



Defense Health Agency

ADMINISTRATIVE INSTRUCTION

NUMBER 6025.04

January 25, 2022

DAD-MA

SUBJECT: Standardization of Depression and Suicide Risk Screening in Primary Care During and Subsequent to the Coronavirus Disease 2019 Pandemic

References: See Enclosure 1.

1. PURPOSE. This Defense Health Agency-Administrative Instruction (DHA-AI), based on the authority of References (a) and (b), and Section 1073c of Reference (f), and in accordance with the guidance of References (c) through (h), establishes the Defense Health Agency (DHA) procedures to screen for depression and suicide risk in the Military Health System in Primary Care during and subsequent to the Coronavirus Disease 2019 (COVID-19) pandemic. This DHA-AI augments existing screening requirements contained in References (e) and (i).
2. APPLICABILITY. This DHA-AI applies to DHA, DHA Components (activities under the authority, direction, and control of the DHA), and DoD healthcare practitioners, and contractors required by the terms of the applicable contract who are involved in the delivery of Primary Care health services to eligible beneficiaries.
3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to Reference (d), to establish uniform accountability, standards, and processes for screening and compliance standards for the delivery of the Patient-Centered Medical Home (PCMH) model of Primary Care in military medical treatment facilities (MTF). This applies to all Primary Care clinics within the direct care system. Examples include, but are not limited to, Family Medicine, Internal Medicine, Pediatrics, Adolescent Medicine, Flight/Aviation/Undersea/Personnel Reliability Clinics, and Operational Medicine. This publication establishes uniform accountability, standards, and processes for depression and suicide risk screening. In order to assess accountability, a DHA Primary Care Clinical Community (PCCC) representative will work with DHA Strategic Planning and Functional Integration to establish the data-pull plan for actionable accountability measures for these screenings from the electronic medical record upon this DHA-AI's publication. The accountability measures will be reviewed at least quarterly. This DHA-AI was initiated by the PCCC leads for each Service. If the PCCC Service Leads

believe there is no longer utility in the screening requirements in this DHA-AI, they will work with a Deputy Assistant Director (DAD), Medical Affairs (MA) representative to rescind or modify this DHA-AI.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. The goal of this instruction is to standardize Primary Care screening and assessment for depression and suicide risk during and subsequent to the coronavirus disease 2019 pandemic. It applies to the direct care setting for those 11 years of age and older. See Enclosure 3.

6. PROPONENT AND WAIVERS. The proponent of this publication is the DAD-MA. When activities are unable to comply with this publication, the activity may request a waiver that must include a justification, to include an analysis of the risk associated with not granting the waiver. The activity director or senior leader will submit the waiver request through their supervisory chain to the DAD-MA to determine if the waiver may be granted by the Director, DHA or his/her designee.

7. RELEASABILITY. **Cleared for public release.** This DHA-AI is available on the Internet from the Health.mil site at: <https://health.mil/Reference-Center/Policies> and is also available to authorized users from the DHA SharePoint site at: <https://info.health.mil/cos/admin/pubs/SitePages/Home.aspx>.

8. EFFECTIVE DATE. This DHA-AI:

a. Is effective upon signature.

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

9. FORMS. The following DHA Forms are available at:

https://info.health.mil/cos/admin/DHA_Forms_Management/Lists/DHA%20Forms%20Management/AllItems.aspx.

a. DHA Form 212, Primary Care Adult Behavioral Health Screening Tool.

b. DHA Form 213, Primary Care Adolescent Behavioral Health Screening Tool.

c. DHA Form 214, Primary Care Behavioral Health Secondary Diagnostic Aid (nine-item Patient Health Questionnaire (PHQ-9)).

d. DHA Form 215, Primary Care Behavioral Health Diagnostic Aid for Patients Ages 11 to 17 (PHQ-9-Adolescent).

/S/
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Director

Enclosures

1. References
2. Responsibilities
3. Procedures
4. Patient Care Options

Glossary

ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
- (b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
- (c) DHA-Procedural Instruction 5025.01, "Publication System," August 24, 2018
- (d) DHA-Procedural Instruction 6025.06, "Standardized Templates for Primary Care Clinical Encounter Documentation," May 16, 2018
- (e) DHA-Procedural Instruction 6025.27, "Integration of Primary Care Behavioral Health (PCBH) Services into Patient-Centered Medical Home (PCMH) and Other Primary Care Service Settings within the Military Health System (MHS)," October 18, 2019
- (f) United States Code, Title 10
- (g) DHA-Procedures Manual 6025.13, "Implementation Guidance for Defense Health Agency Procedures Manual, Clinical Quality Management in the Military Health System," Volumes 1-7, August 29, 2019
- (h) DoD Instruction 6490.06, "Counseling Services for DoD Military, Guard and Reserve, Certain Affiliated Personnel, and Their Family Members," April 21, 2009, as amended
- (i) DoD Instruction 6490.15, "Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCM) Primary Care and Other Primary Care Service Settings," November 20, 2014

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness and the Assistant Secretary of Defense for Health Affairs, the Director, DHA will assign responsibility for tracking PCMH operation compliance outlined in this DHA-AI to the DAD-MA.

2. DAD-MA. The DAD-MA will:
 - a. Monitor compliance with the guidance outlined in this DHA-AI via the DHA PCMH-Advisory Board (PCMH-AB), PCCC, and Primary Care Clinical Management Team (PC-CMT).
 - b. Track measures to assess Primary Care clinic compliance with the standards and processes outlined in this DHA-AI.
 - c. Update this guidance with additional standard processes and procedures in support of continuous clinical quality improvement as recommended by the DHA PCMH-AB, PCCC, and PC-CMT.

3. DAD, STRATEGY, PLANNING, AND FUNCTIONAL INTEGRATION. The DAD, Strategy, Planning, and Functional Integration will work with a PCCC representative to develop, extract, analyze, and report metrics to assess compliance with this DHA-AI. Any metrics used to assess compliance may be used in a peer review process and contain clinical quality assurance information, and thus, are privileged in accordance with Section 1102 of Reference (f).

4. CHAIRS, DHA PCMH-AB, PCCC, and PC-CMT. The Chairs, DHA PCMH-AB, PCCC, and PC-CMT will work collaboratively to:
 - a. Ensure Primary Care clinics receive adequate training and education on the requirements of this DHA-AI.
 - b. Monitor and respond to queries from clinics on implementation of this DHA-AI.
 - c. Collect data on compliance with the requirements of this DHA-AI and the impact that the requirements have on patient care.

5. MARKET, SMALL MARKETS AND STAND-ALONE MILITARY MEDICAL TREATMENT FACILITY ORGANIZATION, MILITARY MEDICAL TREATMENT FACILITY, AND DEFENSE HEALTH AGENCY REGION DIRECTORS. The Market, Small

Markets and Stand-Alone Military Medical Treatment Facility Organization, MTF, and Defense Health Agency Region Directors must ensure MTFs comply with the standards in this DHA-AI and implement corrective actions to ensure compliance.

6. MARKET PC-CMT LEADS AND MTF DIRECTORS. The Market PC-CMT Leads and MTF Directors will:

- a. Implement Primary Care operations as outlined in this DHA-AI.
- b. Comply with the guidance in this DHA-AI, monitor and track performance measures and requirements once they are established, and implement corrective actions.
- c. Route waiver requests for this DHA-AI to DAD-MA.

7. DOD HEALTHCARE PROVIDERS. DoD Healthcare Providers who are credentialed and privileged at an MTF pursuant to Reference (g) are required to comply with this DHA-AI.

ENCLOSURE 3

PROCEDURES

1. SCREENING. All beneficiaries age 11 years and older will be screened at every face-to-face or phone/video virtual Primary Care appointment with their Primary Care Manager (PCM), or other Primary Care provider using the two-item Patient Health Questionnaire (PHQ-2) as the initial depression screen. The PHQ-2 consists of the first two questions of the DHA Form 214, Primary Care Behavioral Health Secondary Diagnostic Aid (PHQ-9) or the DHA Form 215, Primary Care Behavioral Health Diagnostic Aid for Patients Ages 11 to 17 (PHQ-9-Adolescent). Figures 1 and 2 located on pages 9 and 11 of this document depict the depression and suicide screening workflows used during primary care visits for adults and patients 11-17 years of age, respectively.

2. SCREENING METHODS. Patients can answer the questions on a document like the example in Section 1 and 2 of the DHA Form 212, Primary Care Adult Behavioral Health Screening tool, or Sections 1 and 2 of the DHA Form 213, Primary Care Adolescent Behavioral Health Screening tool. The questions may be asked verbally, verbatim, or by using a technological solution approved by DHA for Primary Care for administration of the questions. Patient responses will be recorded in the Behavioral Health (BH)/Other Screening Tab in the applicable electronic health record and, as appropriate for age, the Armed Forces Health Longitudinal Technology Application (AHLTA) Tri-Service Workflow (TSWF) CORE Form (adults), the AHLTA TSWF Pediatrics 7-18 year Alternate Input Method Form in the BH Tab (adolescents), or the MHS GENESIS® Ambulatory Comprehensive Intake, or Pediatric Comprehensive Intake. PCMs are responsible for reviewing patient responses prior to the patient leaving the appointment and discussing the results with the patient.

3. FOLLOW-UP TO POSITIVE SCREEN

a. Patients scoring 3 or greater on the PHQ-2 will complete questions #3 - #9 of the PHQ-9 or PHQ-9-Adolescent like the example in DHA Form 214 or 215. The answers and sum of all nine questions will be recorded in the BH/Other Screening Tab in the AHLTA TSWF CORE Form, the AHLTA TSWF Pediatrics 7-18 year Alternate Input Method Form in the BH Tab, or the MHS GENESIS® Ambulatory Comprehensive Intake, or Pediatric Comprehensive Intake. Patients scoring 10 or higher on the DHA Form 214 or DHA Form 215 may benefit from additional BH assessment and intervention. PCM will discuss screening results and recommendations with the patient (or legally authorized representative as appropriate) and document the discussion in the electronic health record.

b. Enclosure 4 lists patient care options that may be available at the MTF, at the installation, off installation, and within the TRICARE network. PCMs and all other Primary Care providers

must be familiar with what options are available and discuss the benefits of pursuing those options with their patients. Refer to Figure 1 for additional information on workflow and appropriate actions.

c. Clinical Response Options for answers to question #9 of PHQ-9:

(1) A “Not at all” response to question #9 of PHQ-9: No additional suicide risk assessment follow-up indicated.

(2) A response of “several days,” “more than half the days,” or “nearly every day” to question #9 of the PHQ-9: Providers should consider asking additional suicide risk assessment questions, such as current suicidal ideation, prior suicide attempt(s), current psychiatric conditions or symptoms, prior psychiatric hospitalization, recent biopsychosocial stressors, and availability of firearms to determine whether further clinical attention or management is required. When warranted, appropriate further clinical attention may include a referral to a BH Consultant (BHC) or specialty BH if there is no BHC in the clinic for evaluation and comprehensive risk assessment. If immediate evaluation by a BH provider is not feasible, the PCM is responsible for conducting a comprehensive evaluation of suicide risk as outlined in the VA/DoD CPG for Assessment and Management of Patients at Risk for Suicide. Document decision-making and follow-up questioning in the medical record.

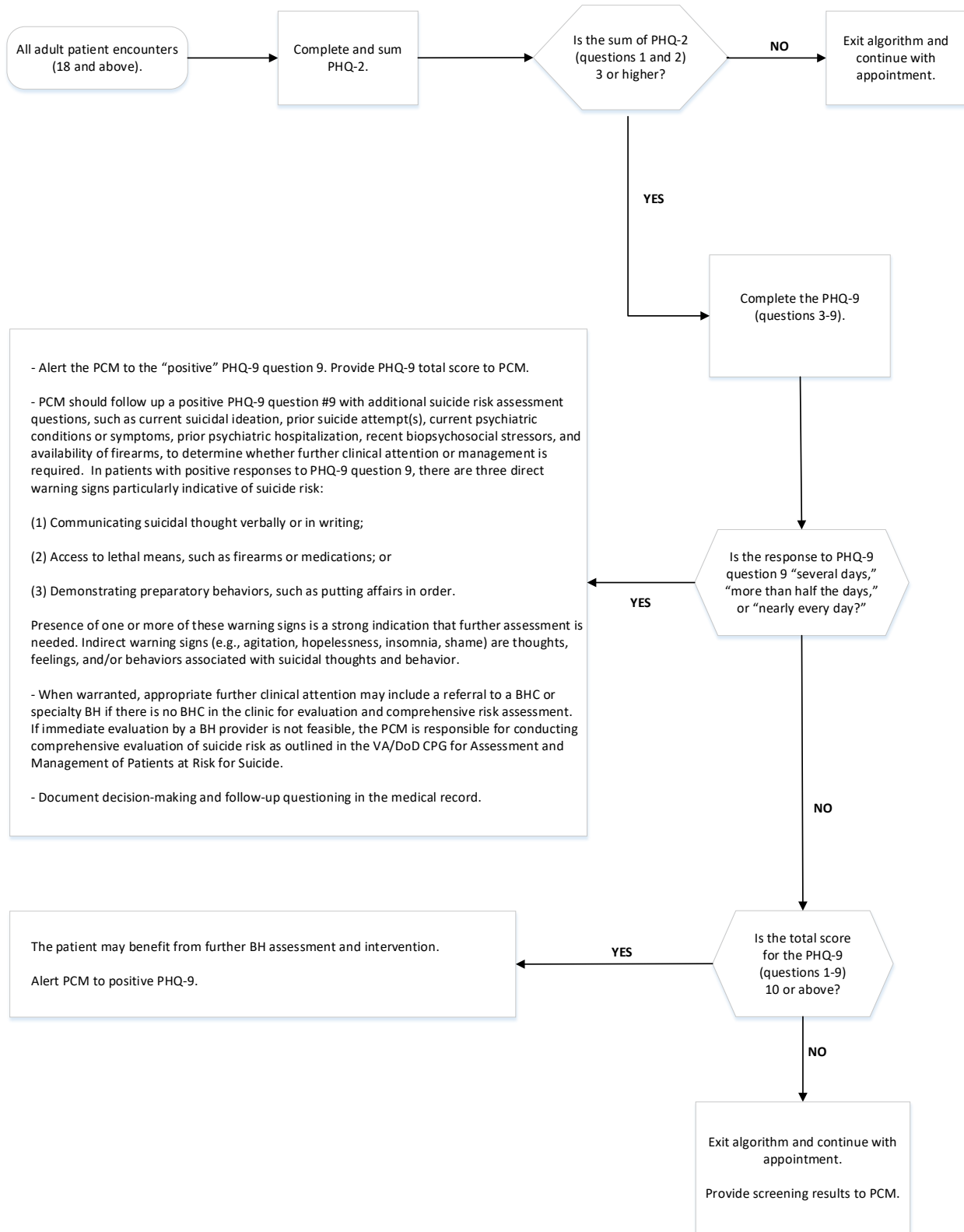


Figure 1. Depression and Suicide Risk Screening Workflow for All Adult Primary Care Visits

e. Patients 11-17 years of age who score 3 or higher on the PHQ-2 will be verbally asked the first four questions of the Ask Suicide Screening Questions (ASQ) suicide screening questionnaire as shown in the example in DHA Form 213. If the patient answers yes to any of the four questions, they will be verbally asked question #5. Refer to Figure 2 for additional information on workflow and appropriate actions.

f. Clinical Response Options for answers to question #9 of PHQ-9 Adolescent and ASQ suicide screening questionnaire.:

(1) A “Not at all” response to question #9 of PHQ-9 Adolescent and "No" on questions #1 - #4 of the ASQ: No additional suicide risk assessment follow-up indicated.

(2) A response of “several days,” “more than half the days,” or “nearly every day” to question #9 of the PHQ-9 adolescent and "Yes" to any of the first four questions of the ASQ and a “No” to question #5 of the ASQ: Provider should consider asking additional suicide risk assessment questions, for example, current suicidal ideation, prior suicide attempt(s), current psychiatric conditions or symptoms, prior psychiatric hospitalization, recent biopsychosocial stressors, and availability of firearms to determine whether further clinical attention or management is required. Further clinical attention may include a referral to a BHC or specialty BH if there is no BHC in the clinic for evaluation and comprehensive risk assessment. Document decision-making and follow-up questioning in the medical record.

(3) A response of "Yes" to any of the first four questions of the ASQ and a "Yes" to question #5 of the ASQ: Immediate clinical follow-up is warranted. Unless clinical judgment indicates otherwise, providers will initiate a referral to a BHC or specialty BH if there is no BHC in the clinic for evaluation and comprehensive risk assessment. If immediate evaluation by a BH provider is not feasible, the PCM is responsible for conducting further suicide risk assessment (see paragraph 3.d.(2) of this enclosure) and initiating appropriate management of risk.

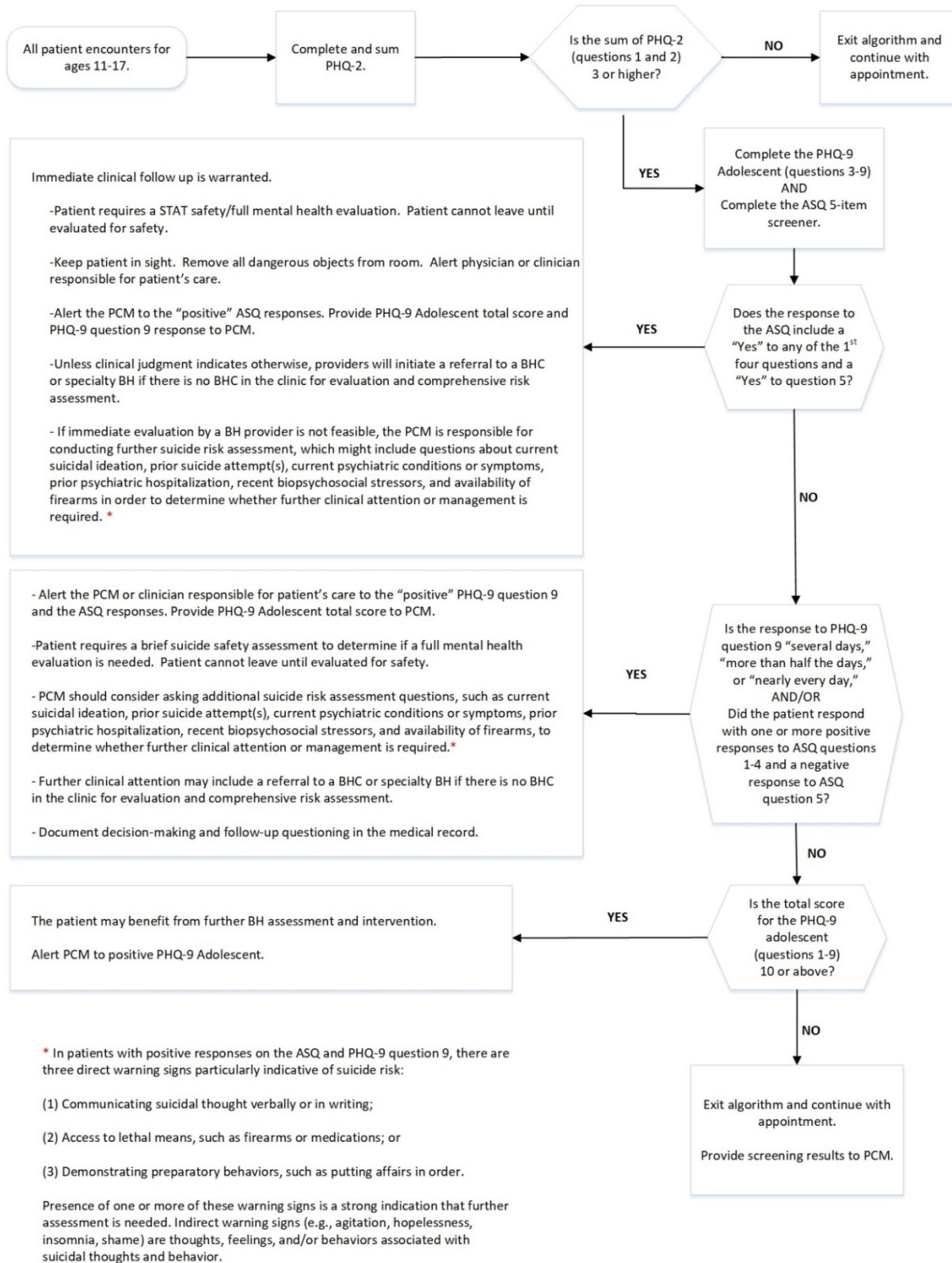


Figure 2. Depression and Suicide Risk Screening Workflow for All Primary Care Visits for Patients 11-17 Years of Age

g. In patients with positive responses on the ASQ and PHQ-9 question #9, there are three direct warning signs particularly indicative of suicide risk:

- (1) Communicating suicidal thought verbally or in writing;
- (2) Access to lethal means such as firearms or medications; or
- (3) Demonstrating preparatory behaviors such as putting affairs in order.

(4) Presence of one or more of these warning signs is a strong indication that further assessment is needed. Indirect warning signs (e.g., agitation, hopelessness, insomnia, shame) are thoughts, feelings, and/or behaviors associated with suicidal thoughts and behavior.

h. Patients with known elevated risk for suicide should be seen in person rather than via telehealth appointments, whenever possible. PCMs who are aware a patient is at elevated risk should attempt to have the patient seen in a face-to-face visit with the BHC and should alert the BHC in advance. PCMs and BHCs must ensure they obtain every patient's emergency contact information at the start of a telehealth appointment, in the event they need to call emergency services to respond. Emergency contact information must include the patient's physical location (address) and phone number. If patient reports he or she is in a parked car, provider must obtain the approximate location and request the patient remain at that location for the duration of the appointment. When working with patients with known elevated risk for suicide, PCMs and BHCs must obtain a name and phone number for a support person (designated by the patient). If providers are conducting a telehealth appointment from an alternate location (e.g., teleworking from home), they must have a second phone line available in the event they need to keep a patient on the line while calling for emergency assistance.

ENCLOSURE 4

PATIENT CARE OPTIONS

1. MTF OPTIONS. BHCs will be considered an initial go-to Primary Care clinic resource for all patients presenting with depression and/or suicide risk. BHCs can see beneficiaries enrolled to the BHC's assigned clinic. BHCs should have same-day availability for warm handoffs and can assess patients at risk and make dispositions regarding the appropriate level of care required. Specialty BH services are also available and should be considered for use as appropriate.

2. INSTALLATION OPTIONS. The following are options, as outlined in Reference (h), for those scoring 10 or greater on the PHQ-9:

a. Health and wellness classes (e.g., stress management) access by beneficiary category may vary.

b. New Parent Support Program for Active Duty and family.

c. Chaplain for Active Duty and family.

d. Military and Family Life Counseling. Supports Service members, their families, and survivors with non-medical counseling worldwide. They provide non-medical, short-term, solution-focused counseling and briefings for circumstances amenable to brief intervention, including, but not limited to, stress and anger management, grief and loss, the deployment cycle, parent-child relationships, couples communication, marital issues, relationships, and relocations based on the needs of the community being served. The counseling approach is psycho-educational, which helps participants learn to anticipate and resolve challenges associated with the military lifestyle. This non-medical support is aimed at preventing the development or exacerbation of BH conditions that may detract from military and family readiness; 1-800-342-9647.

3. OFF-INSTALLATION OPTIONS

a. TRICARE Network Services. These services are available to all beneficiaries. Specialties include, but are not limited to, social workers, psychologists, marriage and family counselors, and psychiatrists. Access will vary depending on provider availability in the local network.

b. Crisis Lines. Available to patients 24 hours a day, 7 days a week. Patients can call the Military Crisis Line (1-800-273-8255, press 1) and/or National Suicide Prevention Lifeline (1-800-273-8255) for assistance related to suicidal thoughts and safety.

4. MILITARY ONESOURCE. Available to Active Duty members and their families 24 hours a day, 7 days a week, it offers a wide range of individualized consultations, coaching, and non-medical counseling for many aspects of military life. Non-medical counseling is supportive in nature and addresses general conditions of living, life skills, improving relationships at home and at work, stress management, adjustment issues (such as those related to returning from a deployment), marital problems, parenting, and grief and loss; 1-800-342-9647, <https://www.militaryonesource.mil/confidential-help/non-medical-counseling/military-onesource/>.

GLOSSARY

ABBREVIATIONS AND ACRONYMS

AHLTA	Armed Forces Health Longitudinal Technology Application
ASQ	Ask Suicide-Screening Questions
BH	behavioral health
BHC	Behavioral Health Consultant
DAD	Deputy Assistant Director
DHA	Defense Health Agency
DHA-AI	Defense Health Agency-Administrative Instruction
MA	Medical Affairs
MILDEP	Military Department
MTF	military medical treatment facility
PCCC	Primary Care Clinical Community
PC-CMT	Primary Care Clinical Management Team
PCM	Primary Care Manager
PCMH	Patient-Centered Medical Home
PCMH-AB	Patient-Centered Medical Home-Advisory Board
PHQ-2	two-item Patient Health Questionnaire
PHQ-9	nine-item Patient Health Questionnaire
TSWF	Tri-Service Workflow