Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA HANDBOOK 1101.11(4)
Transmittal Sheet
April 22, 2015

COORDINATED CARE FOR TRAVELING VETERANS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook provides procedures for VHA personnel regarding patient-centered coordination of care for traveling Veterans.

2. SUMMARY OF MAJOR CHANGES: This VHA Handbook provides updated and detailed procedures for the provision of patient-centered, coordination of care for traveling or permanently relocating Veterans.

Amendment dated July 20, 2021:

a. Adds definitions for Designated Traveling Veteran Coordinator (TVC) health care provider, Joint Legacy Viewer, Permanently Relocating Veteran, Traveling/Relocating Veteran Consult, and Traveling/Relocating Veteran Inter-facility Consult (See paragraph 3).

b. Includes care coordination for permanently relocating Veterans.

c. Mandates the exclusive utilization of the national standardized Traveling/Relocating Veteran (T/RV) Consult Template at all sites.

d. Requires adherence to the T/RV Consult Process, as outlined in the Standard Operating Procedure (SOP): Seamless Care for Traveling and Permanently Relocating Veterans Consult Requirements and Guidelines located on the National TVC SharePoint site at: https://dvagov.sharepoint.com/sites/vhacare-coordination-for-traveling-veterans. ***NOTE:*** *This is an internal VA website that is not available to the public.*

e. Requires adherence to the VHA Office of Community Care Field Guidebook which updates the process for community care referrals for traveling Veterans.

f. Includes a new role and responsibilities for the VA medical facility Chief of Staff or Associate Director Patient Care Services, as established by the VA medical facility organizational structure, which includes appointing a Designated TVC health care provider. (See paragraph 5.d.)

g. Updates responsibilities for the TVC, the Patient Aligned Care Teams (PACT) at the Preferred VA medical facility, and the health care provider at the Alternate VA medical facility (See paragraph 5.e., 5.f., 5.g., 5.k., and 5.l.).

h. Includes a new role and responsibilities for the Designated TVC health care provider. (See paragraph 5.m.).

i. Removes Appendix A – D and replaces references to the process flow maps in those appendices with a link to content located on the National TVC SharePoint

site: https://dvagov.sharepoint.com/sites/vhacare-coordination-for-traveling-veterans. ***NOTE:*** *This is an internal VA website that is not available to the public.*

This Handbook:

a. Replaces the "Referral Case Manager" with the Traveling Veteran Coordinator (TVC) as the designated point of contact for coordinating care for traveling Veterans.

b. Mandates that the designated TVC be a Registered Nurse, Physician Assistant, or Licensed Independent Practitioner (LIP).

c. Describes the roles and responsibilities of the TVC.

d. Clarifies the functions of staff at both the preferred facility and alternate (receiving) facility to ensure the coordination of care for traveling Veterans.

e. Provides updated guidance and instructions for dispensing temporary supplies of maintenance medications for traveling Veterans.

f. Provides updated guidance on multi-PACT assignments (previously known as "dual assignments") for traveling Veterans.

g. Includes resources and tools for the Traveling Veteran Coordinator, Patient Aligned Care Teams (PACT), VA medical facilities, and patients.

3. RELATED ISSUES: VHA Directive 1406, Patient Centered Management Module (PCMM) for Primary Care, dated June 20, 2017 and VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

4. RESPONSIBLE OFFICE: The Office of Primary Care (11PC) is responsible for the contents of this directive. Questions related to the Office Primary Care may be addressed at 202-461-6259 or at VHA11PCPrimaryCareAction@va.gov; Pharmacy may be addressed at 202-461-7326, and Prosthetics may be addressed at VHA12RPSRehabandProstheticsAction@va.gov.

5. RESCISSION: VHA Directive 2007-016, dated May 9, 2007, is rescinded.

6. RECERTIFICATION: This VHA Handbook is due to be recertified on or before the last working day of April 2020. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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Under Secretary for Health

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COORDINATED CARE POLICY FOR TRAVELING VETERANS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides procedures for VHA personnel regarding patient-centered coordination of care for traveling or permanently relocating Veterans that addresses how VHA assists Veterans requesting health care during extended travel away from home or when relocating. It provides guidance to maximize continuity and consistent, appropriate, and safe care for traveling or permanently relocating Veterans in coordination with Patient Aligned Care Teams (PACT) and Specialty Care, including mental health care. It streamlines processes Veterans encounter while seeking outpatient services at alternate facilities and eliminates barriers to timely care. ***NOTE:*** *This Handbook does not address formal inpatient transfer of patients from one VA medical facility to another. For inter-facility transfers, see VHA Directive 1094, Inter-Facility Transfer Policy, dated January 11, 2017. This Handbook also does not address foreign travel. For information about medical care during foreign travel, see VHA Handbook 1601F.05, Hospital Care and Medical Services in Foreign Countries, dated April 1, 2016. For traveling Veterans seeking care at the VA facility in the Philippines, please refer to 38 U.S.C. § 1724 for eligibility requirements and VHA Directive 1521, Outpatient Health Care for United States Veterans Residing In or Visiting the Philippines at the Department of Veterans Affairs Clinic in Manila, dated February 5, 2018.* **AUTHORITY:** 38 U.S.C. §§ 1705-1706, 1710, and 7301(b); 38 C.F.R. §§ 17.35, 17.36.

2. BACKGROUND

a. Traveling and permanently relocating Veterans are expected to receive the same standard of care while traveling or permanently relocating even when not assigned to a PACT at the alternate facility. After initial enrollment occurs, Veterans are eligible to receive health care benefits at any facility where Department of Veterans Affairs (VA) services are offered once registered at that facility.

b. PACTs and other health care teams at the preferred facility are instrumental in educating and guiding the traveling or permanently relocating Veteran so that both Veterans and their health care teams can anticipate care needs and coordinate care at the alternate facility in conjunction with the Traveling Veteran Coordinator (TVC).

c. The TVC, formerly known as the Referral Case Manager, works with the PACT or specialty care providers to coordinate care between the preferred and the alternate facility for Veterans on extended travel or permanently relocating.

3. DEFINITIONS

a. **Alternate Facility.** An alternate facility is a VA medical facility at which a Veteran will receive care, as needed, while on extended travel (including community-based outpatient clinics (CBOC) associated with the alternate facility). Care at the alternate facility does not constitute the major portion of a Veteran’s primary care.

b. **Bridge Supply of Medications.** Bridge supply of medication is a one-time, temporary supply of maintenance medications, generally 10 to 15 days' worth, to ensure availability of maintenance medications until the patient can receive a renewal or refill prescription from the preferred facility.

c. **Designated TVC Health Care Provider.** The Designated TVC health care provider is a health care provider (Advanced Practice Registered Nurse (APRN), physician assistant (PA), or physician) at the Alternate VA medical facility, designated by the VA medical facility Chief of Staff or Associate Director for Patient Care Services, to collaborate with the Alternate VA medical facility Traveling Veteran Coordinator.

d. **Enrollment.** Enrollment occurs once in the VA system, at which time eligibility is verified, a priority group is assigned, and a preferred facility is determined. The enrollment process can occur in-person at the VA medical facility, by telephone, or online.

e. **Electronic health record.** Electronic health record (EHR) is the digital collection of patient health information resulting from clinical patient care, medical testing, and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software including Computerized Patient Record System (CPRS), Veterans Information Systems and Technology Architecture (VistA), and Cerner platforms.

f. **Extended Travel.** Extended travel is a type of travel in which a Veteran travels away from the preferred facility and requires coordinated care with an alternate facility. This need for coordinated care is typically due to either complex clinical needs and/or a prolonged period of time away from the Veteran's principal residence.

g. **Joint Legacy Viewer.** Joint Legacy Viewer (JLV) provides a comprehensive, customizable view of EHR information from all VA, Department of Defense (DoD), and community health information exchange partner facilities where a Veteran has received care.

h. **Lead Coordinator.** The Lead Coordinator is a facility designated RN or social worker assigned to Veterans requiring complex care coordination or specialized case management services (e.g., Operation Enduring Freedom-Operation Iraqi Freedom-Operation New Dawn (OEF-OIF-OND), Serious Mental Illness, SCI/D, and Blind and Vision Rehabilitation Continuum of Care, etc.). The Lead Coordinator serves as the primary point of contact these Veterans and their families or caregivers and communicates with the health care team while leading complex care coordination and case management efforts. (See VA Directive 0007, Interagency Coordination of Complex Care, Benefits, and Services, dated December 24, 2014, and the MOU between VA and DoD for Interagency Complex Care Coordination Requirements for Service Members and Veterans, dated July 29, 2014 at: https://www.health.mil/Reference-Center/Policies.)

i. **Multi-PACT Assignment.** A multi-PACT assignment (previously known as "dual assignment") is a primary care panel assignment status where a patient has been approved for assignment to more than one PACT.

j. **Non-face-to-face Care.** Non face-to-face care is care that is provided in a modality other than face-to-face in a clinical setting (e.g., telephone-based care, telehealth, secure messaging, etc.).

k. **Patient Aligned Care Team.** The Patient Aligned Care Team (PACT) is a team of health care professionals that provides comprehensive primary care in partnership with the patient (and the patient's personal support person(s) (i.e., caregiver)) and manages and coordinates comprehensive health care services consistent with agreed upon goals of care. This includes PACTs for special populations (e.g., GeriPACT, Homeless PACT, and Spinal Cord Injury/Disorder (SCI/D) PACT).

l. **Permanently Relocating Veteran.** A permanently relocating Veteran is a Veteran who is registered at a VA medical facility and is permanently relocating to another geographic location resulting in the need to transfer care to another VA medical facility.

m. **Preferred Facility.** A preferred facility is the VA medical facility that a Veteran selects as the principal site for receiving VA care and consequently, where the major portion of the Veteran's primary care is provided (including CBOCs associated with the preferred facility).

n. **Provider.** Providers are physicians, advanced practice registered nurses (APRN), Physician Assistants (PA), clinical pharmacists, and dentists who provide primary or specialty care to Veterans in accordance with licensure, scope of practice, or functional statement.

o. **Traveling Veteran.** A traveling Veteran who is registered at a VA medical facility and who is preparing to embark on or has embarked upon extended travel (see paragraph 3.d. above) away from his or her primary residence and preferred facility.

p. **Traveling/Relocating Veteran Consult.** A Traveling/Relocating Veteran (T/RV) Consult is an internal consult placed by the VA health care provider (APRN, PA, or physician) to coordinate clinically indicated care for a traveling or permanently relocating Veteran.

q. **Traveling Veteran Coordinator.** A Traveling Veteran Coordinator (TVC) is a Registered Nurse (RN), PA, or LIP who coordinates necessary or ongoing health care for Veterans on extended travel (see paragraph 3.d. above).

r. **Traveling/Relocating Veteran Inter-Facility Consult.** The Traveling Veteran Inter-facility Consult (T/RV IFC) is a T/RV consult that is forwarded electronically by the TVC within the EHR to coordinate care between the Preferred and Alternate VA medical facilities. ***NOTE:*** *This excludes non-traveling Veterans requiring VA health care services*

at another VA medical facility which require formal consultations. See VHA Directive 1232(3), Consult Processes and Procedures, dated August 24, 2016.

s. **VA Provider File.** A VA Provider File is Veterans Health Information and Technology Architecture (VistA) file #200 (also known as the New Person file) that includes all identified providers (or mid-level providers) that have been credentialed at the local VA medical facility and authorized to prescribe medications under licensure or scope of practice. This file is not transferrable between VA locations.

t. **VistA's Register Once Messaging.** VistA's Register Once Messaging (ROM) is a computer program that registers Veterans new to a facility by accessing information from other VHA facilities. A Veteran must be registered at each VA medical facility where they are seeking care.

4. SCOPE

It is VHA policy that traveling and permanently relocating Veterans will have their anticipated or unexpected medical needs coordinated by their preferred facility and the alternate facility to prevent any disruption in their care. This is a shared responsibility between the preferred and alternate facilities to ensure continuity of care.

5. RESPONSIBILITIES

a. **Executive Director for VHA Office of Primary Care.** The Executive Director for VHA Office of Primary Care is responsible for oversight and implementation of this handbook.

b. **Veterans Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is responsible for ensuring that:

(1) There is a designated VISN point of contact (POC) for both the TVC and Primary Care Management Module (PCMM) whose name(s) and contact information are included in the VHA Support Service Center (VSSC) National PCMM TVC list.

(2) The VISN Traveling Veteran POC:

(a) Maintains and updates VSSC to keep the list current at: http://vssc.med.va.gov/pcmm/. ***NOTE:*** *This is an internal VA Web site and is not available to the public.*

(b) Ensures there is a TVC designated for each VA medical facility in the VISN.

(c) Facilitates TVC interaction with VA medical facilities if network intervention is required.

(3) There is a back-up VISN POC identified in VSSC for each VISN POC.

c. **<u>VA Medical Facility Director</u>.** The VA medical facility Director is responsible for ensuring that:

(1) The care for traveling or permanently relocating Veterans is expedited and delivered in a timely, coordinated, and patient-centered manner.

(2) The VA medical facility uses VistA's Register Once Messaging (ROM) functionality to register patients who have enrolled at other facilities by ensuring that Business Office staff are available to complete this function at all times, including weekends and off-hours.

(3) Joint Legacy Viewer (JLV) capabilities in the facility's EHR are activated to facilitate data retrieval between VA facilities and that appropriate staff members have necessary access to these capabilities.

(4) The VA medical facility exclusively utilizes the national standardized Traveling/Relocating Veteran (T/RV) Consult Template and Process, as outlined in the Standard Operating Procedure (SOP): Seamless Care for Traveling and Permanently Relocating Veterans Consult Requirements and Guidelines and T/RV Flow Maps, to coordinate care for traveling and permanently relocating Veterans across VA medical facilities. The SOP and T/RV Flow Maps are located on the National TVC SharePoint site at: https://dvagov.sharepoint.com/sites/vhacare-coordination-for-traveling-veterans.

(5) The VA medical facility has at least one designated TVC to serve as the POC for assisting Veterans and medical facility staff in scheduling appointments; transferring non-electronic records; arranging provider-to-provider contact, if necessary; and generally facilitating the care needs of traveling and permanently relocating Veterans seeking care at alternate VA medical facilities. ***NOTE:*** *The roles and responsibilities of the TVC are outlined in paragraphs 5.e., 5.f., and 5.g.*

(6) The designated TVC:

(a) Is an RN, PA or LIP.

(b) Has Public Key Infrastructure (PKI) access. ***NOTE:*** *Encryption is <u>mandatory</u> for TVCs, to facilitate communication and follow-up.*

(c) TVCs without prescriptive authority, such as RNs, may enter orders for provider signature as permitted by local policy <u>or</u> have a designated provider at their VA medical facility enter orders/consults/etc.

(d) Is identified on the National PCMM/TVC list. The list will be kept current by providing any edits/changes to the VISN TVC POC, who maintains the list for VA medical facilities in that VISN.

(7) A back-up TVC is identified on the VSSC list for each VA medical facility as the emergency/alternate contact to provide coverage, in the absence of the designated facility TVC. ***NOTE:*** *At a minimum, TVCs will identify who is covering for them during*

times of leave – communication can be via Outlook out of Office Assistant and voicemail message.

(8) The VA medical facility has a policy in place that outlines procedures by which traveling and permanently relocating Veterans will receive care coordination and encompasses the elements within this Handbook.

(9) Multi-PACT assignments (previously known as “dual assignments”) to primary care panels in PCMM at preferred and alternate facilities are avoided. Such multiple entries inflate the number of patients present in each provider’s panel, resulting in increased workload for PCMM staff and increased risk for error, particularly when frequent PCMM changes are needed to track the Veteran’s travel status. For that reason, VHA policy states that, in general, patients must have only one PACT within the VA health care system (see VHA Directive 1406, Patient Centered Management Module (PCMM) for Primary Care, dated June 20, 2017).

(a) Exceptions may be approved under two circumstances:

1. Veterans with SCI&D who are receiving highly-complex dual care (such as in a “hub and spokes” system of care) may be assigned two PACTs at the two facilities of SCI&D care. These Veterans may be assigned to a PACT at both the SCI referral center (Hub) and at their own local VA medical facility (Spoke).

2. If a Veteran receives care between two facilities of residence (i.e., south in winter, north in summer) and requires complex PC management (as assessed by the PC clinical leader, or designee, at the patient’s preferred facility), the Veteran may be assigned an identified PACT at each of the geographically distant residences.

(b) Traveling Veterans who do not meet the criteria for the two exceptions or who require only episodic care while traveling should not be assigned a second PACT.

(c) To determine whether a traveling Veteran needing complex primary care management requires a multi-PACT assignment to a PACT at an alternate facility, clinical approval by the PCP, or designee, and coordination with the TVC at both the preferred and alternate facilities is required. Clinical review/approval of multi-PACT assignments must be documented. Potential scenarios may include:

1. If a traveling Veteran provides advance notice to the PACT at the preferred facility of anticipated or planned travel, the PCP, or designee, will contact the TVC (at the preferred facility) to initiate communication with the alternate facility TVC and PC clinical lead or designee. The PCP, or designee, from the preferred and alternate facilities will reach a consensus on whether the traveling Veteran requires a multi-PACT assignment. If the determination is supported, the preferred facility will make the multi-PACT assignment to the alternate facility PACT in PCMM.

2. If a traveling Veteran arrives at an alternate facility without advance travel notification, the traveling Veteran is provided with an appointment with the alternate facility PACT for care and clinical determination for multi-PACT assignment. If the

alternate facility PACT feels that the patient may benefit from a multi-PACT assignment, the PCP, or designee, will contact the TVC at the alternate facility. The alternate facility TVC will initiate communication with the preferred facility TVC and PC clinical lead or designee. The PCP, or designee, from the alternate and preferred facilities will reach a consensus on whether the traveling Veteran requires a multi-PACT assignment (consistent with VHA Directive 1406). If the determination is supported, the alternate facility will make the multi-PACT assignment to the alternate facility PACT in PCMM.

(d) Patients who are traveling and do not require multi-PACT assignments should primarily be managed by their preferred facility PACT using non-face-to-face care modalities as much as possible. Assignment of traveling Veterans to a local PACT at the alternate facility is not a prerequisite for receiving primary or specialty care at the alternate facility.

(10) Procedures and education are emphasized to ensure that patients and facility staff are aware of elements, policy, and procedures established by this Handbook and implemented at the VA medical facility level. It is of utmost importance that an educational plan be established at the VA medical facility to educate patients about their responsibilities and proper procedures to perform prior to extended travel. This includes, but is not limited to, knowledge on obtaining adequate supplies of medications (as appropriate), understanding how to contact their preferred facility TVC and PACT team when necessary, and providing the preferred facility with a temporary address and local contact information while on extended travel. This education can occur through the PACT (see paragraph 5.i.(1) or via other means [e.g., Specialty Care and others] if the patient is not assigned to a PACT.

(11) The VA medical facility selects one of two options to provide a maintenance medication to the traveling Veteran.

(a) Option 1 allows referral of the traveling Veteran to a VA provider that is designated to prescribe medications.

(b) Option 2 allows the medical facility to develop policy which allows clinical pharmacists (not authorized to prescribe) to dispense a bridge supply of maintenance medications for visiting patients. ***NOTE:*** *It is highly recommended that VA medical facilities utilize Option 2 because it reduces the need for an unscheduled or urgent visit to a VA provider.* It is important that the facility ensure there is no delay for Veterans to receive prescription medication, when necessary for their care. If Option 2 is selected, the policy must contain the following elements:

1. The clinical pharmacist will view JLV data to verify that a valid VA prescription for the maintenance medication exists and there are no allergies or drug interactions. For a prescription that is no longer valid or all refills have been exhausted, the clinical pharmacist must verify that the patient has a documented history of chronic treatment with the medication.

2. The policy will allow clinical pharmacists to dispense a bridge supply to the traveling Veteran that will be entered into VistA as a policy order.

3. The policy will identify a designated VA provider to be utilized for all policy orders written by the clinical pharmacist. This VA provider must be a physician and be authorized to prescribe medications at the facility. The clinical pharmacist must notify the designated VA provider that the bridge supply has been dispensed and the policy order has been entered into the EHR. ***NOTE:*** *It is recommended that this designated VA provider be utilized throughout the VA medical facility for all traveling Veterans.*

4. The designated VA provider must review JLV to ensure that continued therapy is monitored and policy orders written by clinical pharmacists are appropriate for the patient. The designated VA provider also must ensure that all policy orders, assessments, treatment recommendations and other related data at the alternate facility are documented clearly in EHR so they may be viewed on JLV at the preferred facility.

5. The originating facility VA provider (typically the patient's PCP from the preferred facility) shall be listed on each prescription by the clinical pharmacist by placing the provider's name and VA medical facility in the comments section of the prescription order or on the labeled prescription instructions.

6. The policy must exclude the provision of controlled substances schedules II-V. In addition, the policy must also exclude medications whose automatic extension raises medication safety concerns and requires a patient assessment, such as medications requiring close laboratory monitoring. For these categories of refill or renewal requests, the clinical pharmacist must direct the patient to the appropriate provider (as in Option 1 above), medical clinic, or emergency room for evaluation.

7. The policy will define clinical circumstances when referrals to higher levels of care are appropriate.

8. The policy should be approved through the appropriate facility oversight committee to include the Pharmacy and Therapeutics Committee and the Medical Executive Committee.

(12) When traveling Veterans register at alternate facilities, they are educated by the alternate facility TVC on how to obtain care from that facility. For example: Veterans seeking bridge supplies of medications they are currently receiving are advised to go directly to the appropriate location as determined by the medical facility.

(13) The VA medical facility supports the laboratory monitoring requirements for prescriptions, including anticoagulation International Normalized Ratio (INR) monitoring, substance abuse urine screening requirements, therapeutic drug level screening levels, and other necessary laboratory studies such as Chemistry Panels or Complete Blood Counts (CBC) as requested by the preferred facility. This care will be coordinated by the respective facility TVC. It is the responsibility of the ordering provider, to notify the Veteran of the test results within 14 days.

(14) Care for the traveling Veteran is carefully coordinated to ensure a seamless continuation of services. This may require one or more services provided through a Community Care contract or sharing agreement. For example, Veterans who need maternity services or specific specialty care that is not available at the alternate facility must be provided with continuous, coordinated coverage during travel as medically appropriate.

(a) The alternate facility is typically responsible for initiating the community care process and entering the community care authorization. The alternate facility is also responsible for coordinating the community care services for the traveling Veteran and for paying any claims for services rendered.

(b) However, for traveling Veterans in need of home health care (i.e. purchased skilled home care, homemaker/home health aide, and Veteran Directed Care) or hospice services, the responsibility for care coordination, authorization and obligation of funds varies depending on where the Veteran receives primary care.

1. If the traveling Veteran receives primary care from the VA facility making the referral for home health care services, that VA facility maintains financial and follow-up for the episode of home health care. (See VHA Handbook 1140.6, Purchased Home Health Care Services Procedures).

2. If the traveling Veteran does ***not*** receive primary care from any VA facility and is placed with home health care or home hospice agencies outside of the Veteran's Primary Service Area, the VA facility or VISN making the placement must authorize care and must obligate funds for a period of time not to exceed 30 days. If home health care or hospice services are expected to exceed 30 days, Veteran responsibility transfers to the VA facility and/or VISN located in the service area where the Veteran is placed. (See VHA Handbook 1140.6, Purchased Home Health Care Services Procedures).

(15) There is an established and uniform system at each VA medical facility to capture the information required of traveling Veterans prior to their departure (i.e., temporary address, phone number, and dates of travel).

d. **VA Medical Facility Chief of Staff or Associate Director for Patient Care Services.** The VA medical facility Chief of Staff or Associate Director for Patient Care Services, as established by the VA medical facility organizational structure, is responsible for:

(1) Ensuring there is at a minimum, one designated TVC health care provider and one back up TVC health care provider for the TVC program to ensure orders are written follow up and support are available to the TVC, noting there may be more than one health care provider that is the accountable health care provider of record depending on care continuation needed. ***NOTE:*** *VA medical facilities may require additional designated staff based on VA medical facility demands (e.g., traveling Veteran program workload: T/RV Consults, PCMM actionable alerts, number of traveling Veterans, etc.)*

or if the VA medical facility is located in a high travel area. TVCs using nursing protocols does not negate the designated TVC health care provider(s) role.

(2) Ensuring there is a contingency plan in place for designated TVC health care provider coverage during planned and unplanned absences.

e. **Traveling Veteran Coordinator.** The TVC, at the alternate and preferred VA medical facilities are responsible for:

(1) Coordinating care between the alternate and preferred VA medical facilities for traveling and permanently relocating Veterans.

(2) Following the T/RV Consult Process, as outlined in the SOP: Seamless Care for Traveling and Permanently Relocating Veterans Consult Requirements and Guidelines and associated T/RV Flow Maps (as indicated) to ensure seamless coordination of care for traveling and permanently relocating Veterans. The SOP and T/RV Flow Maps are located on the National TVC SharePoint site at: https://dvagov.sharepoint.com/sites/vhacare-coordination-for-traveling-veterans. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(3) Developing and cultivating a network of support staff at their own VA medical facility that can assist in care coordination, particularly of specialty services.

(4) Engaging and collaborating with the VA medical facility Lead Coordinator, as needed, when coordinating care for traveling and permanently relocating Veterans who require complex care coordination or specialized case management services (e.g., Operation Enduring Freedom-Operation Iraqi Freedom-Operation New Dawn (OEF-OIF-OND), Serious Mental Illness, SCI/D, and Blind and Vision Rehabilitation Continuum of Care). (See VA Directive 0007, Interagency Coordination of Complex Care, Benefits, and Services and VHA Directive 1010, Transition and Care Management of Ill or Injured Servicemembers and New Veterans, dated November 21, 2016.)

(5) Working with the local Community Care Program Offices to provide clinical input and coordinate care for traveling and permanently relocating Veterans who require medical services not available at the alternate VA medical facility. For example, Women Veterans receiving community maternity care and prenatal care are able to continue such care (including obstetrical services if necessary) at the extended travel location. (See VHA Handbook 1330.03, Maternity Health Care and Coordination). If the Veteran is eligible, community care arrangements must be made in advance of the Veteran's travel to ensure seamless transition of care. ***NOTE:*** *For specific guidance on coordinating community care for traveling and permanently relocating Veterans in need of home health care or hospice services, see paragraph 5.b.(14) and VHA Handbook 1140.6, Purchased Home Health Care Services Procedures.*

(6) Completing the responsibilities as assigned in paragraph 5.f. if at the preferred VA medical facility or 5.g. if at the alternate VA medical facility.

f. **Traveling Veteran Coordinator at the Preferred VA Medical Facility. I**n addition to the responsibilities listed in paragraph 5.e., the TVC at the preferred VA medical facility is responsible for:

(1) Contacting traveling Veterans to discuss care needs and to obtain additional information, as needed.

(2) Coordinating and verifying with the PACT administrative associate or other assigned health administration section (HAS) staff that the Veteran's demographic information (temporary address, phone number, etc.) is updated in the Veterans Health Information Systems and Technology Architecture (VistA) system, as referred to in VHA Directive 1604, Data Entry Requirements for Administrative Data.

(3) Using the Facility Locator Tool, located at: https://www.va.gov/find-locations, to identify which VA medical facility is nearest to where the Veteran will be traveling, based upon the zip code provided with the temporary address. The Veteran must be included in this process, especially when there are multiple facilities in close proximity, to determine the VA medical facility he/she prefers.

(4) Identifying the TVC at the alternate facility, based upon the VSSC national listing.

(5) Communicating with the TVC at the alternate VA medical facility to obtain or send information to coordinate care for Traveling Veterans. ***NOTE:*** *If care needed is time sensitive, contact the alternate VA medical facility TVC by phone, in addition to electronic communications.*

(6) Communicating the outcome of the care coordination back to the requesting provider.

g. **Traveling Veteran Coordinator at the Alternate (Receiving) VA Medical Facility. I**n addition to the responsibilities listed in paragraph 5.e., the TVC at the alternate VA medical facility (receiving) is responsible for:

(1) Acknowledging receipt of the referral, sending confirmation to the preferred facility TVC, and requesting any additional information that is needed.

(2) Facilitating the registration of the Veteran if the Veteran is not already registered.

(3) Entering orders or facilitating order entry by the designated licensed independent practitioner (LIP). Requested care is arranged by entering orders or having the designated provider enter orders for appropriate tests needed at the request of the PACT at the preferred facility.

(4) Communicating with specialty services, as needed, to facilitate care and coordinate appointments.

(5) Contacting the Veteran, as needed, to clarify any information and to communicate care coordination efforts and appointments. Veterans must be informed of care coordination efforts and appointments (e.g., Anticoagulation monitoring, weekly or monthly injections, infusions, imaging studies, Specialty Clinic Consults for specified clinical indications, chemotherapy/radiation oncology continuation or initiation, dialysis, brachytherapy, or home oxygen, etc.).

(6) Communicating via telephone or through sending encrypted messages to the preferred facility TVC outlining care coordination efforts and appointment information.

(7) Documenting care coordination in EHR.

(8) Identifying clinical staff that can provide clinical care, if needed, for unexpected but potentially urgent health care needs for Veterans.

h. **VA Medical Facility Chief of Community Care Office at the Alternate VA Medical Facility.** The VA Medical Facility Chief of Community Care Office at the Alternate VA medical facility is responsible for:

(1) Coordinating the community care referral review process for traveling Veterans who require health care services that are not available at the alternate facility in accordance with VHA Office of Community Care (OCC) Field Guide Book (see OCC Web site: https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx). ***NOTE:*** *This is an internal VA Web site not available to the public.*

(2) Performing an administrative eligibility review of the community care referral, upon receipt of a community care referral in EHR. The administrative eligibility review involves verifying the administrative eligibility and enrollment status of the traveling Veteran for VHA care.

(3) Performing a clinical review of the community care referral, with input from the TVC, upon receipt of a community care referral in EHR. The clinical review will involve determining the availability of services, applying medical necessity criteria, and, if required by local processes, obtaining second level approval.

(4) Alerting appropriate Community Care Office team member(s) to enter the authorization and schedule the appointment for the traveling Veteran in the event the community care referral is both administratively and clinically approved. The authorized service(s) must be arranged in a timely manner utilizing established procedures and care will be provided near the Veteran's extended travel location. The subsequent claims for services rendered are the responsibility of the alternate facility.

(5) Informing the TVC of the status and approval or denial of community care referrals submitted for traveling Veterans.

i. **Facility Chief of Pharmacy.** The facility Chief of Pharmacy is responsible for ensuring that:

(1) Pharmacy staff complies with the medical facility's selected option for providing prescriptions to traveling Veterans (see paragraph 5.b.(11)).

(2) Prescriptions written are filled by the VA medical facility or the assigned Consolidated Mail Outpatient Pharmacy (CMOP). Urgent prescriptions written by a VA provider (Option 1) may be filled at a VA medical facility or community pharmacy under contract (such as in CBOCs without a dispensing pharmacy), as appropriate.

(3) Traveling Veterans are instructed to enter a temporary address at their preferred facility and request prescription refills from the preferred facility through use of the automated refill request line, a refill request form, the internet refill request option in My HealtheVet, or by phoning the preferred facility's outpatient pharmacy during normal business hours prior to traveling.

(4) If Option 2 is selected, a templated policy for providing bridge supplies of medications is available (see Appendix A) to help guide clinical pharmacists in responding to medication needs of traveling Veterans. The policy should contain all elements outlined in paragraph 5.b.(11) and circumstances for providing bridge prescriptions to traveling Veterans (see Appendices A and B). If the patient expresses any health-related complaints or the clinical pharmacist's assessment determines the need for immediate evaluation by a higher level of care, then the patient must be directed to a clinic or emergency room to be evaluated by a provider. In addition, the Chief of Pharmacy must ensure quality assurance reviews are conducted, no less than annually, to ensure prescriptions that use the designated VA provider (Option 2) are reviewed, appropriate, and are according to VA medical facility policy.

(5) Every effort is made to ensure that a Veteran requiring a prescription refill while on travel receives the medication without any disruption in therapy.

(a) Access to a clinical pharmacist, even during peak business hours, by walk in, and by telephone needs to be an established standard in local VA medical facility policy.

(b) If the Veteran resides at a temporary address, routine prescription refills and those not required to treat an emergent condition must be processed and sent to the Veteran by the preferred facility, preferably using CMOP. It is the responsibility of all preferred facility staff to inform PC patients that they need to provide a temporary address, phone number, and dates of travel to the preferred facility's eligibility office or other appropriate staff prior to extended travel (see AppendicesC and D).

(c) Clinical pharmacists are to assist the Veteran in requesting refills from the preferred facility pharmacy and in notifying appropriate personnel of the temporary address so that it can be entered in VistA if necessary. ***NOTE:*** *The preferred facility pharmacy should make every effort to expedite prescription delivery when necessary to ensure patient adherence.*

j. **Facility Chief of Prosthetics.** The facility Chief of Prosthetics is responsible for ensuring that:

(1) When needing repair to a VA-issued prosthetic appliance or device, traveling Veterans should seek care at an alternate VA facility. The prosthetic staff at the alternate facility calls the prosthetics staff at the Veteran's preferred facility and confirms that the appliance or device was provided by that facility. The alternate facility will initiate a purchase order and the service will be authorized and provided. Alternatively, if capabilities exist, the item may be repaired by VA staff according to local policy and procedure. Prosthetics staff at the alternate facility will notify the prosthetics staff at the Veteran's preferred facility to document the repair in the Veteran's Prosthetic Record.

(2) When a traveling Veteran requires a new or replacement item or device to be issued, the Veteran must register at the alternate facility. The Veteran may be referred to urgent care or other clinics for any needed clinical evaluation and to have a consult generated by a clinician at the alternate facility.

(3) When a traveling Veteran is prescribed oxygen for use in the home or ambulatory setting, the Program Clinical Practice Recommendations for the Use of Supplemental Oxygen is to be followed (see http://www.prosthetics.va.gov/Docs/CPR_HomeOxygen.pdf). ***NOTE:*** *This linked document is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*

(4) A traveling Veteran is responsible for transporting or arranging the delivery or shipment of the prosthetic device issued from the preferred facility to the Veteran's traveling location. During traveling or stay at a temporary residence, a duplicate or replacement of a prior issued device from a preferred facility will not be ordered or provided for the Veteran unless it is determined to be medically urgent by a VA clinician at the alternate facility.

(5) Traveling Veterans will not be eligible for Home Improvements and Structural Alterations (HISA) grants during traveling or stay at a temporary residence.

(6) Questions or inquiries regarding services and/or equipment covered during foreign travel should be addressed by the Foreign Medical Program (FMP). See VHA Handbook 1601F.05, Hospital Care and Medical Services in Foreign Countries.

k. **Patient Aligned Care Team at the Preferred VA Medical Facility.** The assigned Patient Aligned Care Team (PACT), Primary Care or Special Population, at the preferred VA medical facility is responsible for ensuring that:

NOTE: *If the traveling Veteran is not assigned to a PACT at a preferred facility (i.e. receiving primary care in the community and only receiving specialty care or mental health care at VA), the specialty care or mental health care provider at the preferred facility is responsible for the tasks listed below:*

(1) The Veteran is educated in:

(a) Informing a member of his or her PACT (or their specialty care or mental health care provider, if not assigned to a PACT) if a period of extended travel is anticipated or

planned and to provide a temporary address, telephone number, and dates of travel. (See Appendices C, D and E for samples of educational tools).

(b) Contacting the PACT (or their specialty care or mental health care provider, if not assigned to a PACT) at the preferred facility for issues that do not require immediate medical attention even after embarking on extended travel. (See Appendices C, D, and E for samples of educational tools).

(2) The Veteran's EHR contains current medication and problem lists.

(3) Determining whether the traveling Veteran is experiencing a planned or unplanned episode of care and following the SOP: Seamless Care for Traveling and Permanently Relocating Veterans Consult Requirements and Guidelines and corresponding T/RV flow map on the National TVC SharePoint site at: https://dvagov.sharepoint.com/sites/vhacare-coordination-for-traveling-veterans. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(4) Determining care coordination needs of permanently relocating Veterans and following the Traveling Veteran and Permanently Relocating Veteran Consult SOP when the Veteran alerts their PACT team of a recent or planned residential relocation. See SOP: Seamless Care for Traveling and Permanently Relocating Veterans Consult Requirements and Guidelines on the National TVC SharePoint site at: https://dvagov.sharepoint.com/sites/vhacare-coordination-for-traveling-veterans. ***NOTE:*** *The T/RV Consult can facilitate but is not a prerequisite for PC reassignment. This is an internal VA website that is not available to the public.* ***NOTE:*** *This is an internal VA website that is not available to the public.*

(5) Reviewing care documented by the Alternate VA Medical Facility for traveling or permanently relocating Veterans in JLV, if available, or EHR.

(6) The PACT (or specialty care or mental health care provider, if the Veteran is not assigned to a PACT) at the preferred facility has primary responsibility for renewals of routine medications, including controlled substances. Only under extenuating circumstances, such as uncertain current health status with a need for concurrent evaluation, should the Veteran be directed to seek care through the closest VA medical facility. The PACT (or specialty care or mental health care provider, if not assigned to a PACT) at the preferred facility should help facilitate that evaluation, as necessary.

l. **Health Care Provider at the Alternate VA Medical Facility.** Whether in primary care or specialty services, the health care provider delivering care to a traveling or permanently relocating Veteran at the at the alternate VA medical facility is responsible for ensuring that:

(1) Collaborating with the alternate facility TVC to ensure seamless care transitions by providing clinical care for traveling and permanently relocating Veterans.

(2) Reviewing the T/RV IFC, JLV, and the electronic health record, when necessary.

(3) Transitioning care appropriately back to the preferred facility health care provider for ongoing care needs when the Veteran returns from travel to the Preferred VA medical facility following the SOP: Seamless Care for Traveling and Permanently Relocating Veterans Consult Requirements and Guidelines and T/RV Flow Maps located on the National TVC SharePoint site at: https://dvagov.sharepoint.com/sites/vhacare-coordination-for-traveling-veterans. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(4) Participating in health care provider-to-provider communication (e.g., handoffs), when necessary.

m. **Designated TVC Health Care Provider.** The designated TVC health care provider is a health care provider (APRN, PA or physician) at the Alternate VA medical facility, designated by the VA medical facility Chief of Staff or Associate Director for Patient Care Services, to collaborate with the Alternate VA medical facility TVC. The Designated TVC health care provider at the Alternate VA medical facility is responsible for:

(1) Collaborating with the alternate facility TVC to ensure seamless care transitions for traveling and permanently relocating Veterans.

(2) Ordering clinical care as requested by the preferred facility health care provider via the T/RV consult process for traveling and permanently relocating Veterans. ***NOTE:*** *If a community care referral is indicated, the Alternate VA medical facility will be responsible for placing the Community Care consult per local processes.*

(3) Reviewing the T/RV IFC, JLV, and the electronic health record, when necessary.

(4) Participating in health care provider-to-provider communication (e.g., handoffs), when necessary.

(5) Communicating outpatient test results to traveling and permanently relocating Veterans in accordance with VHA Directive 1088, Communicating Test Results to Providers and Patients, dated October 7, 2015. ***NOTE:*** *See the Traveling and Permanently Relocating Veteran Consult Process: Diagnostic Test Result Reporting Flow Map on the National TVC SharePoint at: https://dvagov.sharepoint.com/sites/vhacare-coordination-for-traveling-veterans. This is an internal VA website that is not available to the public.*

(6) Communicating to the alternate facility TVC when clinical care is ordered at the Alternate VA medical facility.

6. REFERENCES

(1) VA Directive 0007, Interagency Coordination of Complex Care, Benefits, and Services, dated December 24, 2014.

(2) VHA Directive 1088, Communicating Test Results to Providers and Patients, dated October 7, 2015.

(3) VHA Directive 1601A.01, Registration and Enrollment, dated July 7, 2020.

(4) VHA Directive 1521, Outpatient Health Care for United States Veterans Residing In or Visiting the Philippines at the VA Clinic in Manila, dated February 4, 2018.

(5) VHA Directive 1601, Non-VA Medical Care Program, dated January 22, 2013.

(6) VHA Directive 1601F.05, Hospital Care and Medical Services in Foreign Countries, dated March 31, 2016.

(7) VHA Directive 1604, Data Entry Requirements for Administrative Data, dated April 21, 2016.

(8) VHA Directive 1406, Patient Centered Management Module (PCMM) for Primary Care, dated June 19, 2017.

(9) VHA Directive 1010, Transition and Care Management of Ill or Injured Servicemembers and New Veterans, dated November 21, 2016.

(10) VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook, dated February 4, 2014.

(11) VHA Handbook 1108.11, Clinical Pharmacy Services, dated June 20, 2015.

(12) VHA Handbook 1140.6, Purchased Home Health Care Services Procedures, dated July 21, 2006.

(13) VHA Prosthetic Clinical Management Program (PCMP) Clinical Practice Recommendations Home Use of Supplemental Oxygen (http://www.prosthetics.va.gov/Docs/CPR_HomeOxygen.pdf). ***NOTE:*** *This linked document is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*

(14) Clinical Inventory by Facility (to see if services are available) on VSSC Web site at: https://vaww.vssc.med.va.gov/ClinicalInventory/FacilitySearch/FacilitySearch.aspx. ***NOTE:*** *This is an internal VA Web site and is not available to the public.*

(15) VHA Office of Community Care (OCC) Field Guide Book (See OCC Web site: https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx). ***NOTE:*** *This is an internal VA Web site and is not available to the public.*

(16) PCMM Coordinator and Referral Case Manager List (https://vssc.med.va.gov/PCMMV2/ListCoordinators). ***NOTE:*** *This is an internal VA Web site and is not available to the public.*

(17) VHA Pharmacy Benefits Management Pharmacy Directory: (https://dvagov.sharepoint.com/sites/VHAPBM/Pharmacy_Directory/Lists/Directory/AllItems.aspx?useFiltersInViewXml=1&FilterField1=Duties&FilterValue1=Anticoagulation%20Clinic&FilterType1=LookupMulti&FilterOp1=In). ***NOTE:*** *This is an internal VA Web site and is not available to the public.*

PROCEDURE FOR CLINICAL PHARMACISTS TO PROVIDE TEMPORARY SUPPLIES OF MAINTENANCE MEDICATION AT ALTERNATE FACILITY (OPTION 2)

The Department of Veterans Affairs (VA) medical facility has two options to provide a temporary supply of a maintenance medication to the traveling Veteran. Option 1 allows referral of the traveling Veteran to a VA provider that is authorized to prescribe medications. Option 2 allows the medical facility to develop standard operating procedures which allows clinical pharmacists (not authorized to prescribe) to dispense a bridge supply of a maintenance medication to the traveling Veteran. This Appendix outlines procedures by which clinical pharmacists will dispense bridge supplies if Option 2 is selected by the medical facility.

1. The patient registers at the alternate facility with Veterans Integrated System Technology Architecture (VistA)'s Register Once Messaging (ROM).

2. The patient is directed to the pharmacy or a pharmacy-managed refill clinic.

3. The clinical pharmacist evaluates the request for a temporary supply of medication using JLV capabilities.

a. If the medication is not permitted to be dispensed under a VA medical facility standard operating procedure, or if the patient expresses health concerns or questions, the clinical pharmacist directs the patient to the appropriate medical clinic or emergency room for evaluation.

b. If medication is permitted to be dispensed under VA medical facility standard operating procedure, the clinical pharmacist provides a temporary supply using the following guidelines:

(1) **Active Prescriptions with One or More Refills Available.** If there is an Active Prescription with one or more refills available, the following are implemented**:**

(a) The clinical pharmacist dispenses a bridge supply.

(b) The clinical pharmacist assists the patient in contacting the patient's home pharmacy to document a temporary address so that additional refills may be sent, if needed. Assistance may take the form of providing the patient the phone number of the home pharmacy, making phone calls on behalf of the patient, or making inter-facility consult requests through the electronic health records (EHR).

(c) The clinical pharmacist documents the order as a policy order within VistA using the designated VA Authorized Provider (who must be a physician who is authorized to prescribe medications at the alternate facility) as the VA provider listed on the prescription label. In addition, the original prescribing VA provider’s name from the preferred facility is to be placed in the medication label’s patient instruction field or comments section of the prescription.

(2) **Active Prescriptions for Maintenance Medications with All Refills Used.** If there is an active prescription for maintenance medication with all the refills used, the following is implemented:

(a) The clinical pharmacist dispenses a bridge supply.

(b) The clinical pharmacist assists the patient with contacting the patient's home facility to alert the provider to re-order the medication(s) and to have the medication(s) mailed to a temporary address, if needed.

(c) The clinical pharmacist documents the order as a policy order within VistA using the designated VA Authorized Provider (must be a physician) at the alternate facility as the VA provider listed on the prescription label. In addition, the original prescribing VA provider's name from the preferred facility is to be placed in the medication label's patient instruction field or comments section of the prescription.

(3) **Prescription Expired or no Refills Provided.** If the prescription has expired or no refills are permitted, the following is implemented:

(a) The clinical pharmacist uses professional judgment.

(b) If the clinical pharmacist determines the request to be appropriate (for example, maintenance medication that the patient has been taking for a long time), the clinical pharmacist, acting within the VA medical facility standard operating procedure, dispenses a bridge supply as described above and assists the patient to contact the preferred facility to leave a message for the provider to re-order medication and to have it mailed to the temporary address, if needed. The clinical pharmacist documents the order as a policy order within VistA using the designated VA Authorized Provider (must be a physician) at the alternate facility as the VA provider listed on the prescription label. The clinical pharmacist documents the original prescribing clinician's name from the preferred facility and places it in the medication label's patient instruction field or comments section of the prescription.

(c) If the clinical pharmacist determines the patient requires medical assessment or the medication is outside of the medical facility standard operating procedure, the clinical pharmacist directs the patient to the appropriate medical clinic or emergency room to be evaluated.

PROCEDURE FOR CLINICAL PHARMACISTS TO PROVIDE TEMPORARY SUPPLIES OF MAINTENANCE MEDICATION AT ALTERNATE FACILITY

The following procedural text describes the scenario for managing a patient that presents to the alternate facility who has less than a 10 to 15 day supply of medication.

a. If the Patient is LOW on meds or OUT of meds while away from home and ALSO reports additional medical problems which require medical attention, Refer for individualized clinical evaluation. If the patient is LOW on meds or OUT of meds while away from home and does not ALSO report additional medical problems which require medical attention, Does the patient have LESS than a 10 to 15-day supply of meds on hand?

b. In the event a Patient has LESS than a 10 to 15-day supply of meds on hand; Is drug available for "bridge" therapy? If drug is available for "bridge" therapy, Provide a 'bridge" supply of medication. If drug is not available for "bridge" therapy, Refer for individualized clinical evaluation.

c. If Patient does not have LESS than a 10 to 15-day supply of meds on hand; Has temporary address been changed in VistA at preferred facility? If the patient’s temporary address has been changed in VistA at preferred facility; Instruct patient to reorder medications per usual procedure. If the patient’s temporary address has not been changed in VistA at preferred facility; Pharmacist to contact preferred facility pharmacy & have temporary address changed, Instruct patient to reorder medications per usual procedure.

SAMPLE TRAVELING VETERAN COORDINATOR (TVC) FLYER #1: INFORMATION FOR TRAVELING AND PERMANENTLY RELOCATING VETERANS

ATTENTION:

Veterans who are **on extended travel or who are permanently relocating and need care coordination during period of travel.**

For your continuity of care: If you will require medications, injections, blood tests, or any type of medical follow-up during the time you are away from your Preferred Facility (enter facility name)

1. Inform your Primary Care Provider or Patient Aligned Care Team (PACT) members of your plans to travel as far in advance as possible.
2. Leave your temporary address and contact phone number with the PACT team along with the dates you will be leaving and returning. This will allow us to send any medications and correspondence to your temporary address while you are gone.
3. Request a copy of your health summary and medication list to take with you.
4. Make sure you have enough supply of medications (or enough refills) to last until you return. It is important to request your medications at least 10-14 days prior to running out.

Your PACT Team or Specialty Provider will consult the Traveling Veteran Coordinator to coordinate your care with the Department of Veterans Affairs (VA) facility or clinic closest to where you will be traveling or temporarily residing.

Please contact the Traveling Veteran Coordinator,
(enter TVC name & phone #)
For further assistance

SAMPLE TRAVELING VETERAN COORDINATOR (TVC) FLYER #2: VA MEDICAL FACILITY TRAVELING VETERAN COORDINATOR (TVC) INFORMATION FOR PATIENT ALIGNED CARE TEAMS (PACT)

Do your patients travel seasonally? Do they travel out of state to visit family? Are any of your patients permanently relocating? Do they need ongoing medical attention while they are away or permanently relocating?

Let's put the pieces together to coordinate your patient's care at another Department of Veterans Affairs (VA) Health Care Facility when it is medically necessary!

Each VA Health Care Facility has a Traveling Veteran Coordinator who will help to coordinate this care.

The (enter facility name) Traveling Veteran Coordinator is

(Enter TVC name and #)

If your patients will be traveling or permanently relocating and need labs drawn, specialty injections, urgent follow-up for a newly diagnosed condition, anticoagulation monitoring, follow-up x-rays, etc. and they do NOT have an assigned provider in that state, please contact the Traveling Veteran Coordinator via consult. Provide specific information about the patient's travel dates, where (s)he will be residing (need temporary address and a contact phone #), what care is needed, the date care needs to start, and your contact information. Inform your patient that (s)he will be contacted by the TVC to help coordinate care.

REMEMBER TO:

- **Educate your patient that (enter facility name) is the preferred facility and that the Traveling Veteran Coordinator will help coordinate care that is needed at other VA Health Care facilities.**
- **Complete an electronic consult to the Traveling Veteran Coordinator with** DETAILS **on where patient will be residing including a valid phone number, inclusive dates patient will be gone, specific information about what care is needed, the date care is required, and your contact information.**
- **Be sure the patient has enough refills on their prescriptions to last until (s)he returns to your clinic (routine prescriptions should ideally be refilled by the home facility.)**

Please help your patients plan ahead to facilitate care while they are gone!

SAMPLE TRAVELING VETERAN COORDINATOR (TVC) FLYER #3: VA MEDICAL FACILTY TVC INFORMATION FOR TRAVELING AND PERMANENTLY RELOCATING VETERANS

Are you planning on traveling seasonally?

Are you planning an extended trip away from (insert location of preferred facility here)?

Are you permanently relocating?

If so, you may need some coordination of your medical care with another Department of Veterans Affairs (VA) facility if you do NOT have an assigned physician in that location.

To ensure your care, including medication refills, continues uninterrupted during periods of extended travel or while relocating, please inform your Primary Care or Patient Aligned Care Team (PACT) of such plans in advance of your departure date. This will enable our TVC to arrange for you to receive any needed or continuing VA medical services while you are away or permanently relocating.
Be sure to tell us what your temporary address or new address, if permanently relocating, and telephone number will be so that your medication refills can be sent to you there and we can assist with your care.

For questions call: (enter TVC name and #)