

VHA NATIONAL DUAL CARE POLICY

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes the VHA National Dual Care Policy which delineates a system-wide approach to the coordination and provision of medical care that optimizes the appropriateness, safety, and efficacy of care, medications, prosthetics, and supplies provided to eligible Veterans who are seen by both Department of Veterans Affairs (VA) and community providers.

2. BACKGROUND

a. Each Veteran should have a single assigned primary care provider who oversees all aspects of care. However, some patients choose to see non-VA health care providers as well as VA providers. Common reasons cited for dual care include the desire to use VA comprehensive pharmacy benefits and distance to VA acute and specialty services. Health Services Research and Development (HSR&D) studies have shown a steady increase in dual care among Medicare eligible Veterans from 1997 through 2001. In 2001, 73 percent of VA users who were Medicare eligible also used their Medicare benefits for non-VA health care. Patient characteristics associated with higher rates of dual care include but are not limited to: receiving VA Primary Care at a Community-Based Outpatient Clinic (CBOC); having medical insurance of any type; higher income; and higher level of education.

b. Coordination and continuity of care are core features of high quality primary care. Continuity of primary care has been shown to have significant benefits, including lower rates of hospitalization and lower mortality. By splitting care between two or more health systems and multiple providers, dual care may pose risks to patients. An HSR&D research study of older Medicare eligible patients found increased mortality among dual care patients compared to VA-only users. Another study of patient experiences after stroke found higher rates of re-hospitalization and death among dual care Veterans.

c. Dual care may also contribute to lower professional satisfaction for VA staff. Unlike VA inpatients whose care is managed entirely by VA staff, dual care outpatients may present with requests to VA outpatient staff to obtain medication, tests, or services ordered by non-VA providers. In such situations, VA staff experience concerns regarding legal liability and a sense that their professional skills are devalued.

d. Patients who are recipients of dual care are entitled to the same level of care as other patients. They are eligible for inclusion in the cohorts used in data collection for the various performance measures, monitors, and provider-specific reports implemented by VHA.

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e. Definitions

(1) **Veterans Receiving Dual Care.** Veterans receiving dual care are those who receive ongoing health care in both the community and VA.

(2) **VA Providers.** VA providers are physicians, advanced practice nurses, physician assistants, and other health care professionals who provide primary care or specialty care within the limitations of their individual VA privileges or scopes of practice.

(3) **Community Providers.** Community providers are physicians, advanced practice nurses, physician assistants, and other health care professionals who provide health care to Veterans outside of VA that is not paid for by VA.

(4) **Medication Reconciliation.** Medication reconciliation is the practice of reviewing and documenting all medications (including prescription and over the counter drugs, herbals, and vitamins) that a patient is currently taking from all sources and is completed across the continuum of care as outlined by The Joint Commission National Patient Safety Goal #8.

3. POLICY: It is VHA policy to ensure that the care of Veterans receiving dual care is well coordinated, safe, documented, and appropriate and the professional autonomy and responsibility of VA providers are respected.

4. ACTION

a. **Chief Consultant for Primary Care, Office of Patient Care Services.** The Chief Consultant for Primary Care, Office of Patient Care Services, is responsible for providing national direction and education to support implementation of this Directive.

b. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for ensuring that VISN facilities have dual care policies in place that reflect the content of this Directive.

c. **Facility Director.** The facility Director is responsible for ensuring that:

(1) Patients who receive controlled substances from VA medical centers on a chronic basis are managed by one designated VA provider.

(2) Provision of controlled substances for dual care patients is closely monitored and the patient's care closely coordinated.

(3) Dual care Veterans seeking care, medications, or supplies from VA are enrolled in VHA and have at least one visit per year with a VA provider.

(4) The Veteran is followed and managed by a VA primary care clinician or team, if the Veteran wishes to receive ongoing medication or services for primary care health needs from VA, even if some of the care is provided in the community.

(5) Patients identified as dual care users are educated by the VA provider regarding the risks.

(6) Ensuring the patient and the community provider are notified that except in the instance of fee-basis care and certain provisions in the Millennium Bill and Title 38 United States Code (U.S.C.) for emergency care (see 38 U.S.C. §§ 1725 and 1728 for previously unauthorized non-VA emergency care), VA has no responsibility to pay for testing, medications, or treatment recommended by a non-VA health care provider.

d. **VA Provider.** The VA Provider is responsible for:

(1) Managing the VA care and services that are provided to a patient receiving dual care. The treatment plans must be consistent with the VA National Formulary, VISN, and local processes for obtaining non-formulary agents.

(2) Documenting the list of non-VA providers supplied by the patient in the patient's electronic health record, and coordinating care provided by non-VA providers as made available by the patient and non-VA provider (see Att. A).

(3) Ensuring that medications or diagnostic tests are not ordered for any condition that the VA provider is not managing, or any condition the Veteran does not allow the VA provider to adequately manage.

(4) Ensuring that a treatment or medication plan recommended by community providers is not followed if the VA provider believes the plan is not medically appropriate, or if that plan conflicts with national or local policies related to prescription of non-formulary or restricted medications. The VA provider may, but is not required to, follow recommendations of community providers. When the VA Provider does not follow the recommendations of community providers, the VA provider must communicate the rationale for such decisions and alternative treatment recommendations to the patient. *NOTE: In such cases, the Veteran may use the VA clinical appeals process.*

(5) Communicating the rationale for medication changes or refusal of medications to the Veteran and documenting this communication in the patient's electronic health record.

(6) Prescribing medication and managing the care of the patient for whom the medication is being prescribed within the VA provider's clinical privileges or scope of practice and within the boundaries of the VA provider's clinical expertise. Under no circumstances will a VA provider be permitted to simply re-write prescriptions from an outside provider, unless the VA provider has first made a professional assessment that the prescribed medication is medically appropriate.

(7) Ensuring that when highly-specialized medications (e.g., chemotherapy agents, post-transplant agents, etc.) are being requested by the Veteran, a VA provider with expertise in that specific specialty sees the patient, or the prescribing VA provider is in direct verbal or written contact with a VA specialist, or is acting on the recommendations of a VA specialist. Such communication must be documented in the health record.

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(8) Ensuring that laboratory tests and other necessary monitoring for high-risk medications, such as warfarin, anti-arrhythmics, lithium, chemotherapy, etc., are completed either within or outside VA and documented in the VA patient's electronic health record. If such tests are completed outside of the VA system, the Veteran must provide the results to VA staff and the results are to be documented in the VA patient's electronic health record.

(9) Completing medication reconciliation in accordance with National Patient Safety Goal #8 and local policy including medications prescribed by, or secured outside of, the VA system to diminish the potential safety risk for the dual care patient.

(10) Educating patients identified as dual care users regarding the risks of dual care and the patient's own responsibilities, which are:

(a) Informing their VA provider of all care being provided and medications prescribed by community providers.

(b) Informing the community provider of care being provided through VA. *NOTE: If a provider outside of VA requests medication lists, laboratory results, or other health records, a written request from the outside physician is needed in all instances (see 38 U.S.C. 5702). A signed written authorization by the patient is only required if the records are for conditions related to 38 U.S.C 7332, Protected Health Information, which includes Human Immunodeficiency Virus (HIV), sickle cell anemia, and drug or alcohol abuse. The patient's verbal consent is not acceptable in this circumstance. All disclosures including HIV, sickle cell anemia, and/or drug or alcohol abuse must be tracked and accounted for in the Release of Information (ROI) Records Management software or on a spreadsheet, which is then given to the Privacy Officer for the accounting of the disclosure.*

(c) Supplying the respective VA provider with the names and addresses of all community health care providers that the patient is seeing.

(d) Obtaining all necessary records and documentation from the community provider for use by the VA provider. The patient is responsible for providing the VA provider with written evidence of any treatment plan changes, medication changes, or other changes in care made by the community provider, which must include the reasons for these changes. *NOTE: Costs related to duplication of community records are the responsibility of the Veteran.*

5. REFERENCES

a. Jia H, Zheng Y, Reker DM, Cowper DC, Wu SS, Vogel WB, Young GC, Duncan PW. Multiple system utilization and mortality for veterans with stroke. *Stroke; A Journal of Cerebral Circulation*, 2007 Feb 1; 38(2): 355-60.

b. Wolinsky FD, An H, Liu L, Miller TR, Rosenthal GE Dual use of Medicare and the Veterans Health Administration: are there adverse health outcomes? *BMC Health Services Research* (Electronic Resource <http://www.biomedcentral.com>), 2006 Oct 9; 6: 131.

c. Shen Y, Hendricks A, Li D, Gardner J, Kazis L. VA-Medicare dual beneficiaries' enrollment in Medicare HMOs: access to VA, availability of HMOs, and favorable selection. Medical Care Research and Review, 2005 Aug 1; 62(4): 479-95.

d. Stroupe KT, Hynes DM, Giobbie-Hurder A, Oddone EZ, Weinberger M, Reda DJ, Henderson WG. Patient satisfaction and use of Veterans Affairs versus non-Veterans Affairs healthcare services by veterans. Medical Care, 2005 May 1; 43(5): 453-60.

e. Weeks WB, Mahar PJ, Wright SM. Utilization of VA and Medicare services by Medicare-eligible veterans: the impact of additional access points in a rural setting. Journal of Healthcare Management and American College of Healthcare Executives, 2005 Mar 1; 50(2): 95-106; discussion 106-7.

f. Bean-Mayberry B, Chang CC, McNeil M, Hayes P, Scholle SH Comprehensive care for women veterans: indicators of dual use of VA and non-VA providers. Journal of American Medical Womens Association, 2004 Jul 1; 59(3): 192-7.

g. Borowsky SJ, Cowper DC Dual use of VA and non-VA primary care. Journal of General Internal Medicine, 1999 May 1; 14(5): 274-80.

h. Wasson JH, Sauvigne AE, Mogielnicki RP, Frey WG, Sox CH, Gaudette C, Rockwell A. Continuity of outpatient patient medical care in elderly men. A randomized trial. Journal of the American Medical Association, 1984 Nov 2; 252(17): 2413-7.

i. VHA Handbook 1605.1, Privacy and Release of Information paragraph 9, Accounting of Disclosures.

j. The Joint Commission: National Patient Safety Goal #8: Accurately and completely reconcile medications across the continuum of care.
http://www.jointcommission.org/NR/rdonlyres/5255C16C-25BD-4F67-AFED-624233D21227/0/AHC_NPSG_Outline.pdf

6. FOLLOW-UP RESPONSIBILITY: The Office of Patient Care Services, Chief Consultant for Primary Care (11PC) is responsible for the contents of this Directive. Questions may be addressed to 202-461-7182.

7. RESCISSIONS: VHA Directive 2002-074 dated November 20, 2002, is rescinded. This VHA Directive expires August 31, 2014.

Gerald M. Cross, MD, FAAFP
Acting Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publications Distribution List 8/27/2009

ATTACHMENT A

**SAMPLE LETTER TO COMMUNITY PROVIDERS WHO CARE
FOR DUAL CARE VETERANS**

Dear Colleague,

Some Veterans see non-Department of Veterans Affairs (VA) health care providers in their communities but also receive care from VA. _____(Patient's Name)_____ is requesting to receive medication through VA. VA pharmacies may only fill prescriptions written by VA providers for VA-approved treatment. VA providers are held responsible for the safety and appropriateness of all the medications that they order.

We, at VA, want to meet our mutual patient's needs safely, effectively, and collaboratively. To do this, we need the Veteran's relevant health records to support the prescribed medications and supplies. The records we need include the following:

This medical information can be sent to:

Name
Address

Fax number:

Prescription medications and supplies prescribed by VA providers are limited to those medications included in the VA National Formulary. VA Formulary items are selected when proven to be clinically and cost effective. You can view the VA National Formulary at this internet link (<http://www.pbm.va.gov/NationalFormulary.aspx>). Medications or supplies that are not on the National Formulary are available under certain circumstances. Requests for non-formulary items require documentation that the formulary options have been tried and proven ineffective or are clearly contraindicated.

We encourage patients to provide you with medical information and reports from VA. Copies of VA records can be provided by the patient or obtained from the VA by contacting our Release of Information office at:

_____ (Address) and (Phone Number) _____

We look forward to working with you. If you have any questions, please contact me at _____ (phone number) _____.

Sincerely,

VA Provider
Primary Care Team