Coordinated Veterans' Care Program

Planned and coordinated health care for eligible Gold Card holders with chronic conditions and complex care needs and who are at risk of unplanned hospitalisation

A guide to implementation




This resource provides an overview of the Coordinated Veterans' Care (CVC) Program and is presented in three sections covering key aspects for the health care team involved in preparing, enrolling and providing ongoing care in the CVC Program.

Intended as a brief guide to implementing the CVC Program, it will ideally be used with the CVC Program - A Guide for General Practice (PDF 4.5 MB). Relevant resources for each stage are included with additional information available from the CVC Program website and the Department of Veterans' Affairs (DVA) website.

Accredited training incorporating the latest clinical evidence for self-management care planning in multi-disciplinary care in a primary care environment has been developed for General Practitioners (GP), Practice Nurses (PN), Aboriginal Health Workers (AHW) and Community Nurses (CN). Health professionals are encouraged to undertake the four online modules for more in-depth information with Enrolled Nurses (EN) and AHWs required to complete at least Module One of the online training.

The training can be accessed from https://onlinetraining.cvcprogram.net.au

- Module 1 Is your service ready?
- Module 2 Care Planning and Coordination with the Flinders Program™
- Module 3 Managing Care Plans with disease-specific elements
- Module 4 Veterans' social isolation, mental health and wellbeing.

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Glossary

AHW	Aboriginal Health Worker
APNA	Australian Primary Care Nurses Association
CN	Community Nurse
CVC	Coordinated Veterans' Care Program
DVA	Department of Veterans' Affairs
EN	Enrolled Nurse
GP	General Practitioner
GPMP	General Practice Management Plan
HPOS	Health Professional Online Services
MBS	Medicare Benefit Schedule
NC	Nurse Coordinator
PN	Primary Care Nurse
PM	Practice Manager
PTR	Patient Treatment Report
RACF	Residential Aged Care Facility
VHC	Veterans' Home Care
VHCAA	Veterans' Home Care Assessment Agency

Coordinated Veterans' Care Program Overview

The Coordinated Veterans' Care (CVC) Program provides eligible Gold Card holders with a practice team based model of coordinated health and community care. CVC health care is based around a personalised comprehensive Care Plan developed in collaboration with the CVC participant to educate and empower themselves in improved self-management of their chronic condition/s. Care is an ongoing partnership between the CVC participant, their General Practitioner (GP) and a nurse coordinator.

It is a targeted program for Gold Card holders with one or more chronic conditions, complex care needs and at risk of unplanned hospitalisation. The targeted conditions include:

- congestive heart failure (CHF)
- coronary artery disease (CAD)
- chronic obstructive pulmonary disease (COPD)
- diabetes
- pneumonia.

Care is GP led, with a nurse coordinator working with the CVC participant (and carer if applicable). Implementing the CVC Program involves the following:

- The practice team is aware of and ready to implement the program
- Eligible Gold Card holders are identified
- GP assessment of the Gold Card holder's eligibility to participate
- GP explains the Program to the Gold Card holder and obtains informed consent
- A comprehensive assessment is done by the GP or nurse coordinator
- A care plan is prepared by the care team with the Gold Card holder
- A patient friendly version of the Care Plan is given to the Gold Card holder
- GP may assess a Gold Card holder for social assistance and if appropriate refer them to a Veterans' Home Care (VHC) assessment agency
- Nurse coordinator coordinates all aspects of Gold Card holder's health care using the Care Plan
- Nurse coordinator provides regular feedback to the GP
- Care Plan is reviewed regularly and updated.

Prepare for the CVC Program

While many practices are already delivering proactive, planned, multidisciplinary care, there may be some changes needed to the practice set-up and procedures to implement the CVC Program. GPs who decide to be involved in the CVC Program are responsible for preparing for the program, enrolling participants and providing ongoing care.

The CVC Program provides payments for ongoing team-based, quarterly periods of care to complement the existing fee-for-service arrangements. Note: the CVC MBS items are in addition to all existing MBS Schedule items.

GPs enrol eligible Gold Card holders and provide ongoing, comprehensive and coordinated care with the assistance of the nurse coordinator. The nurse coordinator can be a PN; a CN from a DVA contracted community nursing provider or an AHW. Identifying and appointing a nurse coordinator for each participant on the CVC Program who will have access to a private space when undertaking care coordination and meeting with CVC participants is an essential action for this stage.

The CVC Prepare your Practice Checklist lists questions and suggested responsibilities when reviewing your practice's readiness to implement the CVC Program.

Resources (preparing for the CVC Program)

- DVA Brochure – CVC Program - A Guide for General Practice
- DVA Brochure – Information for Veterans
- DVA Brochure – Information for general practitioners and practice nurses
- DVA Brochure – Information for DVA contracted Community Nursing providers

Contacts

For general queries about the CVC Program Phone: 1300 550 597 info@cvchelpline.net.au	**For queries about payments and claiming** Phone: 1300 550 017	**For CVC Program training and resources:** Phone: 1800 652 357 cvcprogram@flinders.edu.au www.cvcprogram.flinders.edu.au
For details of DVA Contracted Community Nursing Providers Phone: 1300 550 457 (metro areas) Phone**:** 1800 550 457 (non-metro areas)	**For details of Veterans' Home Care Assessment Agencies:** Phone: 1300 550 450	**Information for veterans and carers** Phone: 133 254 Regional Callers: 1800 555 254 CVCProgram@dva.gov.au Mail: CVC Program, GPO Box 9998, Canberra ACT 2601

Enrolling participants in the CVC Program

The CVC Program targets veterans, war widows, war widowers and dependents who are Gold Card holders with one or more chronic condition, complex care needs and at risk of unplanned hospitalisation. The program is primarily focused on Gold Card holders with the following conditions:

- congestive heart failure (CHF)
- coronary artery disease (CAD)
- chronic obstructive pulmonary disease (COPD)
- diabetes
- pneumonia.

Enrolling a potential participant in the program involves:

- a GP assessment of the Gold Card holder's eligibility to participate
- explaining the program to the Gold Card holder and obtaining informed consent
- conducting a needs assessment by the GP and/or nurse coordinator
- preparing a Care Plan with the Gold Card holder
- giving a patient friendly version of the Care Plan to the Gold Card holder
- a GP assessment of the need for social assistance and, if appropriate, referral to a VHC assessment agency.

Identifying potential CVC participants

Individuals may be identified as potential participants for the program in the following ways:

- DVA may identify potential participants using predictive modelling to analyse the health care data of Gold Card holders
- A Gold Card holder may ask to participate
- A care provider – carer, specialist, allied health worker etc, hospital discharge planner or community nurse may recommend a Gold Card holder be assessed by their GP to participate
- GP may identify one of their Gold Card holders as suitable

Initial screening: When identifying a veteran as a possible participant, or a request for an assessment appointment is received, either the GP or PN needs to check the patient's medical record to ensure there are no obvious disqualifying factors (i.e. terminal condition or living in a residential aged care facility: *see Eligibility Checklist*). The Gold Card holder can be contacted and the CVC Program explained to them. An assessment appointment can then be made if the patient is interested in the program.

Assessing eligibility for the program

During the assessment appointment the GP assesses the potential participant using the Eligibility checklist criteria.

Eligibility Checklist

MUST apply	Must NOT Apply
Be a DVA Gold Card holder	Have a terminal disease (diagnosed as likely to be terminal within 12 months of initial admission to CVC Program)
Give informed consent to join the program	Does not consent to join the program
Be a resident of Australia and living in the community	Be a permanent resident in a Residential Aged Care Facility (RACF)
Have one or more chronic conditions such as: • congestive heart failure (CHF) • coronary artery disease (CAD) • chronic obstructive pulmonary disease (COPD) • diabetes • pneumonia	Live overseas
Have complex care needs such as: • multiple comorbidities that complicate treatment • unstable condition with a high risk of acute exacerbation • condition is contributed to by frailty, age and / or social isolation factors • limitations in self-management and monitoring • have multiple care providers • have a complex medication regimen • require frequent monitoring and review • require support with self-management and self-monitoring	Be a participant in any similar Commonwealth program, for example the Department of Social Services coordinated care program (see note below regarding Home Care Packages*)
Be at risk of frequent unplanned hospitalisation	

* Note regarding the Department of Social Services Home Care Packages Program - A Home Care Package is a coordinated package of services tailored to meet specific care needs.
A Home Care Package provides services that can help a person to stay at home and give choice and flexibility in the way that care and support is provided to the client. Home care providers receive funding from the Australian Government to provide these services across four levels of Home Care Packages.

- Level 1 supports people with basic care needs
- Level 2 supports people with low-level care needs (equivalent to the former Community Aged Care Packages)
- Level 3 supports people with intermediate care needs
- Level 4 supports people with high care needs (equivalent to the former Extended Aged Care at Home and Extended Aged Care at Home Dementia packages).

Gold Card holders on Levels 3 or 4 Home Care Packages would be ineligible for the CVC Program as they are already receiving high level coordinated health care.

Consent

When seeking informed consent the GP explains to the Gold Card holder:

- what it means to be on the program
- that their health information will be shared with other health professionals involved in their care
- that a nurse will coordinate their health care
- a Care Plan will be developed by the GP, the nurse coordinator and the Gold Card holder working together
- they will receive a patient friendly version of the Care Plan
- that details of health services used by them through DVA will be made available to their GP
- their privacy will be protected under the relevant legislation

A suggested script for obtaining informed consent can be found on page 32 in the DVA Brochure CVC Program - A Guide for General Practice

Needs assessment

A comprehensive needs assessment of the participant is undertaken to assess their current self-management of their health, lifestyle and mental health by either the GP or nurse coordinator. The CVC Program toolkit includes questionnaires for use in conducting a comprehensive needs assessment – The CVC Program Toolkit – needs assessment

Preparing and finalising a Care Plan

To allow flexibility for GPs, there is no mandated Care Plan template for the CVC Program. There is however, a checklist of the minimum requirements for a Care Plan for a CVC participant which should include:

- a description of all chronic and other health conditions, including:
  - current care guide
  - targets
  - red flags
  - background information
  - current management
  - most recent results
- medications list including dose, frequency and known adherence
- allergies and adverse reactions
- self-management goals and strategies
- any family and / or carer contact details
- significant medical events and results
- other treatment providers and their contact details
- referrals planned and reasons for referral
- devices being used.

The Care Plan is a comprehensive version of a General Practitioner Management Plan (GPMP), which is an existing LMO Fee Schedule item and is billed as a separate service to the CVC items. The GP or nurse coordinator discusses the Care Plan with the participant to ensure that the veteran understands the goals of the Care Plan, the interventions and self-management aspects, the methods of monitoring and evaluating the plan, and the need for regular monitoring and review. It may take several sessions to obtain the information you require for the Care Plan and also prepare the patient friendly version in consultation with the participant. When this is

complete, the participant is asked to consent to the Care Plan and is provided with a patient friendly version of the Care Plan.

Consider the need for social assistance

The GP and /or nurse coordinator should also consider whether the participant could benefit from CVC Social Assistance which provides a short-term service to CVC enrolled patients to enable (re)engagement in community based activities. This requires a GP referral to VHC assessment agency (VHCAA). For information on the nearest VHC assessment agency, phone 1300 550 450 and for further information on Social Assistance refer to the CVC section of the social assistance page on the DVA website.

Enrolment summary

- identify potential participants
- assess eligibility for the program
- gain informed consent
- conduct a needs assessment
- prepare a Care Plan with the participant (*this may be prepared over a period of time)*
- finalise the Care Plan, including a patient friendly version, with the participant
- consider the need for social assistance.

There is no enrolment form to complete and return to DVA. When all steps are completed, the GP records the enrolment and consent on the patient's record. By enrolling a Gold Card holder in the CVC Program, a GP is accepting the clinical leadership and oversight role for the participant.

Submitting the Initial Incentive Payment claim?

The Initial Incentive Payment can now be claimed; the first quarter of care commences but cannot be claimed until the 90 day quarter is complete. Claiming the Initial Incentive Payment will automatically inform DVA that the Gold Card holder is now a participant in the CVC Program. The Initial Incentive Payment is a one-off payment paid only once per Gold Card holder, made to the GP for undertaking steps to meet enrolment requirements. If the nurse coordinator is a CN, it is very important that the GP submits their first claim promptly, as a claim by the CN will be rejected if the GP's Initial Incentive Payment has not yet been made.

Quarterly Care Payments are claimed on a 90 day basis for a period of ongoing clinical care. The Date of Service for each quarterly period is the **first day** of the quarterly period and the claim for payment is made **after the last day** of the quarterly period (more information about CVC billing is included in the Provide ongoing care section).

Resources (enrolling Gold Card holders in the CVC Program)

- DVA Brochure – CVC Program - A Guide for General Practice
- DVA Brochure – Information for general practitioners and practice nurses
- DVA Brochure – Information for Veterans
- DVA Brochure – Information for DVA contracted community nursing providers
- List of DVA-contracted community nursing providers
- The CVC Program toolkit includes questionnaires for use in conducting a comprehensive needs assessment: CVC Program Toolkit – needs assessment
- CVC Provider Helpline info@cvchelpline.net.au
- Department of Veterans' Affairs (DVA) website

Provide ongoing care

The Model of Care for the CVC Program is based on the team, which includes the veteran, the Gold Card holder's carer (if applicable), the GP and the nurse coordinator, who is a PN, CN or AHW. The CVC model encourages a proactive approach by the care team. Utilising tools such as the Flinders Program™ to assess self-management capacity and support results in collaborative problem definition, enables targeted goal setting that leads to a personalised Care Plan. Self-management support is provided by the care team:

- through information so that the veteran better understands what will improve their condition and what will make their condition worse
- using motivational and behaviour change counselling and support addressing the physical and emotional demands of chronic conditions to empower the veteran to follow their self-management goals, e.g. lose weight or do more exercise
- through active and sustained follow-up (reliable follow-up leads to better outcomes) with regular communication with the team reviewing, updating and renewing the Care Plan.

Care planning, coordination and review within the multidisciplinary team through the sharing of health information is a key feature of the CVC Program. The availability of electronic health records (PCEHR) will assist in the sharing of health information amongst all providers of health care for CVC participants.

Ongoing care provided under the CVC Program is not a replacement of the continued interaction between the GP and the patient with regular consultations and medical management still needed.

Coordinate treatment services as per the Care Plan

The nurse coordinator is responsible for coordinating treatment services for each Gold Card holder based on their Care Plan with the GP providing regular advice and guidance to the coordinator. As the nurse coordinator can be a PN, CN or AHW duties will vary slightly. For specific details please refer to pages 23 and 24 of the DVA Brochure – CVC Program - A Guide for General Practice

Coordinating treatment services for the participant involves the following:

- monitor progress according to the Care Plan
- monitor physical and mental condition
- maintain regular contact - at least monthly
- provide advice, e.g. medication, health coaching, motivational counselling
- liaise with the carer and keep them informed of progress and changes to the Care Plan
- make appointments with other care providers if necessary, and provide a copy of the Care Plan to all specialists, allied health practitioners and other care providers (as appropriate and agreed with the GP)
- monitor the actions of all care providers (e.g. prescriptions, tests, referrals and recommendations) through feedback from the veteran, carer, consultation reports and calls to other care providers
- liaise with emergency and / or hospital discharge departments
- consider and address ongoing social isolation issues
- provide regular feedback about the participant's condition to the GP, including advice on their need for social assistance services and alerts where changes occur in their condition
- provide feedback to the GP - at least monthly
- maintain up-to-date records of all monitored actions and coordination activity.

Contact with the participant may be by telephone, in rooms or through home visits. Home visits are not mandatory but highly recommended for PNs and AHWs.

Regularly review, update and renew the Care Plan

The care team is expected to review treatment services for the participant on a regular basis with the Care Plan being reviewed / updated at least every six months and renewed at least every 12 months.

DVA produces a quarterly Patient Treatment Report (PTR) from its payment data for each CVC participant. The report includes health services received, medication history and clinical pathways. The first PTR for a participant is sent to the GP in a hard copy format and subsequent PTRs are available online via Health Professional Online Services (HPOS). The PTR is intended to be used as a support tool to assist in identifying potential gaps in patient care.

Summary of responsibilities

GP	Nurse coordinator - PN or AHW	CN
Eligibility Assessment	Comprehensive needs assessment including a home visit if appropriate	Receive referral and Care Plan from GP
Gain informed consent	Prepare the Care Plan	In-home assessment
Sign off Care Plan with participant's consent	Prepare the patient friendly version of the Care Plan	Prepare CN Management Plan and forward to the GP for review
Consider the need for social assistance	Coordinate care	Prepare patient friendly version of Care Plan
Monitor care coordination	Monitor participant's condition	Coordinate care including visiting the CVC participant at home – at least once every 28 days
Decide whether the participant should continue on the program before the end of a quarterly period of care	Encourage self-management	Monitor participant's condition
Review Care Plan with care coordinator and participant * where a CN is the care coordinator this should be at least monthly	Motivate the participant	Encourage self-management
Arrange for appointments to be made for the participant to attend the practice for a review or renewal	Give feedback to GP and provide reminder of when a quarterly period of care is about to expire	Motivate the participant
	Send new or reviewed Care Plans to other care providers (as appropriate and agreed with GP)	Give feedback to and receive feedback from the GP

Care Plan templates and tools

Instructions for importing Sample Care Plan templates and the Flinders Program™ tools into current versions of Medical Director, Best Practice and Zedmed medical software are available with templates provided for the following documents:

- CVC comprehensive Care Plan
- CVC patient friendly Care Plan
- Care Plan self-management page
- Partners in Health Scale
- Cue and Response interview
- Problem and Goals Assessment.

Accredited training

Online training and resources are provided for GPs, PNs, nurse coordinators, CNs, AHWs and Allied Health Professionals. The accredited training will further develop your understanding of self-management, care planning and the benefits and processes of multi-disciplinary care in a primary care environment. Details of the online training can be found here.

Resources (delivering the CVC Program)

- The CVC Program toolkit includes questionnaires for use in conducting a comprehensive needs assessment: Coordinated Veterans' Care (CVC) Program Toolkit
    - CNAT Quick Reference Guide 12 May 2014 (PDF)
    - CNAT form 7 May 2014 (PDF)
    - CNAT Reference Manual 12 May 2014 (PDF)
- List of DVA-contracted community nursing providers
- CVC Program Veteran's Home Care - Social Assistance
- DVA Brochure – CVC Program - A Guide for General Practice
- DVA Brochure – Information for general practitioners and practice nurses
- DVA Brochure – Information for Veterans
- DVA Brochure – Information for DVA contracted community nursing providers
- List of DVA-contracted community nursing providers
- The downloadable scheduling spreadsheet can be used in your practice to track CVC claiming for enrolled veterans CVC Claiming tracking schedule (Excel)
- Mental Health Resources
  For eligible serving or ex-serving Defence personnel, or their families who are concerned about their mental health visit www.at-ease.dva.gov.au or call the Veterans and Veterans' Families Counselling Service (VVCS) on 1800 011 046 for free, confidential counselling and support 24 hours a day.
  At Ease also has clinical resources and factsheets for health professionals who may be treating members of the veteran and defence community.
  vetAWARE is available for all health professionals as well as for representatives of ex-service organisations who want to learn more about the common mental health challenges faced by veterans and what help is available. To access the vetAWARE online training program, visit DVA's Learning Management System, DVAtrain.

Information for Practice Managers

The CVC Program requires 'buy in' across the whole practice, and excellent teamwork is required to implement high standard coordinated care for the participant in an efficient and effective way. Administrative support for clinical activities, scheduling of participant contact and claiming activities contributes to the success of a 'whole of practice' approach to implementation of the CVC Program Model of Care.

How to claim

By participating in the CVC Program, GPs can claim the following payments through existing payment arrangements with Medicare:

- Initial Incentive Payment for enrolling a participant in the program. This is a one-off payment made to the GP for enrolling a person in the program and completing all enrolment activities.
- Quarterly Care Payments for ongoing care. Paid quarterly as part of ongoing clinical care leadership of a participant in the CVC Program. A claim is submitted upon completion of each quarter (the previous quarter must have expired before claiming) and the new quarter commences.

A GP who uses a PN or AHW as the care coordinator is paid at the higher rate shown in the table below. A GP who uses a CN or does the coordination themselves is paid the lesser amount (where a CN is used, the DVA contracted nursing provider is paid for the nurse coordination activity). In claiming any item, a GP is confirming that all steps necessary for the enrolment of a Gold Card holder or for the ongoing coordination of care have been done. DVA may conduct post payment audits to ensure compliance.

Payments GPs can claim – fees effective 1 July 2014

	Initial Incentive Payment		Quarterly Care Payments		Total year 1	Total year 2 onward
	$	Item #	$	Item #		
GP with PN	$424.15	UP01	$442.65	UP03	**$2194.75**	**$1770.60**
GP without PN	$265.05	UP02	$198.80	UP04	**$1060.25**	**$795.20**

Claiming date ready reckoners

These reckoners will assist in calculating the date of service and the claiming date for each CVC enrolled patient with further information to be found in the How to Claim section on the DVA website.

- CVC Program Ready Reckoner 2012-2015
- Self-populating claiming date ready reckoner (XLS 440 KB)
- The full fee schedule for CVC Program items is on the CVC Program Fees section on the DVA website. Payments are in addition to all existing LMO Fee Schedule items for consultations and chronic disease management items.

- Home Visiting Guidelines
- List of DVA-contracted community nursing providers
- Professional Indemnity – APNA
- CVC Checklist Guide
- CVC Prepare Your Practice check list
- Home Care Packages Guidelines
- Home Care Packages Veterans Eligibility Supplement
- CVC business case financials example
- Medicare benefits schedule
- CVC claiming MBS guide