

MEDICAL MANAGEMENT OF ENROLLED VETERANS RECEIVING SELF-DIRECTED CARE FROM EXTERNAL HEALTH CARE PROVIDERS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive states policy for a system-wide approach to the management of health care for Veterans who receive care from the Department of Veterans Affairs (VA) and who also choose to receive care from external health care providers not at VA expense, known as self-directed care (formerly referred to as “dual care”). **NOTE:** *This directive does not address policy for health care authorized by VA under the Veterans Community Care Program.*

2. SUMMARY OF MAJOR CHANGES:

a. This directive contains an amendment dated April 13, 2022 to add a definition for self-directed care (see paragraph 3.i.).

b. Major changes include:

(1) Changing terminology from “dual care” to “self-directed care” to describe the care that Veterans receive from external health care providers not at VA expense;

(2) Providing updated policy and resources for Veterans Integrated Service Networks (VISN), VA medical facilities, VA providers and VA health care teams to manage and coordinate care for Veterans who receive both VA care and self-directed care managed by external health care providers;

(3) Providing new responsibilities for Assistant Under Secretary for Health for Clinical Services; Executive Director, VHA Office of Primary Care; VA medical facility Director, Chief of Staff, and Associate Director for Patient Care Services (ADPCS); and

(4) Outlining specific processes for partnering with Veterans to improve collaboration and communication between VA and external health care providers furnishing self-directed care.

3. RELATED ISSUES: VHA Directive 1041, Appeal of Veterans Health Administration Clinical Decisions, dated September 28, 2020; VHA Directive 2011-012, Medication Reconciliation, dated March 9, 2011; and VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.

4. RESPONSIBLE OFFICE: The Office of Primary Care (11PC) is responsible for the contents of this directive. Questions may be referred to 202-461-6259 or VHA11PCPrimaryCareAction@va.gov.

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5. RESCISSIONS: VHA Directive 2009-038, VHA National Dual Care Policy, dated August 25, 2009, is rescinded.

6. RECERTIFICATION: This VHA directive is due to be recertified on or before the last working day of October 2026. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF THE
UNDER SECRETARY FOR HEALTH:**

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Assistant Under Secretary for Health
for Clinical Services

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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MEDICAL MANAGEMENT OF ENROLLED VETERANS RECEIVING SELF-DIRECTED CARE FROM EXTERNAL HEALTH CARE PROVIDERS**1. PURPOSE**

This Veterans Health Administration (VHA) directive states policy for a system-wide approach to the management of health care for Veterans who receive care from Department of Veterans Affairs (VA) and who also choose to receive care from external health care providers not at VA expense, known as self-directed care (formerly known as “dual care”). **NOTE:** *This directive does not address any of the policies and procedures for VA authorized care under the Veterans Community Care Program. Please refer to the Office of Community Care Intranet page:*

<https://vaww.va.gov/COMMUNITYCARE/index.asp>. **AUTHORITY:** 38 U.S.C. § 7301(b).

2. BACKGROUND

a. Many Veterans choose to receive care from both VA and external health care providers not at VA expense. This self-directed use of external health care providers was previously referred to as “dual care.”

b. Care coordination between VA and external health care providers is critical to preventing unfavorable health outcomes for Veterans. Care coordination has been shown to significantly benefit Veterans, in that it results in lower rates of hospitalization and lower morbidity and mortality. A 2018 Health Services Research study found that in Veterans who were reliant on the VA for services, increasing continuity with a VA Primary Care Provider (PCP) and high-functioning team-based care clinics was associated with fewer emergency department visits and hospitalizations. Other studies have shown that Veterans dually enrolled in VA and Medicare receiving prescriptions from both sources are at increased risk for receiving potentially unsafe overlapping opioid prescriptions and increased risk of death from prescription opioid overdose (Annals of Internal Medicine, 2018 and 2019). Managing and coordinating care helps to reduce these risks and may increase patient satisfaction. Effective care coordination also reduces costly and unnecessary duplication of services. It also ensures that important clinical information is promptly communicated between VA and external health care providers. Therefore, it is strongly recommended that every enrolled Veteran receiving self-directed health care have a VA health care provider and a VA health care team who partner with the Veteran and their external health care providers to manage and coordinate all aspects of the Veteran’s health care.

c. Improving the Veteran experience by coordinating health care for Veterans who receive care from both VA and external health care providers is an important part of Veteran-centered care. This care coordination can be more effectively managed when VA providers, VA health care teams, and external health care providers work together with the Veteran through improved mechanisms for sharing information and delineating roles and responsibilities.

3. DEFINITIONS

a. **Care Coordination.** Care coordination is a system-wide approach to the deliberate organization of all Veteran care activities between two or more participants or systems to facilitate the appropriate delivery of health care services. It can include, but is not limited to, care management and case management. Within the VHA level of care coordination framework, care coordination falls within the basic level. See VHA Directive 1110.04(1), Integrated Case Management Standards of Practice, dated September 6, 2019.

b. **Care Management.** Care management is a population health approach to longitudinal care coordination focused on primary or secondary prevention of chronic disease and acute condition management. It applies a systems approach to collaboration and the linkage of Veterans, their families, and caregivers to needed services and resources. Care management manages and maintains oversight of a comprehensive plan for a specific cohort of Veterans. Within the VHA level of care coordination framework, care management falls within the moderate level. See VHA Directive 1110.04(1).

c. **Case Management.** Case management is a proactive and collaborative population health approach to longitudinal care coordination focused on chronic disease and acute condition management. Case management includes systems collaboration and the linking of Veterans, families, and caregivers with needed services and resources, including wellness opportunities. Case management includes responsibility for the oversight and management of a comprehensive plan for Veterans with complex care needs. Within the VHA level of care coordination framework, case management falls within the complex level. See VHA Directive 1110.04(1).

d. **Electronic Health Information Exchange.** Electronic health information exchange (HIE) is a system which allows health care professionals and patients to appropriately access and securely share a patient's vital medical information electronically. HIE improves the speed, quality, safety and cost of patient care. **NOTE:** For additional information on the HIE system, visit: <http://www.healthit.gov/providers-professionals/health-information-exchange/what-hie>.

e. **External Health Care Providers.** For purposes of this directive, external health care providers are physicians, advanced practice nurses, physician assistants, and other health care professionals or organizations who provide health care to Veterans outside of the VA health care system and not paid for by VA.

f. **High-Alert Medication.** A high-alert medication is a drug that bears a heightened risk of causing significant adverse events that cause harm to a patient. The consequences of a medication error with these drugs are more devastating to patients. Examples of high-alert medications include warfarin, opioids, insulin, anti-arrhythmics, lithium, chemotherapy, and immunosuppressive agents. **NOTE:** For a listing of high-alert medications in community and ambulatory settings, see <https://www.ismp.org/recommendations/high-alert-medications-community-ambulatory-list>.

g. **Medication Reconciliation.** Medication reconciliation is a process of ensuring the maintenance of accurate, timely, and complete medication information by:

- (1) Obtaining medication information from the patient, patient's caregiver(s), or patient's family member(s) for review.
- (2) Comparing the information obtained from the patient, patient's caregiver(s), or patient's family member(s) to the medication information available in the VA electronic health record (EHR) as defined by VHA Directive 1164, Essential Medication Information Standards, dated June 26, 2015, to identify and address discrepancies.
- (3) Assembling and documenting the medication information in the EHR. Communicating with and providing education to the patient, patient's caregiver(s), or patient's family member(s) regarding updated medication information as defined by VHA Directive 1164.
- (4) Communicating relevant medication information to and between the appropriate members of the VA and non-VA health care team as defined by VHA Directive 1164.

h. **Non-VA Medications.** Non-VA medications currently documented in the EHR are comprised of the following elements:

- (1) Non-VA provider-prescribed medications filled at non-VA pharmacies.
- (2) VA provider-prescribed medication filled at non-VA pharmacies.
- (3) Other: Veteran-obtained medication such as herbals, over-the counter-medications, nutraceuticals, samples, and alternative medications.

i. **Self-directed Care.** For the purposes of this directive, self-directed care is health care delivered to Veterans by external health care providers, not at VA expense.

j. **Veterans Health Information Exchange.** The Veterans Health Information Exchange (VHIE), formerly known as the Veterans Lifetime Electronic Record, is a program which allows VA participating community, or external health care providers, and Veterans to share certain health information from a Veteran's health record electronically. This health information data is exchanged securely through the electronic Health (eHealth) Exchange. This access reduces the need for Veterans and their families to request and carry paper medical records from one health care provider to another. Additional information on VHIE is available at <https://www.va.gov/vhie> and <https://myees.lrn.va.gov/Communities/Veteran%20Health%20Information%20Exchange/SitePages/What%20is%20VHIE.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

4. POLICY

It is VHA policy to ensure that health care provided by VA to Veterans who also receive self-directed care is medically managed so that care is well-coordinated, safe, documented and appropriate.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to assure compliance with this directive and its effectiveness.

c. **Assistant Under Secretary for Health for Clinical Services.** The Assistant Deputy Under Secretary for Health for Clinical Services is responsible for supporting the VHA Office of Primary Care with implementation and oversight of this directive.

d. **Executive Director for VHA Office of Primary Care.** The Executive Director for VHA Office of Primary Care is responsible for updating this directive and VHA-wide communication supporting implementation of this directive.

e. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Conducting ongoing evaluation of resources to fully implement this directive.

f. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring that local procedures, in alignment with national policy, specify roles and responsibilities for all staff (e.g., VA provider, health care team, pharmacy, Health Information Management Service (HIMS)) involved in managing and coordinating care for enrolled Veterans receiving self-directed care. Local procedures must include, but are not limited to, care management, medication management (to include provisions for controlled substances, medication monitoring, and medication reconciliation), provision of medical equipment and prosthetic and sensory aid devices, consultation and referrals, diagnostic testing, sharing of health information, patient transfers, discharge planning, and documentation and monitoring strategies. **NOTE:** For VA medical facility standards operating procedures (SOPs), see the standard template, available at: <https://dvagov.sharepoint.com/sites/VACOVHACOS/10B4/PIRP/10B4/SitePages/Document%20Templates.aspx>. This is an internal VA website that is not available to the public.

(2) Informing external health care providers about how best to interface with VA to enhance coordination of care for Veterans with both VA and external health care providers. **NOTE:** To help facilitate communication and coordination between external health care providers and VA providers, see the “Sample Letter to External Health Care Providers” located on the VHA Office of Primary Care Policy SharePoint at: <https://dvagov.sharepoint.com/sites/VHAOPCOps/Policy/SitePages/Home.aspx>. This sample letter and other resources to facilitate care coordination for enrolled Veterans receiving self-directed care from external health care providers, are located in the “Tools and Resources for the Medical Management of Enrolled Veterans Receiving Self-Directed Care from External Health Care Providers” folder at: <https://dvagov.sharepoint.com/sites/VHAOPCOps/Policy/VHA%20Primary%20Care%20Directives/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAOPCOps%2FPolicy%2FVHA%20Primary%20Care%20Directives%2FVHA%20Directive%201310%20Medical%20Management%20of%20Enrolled%20Veterans%20Receiving%20Self%2DDirected%20Care%20from%20External%20Health%20Care%20Providers&FolderCTID=0x0120002609C4BEB9A57A44B52CF5F6798BE832>. This is an internal VA website that is not available to the public.

(3) Ensuring that Veterans and VA staff, including but not limited to VA clinical staff and administrative staff who are in direct contact with Veterans (e.g., clerical, privacy, release of information, and health administration services staff) are aware of proper procedures for sharing health information and records with external health care providers. Examples of existing information include:

(a) Release of Information Procedures. VHA privacy and release of information (ROI) policies and procedures must be applied prior to releasing copies of any medical or health information (e.g., medication lists, laboratory results, or other health records) for a Veteran to an external health care provider for the care and treatment of the Veteran. A written request from the external health care provider or an authorization signed by the Veteran is required in accordance with VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016; and

(b) Health Information Sharing for Veterans. Options available to Veterans for health information sharing with external health care providers include, but are not limited to, VA ROI; the VA Blue Button feature in My HealthVet (see <http://www.myhealth.va.gov>), the My VA Health patient portal, or VA mobile applications; or participation in electronic health information exchanges, such as the VHIE program. **NOTE:** The VHIE program provides electronic sharing of records with external health care providers. For more information on VHIE contact the VISN or VA medical facility VHIE coordinator or visit <https://www.va.gov/vhie> or <https://myees.lrn.va.gov/Communities/Veteran%20Health%20Information%20Exchange/SitePages/What%20is%20VHIE.aspx>. This is an internal VA website that is not available to the public.

(4) Participating in VHIE and nationally standardized HIE approaches, to support a more complete medical record, as they become available in their communities.

(5) Providing educational materials and resources for Veterans who receive VA care and self-directed care.

(6) Ensuring that in situations where Veterans are receiving high-alert or highly specialized medications (e.g., warfarin, opioids, insulin, anti-arrhythmics, lithium, chemotherapy, immunosuppressive agents) from VA, the frequency of visits and drug monitoring with the VA provider is discussed between the Veteran and VA provider to determine a safe and effective monitoring plan. This monitoring plan will likely necessitate more than one annual visit. **NOTE:** For a listing of high-alert medications in the community and ambulatory settings, see <https://www.ismp.org/recommendations/high-alert-medications-community-ambulatory-list>.

(7) Ensuring compliance with VHA Directive 2011-012, Medication Reconciliation, dated March 9, 2011, and VHA Directive 1164, to diminish the potential safety risk for the patients receiving care in both VA and from external health care providers.

(8) Allocating or re-aligning appropriate resources to fully implement this directive.

g. VA Medical Facility Chief of Staff and Associate Director for Patient Care Services. The VA medical facility Chief of Staff and Associate Director for Patient Care Services (ADPCS) are responsible for ensuring that:

(1) A consistent approach to care management of Veterans receiving self-directed care is implemented across the VA medical facility, as outlined in this directive.

(2) A quality of care monitoring process exists, which may include random health record reviews of Veterans receiving self-directed care.

(3) VA providers assume responsibility for the health care that they are providing, including the prescribing of medications and supplies to Veterans who also receive self-directed care. See paragraphs 5.g.(4), 5.h.(4), and 5.h.(6).

(4) Ensuring that a process is in place for receiving and documenting pertinent information (e.g., drug, dose, laboratory test results, associated clinical findings, adverse events, side effects, and drug interactions) brought in by the Veteran that were performed by external health care providers. This information must be placed into the EHR for the VA provider or prescriber to act properly on the results.

h. VA Provider. The VA provider, in coordination with the VA health care team, is responsible for:

(1) Managing the VA care and services that are provided to a Veteran who is also receiving self-directed care. For Veterans receiving VA primary care, this frequently revolves around the Patient Aligned Care Team (PACT). **NOTE:** See VHA Handbook 1101.10(1), *Patient Aligned Care Team Handbook*, dated February 5, 2014. For those Veterans only receiving VA specialty care or mental health services, the VA specialist or VA mental health provider may manage their VA health care services.

(2) Engaging case managers or proposing reassignment of Veterans to appropriate special population PACTs when patients' needs exceed the resources available to PACT staff or when Veterans' needs require specialized case management services (e.g., case management for Transition and Care Management (previously Operation Enduring Freedom-Operation Iraqi Freedom-Operation New Dawn), Serious Mental Illness (SMI), Spinal Cord Injuries and Disorders (SCI/D), Blind and Vision Rehabilitation Continuum of Care). PACT staff providing care management serves as the primary point of contact for case managers and collaborate with case managers for comprehensive care.

(3) Engaging Veterans to partner in coordinating and managing their health care with external health care providers to ensure their care is safe, effective and personalized. This involves educating Veterans on the importance of sharing their health care information with their VA provider and VA health care team if they choose to obtain self-directed care. The topics of information include, but are not limited to:

(a) Informing their VA provider and VA health care team of the care they are receiving, sharing their external health care provider's contact information, and disclosing the medications prescribed by their external health care provider. This may include written or electronic evidence of care plan changes (e.g., progress note, medication changes, diagnostic findings) made by the external health care provider and the occurrence of adverse events, side effects, or interactions related to these medications. **NOTE:** *Costs related to obtaining or duplicating private health care records are the responsibility of the Veteran;*

(b) Informing the external health care provider of care they receive from VA providers. **NOTE:** *The Veteran can provide this information directly to their external health care provider using VA Blue Button in My HealthVet or Blue Button mobile applications (see <http://www.myhealth.va.gov> and <http://www.va.gov/bluebutton>); and*

(c) Informing their VA provider and VA health care team when they no longer wish to receive care from VA or will receive health care services solely from an external health care provider. Similarly, informing the VA provider when they are no longer receiving care from an external health care provider.

(4) Prescribing medications, supplies, or medical and prosthetic devices to the Veteran and managing the conditions for which they are being prescribed within their clinical privileges or scope of practice, within the boundaries of their clinical expertise, and subject to the following:

(a) Under no circumstances will the VA provider be permitted to simply re-write prescriptions from an external health care provider; the VA provider must first make a professional assessment that the prescribed medication is medically appropriate;

(b) When prescribing medications, the VA provider must actively monitor and manage the care associated with that medication. See VHA Directive 1108.08(1), VHA Formulary Management Process, dated November 2, 2016; and

(c) Prescribing medications and supplies must entail appropriate follow-up to include a face-to-face or virtual care visit (e.g., telephone, clinical video telehealth, or other virtual care modalities) by an appropriate team member, as clinically indicated.

(5) Informing the Veteran that the VA provider may, but is not required to, follow recommendations of external health care providers, making a professional assessment of whether the prescribed medication or treatment plan is medically appropriate, and discussing this assessment with the Veteran. The VA provider, at their discretion, may request consultation with other VA specialists.

(6) Evaluating the medical appropriateness of a treatment plan, diagnostic test, medical and prosthetic devices, or medication recommended by external health care providers and consistency with national policies. If the VA provider believes the external health care provider's treatment or medication plan is not medically appropriate or conflicts with VA, VHA, VISN, or VA medical facility policies, then the VA provider is not required to follow that plan. When the VA provider does not follow the recommendations of external health care providers, the VA provider must document in the EHR and communicate the rationale to the Veteran. For such decisions, alternative treatment recommendations, if available, must be communicated to the Veteran. **NOTE:** *In such cases, the Veteran may use the VHA clinical appeals process provided in VHA Directive 1041, Appeal of Veterans Health Administration Clinical Decisions, dated September 28, 2020.*

(7) Informing the Veteran that VA has a national formulary from which medications and nutritional supplements and supplies are prescribed to Veterans. **NOTE:** See VA National Formulary at <http://www.pbm.va.gov/nationalformulary.asp> and VHA Directive 1108.08(1).

(8) Ensuring that the medication treatment plans are consistent with the VA National Formulary, VISN, and local processes for obtaining non-formulary agents. **NOTE:** See VHA Directive 1108.08(1).

(9) Documenting pertinent external health care provider information (e.g., name, address, telephone number) in the Veteran's EHR, in accordance with local processes and procedures.

(10) Ensuring, when high-alert or highly specialized medications are being requested by the Veteran as therapy recommended from an external health care provider specialist, that the medications are not prescribed until:

(a) A VA PCP submits a formal consultation to a VA specialist, or clinical pharmacy specialist, where appropriate, to evaluate and prescribe the appropriate medications through either an e-consult, in-person or virtual consultation;

(b) Communication and actions the prescribing VA provider takes based on the recommendations of a VA specialist are documented in the EHR (e.g., e-Consults). **NOTE:** *All medication requests and subsequent consultation or communication between VA providers must be documented in the health record (e.g., e-Consults). See VHA*

Directive 1232(3), VHA Consult Processes and Procedures, dated August 24, 2016. This documentation should include a decision between the requesting VA provider and VA specialist about care coordination and surveillance of care for the patient; and

(c) The frequency of visits and drug monitoring is discussed between the Veteran and the prescribing VA provider to determine a safe and effective monitoring plan which must be followed to continue receiving the requested medication. This monitoring plan will likely necessitate more than one annual visit.

(11) Ensuring that laboratory tests and other necessary monitoring are completed.

(12) Documenting pertinent information (e.g., drug, dose, labs, associated clinical findings, adverse events, side effects, drug interactions) in the Veteran's EHR, as appropriate.

(13) Completing medication reconciliation in accordance with VHA Directive 2011-012, VHA Directive 1164, and local procedures including medications prescribed by, or secured outside of, the VA system to diminish the potential safety risk for the Veterans receiving care from both VA and external health care providers. Non-VA medications must be documented in the Veteran's EHR in the non-VA medication list and must be kept up to date.

6. TRAINING

There are no formal training requirements associated with this directive.

7. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems) created by this directive shall be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule (RCS) 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

8. REFERENCES

a. 38 U.S.C. § 5702.

b. VHA Directive 1041, Appeal of Veterans Health Administration Clinical Decisions, dated September 28, 2020.

c. VHA Directive 1108.08(1), VHA Formulary Management Process, dated November 2, 2016.

d. VHA Directive 1110.04(1), Integrated Case Management Standards of Practice, dated September 6, 2019.

e. VHA Directive 1164, Essential Medication Information Standards, dated June 26, 2016.

- f. VHA Directive 1232(3), Consult Processes and Procedures, dated August 24, 2016.
- g. VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.
- h. VHA Directive 2011-012, Medication Reconciliation, dated March 9, 2011.
- i. VHA Handbook 1101.10(1), Patient Aligned Care Team Handbook, dated February 5, 2014.
- j. Department of Veterans Affairs, Veterans Health Administration, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning. 2017 Survey of Veteran Enrollees' Health and Reliance Upon VA.
https://www.va.gov/HEALTHPOLICYPLANNING/SOE2017/VA_Enrollees_Report_Data_Findings_Report2.pdf.
- k. Government Accountability Office (GAO). 2015 High Risk Report, Managing Risks and Improving VA Health Care.
http://www.gao.gov/highrisk/managing_risks_improving_va_health_care/why_did_study#t=0.
- l. Institute for Safe Medication Practices (ISMP) Medication Safety Self Assessment® for Hospitals, 2011. <https://www.ismp.org/assessments/hospitals>. Accessed January 15, 2018.
- m. Reddy, A.; Wong, E.; Canamucio, A.; Nelson, K.; Fihn, S.; Yoon, J.; Werner, R. (2018) "Association between Continuity and Team-Based Care and Health Care Utilization: An Observational Study of Medicare-Eligible Veterans in VA Patient Aligned Care Team.", Health Services Research, 53:6, Part II (December 2018): 5201-5218.
- n. Axon, R.N.; Gebregziabher, M.; Everett, C.J.; Heidenreich, P.; Hunt, K.J. (2016) "Dual Health Care System Use is Associated with Higher Rates of Hospitalization and Hospital Readmission Among Veterans with Heart Failure.", American Heart Journal, April 2016: 157-163.
- o. Carico, R.; Zhao, X.; Thorpe, C.T.; Thorpe, J. M.; Sileanu, F.E.; Cashy, J.P.; Hale, J. A.; Mor, M.K.; Radomski, T.R.; Hausmann, L.R.M.; Donohue, J.M.; Suda, K.J.; Stroupe, K.; Hanlon, J.T.; Good, C.B.; Fine, M.J.; Gellad, W.F. (2018) "Receipt of Overlapping Opioid and Benzodiazepine Prescriptions Among Veterans Dually Enrolled in Medicare Part D and the Department of Veterans Affairs: A Cross-sectional Study.", Annals of Internal Medicine, 2018 Nov 6; 169(9): 593-601.
- p. Moyo, P.; Zhao, X.; Thorpe, C.T.; Thorpe, J.M.; Sileanu, F.E.; Cashy, J.P.; Hale, J.A.; Mor, M.K.; Radomski, T.R.; Donohue, J.M.; Hausmann, Leslie R.M.; Hanlon, J.T.; Good, C.B.; Fine, M.J.; Gellad, W.F. (2019) "Dual Receipt of Prescription Opioids from the Department of Veterans Affairs and Medicare Part D and Prescription Opioid

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Overdose Death Among Veterans: A Nested Case-Control Study.” *Annals of Internal Medicine*, 2019 Apr 2, 170(7): 433-442.