

Information Sheet

The Coordinated Veterans' Care Program – what you need to know

What is the CVC program?

The Department of Veterans' Affairs (DVA) Coordinated Veterans' Care (CVC) Program is a planned and coordinated health care model that provides ongoing, primary and community care, led by a GP with a Care Coordinator who may be a: GP, Practice Nurse, DVA-contracted Community Nurse, or an Aboriginal Health Practitioner, to eligible DVA Gold Card holders who have chronic conditions, complex care needs and are at risk of unplanned hospitalisation.

Main features of the program

- provides ongoing **quarterly periods of care** to complement the existing episodic fee-for-service arrangements
- focuses on the **prevention and improved management** of Gold Card holders' chronic conditions
- **educates and empowers** Gold Card holders to better self-manage their conditions
- uses a **proactive team-based** approach to care
- aims to improve the quality of care of Gold Card holders on the program; and
- results in **healthier** Gold Card holders who have **less need to go to hospital**

Who is eligible?

This program is for **DVA Gold Card holders** and who have one or more chronic conditions that have resulted, or are likely to result in frequent unplanned hospital admissions. They must live in the community within Australia.

In essence, the participant will have complex care needs that may lead to a high risk of acute exacerbation which requires frequent monitoring or could contribute to frailty and/or social isolation.

Examples of these conditions include:

- congestive heart failure
- coronary heart disease
- pneumonia
- COPD
- diabetes.

Who is not eligible?

Patients who live in a residential aged care facility and are receiving coordinated care; patients who have a condition which is likely to be terminal within

12 months; or patients who are enrolled in other programs such as Home Care Packages Level 3 and 4 or other Australian Government coordinated care programs.

How are patients identified?

The decision about whether an individual is eligible for the program is made by the GP, in consultation with the individual. The GP may receive a letter from DVA identifying eligible patient(s), or the GP may identify an eligible patient.

The patient (or their carer) must give informed consent to enrol in the program. Consent is recorded in patients' notes (*no special form is required*).

Training modules

These are online at www.onlinetraining.cvcprogram.net.au or available on USB by request. Training and resources in chronic disease management are accredited and are free-of-charge for general practitioners, Aboriginal health practitioners, practice nurses, practice managers and community nurses.

Training is flexible and self-paced.

Training is not mandatory but highly recommended.

For further information:

General information about the Program:

http://www.dva.gov.au/health_and_wellbeing/health_programs/cvc/Pages/default.aspx

Training and

resources: www.cvcprogram.flinders.edu.au/

CVC Provider Helpline: info@cvchelpline.net.au

Phone: 1300 550 597

For workshop enquiries or to request the training modules on USB please contact:

Email: CVCProgram@flinders.edu.au

Web: www.flinders.edu.au/dvacvc

Phone: 1800 652 357

Fax: 08 8404 2101

For more information, or to request a practice visit, nurse support to assist implementing the CVC Program, or a list of DVA-contracted community nursing providers, contact your Medicare Local.

CARE COORDINATION STEPS

Conducting a needs assessment

An over 75 Health assessment may be undertaken and it is preferable this be done in the patient's home. (*Note home visits are not mandatory but are highly recommended*).

There are recommended questionnaires to assist with assessing a person's current self-management of their health. Please refer to the: Flinders Partners in Health tools and mental health (K 10).

Preparing the care plan

The Nurse or GP prepares the patient centered care plan with the patient. While **there is no mandated CVC care plan**, sample templates that meet the CVC requirements are available in the CVC resource materials and on the CVC website. <https://cvcprogram.flinders.edu.au/resources>

Patient friendly version of the care plan

This version should be in large font using simple language to help the patient monitor symptoms and situations where the patient or carer should contact the practice or seek urgent medical care.

The GP must be involved in the finalisation of the care plan. See CVC Program - A Guide for General Practice (Large PDF 4.4MB) http://www.dva.gov.au/health_and_wellbeing/health_programs/cvc/Documents/GGP.pdf

Enrolment and submitting a claim

At this point the patient is enrolled and the first quarterly period of care has commenced.

Date of service

The date of service for the quarterly period is the first day of the quarterly period. For example, if the period of care runs from 7 May to 6 August, then for billing purposes, the date of service is **7 May** but the claim for UP03 or UP04 cannot be made until after **6 August**. **There must be a min of 90 days between claims.**

Refer to the CVC Program Ready Reckoner

[Self-populating claiming date ready reckoner](#) this reckoner automatically calculates the Date of Service and the claiming date for each CVC enrolled patient. [Claiming date ready reckoner spreadsheet](#) this reckoner helps you to calculate the date of service and the claiming date for each CVC enrolled patient.

Payments

In the first year, payments per participant to GPs amount to:

- \$2194.75 if using a practice nurse
- \$1060.25 if not using a practice nurse.

For subsequent years per participant the payments to GPs are:

- \$1770.60 if using a practice nurse
- \$795.20 if not using a practice nurse.

These amounts are reviewed annually.

The payments are **in addition** to all existing items including all chronic disease management items. All GP consultations involved in enrolling patients on the Program and providing ongoing care may be billed in addition to the CVC Program items.

Care Plan review

The Care Coordinator and GP are expected to review and update the care plan at least 6 monthly and renew it at least every 12 months. At these times the GP is expected to decide if the patient should continue on the Program for the next quarter.

DVA Community Nurses

The GP may refer patients to a DVA-contracted community nursing provider. The Community Nurse will conduct an in-home health assessment and forward a copy of the Community Nurse Management plan to the GP for review and visit the patient monthly.

On-going care

This involves coordinating treatment services as per the care plan, regularly reviewing and renewing the care plan and using a proactive approach to improve the patient's self-management of their chronic conditions.

Through regular contact (at least monthly and may be by telephone) the care coordinator can provide advice and motivational counselling, liaise with the carer to keep them informed of progress, make appointments with other care providers, provide other health professionals with a copy of the care plan, liaise with emergency and / or hospital discharge departments and consider social isolation.

Consider CVC Social Assistance

GPs can refer socially isolated CVC participants to the Veterans Home Care assessment agency, (*call 1300 550 450*), for up to 12 weeks of assistance aimed at increasing participation in community activities.

These services focus on building the confidence of participants to promote ownership and motivation for their ongoing social health, with a view to establishing and maintaining long-term benefits, such as:

- re-entry into community life
- expanding the type and frequency of social contact
- encouraging the veteran to proactively engage with communities of interest. http://www.dva.gov.au/health_and_wellbeing/health_programs/cvc/cvchp/Pages/cvcsa.aspx

Patient Treatment Report

The report is compiled from DVA treatment data and is designed to provide insight into the patients' medical history and display potential opportunities for optimising patient care. It does not replace GP's clinical judgment in treating patients. Provided electronically to GPs four to six weeks after patient enrolment and quarterly thereafter. (*First report is in hard copy then available on HPOS*).