefed per their request (e.g., Commander's Calls, Safety Stand Down Days, etc.), reviewing key indicators and the various clinical intervention and prevention services available on base. In each of these briefings, contact information and referral procedures for local agencies are reviewed and the option of mandatory Commander-Directed Evaluation referrals is discussed. Additional education efforts include briefings at twice annual Wingman Days and annual educational briefs to all medical/professional staff.

In addition to troop education, the USAF engages in robust provider education and is a full partner in the implementation of the President's 2012 National Drug Control Strategy. All prescribing physicians participate in "Do No Harm" training, which educates providers on key oversight and monitoring skills necessary to prevent the misuse of prescription medication. Annual training is conducted with all MTF staff to ensure current awareness of substance abuse indictors, trends, and referral procedures. ADAPT and DDR staff is encouraged to modify these trainings to address issues that may be of particular importance to their specific geographic locations.

In addition to the above educational activities, the USAF provides selected and indicated prevention in the form of focused psychoeducational and evidence-based care that incorporates VA/DoD CPGs and the American Society of Addiction Medicine (ASAM) Guidelines for those referred for services. All referrals to USAF ADAPT receive three sessions worth of brief counseling, regardless of diagnosis, aimed at preventing the misuse and abuse of alcohol-related problems as well as beneficial coping strategies (e.g., stress management, anger management, etc.).

DHA National Capital Region - Medical Directorate (NCR-MD)

The DHA NCR-MD exercises authority, direction, and control over WRNMMC, Fort Belvoir Community Hospital (FBCH), and their subordinate clinics. The WRNMMC Addiction Treatment Services (ATS) program provides educational, outpatient, and intensive outpatient services. The program offers a 12-hour version of PFL, described in the Navy/USMC section above, designed for Service members identified as at-risk for SUDs who may not self-identify as needing help. Topics include defining low risk versus high risk drinking choices, identifying genetic and social risk factors, understanding different stages of alcohol/substance abuse, and learning about how to

prevent alcohol and substances from undermining personal goals and values. The class also directly addresses the potential hazards of prescription medications.

To address the increasingly problematic issue of prescription medication abuse, ATS offers a weekly "Health and Wellness" group that addresses prescription medication abuse and dependence. The WRNMMC Pain Clinic also offers a weekly pain class at ATS that discusses prescription opioid use. The class is also offered via video teleconference to Quantico, the Pentagon, FBCH, and Fort Meade.

At FBCH, there are a number of ways in which Service members are educated about SUDs, including the Alcohol Prevention Education campaign, Military Pathways, Real Warrior Campaign, and during medical encounters (PHAs). Service members are also educated during screening services in Pre-Deployment Health Assessments, Post-Deployment Health Assessments, Post-Deployment Health Reassessments, and Military and Civilian Drug Testing programs.

The FBCH ASAP offers primary prevention and educational briefings to units and Service members across the installation. Providers educate patients on these topics through substance abuse groups, a medication education group facilitated by a doctorate level pharmacist, and individual sessions with the patient's primary therapist and prescriber. The medication education and substance abuse groups address compliance with medications and the dangers of abusing prescription medications, encouraging members to ask questions and monitor their symptoms and effectiveness of use. Therapists also review medications with patients individually and discuss compliance. Prescribers conduct an in-depth medication reconciliation during individual sessions, and closely monitor patients with self-report and laboratory findings. Nursing staff may also provide additional monitoring and education (i.e., how to use a pill box) to minimize risk of misuse. The FBCH ASAP also provides recurrent Web-based and/or unit training (4 hours per year) on various substance abuse topics, 21-hour PFL training for all ASAP-screened Service members, and "Drug Free Workplace" training. A number of other ASAP initiatives address substance abuse education in general. These include: Strong Choices, Alcohol Education Awareness, 100 Days of Summer, Red Ribbon Week, Drunk and Drugged Driving Prevention Program, St. Patrick's Day Prevention Impaired Driving, Children of Alcoholics Week, and advertisement of National Prescription Take-Back campaigns. The FBCH Addiction Medicine Department provides consultation to all specialty services at FBCH on these topics and any other addiction-related subjects.

Prescription Medication / Substance Use Education Program Participation

Below are the estimated number of Service members that participated in Service education programs in FYs 2012, 2013, and 2014.

Army

Table 1. Universal prevention training

	FY 2012	FY 2013	FY 2014
Number of Soldiers (Substance Use)	657,718	554,511	586,918
Training Hours (Substance Use)	16,964	17,027	17,560

Table 2. Alcohol and other drug abuse prevention training

	FY 2012	FY 2013	FY 2014
Number of Soldiers	13,432	11,726	11,497
Training Hours	163,775	146,205	139,555

Navy/USMC

The Navy and USMC continue to offer education programs related to substance use and prescription medication use while working to improve tracking mechanisms so the Department of Navy can better understand the effectiveness of current training and improve future training. The current programs are beneficial and vary in content or format over time due to available resources and changing environments. As a result, some data are not available while data tracking for some offerings was initiated at a later date or only documented locally. The Navy and USMC are working to address these gaps. The tables below provide an overview of available data on the education programs offered by the Department of Navy.

Table 3. Number of Sailors with Navy General Military Training Completions

	FY 2012	FY 2013	FY 2014
Navy's Drug Abuse Policy	37,567	41,335	125,416
Alcohol Abuse Prevention & Control	198,433	245,545	277,862
Responsible Use of Alcohol	60,081	-	-
Tobacco Cessation Policy	29,967	34,422	119,979

Note: Mandatory General Military Training course requirements change each year.

Table 4. Number of Sailors Completing Alcohol and Drug Training

	FY 2012	FY 2013	FY 2014
ADAMS for Leaders	2,544	2,050	1,900
ADAMS for Supervisors	6,846	5,135	3,269
DAPA	1,855	1,773	1,891

Table 5. Number of Sailors with Completions for Bystander Intervention to the Fleet

	As of September 2015
Total Completions	311,845

Table 6. Number of Marines Who Attended Drug Education Offerings

	FY 2014
Marines who attended drug education	43,417
Marines who attended drug summits	1,899
Personnel who received drug education*	98,701

* Personnel include Marines, Sailors, and their families

Table 7. UMAPIT

	As of September 2015
Total Completions	66,161

Table 8. Number of Marines and Sailors Completing PFL 16.0

	FY 2014	FY 2015*
Number of training sessions	184	208
Number of Marines who completed PFL	2,201	2,042

* As of July 31, 2015

Table 9. Number of Marines and Sailors Completing PFL 4.5

	FY 2014	FY 2015*
Number of training sessions	161	129
Number of Marines who completed PFL	3,080	2,090

***** As of July 31, 2015

USAF

All USAF Service members have participated in at least one of the prevention efforts described above, with most participating in multiple efforts. Attendance is not tracked at every prevention and outreach event; therefore, precise numbers are not available. In 2015, drug abuse prevention training was integrated into the Air Force's Resiliency program. The program's goal is to build and sustain mental, physical, social, and spiritual fitness among the Airmen population, who are expected to make sound choices in their everyday approach to work and off-duty life. Master Resilience Trainers were provided drug abuse materials to facilitate prevention training.

Table 10. Universal Prevention Training

	FY 2012	FY 2013	FY 2014
Number of Airmen (Substance Use)	328,592	326,470	312,164

Table 11. Selected (at risk) Prevention

	FY 2012	FY 2013	FY 2014
Number of Airmen (Substance Use)	N/A	4866	4564

DHA NCR-MD

The information below pertains to education provided by behavioral health entities. Commands and other clinical sections at DHA NCR-MD sites may have offered additional educational trainings.

Table 12. DHA NCR-MD ASAP

	FY 2012	FY 2013	FY 2014	FY Total
FBCH Enrollees	-	157	87	244
WRNMCC Enrollees	122	117	135	374

Addiction Treatment

Problems stemming from the misuse and abuse of opioids and other drugs are not new to the MHS. The DoD has prioritized implementation of EBPs and treatments to enhance early recognition and intervention for individuals that may have an emerging prescription drug misuse and substance use concerns.

Army

The Army ASAP provides outpatient treatment services. Therapy is individualized, evidence-based, and used in conjunction with group therapy as appropriate. Group therapy is structured to meet specific needs of participants' treatment plans, goals, and objectives. Referrals to intensive outpatient and residential treatment are made in support of a full continuum of care.

Navy/USMC

Navy Medicine programs are available to all Service members. They include 53 Substance Abuse Rehabilitation Program (SARP) sites. Levels of Navy SARP treatment include: Residential Treatment (4-5 weeks) at 3 sites; Intensive Outpatient Treatment (112-128 hours) at 12 sites; Outpatient Treatment (56-72 hours) at 22 sites; Early Intervention (20 hours) at 34 sites; and evidence-based screening, pre-care, and

continuing care at all of the SARP sites. The intensive outpatient programs (IOPs), as well as the residential programs, offer a variety of therapy modalities to supplement substance abuse care and include yoga, Tai Chi/Qigong, meditation, mindfulness, guided imagery, relaxation, art therapy, music therapy, and acupuncture.

The Navy also makes extensive use of the My Ongoing Recovery Experience (MORE) program. MORE is a Web- and phone-based aftercare program through which nine coaches assist with the continuing care of personnel assigned to all units worldwide, including Navy Ships. Patients enrolled in MORE are provided coaching support for 12 to 18 months and have access to online recovery resources for life. This service is available for Active Duty Service members, Reservists, retirees, and family members.

The Navy runs a highly effective random drug testing program that tests for prescription medications as well as for many other drugs of abuse. As such, it should be noted that all Service members with identified SUDs are offered treatment for their conditions and are afforded the opportunity to complete treatment, even in cases where a Service member is going to be involuntarily separated due to issues related to the substance use. These Service members continue to have access to MORE program services, regardless of duty status, in order to assist with recovery.

Additionally, BUMED and the USMC formalized their model of care in a November 2013 Memorandum of Understanding (MOU). The MOU clarifies that USMC SACCs can treat mild to moderate SUDs, while complex and severe SUDs, or individuals with comorbid conditions, are referred to Navy MTFs. The USMC SACCs provides substance use counseling services to Marines and their family members who meet the diagnostic criteria for mild to moderate SUDs as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5).

SACCs (accredited by the Commission on Accreditation of Rehabilitation Facilities) have utilized the ASAM continuum of care treatment model since 1997. This model is designed to use a combination of diagnosis and patient placement criteria for placing clients in the least intensive/restrictive treatment environment, appropriate to their therapeutic needs. Although there are five levels of care under this model, only three are provided at the SACC: (1) Early Intervention, intended for Marines who have had some difficulty with alcohol but do not have an established pattern of abuse; (2) Outpatient, designed to provide care to Marines who meet the current DSM criteria for mild or moderate SUDs, to address the Marine's needs and achieve permanent changes in alcohol or drug use behaviors; and (3) IOP, designed for Marines who have been diagnosed using current criteria for moderate SUDs requiring a higher level of care.

While discrete, the ASAM levels of care are different segments across a continuum of care. Following the initial screening, clients can enter at any level and move up or down in the treatment continuum, depending on their response to treatment. Treatment services are provided in individual, group, and family formats. Clients whose diagnosis is complex–moderate (meeting certain SUD criteria or having a dual diagnosis) or severe are referred to MTFs. For those clients, the MTF determines the level of care and the

counseling setting. SACC counselors are responsible for coordinating care for clients who start treatment at SACCs, connected to higher levels of care as needed, and referred back to SACCs when clinically indicated. This service model is intended to provide a coordinated, seamless, and comprehensive continuum of services.

USAF

Current policy ensures all Service members who have a substance-related incident or self-identify are referred for appropriate evaluation and treatment. The USAF has incorporated the VA/DoD CPGs for the Management of SUDs, as well as ASAM's established patient placement criteria (discussed above under Navy/USMC). All Service members with a SUD are offered treatment based on their needs, with all USAF bases offering Alcohol Brief Counseling and ASAM Level 1 outpatient treatment options. The USAF adopts a standardized, evidence-based approach to treatment of all SUDs and three options currently exist for outpatient treatment: (1) cognitive behavioral therapy, (2) a cognitive behavioral coping skills training, and (3) SUD group treatment based upon a stages of change therapy manual. Higher levels of care for SUDs vary depending upon the scope of care available at each MTF. If the base cannot provide the level of care, the Service member is referred to the local network, the VA, or another MTF as needed.

The "Sole Provider Program" is a preventative program to help monitor and restrict access to controlled drug prescriptions for Service members who demonstrate a pattern of obtaining prescriptions for controlled substances from multiple sources. The purpose of this program is to assess and mitigate a patient's risk for medication misuse and harm. Both the patient and provider sign an agreement to have a single prescriber for all medications or specific classes of medications to be prescribed. Additionally, MTF pharmacies screen controlled substance prescriptions for trend indicators (e.g., unusually large quantities, multiple providers, etc.), review patient medication profiles, and use the PDTS to help identify drug seeking behaviors and limit potentially dangerous polypharmacy.

DHA NCR-MD

WRNMMC ATS staff is comprised of seasoned clinicians with extensive experience treating SUDs, including seven Licensed Certified Social Workers at the Clinical level with additional addictions certifications (e.g., Master's Addictions Counselor, Certified Chemical Dependency Counselor). The ATS also provides training to Navy interns who have completed the Navy Drug and Alcohol Counselor course through the Surface Warfare Medical Institute. The ATS provides the following treatment options:

- Intensive Outpatient Treatment: 3 days weekly from 0730-1200;
- Outpatient Treatment (includes individual, group, and education);
- PFL (12-hour Educational Class for at-risk individuals following an alcohol related incident). This class also addresses the potential hazards of prescription medications and other substances;
- Service coordination and seamless transitions of care with the FBCH Residential Treatment Center (RTC), a 28-day residential treatment program; and,

- Referral to other inpatient treatment facilities, as appropriate.

The FBCH Addiction Medicine Department provides treatment for SUDs using a cognitive behavioral approach to help clients recognize situations where they are likely to use substances, find ways of avoiding those situations, and learn better ways to cope with feelings and situations that might have, in the past, led to substance abuse. Group therapy interventions centers around addiction, early recovery, relapse prevention, cognitive therapy, seeking safety, and living in balance.

Service members receiving substance abuse treatment at the FBCH RTC, the Co-Occurring Partial Hospital Program, or the Outpatient Addictions Clinic, continue to receive psychoeducation on the dangers of misusing and abusing prescription medications. The FBCH RTC provides the following treatment through a multi-disciplinary team approach with a physician, nurse practitioner, licensed clinical psychologist(s), licensed professional counselor(s), nurses, recreation therapist, art therapist, and psychiatric technicians:

- Group therapy interventions use a cognitive behavioral approach to help clients recognize situations where they are likely to use substances, find ways of avoiding those situations, and learn better ways to cope with feelings and situations that might have, in the past, led to substance abuse. Group interventions center on addiction, early recovery, relapse prevention, cognitive therapy, and seeking safety, to include "King Baby" group therapy sessions (identify Service member's interest in maintaining sobriety in the program) and "Twelve Step and Spirituality" group therapy sessions (built on the Alcoholics Anonymous Model Map of Life);
- Evidence-based and evidence-informed intensive individual therapy for anxiety, depression, SUD, post-traumatic stress disorder, etc. (e.g., cognitive behavioral therapy, Eye Movement Desensitization and Reprocessing, Accelerated Resolution therapy, Cognitive Processing Therapy, prolonged exposure, Acceptance and Commitment Therapy, solution focused therapy, motivational interviewing, etc.);
- Medication management;
- Integrative Medicine modalities (e.g., mindfulness, yoga);
- Recreation and Art therapy; and,
- Psychological Testing.

The FCBH Co-Occurring Partial Hospital Program provides the following group therapy modalities, also through a multi-disciplinary team approach:

- SUD group therapy interventions, as described above, center on addiction, early recovery, and relapse prevention, cognitive therapy, seeking safety, and living in balance;
- Mood Enhancement groups provide patients with a variety of tools to better identify mood states, increase psychological flexibility, recognize values, and make choices more in line with living a meaningful life. Group therapy

interventions center around Acceptance and Commitment Therapy techniques related to concepts of acceptance/willingness, present moment awareness, de-fusion of unhelpful thoughts/storylines, utilizing self-as-context, values and committed actions;

- Combat Trauma groups provide empirically and clinically informed treatment for patients who have experienced one or more traumas during combat. The Graphic Narrative model is utilized to educate patients about the stages of the Instinctual Trauma Response and provide a framework for them to draw out a traumatic memory scene by scene. These Graphic Narratives are presented to the group by the therapist, and a recording of the presentation is reviewed by the patient several times over the course of their treatment. Education is provided on symptom management, grounding techniques, and coping strategies; and,
- Distress Tolerance and Resiliency groups introduce coping skills using a combination of dialectical behavioral therapy and cognitive behavioral therapy techniques and concepts. Group therapy interventions center on the concepts of mindfulness, distress tolerance, emotional regulation, interpersonal effectiveness, and identifying and challenging negative thoughts.

The FCBH Outpatient Substance Abuse Clinic provides the following:

- Medication Management including alcohol and opiate abuse prophylaxis and opiate replacement therapy;
- Toxicological Screening;
- Individual Therapy; and,
- Group Therapy (e.g., Relapse prevention).

The FCBH ASAP provides the following:

- Comprehensive substance use assessment;
- Individual psychoeducation;
- Group-based education (including unit briefings);
- Individual counseling; and,
- 12-step Relapse Prevention program.

Substance Use Treatment Program Participation

Below are the estimated number of Service members that participated in Service treatment programs for SUD in FYs 2012, 2013, and 2014.

Army

The numbers below refer to the number of Soldiers screened, enrolled in outpatient treatment, and/or who attended residential treatment for substance abuse.

Table 13. Treatment

	FY 2012	FY 2013	FY 2014
Number of Soldiers Screened	25,052	22,129	19,447
Enrolled for outpatient treatment	17,203	15,118	12,686
Attended residential treatment	1,898	1,529	1,235

Navy/USMC

The number of incident cases of alcohol use disorder (AUD) and SUD have varied from year to year, but the incidence of cases of both has been decreasing in the 2012-2014 timeframe. Also, as mentioned, Navy BUMED and the USMC Marine and Family Programs established a MOU that allows Service members to receive some AUD and SUD treatment services through the USMC SACCs. Service members receiving treatment through SACCs are not included in Table 14, but are recorded in the Navy Alcohol and Drug Management Information Systems and Behavioral Health Data Surveillance in Table 15.

Table 14. Service Members in Navy Medicine Substance Use Treatment Program Data

	FY 2012	FY 2013	FY 2014
Number of Service member participants	8,724	9,009	7,629

Table 15. Active Duty Marines' Alcohol and Drug Treatment Data

	FY 2012	FY 2013	FY 2014
Outpatient or IOP participants	1,902*	1,531*	1,267**

* Source: Navy Alcohol and Drug Management Information Systems
** Source: Behavioral Health Data Surveillance

USAF

Table 16. USAF Outpatient and Inpatient Patients

	FY 2012	FY 2013	FY 2014
Outpatient (unique patients)	1,732	1,892	2,010
Inpatient (unique patients)	645	636	621

DHA NCR-MD

Table 17. FCBH Admissions and Outpatient Patients

	FY 2012	FY 2013	FY 2014
RTC Admissions	45	178	194
Co-Occurring Partial Program Admits	272	224	282
Addiction Outpatient Patients	31	171	143

Table 18. WRNMMC Admissions and Outpatient Patients

	FY 2012	FY 2013	FY 2014
Individual Encounters	2,016	2,007	2,176
Group Encounters (incl. IOP groups in 2014)	2,119	2,161	3,443
Referrals to PFL	123	106	119
Referrals to inpatient treatment	57	58	49
Referrals to IOP (began March 2014)	N/A	N/A	45
Total referrals	256	231	216

Ongoing Efforts

To build upon momentum in recent years to reduce prescription and illicit drug abuse, the DoD has a number of ongoing efforts to further advance education and treatment programs for prescription drug abuse and SUD.

1. <u>Update TRICARE to Expand MAT and Substance Use Benefit Coverage</u>

The TRICARE benefit offers an array of options for SUD treatment. Currently, TRICARE covers medically necessary services for SUD treatment, including detoxification, rehabilitation, and outpatient care, but only when that outpatient care is provided in a TRICARE authorized SUD Rehabilitation Facility (SUDRF) (per TRICARE Policy Manual, Chapter 7, Section 3.7).

Access to major forms of MAT (i.e., buprenorphine and methadone) under purchased care was unavailable prior to 2013 because of a TRICARE restriction on the use of drug maintenance programs. The October 22, 2013, the FR, "TRICARE: Removal of the Prohibition to Use Addictive Drugs in the Maintenance Treatment of Substance Dependence in TRICARE Beneficiaries" (FR, Vol. 78, No. 204), removed the exclusion of using drugs with addictive potential in the treatment of SUDs, such as use of buprenorphine and methadone, to treat OUD. Removing this restriction was a significant step forward for the DoD in reducing stigma surrounding MAT and an acknowledgement

that opioid misuse is an important medical problem affecting civilian and military populations.

While the 2013 Final Rule removed the prohibition to use addictive drugs in the treatment of SUDs, current restrictions remain that limit access to evidence-based care in general for SUD. Specifically, TRICARE does not reimburse care provided in opioid treatment programs (OTPs) as they are not recognized as authorized TRICARE providers. Furthermore, by current regulation, reimbursement for office-based SUD outpatient treatment provided by TRICARE authorized individual mental health providers, as specified in 32 Code of Federal Regulations (CFR) 199.6, is not permitted. Such outpatient SUD treatment services currently must be provided by a TRICARE approved institutional provider (i.e., a hospital-based or free-standing SUDRF). However, although some accredited TRICARE authorized SUDRFs provide office-based SUD outpatient treatment, institutional providers of SUD care primarily provide services to patients requiring a higher level of SUD care. This counter-therapeutic restriction on access to outpatient treatment by individual professional providers prevents TRICARE from covering office-based opioid treatment (OBOT) provided by qualified physicians. TRICARE currently has an estimated 15,000 to 20,000 beneficiaries with OUD, who under the current benefit, cannot access MAT.

According to the SAMHSA, there are approximately 1155 OTPs in the United States and 31,363 physicians with a DEA waiver to provide MAT for OUD, but none of these facilities or providers is TRICARE-authorized or eligible to be reimbursed by TRICARE under current regulations. In addition, TRICARE currently caps residential and partial hospitalization SUD treatment at a lifetime limit of three treatment episodes. As SUDs are chronic conditions that often involve relapse, this presents an arbitrary barrier to provision of medically-necessary health care and is inconsistent with evidence-based treatment guidelines.

To address current limitations, a TRICARE proposed rule, "TRICARE: Mental Health and Substance Use Disorder Treatment," would expand the SUD benefit to include provision of care in OTPs and allow for coverage of opioid treatment outside of SUDRFs via OBOT. This rule was published in the FR (FR Vol. 81, No. 20) on February 1, 2016, for public comment. Additionally, the DoD is revising TRICARE coverage to cover SUD treatment without imposing co-payments, benefit limitations, and other restrictions that are more stringent than those imposed on medical and surgical benefits. Although TRICARE is not a group health plan subject to the 2008 Mental Health Parity and Addiction Equity Act, the provisions of this Act serve as a model for TRICARE in proposing changes to existing benefit coverage.

This rule proposes expanded treatment of OUD, with the provision of MAT through both TRICARE authorized institutional and individual providers. This rule proposes TRICARE coverage of OTPs, with the inclusion of a definition of OTPs in 32 CFR 199.2 and the requirements for OTPs to become TRICARE authorized institutional providers outlined in 32 CFR 199.6. Additionally, this rule proposes coverage of OBOT, as defined in 32 CFR 199.2, and coverage of MAT as treatment of opioid dependence by TRICARE authorized physicians delivering OBOT on an outpatient basis as extended in

32 CFR 199.4. Coverage of outpatient SUD treatment by TRICARE authorized providers, to include OTPs and physician providers of OBOT, will enhance access to care, facilitate early intervention for SUDs, and help reduce relapse to opioid and other substance use.

2. Update MAT Policy for Active Duty Service Members

The DoD has made MAT available to Service members with an OUD in the direct care system; however, personnel and medical policies and procedures associated with MAT are not uniform across the MHS. For example, it has not officially been established whether Service members are deployable on MAT or what the impact of long-term MAT is on military readiness. In addition, administrative separation for OUD is often dependent upon Commander preferences, and there is variability across the Services regarding how long a Service member can remain on MAT before a medical profile (likely leading to separation from service) is required.

The DoD is evaluating Service and DHA policies and procedures with the goal of issuing consolidated guidance regarding MAT that will have Tri-Service SG endorsement. The DoD will update policies for MAT to reconcile medical and personnel policy with current EBP guidelines, which will inform the development of Service-specific instructions that are consistent in applying the same standards. The updated polices, specifically DoDI 1010.04, "Problematic Substance Use by DoD Personnel," and DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," will address treatment approach, duration, monitoring, follow-up, deployability, and readiness of Service members receiving MAT.

3. Increase Availability of DEA Waiver Trained Providers

The DoD is committed to further expanding the number of MTF providers with DEA waivers. The DHA is coordinating quarterly trainings that will include instruction on managing buprenorphine prescriptions as well as oral/injectable naltrexone prescriptions with a goal of training an additional 100 providers in FY 2016. The DoD is currently reviewing TRICARE direct care encounters and purchased care claims to determine current utilization of MAT and develop a model for projecting potential demand for MAT based upon the number of beneficiaries with any diagnosis of OUD. These data will be used to target outreach and retention efforts of DEA waivered providers, to establish training goals for FY 2017 and subsequent years across Service affiliation and geographic location, and to identify staffing targets for DEA waivered providers in specific MTFs.

4. Update CPG for the Management of Opioid Therapy for Chronic Pain

The MHS continues to improve utilization and review of the existing pain-related CPGs that provide prescribing guidance and help providers mitigate the risks of opioid misuse. The VA/DoD completed a revision to the CPG for the Management of SUDs in 2015, and recently began updates to the CPG for Management of Opioid Therapy for Chronic Pain in October 2015. As referenced above and detailed in previous reports, the CPGs provide guidance on the diagnosis, treatment, and management of patients based upon clinical evidence obtained from an intensive and comprehensive review and analysis of published medical literature. Compliance with CPGs is often part of the peer review process.

The VA/DoD EBPWG oversees development, implementation, and review of this portfolio of CPGs. The Work Group has established a rigorous process for the development of all CPGs that includes a systematic review of all available appropriate evidence, including guidelines, completed by a disinterested party, to minimize bias and that considers the quality and consistency of the evidence and the magnitude of benefits and harms. A panel of clinical experts within the VA/DoD has been convened for the CPG for Management of Opioid Therapy to interpret the evidence, assess its ability to be applied in the clinical setting and its applicability to the population of interest, and assess the overall strength of evidence for a particular recommendation.

5. Update Pain Management and Prescription Drug Abuse Training

Recently the DVCIPM coordinates VA/DoD pain organizations to participate in the JPEP which provides a standardized DoD and VA pain management curriculum for widespread use in education and training programs to improve the pain management competencies of the combined federal clinical workforce. The JPEP focuses on the needs of providers and patients in primary care, and provides a holistic, multi-modal, and multi-disciplinary pain care model that supports the balanced use of medications, procedures, specialty care, and self-care approaches for pain management.

In 2015, DVCIPM in coordination with DoD and VA completed the initial curriculum development of JPEP and instructional design tasks. Completed pain modules have been integrated into the VA mini residency program in addition to the VA and DoD-led Pain Extension for Community Healthcare Outcomes tele-mentoring initiatives. In 2016, the DVCIPM will conduct level 1-4 content evaluation of JPEP and coordinate with the DHA Education and Training Directorate and VA Employee Education System to make materials available through “e-learning” platforms. The DVCIPM also developed a pain video intended to provide pain management orientation for clinicians, patients, families, and leaders. The five minute video provides a simple overview of pain, general treatment options, recommended coping strategies, and proper role of medications for pain relief (https://player.vimeo.com/video/137163303).

The JPEP curriculum meets and exceeds recently released criteria in the CDC Guideline for Prescribing Opioids for Chronic Pain. Although the CDC’s prescribing guidelines are a timely and important step towards addressing this complex problem, many pain experts

and organizations have expressed concerns about the limited scope of the CDC guidelines and the process by which they were developed. Given the narrow focus on drug management in the Presidential Memorandum addressing Prescription Drug Abuse and Heroin Use, it is perhaps understandable that the CDC guidelines almost exclusively focus on the symptom of opioid misuse and abuse, rather than the root cause of the problem, a poorly managed chronic pain. The JPEP curriculum not only includes the essentials of quality pain management, but also provides information on appropriate use, risks, and contraindications for opioids and other prescription pain medications as well as other treatment approaches. This material will be part of the balanced strategy from the MHS and VA to address the overuse and abuse of opioids.

In addition, the USU Hebert SOM "America's Medical School" was the first medical school in the nation to formally and fully incorporate DVCIPM's JPEP curriculum into its medical education program. Topics include the objective assessment of pain, pain management techniques (to include consideration of pharmacologic, non-pharmacologic, and integrative medicine approaches), and specific considerations associated with complex pain syndromes (ex: neuropathic, spinal pain, myofascial pain, visceral pain, etc), as well as managing pain in special populations (ex: geriatric and pediatric patients). These are all addressed and periodically reinforced at various points throughout the four year SOM curriculum. Taken together, this instruction provides a solid foundation for educating emerging physicians in the benefits of utilizing a multi-faceted approach to the management of acute and chronic pain, conditions which all too frequently result in an increased reliance on narcotic analgesics, and which may subsequently lead to the development of one or more substance abuse disorders.

The DoD is exploring whether to use the JPEP as a more comprehensive training on pain management and opioid prescribing practice instead of the current "Do No Harm" training. The curriculum not only includes the essentials of quality pain management, but also provides information on appropriate use, risks, and contraindications for opioids and other prescription pain medications as well as other treatment approaches. This material will be part of the balanced strategy from the MHS and VA to address the overuse and abuse of opioids.

6. Provide Tools and Infrastructure to Support Clinical Practice and Research Advancements in Pain Management

Validated, patient reported, pain-related outcomes data are essential to establishing the efficacy of the appropriate opioid utilization and use of non-opioid treatment options. Based on the findings in the 2010 DoD Pain Management Task Force Report and National Institutes of Health (NIH) Patient Reported Outcomes Measurement Information System (PROMIS) measures, the MHS and VA are developing capabilities to measure and report patient reported, pain outcomes data to address this critical requirement.

Current pain assessments fail to measure impact of pain on critical indicators such as sleep, activity, mood, and stress. They tend to focus the patient-provider goal of a pain level of zero out of ten on the pain scale, with little discussion on maximizing function

and understanding that complete pain remission may not be realistic. To support and advance effective multidisciplinary pain management approaches that reduce reliance on prescription drugs, the DoD is collaborating with the VA to develop and validate the Defense and Veterans Pain Rating Scale (DVPRS). The DVPRS is a graphic tool clinicians can use to facilitate self-reported pain diagnoses from patients. There are four follow-up questions that standardize clinical assessment and patient ratings of functional activity, mood, sleep, and stress. Standardization of how patients are queried about their pain will provide the DoD and VA an advantage in evaluating treatment outcomes, and developing effective pain treatment strategies.

The DVPRS is being integrated into clinical practice in pain specialty clinics across the MHS as well as Army Patient Centered Medical Homes. The DVPRS also serves as a screening instrument for the Pain Assessment Screening Tool and Outcomes Registry (PASTOR), a more comprehensive and complex capability for pain assessment and clinical decision making. The PASTOR was developed in response to several recommendations for the DoD and VA to transform pain management by adopting a population-level prevention and management strategies; to develop better data to shape pain management efforts; and to address gaps in pain education of medical providers.

The initial PASTOR concept was adapted to leverage the NIH PROMIS, a 10-plus year initiative with a federal government investment of over $100 million. The vision is to link the PASTOR and PROMIS databases together in order to improve and expedite PASTOR implementation in the MHS. PASTOR development and implementation is being conducted in two areas: a tool for pain research (PASTOR REDCap Research) and a clinical decision making tool integrated into the DoD electronic health record. The PASTOR REDCap Research tool greatly enhances the utilization of the NIH PROMIS tools in a variety of clinical pain research scenarios. The REDCap database is open source software, developed and maintained by a consortium of over 1,450 research institutions, with 229,000 end users, and a strong track record among academic research institutions. The PASTOR REDCap Research database was created as a modular application to allow for fast and easy distribution of the software to existing REDCap institutions. The PASTOR REDCap Research is the main research database for pain-related research protocol submissions, creating an unparalleled and unique level of standardization of validated research measurement tools. Current research partners, such as Duke University, and many military researchers, have expressed interest in utilizing the PASTOR REDCap Research as the source for clinical outcome measures. PASTOR REDCap is becoming the designated clinical outcomes tool for DoD pain related research projects.

7. DTB Programs

In addition to continuing to partner with the DEA on Prescription DTB Events, the USD(P&R) will publish a DTB DoDI in April 2016. The DTB DoDI was formally coordinated and concurred upon by the Services and is being coordinated for USD(P&R)'s signature. Its companion procedures document, the DHA IPM, which outlines a standard process and details tasks to be completed by MTFs to ensure successful implementation of the DTB Program, is in formal coordination. In addition, the DTB IPM addresses provider and beneficiary training and education on the proper disposal of prescription medications. The Communications Plan section details the educational components of this program and all educational materials will be in compliance with existing DEA, FDA, and EPA regulations. The DoD POD is also exploring relationships with vendors to offer other DTB products and services.

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Appendix A: List of Acronyms

AAPP	Alcohol Abuse Prevention Program
ADAMS	Alcohol and Drug Abuse Management Seminar
ADAPT	Alcohol and Drug Abuse Prevention and Treatment
AR	Army Regulation
ARNG	Army National Guard
ASAM	American Society of Addiction Medicine
ASAP	Army Substance Abuse Program
ATS	Addiction Treatment Services
AUD	alcohol use disorder
BUMED	Bureau of Medicine and Surgery
CDC	Centers for Disease Control and Prevention
CD-MART	Controlled Drug Medication Analysis and Reporting Tool
CFR	Code of Federal Regulations
CPG	Clinical Practice Guideline
DAPA	Drug and Alcohol Program Advisor
DDR	Drug Demand Reduction
DDRP	Drug Demand Reduction Program
DEA	Drug Enforcement Administration
DHA	Defense Health Agency
DoD	Department of Defense
DoDI	Department of Defense Instruction
DSM	Diagnostic and Statistical Manual of Mental Disorders
DTB	Drug Take-Back
DVCIPM	Defense and Veterans Center for Integrative Pain Management
DVPRS	Defense and Veterans Pain Rating Scale
EBP	evidence-based practice
EBPWG	Evidence-Based Practice Work Group
EPA	United States Environmental Protection Agency
FBCH	Fort Belvoir Community Hospital
FDA	United States Food and Drug Administration
FR	Federal Register
FY	Fiscal Year
IOM	Institute of Medicine
IOP	intensive outpatient program
IPM	Interim Procedures Memorandum
JPEP	Joint Pain Education Project
MAT	Medication-Assisted Treatment
MHA	mental health assessment
MHS	Military Health System
MOP	Mail Order Pharmacy
MORE	My Ongoing Recovery Experience
MOU	Memorandum of Understanding
MTF	military treatment facility

NCR-MD	National Capital Region-Medical Directorate
NDAA	National Defense Authorization Act
NIH	National Institutes of Health
OBOT	office-based opioid treatment
ONDCP	Office of National Drug Control Policy
OTP	opioid treatment program
OUD	opioid use disorder
PASTOR	Pain Assessment Screening Tool and Outcomes Registry
PDTS	Pharmacy Data Transaction Service
PFL	PRIME for Life®
PHA	Periodic Health Assessment
PMP	Prescription Monitoring Program
POD	Pharmacy Operations Division
Poly-MART	Polypharmacy Medication Analysis and Reporting Tool
PROMIS	Patient Reported Outcomes Measurement Information System
RTC	Residential Treatment Center
SACC	Substance Abuse Counseling Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SARP	Substance Abuse Rehabilitation Program
SG	Surgeon General
SOM	School of Medicine
SUD	substance use disorder
SUDRF	Substance Use Disorder Rehabilitation Facility
UMAPIT	Unit Marine Awareness and Prevention Integrated Training
USAF	United States Air Force
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USMC	United States Marine Corps
USU	Uniformed Services University
VA	Department of Veterans Affairs
WRNMMC	Walter Reed National Military Medical Center