

Care Transitions: Opportunities to Better Serve the Traveling Patient

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As the COVID-19 vaccine rollout continues, people are beginning to travel again. Before the pandemic, travel was an integral part of daily life. Many baby boomers traveled to spend time with loved ones, change residence based on seasons, or simply enjoy retirement.¹ Nearly 80% of older adults have at least 2 chronic diseases that require regular health care.² A 2019 survey by AARP reported that 32% of baby boomers felt their health was a major obstacle to traveling.¹ The Veterans Health Administration (VHA) Traveling Veterans Program (TVP) provides a framework for care transitions among patients with chronic illness that can occur nationally across a health care system by leveraging integrated electronic health records (EHRs) and a structured care transition program.

The TVP, which was started in 2015, ensures that veterans receive uninterrupted patient-centered care, regardless of their location. A coordinator, who is a nurse or advanced practitioner at a Veterans Affairs (VA) facility, utilizes the EHR and communicates with the destination facility to transfer care by registering the patient, scheduling appointments based on dates recommended by the referring provider, and bridging communication between patients and facilities.

Care Transitions: Implementation in Non-VA Networks

The term *care transitions* refers to the movement of a patient between 2 health care settings; successful transitions require effective provider communication and patient engagement.³ In the private sector, specialized services, such as home hospice and dialysis, that have access to a national network of facilities have been successful at performing care transitions for the traveling patient. These services utilize a coordinator to identify the appropriate destination facility, verify insurance, schedule an appointment, and contact the patient.^{4,5} If a network does not have facilities at the patient's destination, coordinators help identify an alternate agency in the area.^{4,5} Although large health systems such as Kaiser Permanente offer a pathway to establish medical records and accounts in other locations within their system, the patient is responsible for obtaining a local medical record number, identifying the appropriate destination facility, and

TAKEAWAY POINTS

- ▶ We provide a framework for how high-quality, consistent, and timely care can be transferred nationally for the traveling patient with chronic illness.
- ▶ The Veterans Health Administration Traveling Veterans Program facilitates patient-centered care and can be adopted by other integrated health systems.
- ▶ Future research should focus on implementation of existing models of travel coordination programs and electronic health record integration while maintaining high-quality care.

scheduling appointments.⁶ Structured care transition programs may further improve continuity of care for the traveling patient who belongs to a large health care network.

Integrated EHR: Key to Mobility

Transferring medical records between disparate health systems can be inefficient and time consuming. Large health systems such as VHA and Kaiser Permanente benefit from an integrated EHR, which facilitates continuity of care for a patient who is traveling or moving. Advances in EHR integration through programs such as Epic's Care Everywhere and the CommonWell Health Alliance allow providers who are not affiliated with the same health care systems to electronically share records. The seamless transfer of medical records for patients with complex chronic illness is a major step toward alleviating health concerns as a barrier to travel.

Telemedicine: An Incomplete Solution

Telemedicine has gained traction during the pandemic, and many providers and patients have adopted telemedicine as an alternative to in-person visits. Various state medical boards have modified restrictions for providers performing telemedicine follow-up care or prescribing nonnarcotic medications for patients in a different state.⁷ If these changes continue post pandemic, this could expand continuity of care with a traveling patient's primary provider. However, patients who do not live in a state with these

modifications or who require in-person services, such as procedures, laboratory tests, imaging, or intravenous medications, still need a pathway to avoid interruptions in care and prevent unnecessary emergency department or urgent care visits.

Patient Satisfaction: Case Example

In an era of personalized care, patient satisfaction is recognized as a performance indicator for providers and hospitals. We present the case of a patient, aged 68 years, who receives all health care within the VHA. He was planning a trip across the United States but then received a diagnosis of metastatic cancer in January 2020. He was prepared to cancel the trip due to needing intravenous immunotherapy, laboratory tests, and clinic visits, but his doctor recommended the TVP. Given his limited prognosis, the patient and his wife decided to drive across the country, following strict quarantine protocols while living in their recreational vehicle and avoiding COVID-19 surge areas. He received timely cancer treatment through successful care transitions in 5 VA facilities.

The veteran stated that he had a fantastic experience and expressed great appreciation for TVP, because otherwise he could not have traveled for an extended period and received cancer care. He was pleased with the high-quality, consistent care provided at all facilities, despite meeting a new team each time. He recognized the complex logistics performed by the coordinator, such as patient registration, communication with the patient and providers, and timely appointment scheduling based on his treatment plan. However, patient navigation barriers included providers who were not familiar with TVP when referral was needed for the next destination, inability to independently schedule appointments without a coordinator, and understanding the coordinator's role in the process.

Communication: Successful Handoffs

Clear communication among facilities, providers, and the patient is critical for successful handoffs during care transitions. Similar to a hospital discharge summary, TVP requires the referring provider to state the date when follow-up is needed, specialty or primary care services that need to be scheduled, and a brief summary of recommended treatment or monitoring at the next visit. Rather than requiring the patient to navigate the new patient process, TVP utilizes coordinators as bridges between facilities to transfer key information and confirm timely continuity of care. These coordinators ensure that the required information and documentation are present to facilitate patient handoffs. Enhanced communication allows patients to continue care as an established patient in the

system. Thus, waiting times are reduced and timely access to health services is improved.

Conclusions

Continuity of care for the traveling patient with chronic illness is feasible and provides an opportunity to improve timely access to health care, patient satisfaction, and quality of life. The VHA TVP facilitates patient-centered care and can be adopted by other health systems to encourage successful care transitions for the traveling patient. To expand traveling patient programs on a larger scale, future research should focus on implementation of existing models of travel coordination programs and EHR integration while maintaining high-quality care. ■

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