# Did you know that cdmNet can be used to simplify the management of your patients under the Coordinated Veterans' Care Program?

The Coordinated Veterans' Care (CVC) Program aims to improve the wellbeing and quality of care for chronically ill Gold Card holders through coordinated team care. The program is an initiative of the Department of Veterans' Affairs (DVA).

DVA provides substantial incentives to participate in the CVC program. A practice with 50 eligible Gold Card veterans can earn more than $100,000 per year from the program.

Using cdmNet to manage your CVC patients will reduce workload and paperwork, generate best practice care plans for participants, maximise patient health outcomes, and maximise practice revenues.

## Program Information

The CVC program is a planned and coordinated health care model for veterans, widowers, war widows and dependents who are Gold Card holders with complex care needs, one or more chronic conditions and those at risk of being admitted or readmitted to hospital. The program covers the following conditions:

- diabetes
- congestive heart failure
- coronary artery disease
- chronic obstructive pulmonary disease
- pneumonia

The aims of the program are improved quality of care and better health outcomes for participants, resulting in less need to access hospital services. This is achieved through the provision of preventative and improved management of participants' chronic conditions via education and a proactive, team-based approach to care.

CVC health care is based upon a regularly reviewed, personalised and comprehensive care plan. Care is an ongoing partnership between the CVC participant, their General Practitioner (GP) and a nurse coordinator. The nurse coordinator role is usually performed by a practice nurse.

The nurse coordinator should be in regular contact with the patient (and carer) roughly every six weeks, to assist with making appointments, monitor the patients' progress, assist in self-management and give regular feedback. The GP and nurse coordinator will regularly review the care plan to monitor progress, make any necessary changes, and ensure care is ongoing and planned.

Where the participant lives within reasonable time and distance from the practice, the nurse coordinator is expected to make a home visit within the first month of the participant being admitted to the program and at least one home visit per year.

# Why Use cdmNet?

The Royal Australian College of General Practitioners has endorsed cdmNet as a product supporting quality improvement in general practice. The College recognises that cdmNet is a useful tool for helping general practitioners in managing patients with chronic disease. (Visit cdm.net.au/media for further information.)

In addition to the benefits that cdmNet provides to the management of your chronically ill patients, cdmNet provides particular benefits for practices involved with the CVC Program.

### Better Health Outcomes

cdmNet, as the leading Australian chronic disease management solution, is ideally suited to provide best practice care plans for management of CVC patients in addition to a wealth of functionality aimed at ensuring the entire care team and the patient know what they need to do and when they need to do it[1].

In addition, as cdmNet is web-based, nurses can securely access and contribute to care plans when visiting the patient in their home from any internet-enabled device, including smartphones.

### Reduced Workload

cdmNet reduces the amount of manual paperwork required for CVC patients by automatically generating a care plan and capturing all the information needed for the CVC program requirements.  cdmNet also helps ensure regular follow up and review (four times higher than the national average[1]) and can help track home visits to make sure your practice adheres to the CVC program guidelines.

### Optimised financial benefits

Using cdmNet to reduce workload can optimise the cost/revenue ratio for CVC and related MBS Items while providing clinically proven, superior health outcomes for CVC patients.

*Figure 1.  Initial and ongoing yearly revenue for best practice management of CVC patients*

| | | per patient year 1 | per patient ongoing |
|---|---|---|---|
| **Core payments** | GPMP/TCA/Review | 677 | 677 |
| | CVC initial incentive payment | 408 | |
| | CVC annual payment (ongoing) | 1,703 | 1,703 |
| | Total | 2,789 | 2,381 |
| **Other enabled payments** | Nurse 10997 | 55 | 55 |
| | SIP | 40 | 40 |
| | Home Medicines Review | 152 | 152 |
| | Total | 247 | 247 |

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[1] Wickramasinghe LK et al., Impact on diabetes management of General Practice Management Plans, Team Care Arrangements and reviews Med J Aust 2013; 199 (4): 261-265

# Using cdmNet for the CVC program

## The cdmNet care plan

Upon determining patient eligibility for the program, cdmNet will automatically create a best practice plan. The plan covers all items required for the CVC program, allowing providers to focus on customising the plan for the patient's individual requirements and adding red flags as appropriate.
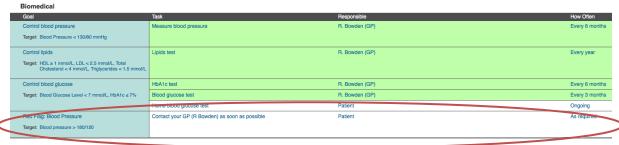
## Creating red flag goals in cdmNet

One key feature of the CVC program is the recording of "red flag" conditions for care providers and the patient. Red flag conditions are not automatically created by cdmNet as they need to be individualised to the patient.

After creating the care plan for the patient in cdmNet, you will therefore need to add the appropriate red flags to the cdmNet care plan. To do this, simply create an additional goal called "Red flag" and an associated target under the relevant section of the care plan (e.g., Biomedical) and specify the required response as a Task for that goal.

For example, a patient with diabetes may need a red flag in relation to blood pressure readings for extreme hypertension, above 180/120 mmHg, requiring the patient to urgently seek medical assistance. To set this in cdmNet:

1. Add a new goal ("Add Goal") under the Biomedical section of the cdmNet care plan, edit the name to be "Red Flag: Blood Pressure", and edit the Target to be "Blood Pressure > 180/120"
2. Edit the name of the associated Task to be "Contact your GP as soon as possible" and set the Responsible Party to "Patient".

*Figure 2. Example of a Red Flag in a cdmNet care plan*

**Biomedical**

| Goal | Task | Responsible | How Often |
|---|---|---|---|
| Control blood pressure <br> Target: Blood Pressure < 130/80 mmHg | Measure blood pressure | R. Bowden (GP) | Every 6 months |
| Control lipids <br> Target: HDL ≥ 1 mmol/L, LDL < 2.5 mmol/L, Total Cholesterol < 4 mmol/L, Triglycerides < 1.5 mmol/L | Lipids test | R. Bowden (GP) | Every year |
| Control blood glucose <br> Target: Blood Glucose Level < 7 mmol/L, HbA1c ≤ 7% | HbA1c test | R. Bowden (GP) | Every 6 months |
| | Blood glucose test | R. Bowden (GP) | Every 3 months |
| | Home blood glucose test | Patient | Ongoing |
| Red Flag: Blood Pressure <br> Target: Blood pressure > 180/120 | Contact your GP (R Bowden) as soon as possible | Patient | As required |

The patient Red Flag goals will appear in the Patient Summary plan, which are filed under the "Documents" tab in cdmNet, and which can be printed and given to the patient.

| Optimise mobility | Preserve mobility | Wheelchair used for long distances (As required) |
|---|---|---|
| Control blood glucose | Blood Glucose Level < 7 mmol/L, HbA1c ≤ 7% | Home blood glucose test |
| Red Flag: Blood Pressure | Blood pressure > 180/120 | Contact your GP (R Bowden) as soon as possible (As required) |
| Avoid foot complications | Minimise foot complications | Foot check |
| Avoid cardiovascular complications | No adverse cardiovascular effects | Action to achieve target |

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### Including patient support devices in a cdmNet care plan

The CVC Program requires that patient aids and devices be included in the care plan. This can be done in cdmNet by adding an appropriate goal and task in the cdmNet care plan under the Lifestyle section. For example, to add information about a patient requiring a wheelchair for longer distances:

1. Go to "Add Goal" in the Lifestyle section of the care plan (Planning tab) and select "Optimise Mobility".
2. Edit the associated Task to be "Wheelchair used for longer distances" and assign the Responsible Party on the Task to the patient as shown below.

*Figure 3. Example of including a patient support device in a cdmNet care plan*

| Optimise mobility | Wheelchair used for long distances | Patient |
|---|---|---|
| Target: Preserve mobility | | |

## Further Information

### CVC Program

The DVA web site has various resources available and on-line training for health professionals: See
http://www.dva.gov.au/health_and_wellbeing/health_programs/cvc/cvchp/Pages/index.aspx

- A Guide for General Practice
- Eligibility criteria
- How to set up your practice
- How to claim

### cdmNet

If you are not already a user of cdmNet, you can register at cdm.net.au/register. Online training videos are available at cdm.net.au/training and webinars at cdm.net.au/webinars.

Further information on cdmNet is accessible via our websites precedencehealthcare.com, cdm.net.au/help, or by contacting Precedence Health Care on (03) 9023 0800 or info@precedencehealthcare.com