

For more information:

Call 1300 550 597

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Coordinated Veterans' Care Program

Department of Veterans' Affairs –  
Coordinated Veterans' Care Program

## Information for DVA contracted community nursing providers



Australian Government  
Department of Veterans' Affairs

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



Australian Government  
Department of Veterans' Affairs



Coordinated Veterans' Care Program





# The Coordinated Veterans' Care Program

## What is the program about?

The Coordinated Veterans' Care Program (CVC Program) is a new Department of Veterans' Affairs (DVA) program to better manage and coordinate primary and community care for Gold Card holders who are most at risk of being admitted or readmitted to hospital. Gold Card holders includes veterans, war widows, war widowers and dependants, hereafter referred to as 'veterans'.

The Program is targeted only at Gold Card holders most at risk and is only for around 10% of Gold Card holders living in the community. Chronic disease management items are still available for the remainder of Gold Card holders.

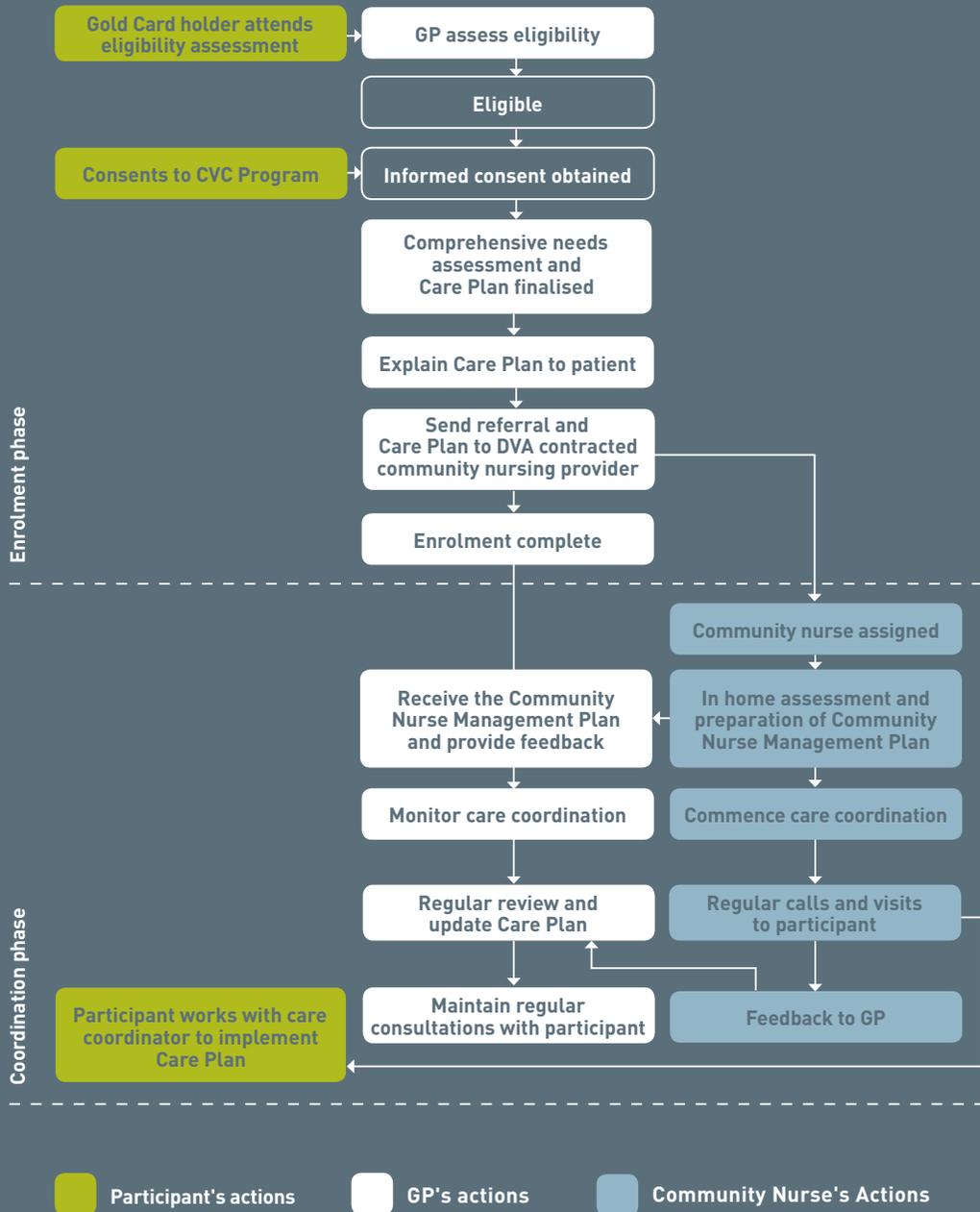
The CVC Program is focussed on providing additional support for veterans with one or more chronic diseases or conditions, and who have been identified as having complex care needs.

## What is the community nurse's role?

The key element of the CVC Program is the core team of the participant, the participant's carer (if applicable), the nurse coordinator and the GP. The team uses care planning, coordination and review as tools to focus on better management and self management of the CVC participants' health. Regular dialogue between the community nurse and the GP is vital to the success of the program. The role of the community nurse is to coordinate care for the CVC participant by:

- receiving the GP Care Plan and referral
- monitoring Care Plan progress
- providing health coaching and motivational counselling
- if agreed with the GP, providing a copy of the GP Care Plan to relevant health practitioners and care providers, and monitoring actions
- liaising with the CVC participant's carer to ensure they are kept informed of progress and changes to the GP Care Plan
- maintaining accurate records of all actions and coordination activities
- keep in regular contact and undertake a home visit at least once every 28 days.

# How does the CVC Program work?



# Who is the CVC program for?

Only current DVA Gold Card holders are eligible to participate in the CVC Program. To be enrolled the CVC participant must also:

- In the opinion of the GP have one or more chronic conditions that:
  - has resulted, or could reasonably result in frequent hospitalisations
  - has complex care needs
  - requires a treatment regimen that involves complex ongoing care.
- To the best of the GP's knowledge **none** of the following apply to the CVC participant:
  - lives in a residential aged care facility
  - has been diagnosed with a condition that in the opinion of the GP would likely be terminal within 12 months
  - is 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 and Ageing** program.

The decision to enrol a participant in the CVC Program is made by the GP – following an assessment against the eligibility criteria and with the informed consent of the veteran.

**Participation in the CVC Program is not mandatory and only those eligible Gold Card holders who consent will be enrolled on the program.**



# Enrolling a participant in the CVC program

## How are CVC participants enrolled in the program?

Veterans may be identified to participate in the CVC Program in one of the following ways:

- veteran and GP receive letter from DVA advising they have been identified as a potential participant
- GP identifies veteran as potential participant
- veteran self identifies as potential participant

Once a veteran has been identified as a potential participant and is interested, an appointment is scheduled and the GP conducts an eligibility assessment.

If the veteran is eligible, the GP conducts a needs assessment, prepares a GP Care Plan and records the veteran's consent to participate. If the GP then wishes to engage a DVA contracted community nursing provider, the GP attaches the GP Care Plan to the referral to the community nursing provider, faxes the referral and a community nurse is engaged.

## Next Steps

Once engaged, the community nurse prepares a Community Nurse Management Plan and visits the veteran at least once every 28 days to assess their progress. The community nurse then provides feedback to the GP every 28 days on the progress and wellbeing of the veteran.

When a participant is being enrolled in the CVC Program, or any time afterwards, the GP may refer socially isolated CVC participants for social assistance. This will be short term (up to 12 weeks) assistance aimed at increasing the participation in community activity.

The community nurse can also recommend to the GP that the CVC participant could benefit from the social assistance service.



## Where can I find more information?

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