

Department of Veterans' Affairs –  
Coordinated Veterans' Care Program



Australian Government

Department of Veterans' Affairs

# Information for Veterans



Coordinated Veterans' Care Program



# The Coordinated Veterans' Care (CVC) Program

## What is the CVC Program about?

The new CVC Program provides planned and coordinated care for Gold Card holders who are most at risk of unplanned hospitalisation due to chronic illness and complex care needs.

The focus of the program is on prevention and improved management of chronic diseases resulting in improved quality of life, and reduced risk of hospitalisations. The program is voluntary and is in addition to any existing DVA services.

## What does it mean for me?

If you are eligible (see page 3) and enrolled in the CVC Program, your ongoing and planned care will be based on a personalised Care Plan developed by your General Practitioner (GP) along with a nurse coordinator and in consultation with you. The GP and the nurse coordinator will work closely with you to help you understand your health needs, assist you in managing your conditions and to coordinate the various aspects of your care.

All of this will be in your Care Plan. Your Care Plan will be regularly reviewed and you will be given a patient friendly version of the plan to take home and keep handy as a reminder of your medications, appointments and health goals.

## When did the program start?

The CVC program started on 1 May 2011. DVA will progressively write to Gold Card holders who may benefit from the program. It is not essential to be enrolled in the program by 1 May. Eligible Gold card holders can be enrolled anytime after 1 May.

## Is the CVC Program for me?

The decision about whether you are eligible for the CVC Program and whether it is the right option for you, will be made by the GP in consultation with yourself.

You must have a Gold Card and cannot be:

- living in a residential aged care facility
- diagnosed with a condition that is likely to be terminal within 12 months or
- participating in any of the following Commonwealth Department of Health and Ageing programs:
  - Extended Aged Care at Home
  - Community Aged Care Package
  - Transition Care
  - any other similar Department of Health program.

In assessing your eligibility for the program, the GP will decide whether you have chronic conditions, complex care needs, are at risk of frequent hospitalisation and would benefit from the program.

## How do I enrol onto the CVC Program?

You may access the program through your GP who will conduct an assessment to see whether you are eligible. The assessment appointment can happen in a number of ways:

- DVA will identify and write to those most at risk of hospitalisation and encourage them to seek an assessment by their GP
- your GP or another care provider may suggest you make an appointment with your GP for an assessment
- you may approach your GP for an assessment.

You will need to make an appointment with your GP, ensuring that sufficient consultation time is allowed for a CVC assessment.

If your GP agrees that you are eligible, the GP will explain the program and ask you to consent to the sharing of your relevant health information with all of your health care providers.



# Jack's\* story

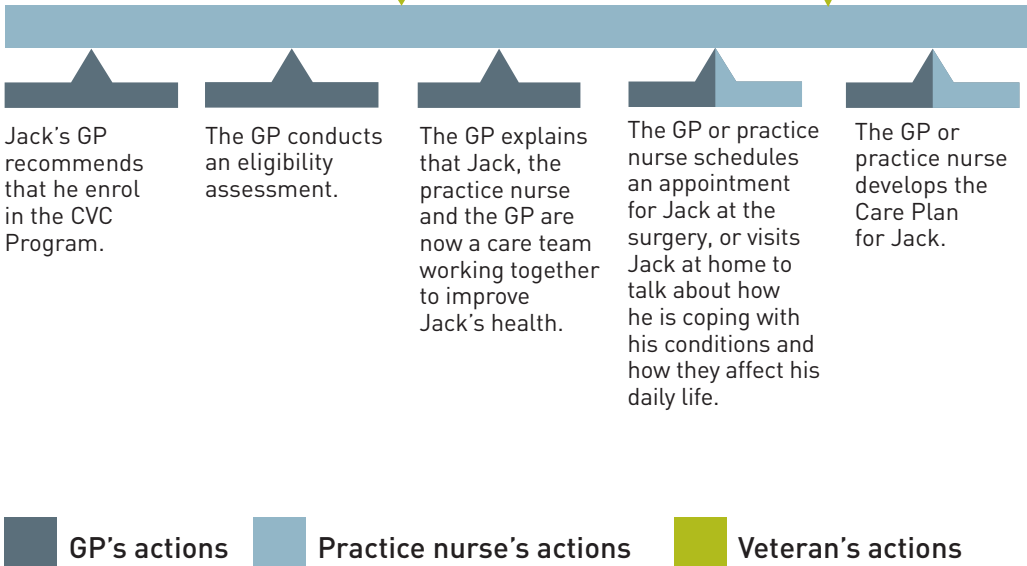


## Jack – age 70

- Gold Card veteran
- Diabetes
- Hypertension
- Congestive heart failure
- Forgets medications
- Poor diet
- Has been hospitalised twice within the last 6 months

Jack is eligible, agrees to participate and gives his consent.

Jack answers questions about how much he understands and copes with his conditions and what he might do differently to improve his health.



\*Jack's story is representative only and used as an example of how the care planning cycle may progress.

Jack consents to the Care Plan which includes information on Jack's health problems and needs, goals, planned actions by health professionals, patient actions and involved service providers.

Jack receives a simple version of the Care Plan which he takes home to remind him of what he has to do.

When Jack sees his GP for regular appointments they talk about the Care Plan and how Jack is getting on with the things in the plan he can do for himself.

After some time on the program, Jack is taking all his medications on time, has improved his diet and health, and he has not been hospitalised. Jack stays on the program and enjoys being healthier and happier.

The practice nurse regularly calls or visits Jack to see how he is getting on and whether he is sticking to the Care Plan.

The practice nurse regularly talks to the GP about how Jack is going.

## Where can I find more information?

Call 133 254

Email [cvcprogram@dva.gov.au](mailto:cvcprogram@dva.gov.au)

Visit [www.dva.gov.au/cvc.htm](http://www.dva.gov.au/cvc.htm)

**For more information:**

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**Coordinated Veterans' Care Program**

The Coordinated Veterans' Care Program is a Department of Veterans' Affairs initiative, supported by primary service provider, Bupa Health Dialog.



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