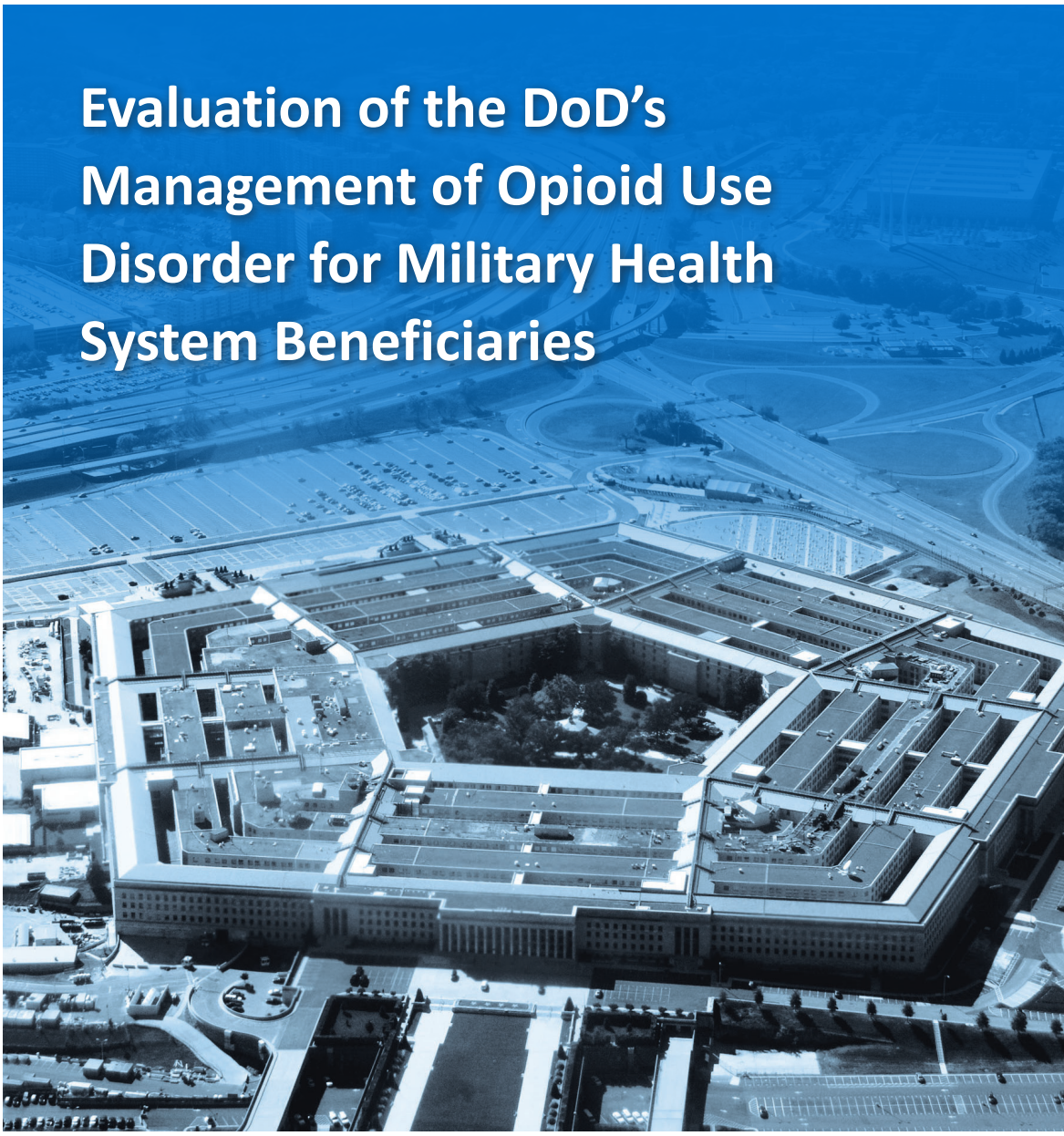
Report No. DODIG-2019-091

INSPECTOR GENERAL

U.S. Department of Defense

JUNE 10, 2019

Evaluation of the DoD's Management of Opioid Use Disorder for Military Health System Beneficiaries



INTEGRITY ★ INDEPENDENCE ★ EXCELLENCE


INSPECTOR GENERAL
INTEGRITY
EFFICIENCY
DEPARTMENT OF DEFENSE

Results in Brief

Evaluation of the DoD's Management of Opioid Use Disorder for Military Health System Beneficiaries

June 10, 2019

Objective

We determined whether the DoD's management of opioid use disorder treatment aligned with DoD policies and national guidance. Specifically, we determined whether the DoD:

- had policies and programs in place to manage the treatment of opioid use disorder for Military Health System beneficiaries; and
- established and implemented opioid use disorder treatment outcome and process measures to inform quality improvements.

Background

Opioids are a broad group of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone, hydrocodone, and codeine. Opioids reduce the perception of pain but can also produce drowsiness, mental confusion, euphoria, nausea, and constipation. Also, depending on the amount of drug taken, opioids can depress respiration. Opioids can cause serious health effects in those who misuse them.

Opioid use disorder is a substance abuse disorder associated with the recurrent use of opioids that causes significant impairments, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The DoD has incorporated opioid use disorder within DoD substance use disorder policies and programs.

Background (cont'd)

On October 26, 2017, the White House issued a Presidential memorandum directing the heads of Executive departments and agencies to exercise all appropriate emergency authorities to reduce the number of deaths and to minimize the devastation of the opioid crisis. On the same day, the Acting Secretary of Health and Human Services determined that the nationwide opioid crisis was a public health emergency.

In the October 2017 DoD Report to Congress on "Prescription Opioid Abuse and Effects on Readiness," the Office of the Under Secretary of Defense for Personnel and Readiness reported that prescription opioid misuse in service members remained an issue of concern for the DoD because it negatively affects performance, military readiness, and the DoD's overall mission.

Findings

We determined that the DoD has policies and programs in place to manage the treatment of opioid use disorder for Military Health System (MHS) beneficiaries.

However, we also found that Marine Corps Substance Abuse Counseling Center (SACC) counselors made substance use disorder diagnoses in violation of DoD and Navy Bureau of Medicine and Surgery (BUMED) policies. Although the SACC counselors were licensed, the SACC counselors:

- were not granted clinical privileges, and
- did not have access to the DoD Health Record system.

As a result, the Marine Corps SACC counselors could not document the substance use disorders in the DoD Health Record, which could impact quality of care provided to MHS beneficiaries and the quality of medical data in the DoD Health Record.

Additionally, we found that the DoD did not implement DoD-wide standard outcome and process measures specific to opioid use disorder, such as the percentage of opioid use disorder patients who initiated treatment

Results in Brief

Evaluation of the DoD's Management of Opioid Use Disorder for Military Health System Beneficiaries

Findings (cont'd)

within 14 days of diagnosis.[1] This occurred because DoD Instruction (DoDI) 1010.04 does not identify the organization responsible for adopting minimum program and outcome measures to compare program performance and identify best practices. As a result, the MHS had no mechanism to compare the performance of opioid use disorder treatment programs to civilian benchmarks or across Military Treatment Facilities (MTFs) to identify best practices and any outliers that need improvement. Additionally, due to a lack of standard methodology to identify the population of patients with opioid use disorder, the full extent of the DoD's opioid use disorder population is unclear.

Recommendations

We recommend that the Secretary of the Navy:

- Modify Marine Corps orders, policies, and memorandums of understanding to reflect that SACC counselors may not independently make substance use disorder diagnoses without clinical privileges and that all substance use disorder diagnoses must be documented in the DoD Health Record;
- Review all historical records of individuals served by the Marine Corps Substance Abuse Counseling Centers and document all appropriate medical information using the DoD Health Record; and
- Certify that all substance use disorder diagnoses are made by a privileged health care provider, and that all diagnoses are documented in the DoD Health Record.

We recommend that the Assistant Secretary of Defense (Health Affairs):

- standardize the methodology to identify the population of patients with opioid use disorder, and
- establish and implement minimum standard outcome and process measures for the treatment of opioid use disorder.

Management Comments and Our Response

The Deputy Assistant Secretary of the Navy (Military Manpower & Personnel), responding on behalf of the Secretary of the Navy, did not address the specifics of our recommendations. Specifically, the Deputy Assistant Secretary stated that the Department of the Navy requests that the recommendations related to modifying Marine Corps orders, policies, and memorandums of understanding be modified to state that the Department of Navy should continue conducting its internal evaluation of the program and address any pertinent findings. While we did not adjust the recommendation as requested, we did update them to clarify the actions that we recommend the Secretary of the Navy take to address the findings of the report.

We consider the recommendations to the Secretary of the Navy to be unresolved. We request that the Secretary provide comments in response to the final report that address the recommendations on modifying Marine Corp Substance Abuse Counseling Centers' policies, position descriptions, and records for

[1] The National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) has the "Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment" metric, which measures the following: (1) percentage of beneficiaries who initiated treatment through an inpatient alcohol and other drug admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication-assisted treatment within 14 days of diagnosis; and (2) percentage of beneficiaries who initiated treatment and who had two or more additional alcohol and other drug services or medication-assisted treatment within 34 days of the initiation visit.

Comments (cont'd)

consistency with DoD policy on substance use disorder diagnoses; and certifying diagnoses by privileged health care providers and documentation in the DoD Health Record.

The Principal Deputy Assistant Secretary of Defense (Health Affairs) (PDASD[HA]), responding on behalf of the Assistant Secretary of Defense (Health Affairs), agreed with our recommendation to standardize the methodology to identify the population of patients with opioid use disorder within the Military Health System, and will update DoD and Defense Health Agency instructions to issue a DoD-wide standard of reporting.

The PDASD(HA) also agreed with our recommendation to establish and implement minimum standard outcome and process measures, including data for both direct care and purchased care, for the treatment of opioid use disorder. The DoD will ratify in policy the sustainment of two clinical outcome measures—opioid use disorder prevalence and opioid overdose death rates.

Therefore, the recommendations are resolved but remain open. We will close these recommendations once we receive and review the documents to ensure that the issues are addressed.

Please see the Recommendations Table on the next page for the status of recommendations.

Recommendations Table

Management	Recommendations Unresolved	Recommendations Resolved	Recommendations Closed
Secretary of the Navy	A.1, A.2, A.3, A.4	None	None
Assistant Secretary of Defense (Health Affairs)	None	B.1, B.2	None

Note: The following categories are used to describe agency management's comments to individual recommendations.

- **Unresolved** – Management has not agreed to implement the recommendation or has not proposed actions that will address the recommendation.
- **Resolved** – Management agreed to implement the recommendation or has proposed actions that will address the underlying finding that generated the recommendation.
- **Closed** – OIG verified that the agreed upon corrective actions were implemented.

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

June 10, 2019

MEMORANDUM FOR SECRETARY OF THE NAVY
ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

SUBJECT: Evaluation of the DoD's Management of Opioid Use Disorder for Military Health System Beneficiaries (Report No. DODIG-2019-091)

We are providing this final report for review and comment. We conducted this evaluation from May 2018 through April 2019 in accordance with the "Quality Standards for Inspections and Evaluations," published in January 2012 by the Council of the Inspectors General on Integrity and Efficiency.

We considered management comments to a draft report while preparing the final report. Comments from the Secretary of the Navy did not specifically address Recommendations A.1, A.2, A.3, and A.4, and they remain unresolved. DoD Instruction 7650.03 requires that all recommendations be resolved promptly. We request that the Secretary of the Navy provide a written response for each recommendation, specifically stating whether he agrees or disagrees. If the Secretary of the Navy agrees, we request a copy of his intended plan of action(s) and a completion date(s). If the Secretary of the Navy disagrees, we request that he send us his rationale and proposed alternative corrective action plan(s) by July 1, 2019. Please send a PDF file containing your comments to [redacted] Copies of your comments must have the actual signature of the authorizing official for your organization. We cannot accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET).

Comments from the Assistant Secretary of Defense (Health Affairs) were responsive and conformed to the requirements of DoD Instruction 7650.03. Therefore, no additional comments are required regarding Finding B of this report.

We appreciate the courtesies extended to the staff. Please direct questions to [redacted]

Michael J. Roark
Deputy Inspector General
for Evaluations

Contents

Introduction

Objective

We determined whether the DoD's management of opioid use disorder treatment aligned with DoD policies and national guidance. Specifically, we determined whether the DoD:

- had policies and programs in place to manage the treatment of opioid use disorder for Military Health System (MHS) beneficiaries, in accordance with DoD policy and national guidance; and
- established and implemented opioid use disorder treatment outcome and process measures to inform quality improvements, in accordance with DoD policy and national guidance.

Background

Opioids are a broad group of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone, hydrocodone, and codeine. Opioids reduce the perception of pain but can also produce drowsiness, mental confusion, euphoria, nausea, constipation, and, depending on the amount of drug taken, can depress respiration. Opioids can cause serious health effects in those who misuse them.[2]

The Opioids Crisis Is Declared a Public Health Emergency

On October 25, 2017, representatives from the Department of Health and Human Services (HHS) testified to members of Congress regarding federal efforts to combat the opioid crisis.[3] There was a significant rise in opioid prescriptions beginning in the mid-to-late 1990s. Not only did the volume of opioids prescribed increase, but health care providers began to prescribe opioids to treat pain in ways that are now known as high-risk. For example, prescribing higher doses for longer durations has been associated with opioid abuse, addiction, and overdose. The HHS representatives stated that over the previous 15 years, communities across the United States have been devastated by increasing prescription and illicit opioid abuse, addiction, and overdose. According to the HHS's Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health in 2016, more than 11 million Americans misused prescription opioids, nearly 1 million used heroin, and 2.1 million had an opioid use disorder due to prescription opioids or heroin.

[2] According to Substance Abuse and Mental Health Services Administration (SAMHSA).

[3] House Committee on Energy and Commerce, "Federal Efforts to Combat the Opioid Crisis: A Status Update on CARA and Other Initiatives," October 25, 2017.

On October 26, 2017, Presidential Memorandum 2017-23787, "Combatting the National Drug Demand and Opioid Crisis," directed that "[T]he heads of executive departments and agencies, as appropriate and consistent with law, shall exercise all appropriate emergency authorities, as well as other relevant authorities, to reduce the number of deaths and minimize the devastation the drug demand and opioid crisis inflicts upon American communities." On the same day, the Acting Secretary of Health and Human Services determined that the nationwide opioid crisis was a public health emergency.

On October 24, 2018, the President signed Public Law 115-271, the "Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act," known as the "SUPPORT for Patients and Communities Act." The White House issued a statement stating that the law reduces access to and the supply of opioids and expands access to opioid use disorder prevention, treatment, and recovery services.

Substance Use Disorder Defined

Substance use disorders (SUDs) occur when the recurrent use of alcohol or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[4] According to the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders," Fifth Edition (DSM-5), a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.[5] According to the DSM-5, opioid use disorder is a type of substance use disorder.

Opioid Use Disorder Among MHS Beneficiaries

In its October 2017 DoD Report to Congress on "Prescription Opioid Abuse and Effects on Readiness," the Office of the Under Secretary of Defense for Personnel and Readiness reported that:

- prescription opioid misuse in service members remains an issue of concern because it negatively affects performance, military readiness, and the overall mission; and
- an estimated 25,000 TRICARE beneficiaries in the MHS have an opioid use disorder.

[4] According to the Department of Health and Human Service's Substance Abuse and Mental Health Services Administration.

[5] The American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" (DSM) is a classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders. The DSM is intended to serve as a guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders.

Addictive Substance Misuse Advisory Committee

Within the DoD, the Addictive Substance Misuse Advisory Committee (ASMAC) serves as a central point for information dissemination, analysis, integration, and program coordination. The committee also identifies policy needs and solves problems within the MHS related to legal and illegal addictive substance use and substance use disorders.

The ASMAC is a standing advisory committee to the Medical Personnel Executive Steering Committee, which reports to the Under Secretary of Defense for Personnel and Readiness as necessary.[6] The ASMAC charter does not give the ASMAC the authority to direct the Services to comply with its advice and recommendations.

The ASMAC identifies DoD issues, initiatives, and best practices related to the prevention and treatment of addictive substance misuse and substance use disorders, in order to:

- provide advice and recommendations for DoD policies and programs;
- make recommendations for economic and legislative support affecting personnel, quality of care, and addictive substance misuse policies and programs; and
- make recommendations for information sharing, dissemination, and program adoption.[7]

[6] According to DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction into the Military Services," May 6, 2018, the Medical Personnel Executive Steering Committee ensures medical and personnel community coordination when changing policies that affect each community and other relevant DoD Components.

[7] Addictive Substance Misuse Advisory Committee (ASMAC) Charter, paragraph 4.

Finding A

The DoD Has Policies and Programs in Place, But Diagnoses by Marine Corps Counselors Violated DoD and Navy Policy

The DoD has policies and programs in place to manage the treatment of opioid use disorder for MHS beneficiaries within its substance use disorder policies and programs. However, contrary to DoD and Navy Bureau of Medicine and Surgery (BUMED) policies, Marine Corps Substance Abuse Counseling Center (SACC) counselors made substance use disorder (SUD) diagnoses without meeting all of the DoD and BUMED requirements. Although the SACC counselors were licensed, the SACC counselors:

- were not granted clinical privileges (proper authority), and
- did not have access to the DoD Health Record system (proper documentation).

This occurred because Marine Corps SACC policies erroneously permit the SACC counselors to independently make SUD diagnoses without also requiring them to be granted clinical privileges.

As a result, the Marine Corps SACC counselors made SUD diagnoses but did not document them in the DoD Health Record, as required, which:

- increased the potential for DoD health care providers to unknowingly prescribe opioids or other high-risk medications to individuals who are at high risk of misuse or overdose, and
- understated the full extent of the DoD's opioid use disorder problem.

Discussion

DoD Policies and Programs on the Treatment of Opioid Use Disorder

The DoD has policies and programs in place to manage the treatment of opioid use disorder for MHS beneficiaries within its substance use disorder policies and programs. DoD Instruction (DoDI) 1010.04, establishes policies, assigns responsibilities, and prescribes procedures for problematic alcohol and drug use prevention, identification, diagnosis, and treatment for DoD military

and civilian personnel.[8] DoDI 1010.04 directs the Assistant Secretary of Defense (Health Affairs) (ASD[HA]) to develop and distribute treatment program guidance for substance use disorder, and to make substance use treatment services available to meet the needs of MHS beneficiaries. The policy also assigns the primary responsibility for the provision of substance use disorder treatment within the direct care system to the Service medical departments.[9]

As shown in the table, each Military Service developed its own substance abuse policy and program, which applies to the management of opioid use disorder.

Table. Service Policies and Programs

Service	Program	Policy
Army	Army Substance Abuse Program	• Army Regulation 600-85, "The Army Substance Abuse Program," November 28, 2016.
Navy	Navy Substance Abuse Rehabilitation Program	• Office of the Chief of Naval Operations Instruction 5350.4D, "Navy Alcohol and Drug Abuse Prevention and Control," June 4, 2009. • Bureau of Medicine and Surgery (BUMED) Instruction 5353.4B, "Standards for Provision of Substance Related Disorder Treatment Services," July 6, 2015.
Marine Corps	Marine Corps Substance Abuse Program*	• Marine Corps Order (MCO) 5300.17A, "Marine Corps Substance Abuse Program," June 25, 2018.
Air Force	Air Force Alcohol and Drug Awareness Program and Treatment	• Air Force Instruction 44-121, "Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program," July 8, 2014.

* According to MCO 5300.17A, Substance Abuse Program activities are performed by substance abuse counselors and prevention personnel located at installation Substance Abuse Counseling Centers (SACCs).

Source: Generated by the DoD OIG with information provided by Service medical department officials.

In addition, MHS beneficiaries have access to opioid use disorder treatment either within a Military Treatment Facility (MTF) or through the TRICARE benefit (purchased care system).[10] Please see Appendix B for additional detail regarding these policies.

[8] DoDI 1010.04, "Problematic Substance Use by DoD Personnel," February 20, 2014.

[9] The direct care system comprises the health care facilities and medical support organizations owned by the DoD and managed by the Services Surgeons General in accordance with applicable federal laws, regulations, and the DoD Manual 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," October 29, 2013.

[10] The purchased care system consists of civilian providers (including individuals, groups, hospitals, and clinics) who have agreed to accept the DoD and uniformed services beneficiaries enrolled in the regional managed care program authorized by the ASD(HA), according to DoD Manual 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," October 29, 2013.

Although the DoD has policies and programs in place to manage the treatment of opioid use disorder for MHS beneficiaries, we found that the Marine Corps SACC counselors made SUD diagnoses contrary to DoD and BUMED policies.

Marine Corps Substance Abuse Counseling Centers

The Marine Corps established its SACCs in 1993. According to Marine Corps policy, qualified personnel at the installation SACCs provide evidence-based and evidence-informed substance misuse prevention education and SUD counseling services to marines, attached sailors, and their family members.[11] As of October 2018, there were 17 SACCs worldwide with an annual program budget of about $13 million.

Criteria Within DoD and BUMED Policies

DoD personnel who make substance use disorder diagnoses must comply with the following DoD and BUMED policy requirements.

Proper Authority

DoDI 1010.04 states that a SUD diagnosis can be made only by a licensed and privileged health care provider.[12]

Licensure

Section 1094, title 10, United States Code, states that a person under the jurisdiction of the Secretary of a Military Department may not provide health care independently as a health care professional unless the person has a current license to provide such care. According to DoD Manual 6025.13, the statutory requirement is applicable to all DoD providers practicing independently in all care settings.[13] Health care providers requiring licensure include clinical psychologists, licensed professional counselors, and social workers.

Privileges

According to DoD Manual 6025.13, clinical privilege is the permission to provide medical and other patient care services in the granting institution, within defined limits, based on the individual's education, professional license, experience, competence, ability, health, and judgment. Clinical privileges define the scope and limits of practice for providers.

---

11 According to MCO 5300.17A, "Marine Corps Substance Abuse Program," June 25, 2018.

12 DoDI 1010.04, "Problematic Substance Use by DoD Personnel," February 20, 2014.

13 DoD Manual 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," October 29, 2013.

Additionally, BUMED Instruction 6010.30 requires that providers have clinical privileges if they are responsible for making independent decisions to diagnose, initiate, alter, or terminate a regimen of clinical care.[14] It also states, "The potential consequences of unqualified or impaired health care providers or provider misconduct are so significant that complete verification of credentials and complete control of the clinical privileging process is imperative."

Proper Documentation

According to DoDI 6040.45, any summary of diagnoses pertaining to mental health care must be documented in the DoD Health Record.[15] The DoD Health Record includes all medical and dental care documentation, including mental health care documentation that has been recorded for that individual.

Proper Funding

DoD Directive 5136.01 places the responsibility for DoD medical and dental programs under the Defense Health Program, as administered by the Assistant Secretary of Defense for Health Affairs.[16] DoD Directive 5136.01 states that the ASD(HA):

> Prepares and submits, in the DoD Planning, Programming, Budgeting, and Execution (PPBE) process, a DoD Unified Medical Program budget to provide resources for the DoD MHS. Consistent with applicable law, accounts for all funding for the DoD MHS, including operations and maintenance; procurement; and research, development, test, and evaluation in the single Defense Health Program (DHP) appropriations account, but keeps funds for medical facility military construction in a separate single appropriations account.

The SACC Counselors Made SUD Diagnoses in Violation of DoD and BUMED Policies

We found that the Marine Corps SACC counselors independently made SUD diagnoses without fulfilling all of the DoD and BUMED requirements previously discussed.

---

14 BUMED Instruction 6010.30, "Credentialing and Privileging Program," March 27, 2015, states, "The authority for providers to independently diagnose, initiate, alter, or terminate regimens of health care is conveyed only through the issuance of medical staff appointments to the medical or dental staff." It also states, "Medical staff appointments must be accompanied by clinical privileges defining the scope and limits of practice authorized."

15 DoDI 6040.45, "DoD Health Record Life Cycle Management," November 16, 2015, incorporating change 1, April 11, 2017.

16 DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs," September 30, 2013, incorporating change 1, August 10, 2017.

SACC Counselors Made SUD Diagnoses

During our site visits, representatives from the executive staff of the Marine and Family Programs Division stated that the Marine Corps SACC counselors independently made SUD diagnoses. In response to our request for information, SACC branch heads, directors, and program managers confirmed that their SACC personnel made SUD diagnoses. Moreover, we asked the Marine and Family Program Division staff to provide examples of how the SACCs document a medical diagnosis of SUD. In response, we received 16 Substance Use Assessment Summary forms from various SACCs, which included SUD diagnostic information and recommended levels of care. Finally, a SACC director provided us with a Substance Use Assessment Summary, which indicated that SACC personnel made a SUD diagnosis without documented approval from a privileged health care provider.[17]

Proper Authority

According to the SACC counselors' position descriptions, part of their duties is to perform diagnoses. Although the position descriptions require SACC counselors to be licensed as part of the condition of employment, the position descriptions did not require them to be granted clinical privileges. After interviewing Marine and Family Programs Division staff and obtaining information from the same 17 SACC leaders, we found that the SACC counselors were licensed; however, none of the SACC personnel had clinical privileges.

Making SUD diagnoses without clinical privileges violates DoD and BUMED policies. DoDI 1010.04 states that a "SUD diagnosis can only be made by a licensed and privileged healthcare provider." Additionally, BUMED Instruction 6010.30 requires that providers have clinical privileges if they are responsible for making independent decisions to diagnose, initiate, alter, or terminate a regimen of clinical care.[18] Thus, the SACC counselors violated DoD and BUMED policies when they independently made SUD diagnoses without being clinically privileged.

Proper Documentation

The Marine and Family Programs executive staff stated that the SACC counselors did not have access to the DoD Health Record and did not document their diagnoses in the DoD Health Record. Instead, the SACC counselors documented diagnoses in an online database system called the DoD Case Management System, which is

[17] The SACC counselors documented their assessments and diagnoses in a standard form called the Substance Use Assessment Summary.

[18] BUMED Instruction 6010.30, "Credentialing and Privileging Program," March 27, 2015, states, "The authority for providers to independently diagnose, initiate, alter, or terminate regimens of health care is conveyed only through the issuance of medical staff appointments to the medical or dental staff." It also states, "Medical staff appointments must be accompanied by clinical privileges defining the scope and limits of practice authorized."

not part of the DoD Health Record. This occurred because the Marine and Family Programs executive staff misinterpreted the DoDI 6040.45 in a way that allowed the SACC counselors to document diagnoses outside the DoD Health Record. However, DoDI 6040.45 explicitly states that any summary of diagnosis must be documented in the DoD Health Record. Therefore, any diagnosis made by the SACC counselors should have been documented in the DoD Health Record.

Proper Funding

In addition to the issues discussed above regarding clinical privileges and documentation, we determined that the Marine Corps SACCs were not funded with Defense Health Program funds. According to a finance official from the Marine and Family Programs Division, the Marine Corps SACC's $13 million program is funded with Warfighter and Family Services funds instead of Defense Health Program funds.

According to DoDI 1010.04, a SUD diagnosis can only be made by a licensed and privileged health care provider. Additionally, BUMED Instruction 6010.30 requires that providers have clinical privileges if they are responsible for making independent decisions to diagnose. According to the DoD Manual 6025.13, clinical privileges are defined as the permission to provide medical and other patient care services. Therefore, personnel who make SUD diagnoses are performing a medical function and should be funded with Defense Health Program funds. DoD Directive 5136.01 states that the ASD(HA) prepares and submits a DoD Unified Medical Program budget to provide resources for the DoD MHS. Consistent with applicable law, the ASD(HA) accounts for all funding for the DoD MHS in a single Defense Health Program appropriations account.[19] However, the Marine Corps SACC counselors who made SUD diagnoses are not funded by the Defense Health Program and as a result are not included in the ASD(HA) oversight of funds spent on the DoD medical program.

Marine Corps SACC Policies Erroneously Permit SACC Counselors to Make SUD Diagnoses

Marine Corps SACC counselors independently made SUD diagnoses because the Marine Corps SACC policies are counter to higher-level policy. The Marine Corps policies permit the SACC counselors to independently make SUD diagnoses without clinical privileges, without access to the DoD Health Record, and outside Defense Health Program funding.

[19] DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, incorporating change 1, August 10, 2017, states ASD(HA) "Prepares and submits, in the DoD Planning, Programming, Budgeting, and Execution (PPBE) process, a DoD Unified Medical Program budget to provide resources for the DoD MHS. Consistent with applicable law, accounts for all funding for the DoD MHS, including operations and maintenance; procurement; and research, development, test, and evaluation in the single Defense Health Program (DHP) appropriations account, but keeps funds for medical facility military construction in a separate single appropriations account."

Three policies provide specific guidance for the Marine Corps SACCs:

- Memorandum of Understanding (MOU) between the Navy Bureau of Medicine and Surgery (BUMED), Marine and Family Programs Division (MF), and Marine Corps Health Services (HS), "Psychological Health Services for Active Duty Marines and Their Family Members," June 18, 2018;
- Marine Corps Order (MCO) 1754.14, "Marine Corps Community Counseling Program (CCP)," April 4, 2016; and
- MCO 5300.17A, "Marine Corps Substance Abuse Program," June 25, 2018.

We reviewed the policies for the Marine Corps SACCs and determined that the policies are inconsistent with DoD and BUMED policies. Marine Corps SACC policies do not require SACC counselors to be granted clinical privileges before they can independently make SUD diagnoses. MCO 5300.17A allows SACC counselors to make SUD diagnoses without being clinically privileged, which is counter to DoD and BUMED policy.

Further, the standard position descriptions for the SACC counselors authorize them to perform SUD diagnoses. However, the position descriptions did not require them to obtain clinical privileges. The SACC counselors documented the diagnoses and behavioral health services they rendered in an online database system called the DoD Case Management System. However, DoD health care providers at the MTFs do not have access to the DoD Case Management System. This lack of information sharing could result in quality of care concerns. Specifically, according to ASMAC Substance Subcommittee members, DoD health care providers may not know that a SUD diagnosis has been made, and could prescribe opioids to someone who is susceptible to opioid misuse because the diagnosis was not in the DoD Health Record system. A Navy BUMED official also expressed concern that not including the SUD diagnoses in the DoD Health Record impacts continuity of care.[20]

Additionally, because Marine Corps SACC counselors did not document SUD diagnoses in the DoD Health Record, the number of MHS beneficiaries with an opioid use disorder could be understated, presenting a data quality problem in which the full extent of the DoD's opioid use disorder problem is unknown.

[20] According to the American Academy of Family Physicians, continuity of care is concerned with quality of care over time. It is the process by which the patient and the physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost effective medical care.

Conclusion

The DoD established policies and programs throughout the DoD to manage the treatment of opioid use disorder for MHS beneficiaries within its substance use disorder policies and programs. However, the Marine Corps SACC counselors made SUD diagnoses without proper authority and proper documentation.

The Marine Corps SACC counselors made SUD diagnoses, but did not document them in the DoD Health Record as required. Failure to record the SUD diagnoses correctly within the DoD Health Record system potentially impacted DoD quality of care and medical data quality. The absence of appropriate diagnostic record keeping increased the potential for DoD health care providers to unknowingly prescribe opioids or other high-risk medications to individuals who are at high risk of misuse or overdose. The failure to properly record SUD diagnoses within the approved DoD Health Record system risked understating the full extent of the DoD's opioid use disorder problem. Lastly, the Marine Corps SACCs are funded with Warfighter and Family Services funds, while DoD requires the Defense Health Program to fund medical activities through the single Defense Health Program appropriations account.

Recommendations, Management Comments, and Our Response

Recommendation A

We recommend that the Secretary of the Navy:

1. **Modify Marine Corps orders and policies, and memorandums of understanding between the Marine Corps and the Bureau of Medicine and Surgery, to be consistent with Department of Defense Instruction 1010.04, Bureau of Medicine and Surgery Instruction 6010.30, and Department of Defense Instruction 6040.45, to reflect that:**
   - **Substance Abuse Counseling Center counselors may not independently make substance use disorder diagnoses without clinical privileges, and**
   - **all substance use disorder diagnoses must be documented in the DoD Health Record.**
2. **Modify the position descriptions for the Marine Corps Substance Abuse Counseling Centers' directors and counselors to ensure that, with respect to diagnosis and treatment of substance use disorder cases, their authorities and duties are consistent with Department of Defense Instruction 1010.04 and Bureau of Medicine and Surgery Instruction 6010.30.**

3. **Review all historical records of individuals served by the Marine Corps Substance Abuse Counseling Centers and document all appropriate medical information about substance use disorder diagnosis and treatment within the DoD Health Record, consistent with Department of Defense Instruction 6040.45.**
4. **Certify that all substance use disorder diagnoses are made by a privileged health care provider and that all diagnoses are documented in the DoD Health Record.**

Management Comments Required

The Deputy Assistant Secretary of the Navy (Military Manpower & Personnel) responding on behalf of the Secretary of the Navy, provided comments but did not specifically agree or disagree with Recommendations A.1, A.2, A.3, and A.4.

The Deputy Assistant Secretary of the Navy also disagreed with our depiction of the Marine Corps and stated the Department of the Navy did not understand the exact problem being addressed or the extent of the problem. He also stated that the Department of the Navy cannot determine if policy is not being followed or if modification of current policy is necessary. He further stated that a review of the implementation of the DoD, Secretary of the Navy, and Bureau of Medicine and Surgery (BUMED) published directives and policies, as well as the Memorandum of Understanding between BUMED and the Marine Corps, is already underway and expected to be completed by September 30, 2019. The Deputy Assistant Secretary requested that we modify Recommendations A.1 and A.2 to state that the Department of Navy should continue conducting its internal evaluation of the program and address any pertinent findings.

Our Response

Comments from the Deputy Assistant Secretary of the Navy (Military Manpower & Personnel) did not address the specifics of the recommendations. Therefore, the recommendations remain unresolved.

We determined that Marine Corps policies permitted the SACC counselors to independently make SUD diagnoses without also requiring them to be granted clinical privileges. This is contrary to DoD and Navy BUMED policies, which require health care providers who make SUD diagnoses to be licensed and privileged.

The Department of the Navy requested that we modify Recommendations A.1 and A.2 to state that the Department of the Navy should continue conducting its internal review. Modifying the recommendations is not warranted because the Department of the Navy's response does not explicitly state that the internal

review includes Marine Corps policies. Specifically, the Marine Corps Orders were not included in the list of policies under review. In addition, the response did not state whether the Department of the Navy's internal review is applicable to, or a result of, our recommendations.

However, we did adjust the recommendations to clarify the actions the Secretary of the Navy should take to address the findings of the report. We changed the focus of Recommendation A.4 from investigating a potential funding violation to addressing the issue of unprivileged health care providers diagnosing SUDs and not documenting the SUD diagnoses in the DoD Health Record. We request that the Secretary of the Navy provide a written response for each recommendation, specifically stating whether he agrees or disagrees. We also request a copy of the Secretary's intended plan of action(s), and an expected completion date(s) by July 1, 2019.

Finding B

The DoD Did Not Implement DoD-Wide Outcome and Process Measures for Opioid Use Disorder

We found that the DoD did not establish and implement:

- a standard methodology to identify the population of patients with opioid use disorder, and
- standard outcome and process measures for the treatment of opioid use disorder to inform quality improvements.

This occurred because DoD Instruction (DoDI) 1010.04 did not identify the entity responsible for adopting minimum program outcome and process measures to compare programs and identify best practices.

As a result, the DoD did not have consistent opioid use disorder data from the Services to compare programs and identify best practices, as required by DoDI 1010.04; and the full extent of the DoD's opioid use disorder population remained unclear.

Discussion

DoD policy and national guidance require opioid treatment programs to measure patient treatment outcomes and processes to inform quality improvement. The Department of Health and Human Services "Federal Guidelines for Opioid Treatment Programs," January 2015, states, "A continuous quality improvement plan should include, at a minimum: Measurement and monitoring of patient treatment outcomes and processes on a regular basis [...] to inform quality improvement."

In addition, DoDI 1010.04 states that "[policy]... [f]acilitates the adoption of minimum program outcome and process measures to compare programs and identify best practices and effective services through the guidance of the DoD Addictive Substance Misuse Advisory Committee (ASMAC)."[21] As written, DoDI 1010.04 does not designate a position or entity to perform this task. The DoDI requires the ASMAC to provide guidance, but it does not give the committee the authority or responsibility necessary to develop and implement minimum program outcome[s] and process measures needed for the DoD. Based on discussions with members of the ASMAC Substance Subcommittee, we confirmed

[21] DoDI 1010.04, "Problematic Substance Use by DoD Personnel," February 20, 2014, paragraph 3.b.

that the DoD did not establish and implement DoD-wide minimum outcome and process measures for the treatment of opioid use disorder to inform quality improvements, such as the percentage of opioid use disorder patients who initiated treatment within 14 days of diagnosis.[22]

Lack of Standard Methodology to Identify Opioid Use Disorder Population

There was no standard methodology to identify the opioid use disorder population among the Defense Health Agency (DHA) and the Service medical departments. In its 2017 Report to Congress on "Prescription Opioid Abuse and Effects on Readiness," the DoD estimated that there were 25,000 beneficiaries with an opioid use disorder in the MHS.[23] We asked DHA and Service medical department officials for the number of MHS beneficiaries with an opioid use disorder in 2017, along with the methodology used to identify the data. Although DHA and Service medical department officials used the same database to identify their opioid use disorder population, differences in the Services' data parameters and variability in their methodologies resulted in different numbers.[24] For example, one Service only included direct care outpatient services in their methodology. The differences in methodology included:

- outpatient and inpatient services provided in the direct care and purchased care systems;
- types of diagnosis codes; and
- the number of diagnosis fields in the encounter.

Lack of Opioid Use Disorder Outcome and Process Measures

As of August 2018, the Military Health System public website listed 12 measures related to substance use.[25] However, the data were not fully populated and were only available for eight metrics from a small number of Military Treatment Facilities for various quarters in CY 2016. Although there are specific measures for screening and treatment of alcohol and tobacco use, such as "Tobacco Use Treatment Provided or Offered at Discharge," the website did not list any measures specific to opioid use disorder.

---

[22] The National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) has the "Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment" metric, which measures the following: (1) percentage of beneficiaries who initiated treatment through an inpatient alcohol and other drug admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication-assisted treatment within 14 days of diagnosis; (2) percentage of beneficiaries who initiated treatment and who had two or more additional alcohol and other drug services or medication-assisted treatment within 34 days of the initiation visit.

[23] "House Report 114–537, Accompanying H.R. 4909, the National Defense Authorization Act for Fiscal Year 2017: Report on Prescription Opioid Abuse and Effects on Readiness," October 29, 2017.

[24] The database used by DHA and Service medical department officials is called the Military Health System Management Analysis and Reporting Tool (M2).

[25] The public website is located at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Patient-Portal-for-MHS-Quality-Patient-Safety-and-Access-Information/See-How-Were-Doing.

Based on discussions with the Service and National Capital Region Medical Directorate representatives to the ASMAC Substance Subcommittee, none of the Services or the National Capital Region Medical Directorate have minimum outcome or process measures specific to opioid use disorder to inform quality improvements. ASD(HA) used two outcome measures for opioid use disorder that were reported to Congress.[26] These two measures were the number and rate of opioid overdose deaths and MHS beneficiaries diagnosed with an opioid use disorder. However, DHA and the Service medical departments did not use these measures.

Inability to Compare Programs

DHA and the Service medical departments each used their own methodologies to identify the opioid use disorder population to inform their internal policies and programs. Although ASD(HA) identified two opioid use disorder outcome measures, those measures were not universally applied by DHA and the Service medical departments. The MHS had no mechanism to compare the performance of opioid use disorder treatment programs to civilian benchmarks or across MTFs to identify best practices and any outliers that need improvement. This is because the DoD did not develop a consistent methodology to define and identify the opioid use disorder population, nor did it standardize opioid use disorder minimum measures. Additionally, the full extent of the DoD's opioid use disorder population was unclear, as each Service had a different methodology to identify the opioid use disorder population.

Way Ahead: Standard Data Collection Tool

Effective January 1, 2018, The Joint Commission required health care organizations to assess outcomes by using a standardized tool or instrument.[27] On July 12, 2018, the DHA published DHA Procedural Instruction 6490.01, "Behavioral Health (BH) Treatment and Outcomes Monitoring," which addresses how the DoD will standardize behavioral health outcome data collection to:

- assess variations in mental health and substance use care among in-garrison Military Treatment Facilities (MTFs) and clinics;
- assess the relationship of treatment protocols and practices to behavioral health outcomes; and

[26] "House Report 114–537, Accompanying H.R. 4909, the National Defense Authorization Act for Fiscal Year 2017: Report on Prescription Opioid Abuse and Effects on Readiness," October 29, 2017. "Prepared Statement … Regarding The Current State and Future Aims in Opioid Use, and Abuse-Research, Diagnostic Testing and Evaluation, and Treatment Before the house Armed Services Committee Subcommittee on Military Personnel," April 19, 2018.

[27] The Joint Commission is an independent organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States and reflects an organization's commitment to meeting certain performance standards.

- identify barriers to provider implementation of evidence-based clinical guidance approved by the DoD.[28]

This behavioral health treatment and outcomes policy also requires the Surgeons General of the Military Departments and the Director of the National Capital Region Medical Directorate to fully implement the Behavioral Health Data Portal within substance use disorder clinics.[29] The Behavioral Health Data Portal application collects standard data and tracks individual behavioral health outcomes. Although the Behavioral Health Data Portal can only track individual treatment outcomes, the application has the capability to aggregate treatment outcome data in the future, according to a senior Army official.

Within the Behavioral Health Data Portal, there is a 17-item self-reported alcohol and drug use questionnaire called the Brief Addiction Monitor (BAM). According to an official from the U.S. Army Medical Command Substance Use Disorder Clinical Care Office, the DoD plans to use the BAM data for opioid use disorder outcome metrics in the future.[30] As stated above, DHA Procedural Instruction 6490.01, "Behavioral Health (BH) Treatment and Outcomes Monitoring," addresses how the DoD will standardize Behavioral Health outcome data collection to assess variations in mental health and substance use care among in-garrison MTFs and clinics. DHA Procedural Instruction 6490.01 is not applicable to the purchased care system, and the relevant portions of the TRICARE Policy Manual 6010.60M, April 1, 2015, do not require TRICARE-authorized providers to use the BAM assessment. If the direct care system uses the BAM to assess treatment outcomes, and the TRICARE-authorized providers use a different method, this may limit the DoD's ability to make external comparisons.

Conclusion

The DoD did not establish and implement minimum DoD-wide standard outcome and process measures for the treatment of opioid use disorder, to inform quality improvements.[31] This occurred because DoDI 1010.04 did not identify the organization responsible for performing this task. As a result, the DoD did not have consistent opioid use disorder data from the Services to compare programs and identify best practices, as required by DoD Instruction 1010.04; and the full extent of DoD's opioid use disorder population was unclear.

---

[28] DHA Procedural Instruction 6490.01, "Behavioral Health (BH) Treatment and Outcomes Monitoring," July 12, 2018, paragraph 1.b.

[29] DHA Procedural Instruction 6490.01, "Behavioral Health (BH) Treatment and Outcomes Monitoring," July 12, 2018, enclosure 2, paragraph 2.f.

[30] DHA Procedural Instruction 6490.01, "Behavioral Health (BH) Treatment and Outcomes Monitoring," July 12, 2018 designates the Army as the DoD lead service for maintenance and sustainment of the Behavioral Health Data Portal.

[31] DoD Instruction 1010.04, "Problematic Substance Use by DoD Personnel," February 20, 2014, paragraph 3.b., states "POLICY…Facilitates the adoption of minimum program outcome and process measures to compare programs and identify best practices and effective services."

Recommendation

Recommendation B

We recommend that the Assistant Secretary of Defense (Health Affairs) develop policy to:

1. **Standardize the methodology to identify the population of patients with opioid use disorder within the Military Health System.**
2. **Establish and implement minimum standard outcome and process measures, including data for both direct care and purchased care, for the treatment of opioid use disorder.[32]**

Assistant Secretary of Defense for Health Affairs Comments

The Principal Deputy Assistant Secretary of Defense for Health Affairs (PDASD[HA]), responding on behalf of the Assistant Secretary of Defense (Health Affairs), agreed with our recommendation to standardize the methodology to identify the population of patients with opioid use disorder within the Military Health System, and will update DoD and DHA instructions to issue a DoD-wide standard of reporting.

The PDASD(HA) also agreed with our recommendation to establish and implement minimum standard outcome and process measures, including data for both direct care and purchased care, for the treatment of opioid use disorder. The PDASD(HA) stated that the DoD will ratify in policy the sustainment of two clinical outcome measures—opioid use disorder prevalence and opioid overdose death rates. The PDASD(HA) also stated that the DoD will develop a mechanism in policy to track how effectively patients are availed to evidence-based treatment services. Finally, the PDASD(HA) noted that the Addictive Substance Misuse Advisory Committee will track process measures, including opiate prescription rates.

PDASD(HA) stated that the DoD has lower opioid use disorder prevalence and fewer overdose deaths compared to the civilian population, representing a public health success. PDASD(HA) provided additional comments on the prevention and treatment of opioid use disorder and stated that ensuring the availability of medication assisted therapy is likely the best approach to the treatment of opioid use disorder. The PDASD(HA) also disagreed that the Brief Addiction Monitor data is well suited for defining opioid use disorder outcomes.

[32] According to DoD Manual 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," October 29, 2013, the purchased care system consists of civilian providers (including individuals, groups, hospitals, and clinics) who have agreed to accept the DoD and uniformed services beneficiaries enrolled in the regional managed care program authorized by the ASD(HA). Providers in the purchased care system deliver health care at negotiated rates, adhere to provider agreements, and follow other requirements of the managed care program.

Our Response

Comments from the PDASD(HA) addressed the specifics of the recommendations. Therefore, the recommendations are resolved but remain open.

For Recommendation B.1 we request that the Assistant Secretary of Defense (Health Affairs) (ASD[HA]) send us written notification when the intended actions have been completed, including:

1. A copy of the updated DoD Instruction 1010.04, describing the DoD-wide standard of reporting, and
2. A copy of the Defense Health Agency Procedural Instruction, which will reflect the implementation guidelines for DoD Instruction 1010.04, describing the DoD-wide standard of reporting.

For Recommendation B.2 we request that the ASD(HA) send us written notification of a projected completion date, a list of the policies requiring a modification, and copies of the updated policies. We will close these recommendations once we verify that corrective actions have been implemented.

We maintain that it is premature for PDASD(HA) to state that opioid use prevalence and overdose death rates are lower among the DoD population relative to the civilian population. As we determined in this evaluation, the DoD does not have a consistent methodology to define and identify the opioid use disorder population, nor does it have standardized opioid use disorder outcome measures. Though the PDASD(HA) disagreed with the Brief Addiction Monitor data being well suited for defining opioid use disorder outcomes, we mentioned the Brief Addiction Monitor in the report to illustrate the DoD's action to collect and measure treatment outcomes. The Defense Health Agency recently published a procedural instruction implementing the Brief Addiction Monitor as one of the minimum measurement capabilities of the Behavioral Health Data Portal.

Appendix A

Scope and Methodology

We conducted this evaluation from May 2018 through April 2019 in accordance with the "Quality Standards for Inspection and Evaluation," published in January 2012 by the Council of Inspectors General on Integrity and Efficiency. Those standards require that we adequately plan the evaluation to ensure that objectives are met and that we perform the evaluation to obtain sufficient, competent, and relevant evidence to support the findings, conclusions, and recommendations. We believe that the evidence obtained was sufficient, competent, and relevant to lead a reasonable person to sustain the findings, conclusions, and recommendations.

We limited the scope of this evaluation to the specific diagnosis category of opioid use disorder, which is a type of substance use disorder. The scope focused on the management of opioid use disorder treatment provided to Military Health System beneficiaries by the DoD, regardless of the location of care.

To evaluate our objectives we reviewed the following documents:

- DoD Instruction 1010.04, "Problematic Substance Use by DoD Personnel," February 20, 2014
- Presidential Memorandum, "Addressing Prescription Drug Abuse and Heroin Use," October 21, 2015
- Presidential Memorandum, "Combatting the National Drug Demand and Opioid Crisis," October 26, 2017
- Report to Congress on Prescription Drug Abuse, March 2016
- Report to Congress on Prescription Opioid Abuse and Effects on Readiness, October 2017
- Army Regulation 600-85, "The Army Substance Abuse Program," November 28, 2016
- Air Force Instruction 44-121, "Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program," July 8, 2014
- Office of the Chief of Naval Operations Instruction 5350.4D, "Navy Alcohol and Drug Abuse Prevention and Control," June 4, 2009
- Bureau of Medicine and Surgery (BUMED) Instruction 5353.4B, "Standards for Provision of Substance Related Disorder Treatment Services," July 6, 2015
- Bureau of Medicine and Surgery (BUMED) Instruction 6010.30, "Credentialing and Privileging Program," March 27, 2015

- Marine Corps Order (MCO) 5300.17, "Marine Corps Substance Abuse Program," April 11, 2011
- Marine Corps Order (MCO) 5300.17A, "Marine Corps Substance Abuse Program," June 25, 2018
- Memorandum of Understanding (MOU) between the Navy Bureau of Medicine and Surgery (BUMED), Marine and Family Programs Division (MF), and Marine Corps Health Services (HS), "Establishment of a Comprehensive System of Psychological Health Services for Active Duty Marines and Their Families," November 5, 2013
- Memorandum of Understanding (MOU) between the Navy Bureau of Medicine and Surgery (BUMED), Marine and Family Programs Division (MF), and Marine Corps Health Services (HS), "Psychological Health Services for Active Duty Marines and Their Family Members," June 18, 2018
- VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders, Version 3.0 – 2015
- Substance Use Disorders in the U.S. Armed Forces, Committee on Prevention, Diagnosis, Treatment, and Management of Substance Use Disorders in the U.S. Armed Forces; Board on the Health of Select Populations; Institute of Medicine, 2013
- TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 11, Section 2.8 Opioid Treatment Program (OTP) Standards, Issue Date: June 13, 2017, Revision: C-13, November 15, 2017
- TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 11, Section 2.5 Psychiatric and Substance Use Disorder (SUD) Partial Hospitalization Program (PHP) Standards, Issue Date: June 14, 1993, Revision: C-13, November 15, 2017
- TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 11, Section 2.7 Intensive Outpatient Program (IOP) Standards, Issue Date: June 13, 2017, Revision: C-13, November 15, 2017
- TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 11, Addendum D Participation Agreement For Inpatient/Residential Substance Use Disorder Rehabilitation Facility (SUDRF) Services For TRICARE Beneficiaries, Revision: C-13, November 15, 2017
- Public Law 115-271, "Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act," October 24, 2018

We performed site visits and interviewed personnel at these locations:

- Assistant Secretary of Defense for Health Affairs, Defense Health Headquarters, Falls Church, Virginia;
- Defense Health Agency, Defense Health Headquarters, Falls Church, Virginia;
- U.S. Army Medical Command, Defense Health Headquarters, Falls Church, Virginia;
- U.S. Navy Bureau of Medicine and Surgery, Defense Health Headquarters, Falls Church, Virginia;
- Air Force Medical Operations Agency, Lackland Air Force Base, San Antonio, Texas; and
- National Capital Region Medical Directorate, Walter Reed National Military Medical Center, Bethesda, Maryland.

After learning more about the Marine Corps Substance Abuse Counseling Centers (SACCs), we performed additional fieldwork including visiting these locations:

- Marine and Family Programs Division, Marine Corps Base Quantico, Virginia;
- Quantico SACC, Marine Corps Base Quantico, Virginia;
- Naval Health Clinic Quantico, Behavioral Health Department, Marine Corps Base Quantico, Virginia;
- Headquarters Marine Corps, Health Services Division, Arlington, Virginia; and
- U.S. Navy Bureau of Medicine and Surgery Legal, Defense Health Headquarters, Falls Church, Virginia.

We also requested additional information from these offices to better understand the services the Marine Corps SACCs provided Military Health System beneficiaries and the SACC counselors' scope of service:

- Marine and Family Program Division, Behavioral Health Branch;
- Marine and Family Programs Executive Staff Counsel;
- Albany SACC;
- Camp Lejeune SACC;
- New River SACC;
- Camp Pendleton SACC;
- Barstow SACC;
- Cherry Point SACC;

- Hawaii SACC;
- Henderson Hall SACC;
- Iwakuni SACC;
- Miramar SACC;
- Parris Island SACC;
- Beaufort SACC;
- Okinawa SACC;
- Quantico SACC;
- San Diego SACC;
- Twentynine Palms SACC; and
- Yuma SACC.

Based on our objectives, we analyzed the information gathered to formalize the findings, conclusions, and recommendations.

Use of Computer-Processed Data

We used computer-processed data to perform this evaluation. Specifically, we requested the Defense Health Agency and the Services to provide the number of Military Health System beneficiaries diagnosed with an opioid use disorder in CY 2017 by enrollment site, along with the methodology used to identify the opioid use disorder population. The officials from the Psychological Health Center of Excellence (PHCoE), Army, Navy, and Air Force all used the Military Health System Management Analysis and Reporting Tool to obtain the requested data.[33]

As discussed in Finding B, we observed that each Service used a different methodology to obtain the number of MHS beneficiaries with an opioid use disorder diagnosis. This resulted in wide disparities in the reported number of Military Health System beneficiaries diagnosed with an opioid use disorder among the Services and PHCoE. The disparities were due to a lack of standard methodology to identify the MHS opioid use disorder population. We determined the methodology information provided by the Services and the PHCoE was sufficiently reliable to support our findings and conclusions.

[33] According to the official MHS website, the Military Health System Management Analysis and Reporting Tool provides a robust dynamic reporting capability in a secure web environment to deliver summary and detailed clinical, population, and financial data.

Prior Coverage

During the last five years, the Government Accountability Office (GAO) and the Department of Defense (DoD) have published a total of three reports discussing opioid use disorder.

GAO

Report No. GAO-18-44, "Opioid Use Disorders: HHS Needs Measures to Assess the Effectiveness of Efforts to Expand Access to Medication-Assisted Treatment," October 2017

> The Department of Health and Human Services (HHS) has not adopted specific performance measures with targets specifying the magnitude of the increases that HHS hopes to achieve through its efforts to expand access to medication-assisted treatment for opioids. As a result, HHS will not have an effective means to determine whether its efforts are helping to expand access to medication-assisted treatment or whether new approaches are needed. The GAO recommended that HHS take two actions: (1) establish performance measures with targets related to expanding access to medication-assisted treatment, and (2) establish timeframes for its evaluation of its efforts to expand access to medication-assisted treatment.

Unrestricted GAO reports can be accessed at http://www.gao.gov.

DoD and Service Level Reports

The DoD's response to House Report 114-139, accompanying House Report 2685, the DoD Appropriations Bill 2016, Report on Prescription Drug Abuse, March 2016

> The Office of the Under Secretary of Defense for Personnel and Readiness stated that the DoD would update pain management and prescription drug abuse training, revise the clinical practice guideline on the Management of Opioid Therapy for Chronic Pain, and issue consolidated guidance regarding treatment options for opioid use disorder.

The DoD's response to House Report 114-537, accompanying House Report 4909, the National Defense Authorization Act for Fiscal Year 2017, Report on Prescription Opioid Abuse and Effects on Readiness, October 2017

> The report included that prescription opioid misuse in service members remains an issue of concern because it negatively affects performance, military readiness, and the overall mission. The report identified that there are about 25,000 TRICARE beneficiaries with an opioid use disorder, and there were 35 opioid-related deaths among active duty service members in 2015.

Appendix B

DoD Policy on the Treatment of Opioid Use Disorder

The DoD Instruction (DoDI) 1010.04, "Problematic Substance Use by DoD Personnel," February 20, 2014, is the primary DoD policy that addresses substance use disorders in the DoD, including opioid use disorder. The instruction established policies, assigned responsibilities, and prescribed procedures for problematic alcohol and drug use prevention, identification, diagnosis, and treatment for DoD military and civilian personnel. It directed the Assistant Secretary of Defense for Health Affairs to develop and distribute substance use disorder treatment program guidance, and to make available substance use treatment services necessary to meet the needs of MHS beneficiaries. The policy also assigned the Service medical departments the primary responsibility for the provision of substance use disorder treatment within the direct care system.[34]

The Department of Veterans Affairs and the DoD developed a clinical practice guideline for the management of substance use disorders based on a systematic review of both clinical and epidemiological evidence. This clinical practice guideline is intended to provide health care providers with a framework by which to evaluate, treat, and manage the individual needs and preferences of patients with substance use disorders, thereby leading to improved clinical outcomes. The treatment of opioid use disorder is covered within this clinical practice guideline.

Service Policies on the Treatment of Opioid Use Disorder

Each Military Service has its own policies to manage the treatment of opioid use disorder within its overarching substance abuse policies.

Army Policy

Army Regulation 600-85, "The Army Substance Abuse Program," November 28, 2016, provides alcohol and drug abuse prevention and control policies, procedures, and responsibilities for all soldiers of all components, Army civilian corps members, and other personnel eligible for Army Substance Abuse Program Services.[35] It also includes guidance for military family members and military retirees and their families.

[34] According to DoD Manual 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," October 29, 2013, the direct care system is the health care facilities and medical support organizations owned by the DoD and managed by the Services Surgeons General in accordance with applicable federal laws and regulations.

[35] Army Civilian Corps members are Federal Civil Service employees who work for the Department of the Army.

Navy Policy

Office of the Chief of Naval Operations Instruction (OPNAVINST) 5350.4D, "Navy Alcohol and Drug Abuse Prevention and Control," June 4, 2009, provides policy for alcohol and drug abuse prevention in the Department of the Navy. Although it provides comprehensive alcohol and other drug abuse prevention and control policy and procedures for all Navy military personnel, it states that eligible family members may receive alcohol and drug abuse services offered through the service member's selected dependent health care plan option. In addition, the Navy also uses Bureau of Medicine and Surgery (BUMED) Instruction 5353.4B, "Standards for Provision of Substance Related Disorder Treatment Services," July 6, 2015, to establish and update a set of standards for the provision of substance related disorder treatment services within the Department of the Navy.

Marine Corps Policy

Marine Corps Order (MCO) 5300.17A, "Marine Corps Substance Abuse Program," June 25, 2018, provides policy and procedural guidance for the Marine Corps Substance Abuse Program, to execute a comprehensive, standardized, and effective substance abuse program throughout the Marine Corps. This policy states that the Substance Abuse Program prevention and counseling services are provided to active duty marines and sailors attached to Marine Corps units. It does not address Marine Corps family member services.

The Memorandum of Understanding (MOU) between the Navy Bureau of Medicine and Surgery (BUMED), the Marine and Family Programs Division (MF), and the Marine Corps Health Services (HS), "Psychological Health Services for Active Duty Marines and Their Family Members," June 18, 2018, was developed to:

- define the full continuum of care offered on Marine Corps installations to marines, sailors attached to Marine Corps units, and their family members;
- establish clear lines of communication among all entities involved in these services; and
- leverage and augment existing systems while delineating the responsibilities of all parties.[36]

[36] The Navy Bureau of Medicine and Surgery (BUMED) falls under the Navy Surgeon General. The Marine and Family Programs Division (MF) falls under the Deputy Commandant for Manpower and Reserve Affairs. The Marine Corps Health Services (HS) falls under the Deputy Commandant for Installation and Logistics.

Air Force Policy

Air Force Instruction 44-121, "Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program," July 8, 2014, provides guidance for the identification, treatment, and management of personnel with substance use disorders and describes Air Force policy regarding alcohol abuse, prescription drug abuse, and drug abuse.

Service Programs for the Treatment of Opioid Use Disorder

Each military Service has its own substance abuse program, including the management of opioid use disorder treatment. These programs consist of:

- the Army Substance Abuse Program,
- the Navy Substance Abuse Rehabilitation Program,
- the Marine Corps Substance Abuse Counseling Centers, and
- the Air Force Alcohol and Drug Awareness Program and Treatment.

Army Substance Abuse Program

The overall objectives of the Army Substance Abuse Program are to:

- increase individual fitness and overall unit readiness;
- provide services that are proactive and responsive to the needs of the Army's workforce and emphasize alcohol and other drug abuse deterrence, prevention, education, and rehabilitation;
- implement alcohol and other drug risk reduction and prevention strategies that respond to potential problems before they jeopardize readiness, productivity, and careers;
- restore to duty those substance-impaired soldiers who have the potential for continued military service;
- provide effective alcohol and other drug abuse prevention and education at all levels of command, and encourage commanders to provide alcohol and drug-free leisure activities;
- ensure all personnel assigned to Army Substance Abuse Program staff are appropriately trained and experienced to accomplish their missions;
- achieve maximum productivity and reduce absenteeism and attrition among civilian corps members by reducing the effects of the abuse of alcohol and other drugs; and
- improve readiness by extending services to the soldiers, civilian corps members, and family members.

In 2017, the Army Substance Abuse Program's treatment and rehabilitation function was realigned from the U.S. Army Installation Management Command (IMCOM) to the U.S. Army Medical Command (MEDCOM) to seamlessly integrate Substance Use Disorder Clinical Care delivery within MEDCOM's Behavioral Health System of Care.

Navy Substance Abuse Rehabilitation Program

The primary objectives of the Navy Substance Abuse Rehabilitation Program are to:

- promote readiness, health, and wellness through the prevention and treatment of substance abuse;
- prevent the negative consequences of substance abuse to individuals, families, and organizations;
- provide comprehensive education and treatment to individuals who experience problems attributed to substance abuse; and
- return identified substance abusers to unrestricted duty status or to assist them in their transition to civilian life, as appropriate.

Marine Corps Substance Abuse Counseling Centers

The goals of the Marine Corps Substance Abuse Counseling Centers are to:

- support marines to functional social, psychological, familial, and employment health; and
- mitigate substance misuse related barriers to mission readiness.[37]

The Quantico Substance Abuse Counseling Center website states that the Substance Abuse Counseling Centers' mission is to promote operational readiness health and wellness through substance abuse prevention, early intervention, and treatment services for military service members.

Air Force Alcohol and Drug Awareness Program and Treatment

The primary objectives of the Air Force Alcohol and Drug Awareness Program and Treatment program are to:

- promote readiness, health, and wellness through the prevention and treatment of substance misuse and abuse;
- minimize the negative consequences of substance misuse and abuse to individuals, families, and organizations;
- provide comprehensive education and treatment to individuals who experience problems attributed to substance misuse or abuse; and

[37] MCO 5300.17A, "Marine Corps Substance Abuse Program," June 25, 2018.

- restore function and return identified substance abusers to unrestricted duty status or to assist them in their transition to civilian life, as appropriate.

The Air Force Alcohol and Drug Awareness Program and Treatment program addresses these objectives through the delivery of four activities consisting of: (1) universal (primary) prevention and education; (2) selective (targeted) prevention; (3) indicated prevention; and (4) treatment and continuing care (aftercare).

TRICARE Programs for the Treatment of Opioid Use Disorder

In addition to the treatment services offered within the direct care system, the DoD provides a TRICARE benefit for eligible Military Health System beneficiaries for the treatment of opioid use disorder. On October 3, 2016, TRICARE implemented improvements to its mental health and substance use disorder benefits, including lowering the co-payments from $25 to $12 per substance use disorder visit for non-active duty beneficiaries, retirees, their family members, and survivors. TRICARE also eliminated day-limits for partial hospitalization services, residential substance use disorder care, and other mental health treatment. On July 13, 2017, TRICARE further expanded treatment options for opioid use disorder, by covering medication-assisted treatment and office-based opioid treatment for eligible Military Health System beneficiaries with an opioid use disorder diagnosis. These policy and benefit changes gave Military Health System beneficiaries more flexibility to seek the right level of care for their substance use disorder and mental health needs.

Management Comments

Secretary of the Navy

DEPARTMENT OF THE NAVY
OFFICE OF THE ASSISTANT SECRETARY
(MANPOWER AND RESERVE AFFAIRS)
1000 NAVY PENTAGON
WASHINGTON, D.C. 20350-1000

MAR 28 2019

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL

SUBJECT: Formal Coordination Request for Inspector General's Draft Report: "The DoD's Management of Opioid Use Disorder for Military Health System Beneficiaries"

The Department of the Navy (DON) appreciates the opportunity to review and provide comments on "The DoD's Management of Opioid Use Disorder for Military Health System Beneficiaries." The DON non-concurs with the overly negative depiction of the Marine Corps. Additionally, it is unclear to the DON the exact problem being addressed or the extent of the potential problem; thus, we cannot determine if policy is not being followed or if modification of current policy is necessary. A review of the implementation of Department of Defense (DOD), Secretary of the Navy, and Bureau of Medicine and Surgery (BUMED) published directives and policies as well as the Memorandum of Understanding between BUMED and the Marine Corps is already underway. Any discrepancy of these policies will be addressed by the DON. We expect completion by September 30, 2019. Given this review, the DON requests Recommendation 1 and 2 are modified to state that the DON should continue conducting its internal evaluation of this program and address any pertinent findings.

It is also important to note in the report, as of October 2018, the Defense Health Agency (DHA) assumed authority, direction, and control for standardization of clinical policy and medical treatment facility credentialing procedures. Navy Mental Health and Substance subject matter experts are working the DHA "Problematic Substance Use by DOD Personnel" Procedural Instruction as DHA assumes policy responsibilities previously held by the Surgeon General.

My point of contact for this matter is [redacted]

Russell W. Beland
Deputy Assistant Secretary of the Navy
(Military Manpower & Personnel)

Assistant Secretary of Defense Health Affairs

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 20 2019

Elias G. Nimmer
DoD Office of the Inspector General
4800 Mark Center Drive, Suite 02J25
Alexandria, VA 22350-1500

Dear Dr. Nimmer:

This is the Department of Defense (DoD) response to the recommendations contained in the DoD Inspector General (IG) Draft Report titled, The DoD's Management of Opioid Use Disorder for Military Health System Beneficiaries - Project No. D2018-D00SPO-0156.000, dated March 18, 2019. Enclosed is the DoD's response to the recommendations.

We sincerely thank the DoD IG team members for developing this report and for the opportunity to review and provide comments for inclusion in the final report. Should you have any questions, please contact [redacted], Defense Health Agency Audit Liaison Officer. [redacted]

Sincerely,

for Tom McCaffery
Principal Deputy Assistant Secretary of
Defense (Health Affairs)

Enclosure:
As stated

Assistant Secretary of Defense Health Affairs (cont'd)

Subject: "The DoD's Management of Opioid Use Disorder for Military Health System Beneficiaries - Project No. D2018-D00SPO-0156.000, March 18, 2019

Recommendation B1:

We recommend that the Assistant Secretary of Defense for Health Affairs develop policy to standardize the methodology to identify the population of patients with opioid use disorder within the Military Health System

Department of Defense (DoD) Position: Concur

This issue will be remedied by issuing a DoD-wide standard of reporting through modification of DoD and DHA instructions and the definition of "caseness" below:

1. DoD Instruction (DoDI) 1010.04: The current instruction was last revised on February 20, 2014. An update to the instruction will be complete by fiscal year (FY) 2020 and will include changes in its administrative and scientific fields.
2. The National Defense Authorization Act FY17, Sec. 702 establishes a four year timeframe for the transition of Military Treatment Facilities (MTFs) from their respective Services to Defense Health Agency (DHA) starting in FY 19. Implementation guidelines for DoDI 1010.04 will be incorporated in a parallel DHA Procedural Instruction prior to full integration.
3. The Armed Forces Health Surveillance Branch, a unit of DHA, issues definitions for caseness. Caseness is an incidence measure that is essential to strictly identify individuals who carry a diagnosis. A strict use of the definition will be mandated for reporting in the policies above.

It should be noted that incidence measures alone do not assess the population burden of a specific diagnosis. They must be integrated with reliable outcome measures (such as overdose deaths) and process measures (discussed in the next section).

Recommendation B2:

We recommend that the Assistant Secretary of Defense (Health Affairs) develop policy to establish and implement minimum standard outcome and process measures, including data for both direct care and purchased care, for the treatment of opioid use disorder.

DoD Position: Concur with Comment

While DoD agrees with many of the discussion points that buttress the discussion, it disagrees with some points in regard to which process and outcome measures are best to use. DoD has in many ways been spared from the nation's scourge of opiate misuse and death. Some of DoD's outcomes—far fewer overdose deaths against a matched civilian cohort and lower prevalence rates of opiate use disorders across most beneficiary classes—represent a public heath success. This success might be attributable to coordination between personnel and readiness assets (e.g

Assistant Secretary of Defense Health Affairs (cont'd)

accession/discharge equities and drug demand reduction programming including the random urinalysis program) and medical equities outside of the realm of addiction treatment.

DoD will ratify in policy the sustainment of two clinical outcome measures tracked in DHA—the prevalence of opioid use disorder, which is tracked across beneficiary classes through DHA's Armed Forces Health Surveillance Branch, and opioid overdose death rates in the Active Duty force, which is tracked by the DHA Psychological Health Center of Excellence in consultation with the DHA's Armed Forces Medical Examiner. These data will be refreshed in accordance with medical surveillance principals, and made readily available to stakeholders including the Assistant Secretary of Defense for Health Affairs and Director, DHA.

DoD disagrees that screening measures in clinical data portals, such as the Brief Addiction Monitor, are well suited to defining opiate use disorder outcomes in any of its populations, including the cohort of individuals treated in the TRICARE network. It is important to note that screening, brief intervention and referral to treatment has been shown to be an ineffective systems approach to opiate use disorders.

In regard to treatment, or tertiary (indicated) prevention, there are three evidence-based treatment approaches to opiate use disorders—prescription of buprenorphine, methadone or naltrexone. All of these are medication assisted therapies which involve medical monitoring and biological assays that assess for ongoing use. Ensuring the availability of medication assisted therapy—delivered by privileged providers in both direct and network care—is likely the best approach to tertiary prevention. In contrast to the national picture, DoD has a surfeit of clinical capability in this realm.

DoD agrees there is work to do in treatment monitoring. Its public health approach to the opiate scourge to date has mainly focused on primary and secondary (universal and selected) prevention such as stepped care pain treatment protocols, pharmacy controls and aggressive demand reduction strategies including drug testing, interdiction and policies in regard to accessions and discharges. While standardization and optimization of military opiate treatment services is a stand-alone good practice, and could help identify new best practices, it is important to note that opiate use disorders have been well-studied, highly funded by the NIH, and that established best practices are published in refereed literature. To that end, DoD will develop a mechanism in policy to track how effectively patients are availed to evidence-based treatment services.

Finally, DoD will track positive opiate screens in the Active Duty force through regular updates to its Addictive Substance Misuse Advisory Committee. The Committee will also track process measures tracked by DHA Pharmacy Operations Department including opiate prescription rates, morphine milligram equivalent breakouts, geographic prescription heat maps and other measures for prescription drug tracking in direct and network care.

Acronyms and Abbreviations

ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASMAC	Addictive Substance Misuse Advisory Committee
BUMED	Navy Bureau of Medicine and Surgery
DASD(HSP&O)	The Deputy Assistant Secretary of Defense for Health Services Policy and Oversight
DHA	Defense Health Agency
DoDI	Department of Defense Instruction
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
HHS	Department of Health and Human Services
MCO	Marine Corps Order
MHS	Military Health System
MOU	Memorandum of Understanding
MTF	Military Treatment Facility
OIG	Office of Inspector General
PHCoE	Psychological Health Center of Excellence
SACC	Substance Abuse Counseling Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SECNAV	Secretary of the Navy
SUD	Substance Use Disorder

Glossary

Clinical privileging. The process whereby a health care practitioner is granted the permission and responsibility to independently provide specified medical or dental care within the scope of his or her licensure, certification, or registration. Clinical privileges define the scope and limits of practice for individual practitioners.[38]

Health care practitioners (Licensed Independent Practitioners). Licensed military (active duty and reserve) and the Department of the Navy civilian providers (Federal civil service, foreign national hire, contract, or resource sharing agreement and clinical support agreement) are required to be granted delineated clinical privileges to independently diagnose, initiate, alter or terminate health care treatment regimens within the scope of their licensure. This includes physicians, dentists, marriage and family therapists, nurse practitioners, nurse midwives, nurse anesthetists, clinical psychologists, optometrists, clinical dieticians, podiatrists, clinical social workers, pharmacists, physical therapists, occupational therapists, audiologists, speech pathologists, and physician assistants.[39]

[38] OPNAV Instruction 6320.7A, Marines Corps Order 6320.4, BUMED-M3B62, "Health Care Quality Assurance Policies for Operating Forces," August 15, 2007.

[39] OPNAV Instruction 6320.7A, Marines Corps Order 6320.4, BUMED-M3B62, "Health Care Quality Assurance Policies for Operating Forces," August 15, 2007.


INSPECTOR GENERAL
INTEGRITY
EFFICIENCY
DEPARTMENT OF DEFENSE

Whistleblower Protection
U.S. Department of Defense

Whistleblower Protection safeguards DoD employees against retaliation for protected disclosures that expose possible waste, fraud, and abuse in government programs. For more information, please visit the Whistleblower webpage at http://www.dodig.mil/Components/Administrative-Investigations/Whistleblower-Reprisal-Investigations/Whisteblower-Reprisal/ or contact the Whistleblower Protection Coordinator at Whistleblowerprotectioncoordinator@dodig.mil

For more information about DoD OIG reports or activities, please contact us:

Congressional Liaison
703.604.8324

Media Contact
public.affairs@dodig.mil; 703.604.8324

DoD OIG Mailing Lists
www.dodig.mil/Mailing-Lists/

Twitter
www.twitter.com/DoD_IG

DoD Hotline
www.dodig.mil/hotline

DEPARTMENT OF DEFENSE | OFFICE OF INSPECTOR GENERAL

4800 Mark Center Drive
Alexandria, Virginia 22350-1500
www.dodig.mil
Defense Hotline 1.800.424.9098