Department of Veterans' Affairs Treatment Cycle Initiative Evaluation

FINAL REPORT

QUEENSLAND UNIVERSITY OF TECHNOLOGY (QUT) Kelvin Grove, Queensland

SECTION 1: INTRODUCTION

Acknowledgements

Acknowledgement of Country

The Department of Veterans' Affairs (DVA) acknowledges the Traditional Custodians of Country throughout Australia. We pay our respects to Elders past and present.

We recognise and celebrate Aboriginal and Torres Strait Islander people as the First Peoples of Australia and their continuing spiritual and cultural connection to land, sea and community (DVA, n.d.-a).

In keeping with the spirit of Reconciliation, QUT acknowledge the Turbal, Jagera/Yuggera, Kabi Kabi and Jinbara Peoples as the Traditional Owners of the lands where QUT now stands—and recognise that these have always been places of teaching and learning.

QUT wishes to pay respect to the Elders—past, present and emerging and acknowledge the important role Aboriginal and Torres Strait Islander people continue to play within the QUT community (Anderson, 2020).

Acknowledgement of Service

The Australian Defence Veterans' Covenant serves to recognise and acknowledge the unique nature of military service and the contribution of veterans and their families (DVA, n.d.-b).

Acknowledgement of Contribution

We acknowledge people with a lived experience of allied health treatment cycle arrangements, their families, friends and supporters. We acknowledge all who provided input into this evaluation process, including current and former serving members of the Australian Defence Force and their families, service providers and professional organisations, the DVA Advisory Group and the QUT Expert Reference Group convened for the purposes of this evaluation.

We also acknowledge the input received from Commonwealth agencies, including representatives from the Department of Veterans' Affairs and Primary Health Networks.

The QUT evaluation team

Table 1.1: QUT evaluation team

Name	Position and affiliation
Louise Baldwin l.baldwin@qut.edu.au	Co-Chief Investigator/Researcher QUT, Faculty of Health School—Public Health and Social Work
Dr Kerri-Ann Woodbury kerriann.woodbury@qut.edu.au	Co-Chief Investigator and Project Advisor for Veteran's Health QUT, Faculty of Health School—Clinical Sciences, Paramedicine
Prof. Vivienne Tippett vivienne.tippett@qut.edu.au	Project Expert—Health Services Demand, Performance and Outcomes QUT, Faculty of Health School—Clinical Sciences
Assoc. Prof. Renata Meuter r.meuter@qut.edu.au	Project Expert—Health Services Consumer Communication QUT, Faculty of Health School—Psychology and Counselling
Dr Amina Tariq a.tariq@qut.edu.au	Project Expert—Health Information Management and Interprofessional Communication QUT, Faculty of Health School—Public Health and Social Work
Prof. Steve McPhail steven.mcphail@qut.edu.au	Project Expert—Health Services and Health Economics QUT, Faculty of Health School—Public Health and Social Work
Dr Sanjeewa Kularatna sanjeewa.kularatna@qut.edu.au	Project Expert—Health Services and Health Economics, Senior Research Fellow QUT, Faculty of Health School—Public Health and Social Work

Core research team		
Caitlin Cole	Project Manager	caitlin.cole@qut.edu.au
Jessica Woodward	Research Assistant	jl.woodward@qut.edu.au
Stacey Pizzino	Research Assistant	stacey.pizzino@qut.edu.au
Health economics analysis		
Rex Parsons	Senior Research Assistant	
Sameera Senanayake	Research Fellow	

About this document

Enquiries about this publication should be directed to:

Contact details: Dr Kerri-Ann Woodbury
kerriann.woodbury@qut.edu.au

Abbreviations

ABS	Australian Bureau of Statistics
ADF	Australian Defence Force
AHP	Allied health provider
AMA	Australian Medical Association
ASGS	Australian Statistical Geography Standard
DVA	Department of Veterans' Affairs
ESO	Ex-service organisations
GEE	Generalized estimating equation
GP	General practitioner
Health providers	Medical (GP) and allied health providers
PEMAT-P Materials	Patient Education Material Assessment tool for Printable
PHN	Primary health networks
QUT	Queensland University of Technology
RACGP	Royal Australian College of General Practitioners
REPOC	Research ethics point of contact
TPI	Totally and permanently incapacitated

Key definitions

For the purposes of this project, the following definitions will be used:

Engagement: number and quality of interactions

Operational impact: measure of change in experience related to time, energy, cost and/or administrative requirements

Quality of care: the quality of service provision to meet health needs

Clinical resources: generic templates provided to GPs and AHPs by DVA (publicly available)

Care coordination: the act of the clinical and administrative oversight of an individual's care across all health practitioners for all health conditions for that individual

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Introduction

Context for this evaluation

In 2018, the Australian Government announced a budget measure to improve the Department of Veterans' Affairs (DVA) dental and allied health arrangements for the veteran community. The reform package included treatment cycle arrangements for general practitioner (GP) referrals for allied health services, which came into effect on 1 October 2019.

On 29 April 2020, DVA released a Request for Quotation (RFQ) to evaluate the treatment cycle arrangements. Queensland University of Technology (QUT) submitted a response to the RFQ that satisfied all criteria established in the statement of requirements and met all conditions set out in the deed of standing offer. In June 2020, QUT was contracted by DVA through an open competitive tender process to undertake an evaluation of the change to the treatment cycle arrangements. QUT then undertook a formative evaluation of the treatment cycle arrangements, which examined the implementation and impact of recent changes to allied health arrangements for DVA clients.

The aim of this project was to evaluate the implementation of the treatment cycle for allied health referrals and assess whether these arrangements contribute to the intended policy outcomes for DVA clients and health service providers. The project was guided by a series of evaluation questions, which are discussed in the evaluation methodology section.

This evaluation investigated the impact of recent changes to allied health arrangements for DVA clients, GPs and Allied Health Providers (AHPs), as well as data from stakeholders within veteran and health care community organisations. The evaluation is specific to the health arrangements affected by the treatment cycle arrangements, specifically chiropractic, clinical or general psychology, diabetes education, dietetics, exercise physiology and physiotherapy, neuropsychology, occupational therapy (including mental health), orthotics, osteopathy, podiatry, social work (including mental health) and speech pathology. Dental, optical and counselling through Open Arms are excluded, as these services are not included under the

treatment cycle arrangements. The evaluation questions that directed data collection are as follows:

Evaluation questions

1. How well have arrangements been implemented?
    a. the usefulness and clarity of provider notes and clinical resources
    b. the operational impact of the treatment cycle on general practitioners and AHPs
    c. the experiences of DVA clients transitioning to the new treatment cycle—this should compare the experience of various demographics and different segments of the treatment population
    d. the effectiveness of DVA's communication strategy in educating stakeholders and ensuring compliance with treatment cycle arrangements.
2. How have stakeholders engaged with the arrangements?
    a. changes in service usage patterns
    b. changes in DVA health expenditure resulting from the treatment cycle.
3. What outcomes have been achieved by the arrangements?
    a. whether the treatment cycle has improved quality of care and increased GP engagement in allied health interventions
    b. whether the goal of improving client care coordination and ensuring access to clinically required treatment has been achieved
    c. the efficacy of the At Risk Client Framework in supporting vulnerable clients with complex care needs.

The evaluation examined the operational impacts of the treatment cycle on clients and providers to answer the evaluation questions. Additionally, the evaluation measured changes in service usage patterns and health care expenditure, and it explored whether the treatment cycle improved the quality of care for clients and clinical communication between providers.

Evaluation methodology

A series of parallel methodologies were undertaken for the evaluation (see Figure 1.1):

- a **national survey** of GPs, AHPs and DVA clients to assess the impact and outcomes of the treatment cycle arrangements and how stakeholders have engaged with the arrangements, open from 24 November 2020 to 12 March 2021
- in-depth **semi-structured qualitative interviews** with a selection of GPs, AHPs and DVA clients to further explore survey themes and findings, held between 7 January and 12 March 2021
- a **stakeholder feedback survey** to engage with key ex-service organisations (ESOs) and professional associations
- a comprehensive **document analysis** of all DVA communications concerning the treatment cycle arrangements to assess the effectiveness of DVA's communication strategy
- quantitative data analysis of **health service usage (health economics)** throughout the implementation of the treatment cycle arrangements.

Detailed results from each of these methodologies are contained in the relevant sections of this report.

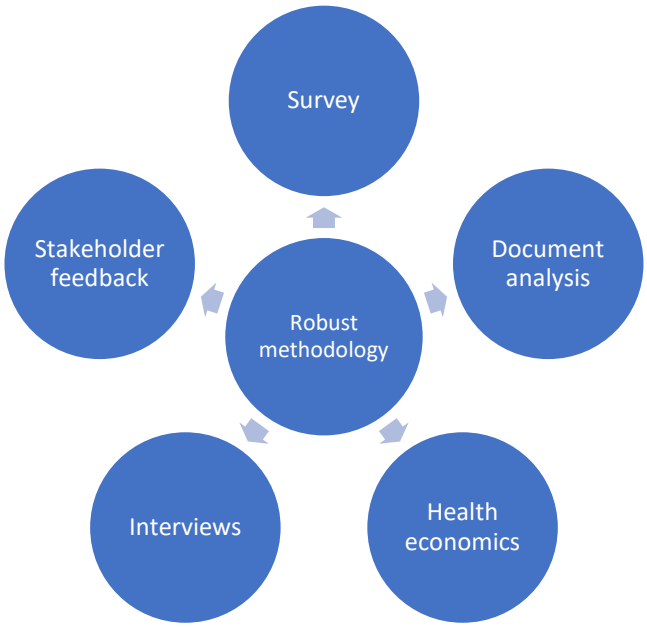


Figure 1.1: Evaluation methodology

Evaluation framework

The evaluation engaged three core informant groups: GPs, AHPs, and DVA clients (see Figure 1.2).

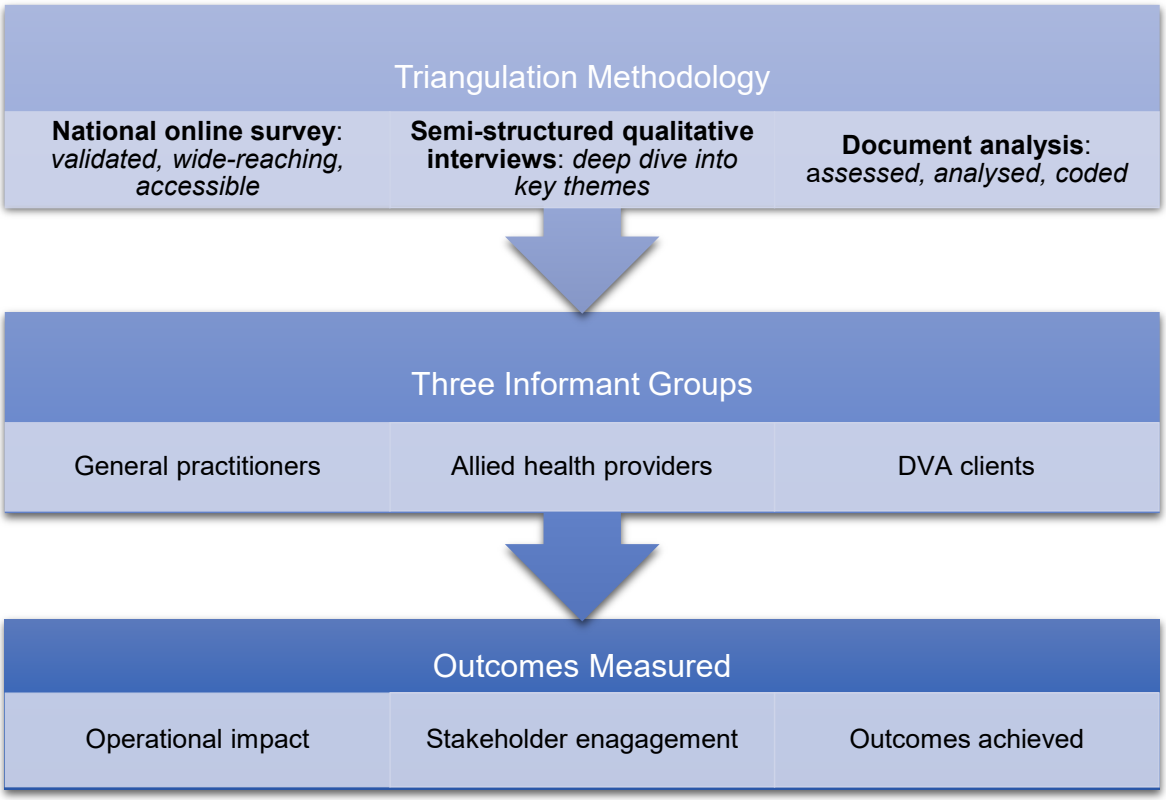


Figure 1.2: Evaluation framework

Ethics

To meet the ethical requirements of the Departments of Defence and Veterans' Affairs Human Research Ethics Committee (DDVA HREC), the team completed and submitted the quality assurance and evaluation activity checklist. All survey questions, participant information sheets, and recruitment materials were submitted as required. The DDVA HREC deemed this project an 'evaluation activity', which, therefore, does not require ethics approval outside the quality assurance and evaluation activity checklist, which is consistent with the National Statement.

As a result of the submission, DDVA HREC confirmed that the guidance 'Ethical Considerations in Quality Assurance and Evaluation Activities, NHMRC 2014' had been applied in preparation for and in conducting of this body of work, with consideration to the individuals who were approached to participate, and this has

been acknowledged by the DDVA HREC. It was confirmed that, as an evaluation activity, no further ethical approval was required.

Complexity of allied health care provision and funding

The complexity of the healthcare system, and the DVA's position as a health care funder, cannot be underestimated. Health resource allocation is fraught with competing aims, where budgets and resource allocation compete with the best clinical outcomes for patients and access to services. The wider Australian health system also battles with similar issues, with rapid urbanisation and continuing inequitable access to health for sections of the population such as Indigenous Australians (Macri, 2016). The changing demographics of the Australian veteran population are an additional issue that adds to the intricacy of DVA funding and health provision. The number of older veterans within the veteran population is declining, and the changing nature of military conflicts has resulted in a population with different treatment needs compared to those in earlier conflicts (Productivity Commission, 2019). As the veteran population changes over time, DVA must balance access, relevance, efficiency and effectiveness in delivering its programs to ensure good quality health outcomes for clients requiring assistance and support.

The US Department of Veterans' Affairs (VA) faced similar issues regarding veterans' access to care and the quality of care delivered. Congress enacted the '*Veterans Access, Choice, and Accountability Act of 2014*' to address access issues by expanding the criteria for veterans to seek care from civilian providers (Farmer et al., 2016). Given that the VA system is very different from DVA, such as VA running their own veteran-specific hospitals for inpatient and outpatient care, the conclusions drawn from the 2014 Act cannot be replicated in an Australian context. However, it is useful to note that government veteran departments are experiencing similar problems across the world.

In the Australian setting, Medicare and the National Disability Insurance Scheme (NDIS) are two funders that deal with the complex nature of allied health provision to a large treatment population. The different ways in which these schemes have approached allied health provision are outlined below. Other national funders of allied health provision, such as My Aged Care, private health insurance, Primary

Health Network programs, and community health services, are too dissimilar to DVA for comparison in this report.

Similar to DVA, NDIS has qualifying criteria for their treatment population: for allied health treatment to be approved under the NDIS, it must be deemed necessary as part of the participant's daily life and result directly from the participant's disability (National Disability Insurance Agency [NDIA], 2021a). Funding is based on an individual needs basis following an independent assessment, in line with the participant's own identified goals (NDIA, 2021a). As of 31 December 2020, the scheme had just under 433,000 active participants with approved plans (NDIA, 2020). As of that date, $28,203 million total committed supports and $9,824 million total payments had been made (note there is a lag between when support is provided and when it is paid) (NDIA, 2020). The NDIS requires allied health practitioners who provide services under their scheme to report on their patient plans to ascertain whether it meets their reasonable and necessary criteria (NDIA, 2021aa). The NDIS provides report writing tips but no forms or templates for reporting.

Medicare provides allied health services to clients following a GP referral (AHPA, n.d.). All Australian residents (inclusive of citizens and permanent visa holders) are eligible to access Medicare (Biggs, 2016). Unlike services provided under DVA and the NDIS, practitioners may choose to set their own fees for service: the 'gap' between the amount Medicare pays for a service and what the practitioner charges is borne by the patient (Biggs, 2016). The Department of Health (2021) report that in 2021 the average patient contribution to cover the 'gap' is $72.75. The number of Medicare-funded visits allowable each year is capped, and that capped number differs between allied health services. The capped number of services also differs based on the chronic health status of patients and other qualifying criteria, such as Indigenous status. Under the Medicare scheme, AHPs need to provide patients' reports to the referring GP following the first and last service (more often if deemed clinically necessary).

Given the complexity of DVA funding with access to 16 different allied health specialties across hundreds of thousands of health care interactions, with tens of thousands of providers, there will inevitably be pressures and challenges in ensuring

the best possible care that meets all needs at the right time in the right way. To some extent, trade-offs may need to be made. An appropriate trade-off may be aiming to promote administrative simplicity and minimising the burden of administrative overheads on health care professionals while ensuring quality of care with robust regulatory structures.

About the veteran community in Australia

As of December 2020, DVA reported their treatment population as 257,211 clients. DVA has estimated that the treatment population will increase to 300,500 by 2023 and 310,900 by 2030 (DVA, 2019a). The inclusion of a veteran identifier question in the 2021 Census may better indicate the number of veterans in the community, but as this will be self-reported data, it will not be conclusive (DVA, 2019a).

The treatment population consists of veterans and dependents who have been issued a Gold or White card entitling them to medical and other treatments at the department's expense under the *Veterans' Entitlements Act 1986*, *Military Rehabilitation and Compensation Act 2004*, *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*, *Australian Participants in British Nuclear Tests and British Commonwealth Occupation Force (Treatment) Act 2006* or *Treatment Benefits (Special Access) Act 2019* (DVA Data and Insights Branch, 2020).

About veterans' health in Australia

Veterans and their families are an important population group for health and welfare monitoring as the unique nature of service in the Australian Defence Force (ADF) promotes protective factors and risk factors that affect health and welfare outcomes (see Table 1.2). While the number of women serving in the ADF continues to increase, women currently account for 18% of all ADF personnel (Roy Morgan, 2020). As such, much of the information and data regarding veteran health are skewed towards males.

Table 1.2: Protective and risk factors for veterans

Protective factors	Risk factors
Maintain physical fitness	Exposure to trauma
Regular health and fitness assessments	Prolonged isolation
Access to health care	Overseas deployments
Access to welfare services	Changes in social support
Stable employment	Frequent relocation
Secure finances	Transitioning from military to civilian lifestyle

About veterans' health care in Australia

Once an ADF member transitions from military to civilian life, health care services are available under the same conditions that apply to other Australians, including Medicare, State and Territory government health arrangements and private sector services. Veterans may also be entitled to support administered or funded by DVA for some health conditions. This support consists of a range of pensions, compensation and income support payments, as well as health and welfare services (including medical, dental, allied health, specialist services, hospitals, pharmaceuticals, rehabilitation, counselling, transport and home care). Dependants such as partners, widow(er)s or children of veterans may also be entitled to certain DVA payments and benefits, depending on their circumstances. DVA funding of health care for entitled veterans is 'demand-driven and uncapped'—this means that the Australian Government increases health care funding if needed (DVA, 2020b).

About the allied health treatment cycle arrangements

On 1 October 2019, referrals from GPs to AHPs changed for DVA clients. Under the treatment cycle arrangements, referrals from GPs to an AHP are valid for up to 12 sessions or a year, whichever ends first. DVA clients may have as many treatment cycles as the GP determines clinically required and can continue to see several AHPs at the same time.

There are 16 recognised allied health service types available through the treatment cycle arrangements:

1. Chiropractic
2. Clinical psychology
3. Diabetes education
4. Dietetics
5. Exercise physiology
6. General psychology
7. Physiotherapy
8. Neuropsychology
9. Occupational therapy
10. Occupational therapy mental health
11. Orthotics
12. Osteopathy
13. Podiatry
14. Social work
15. Social work mental health
16. Speech pathology

At Risk Client Framework

The At Risk Client Framework sits within the allied health treatment cycle arrangements and gives GPs the option to provide a more tailored referral arrangement specific to the veteran's health needs (DVA, 2019b). Options available include allied health referrals that are valid for three, six or twelve months. The GP may also, if eligible, enrol the veteran Coordinated Veterans' Care program, which is for a specific cohort of veterans with severe and complex health needs (DVA, n.d.-c).

The At Risk Client Framework referral does not need approval from DVA; if the clients usual GP determines that a veteran meets the criteria, they can complete the DVA assessment form, and the veteran can access the allied health services needed for the timeframe they have been allocated. The usual end-of-cycle reporting requirements remain.

Totally and Permanently Incapacitated veterans

A veteran who is severely disabled and unable to partake in an otherwise normal working life due to permanent incapacity resulting from their ADF service may be classed as totally and permanently incapacitated (TPI) (Tune, 2019). TPI veterans receive payments, benefits and access to health care in a way that differs from other veterans with accepted claims through DVA.

The allied health treatment cycle does not apply to TPI veterans who are accessing physiotherapy or exercise physiology. TPI veterans must have an annual or indefinite referral to these services from their GP, and the 12-session reporting policy

does not apply (DVA, n.d.-d). TPI veterans must adhere to the allied health treatment cycle arrangements to access all other AHPs.

Purpose of the treatment cycle arrangements

The purpose of the treatment cycle arrangements is to:

1. improve the **quality of care** for DVA clients and **strengthen clinical communication** between health care providers by:
    a. promoting an increase in the opportunities for GPs and AHPs to **provide coordinated care** (increased GP engagement, increase in GP visibility of clinical goals and progress)
    b. fostering **regular communication** between treating professionals at the beginning and end of a treatment cycle (providing a model of care that supports collaboration and communication between treating health professionals and better coordination of care for complex patients)
    c. providing more opportunities to **review clinical goals and outcomes** for the individual veteran
2. provide better, **targeted allied health expenditure** by ensuring clinically necessary services for DVA clients by:
    a. ensuring veterans' access to **clinically required treatment**
    b. increasing the GP's role in assessing the **appropriateness of ongoing treatment** across one or more modalities in conjunction with the AHPs.

Figure 1.3 visually demonstrates the application of the treatment cycle referral arrangements and utilisation of allied health services.

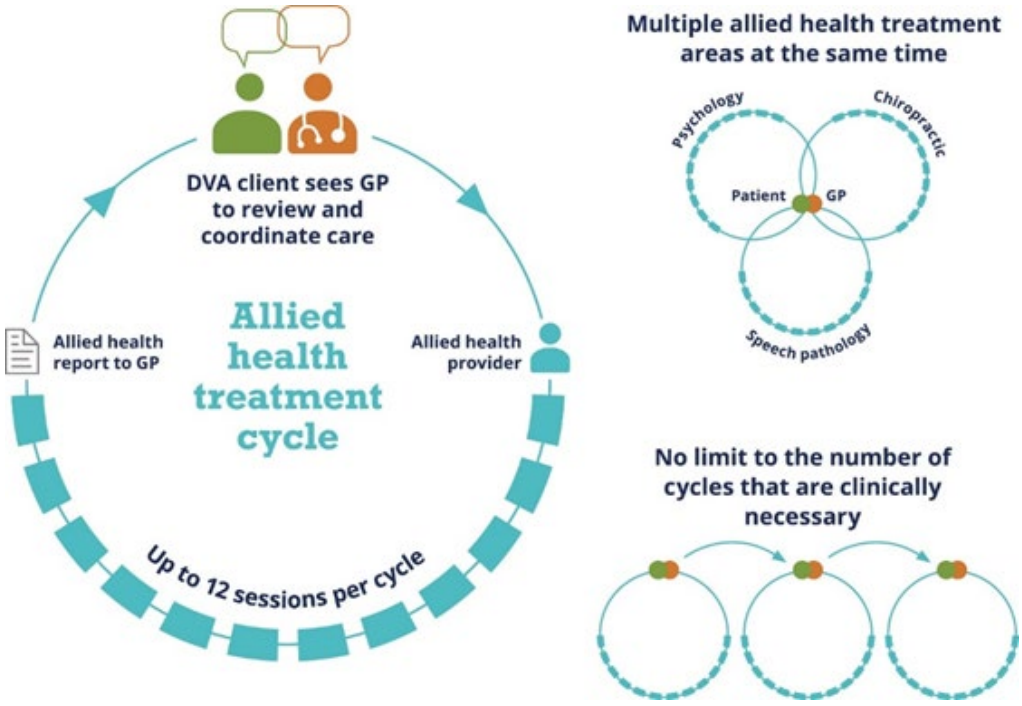


Figure 1.3: DVA infographic to describe the treatment cycle arrangements

Previously, referrals were valid for 12 months or indefinitely for ongoing conditions. The treatment cycle arrangements aim to improve the quality of care for DVA clients by supporting better coordination and communication between GPs, AHPs and clients. The differences between referral arrangements are detailed in Table 1.3.

Table 1.3: Comparison of previous and current referral arrangements

#	Previous referral arrangements	Current referral arrangements
1.	The DVA client talks to the GP about their health needs.	The DVA client talks to the GP about their health needs.
2.	The DVA client receives a referral for an AHP from the GP.	The DVA client receives a referral for an AHP from the GP.
3.	The referral is valid for 12 months or indefinitely for ongoing conditions.	The referral is valid for 12 sessions (one cycle) or 12 months (whichever ends first).
4.	Unlimited sessions are available to meet the DVA clients' health needs.	Unlimited cycles are available to meet the DVA client's health needs.
5.	If the referral was for 12 months, the GP consults the DVA client to decide if another referral is needed for additional treatment (usually another 12 months).	The AHP writes a report on the health outcomes and sends the report to the GP.
6.		The GP reviews the report on the DVA client's health outcomes and consults the DVA client to decide if another referral is needed for additional treatment cycles.

SECTION 2: METHODS

Translating the evaluation methodology

The multiple research methodologies chosen for this evaluation were designed to capture a wide range of experiences from those affected by the treatment cycle arrangements. When collecting qualitative data, it is important to acknowledge that respondents are reporting their experiences of health care provision within their own lived context. The evaluation presents the experiences of all respondents who participated in the project, but acknowledge that these experiences should be contextualised within the larger framework of the Australian health care system, DVA's complex position as a health care funder and the lived experiences of individuals participating in the treatment cycle arrangements.

Any data presented from the surveys or interviews must be considered carefully and not taken as generalisable of all experiences for that cohort. Some respondents took the survey and interviews as an opportunity to air their grievances with the wider DVA system; while valid and important, the responses did not always pertain specifically to the treatment cycle arrangements being evaluated.

Survey methodology

Survey design

An online mixed-methods questionnaire was developed to seek feedback from GPs, AHPs and DVA clients. The 165-item questionnaire was administered via QUT's Key Survey online data collection program.

The survey was designed to capture quantitative and qualitative data to answer the evaluation questions. In addition, several design elements were considered and controlled for, such as willingness to engage, distress, privacy, data storage, complaints and eligibility. These are discussed in more detail below (see Table 2.1).

Table 2.1: Survey design strategy

Issue	Management strategy
Participant willingness to engage	Participation was entirely voluntary; informed consent was obtained; participants were encouraged to self-exclude if necessary (i.e., possible distress). Participants could withdraw at any time by exiting the survey or withdrawing consent during the interview.
Participant distress	Participants were encouraged to contact the following support services if needed: • Open Arms—Veterans & Families Counselling 1800 011 046 • QUT Psychology Clinic 07 3138 0999 • LifeLine 13 11 14 • QUT evaluation team 07 3138 0737 These details were provided before each survey and interview and on the project website.
Privacy, confidentiality and anonymity	Survey responses were anonymous (no identifying information was obtained). Interviews were transcribed and de-identified for reporting and analysis purposes.
Data storage and use	Data were stored on password-protected computers and saved on the secure QUT server, only accessible by the evaluation team. Data are stored and archived for 7 years per QUT research protocols. Data would only be used anonymously in writing the final evaluation report (for DVA internal purposes only). No data would be publicly reported or published by QUT.
Complaints and concerns	Participants were encouraged to contact the evaluation team or the DVA Research Ethics Point of Contact (REPOC) with complaints or concerns.

SECTION 2: SURVEY METHODOLOGY

Participant eligibility

Inclusion criteria for surveys

The inclusion criteria for the survey and interview elements of the evaluation were that participants were over 18 years old and one of the following:

- a DVA client that has accessed at least one treatment cycle for relevant allied health treatment
- a GP that has referred at least one DVA client to an AHP to commence a treatment cycle
- an AHP that has commenced at least one treatment cycle with a DVA client for one of the recognised service types.

Exclusion criteria for surveys

The following exclusion criteria are based on the same exemptions listed on the DVA website (DVA, 2020c). Participants were not eligible to contribute to this evaluation if they only accessed or provided one or more of the following treatment types:

- dental services
- optical services
- hearing services
- counselling services with Open Arms—Veterans & Families Counselling
- therapies that have other treatment limits.

Draft survey validation

Questions were developed to provide data on the impacts of the treatment cycle arrangements, perceptions of quality of care, care coordination, participant attitudes of the treatment cycle processes, provider notes and clinical resources. Questions were drafted and submitted to DVA for review. Upon successful review, the questions were further validated by volunteers from each interest group (one DVA client, GP and AHP).

Online tool used

Key Survey software was used to develop and distribute the survey to DVA clients, GPs and relevant AHPs. The survey flow was designed so that there were three distinct subsets of questions tailored to capture the opinions and experiences of all

three populations. Participants accessed the survey through one link, which directed participants to the relevant questions by selecting whether they were a DVA client, GP or AHP. Data were collected between 24 November 2020 and 12 March 2021.

Question structure

The survey collected quantitative data with some qualitative response options. A range of question types was used, such as Likert scales, multiple-choice selection and qualitative questions. The survey collected general demographic data but did not collect any individually identifiable information to protect participant anonymity. The number and type of questions per participant group is detailed in Table 2.2. A copy of the survey questionnaire can be found in Appendix 1.

Table 2.2: Question type and number of questions per participant group

Type and number of questions	DVA clients	GPs	AHPs
TC awareness and information	11	12	12
Allied health services	1	1	1
COVID-19 impacts	7	6	7
Transition to TC	2	2	2
Impacts and interaction changes	2	2	2
Quality of care	8	8	8
Care coordination (client and GP)	5	5	N/A
Care coordination (client and AHP)	8	N/A	5
Care coordination (GP and AHP)	6	9	9
Care coordination	1	6	6
Other impacts	1	1	1
At Risk Client Framework efficacy	N/A	8	N/A
Total questions	**52**	**60**	**53**

Note: TC: Treatment cycle

Participant recruitment

The evaluation team conducted an online search to identify relevant veteran and health care organisations to approach, which was confirmed when DVA provided the communication strategy they had previously used. The survey was distributed by email to various ESOs, veterans' associations, professional health associations,

primary health networks (PHNs), state hospitals and health services. In addition, the survey was promoted through DVA communication channels (refer to Table 2.3).

The survey was further promoted to veterans and relevant health providers by community organisations and public health services via social media, websites, and online newsletters. In addition, the evaluation team engaged two paid recruitment agencies to specifically target GPs due to low engagement from the GP participant group in the early stages of recruitment. AMPco and PureProfile were engaged in February 2021.

Table 2.3: Recruitment strategy for organisation engagement

Organisation type	Participant type	# Contacted
ESOs and veterans' associations	DVA clients	47
Medical associations and practices	GPs	86
Allied health associations	AHPs	24
State hospital and health services	GPs and AHPs	24
Primary health networks	GPs and AHPs	30
Total		**211**

Participant sample sizes

The following population and sample sizes are representative of all registered practising GPs, specialist practitioners and AHPs in Australia. The relevant population and sample sizes for clients, GPs and AHPs may differ from those reported below as not all DVA clients, GPs and AHPs will be involved in transitioning to and implementing the allied health treatment cycle arrangements.

The following population sizes for GPs and AHPs were obtained from data reported by the Australian Health Practitioner Regulation Agency (Ahpra) and were current as of June 2020 (Australian Diabetes Educators Association, 2019; Australian Orthotic Prosthetic Association, 2012; Chiropractic Board Ahpra, 2020; Dietitians Association of Australia, n.d.; Deloitte, 2016; Medical Board Ahpra, 2020; Occupational Therapy Board Ahpra, 2020; Osteopathy Board Ahpra, 2020; Parliament of Australia, n.d.; Physiotherapy Board Ahpra, 2020; Podiatry Board Ahpra, 2020; Psychology Board Ahpra, 2020). The population size for DVA clients (treatment population) was obtained from the DVA website and was current as of June 2020 (DVA Data and

Insights Branch, 2020). The following sample sizes were calculated using the population size with a confidence interval of 95% and a margin of error of 5% (Qualtrics, n.d.). See Table 2.4 for population size, proposed sample size and actual sample size.

Table 2.4: Population sample sizes

Population type	Population size	Sample size	Actual sample
DVA clients	243,215	384	399
GPs	104,097	382	148
AHPs	154,594	384	441
Total	**501,906**	**1150**	**988**

Expression of interest

The survey was voluntary and anonymous as no personal details were collected as part of the data. At the end of the survey, participants were directed to a separate page with an option to express interest in being contacted for an interview. This will be discussed in more detail in the interview methodology section.

Survey demographics

There was a total of 988 survey responses collected, consisting of 399 DVA clients, 148 GPs and 441 AHPs (see Table 2.5). Total responses were evenly distributed by gender (43% female, 56% male); however, when dividing by gender and participant type, females were less represented in the DVA client (23%) and GP (35%) populations. This reflects the general distribution of gender in these populations, with 27% of DVA clients in 2020 being female (DVA, 2020d) and 45% of GPs practising in Australia being female (Royal Australian College of General Practitioners [RACGP], 2018). Females were more highly represented in the AHP population (65%). Survey data were captured from all Australian states and territories, representing 586 unique postcodes across regional and metropolitan areas (refer to Figure 2.1).

Table 2.5: Participant age and gender

Participant type	Female		Male		Not stated	Total	Age range	Mean
	N =	%	N =	%	N =			
DVA clients	92	23	306	77	1	399	20–97	59
GPs	52	35	96	65	0	148	21–78	44
AHPs	285	65	148	34	8	441	21–68	39
Total	**429**	**43**	**550**	**56**	**9**	**988**		

Note: All percentages are rounded to the closest whole number

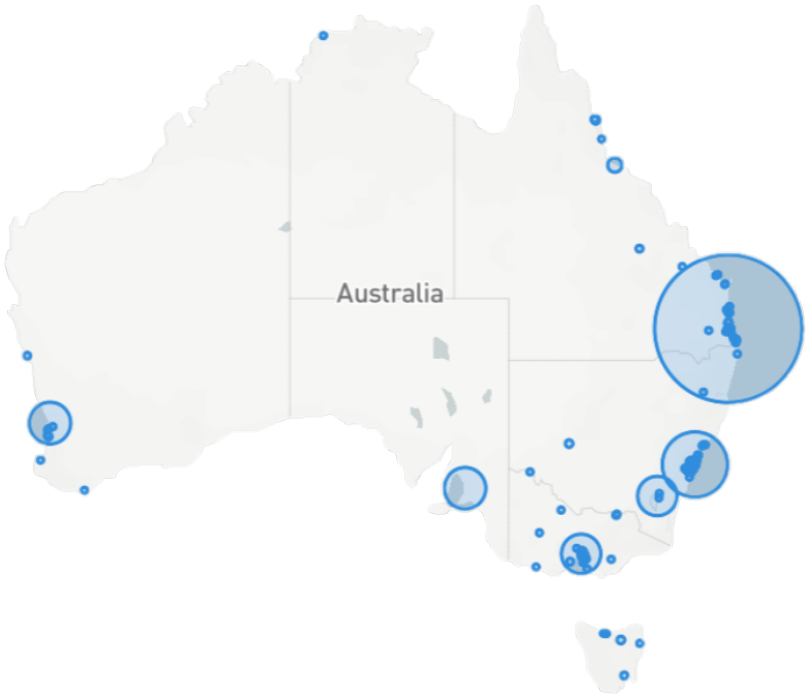


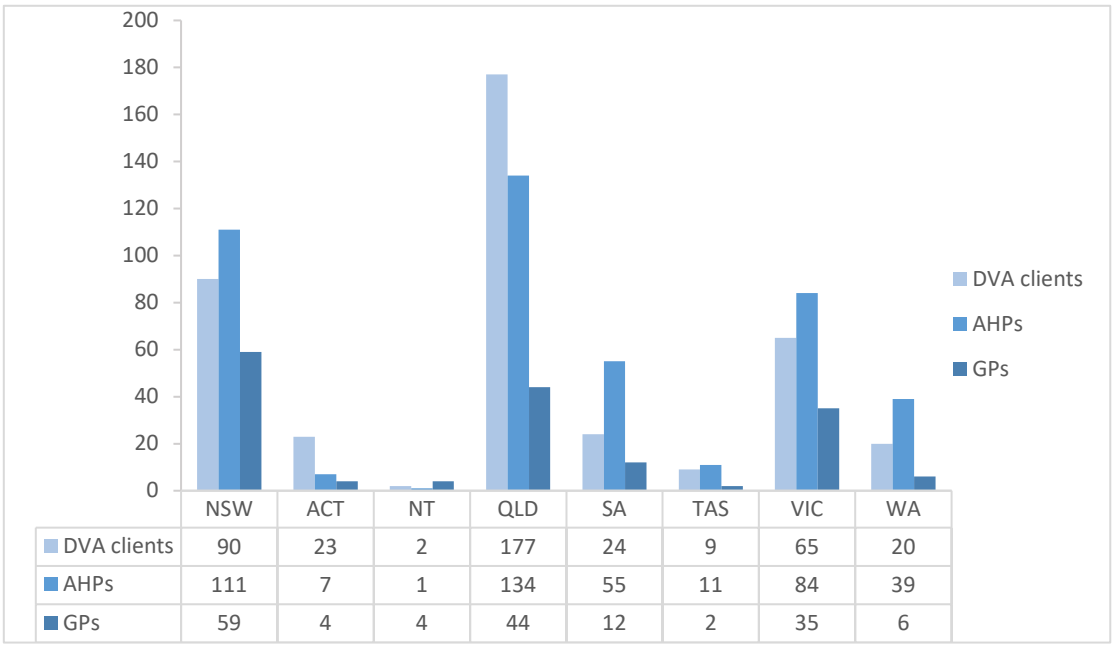
Figure 2.1: Map of survey participant distribution across Australia

The majority of data captured across the participant groups were from Queensland residents (n = 355), with New South Wales (n = 260) and Victoria (n = 184) also representing significant numbers of participants. Veterans were represented across their usual state or territory of residency, as demonstrated in Table 2.6 and Figure 2.2 (DVA Data and Insights Branch, 2020).

Table 2.6: DVA treatment population by state or territory and age

DVA clients by state or territory			DVA clients by age group		
Region	**n =**	**%**	**Age range**	**n =**	**%**
NSW/ACT	79,658	31	< 60	114,981	45
QLD	79,682	31	60–69	33,073	13
SA/NT	24,082	9	70–79	53,790	21
TAS	6,712	3	80–89	24,234	9
VIC	41,129	16	90 >	31,132	12
WA	24,359	10			
Total	**257,211**	**100**	**Total**	**257,211**	**100**

Note: Overseas residents were included in total but not reported. ACT and NT were included within NSW and SA, respectively. Unknown ages were included in the total but not reported separately. All percentages are rounded to the closest whole number.



	NSW	ACT	NT	QLD	SA	TAS	VIC	WA
DVA clients	90	23	2	177	24	9	65	20
AHPs	111	7	1	134	55	11	84	39
GPs	59	4	4	44	12	2	35	6

Figure 2.2: Survey participant numbers by state or territory and group

AHPs were represented across all 16 allied health service types funded by DVA and are detailed in Table 2.7.

Table 2.7: AHPs by service type

Service type	n =	Service type	n =
Chiropractors	20	Orthotists	2
Clinical psychologists	11	Osteopaths	13
Diabetes educators	8	Physiotherapists	86
Dietitians	22	Podiatrists	117
Exercise physiologists	44	Psychologists	14
Neuropsychologists	1	Social workers	9
Occupational therapists	50	Social workers (mental health)	12
Occupational therapists (mental health)	3	Speech pathologists	10

Interview methodology

Interview design

Semi-structured interviews were implemented as a qualitative methodology to complement the quantitative survey data. Semi-structured interviews were chosen to capture rich data that reflect the experiences and opinions of participating medical professionals, service providers and DVA clients. The use of qualitative interviews allowed in-depth exploration of factors and themes that may not otherwise be captured by the survey methodology (DeJonckheere & Vaughn, 2019; Dempsey et al., 2016).

The interview questions were designed to complement the topics of the survey while allowing for deeper exploration of key concepts (see Appendix 3 for the complete list of interview questions). The questions were designed to expressly address the evaluation questions, namely, how well the arrangements were implemented according to DVA clients, GPs and AHPs and how the stakeholders engaged with the treatment cycle arrangements.

The interview questions were written by one research assistant and reviewed and approved by the wider research team prior to validation. The interview processes, including recording software and technology, were tested and validated among research team members before being implemented.

Eligibility

Inclusion criteria for interviews

Inclusion criteria were the same for the survey and interview elements of the evaluation. Participants were required to be over 18 years old and one of the following:

- a DVA client that has accessed at least one treatment cycle for relevant allied health treatment
- a GP that has referred at least one DVA client to an AHP to commence a treatment cycle

- an AHP that has commenced at least one treatment cycle with a DVA client for one of the recognised service types.

Exclusion criteria for interviews

The following exclusion criteria are based on the same exemptions listed on the DVA website (DVA, 2020c). Participants were not eligible to contribute to this evaluation if they only accessed or provided one or more of the following treatment types:

- dental services
- optical services
- hearing services
- counselling services with Open Arms—Veterans & Families Counselling
- therapies that have other treatment limits.

Participant recruitment

Eligible participants for the semi-structured interviews were DVA clients, GPs or AHPs that had met the eligibility requirements for and subsequently completed the online survey. Upon completing the survey, participants were directed to a separate webpage to capture their willingness to be contacted for the interviews. This expression of interest was not linked to their survey responses to ensure anonymity. Participants had to provide valid contact information in their expression of interest. The evaluation team contacted eligible participants to schedule a mutually agreeable time and date for the interview.

A total of 115 participants expressed interest to be interviewed. Fourteen chose to opt out following initial contact, and 50 participants did not respond to initial or follow-up contact. Six participants were denied an interview as their responses were received outside the timeframe for inclusion in the report.

A total of 42 participants were interviewed (see Table 2.8) from all Australian states and territories except Tasmania. See Figure 2.3 for the geographic location of interview participants. Of the 13 AHPs interviewed, there were five occupational therapists, two osteopaths, two exercise physiologists, three podiatrists and one dietician.

Figure 2.3: Interview participant geographic location

Table 2.8: Interview participants

DVA clients	GPs	AHPs	Total
26	3	13	**42**

Evidence indicates that the primary themes identified within a qualitative analysis are frequently uncovered within the first 10 interviews (Guest et al., 2006; Hennink et al., 2017), and this was supported by saturation of themes being reached with DVA client and AHP interview data. Saturation was not reached with GP interview data, and this is addressed within the project limitations.

Interviews (n = 42) were conducted between 7th January and 12th March in 2021, primarily utilising an online web conferencing platform (Zoom). A small number of clients were interviewed via telephone, as was their personal preference. All interviews were audio-recorded. All interviews were conducted by one research associate, who holds tertiary qualifications in psychology and qualitative data collection methods.

Interviews were voluntary and could be discontinued at any time by the participant withdrawing consent. The interviewer gained express consent from the participant immediately before proceeding with the interview. Interviews had no fixed length and

were subject to what the participants shared in terms of the depth of their opinions and experiences. Most interviews ranged between 20 to 40 minutes, with a small number exceeding 60 minutes. While there was a pre-approved list of guiding questions, the interview process was semi-structured in the timing and order of questions asked. Depending on the responses given by participants, the researcher probed further on some topics or excluded some questions based on the relevance to the participant's described experiences.

Data analysis

Interview data were de-identified and professionally transcribed. Data were analysed by three members of the team for initial themes using thematic content analysis (Burnard et al., 2008; Miller & Crabtree, 1999). Thematic analysis was chosen as the most appropriate method as it allowed the team to fully explore the concepts as reflected in the data without the requirement of a theoretical model (Burnard et al., 2008). Data were organised and thematically coded using NVivo v12 software.

After initial themes were identified, a research assistant developed a coding scheme and applied this to all interview data. This coding scheme was used to summarise and categorise all themes present in the interviews and allowed the team to identify overarching themes that were present in the data. These themes were reviewed and second-coded by one of the Chief Investigators (CIs). Once the second coding was complete, themes were analysed and reported, with relevant quotes extracted from the interview data to further support the analysis.

Stakeholder feedback methodology

Survey design

The stakeholder feedback survey was designed to capture the broad opinions of stakeholders that may have been affected by the treatment cycle arrangements. The feedback was qualitative and designed to be provided at an organisational and community level. Data were collected between 24 November 2020 and 12 March 2021.

Structure of questions

The questions were structured to elicit similar information from individual respondents but at an organisational level. The questions were purposefully written to align with the treatment cycle evaluation questions. The survey asked some basic demographic questions and then asked respondents to answer four questions about the treatment cycle arrangements and their organisation's opinions of their implementation (see Appendix 5 for the complete stakeholder feedback form):

1. In your opinion, how well have the treatment cycle arrangements been implemented?
2. In your opinion, how effective has DVA's communication strategy been in educating stakeholders about the treatment cycle arrangements?
3. In your opinion, how have you or your organisation, as DVA stakeholders, engaged with the arrangements?
4. What is your or your organisation's opinion on the outcomes of the treatment cycle arrangements? (Consider the improved quality of care and improved care coordination).

Online tool utilised

Stakeholders were invited to complete the survey via a fillable PDF and submit it via email to the evaluation team. Alternatively, stakeholders could complete the survey online through QUT's Key Survey system.

Recruitment

Stakeholders were identified in the following ways:

- The DVA identified stakeholders as part of the ESO Round Table and other similar activities. DVA directly emailed the sectaries of these forums and requested that they distribute the PDF to their membership.
- DVA organised for their clinical advisors to receive an email with a link to the PDF or online survey.
- The evaluation team compiled a list of ESOs and professional associations (medical and allied health), which were directly emailed by the team inviting participation.
- Evaluation team members and DVA made social media posts on Facebook and LinkedIn. The evaluation team tagged appropriate organisations in an effort to recruit them to participate.

Data analysis

Survey data collected were entirely qualitative. After completing the data collection period, survey data were organised and coded using NVivo v12 software. A coding scheme was used to summarise and categorise all responses to the survey questions. Coding and categorisation were completed by one researcher and subsequently reviewed and second-coded by a second researcher. The results are presented by survey question.

Stakeholder responses were received from every state and territory in Australia, as well as some stakeholder organisations that were national or multi-state/territory.

Stakeholder feedback demographics

There was an almost equal representation of professional associations (i.e., associations that are not Defence or veteran-specific but represent professionals more broadly) and ESOs. The ‘other’ category describes survey responses in which respondents did not state their affiliation, and after examining their responses, are most likely individuals who completed the stakeholder response form. Figure 2.4 shows the geographic distribution of stakeholders, and Figure 2.5 depicts the

breakdown of veteran v. health professional associations. Table 2.9 states the number of responses by organisation type.

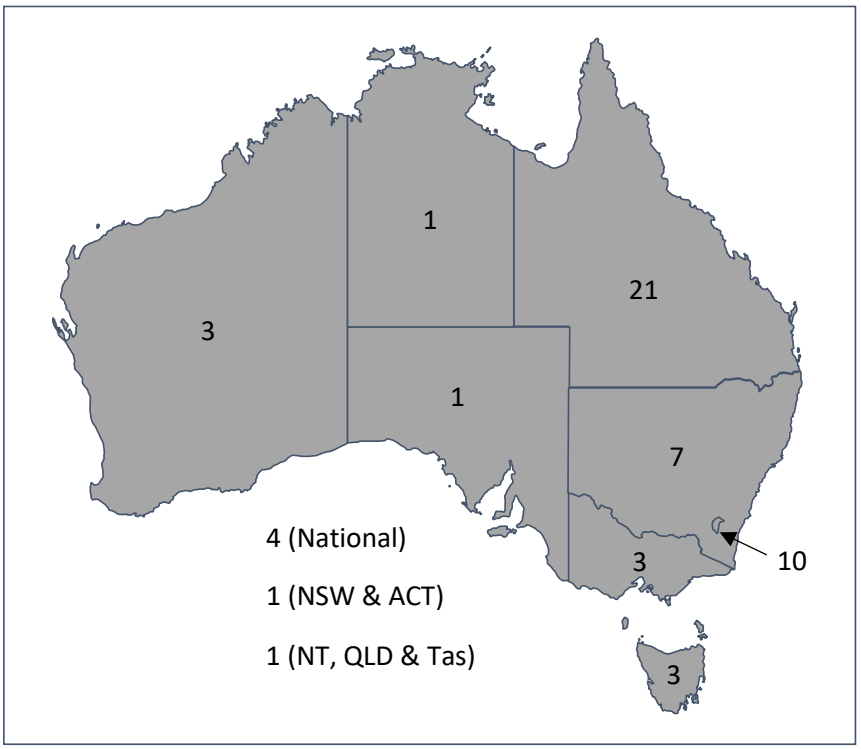


Figure 2.4: Location of stakeholders

Figure 2.5: Stakeholder responses

Table 2.9: Stakeholder organisation types and responses

Organisation type	No. of responses
Ex-service organisation	24
Professional association: AHP	25
Professional association: GP	2
Other	4
Total	**55**

SECTION 2: DOCUMENT ANALYSIS METHODOLOGY

Document analysis methodology

The document analysis was undertaken to address research question 1d, which aimed to evaluate the effectiveness of DVA's communication strategy in educating stakeholders and ensuring compliance with treatment cycle arrangements. The body of DVA communication documents included web content from the DVA website, notes and letters sent to GPs and AHPs, outlines of treatment cycle arrangements, fee schedules, and templates for AHP and GP use. These documents were reviewed and assessed for their congruence with the desired outcomes of the treatment cycle and their clarity for clients, AHPs and GPs.

Design

The research team received 78 documents from DVA to be appraised within the document analysis. These documents included communications between DVA and stakeholders (i.e., clients, GPs, AHPs and associated professional bodies), records of web content and professional notes and fee schedules (see Table 2.10 for a summary of the documents analysed). Data extraction from the documents was conducted using content analysis methodology and involved extraction of the following general information: document title, publisher, intended audience, date and summary. The evaluation questions were used as a guide, and all documents were reviewed and data extracted into a Microsoft Excel spreadsheet.

Table 2.10: Total documents included in the analysis

	Intended audience					
Document type	**GPs**	**AHPs**	**DVA clients**	**GPs and AHPs**	**GPs, AHPs & DVA clients**	**Total # documents**
Web content *(published on DVA website)*	2	15	3	1	2	23
Notes detailing provision of GP and AHP services	1	13*	N/A	0	N/A	14
Letters	2	5	2	0	0	9
Schedule of fees	0	16	N/A	0	0	16
Form templates for AHPs *(End of Cycle report and Patient Care Plan)*	N/A	2	N/A	N/A	N/A	2
General outlines of the treatment cycle arrangements	2	4	2	1	0	9
General notice of changes	0	0	0	0	3	3
Specific outlines for GPs *(TPI and At Risk Client Framework)*	2	N/A	N/A	N/A	N/A	2
Total						**78**

Note: 11 notes were addressed to specific allied health professions: exercise physiologists, physiotherapists, chiropractors, diabetes educators, dieticians, occupational therapists, osteopaths, podiatrists, social workers, speech pathologists and orthotists. One was addressed to mental health care providers as a group and one to AHPs in general.

Measures

Each document was appraised using the Patient Education Material Assessment tool (PEMAT-P) (Shoemaker et al., 2014) and the Health Literacy Checklist for Written Consumer Resources (North Western Melbourne Primary Health Network, 2014).

Both tools were applied to ensure a comprehensive evaluation of the materials (the PEMAT-P and Health Literacy Checklist are included in Appendices 6 and 7).

The PEMAT-P systematically evaluates and compares the **understandability** and **actionability** of patient education materials. The tool consists of 19 items scored as either 0 (disagree), 1 (agree) or N/A (not applicable), with percentages calculated to provide separate scores for each. The higher the score, the more understandable or actionable the material. For example, a document that receives an understandability score of 90% is more understandable than one that receives an understandability score of 60%, and the same for actionability (refer to Table 3.13 for the complete document PEMAT-P scores).

Further, the Health Literacy Checklist for Written Consumer Resources was adapted to the needs of the document analysis to provide a basic guide for ensuring that DVA resources written for stakeholders are clear and easy to understand. The adjusted Health Literacy Checklist was applied to relevant documents to assess content, language and presentation of key messages, with values tallied to provide an overall score out of 13 for comparison (refer to Table 3.13). These tools provided quantitative figures regarding the communication strategy.

Subjectivity control

Further, the documents were appraised against the evaluation questions with relevant content extracted verbatim into an excel spreadsheet to ensure full transparency of the document analysis process. Subjectivity was mitigated in the appraisal, as a second evaluator randomly selected and reviewed 20% of the documents. These were compared to determine any discrepancies between the primary and secondary evaluator and then brought to the evaluation team for further review.

Health economics methodology

Health economics design

To assess changes in service usage patterns and health care expenditure, our expert team with the Australian Centre for Health Service Innovation combined their health economics expertise with big data capabilities to provide robust data analysis and reporting. This part contains the quantitative analysis of the health service usage by DVA clients. The R programming language (version 3.6.0) was used to analyse the data.

The impact of implementing the treatment cycle arrangements for allied health referrals was assessed using the pre- and post-health-service-utilising information provided by the DVA. As the treatment cycle was implemented from 1st October 2019, we determined the pre-health-service stage as any treatment or referral provided before this date. Subsequently, the post-health-service stage was determined as referrals and services provided after 1st October 2019. We hypothesised that the treatment cycle would create less allied health usage from DVA clients and provide cost savings.

The service utilisation by DVA clients before and after the implementation of the treatment cycle in terms of AHP services were compared. AHP services included chiropractic, diabetes education, dietetics, exercise physiology, occupational therapy, orthotics, osteopathy, physiotherapy, podiatry, psychology, social work and speech pathology.

We have provided descriptive information regarding the amount of service utilisation and costs compared between pre– and post–treatment cycle.

SECTION 3: FINDINGS

DVA client findings

DVA client survey results

Key findings for DVA clients are presented here. For a full report of DVA Client survey results, please see Appendix 2.1, Q17–44, and Appendix 2.2.

DVA clients: Information about treatment cycle arrangements

DVA clients' knowledge of the treatment cycle was measured in two parts: first, when clients first became aware of the treatment and where they received information about the treatment cycle (multiple responses were allowed for this question, which is why the total does not add to 100%):

- 62% (n = 250) of clients were aware of the treatment cycle before October 2019.
- 40% (n = 161) of clients received information from DVA about the treatment cycle before October 2019.
- 35% (n = 138) of clients reported that they were informed about the treatment cycle from their GP.

Second, client knowledge of the treatment cycle arrangements was measured by asking clients what they thought of the quality, understandability, actionability and relevance of information. The possible responses were 'agree', 'somewhat agree', 'neither agree nor disagree', 'somewhat disagree' and 'disagree'. Responses were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes.

- 53% (n = 210) of clients thought the information was easy to understand, and 50% (n = 201) of clients thought the information was relevant to their needs.
- 57% (n = 229) of clients reported that they were prepared for the changes, and 62% (n = 245) of clients reported that they understood the changes.
- 72% (n = 287) of clients reported that they were confident with the referral changes; however, only 34% (n = 134) of clients reported they were satisfied with the changes (see Figure 3.1).

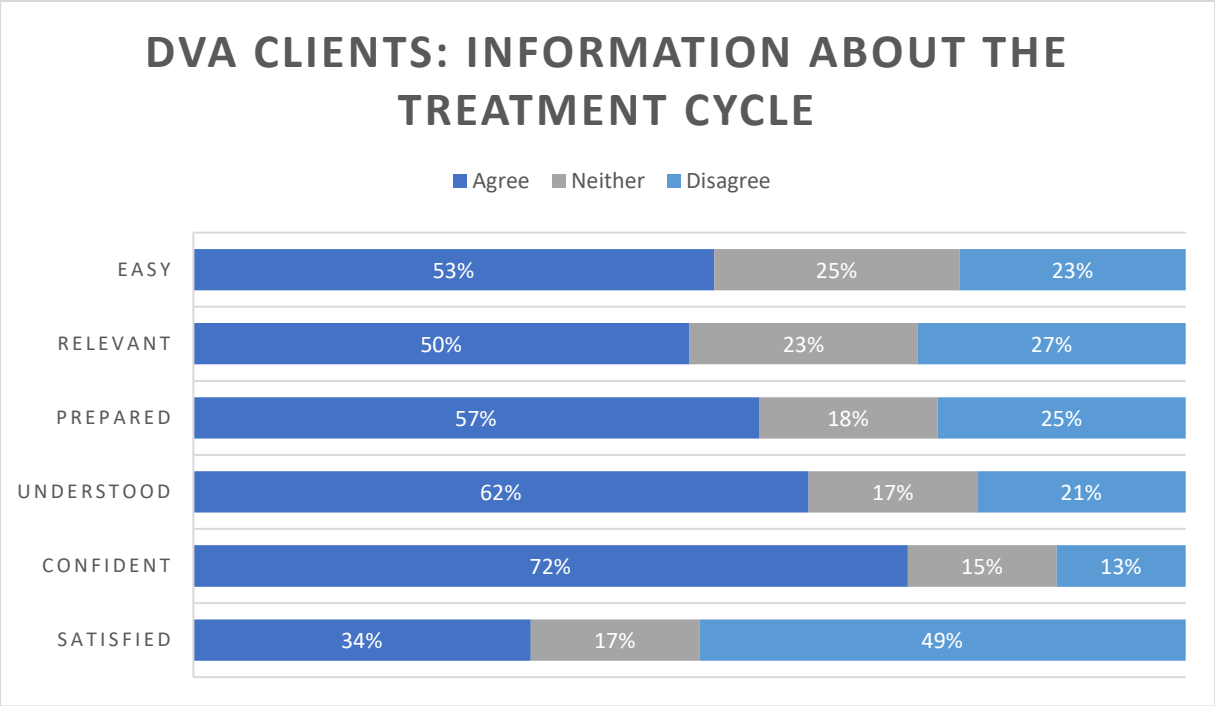


Figure 3.1: Client perspective on treatment cycle information

DVA clients: Client age and communication of the treatment cycle

When analysed by age, DVA clients were more likely to be positive towards the communication of the treatment cycle if they were 50 years old or younger. The analysis revealed that 63% (n = 82) of DVA clients 50 years old or younger found the information easy to understand, compared to 47% (n = 127) of DVA clients aged over 50 years old. DVA clients 50 years or younger were also more likely to find the information relevant to their needs (59%, n = 76) and of high quality (56%, n = 72). Clients over 50 years old were more likely to be unsure of the quality of available information about the treatment cycle, with 43% (n = 117) neither agreeing nor disagreeing that the information was high quality. They were also more likely to disagree that the available information was relevant to their needs when compared to the younger cohort, with 32% (n = 86) of clients older than 50 indicating that they disagreed; this is compared to 17% (n = 22) of clients 50 and younger indicating that they disagreed that the information is relevant to their needs. All noted statistics are significant, with the full reporting available in Table 3.1.

Table 3.1: Communication of the treatment cycle by DVA client age

DVA clients: Available information about the allied health treatment cycle arrangements is:	**Agree N (%)**	**Neither agree nor disagree N (%)**	**Disagree N (%)**	**Sig.**
Easy to understand				
Equal or less than 50 years	82 (63.6)	26 (20.1)	21 (16.3)	< 0.05#
More than 50 years	127 (47.0)	73 (27.0)	70 (25.9)	
Relevant to my needs				
Equal or less than 50 years	76 (58.9)	31 (24.0)	22 (17.0)	< 0.05#
More than 50 years	125 (46.3)	59 (21.8)	86 (31.8)	
High quality				
Equal or less than 50 years	72 (55.8)	36 (27.9)	21 (16.2)	< 0.05#
More than 50 years	87 (32.2)	117 (43.3)	66 (24.4)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

DVA clients: COVID-19 impacts

While COVID-19 was not directly related to implementing the treatment cycle, the impacts of COVID-19 and subsequent restrictions across Australia were experienced by clients. Therefore, clients were asked if and how their GP and AHP services were affected by COVID-19; response options were 'yes' or 'no'. A total of 54% (n = 214) of clients reported impacts to their GP services due to COVID-19, and 53% (n = 212) of clients reported impacts to their AHP services due to COVID-19.

Additionally, clients were asked how their services had changed due to COVID-19. The responses included 'more telehealth', 'less in-person consultation', 'did not access services' or 'no change in services'. In total, 57% (n = 228) of clients reported an increase in telehealth (multiple responses were allowed for this question).

DVA clients: Transitioning to the treatment cycle

Clients were asked when they had transitioned to the treatment cycle arrangements, with responses ranging from October 2019 – October 2020 (time of survey distribution), with two qualifier responses including 'I'm not sure' and 'I haven't transitioned to the treatment cycle'. In total, 48% (n = 192) of clients reported that they transitioned to the treatment cycle in October 2019.

Additionally, to establish allied health service usage baselines, clients were asked when they had received allied health services 'before October 2019 only', 'after

October 2019 only', 'before and after October 2019', or if they had never received allied health services. In total, 78% (n = 310) of clients reported accessing allied health services both before and after the treatment cycle was implemented in October 2019.

DVA clients: Satisfaction with the treatment cycle by location

DVA client satisfaction with the treatment cycle was analysed by client geographic location (see Table 3.2). Differences in DVA client knowledge of the treatment cycle arrangements between states was found to be statistically significant, with clients located outside Queensland, New South Wales and Victoria being less likely to report that they had sufficient knowledge of the changes (49%, n = 41) when compared to these states.

Table 3.2: Satisfaction with the treatment cycle by DVA client state

DVA clients: Since 1 October 2019, think about the first time you visited your GP for an allied health treatment referral.	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
I was prepared for the changes.				
Queensland	102 (58.3)	32 (18.3)	41 (23.4)	NS
New South Wales	50 (58.8)	12 (14.1)	23 (27.1)	
Victoria	35 (54.7)	15 (23.4)	14 (21.9)	
Other	42 (56.0)	12 (16.0)	21 (28.0)	
I understood the changes.				
Queensland	114 (65.1)	26 (14.9)	35 (20.0)	NS
New South Wales	51 (60.0)	18 (21.2)	16 (18.8)	
Victoria	39 (60.9)	12 (18.8)	13 (20.3)	
Other	41 (54.7)	13 (17.3)	21 (28.0)	
I had sufficient knowledge about the changes.				
Queensland	101 (57.7)	37 (21.1)	37 (21.1)	< 0.05#
New South Wales	53 (62.4)	12 (14.1)	20 (23.5)	
Victoria	39 (60.9)	18 (28.1)	7 (10.9)	
Other	37 (49.3)	13 (17.3)	25 (33.3)	
I was confident asking my GP for a referral to a treatment cycle.				
Queensland	129 (73.7)	23 (13.1)	23 (13.1)	NS
New South Wales	68 (80.0)	10 (11.8)	7 (8.2)	
Victoria	43 (67.2)	11 (17.2)	10 (15.6)	
Other	47 (62.7)	18 (24.0)	10 (13.3)	
I was satisfied with the changes.				
Queensland	50 (28.6)	25 (14.3)	100 (57.1)	< 0.05#
New South Wales	39 (45.9)	13 (15.3)	33 (38.8)	
Victoria	29 (45.3)	16 (25.0)	19 (29.7)	
Other	16 (21.3)	16 (21.3)	43 (57.3)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

DVA clients: Impacts of the treatment cycle

Participants were asked 'how have you been impacted by the changes to allied health treatment cycle arrangements? (select one only)'. The choices provided were 'positively impacted', 'negatively impacted' and 'not been impacted'. These data indicate the respondents' perceptions of how the treatment cycle has impacted them. In total, 22% (n = 89) of clients reported being positively impacted, 41% (n = 164) reported being negatively impacted, and 37% (n = 147) reported not being impacted by the treatment cycle (see Figure 3.2). In addition, clients were asked, 'have you

experienced changes in the amount you see your GP? (select one only)'. The response options included 'I see my GP more', 'I see my GP less' and 'I see my GP the same amount'. In total, 54% (n = 214) of clients reported that they see their GP more, 12% (n = 47) reported seeing their GP less, and 34% (n = 138) reported seeing their GP the same amount (see Figure 3.3).

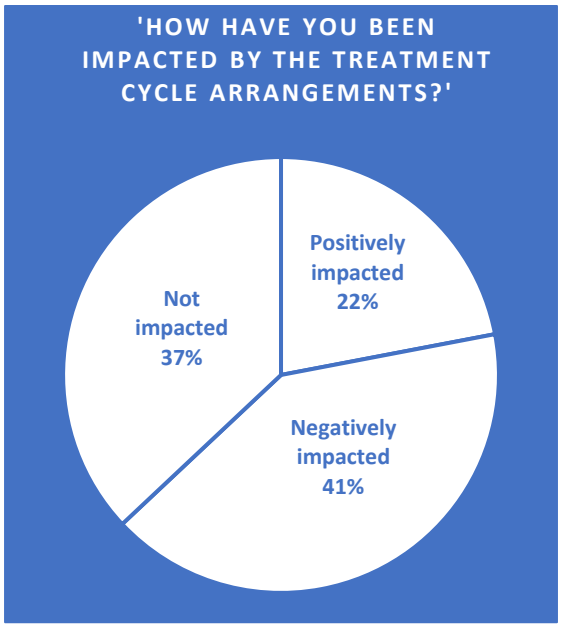


Figure 3.2: Clients' perceived impacts of the treatment cycle arrangements

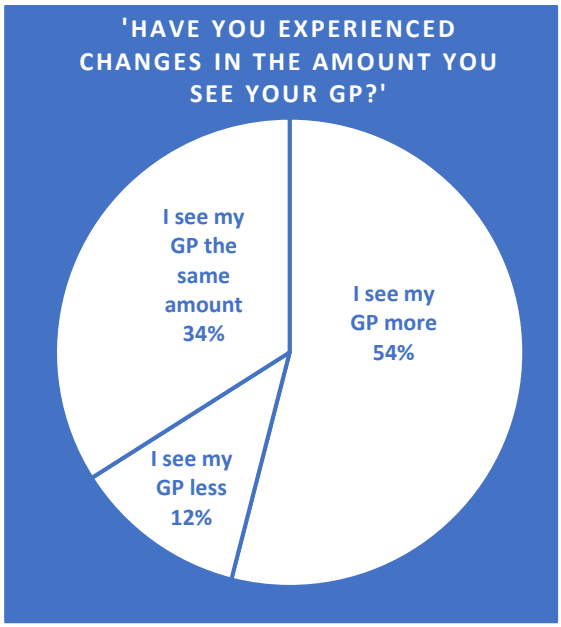


Figure 3.3: Clients' perceived changes to seeing their GP

When analysed by gender, age and state, the impact of the treatment cycle arrangements on DVA clients was mixed. The age and geographic location of DVA clients were significant when considering whether the impact of the treatment cycle is perceived to be positive, negative or not impactful at all. DVA clients aged over 50 years were slightly more likely (46%, n = 123) to report being negatively impacted by the treatment cycle compared to the younger cohort (32%, n = 41). DVA clients 50 years old or younger were more likely to report that they have been positively impacted by the treatment cycle, with 38% (n = 49) indicating positive impacts compared to 15% (n = 40) of the older cohort.

Geographic location within Australia was also found to be statistically significant when considering the perceived impact of the treatment cycle on DVA clients. DVA clients located in Queensland were less likely to report that they have been positively

impacted by the changes (18%, n = 31), compared to NSW (31%, n = 26), Victoria (25%, n = 16) and other states (21%, n = 16). DVA clients in Queensland and other states were more likely to report being negatively impacted, with 47% (n = 83) and 48% (n = 36) reporting this, respectively. Gender did not have a statistically significant influence on the responses. The complete analysis is detailed in Table 3.3.

Table 3.3: Perceived impact of the treatment cycle by DVA client gender, age and state

DVA clients: impacted by the changes to allied health treatment cycle arrangements.	**I have been negatively impacted by the changes N (%)**	**I have not been impacted by the changes N (%)**	**I have been positively impacted by the changes N (%)**	**Sig.**
Gender				
Male	134 (43.8)	109 (35.6)	63 (20.6)	NS
Female	30 (32.6)	37 (40.2)	25 (27.2)	
Age				
Equal or less than 50 years	41 (31.8)	39 (30.2)	49 (38.0)	< 0.05#
More than 50 years	123 (45.6)	107 (39.6)	40 (14.8)	
State				
Queensland	83 (47.4)	61 (34.9)	31 (17.7)	< 0.05#
New South Wales	23 (27.1)	36 (42.4)	26 (30.6)	
Victoria	22 (34.4)	26 (40.6)	16 (25.0)	
Other	36 (48.0)	23 (30.7)	16 (21.3)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

DVA clients: Quality of care

Quality of care was measured by asking clients eight questions related to the quality of care measures, with a response range of ‘agree’, ‘somewhat agree’, ‘neither agree nor disagree’, ‘somewhat disagree’, and ‘disagree’. Responses were consolidated into ‘agree’, ‘neither’ and ‘disagree’ for reporting purposes. In total, 71% (n = 283) of clients reported requiring more referrals to meet their health care needs, and 34% (n = 137) reported that they are more engaged in how their health care needs are met. Further, 40% (n = 157) of clients reported that they discuss and review their health care needs more often and in more detail with their GP, which is similar to the 39% (n = 156) of clients that reported that they discuss and review their health care needs more often and in more detail with their AHP. In total, 29% (n = 117) of clients

reported that their health care needs are better met by the treatment cycle. In addition, 26% (n = 104) of clients reported that they have better access to necessary services to meet their health care needs and that they receive better quality health care overall. Finally, 30% (n = 118) of clients reported they receive better targeted support based on their health care needs (see Figure 3.4).

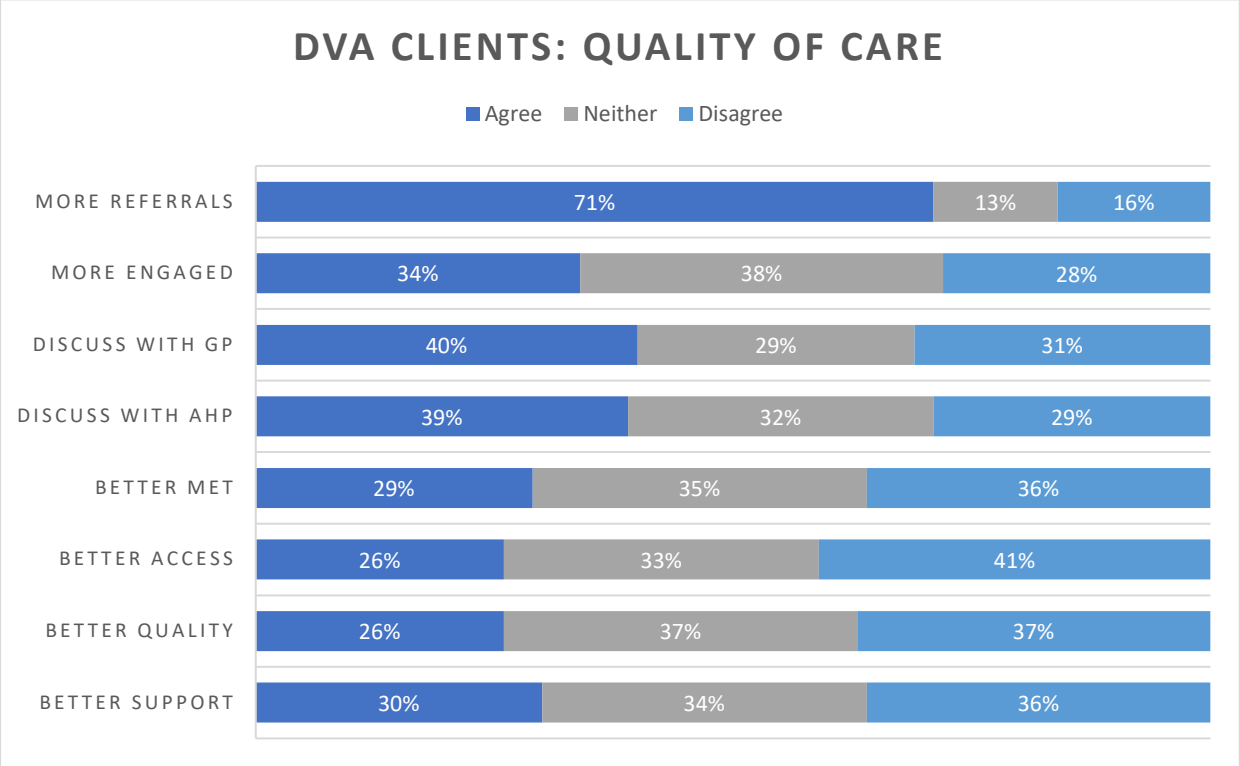


Figure 3.4: Client perspective of quality of care

DVA clients: Quality of care by age

DVA client opinions on the quality of care provided by the treatment cycle were further analysed by client age, as detailed in Table 3.4. DVA clients aged 50 years and younger were more likely to report that they discuss and review their health care needs with their GP more often and in more detail (52%, n = 67) compared to the older cohort (33%, n = 90). Clients aged 50 and younger were also more likely to report that their health care needs are better met (48%, n = 62); they have better access to necessary services (44%, n = 57); they receive better, targeted care (50%, n = 64); and that they receive a better quality of health care overall (46%, n = 59) compared to the older cohort.

Table 3.4: Perceived quality of care by DVA client age

DVA clients: Has your quality of health care changed?	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
I require more referrals from my GP to meet my health care needs.				
Equal or less than 50 years	89 (69.0)	18 (14.0)	22 (17.1)	NS
More than 50 years	194 (71.9)	35 (13.0)	41 (15.2)	
I am more engaged in how my health care needs are met.				
Equal or less than 50 years	55 (42.6)	42 (32.6)	32 (24.8)	NS
More than 50 years	82 (30.4)	110 (40.7)	78 (28.9)	
My GP and I discuss and review my health care needs more often and in more detail.				
Equal or less than 50 years	67 (51.9)	33 (25.6)	29 (22.5)	< 0.05#
More than 50 years	90 (33.3)	84 (31.1)	96 (35.6)	
My AHP and I discuss and review my health care needs more often and in more detail.				
Equal or less than 50 years	60 (46.5)	37 (28.7)	32 (24.8)	NS
More than 50 years	96 (35.6)	90 (33.3)	84 (31.1)	
My health care needs are better met.				
Equal or less than 50 years	62 (48.1)	32 (24.8)	35 (27.1)	< 0.05#
More than 50 years	55 (20.4)	107 (39.6)	108 (40.0)	
I have better access to necessary services for my health care needs.				
Equal or less than 50 years	57 (44.2)	31 (24.0)	41 (31.8)	< 0.05#
More than 50 years	48 (17.8)	101 (37.4)	121 (44.8)	
I receive better quality of health care overall.				
Equal or less than 50 years	59 (45.7)	35 (27.1)	35 (27.1)	< 0.05#
More than 50 years	45 (16.7)	113 (41.9)	112 (41.5)	
I receive better, targeted support based on my health care needs.				
Equal or less than 50 years	64 (49.6)	33 (25.6)	32 (24.8)	< 0.05#
More than 50 years	54 (20.0)	104 (38.5)	112 (41.5)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

DVA clients: Care coordination

Care coordination was measured by asking clients who coordinates their care, with five options provided. These included themselves, their GP, their AHP, their GP and AHP jointly or someone else (other). The results revealed that:

- 56% (n = 223) of clients reported they coordinate their health care needs.
- 25% (n = 98) of clients reported their GP coordinates their health care needs.
- 12% (n = 47) of clients reported their GP and AHP consult each other to jointly coordinate their health care needs.

DVA clients: Care coordination with GP

Clients were asked how their care coordination with their GP has changed since the implementation of the treatment cycle arrangements (see Appendix 2.1, Q37). The results were similar to other questions asked about client, GP and AHP care coordination. Therefore, only questions pertinent to client and GP care coordination are presented below (see Figure 3.5):

- 40% (n = 158) of clients reported that they discuss their health care needs with their GP in more detail before starting a treatment cycle.
- 37% (n = 147) of clients reported that they review their ongoing health care needs with their GP in more detail after finishing a treatment cycle.
- 61% (n = 242) of clients reported that the number of interactions with their GP has increased.
- 29% (n = 115) of clients reported that the quality of their interactions with their GP has improved.
- 36% (n = 145) of clients reported that they have more opportunities to discuss and review their health care needs with their GP.

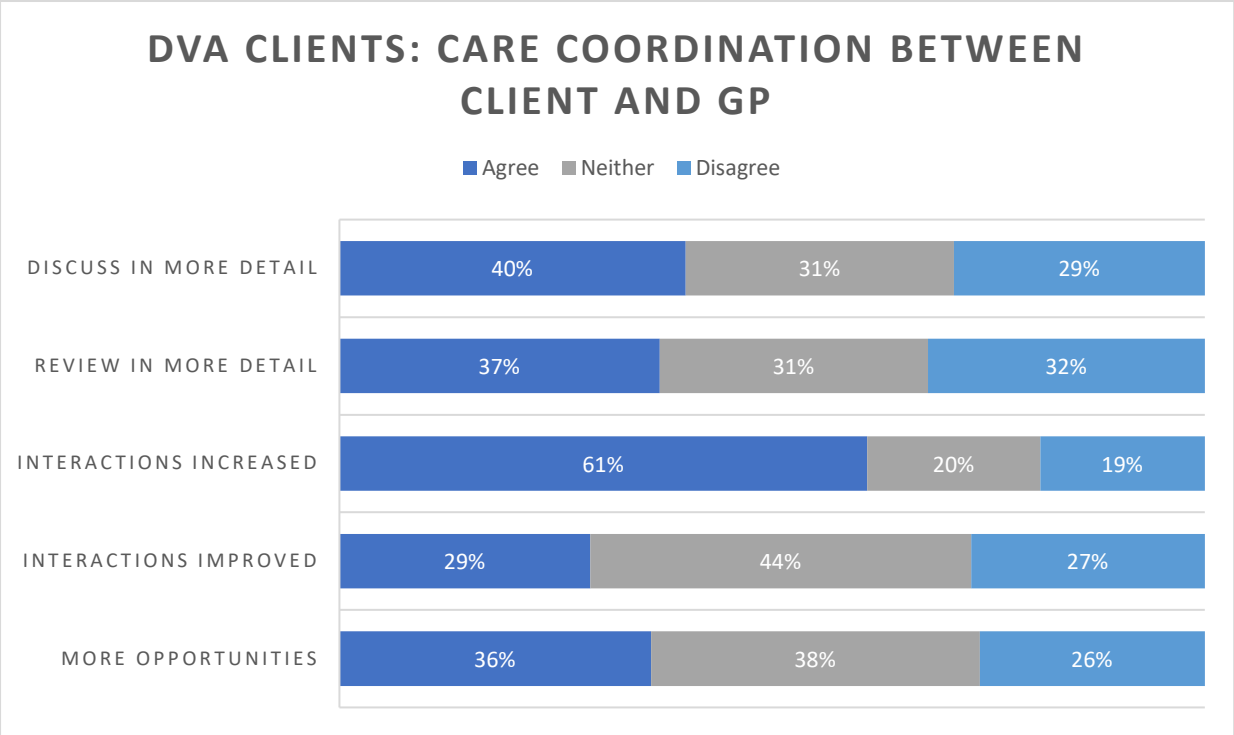


Figure 3.5: Client perspective of care coordination between clients and GPs

DVA clients: Care coordination with AHP

Clients were asked how their care coordination with their AHP has changed since implementing the treatment cycle arrangements. Results were similar to other questions asked about client, GP and AHP care coordination. Therefore, only questions pertinent to the client and AHP care coordination are presented below (see Appendix 2.1, Q39, Figure 3.6 and Figure 3.7):

- 50% (n = 200) of clients reported they develop a Patient Care Plan (PCP) with their AHP before commencing a treatment cycle.
- 51% (n = 203) of clients reported that their PCP details their health care needs.
- 63% (n = 249) of clients reported that their AHPs write notes and assess their health care needs.
- 40% (n = 158) of clients reported that they discuss their health care needs with their AHP in more detail before starting a treatment cycle.
- 42% (n = 165) of clients reported that they review their ongoing health care needs with their AHP in more detail after finishing a treatment cycle.

- 35% (n = 140) of clients reported that the number of interactions with their AHP has increased.
- 31% (n = 125) of clients reported that the quality of their interactions with their AHP has improved.
- 31% (n = 123) of clients reported having more opportunities to discuss and review their health care needs with their AHP.

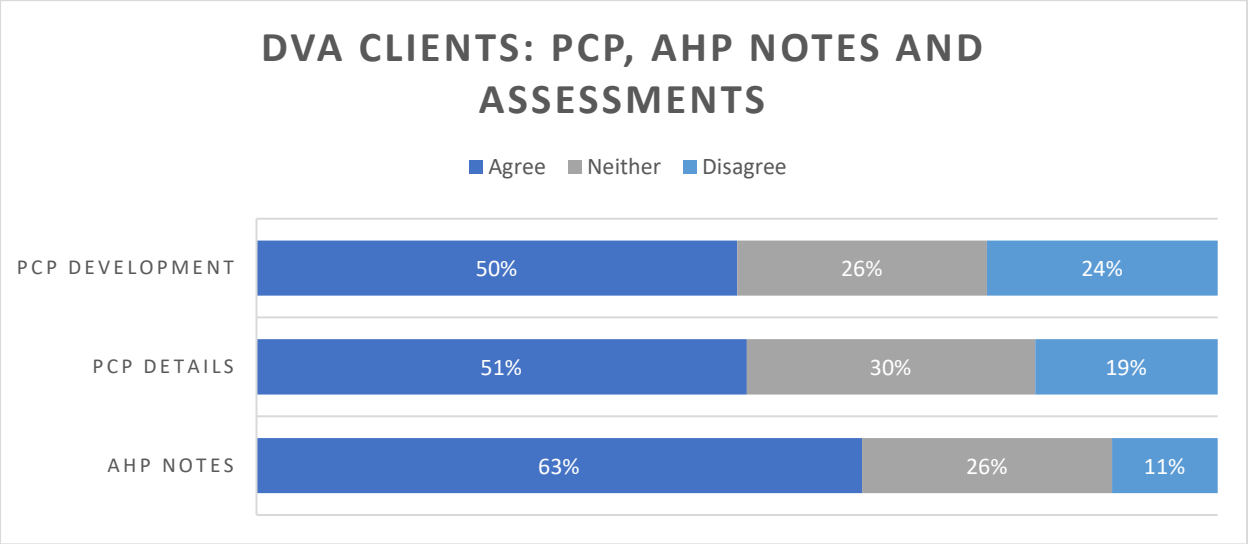


Figure 3.6: Client perspectives of PCP, AHP notes and assessments

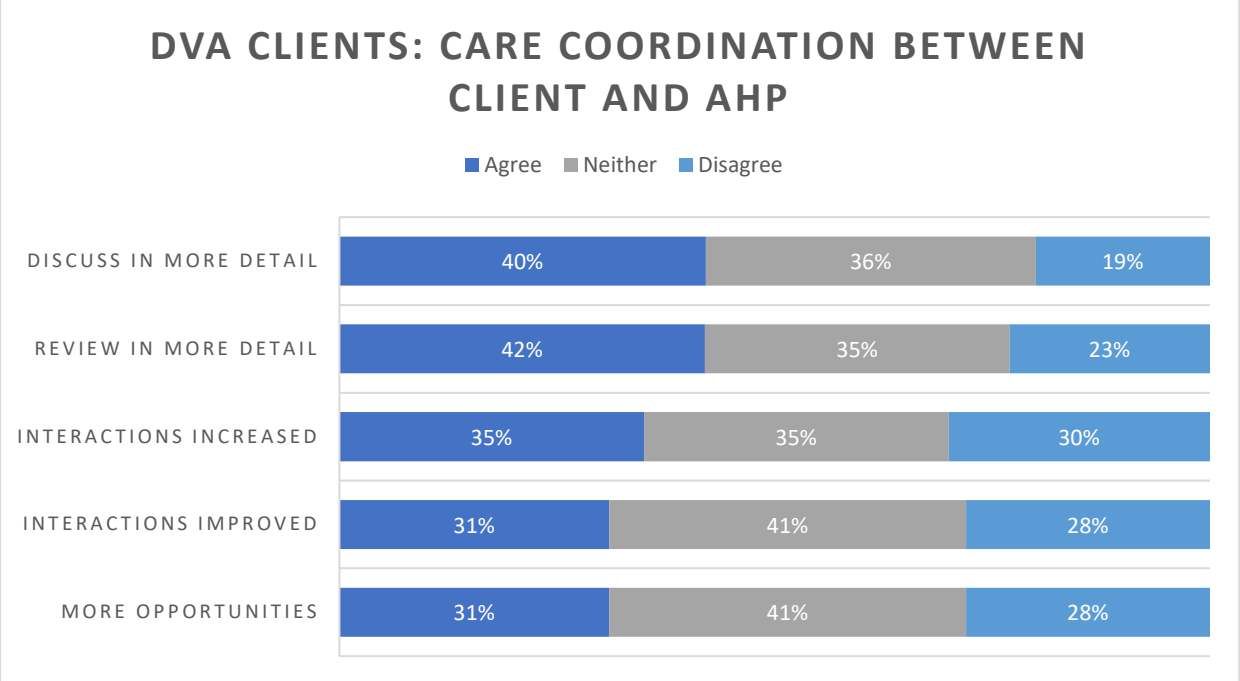


Figure 3.7: Client perspectives of care coordination between clients and AHPs

DVA clients: Care coordination between AHP and GP

Care coordination was measured in three blocks comprised of client and GP, client and AHP, and GP and AHP. Results were similar across the three blocks. The reported results are from the GP and AHP block, and comprehensive results can be viewed in Appendix 2.1. Overall, 52% (n = 206) of clients reported that their AHPs provide reports to their GP, and 42% (n = 169) of clients reported that their GP reviews the reports, discusses the report and seeks their opinion. In total, 50% (n = 200) of clients reported that their GP makes additional referrals based on the report and their opinion. Further, 54% (n = 216) of clients reported feeling included in the decision-making process to meet their health care needs. Finally, 46% (n = 184) of clients felt informed about communications, decisions, and recommendations between their GP and AHPs (see Figure 3.8).

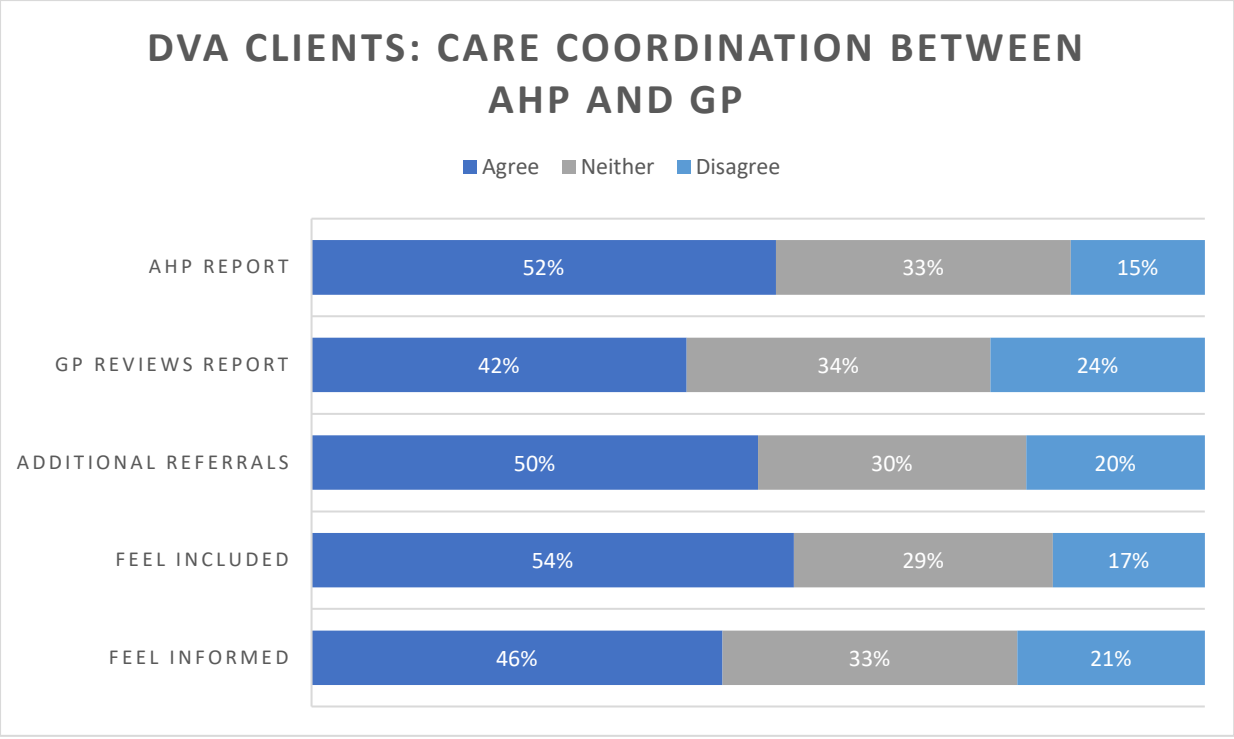


Figure 3.8: Client perspectives of care coordination between AHPs and GPs

DVA clients: Other impacts and themes

Text responses were obtained from DVA clients in the last survey question: 'Compared to before 1 October 2019, I now think that the referral process for treatment cycle arrangements is…'. This question allowed clients to select multiple responses and provide text comments. Note that all text comments quoted in this

report are verbatim from the responses provided: they may or may not be reflective of DVA policy and practice but are an uncensored statement of an individual's experiences and perspectives.

The impacts included 14 options, including more time-consuming or time-efficient; more or less expensive; more complex or simpler and more straightforward; more or less effective; unimproved or improved; worse or improved and better; more or less flexible, responsive, and dynamic; other; and none of the above. The results revealed that:

- 70% (n = 279) of clients reported that the treatment cycle is more time-consuming.
- 35% (n = 140) of clients reported that the treatment cycle is more expensive.
- 44% (n = 176) of clients reported that the treatment cycle is more complex.
- 36% (n = 142) of clients reported that the treatment cycle is less effective.
- 34% (n = 135) of clients reported that the treatment cycle is unimproved and worse as well as less flexible, responsive, and dynamic.

Client and GP engagement

Clients reported feeling inconvenienced by the increased number of GP visits, which were perceived as a waste of time and money. Clients reported feeling like they needed to seek an 'unnecessary' referral, especially those who work full-time or have lifelong conditions. Clients also reported feeling like they were an 'inconvenience' to AHPs and GPs by requiring more appointments. Further, some survey responses described additional GP appointments as provoking stress, anxiety and frustration due to restrictions on appointment times (especially those in rural areas where it is difficult to access GPs) and requiring longer GP appointments (e.g., 30 minutes). Clients also described feeling that GPs are not patient-focused and are unaware of clients' needs. In contrast, some clients reported more communication between their GP and AHP and that their GP is now more aware of their treatment and progress.

'The GP doesn't understand why I need so many referrals for the same thing and constantly wants to terminate treatment'. (DVA client, survey response)

Expenses and costs

Within the qualitative survey responses, DVA clients described increased expenses and costs due to the treatment cycle arrangements. The reasons given for the increased costs were:

- cost of child care or loss of income (taking time off work to attend GP)
- costs associated with time and travel or transport for more GP visits and clinics charging additional costs for appointments
- self-payments covering the cost of treatment when waiting on a new referral

Some respondents also believed the extra costs of GP visits could be better allocated for other veterans to access necessary care/support services.

> *'My rehabilitation needs are long term and as such I believe cases should be assessed individually. I am also unable to access extended appointments for my conditions even if medically necessary, due to the restrictions of cost imposed by DVA, limiting my care I can receive'. (DVA client, survey response)*

Service impacts and outcomes

Within the survey, DVA clients were asked to expand upon the impacts of the treatment cycle arrangements on their health care service and health outcomes. Clients described service impacts and outcomes in the following ways:

- The treatment cycles are too short and described as insufficient to address client health care needs, especially for complex or chronic health conditions.
- There is a loss of treatment time due to paperwork and assessments.
- The treatment cycles are more bureaucratic, with no quality of care added.
- Clients describe not being able to access services due to expired referrals, which negatively affects health conditions.
- Clients describe discontinuing services or experiencing gaps in their treatment due to requiring more referrals and not being able to access the GP in time.
- In contrast, clients also describe the treatment cycle as making goals and changes to care easily identifiable and modifiable.

'Some companies won't take on DVA clients because too much paperwork involved'. (DVA client, survey response)

Psychosocial impacts

DVA clients were asked within the qualitative responses to expand upon their attitudes towards the treatment cycle arrangements. As part of this, clients described a range of psychosocial impacts resulting from the treatment cycle arrangements. Clients described feeling pressure and stress to coordinate their own care by monitoring or tracking their sessions across multiple AHP services. Clients stated that the treatment cycle arrangements have contributed to adverse mental health outcomes such as stress, anxiety and frustration. The treatment cycle arrangements were described as 'additional steps to access care without any perceived benefit' and that it was bureaucratic and time-consuming, involving additional administration and lack of care for veterans.

'The stress in ensuring that I am up to date with referrals constantly is making it less effective'. (DVA client, survey response)

DVA client interview results

Results are presented according to the themes identified within the data. For a full report of interview results, please see Appendix 4.

DVA clients: Availability, quality and clarity of information

Communication of treatment cycle

Within DVA client interviews, participants presented generally negative feedback regarding the availability of information about the treatment cycle arrangements and the timeliness of the communication. Interviewers and participants understood availability as the ease with which the audience can access the required information. If the information needs to be searched for, it has poor availability. If the information is provided in a forum that is easy to access or within expected communication channels, it has good availability. In interviews, clients reported that information

about the treatment cycle arrangements was hard to find or required more investigation by the client. There were multiple reports of clients finding the information from alternative sources rather than directly from DVA sources. Feedback about the quality of information about the treatment cycle arrangements was mixed; interviewees provided some contradictory feedback, but overall, the quality of the information was accepted as good to adequate. Despite this, the reasons for the changes were reported as confusing or lacking logic that could be understood by interviewees.

> *'The information provided was adequate. I can't really say any more than that. I was happy with the information. I was not happy with the fact that it was happening'. (DVA client, 84, ACT)*

DVA client interviewees described that communication of the treatment cycle was often disseminated through veteran-to-veteran communication or veteran advocate or support groups. Three interviewees described that the treatment cycle had affected their ability to experience veteran-to-veteran communication by limiting social contact maintained through exercise groups with physiotherapists or exercise physiologists. Further, some DVA clients expressed frustration at the perceived lack of consultation from DVA about the treatment cycle arrangements.

Perceptions of the treatment cycle arrangements

Throughout the client interviews, there were multiple reports of the treatment cycle arrangements being perceived as confusing, frustrating or clients not understanding the reasons behind the changes. DVA clients and AHPs spoke of the treatment cycle arrangements as a 'cost-saving' measure, often referring to this as their 'understanding' or 'belief' of the true reason for the change. No reference was made to DVA communications specifying this, but rather it was an assumption circulated within the DVA client and health care community.

'I think my understanding, or my belief is that it's a cost driven thing… if DVA is looking to cut back on the, you know, people using services for too long without review, then why not put a time base on it rather than a number of visits? Unless it is just all about cost. That's my question'. (DVA client, 44, NT)

In addition to the belief that the treatment cycle was a cost-saving measure, a common theme across interviewees was that the treatment cycle arrangements were developed in response to individuals (whether DVA clients or AHPs) 'taking advantage' of the previous system. Respondents described being offended by what they perceived as being 'whack[ed] with the same big sledgehammer', referring to being punished for the poor behaviours of others under the previous referral system or arrangements.

DVA clients: COVID-19 impacts

As a result of COVID-19, some DVA client interviewees reported general disruption of access to health care services, with more severe impacts reported from clients in Victoria. Most clients reported minimal impact to their health care services overall, but many clients reported the cancellation of AHP services. Multiple clients reported difficulty in accessing appointments to receive health care from GPs or referrals for the treatment cycle as a result of COVID-19 disruption. Other clients reported reluctance to attend appointments with AHPs or GPs due to concern for their own health or the health of others. There were multiple positive reports from clients, AHPs and GPs regarding the availability of telehealth as an alternative treatment option.

'Getting to access the GP was very difficult, because he was very busy and screening people. In fact, for a little while it was Zoom only and then it was screening people and because I'm complex, he kept saying, I'd prefer you don't come in'. (DVA client, 57, NT)

DVA clients: Clinical notes and administration

Increased burden of administration

A common theme in DVA client interviews was the increased level of administration required as a result of the treatment cycle arrangements. Client interviewees reported needing to spend time and effort recording GP and AHP visits to keep track of the treatment cycles. Many described their perceived need to keep personal diaries, spreadsheets or notebooks to ensure that they had referrals for their health care requirements. This also indicates a certain level of client-coordinated care (DVA clients coordinating their own health care).

> *'Unless I write down in my diary what number treatment I'm having, and I write it in a diary about three weeks before I need a new one, then sometimes you can't even get in to see any doctor just to get them to write a referral'. (DVA client, 56, QLD)*

One DVA client interviewee reported feeling 'embarrassed' that they were causing trouble for AHPs that do not get paid 'as much' to see them as opposed to non-DVA clients.

> *'What we have found—speaking to a couple of veterans, there are less [unclear] DVA providers in Darwin, because they don't get paid as much and we're too—it's too complicated … Because then I'd get all frustrated because I—then I was embarrassed that I was so much trouble to these people who don't get paid as much'. (DVA client, 57, NT)*

Impact of the treatment cycle arrangements on DVA client health outcomes

Multiple DVA client interviewees described experiencing setbacks in treatment or health care due to an inability to access a GP for referral within the cycle. Other DVA client interviewees reported that the treatment cycle affects their mental health due to the increased complexity of service provision and increased requirements to discuss their health care. One GP interviewee expressed disappointment in the

inclusion of psychology in the treatment cycle due to the increased burden of extra GP appointments for vulnerable patients.

'It's probably more to do with maintaining my own mental health. The medical care from DVA, it's all paid for, which I'm not whinging about that at all, but accessing it requires a lot of frustration that sometimes you wonder if it's worth it and in this case, I didn't think it was'. (DVA client, 44, NT)

'So you're also mindful of the psychological impacts of re-hashing these questionnaires all the time because most of them are also people that are trying to get along with life and don't want to be having to re-live all that stuff again'. (AHP, Osteopath, NSW)

'The other thing that disappointed me is that they included psychology in it, because psychology for DVA clients is so important. To have that not limited, but to have that extra burden, that patients have to come in for an extra appointment when psychology is so important. That was very disappointing that they included that'. (GP, QLD)

DVA clients not accessing health care due to treatment cycle arrangements

Multiple DVA client interviewees reported not attending AHP appointments due to the treatment cycle arrangements. Interviewees described the difficulty or inconvenience of attending GP appointments as the reason for cancelling AHP services. This was reported as temporary in some cases and permanent in others.

'If I can't see the doctor within the week or even the fortnight, that means I have to forego my appointments and wait till I get the new referral. That can be a couple of weeks, a month even in between … I've known a few people that just cut it away altogether and they go without rather than having to deal with it. It's not good'. (DVA client, 30, QLD)

'As I said, it just takes more time to coordinate it. When I go in and ask for a referral, the GP goes, yeah, no worries. There's no discussion about it'. (DVA client, 58, QLD)

DVA clients: Care coordination

Client experience: More regular contact with the GP

Some DVA clients noted that they were experiencing more contact with their GP because of the treatment cycle and that this has had a positive impact on their care coordination.

'I believe it's a good thing because what it's actually done, it's put you in much more regular contact with your general practitioner... My opinion of it is it's very positive and very much in the interest of the veteran and the recipient actually'. (DVA client, 81, NSW)

Health care coordination

When asked about the coordination of health care, DVA, GPs and AHPs all felt responsible for the maintenance and ongoing management of DVA clients' care. This may have resulted from a lack of clarification around the question asked, which is addressed in the project limitations.

Health care coordination: DVA clients

DVA client interviewees described their personal responsibility for managing the number of AHP appointments they had left as part of the treatment cycle arrangements and their own coordination of GP appointments for the ongoing provision of care. Two DVA clients mentioned that the GP coordinates their health care through the PCP, though this is in conjunction with their own care management. Some DVA clients described AHPs monitoring the number of appointments they have and informing the client when they needed to receive a new referral. One DVA client reported a change in coordination of care from the GP to himself after the treatment cycle arrangements due to a lack of time from the GP once the arrangements were implemented.

DVA clients: Client experience

DVA clients speaking to local members about the treatment cycle

Two clients felt strongly enough about the treatment cycle to write to their local members about the changes.

> *'As a group, we wrote a letter to the local member, protesting, and the feedback we got from the gentleman that saw it was, thanks for your letter, very interesting, don't call us, we'll call you. Typical politician-type answer'. (DVA client, 72, QLD)*

DVA clients: At Risk Client Framework

Within the interviews, there were mentions of the At Risk Client Framework from DVA clients without prompting from the interviewer. The framework was described by DVA clients as a way to 'get around' the treatment cycle, with one DVA client describing it as a 'loophole'. In general, DVA clients feel it is a positive way to avoid the 12-session limitation. Two DVA clients described that they had brought the framework to the attention of their GP after hearing about it elsewhere.

> *'Yes, that's right. If it was 12 weeks, I'd be grinding my teeth [laughs]. Given this is all private and confidential, that's [At Risk Client Framework] how I'm getting around the 12-week side of things … That form doesn't seem to be easy to find on the DVA website'. (DVA client, 72, QLD)*

GP findings

GP survey results

Key findings for GPs are presented here. For a full report of GP survey results, please see Appendix 2.1, Q17–18, Q45–70.

GP: Information about the treatment cycle

GP knowledge of the treatment cycle was measured in two parts: first by when the GP first became aware of and subsequently by where they received information about the treatment cycle arrangements. The results indicated that:

- 49% (n = 73) of GPs were aware of the treatment cycle arrangements before October 2019.
- 39% (n = 58) of GPs received information directly from DVA about the treatment cycle arrangements before October 2019.
- 28% (n = 41) of GPs reported that they were informed about the treatment cycle arrangements from their DVA clients (multiple responses were allowed for this question).
- 87% (n = 128) of GPs reported they have consulted DVA clients under the treatment cycle arrangements (this was an additional screening question).

GP knowledge of the treatment cycle arrangements was also measured by asking GPs what they thought of the quality, understandability, actionability and relevance of the information provided about the treatment cycle. Responses were provided on a Likert scale that ranged from ‘strongly agree’ to ‘strongly disagree’, which were consolidated into ‘agree’, ‘neither’ and ‘disagree’ for reporting purposes. Overall, 64% (n = 95) of GPs thought the information was easy to understand, and 72% (n = 106) thought it was relevant to their practice. In total, 76% (n = 113) of GPs reported that the information was relevant to their clients’ needs. Further, 58% (n = 85) of GPs reported they were prepared for the changes, and 60% (n = 90) reported that they understood the changes. In addition, 62% (n = 92) of GPs reported feeling confident with the referral changes, and 57% (n = 84) reported that they were satisfied with the changes (see Figure 3.9).

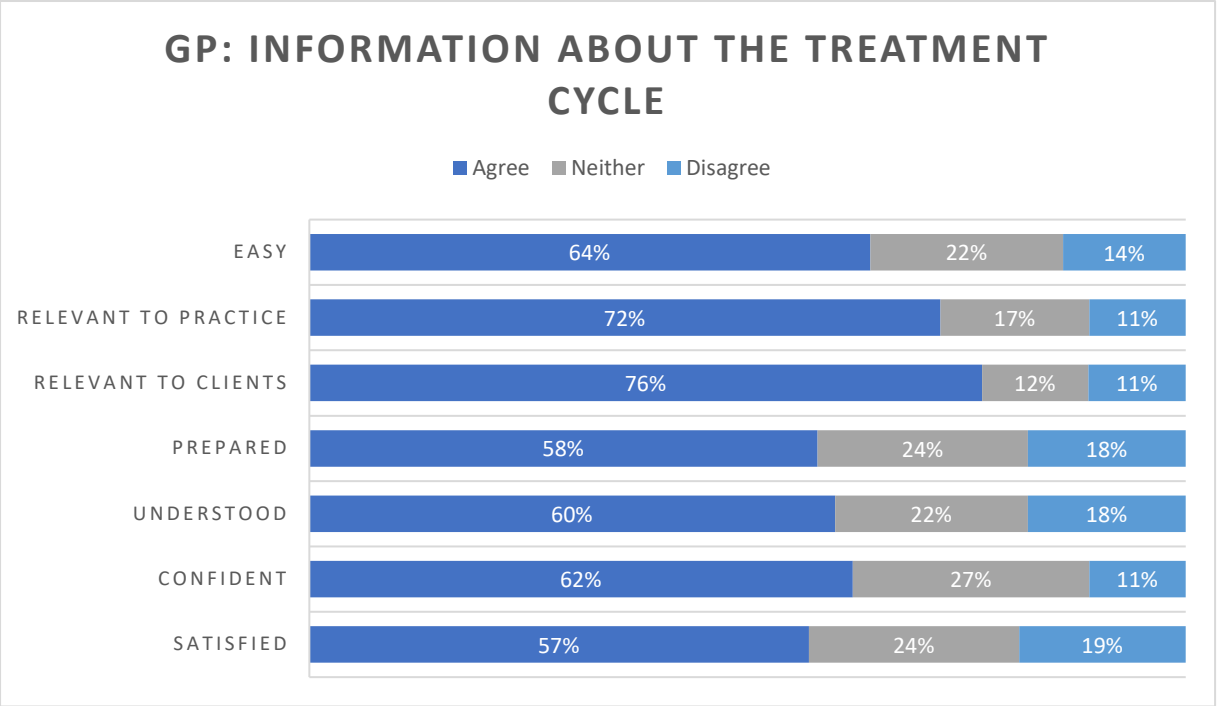


Figure 3.9: GP perspective on treatment cycle information

GP: COVID-19 impacts

GPs were asked if their GP services were impacted by COVID-19; response options were 'yes' or 'no'. In total, 62% (n = 92) of GPs indicated that they experienced impacts to their GP services due to COVID-19. Additionally, GPs were asked how their services had changed due to COVID-19. Responses included 'more telehealth', 'less in-person consultation', 'clients did not access services', 'no change in services', 'none of these' or 'other'. Overall, 62% (n = 91) of GPs reported an increase in telehealth.

GP: Implementing the treatment cycle

GPs were asked when they implemented the treatment cycle arrangements, with responses ranging from October 2019 – October 2020 (time of survey distribution), with two qualifier responses, including 'I'm not sure' and 'I have not implemented the treatment cycle'. Of the GPs, 29% (n = 43) reported implementing the treatment cycle in October 2019.

Additionally, to establish baseline usage of allied health services for DVA clients, GPs were asked when they had referred their DVA clients to allied health services.

Responses included ‘before October 2019 only’, ‘after October 2019 only’, ‘before and after October 2019’, and ‘I have never referred DVA clients for allied health services’. A total of 53% (n = 78) of GPs consulted with DVA clients both before and after the treatment cycle was implemented in October 2019.

GP: Satisfaction with the treatment cycle arrangements by age and location

GP satisfaction with the treatment cycle arrangements was analysed by age and geographic location. It was found that GPs 50 years old and younger were more likely to report that they were satisfied with the changes (63%, n = 72) compared to the older cohort (36%, n = 12). When analysed by geographic location, GPs in Queensland (34%, n = 13) and other states (South Australia, Tasmania, Northern Territory, Western Australia and ACT; 30%, n = 7) were more likely to report that they were not satisfied with the changes when compared to GPs in Victoria and New South Wales. New South Wales GPs were the most positive about the treatment cycle, with 65% (n = 35) reporting satisfaction with the changes. These statistics are shown in full in Table 3.5 and Table 3.6.

Table 3.5: Satisfaction with the treatment cycle by GP age

GPs: Since 1 October 2019, think about the first time you made a referral for a DVA client under the allied health treatment cycle arrangements.	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
I was prepared for the changes.				
Equal or less than 50 years	70 (60.9)	25 (21.7)	20 (17.4)	NS
More than 50 years	15 (45.5)	11 (33.3)	7 (21.2)	
I understood the changes.				
Equal or less than 50 years	73 (63.5)	23 (20.0)	19 (16.5)	NS
More than 50 years	17 (51.5)	9 (27.3)	7 (21.2)	
I had sufficient knowledge about the changes.				
Equal or less than 50 years	79 (68.7)	20 (17.4)	16 (13.9)	NS
More than 50 years	18 (54.5)	8 (24.2)	7 (21.2)	
I was confident referring DVA clients to a treatment cycle.				
Equal or less than 50 years	74 (64.3)	30 (26.1)	11 (9.6)	NS
More than 50 years	18 (54.5)	10 (30.3)	5 (15.2)	
I was satisfied with the changes.				
Equal or less than 50 years	72 (62.6)	23 (20)	20 (17.4)	< 0.05#
More than 50 years	12 (36.4)	12 (36.4)	9 (27.3)	
I have provided allied health services for DVA clients under the treatment cycle arrangements.				
Equal or less than 50 years	64 (55.7)	41 (35.7)	10 (8.7)	NS
More than 50 years	13 (39.4)	13 (39.4)	7 (21.2)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

Table 3.6: Satisfaction with the treatment cycle by GP state

GPs: Since 1 October 2019, think about the first time you made a referral for a DVA client under the allied health treatment cycle arrangements.	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
I was prepared for the changes.				
Queensland	21 (55.3)	5 (13.2)	12 (31.6)	NS
New South Wales	34 (63.0)	15 (27.8)	5 (9.3)	
Victoria	17 (51.5)	10 (30.3)	6 (18.2)	
Other	13 (56.5)	6 (26.1)	4 (17.4)	
I understood the changes.				
Queensland	23 (60.5)	5 (13.2)	10 (26.3)	NS
New South Wales	35 (64.8)	13 (24.1)	6 (11.1)	
Victoria	16 (48.5)	11 (33.3)	6 (18.2)	
Other	16 (69.6)	3 (13)	4 (17.4)	
I had sufficient knowledge about the changes.				
Queensland	24 (63.2)	5 (13.2)	9 (23.7)	NS
New South Wales	38 (70.4)	11 (20.4)	5 (9.3)	
Victoria	18 (54.5)	10 (30.3)	5 (15.2)	
Other	17 (73.9)	2 (8.7)	4 (17.4)	
I was confident referring DVA clients to a treatment cycle.				
Queensland	26 (68.4)	6 (15.8)	6 (15.8)	NS
New South Wales	33 (61.1)	19 (35.2)	2 (3.7)	
Victoria	17 (51.5)	11 (33.3)	5 (15.2)	
Other	16 (69.6)	4 (17.4)	3 (13)	
I was satisfied with the changes.				
Queensland	15 (39.5)	10 (26.3)	13 (34.2)	< 0.05#
New South Wales	35 (64.8)	15 (27.8)	4 (7.4)	
Victoria	19 (57.6)	9 (27.3)	5 (15.2)	
Other	15 (65.2)	1 (4.3)	7 (30.4)	
I have provided allied health services for DVA clients under the treatment cycle arrangements.				
Queensland	16 (42.1)	13 (34.2)	9 (23.7)	NS
New South Wales	33 (61.1)	18 (33.3)	3 (5.6)	
Victoria	16 (48.5)	14 (42.4)	3 (9.1)	
Other	12 (52.2)	9 (39.1)	2 (8.7)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

GP: Impacts of the treatment cycle arrangements

Participants were asked 'how have you been impacted by the changes to allied health treatment cycle arrangements? (select one only)'. The choices provided were 'positively impacted', 'negatively impacted', and 'not been impacted'. These data indicate respondents' perceptions about how the treatment cycle arrangements have affected them. Overall, 45% (n = 67) of GPs were positively affected by the treatment cycle arrangements, 25% (n = 37) of GPs were negatively impacted, and 30%

(n = 45) of GPs were not affected (see Figure 3.10). In addition, GPs were asked, 'have you experienced changes in the amount you see your DVA clients? (select one only)'. The response options included 'I see my DVA clients more', 'I see my DVA clients less', and 'I see my DVA clients the same amount' or 'other'. A total of 46% (n = 68) of GPs reported that they see their DVA clients more, 15% (n = 22) reported seeing their DVA clients less, and 37% (n = 55) reported seeing their DVA clients the same amount. Finally, 2% (n = 3) of GPs selected 'other' (see Figure 3.11).

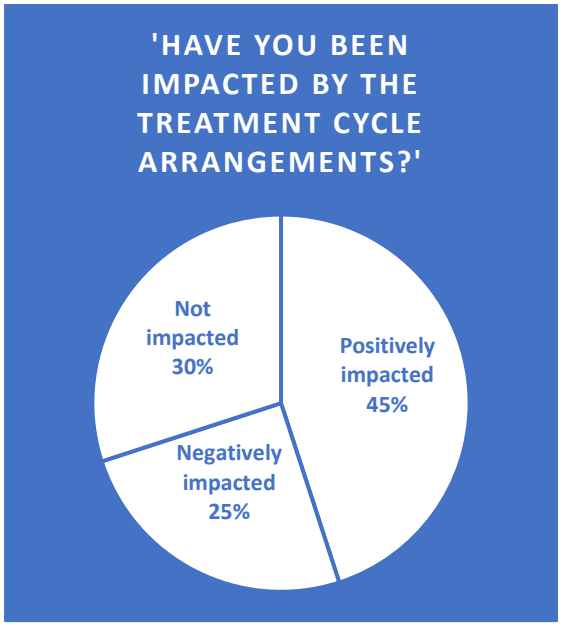


Figure 3.10: GPs' perceived impacts of treatment cycle arrangements

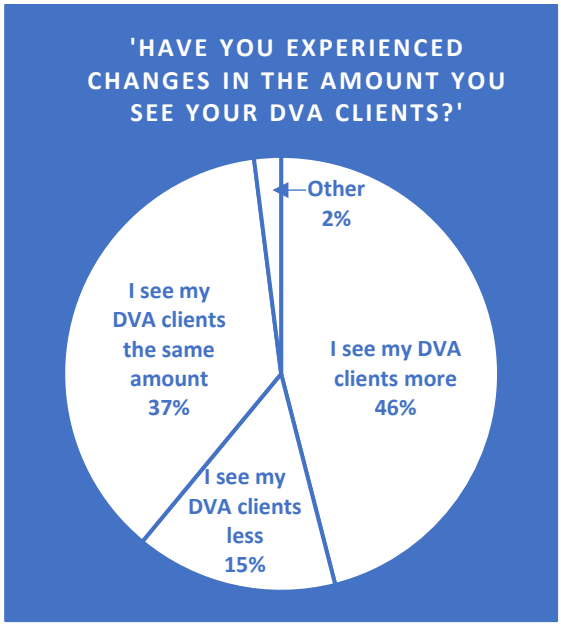


Figure 3.11: GPs' perceived interaction changes with DVA clients

GP: Quality of care

Quality of care was measured by asking GPs eight questions regarding the quality of care factors, with a response range of 'agree', 'somewhat agree', 'neither agree nor disagree', 'somewhat disagree', and 'disagree'. Responses were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes. In total, 55% (n = 82) of GPs reported issuing more referrals to meet their DVA clients' health care needs. A further 51% (n = 75) of GPs reported they contribute more to how their DVA clients' health care needs are met. In addition, 57% (n = 84) of GPs reported they discuss and review their DVA clients' health care needs more often and in more detail with them. In total, 60% (n = 89) of GPs reported they discuss and review their DVA clients' health care needs more often and in more detail with their clients' AHPs.

Overall, 54% (n = 79) of GPs reported that their DVA clients' health care needs are better met by the treatment cycle, and 55% (n = 82) GPs reported that their DVA clients have better access to necessary services to meet their health care needs. Finally, 58% (n = 86) of GPs reported their DVA clients receive better, targeted support based on their health care needs and that they receive better quality health care overall (see Figure 3.12).

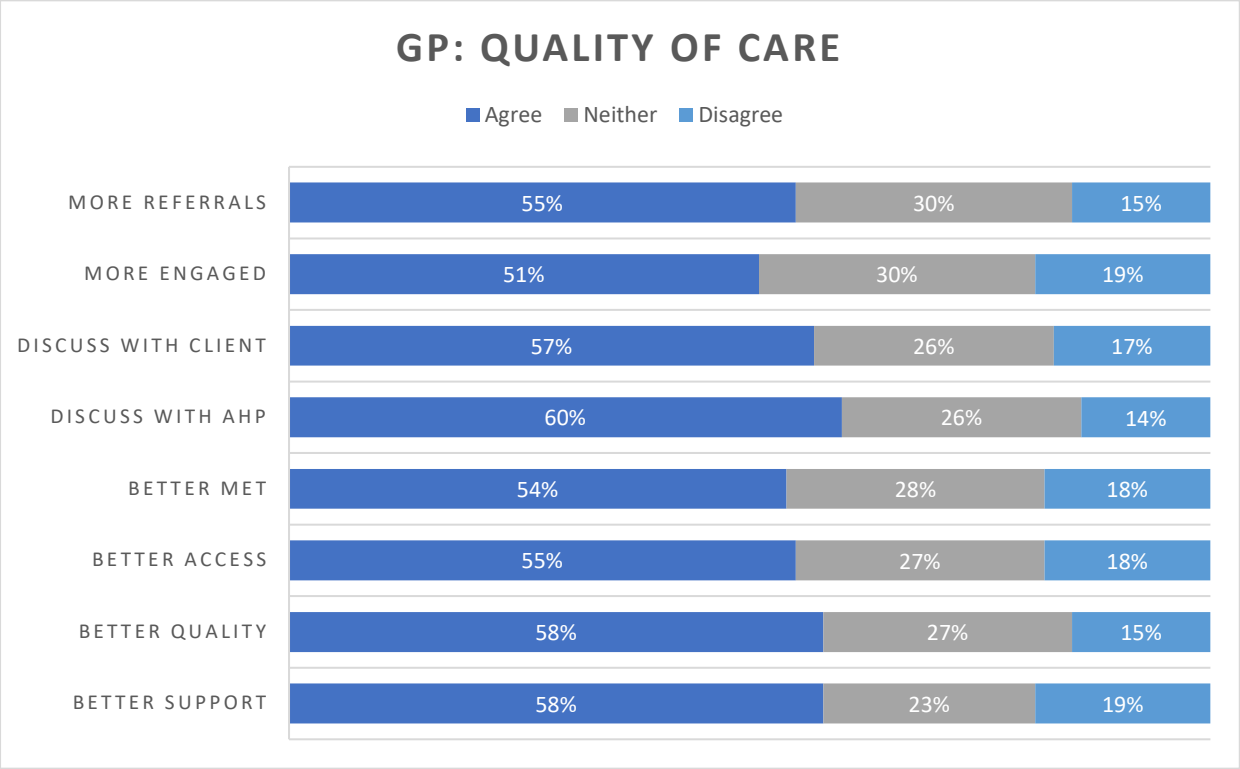


Figure 3.12: GP perspectives on quality of care

GP opinions of the quality of care provided to patients as a result of the treatment cycle were analysed by GP age, with five questions being found statistically significant. GPs aged 50 years or younger were more likely to agree that they provide more referrals for DVA clients to meet their health care needs (61%, n = 70) compared to GPs aged over 50 years, who were more likely to report that they were unsure (52%, n = 17). Similarly, younger GPs were more likely to report that they contribute more to how their DVA clients' health care needs are met (56%, n = 64), compared to the older cohort, who were more likely to be unsure (46%, n = 15). GPs in the 50 years and younger group were also more likely to report that they discuss the needs of their clients with AHPs (66%, n = 76) and that their clients receive better

quality health care overall (66%, n = 76) along with better, targeted health care (65%, n = 75). GPs in the older cohort were more likely to be unsure about each of these measures when compared to the younger group of GPs. These statistics are detailed in Table 3.7.

Table 3.7: Perceived quality of care by GP age

GPs: has your practice of quality health care for DVA clients changed?	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
I make more referrals for my DVA clients to meet their health care needs.				
Equal or less than 50 years	70 (60.9)	28 (24.3)	17 (14.8)	< 0.05#
More than 50 years	12 (36.4)	17 (51.5)	4 (12.1)	
I contribute more to how my DVA clients health care needs are met.				
Equal or less than 50 years	64 (55.7)	29 (25.2)	22 (19.1)	< 0.05#
More than 50 years	11 (33.3)	15 (45.5)	7 (21.2)	
My DVA clients and I discuss and review their health care needs more often and in more detail.				
Equal or less than 50 years	69 (60.0)	25 (21.7)	21 (18.3)	NS
More than 50 years	15 (45.5)	14 (42.4)	4 (12.1)	
My DVA client's AHP and I discuss and review our client's health care needs more often and in more detail.				
Equal or less than 50 years	76 (66.1)	21 (18.3)	18 (15.7)	< 0.05#
More than 50 years	13 (39.4)	17 (51.5)	3 (9.1)	
My DVA clients' health care needs are better met.				
Equal or less than 50 years	67 (58.3)	28 (24.3)	20 (17.4)	NS
More than 50 years	12 (36.4)	14 (42.4)	7 (21.2)	
My DVA clients have better access to necessary services to meet their health care needs.				
Equal or less than 50 years	69 (60.0)	28 (24.3)	18 (15.7)	NS
More than 50 years	13 (39.4)	12 (36.4)	8 (24.2)	
My DVA clients receive better quality of health care overall.				
Equal or less than 50 years	76 (66.1)	25 (21.7)	14 (12.2)	< 0.05#
More than 50 years	10 (30.3)	15 (45.5)	8 (24.2)	
My DVA clients receive better, targeted support based on their health care needs.				
Equal or less than 50 years	75 (65.2)	21 (18.3)	19 (16.5)	< 0.05#
More than 50 years	11 (33.3)	13 (39.4)	9 (27.3)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

GP: Care coordination

Care coordination was measured by asking GPs who coordinates their DVA clients' care, with five options including themselves, their DVA client, their client's AHP, jointly with their client's AHP, someone else, or jointly coordinated with others. Comprehensive results can be viewed in Appendix 2.1, Q65. The results can be summarised as follows (this question was answered on a yes or no basis for each option, hence why the total percentages do not equal 100%):

- 70% (n = 104) of GPs reported that they coordinate their DVA clients' health care.
- 63% (n = 93) of GPs reported that their DVA clients coordinate their health care.
- 57% (n = 85) of GPs reported their DVA client's AHP coordinates their health care.

GP: Care coordination with DVA clients

Care coordination was measured by asking GPs five questions; responses ranged from 'agree' to 'disagree' and were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes (see Figure 3.13). Comprehensive results can be viewed in Appendix 2.1, Q63. The results are as follows:

- 58% (n = 85) of GPs reported that before making a referral to treatment cycles, they discuss their DVA client's health care needs with them in more detail.
- 59% (n = 87) of GPs reported that after finishing a treatment cycle, they review their DVA client's ongoing health care needs with them in more detail.
- 59% (n = 87) of GPs reported that the number of interactions with their DVA clients has increased.
- 55% (n = 81) of GPs reported that the quality of their interactions with their DVA clients has improved.
- 60% (n = 88) of GPs reported that they have more opportunities to discuss and review their DVA client's health care needs with them.

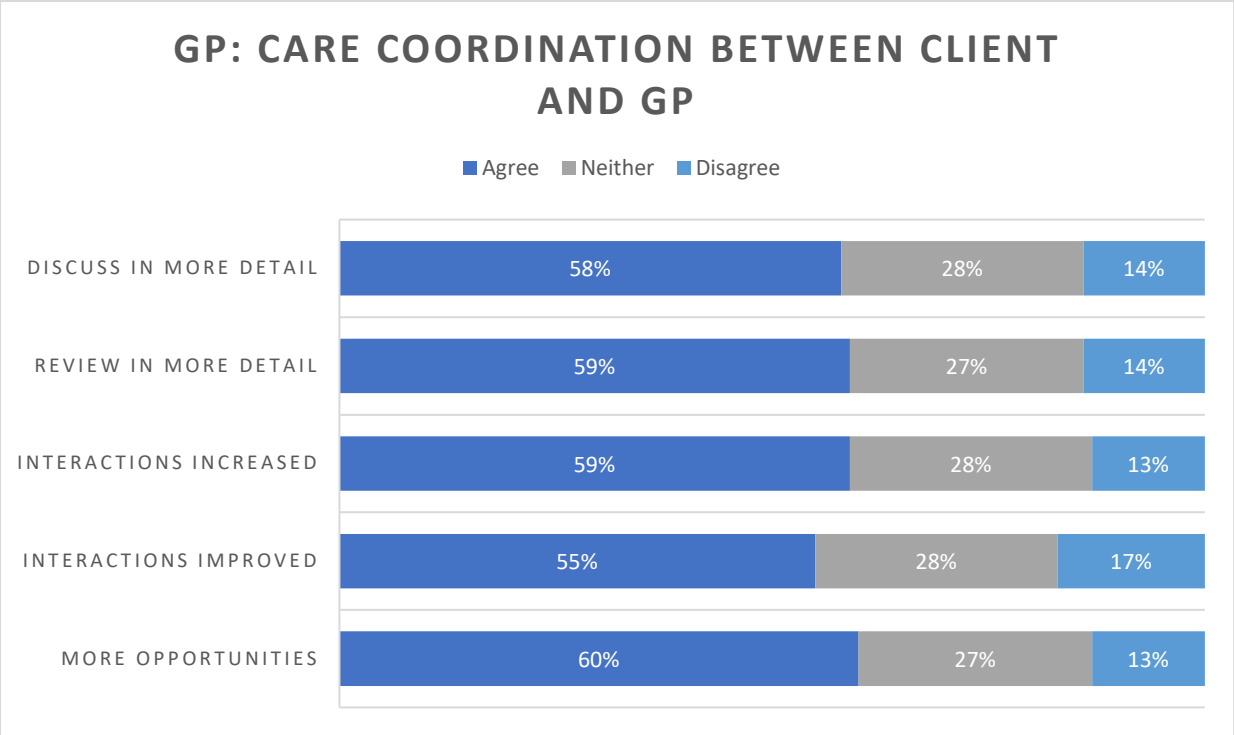


Figure 3.13: GP perspectives on care coordination between clients and GPs

GP: Care coordination between AHPs and GPs

Care coordination was measured by asking GPs nine questions; responses ranged from 'agree' to 'disagree' and were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes. Comprehensive results can be viewed in Appendix 2.1, Q66.

Overall, 61% (n = 91) of GPs reported that their DVA clients' AHPs provide reports. A further 65% (n = 96) of GPs reported that they review and discuss the reports with their clients and seek their opinion. A total of 69% (n = 102) of GPs reported they make additional referrals based on the report, their client's opinion and their own professional judgement. Overall, 73% (n = 108) of GPs reported that they ensure their DVA clients are included in the decision-making process to meet their health care needs. In addition, 68% (n = 101) of GPs reported they ensure their DVA clients are informed about communications, decisions and recommendations between them and their AHPs. Finally, 64% (n = 94) of GPs reported having more opportunities to discuss and review their DVA client's health care needs with their AHP (see Figure 3.14).

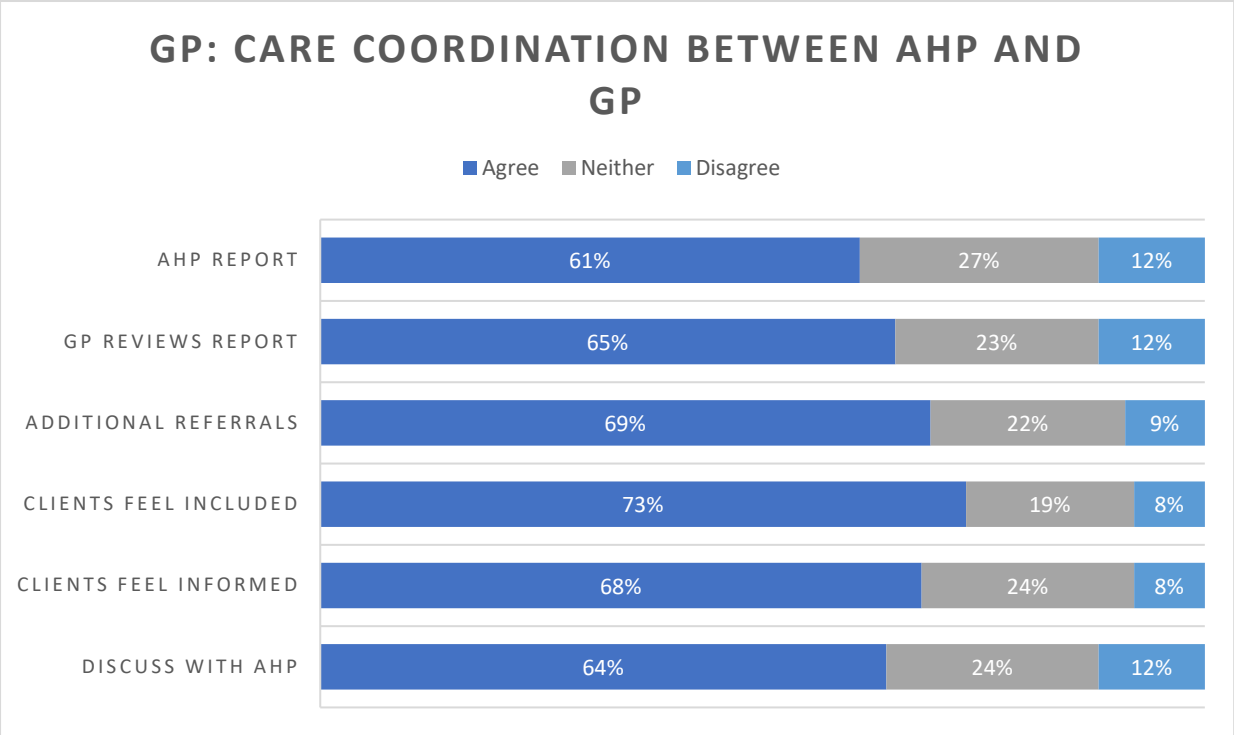


Figure 3.14: GP perspectives on care coordination between AHPs and GPs

GP: At Risk Client Framework efficacy

The efficacy of the At Risk Client Framework was measured by asking GPs eight questions about their opinion of the framework. Responses ranged from 'agree', 'somewhat agree', 'somewhat disagree', and 'disagree'. The responses were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes. In total, 57% (n = 84) of GPs thought they had sufficient knowledge about the framework, and 58% (n = 86) of GPs reported they understood the framework. Further, 63% (n = 94) of GPs reported applying the framework, and 62% (n = 92) were satisfied with the framework criteria. In addition, 54% (n = 80) of GPs agreed that the framework meets complex health care needs, and 60% (n = 89) of GPs believe the framework ensures quality primary coordinated care. Finally, 53% (n = 79) of GPs agreed that few DVA clients require the framework (see Figure 3.15).

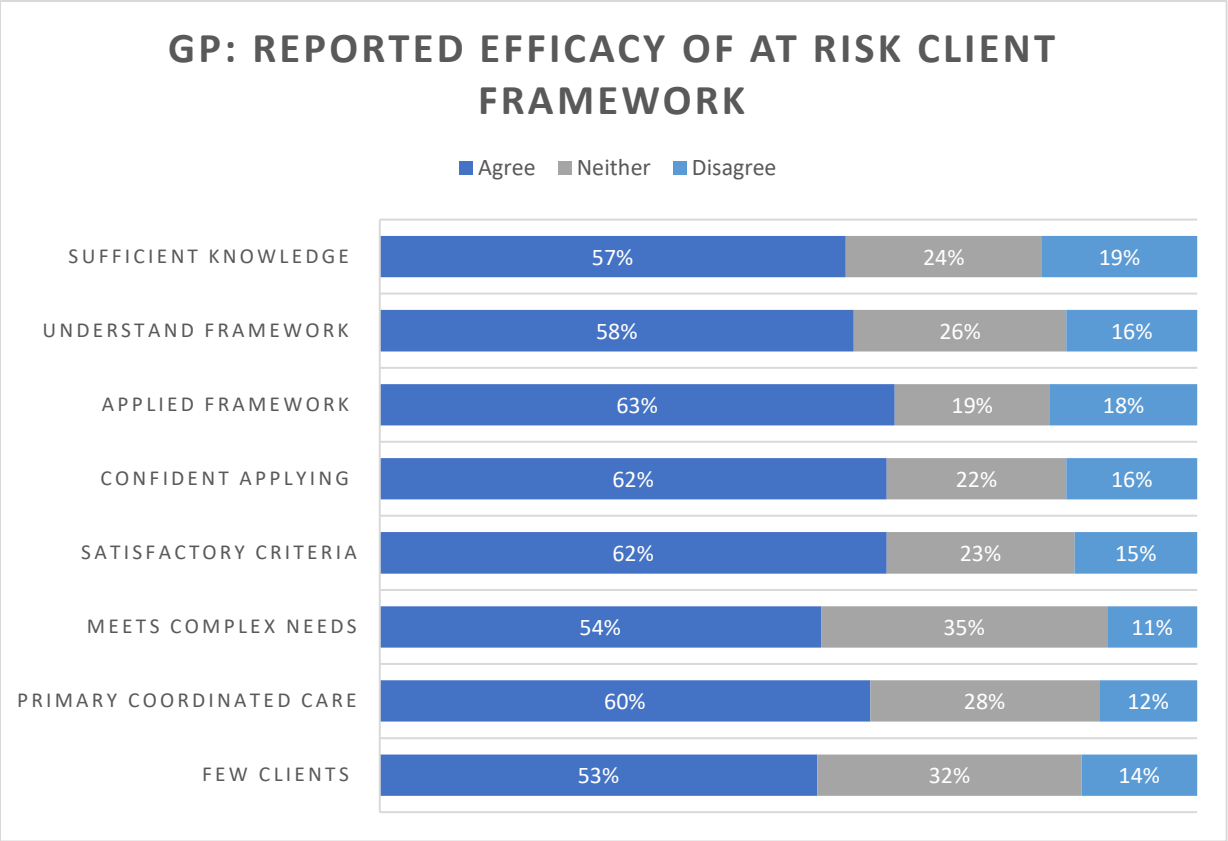


Figure 3.15: Reported efficacy of the At Risk Client Framework

GP opinions on the At Risk Client Framework were analysed by the age and gender of GP survey respondents (see Table 3.8). Both GP age and gender differences were found to be statistically significant in regard to the following statement: 'A very small percentage of DVA clients require tailored referral arrangements under the framework'. GPs 50 years old and younger were more likely to agree with this statement (57%, n = 66) than GPs in the older age group (40%, n = 13). Male GPs were more likely to agree (58%, n = 56) or be unsure regarding the statement (34%, n = 33), compared to female GPs, who were more evenly spread across agree, disagree, and unsure responses.

Table 3.8: Professional opinion of the At Risk Client Framework by GP age and gender

GPs: Professional opinion of the At Risk Client Framework	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
A very small percentage of DVA clients require tailored referral arrangements under the framework.				
Equal or less than 50 years	66 (57.4)	34 (29.6)	15 (13.0)	< 0.05#
More than 50 years	13 (39.4)	14 (42.4)	6 (18.2)	
Male	56 (58.3)	33 (34.4)	7 (7.3)	< 0.05#
Female	23 (44.2)	15 (28.8)	14 (26.9)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

GP: Other impacts and themes

Text responses were obtained from GPs in the last question of the survey, which asked GPs to respond to the following question: 'compared to before 1 October 2019, I now think that the referral process for treatment cycle arrangements is…'. This question allowed GPs to select multiple responses and provide text comments. The impacts included 16 options, including more time-consuming or time-efficient, more or less expensive, more complex or simpler and straightforward, more or less effective, unimproved or improved, more or less flexible, more or less administrative, other and none of the above. For full details, see Appendix 2.1, Q70.

- 49% (n = 73) of GPs reported that the treatment cycle is more time-consuming.
- 29% (n = 44) of GPs reported that the treatment cycle is more expensive.
- 28% (n = 42) of GPs reported that the treatment cycle is more complex.
- 29% (n = 44) of GPs reported that the treatment cycle is more effective.
- 26% (n = 38) of GPs reported the treatment cycle is better and improved.
- 32% (n = 48) of GPs reported the treatment cycle is less administrative.

For the text responses to the above question, the following themes were identified.

GP administrative burden

GP survey respondents reported that client referrals for treatment cycles often do not match, resulting in multiple referrals for multiple conditions.

'One of my patients has twice weekly physio in the home, as well as OT regularly and social work support. None of the DVA cycles match up and I am forever receiving requests from the various agencies to write another referral cycle. It is driving me insane with just this one patient, let alone all the others'. (GP, survey response)

Further, GP survey responses indicated that the treatment cycle involved more appointments and consultations each week just for referrals and paperwork. This resulted in increased consultation times due to the complexity of the referral process. Some GP responses indicated that GPs were required to complete paperwork or referrals unpaid and in their own time. Survey responses also indicated that the forms required are longer, not auto-populated, and cannot be downloaded from the DVA website. GPs reported that referral templates are not user-friendly nor fit for purpose and that the relevant areas are too small and time-consuming.

GP survey respondents also reported issues with receiving End of Cycle reports from AHPs. One respondent explained that, despite increased reporting, they rarely read reports unless it was for an acute issue.

'The increased reporting requirements for AHPs are just bureaucratic red tape. I rarely read them unless it is regarding an acute issue. If a vet[eran] feels they are benefiting, then I will always re-refer them regardless of the report. Putting more paperwork in place doesn't make the system better'. (GP, survey response)

GP opinions of service impacts and outcomes

Some GP survey respondents described the treatment cycle arrangements as not suitable for chronic conditions, especially those with no change in outcomes over time. In contrast, other GP respondents describe the treatment cycle as providing better care. Comments included that the treatment cycle is better for acute care, that more frequent reviews are good, it is more thorough for diabetes care (e.g., podiatry) and that they are seeing DVA clients less.

'For acute care which often turns in to unnecessary chronic care it is good to have limitations'. (GP, survey response)

GP expenses and costs

Survey responses from GPs describe that increased expenses resulting from the treatment cycle arrangements can be attributed to the increased cost to Medicare (consultation billing). Responses also described the unnecessary consultation fees resulting from the treatment cycle arrangements when 12 sessions are insufficient to address clients' health care needs.

'I have to facilitate approx. 20 extra consults per week, charged to Medicare, to facilitate referrals which takes away from my other patients' ability to see me'. (GP, survey response)

GP attitudes towards the treatment cycle arrangements

Overall comments about the treatment cycle arrangements from GPs included that they did not understand the requirements and that they were guessing what to do. Other comments included that they felt that the treatment cycle is bureaucratic, and another respondent explained that they believe that the treatment cycle is worse but provides better feedback from AHPs (especially physiotherapists).

'I still do not fully understand what all the requirements are. DVA have never given me any information—I just have to take my best guess what to do'. (GP survey response)

GP interview results

Results have been presented according to the themes identified within the data. For a full report of interview results, please see Appendix 4.

GP: Perception of treatment cycle communication

There were mixed reports from GP interview participants regarding the communication of the treatment cycle arrangements. Similar to DVA clients, one GP reported that the quality of the information was 'okay' but not clear in communicating the reasons behind the changes and that they would have preferred to be consulted on the changes. One GP interviewee noted that they did not know of the treatment cycle arrangements until completing the survey for this report. There was a recommendation that face-to-face communication, rather than letters or emails, is the most effective way for DVA to communicate information with GPs. Another GP interviewee noted that communication through professional associations was the most common channel of information about the treatment cycle arrangements.

'The first I heard about it was through advocates and patients who told me it was coming. Then I didn't really receive anything until the 11th hour in the sense of it was only either weeks or a month prior to the cycle starting or the requirement starting that I actually heard from DVA and then heard from RACGP'. (GP, QLD)

Communication between GPs and AHPs

Interviews with AHPs revealed the belief that the information presented in the End of Cycle reports will not be read by GPs. Interestingly, this was confirmed by interviews with GPs, who reported that there were too many reports pertaining to DVA clients for them to read them all. Some AHP interviewees described their frustration and difficulties when trying to communicate with GPs and reported that they feel that they are not listened to by GPs.

'We have to send reports to the doctors which are not really showing any major need to communicate so I feel like you're—overcommunicating with the GPs. So, I'm concerned that when I do need to send them emails, they're not going to really pay attention because I'm sending them emails regularly regarding DVAs with no significant information to report'. (AHP, Osteopath, NSW)

'But the other problem about that is that because I have so many DVA clients, I get so many allied health reports, that it's difficult to spend a lot of time in each one, reading them all through and dissecting everything that they say'. (GP, QLD)

GP: Increased burden of administration

An increased administration load was described by GP interviewees. One DVA client interviewee reported an interaction with their GP in which the doctors complained of a higher administration load due to the treatment cycle arrangements. Similar to AHP interviewee reporting, GPs also linked the increased administration to financial issues of DVA remuneration.

'It's just added an administrative burden to my life which I was already busy enough, I didn't really need. So it's just adding an extra layer of complexity to the DVA patient's life, to my life, to receptionists. Of course, every time we need another referral, it's just another administrative step for the receptionist. We don't get paid for those administrative steps, so whether that means they have to scan it and email it to the patient, if you add that extra burden regularly it adds up for their time'. (GP, 39, QLD)

GP: Health care coordination

All GP interviewees reported that they are the sole coordinators of patient health care.

'Yes, that's the whole purpose [of the treatment cycle arrangements], to try and use the GP as the gatekeeper and coordinator, with discussion with the other allied health in respect to the patient'. (GP, VIC)

GP: At Risk Client Framework

None of the GPs interviewed was very familiar with the framework. One had not heard of it at all.

'Yeah, now that you've mentioned it, I didn't know the name of it, but one of my patients had mentioned it or asked about it a while back and I hadn't had a chance to look into it. Again it's just you get so many information emails come through every week and there's only a certain amount of time to read them all and get a handle on what's required of them'. (GP, QLD)

AHP findings

AHP survey results

Key findings for AHPs are presented here. For a full report of AHP survey results, please see Appendix 2.1, Q17–18, Q45–47, Q71–89.

AHP: Information about the treatment cycle arrangements

AHP knowledge about the treatment cycle arrangements was measured in two parts: First, by when AHPs first became aware of the treatment cycle arrangements, and second, where they received information about the treatment cycle. The results are as follows (multiple responses were allowed for this question):

- 72% (n = 316) of AHPs were aware of the treatment cycle arrangements before October 2019.
- 41% (n = 181) of AHPs received information from DVA about the treatment cycle arrangements before October 2019.
- 37% (n = 164) of AHPs reported being informed about the treatment cycle arrangements from their professional association (email/letter).

AHP knowledge of the treatment cycle was further measured by asking AHPs what they thought of the quality, understandability, actionability and relevance of information available about the treatment cycle arrangements. Responses ranged from ‘agree’, ‘somewhat agree’, ‘somewhat disagree’, to ‘disagree’. These categories were consolidated into ‘agree’, ‘neither’ and ‘disagree’ for reporting purposes. Overall, 53% (n = 234) of AHPs thought the information was easy to understand, and 64% (n = 284) of AHPs thought the information was relevant to their practice. A total of 52% (n = 230) of AHPs reported that the information was relevant to their clients’ needs. Further, 57% (n = 254) of AHPs reported they were prepared for the treatment cycle arrangements, and 65% (n = 286) of AHPs reported that they understood the changes. In addition, 64% (n = 283) of AHPs reported they were confident with the referral changes, and 27% (n = 119) AHPs reported satisfaction with the changes (see Figure 3.16).

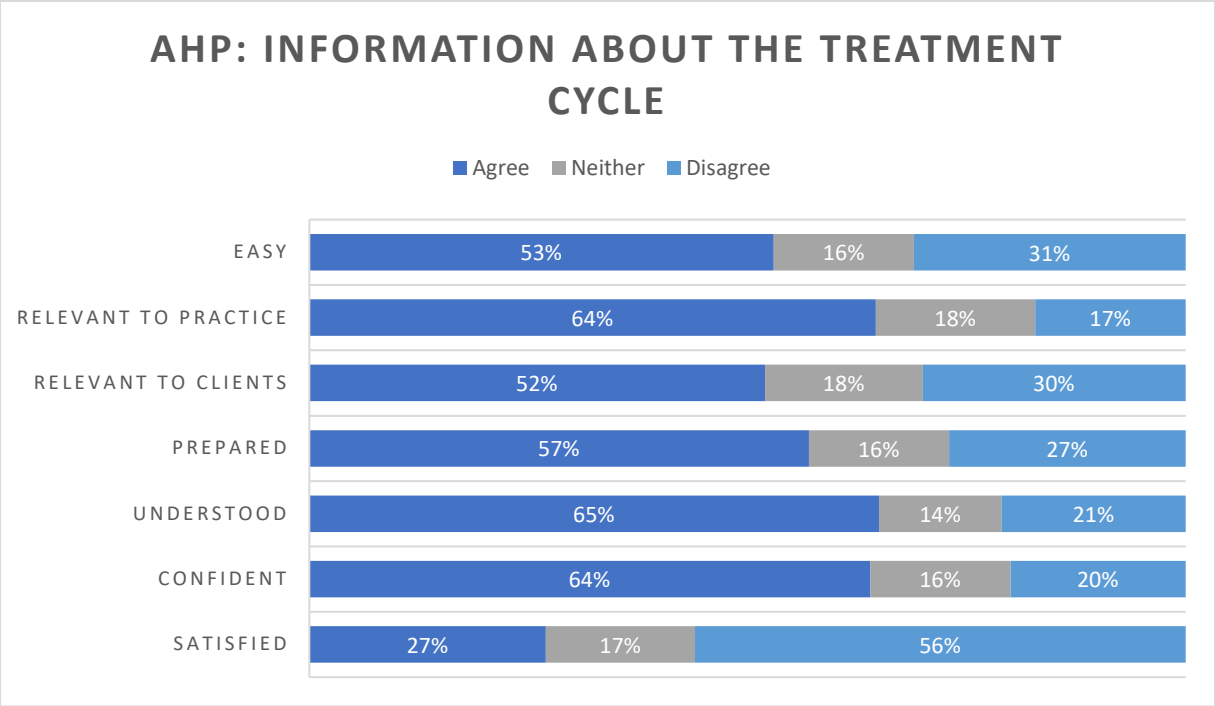


Figure 3.16: AHP perspectives on information about treatment cycle arrangements

AHP: Implementing the treatment cycle arrangements

AHPs were asked when they implemented the treatment cycle with responses ranging from October 2019 – October 2020 (time of survey distribution), with two qualifier responses including 'I'm not sure' and 'I have not implemented the treatment cycle'. In total, 56% (n = 247) of AHPs implemented the treatment cycle in October 2019.

Additionally, to establish DVA clients' baseline usage for allied health services, AHPs were asked when they had treated their DVA clients for allied health services. Responses included 'before October 2019 only', 'after October 2019 only', 'before and after October 2019' and 'I have never treated DVA clients for allied health services'. Overall, 82% (n = 363) of AHPs treated DVA clients both before and after the treatment cycle was implemented in October 2019.

AHP: Impacts of the treatment cycle arrangements

AHP survey respondents were asked, 'how have you been impacted by the changes to allied health treatment cycle arrangements? (select one only)'. The choices provided were 'positively impacted', 'negatively impacted' and 'not been impacted'.

These data indicate the respondents' perceptions about how the treatment cycle has affected them. Overall, 13% (n = 56) of AHPs reported being positively affected, 54% (n = 240) reported being negatively affected, and 33% (n = 145) were not affected by the treatment cycle (see Figure 3.17). In addition, AHPs were asked, 'have you experienced changes in the amount you see your DVA clients?'. The response options included 'I see my DVA clients more', 'I see my DVA clients less', 'I see my DVA clients the same amount' or 'other'. In total, 9% (n = 39) of AHPs reported that they see their DVA clients more, 23% (n = 101) reported seeing their DVA clients less, 63% (n = 276) reported seeing their DVA clients the same amount, and 5% (n = 25) selected 'other' (see Figure 3.18).

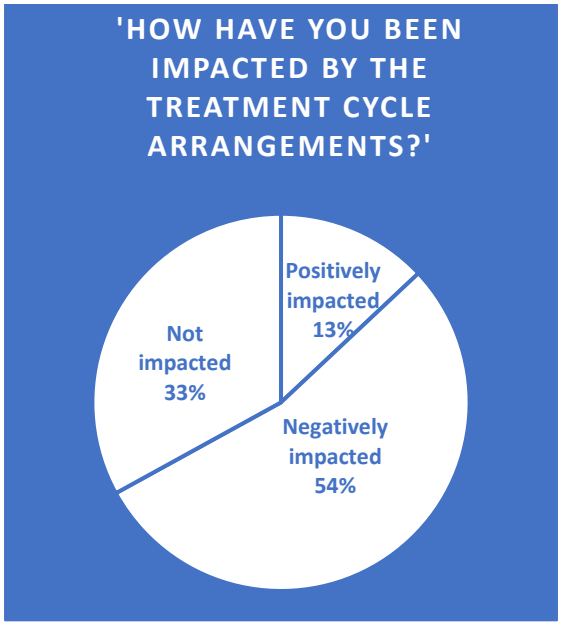


Figure 3.17: AHP perceived impacts of treatment cycle arrangements

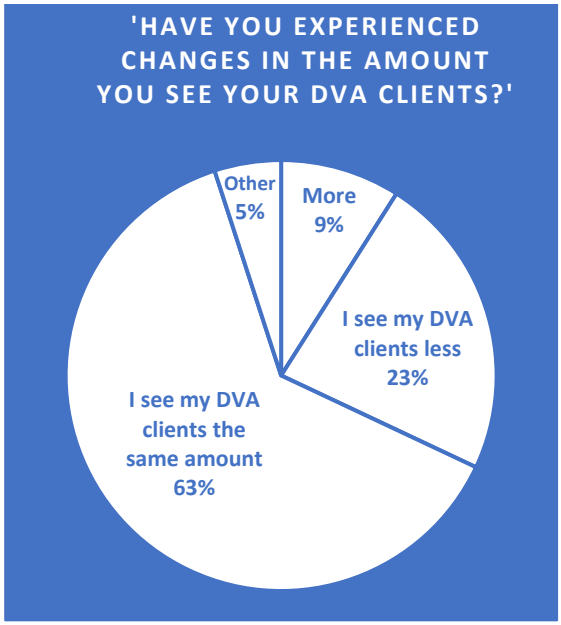


Figure 3.18: AHP perceived changes to interactions with clients

AHP perspectives about the impact of the treatment cycle arrangements were further analysed by AHP gender, age and geographic location. Only AHP state of practice was statistically significant, as detailed in Table 3.9. AHPs practising in New South Wales were slightly more likely to report being positively affected by the treatment cycle arrangements (22%, n = 23) than other states and territories.

Table 3.9: Perceived impact of the treatment cycle arrangements by AHP gender, age and state

AHPs: impacted by the changes to referrals for allied health treatment cycle arrangements	**I have been negatively impacted by the changes N (%)**	**I have not been impacted by the changes N (%)**	**I have been positively impacted by the changes N (%)**	**Sig.**
Gender				
Male	83 (53.5)	48 (31.0)	24 (15.5)	NS
Female	150 (52.6)	96 (33.7)	39 (13.7)	
Prefer not to say	7 (87.5)	1 (12.5)	0 (0.0)	
Age				
Equal or less than 50 years	182 (51.7)	121 (34.4)	49 (13.9)	
More than 50 years	57 (65.5)	23 (26.4)	7 (8.0)	
State				
Queensland	77 (57.9)	47 (35.3)	9 (6.8)	< 0.05#
New South Wales	47 (43.9)	37 (34.6)	23 (21.5)	
Victoria	51 (58.0)	27 (30.7)	10 (11.4)	
Other	65 (57.5)	34 (30.1)	14 (12.4)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

AHP: COVID-19 impacts

AHPs were asked if their health services were affected by COVID-19; response options were ‘yes’ or ‘no’. Overall, 74% (n = 327) of AHPs reported impacts to their allied health services due to COVID-19. Additionally, AHPs were asked how their services had changed due to COVID-19. Responses included ‘more telehealth’, ‘less in-person consultation’, ‘clients did not access services’, ‘no change in services’, ‘none of these’ or ‘other’. In total, 38% (n = 168) of AHPs reported an increase in telehealth, and 51% (n = 224) of AHPs reported fewer in-person consultations.

AHP: Quality of care

Quality of care was measured by asking AHPs eight questions regarding the quality of care measures, with a response range of ‘agree’, ‘’somewhat agree, ‘neither agree’ ‘nor disagree’, ‘somewhat disagree’ and ‘disagree’. Responses were consolidated into ‘agree’, ‘neither’ and ‘disagree’ for reporting purposes. Overall, 21% (n = 94) of AHPs reported receiving more referrals to meet their DVA clients’ health care needs. A further 25% (n = 109) of AHPs reported contributing more to

how their DVA clients' health care needs are met. In addition, 31% (n = 137) of AHPs reported that they discuss and review their DVA clients' health care needs more often and in more detail with them, while 35% (n = 153) reported that they discuss and review their DVA clients' health care needs more often and in more detail with their client's GP. A total of 49% (n = 215) of AHPs disagreed with the statement that their DVA clients' health care needs are better met by the treatment cycle, and 52% (n = 230) of AHPs disagreed that their DVA clients' have better access to necessary services to meet their health care needs. Finally, 46% (n = 201) of AHPs disagreed that their DVA clients receive better, targeted support based on their health care needs and that they receive better quality health care overall (see Figure 3.19).

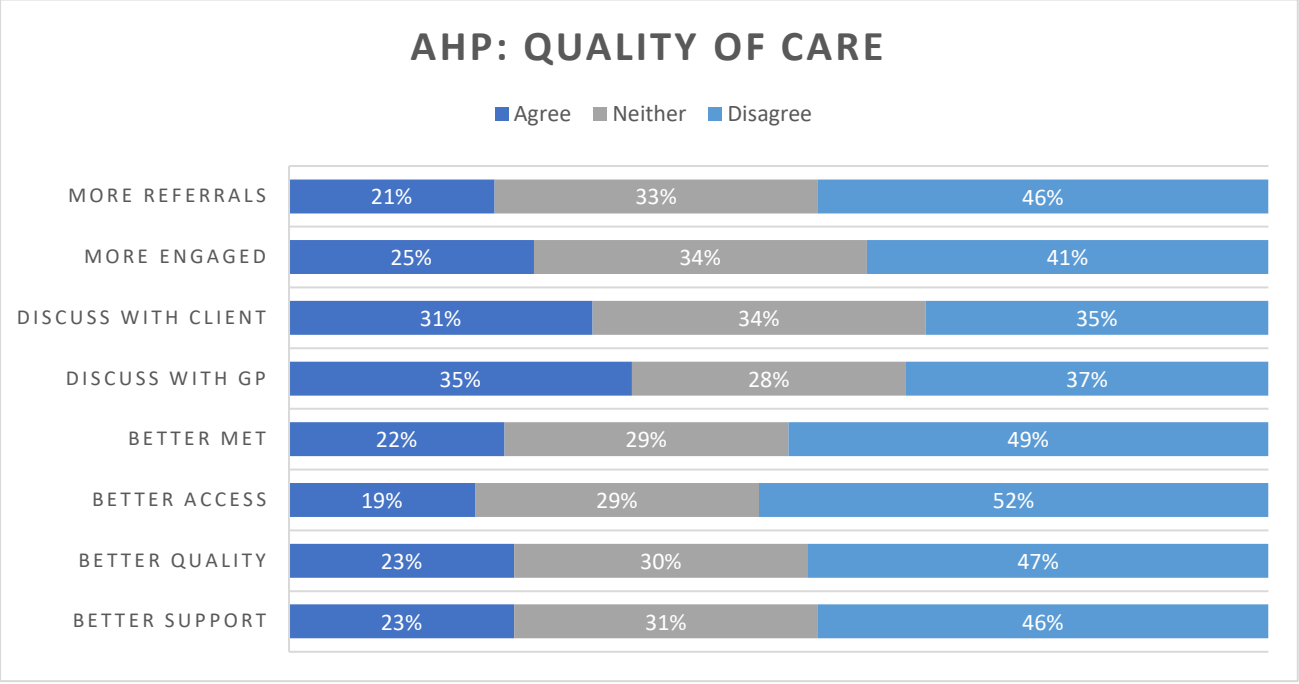


Figure 3.19: AHP perspectives on quality of care

AHP: Quality of care by age

AHP perspectives on the quality of care as a result of the treatment cycle arrangements were analysed by the age of AHP respondents (see Table 3.10). AHPs aged over 50 years were more likely to disagree with the statement 'I discuss and review my DVA client's health care needs with them more often and in more detail' (49%, n = 43) than AHPs aged 50 years old or younger. This younger cohort was more evenly spread across 'agree', 'disagree', and 'neither agree nor disagree' responses. AHPs aged 50 years or younger were also slightly more likely to agree

that they receive and accept more referrals for DVA clients (24%, n = 85) than AHPs aged over 50 years (10%, n = 9).

Table 3.10: Perceived quality of care by AHP age

AHPs: has your practice of quality health care for DVA clients changed?	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
I receive and accept more referrals for my DVA clients to meet their health care needs.				
Equal or less than 50 years	85 (24.1)	116 (33.0)	151 (42.9)	< 0.05#
More than 50 years	9 (10.3)	28 (32.2)	50 (57.5)	
I contribute more to how my DVA clients' health care needs are met.				
Equal or less than 50 years	91 (25.9)	123 (34.9)	138 (39.2)	NS
More than 50 years	18 (20.7)	27 (31.0)	42 (48.3)	
I discuss and review my DVA clients' health care needs with them more often and in more detail.				
Equal or less than 50 years	116 (33.0)	129 (36.6)	107 (30.4)	< 0.05#
More than 50 years	21 (24.1)	23 (26.4)	43 (49.4)	
I discuss and review my DVA clients' ongoing health care needs with their GPs more often and in more detail.				
Equal or less than 50 years	123 (34.9)	101 (28.7)	128 (36.4)	NS
More than 50 years	30 (34.5)	22 (25.3)	35 (40.2)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

AHP: Care coordination

Care coordination was measured by asking AHPs who coordinates their DVA clients' care. Survey respondents were provided six options, including themselves, their DVA client, their client's GP, jointly with their client's GP, someone else, or jointly coordinated with others. See Appendix 2.1, Q86 for all responses. The results are compiled as follows (each question required a yes or no answer, hence why the total percentages do not equal 100%):

- 57% (n = 251) of AHPs reported coordinating their DVA clients' health care.
- 62% (n = 271) of AHPs reported that their DVA clients coordinate their health care.

- 79% (n = 347) of AHPs reported that their DVA client's GP coordinates their health care.

AHP: Care coordination with clients

Care coordination was measured by asking AHPs five questions; responses ranged from 'agree' to 'disagree' and were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes (see Figure 3.20). Comprehensive results can be viewed in Appendix 2.1, Q84. The results revealed the following:

- 32% (n = 139) of AHPs reported that before starting treatment cycle arrangements, they discuss their DVA client's health care needs with them in more detail.
- 36% (n = 159) of AHPs reported that after finishing a treatment cycle, they review their DVA client's ongoing health care needs with them in more detail.
- 18% (n = 79) of AHPs reported that the number of interactions with their DVA clients had increased.
- 21% (n = 91) of AHPs reported that the quality of their interactions with their DVA clients had improved.
- 22% (n = 98) of AHPs reported having more opportunities to discuss and review their DVA client's health care needs with them.

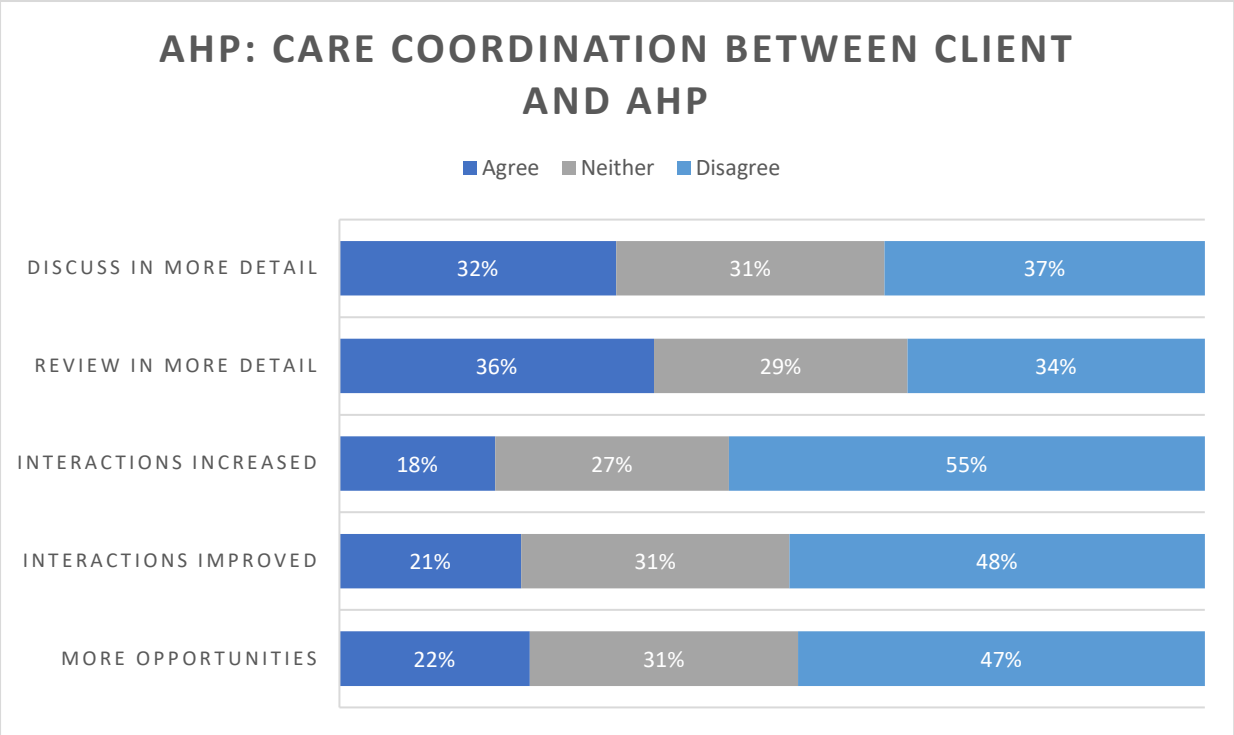


Figure 3.20: AHP perspectives on care coordination between clients and AHPs

AHP: Care coordination between AHPs and GPs

Care coordination was measured by asking AHPs nine questions; responses were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes. Comprehensive results can be viewed in Appendix 2.1, Q17–18, Q45–47, and Q71–89. Overall, 78% (n = 342) of AHPs reported that they provide reports to their DVA client's GP. A further 65% (n = 285) of AHPs reported that they review and discuss the reports with their clients and seek their opinion. A total of 60% (n = 265) of AHPs reported accepting additional referrals based on the report, their client's opinion and the GPs professional judgement. In addition, 76% (n = 336) of AHPs reported ensuring their DVA clients are included in the decision-making process to meet their health care needs, and 75% (n = 331) of AHPs reported ensuring their DVA clients are informed about communications, decisions and recommendations between them and their GP. Finally, 30% (n = 132) of AHPs reported having more opportunities to discuss and review their DVA client's health care needs with their GP (see Figure 3.21).

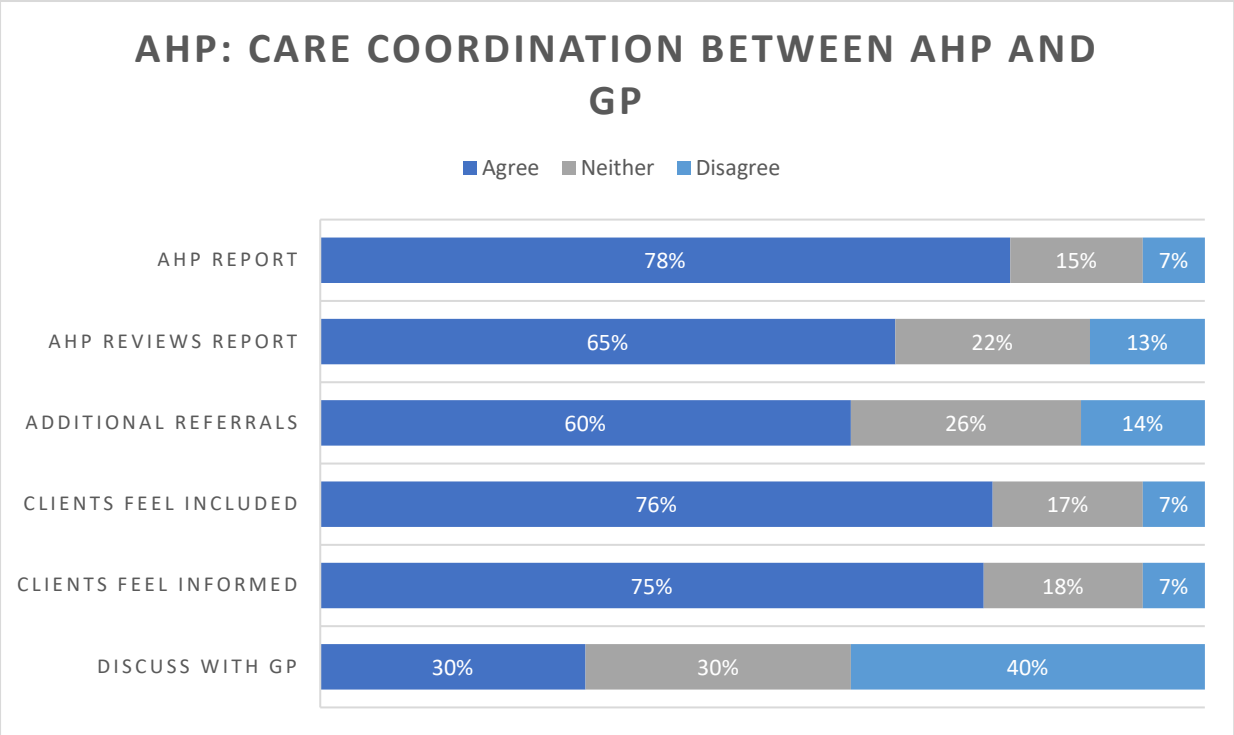


Figure 3.21: AHP perspectives on care coordination between AHPs and GPs

AHP: Other impacts and themes

Themes were obtained from the last question in the survey, which asked AHPs, 'compared to before 1 October 2019, I now think that the referral process for treatment cycle arrangements is…' and allowed AHPs to select multiple responses and provide comments. The impacts included 16 options: more time-consuming or time-efficient; more or less expensive; more complex or simpler and more straightforward; more or less effective; unimproved and worse or improved and better; more or less flexible, responsive and dynamic; more or less administrative; other; and none of the above. The final survey results are as follows:

- 76% (n = 335) of AHPs reported that the treatment cycle arrangements are more time-consuming.
- 41% (n = 180) of AHPs reported that the treatment cycle arrangements are more expensive.
- 56% (n = 246) of AHPs reported that the treatment cycle arrangements are more complex.

- 38% (n = 166) of AHPs reported that the treatment cycle arrangements are less effective.
- 40% (n = 177) of AHPs reported that the treatment cycle arrangements are unimproved and worse.
- 36% (n = 160) of AHPs reported that the treatment cycle arrangements are less flexible, responsive and dynamic.
- 71% (n = 314) of AHPs reported that the treatment cycle arrangements are more administrative.

AHP administrative burden

Similar to the GPs' text responses, AHP survey respondents described the treatment cycle as significantly more time-consuming regarding administration. AHPs described having to constantly monitor referrals and appointments. They also had to schedule completing the End of Cycle report to continue providing care without gaps. AHP respondents reported significantly increased time spent following up requests for additional referrals and that there was more time spent on assessments and paperwork (End of Cycle report) than treatment provision.

> *'This is massive. The HUGE amount of extra documentation is not compensated financially. Also chasing up GP's to get ongoing referrals is a nightmare. It takes forever and we do not get paid for it. It also then means treatment for the veterans is delayed as we cannot see them without an additional referral'. (AHP, survey response, participant's capitalisation for emphasis)*

Reports, frameworks and assessments

AHP survey responses described the report formats as 'smaller' but insufficient for capturing treatment plans and outcomes and that they cannot capture what was actually done with the patient. AHP comments report that the End of Cycle report format is too specific and does not accurately reflect patient treatment and outcomes. Another AHP comment notes that report formats require information that is not relevant to all clients and allied health services. Overall, AHP comments

reflected that additional reporting requirements have resulted from the treatment cycle arrangements with no benefit to clients.

> *'Paperwork not fit for purpose. Not specific to that patient. A letter detailing treatment plans/option and frequencies/health constraints would be more beneficial. I'm sure the GPs don't understand half of that form'. (AHP, survey response)*

AHP service impacts and outcomes

Some AHP text responses reported that the treatment cycle has resulted in more straightforward service. One AHP noted that the treatment cycle was 'more defined, as patients were aware of the treatment plan'. Other AHP comments reported that the arrangements were more effective for establishing timeframes for goals and that the standardisation of care with outcome measures was positive.

> *'More defined and patients aware of the plan'. (AHP, survey response)*
>
> *'[More effective] in terms of implementing a timeframe for goals'. (AHP, survey response)*

In contrast, other AHP text responses described fewer or slower outcomes for patients as a result of the treatment cycle arrangements because of minimal changes within 12 sessions (particularly for chronic conditions). Text comments included that the treatment cycle arrangements negatively impact continuity of care, that there was additional time spent explaining changes to clients and GPs and that there were delays in service provision due to expired referrals.

'Especially if a client is living with a chronic, complex disease and not exempt from the 12-session treatment cycle. MANY DVA clients live with ongoing, complex, chronic disorders, conditions that require ongoing care. Unless there is an acute injury most DVA clients would require more than one 12-session treatment cycle'. (AHP, survey response, participant's capitalisation for emphasis))

AHP expenses and costs

The AHP survey responses reported an overarching theme of increased expenses and costs resulting from the treatment cycle arrangements. The reasons for increased costs were attributed to a wide range of causes; some of these included costs associated with more staff required to follow up on referrals, the End of Cycle report fee ($30) being insufficient to cover the cost of time required to write it, other unpaid administrative costs (e.g., report writing and referral follow-up) and not being paid for initial consultations and assessments. In addition, AHP comments on costs included increased expenses related to software upgrades to accommodate the new templates. Some AHPs noted the treatment cycle arrangements resulting in fewer expenses because clients were forgoing treatment to avoid more GP visits. Further, telehealth options were perceived as a significant improvement for client care and outcomes and were reported as more cost and time-effective.

'Increased admin time to follow up on referrals. Together with low rates offered by DVA, I and my colleagues are likely to cease servicing DVA clients in 2021'. (AHP, survey response)

AHP attitudes towards the treatment cycle

AHP text responses further reported that the treatment cycle arrangements were perceived as not suitable for patients with chronic conditions. In addition, AHPs noted that the treatment cycle arrangements seemed to apply more to physical health than mental health outcomes. AHP comments noted that their perception of the process is more bureaucratic than care-focused. Similar to the GP text

responses, AHP respondents noted that they believed the treatment cycle is not suitable for more complex clients (i.e., those requiring multiple visits to GPs for referrals) and that the 12 sessions provided within the cycle are not sufficient for clients who require more treatment. Further, AHPs noted feeling that there was less autonomy for AHPs and that it seemed like DVA assumed that providers were not assessing and using clinical discernment prior to the treatment cycle arrangements. Overall, some comments reported that the treatment cycle arrangements improved treatment structures and control measures, but with increased paperwork no improvement in quality of care.

'This change is not client-centred at all. It is purely another mechanism to reduce the support to our war veterans and cut costs'. (AHP, survey response)

AHP perception of client impacts

AHP text responses indicate that AHPs' experiences with clients within the treatment cycle arrangements have been complicated. AHPs report experiences indicating that clients do not understand the changes and that the treatment cycle arrangements are perceived as a barrier to treatment and seeing clients. AHPs indicated that they believe clients are worse off under the arrangements and that clients have had negative attitudes towards the treatment cycle, affecting their engagement, treatment and outcomes. AHPs reported that clients were stressed about referrals being valid as opposed to treatment outcomes and were are opting to self-exclude from AHP services.

'The clients most affected have been those with mental health conditions—the treatment cycle has at times created unnecessary stress and anxiety due to poor communication to the clients from DVA, a sense that if they require more than 12 sessions they are doing the wrong thing and that DVA is trying to minimise their access to health services during times of need'. (AHP, survey response)

AHP and GP engagement

The text responses of AHPs within the survey report that AHPs believe that the treatment cycle arrangements are becoming easier with time; however, there are still concerns regarding ongoing care coordination for patients. AHPs reported no improvement in GP and AHP communication and uncertainty around whether GPs read reports. Some AHP text responses describe the belief that GPs simply issue referrals, regardless of whether they are clinically necessary or not. AHPs report that they believe GPs are frustrated at having to constantly issue referrals. Despite this, some AHP comments report that there are more client updates due to the treatment cycle arrangements and that there are opportunities to discuss client needs.

'Unimproved. The GP isn't looking at the ECR at all. They are giving out referrals whenever the client asks whether they are on their 2nd session or 12th session. In a small rural town they [clients] also don't see the same GP each time'. (AHP, survey response)

Other themes

The survey text responses included multiple reports that AHPs are becoming hesitant to take on new DVA clients due to increased paperwork and complexity. AHPs note that taking on DVA clients is less appealing because the remuneration is double for private or NDIS clients. Further, the text responses describe that AHPs are experiencing higher stress levels as clients and GPs do not understand the changes. It is a burden on AHPs to explain these changes, especially for elderly clients who need reminders for referrals.

'Sadly, due to the requirements of the 12-session treatment cycle and time and administration involved in arranging new referrals after 12 sessions and reporting (and only a $30 payment), after almost 10 years of working with DVA clients and their GPs, I hesitate now when asked to see a new DVA client'. (AHP, survey response)

AHP interview results

Results have been presented according to the themes identified within the data. For a full report of interview results, please see Appendix 4.

AHP: Perception of treatment cycle communication

During interviews with AHPs, there were many reports that the information about treatment cycle arrangements was difficult to read, hard to keep up with and too long for their current administration capabilities. Some AHPs described the communication of the treatment cycle arrangements as adequate, but it was difficult for them to communicate the changes to their DVA clients. There were complaints from AHPs that the communication about claiming procedures were inadequate and resulted in non-payment for consults or treatment with DVA clients and other payment issues. Regarding the availability of communications from DVA, most AHPs reported receiving information through professional associations rather than directly from DVA. AHPs generally reported that the communication regarding the treatment cycle arrangements was poor, with only one AHP interviewee describing the information as 'useful'. AHPs generally described communication about the treatment cycle arrangements as inadequate, and as a result, they did not feel prepared for implementing the arrangements. In addition, AHP interviewees reported the belief that the treatment cycle was a cost-saving measure. Another common theme across interviewees' responses was that the treatment cycle arrangements were developed in response to individuals 'taking advantage' of the previous system.

> *'Yeah, so it was a little bit confusing a little bit to get our head around. I felt we still understood it, it wasn't like it was not understandable, but I did feel we got information, the clients didn't. It was very difficult to change the system with the clients, that's probably what we found the hardest'. (AHP, exercise physiology, NSW)*

An AHP interviewee in Victoria noted that the communication of the treatment cycle arrangements was complicated and overshadowed by the ongoing COVID-19 response for AHPs. GPs noted that during the response to COVID-19, they used

telehealth more often and conducted fewer in-person consultations. However, there was feedback from clients and AHPs that GPs needed to see clients in person to issue referrals; otherwise, the referral was not considered valid by DVA and AHPs.

AHPs: Increased burden of administration

In addition to DVA clients' difficulties with administration, AHP interviewees reported a significantly increased administration load, particularly in relation to the implementation timeline of October 2019. Two AHP interviewees reported having to employ further support roles within their businesses to address the increased administrative load. The increased burden of administration was often related to the perceived inadequate financial remuneration from DVA: that it is not enough to cover the cost of increased administration for AHPs treating DVA clients. Within AHP interviews, there were mixed responses to the End of Cycle report from AHPs; some found it to be a positive change, while others found it was too restrictive, did not communicate valuable information, or repeated information that was already being communicated.

> *'What it has done is it's created an enormous amount of administrative burden to make sure all the documentation is in place. Then even when the document is in place and I send it off to the doctor, it's created even more complexity with administration around did we get a referral back'. (AHP Dietician, NSW)*

Further, multiple AHP interviewees reported not wanting to take on DVA clients or continue seeing their current DVA clients due to the administrative and financial burden of the treatment cycle process.

> *'I think a lot of OTs [occupational therapists] chose not to do DVA work anymore because it just doesn't cover costs. I actually used to have three therapists. I've had to let them all go, because what DVA provide doesn't actually cover the cost of them'. (AHP, Occupational Therapist, QLD)*

Service impacts

AHP attitudes to treatment cycle arrangements: Negative impacts on patient care and outcomes

Multiple AHP interviewees described significant impacts to their health care provision and continuity of care due to the treatment cycle arrangements. AHP interviewees reported gaps in continuity of care due to clients not having GP referrals or not being able to contact GPs to provide referrals for patients. AHP interviewees also described impacts on care for patients unable to understand the treatment cycle arrangements due to impaired mental or physical functioning (e.g., 'cognitive deficits or vision impairment or poor hearing' [AHP, Occupational Therapist, NSW]).

> *'I'm not sure that it [the treatment cycle arrangement] improves patient outcomes, put it that way'. (AHP, Osteopath, VIC)*

AHP interviewees also described feeling restricted and unsure about how the treatment cycle affects their provision of care, especially in regard to specific instances of care. For example, an AHP interviewee described how an osteopath might be unsure how to treat back v. shoulder v. other parts of the body. There were also reports of negative impacts on patient care related to the increased administrative burden and remuneration issues for AHPs.

Health care billing and financial burden on GPs and AHPs

AHP interviewees noted that the remuneration received for DVA patients is not sufficient to cover the cost of treating those patients in addition to the administrative requirements. This has resulted in some AHPs reporting that they are unwilling to accept DVA clients for treatment or that the remuneration does not cover longer appointments, affecting the quality of patient care.

'As all referrals now expire, I have to chase the GP up. As we're already poorly paid, I now have more unpaid time chasing up things in order to provide a decent service to the most marginalised of people'. (AHP, Occupational Therapist, QLD)

AHPs: Health care coordination

AHPs reported taking an active role in the health coordination of their patients, with occupational therapists being particularly vocal about their role in health care coordination. Many AHPs indicated that it should be the GPs taking on the role of health care coordination; despite this, AHPs are involved in suggesting referrals, coordinating with families and other forms of patient care. AHPs reported the belief that GPs are time-poor and unable to take on the role of care coordination.

'The care coordination and communication is now far worse because we are now heavily reliant on GP clinics to have their administrative act together in getting referrals out. That is an ongoing struggle'. (AHP, Occupational Therapist, QLD)

At Risk Client Framework

During the interviews, AHPs mentioned the At Risk Client Framework without being prompted by the interviewer. In general, AHPs felt it was a positive way to avoid the 12-session limitation.

'I know they have their complex referral system. I can't remember the wording they use for it but that's still only 12 months. It still doesn't acknowledge chronic conditions. So it's ridiculous and we've had all sorts of variations'. (AHP, Occupational Therapist, QLD)

Stakeholder feedback results

The following section outlines the results from the stakeholder feedback surveys. Findings are presented by question and have been summarised from the qualitative data received within the surveys.

Q1. In your opinion, how well have the treatment cycle arrangements been implemented?

Question 1 asked stakeholders to comment on how well the treatment cycle arrangements had been implemented. Stakeholder responses to this question varied, with positive, negative and neutral responses received. Positive feedback indicated that the respondents believed the treatment cycle arrangements had been implemented well, and others reported that they had experienced a seamless transition.

Other responses were more neutral towards the implementation, noting that the transition to the treatment cycle arrangements has been 'OK', although communication about the changes could have been better. Others reported no change or improvement.

Negative responses were more commonly received from professional associations and primarily noted concerns about the additional administrative workload created by the treatment cycle arrangements. Other responses described issues with specific allied health specialities and that GPs in their professional networks were unaware of the changes to the treatment cycle arrangements. One response reported that the implementation had resulted in an additional burden on veterans for more GP appointments. See Figure 3.22 for a summary of Question 1 responses.

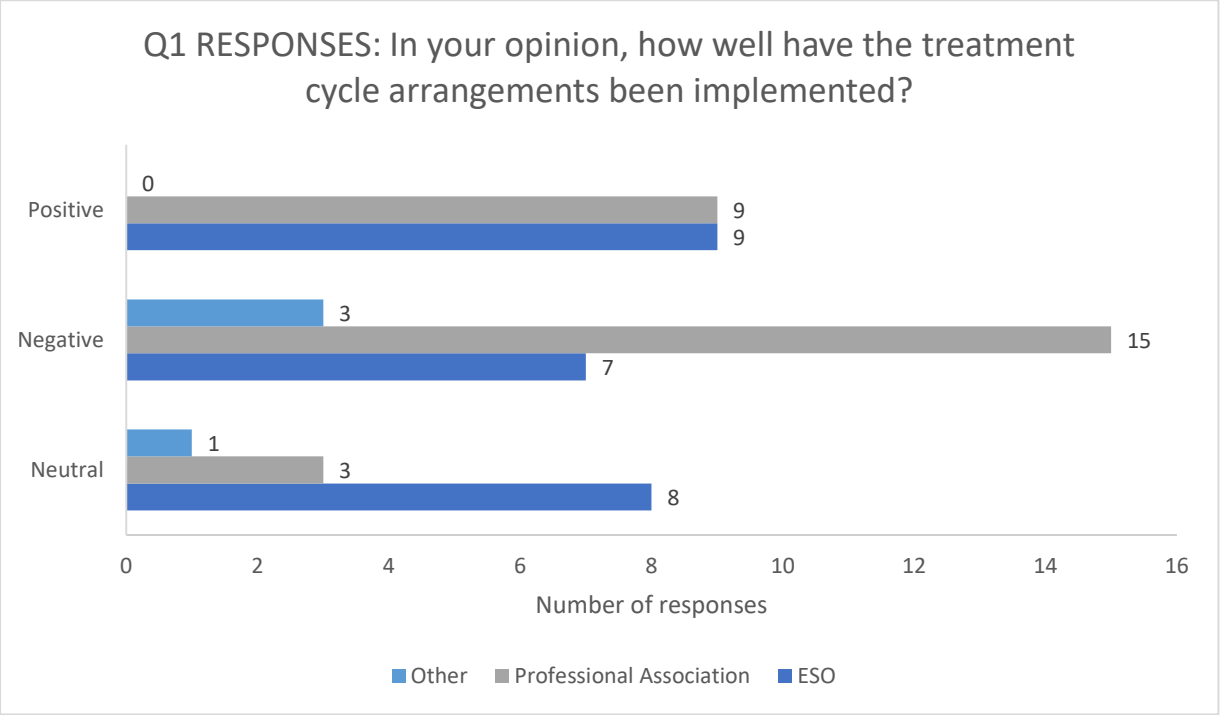


Figure 3.22: Question 1, stakeholder responses

Q2. In your opinion, how effective has DVA's communication strategy been in educating stakeholders about the treatment cycle arrangements?

Question two asked stakeholders to comment on the effectiveness of the communication strategy in educating them about the treatment cycle arrangements. In response to this question, stakeholders reported a variety of different opinions on the communication strategy regarding the treatment cycle arrangements. Positive responses were received from professional associations and ESOs and noted that there was clear communication directly to clinicians and on the DVA website. Respondents described experiencing good engagement from DVA with peak bodies regarding the changes.

In contrast, some stakeholders reported a negative sentiment towards the communication strategy. Negative responses were received from professional associations and ESOs in equal amounts for this question. Responses described poor communication from DVA regarding the changes. One survey respondent reported the belief that there appeared to be different guidelines for different stakeholders.

Other responses from professional associations and ESOs reported more neutral sentiments. One survey respondent described initial communication from DVA as confusing but noted that subsequent communication was much clearer. Another respondent noted that, while they felt that DVA clients were aware of the changes, it seemed that their GPs were not. See Figure 3.23 for a summary of Question 2 responses.

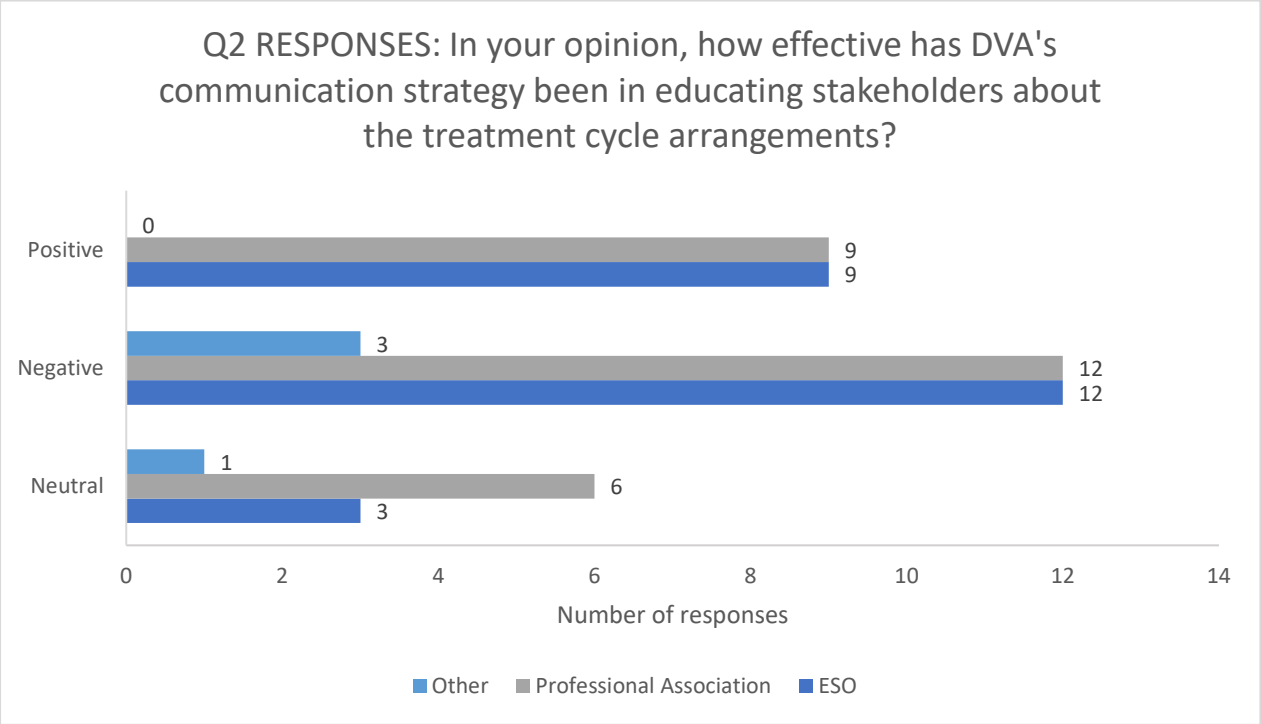


Figure 3.23: Question 2, stakeholder responses

Q3. In your opinion, how have you or your organisation, as DVA stakeholders, engaged with the arrangements?

Question 3 asked stakeholders to report on how their organisation had engaged with the treatment cycle arrangements. Responses to this question were varied, spanning positive, negative and neutral answers. ESO sentiments were evenly distributed, with equal responses received for all three sentimental categories. Professional associations were more likely to report positive responses to this question. Positive responses included participants reporting that they have engaged with the arrangements to the best of their ability and that there had been 'no issues so far'.

Negative responses to this question described respondents feeling like they had no choice in implementing the treatment cycle arrangements, noting that they felt that they had to accept and implement the changes. Further survey responses described more administrative hurdles due to the arrangements, and others noted that the changes are unfair to TPI DVA clients. Other responses claimed that the changes were not clinically necessary.

Other survey respondents noted that they were unsure of the impacts of the treatment cycle arrangements. See Figure 3.24 for the summary of Question 3 responses.

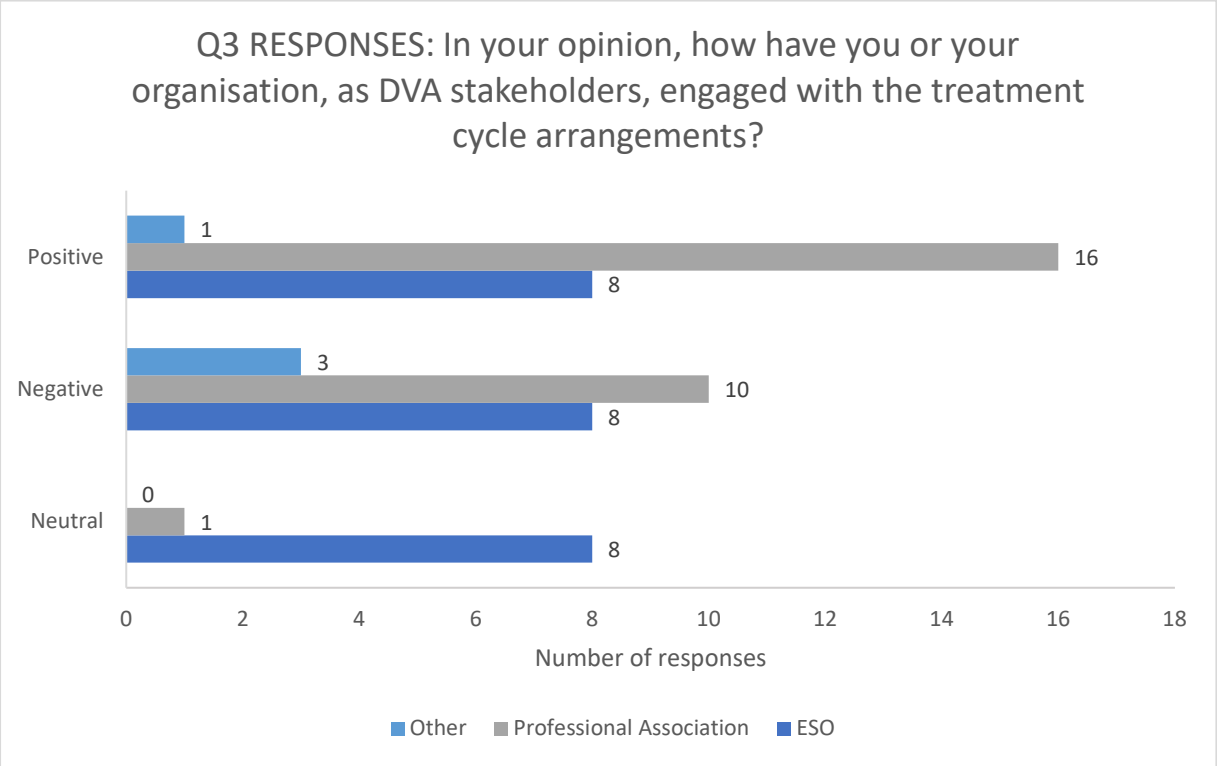


Figure 3.24: Question 3, stakeholder responses

Q4. What is your or your organisation's opinion on the outcomes of the treatment cycle arrangements? (Consider improved quality of care and improved care coordination).

Question 4 asked stakeholders to report on their organisation's opinion of the outcome of the treatment cycle arrangements. Similar to previous questions, sentiments varied, with respondents reporting positive, neutral and negative responses. Professional associations were fairly evenly split between positive and

negative responses, with negative responses being slightly more common. ESOs were more likely to report negative responses, although there were some positive answers received.

Positive responses to question four included descriptions of patient-centred, goal-focused care resulting from the treatment cycle arrangements. One respondent noted that the treatment cycle reports were a good way to track progress. Another response noted that they hope the treatment cycle arrangements will result in a drop in unnecessary care.

Negative responses to this question were also received. One respondent stated that GPs were not conducting case management as expected. Further responses indicated that patients with long-term conditions feel disadvantaged, and others noted that the new system was confusing to them. Other responses were more neutral, noting that it is too early to determine their opinion of the treatment cycle arrangements. For a full summary of Question 4 responses, see Figure 3.25.

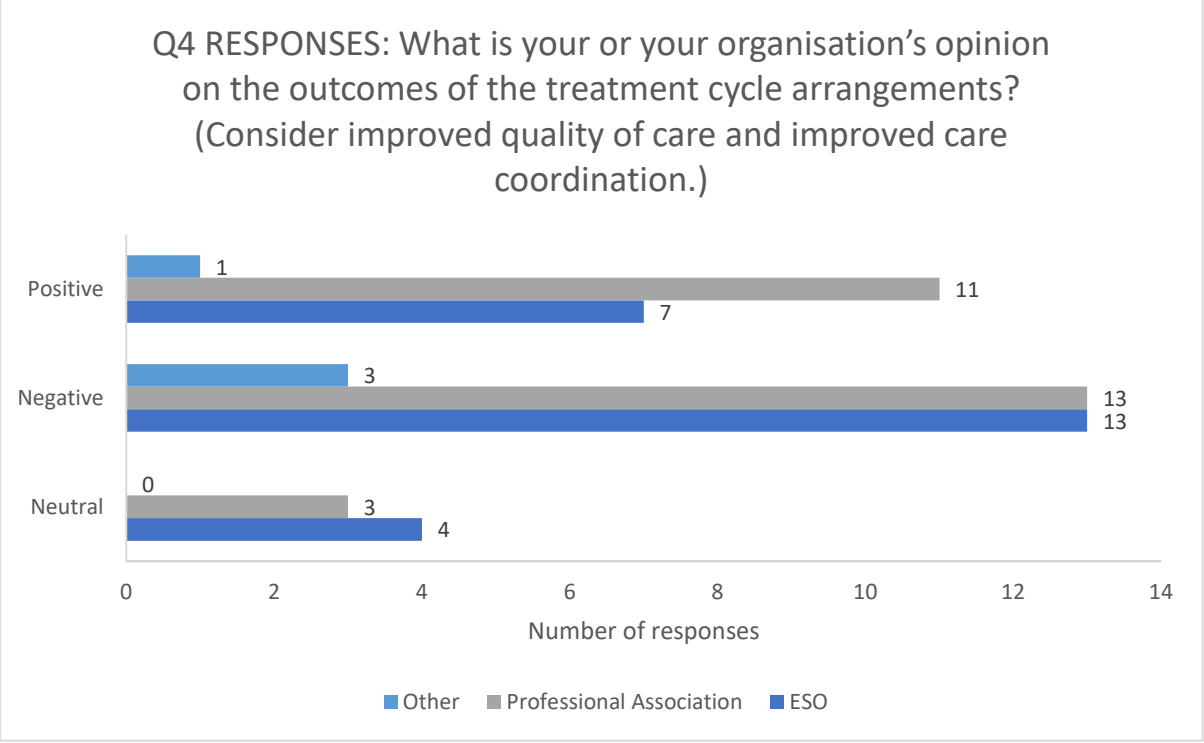


Figure 3.25: Question 4, stakeholder responses

Document analysis results

Overall, materials had higher understandability but lower actionability, with 48 documents scoring very good PEMAT-P understandability ratings (>90% of items met). See Table 3.11 for the statistical measures of PEMAT-P and Table 3.12 for the basic statistical measures of the Health Literacy Checklist. The remaining documents achieved scores between 77% and 89% (n = 30), indicating efforts to ensure the understandability of the content. Measures that advanced the understandability of the documents included the use of everyday language, active voice, informative headers, material breaks and visual cues (e.g., dot points). The use of relevant visual aids with clear captions would have improved the overall understandability score for the documents.

Table 3.11: Basic statistical measures of PEMAT-P

PEMAT-P	N	Mean	Median	SD	Minimum	Maximum
Understandability	78	89.58	91.00	6.83	77.00	100.00
Actionability	78	64.54	60.00	16.67	40.00	100.00

Table 3.12: Basic statistical measures of the Health Literacy Checklist

Health Literacy Checklist	N	Mean	Median	SD	Minimum	Maximum
Checklist score	47	9.83	8.00	1.96	8.00	12.00

The actionability was very good for one document (>90% of items met), with the majority of resources achieving scores between 50 and 89% (n = 60). Further, 22% (n = 17) of documents scored actionability ratings of less than 50%. For the articles returning higher ratings, actionability was promoted by directly addressing the user and breaking down actions into tangible and explicit steps. Actionability for the documents could be improved by providing tangible tools (e.g., a checklist) to help the user take action or by providing visual aids to demonstrate instructions more explicitly.

The overall scores for the Health Literacy Checklist were good and congruent with the higher PEMAT-P understandability ratings of the documents, with all relevant documents tallying a score of eight or over in the PEMAT-P from a total of 13 items (n = 47). Health literacy was encouraged using supportive elements such as short

sentence and paragraph structure; focused content; up-to-date information, including the date of publication within the documents; personalised, consistent and positive language; plain language; active voice; headings and text boxes; and adequate spacing across the documents.

Operational impact of the treatment cycle arrangements

The document analysis intended to address how the operational impact of the change in treatment cycle arrangements on GPs and AHPs was expressed through documented DVA communication. Many documents detailed evidence of the potential operational impact of the treatment cycle arrangements, specifically stating 'more GP involvement in ongoing care' (Document 3), outlining the change in patient care actions for AHPs (Documents 10–15) and stating clear operational changes in letters and web content communications (Documents 39–41, 60, 68–69 and 72–74). All documents that outlined operational impacts were aimed at GP and AHP audiences and outlined the actions required for GPs and AHPs to be compliant with the new treatment cycle arrangements.

Raising awareness of the treatment cycle arrangements among DVA clients, GPs and AHPs

A number of the documents analysed (n = 25) included statements informing the intended audience of the treatment cycle arrangements. Of the documents stating the treatment cycle arrangements, three addressed all three stakeholder groups (DVA clients, GPs and AHPs), five addressed DVA clients, 12 addressed AHPs, and five addressed AHPs.

These results can be compared with the GP surveys, where 64% (n = 95) of GPs stated the information available about the treatment cycle arrangements was 'easy to understand', 66% (n = 97) stated that they had 'sufficient knowledge about the changes' and 60% (n = 90) reported they 'understood the changes'.

DVA client survey results were similar, although a little lower: 53% (n = 210) stated the information available about the treatment cycle arrangements was 'easy to understand', 58% (n = 230) stated that they had 'sufficient knowledge about the changes' and 62% (n = 245) reported they 'understood the changes'.

AHPs were similar in this respect: 53% (n = 234) stated the information available about the treatment cycle arrangements was 'easy to understand', 55% (n = 245) stated that they had 'sufficient knowledge about the changes' and 65% (n = 286) reported they 'understood the changes'.

Perceptions of the changes: A cost-saving measure v. improving quality of care

Thirty documents stated that the aim of the treatment cycle arrangements was to improve the communication between health care professionals quality of care for patients. 'The treatment cycle is designed to improve quality of care for DVA cardholders, with more GP involvement in ongoing care' (Document 3). This is similar to the communication aimed at DVA clients: 'By improving communication and coordination between you, your GP and your allied health providers, the treatment cycle means that everyone can work together to make sure you get the best treatment for your needs' (Documents 8 and 9).

These results can be compared with the interview data, where DVA clients and AHPs spoke of the treatment cycle arrangements as a 'cost-saving' measure': for example, 'I think my understanding or my belief is that it's a cost-driven thing' (DVA client), 'as I understand it, the whole thing was to cut down costs' (DVA client) and 'I felt that it was really about saving some money under the guise of, oh, let's make it much better for the patients … I know they said it was all about patient outcomes, but I suspect it was not' (AHP, VIC).

In comparison, the AHPs' survey responses to the statement, 'quality of interactions between my DVA client's GP and I have improved', were that 24% agree (n = 104) and 43% disagree (n = 192). This was accompanied by a similar response to the statement, 'my DVA client's GP and I have more opportunities to discuss and review their health care needs', with results indicating that 30% agree (n = 132) and 40% disagree (n = 177).

However, GPs responded more favourably to the statement, 'the quality of interactions between my DVA client's AHP and I have improved', with 57% agreeing (n = 84). Further, 64% (n = 94) of GPs agreed that 'my DVA client's AHP and I have more opportunities to discuss and review their health care needs'.

Ensuring stakeholders are aware of the purpose and operational arrangements of the treatment cycle arrangements

Forty-six of the documents analysed stated clear processes of the treatment cycle. Comparatively, the interview data indicated that the quality of the information was accepted as good or adequate (this is supported by PEMAT-P and Health Literacy Checklist scores), albeit the changes themselves were reported as confusing or lacking a logic that could be understood by interview participants. For example, '*the information provided was adequate. I can't really say any more than that. I was happy with the information. I was not happy with the fact that it was happening*' (DVA client).

This was further supported by survey data, with 40% (n = 159) of DVA clients, 67% (n = 98) of GPs, and 36% (n = 161) of AHPs agreeing that the information provided was of high quality but only 34% (n = 134) of DVA clients, 57% (n = 84) of GPs and 27% (n = 119) of AHPs reporting that they were 'satisfied with the changes'. Despite documents outlining the purpose of the treatment cycle, this was not supported by the stated understanding of the treatment cycle arrangements in interview and survey data.

In conclusion, the document analysis provided additional rigour to the evaluation process. Effectively communicating change is crucial to the success of any health program or service. How change is communicated—the language and formatting used through to the distribution and access to information—affects the success of change implementation. Table 3.13 presents the comprehensive document analysis results for this section.

Table 3.13: Document analysis results

	PEMAT-P score (%)		Health Literacy Checklist (X/13)
Document title	**Understandability**	**Actionability**	**Checklist score**
1. Allied health treatment cycle arrangements continue during pandemic	82	60	12
2. Allied health referral changes deferred to 1 October 2019	92	60	12
3. Changes to process for allied health referrals	92	60	12
4. DVA treatment cycle: At Risk Client Framework	100	83	11
5. TPI decision tree	100	83	9
6. End of Cycle report for allied health providers	91	80	N/A
7. DVA treatment cycle: Guide to the treatment cycle for GPs and allied health providers	94	60	10
8. Allied health treatment cycle: TPI clients	100	80	12
9. Allied health treatment cycle: DVA clients	100	80	12
10. Allied health treatment cycle: Physiotherapists and exercise physiologists	100	80	12
11. Allied health treatment cycle: Physiotherapy and exercise physiology practice teams	100	80	12
12. Allied health treatment cycle: Allied health providers	100	80	12
13. Allied health treatment cycle: Allied health practice team	100	80	12
14. Allied health treatment cycle: General practitioners	100	80	12

15. Allied health treatment cycle: General practice teams	100	80	12
16. Patient Care Plan template for allied health providers	100	83	N/A
17. Chiropractors Schedule of Fees	86	83	N/A
18. Clinical psychology Schedule of Fees	86	83	N/A
19. Diabetes educators Schedule of Fees	86	83	N/A
20. Dietitians Schedule of Fees	86	83	N/A
21. Exercise physiology Schedule of Fees	86	83	N/A
22. Neuropsychologists Schedule of Fees	86	83	N/A
23. Occupational therapists (mental health) Schedule of Fees	86	83	N/A
24. Occupational therapists Schedule of Fees	86	83	N/A
25. Orthotists Schedule of Fees	86	83	N/A
26. Osteopaths Schedule of Fees	86	83	N/A
27. Physiotherapists Schedule of Fees	86	83	N/A
28. Podiatrists Schedule of Fees	86	83	N/A
29. Psychologists Schedule of Fees	86	83	N/A
30. Social worker (mental health) Schedule of Fees	86	83	N/A
31. Social worker Schedule of Fees	86	83	N/A
32. Speech pathologists Schedule of Fees	86	83	N/A

33. Letter to Specialist Medical College—RACMA	91	60	12
34. Letter to Australian Podiatry Association	100	100	12
35. APodA deferral letter	92	60	12
36. Marino Podiatry letter	92	67	12
37. Letter A—TPI clients	93	60	12
38. Letter B—DVA clients	93	60	12
39. Letter C—Exercise physiologists and physiotherapists	93	60	12
40. Letter D—AHP	93	60	12
41. Letter E—General practitioners	93	60	12
42. Notes for exercise physiologists	85	40	N/A
43. Notes for mental health care providers	85	40	N/A
44. Notes for allied health providers: General	94	50	N/A
45. Notes for general practitioners	77	40	N/A
46. Notes for physiotherapists	77	40	N/A
47. Notes for chiropractors	77	40	N/A
48. Notes for diabetes educators	77	40	N/A
49. Notes for dietitians	77	40	N/A
50. Notes for occupational therapists	77	40	N/A

51. Notes for osteopaths	77	40	N/A
52. Notes for podiatrists	77	40	N/A
53. Notes for social workers	77	40	N/A
54. Notes for speech pathologists	77	40	N/A
55. Notes for orthotists	77	40	8
56. Web content—Allied health professionals page—1 October publication	91	60	8
57. Web content—Allied health treatment cycle page—1 October publication	92	60	8
58. Web content—Allied health treatment cycle page—3 December update	92	60	8
59. Web content—Dental and allied health fee schedules page—1 October publication	92	40	8
60. Web content—FAQ AHPs	92	60	8
61. FAQ as at 1 October 2019 which mention rehabilitation	91	60	8
62. Web content—FAQs GPs	91	60	8
63. Web content—Improved dental and allied health (for clients) page—1 October publication	92	60	8
64. Web content—Improved dental and allied health (provide) page—1 October publication	92	60	8
65. Web content—Notes for providers page—1 October publication	92	60	8
66. Web content—Treatment cycle—AHP page—1 October publication	93	80	8
67. Web content—Treatment cycle—revised web page for 9 Sept publication	92	60	8

68. Web content—Treatment cycle—AHP FAQs—5 December update	91	60	8
69. Web content—Treatment cycle—AHP FAQs updated 031019	91	60	8
70. Web content—Treatment cycle—Client FAQs—5 December update	91	60	8
71. Web content—Treatment cycle—Clients page—1 October publication	94	80	8
72. Web content—Treatment cycle—GPs FAQ—5 December update	91	60	8
73. Web content—Treatment cycle—GPs FAQ updated 031019	91	60	8
74. Web content—Treatment cycle—GP page—1 October publication	92	60	8
75. Web content—Treatment cycle—Allied health fee schedules page for 9 Sept publication	92	40	8
76. Web content—Treatment cycle—Allied health professionals page for 9 Sept publication	91	60	8
77. Web content—Treatment cycle—notes for providers page for 9 Sept publication	92	40	8
78. Web content—Treatment cycle—published 30 Aug 19	92	40	8

Health economics results

Cost of allied health services

This economic analysis was based on costs acquired on the date of service provision. This descriptive analysis presents total daily spending, mean monthly spending for a client, the average cost of service and total spending, number of appointments, annual spending, mean monthly per-client spending by states and mean monthly per-client spending by remoteness. We hypothesised that the treatment cycle arrangements reduced the costs of service.

Total daily spending

Figure 3.26 shows the daily spending of different allied health services over time. There was a general downward trend in the daily expenditure for osteopathic (G), physiotherapy (H), podiatry (I) and speech pathology (L) services, which continued after the intervention (2019 October). In contrast, an upward trend of the daily expenditure, which continued after the intervention, was observed in the following services: diabetes educators (B), dietetics (C), exercise physiologists (D) and psychology (J). There was a sharp upward trend in the cost of psychology, which increased further after the intervention. The upward trend of expenditure in orthotists (F) then experienced a downward trend after the treatment cycle arrangements were implemented.

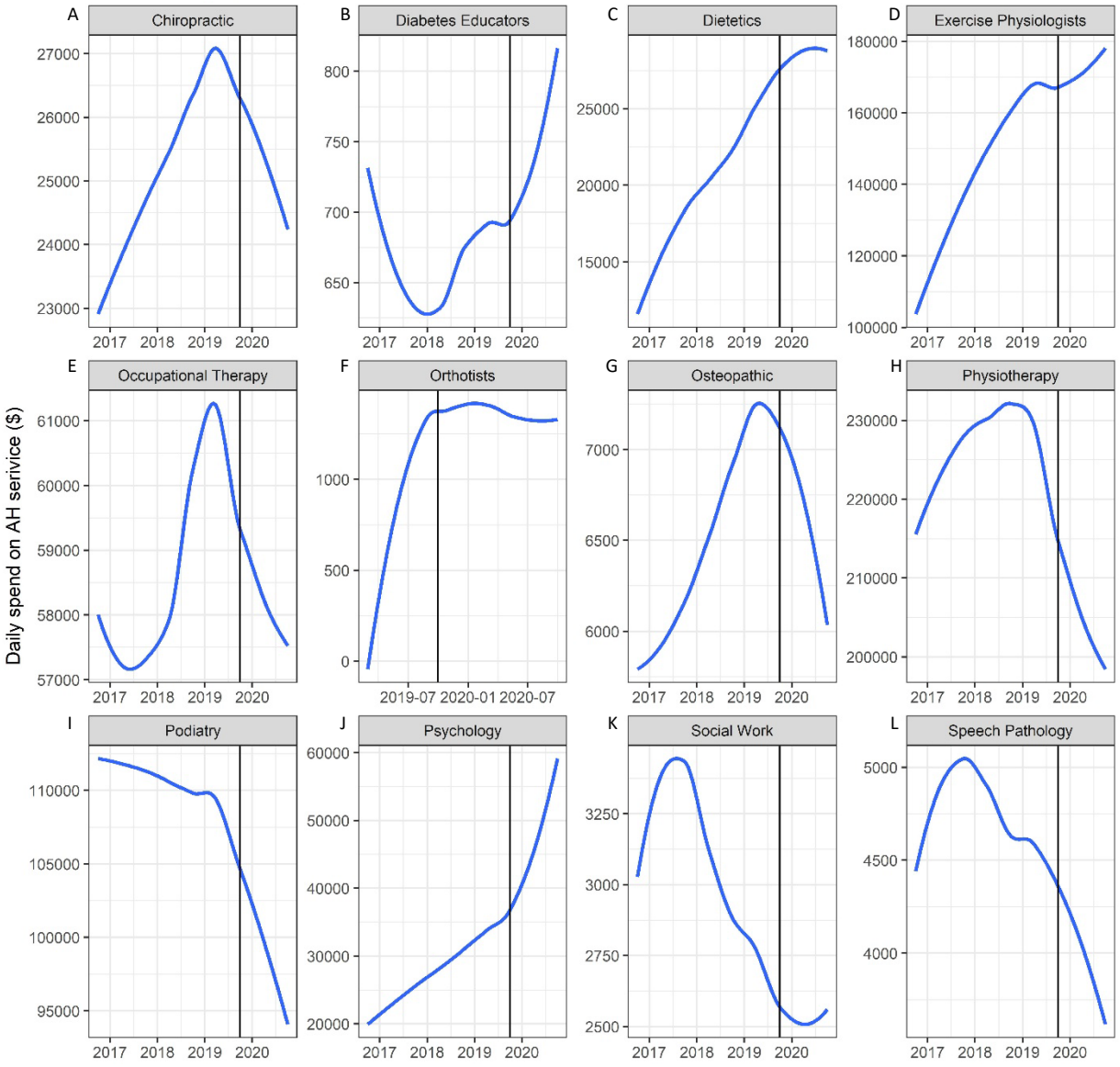


Figure 3.26: Total daily spending for different allied health services. A = Chiropractic; B = Diabetes educators; C = Dietetics; D = Exercise physiologists; E = Occupational therapy; F = Orthotists; G = Osteopathic; H = Physiotherapy; I = Podiatry; J = Psychology; K = Social work; L = Speech pathology. Black vertical lines denote October 2019 (intervention)—the area to the right of the line indicates the post-intervention period. Cost of occupational therapy and social work include mental health services associated those particular services. Podiatry cost does not include costs associated with medical grade footwear. *Data were smoothened (blue line) to detect the trend using local polynomial regression.*

Mean monthly spending for a DVA client

The spending data were aggregated per client per month and summed for each allied health service. Only the clients who received a particular service within a particular month were included, and their average total spend for each month is plotted in Figure 3.27. Monthly average spending by clients who received a particular service gradually increased in chiropractic (A), diabetes educators (B), dietetics (C), osteopathic (G), podiatry (I) and speech pathology (L). However, in social work (K), the per-client (clients who received a particular service) average cost gradually decreased over time. After the implementation of the treatment cycle arrangements, the increasing trend of average monthly spending by clients who received a particular service was reversed to a decreasing trend in occupational therapy (E) while the decreasing trend of exercise physiologists (D), orthotists (F), physiotherapy (H) and psychology (J) was reversed to an increasing trend.

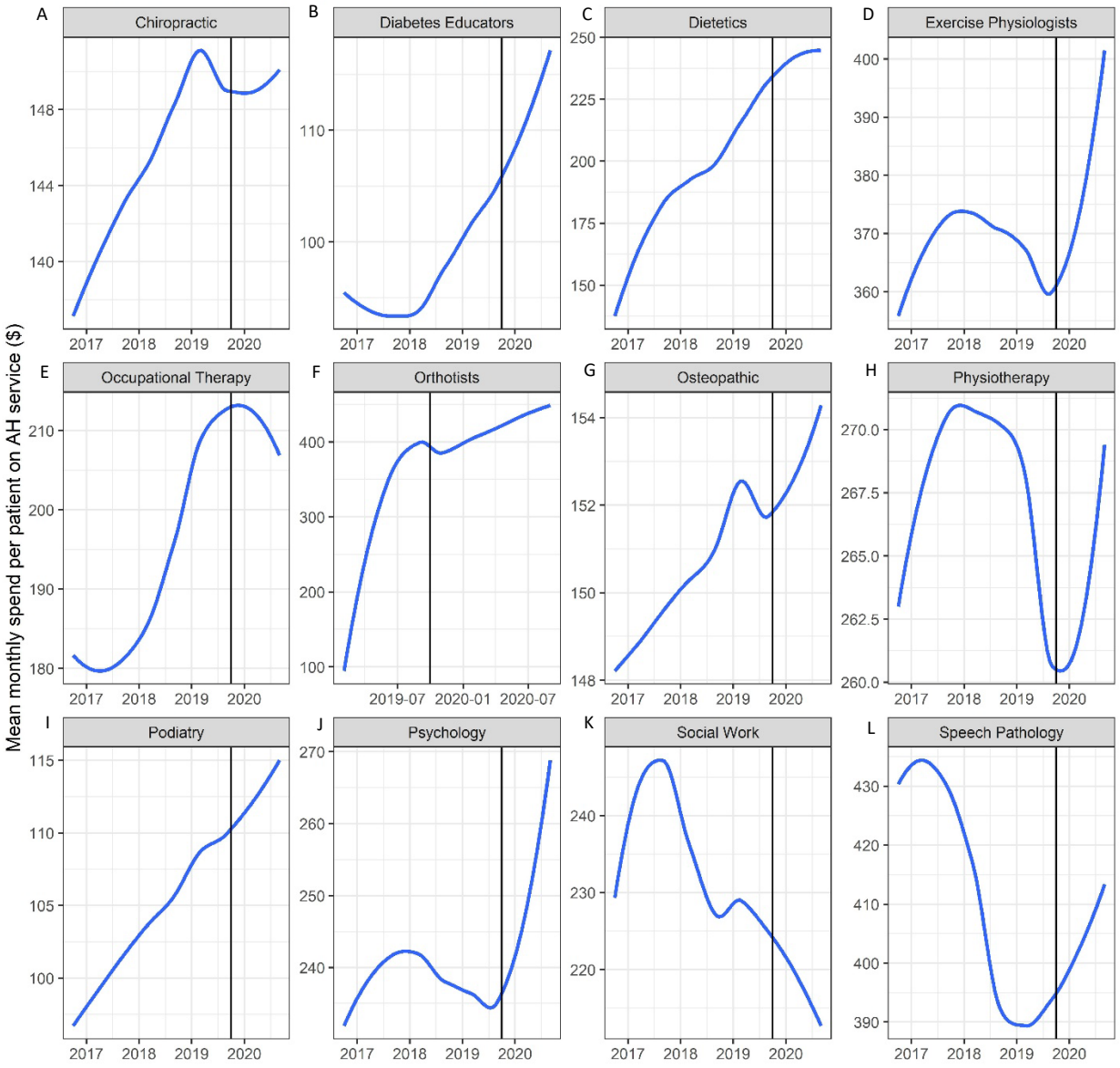


Figure 3.27: Average monthly spending on allied health services by clients receiving that service. A = Chiropractic; B = Diabetes educators; C = Dietetics; D = Exercise physiologists; E = Occupational therapy; F = Orthotists; G = Osteopathic; H = Physiotherapy; I = Podiatry; J = Psychology; K = Social work; L = Speech pathology. Black vertical line denotes October 2019 (intervention)—the area to the right of the line indicates the post-intervention period. Cost of occupational therapy and social work include mental health services associated those particular services. Podiatry cost does not include costs associated with medical grade footwear. Data were smoothened (blue line) to detect the trend using local polynomial regression.

Average cost of service and total spending

Table 3.14 describes the average cost of service per appointment and the total spending on particular allied health services within a 12-month period. The annual total cost ranged from AUD 215 million (October 2016 – September 2017) to AUD 243 million (October 2018 – September 2019). The most expensive service was physiotherapy (approximately 35% of the total cost), followed by exercise physiology (approximately 24% of the total cost). As such, physiotherapy (approximately 35% of the total cost), exercise physiology (approximately 24% of the total cost) and podiatry (approximately 17% of the total cost) accounted for nearly 76% of the total cost. The total expenditure was AUD 10 million less in October 2019 – September 2020, compared to the previous year (October 2018 – September 2019).

Number of appointments and annual spending

An appointment was defined as an individual visit to a particular allied health service. The total number of allied health service appointments in October 2019 – September 2020 was lower than in the two previous years (254,878 fewer than October 2018 – September 2019 and 191,332 fewer than October 2017 – September 2018) (see Table 3.15). The highest number of reductions was noted in physiotherapy, followed by podiatry. Compared to the three previous years, the mean allied health service appointments per patient was lower in October 2019 – September 2020 (132.2 appointments per patient who has accessed services per year). Physiotherapy was the most frequently used service (approximately 23 appointments per patient per year), followed by exercise physiology (approximately five appointments per client per year) and podiatry (approximately two appointments per client per year).

Table 3.14: Average cost of service and total spending on allied health services

Service category	Oct 2016 – Sep 2017			Oct 2017 – Sep 2018			Oct 2018 Oct – Sep 2019			Oct 2019 – Sep 2020 *(post-intervention)*		
	Mean (AUD)	Total (AUD)	%	Mean (AUD)	Total (AUD)	%	Mean (AUD)	Total (AUD)	%	Mean (AUD)	Total (AUD)	%
Chiropractic	64	8,710,491	4.0	64	9,208,158	4.0	65	9,854,022	4.1	66	9,083,755	3.9
Diabetes educators	80	203,555	0.1	79	187,194	0.1	83	219,171	0.1	87	232,879	0.1
Dietetics	116	5,444,179	2.5	117	7,278,333	3.1	122	9,047,563	3.7	123	10,443,800	4.5
Exercise physiologists	65	44,175,554	20.5	66	54,466,865	23.5	67	61,072,803	25.1	70	61,508,649	26.4
Occupational therapy	108	21,147,835	9.8	109	21,189,938	9.1	117	22,167,588	9.1	130	20,890,085	9.0
Orthotists	NA	NA		NA	NA		325	123,440	0.1	375	368,319	0.2
Osteopathic	64	2,120,632	1.0	64	2,315,454	1.0	65	2,561,180	1.1	66	2,398,996	1.0
Physiotherapy	65	81,706,946	37.9	65	83,676,460	36.1	66	83,434,405	34.3	68	73,654,127	31.6
Podiatry	90	40,890,847	19.0	93	40,279,610	17.4	98	39,649,221	16.3	101	36,105,544	15.5
Psychology	127	8,234,425	3.8	128	10,267,685	4.4	128	12,335,713	5.1	125	16,407,460	7.0
Social work	109	1,232,330	0.6	111	1,105,771	0.5	115	968,294	0.4	109	873,354	0.4
Speech pathology	147	1,658,389	0.8	150	1,631,475	0.7	152	1,549,159	0.6	158	1,307,047	0.6
Total	**1,034**	**215,525,183**	**100.0**	**1,046**	**231,606,943**	**100.0**	**1,403**	**242,982,559**	**100.0**	**1,477**	**233,274,015**	**100.0**

Note: Cost of occupational therapy and social work includes mental health services associated with those particular services. Podiatry cost does not include costs associated with medical grade footwear.

Table 3.15: Mean annual number of appointments and mean annual spending per DVA client and total annual appointments according to different allied health services (includes all clients in the population)

Service category	Oct 2016 – Sep 2017			Oct 2017 – Sep 2018			Oct 2018 – Sep 2019			Oct 2019 – Sep 2020 *(post-intervention)*		
	Mean per patient			Mean per patient			Mean per patient			Mean per patient		
	No. appt	Annual $	Total appt	No. appt	Annual $	Total appt	No. appt	Annual $	Total appt	No. appt	Annual $	Total appt
Psychology	9.6	1,220.9	65,552.0	9.6	1,234.8	80,931.0	9.3	1,200.7	96,679.0	9.8	1,237.1	131,494.0
Podiatry	6.2	559.9	454,502.0	6.3	589.1	432,754.0	6.3	616.3	406,925.0	6.0	605.7	359,217.0
Occupational therapy	5.1	547.7	197,501.0	5.3	582.4	195,936.0	5.6	653.6	190,352.0	5.2	676.4	161,849.0
Physiotherapy	23.3	1,528.3	1,259,372.0	23.7	1,555.0	1,286,415.0	23.2	1,549.1	1,262,232.0	20.7	1,423.1	1,084,681.0
Chiropractic	14.9	958.3	137,129.0	15.3	986.9	144,450.0	15.7	1,027.1	152,173.0	14.4	954.2	138,179.0
Exercise physiologists	40.3	2,621.4	687,187.0	40.3	2,657.6	835,730.0	39.5	2,663.4	917,951.0	36.0	2,517.1	889,622.0
Dietetics	5.4	629.0	47,344.0	6.7	781.5	62,530.0	7.4	908.2	74,264.0	8.7	1,079.2	85,439.0
Diabetes educators	2.8	222.8	2,561.0	2.7	214.4	2,374.0	3.0	246.8	2,642.0	3.1	270.5	2,715.0
Speech pathology	8.9	1,311.3	11,288.0	7.5	1,137.4	10,994.0	6.8	1,036.4	10,282.0	6.6	1,045.2	8,343.0
Orthotists	13.8	888.6	33,446.0	13.8	895.5	36,412.0	13.8	904.1	39,683.0	12.5	828.0	36,643.0
Osteopathic	9.3	1,014.7	11,361.0	8.4	937.5	9,963.0	8.7	996.9	8,470.0	7.7	844.7	7,989.0
Social work	9.6	1,220.9	65,552.0	9.6	1,234.8	80,931.0	9.3	1,200.7	96,679.0	9.8	1,237.1	131,494.0
Total	**139.5**	**11,502.8**	**2,907,243.0**	**139.6**	**11,572.2**	**3,098,489.0**	**140.6**	**12,252.0**	**3,161,035.0**	**132.2**	**12,023.9**	**2,907,157.0**

Note: Cost of occupational therapy and social work include mental health services associated with those particular services. Podiatry cost does not include costs associated with medical grade footwear.

Distribution of allied health costs according to states and remoteness

Mean monthly per-client spending by states

In all states, the mean monthly spending per client in the population had fluctuating trends without any relationship to the intervention (see Figure 3.28). The Australian Capital Territory (ACT), New South Wales (NSW), Northern Territory (NT), South Australia (SA) and Victoria (VIC) had the mean monthly spending per patient ranging between $300 to $350, while a higher range ($400 to $450) was noticed in Queensland (QLD) and Western Australia (WA). The lowest mean monthly spending per patient was recorded in Tasmania (TAS).

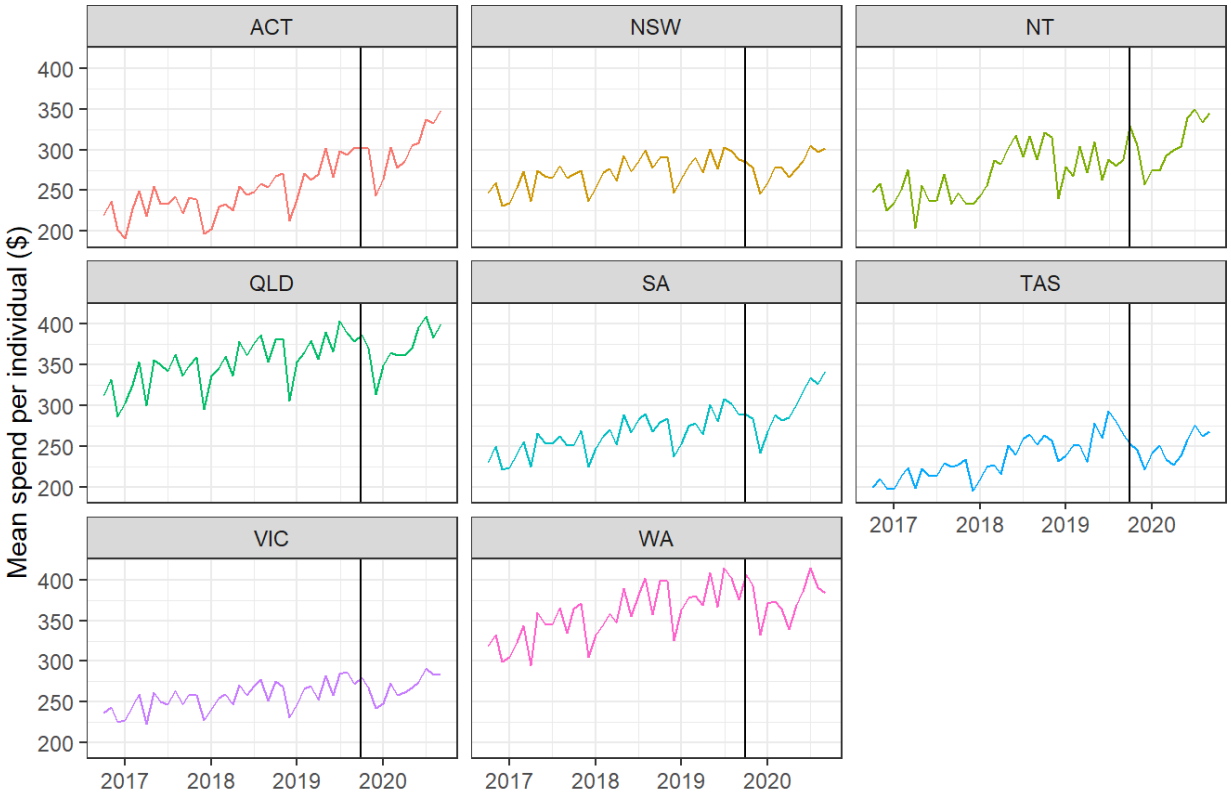


Figure 3.28: Mean monthly spending on allied health services in each state over a 3-year period. Black vertical line denotes October 2019 (intervention)—the area to the right of the line indicates the post-intervention period.

Total daily spending by remoteness

The total daily spending and mean monthly spending per individual on different allied health services according to the remoteness of the service provider location are given in Figures 3.29 and 3.30, respectively. The remoteness of the provider location was classified based on the Remoteness Areas Structure within the Australian Statistical Geography Standard (ASGS), published on the Australian Bureau of Statistics (ABS) website (ABS, 2018). There was an increasing trend of total daily spending in major cities, inner regional and outer regional areas since October 2016, continuing until the first quarter of 2019 (see Figure 3.29). Since then, the trend has reversed, and a decreasing trend continued until September 2020. The total daily spending in very remote areas gradually increased after the treatment cycle arrangements were implemented.

Figure 3.29: Total daily spending on allied health services over a 3-year period in areas of varied remoteness. Black vertical line denotes October 2019 (intervention)—the area to the right of the line indicates the post-intervention period.

Mean monthly spending per client by remoteness

The mean monthly spending per individual in major cities, inner regional and outer regional areas was similar, with the overall average around $325 and no noticeable change noted after the treatment cycle arrangements were implemented (see Figure 3.30). The mean monthly spending per individual in very remote areas showed a wide variation, and the overall average was higher than the other areas.

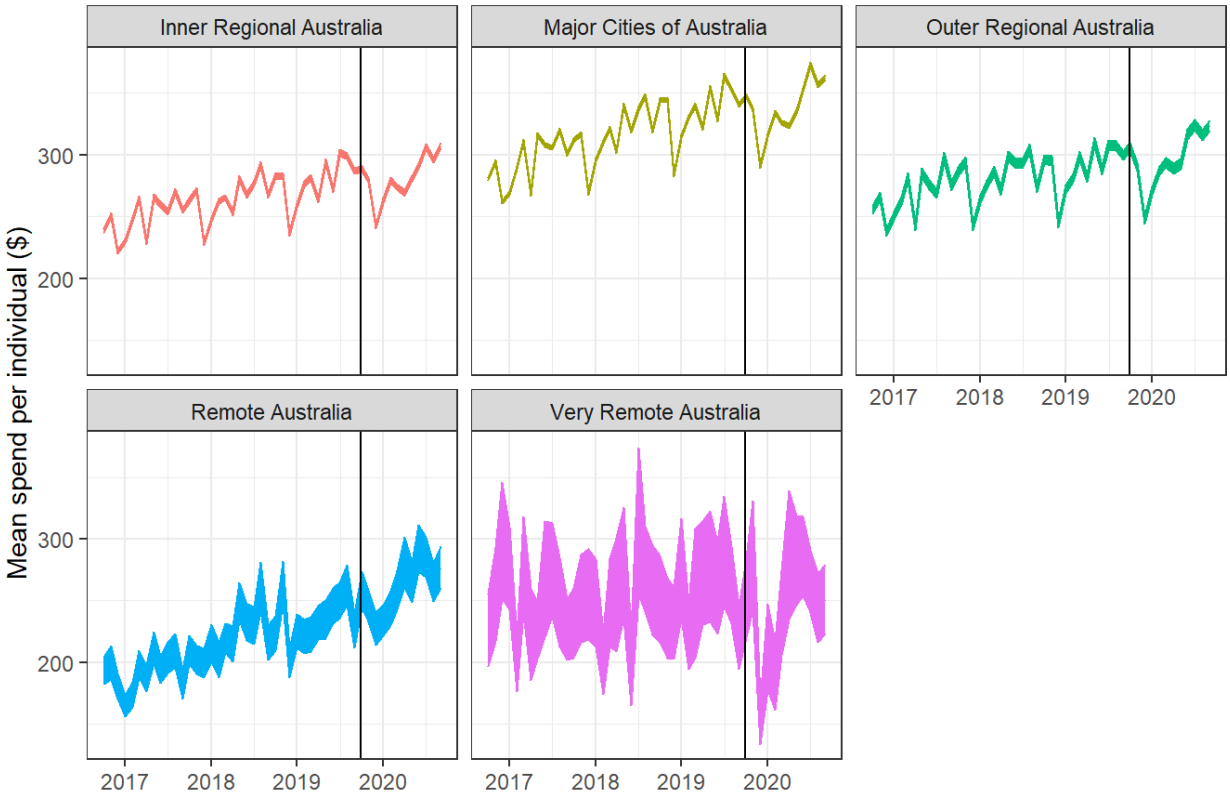


Figure 3.30: Mean monthly spending on allied health services over a 3-year period in areas of varied remoteness. Black vertical line denotes October 2019 (intervention)—the area to the right of the line indicates the post-intervention period.

Multivariable analysis to estimate the reduction in spending associated with the treatment cycle

Generalized estimating equation (GEE) regression was used to evaluate the reduction in spending associated with the treatment cycle arrangements. A detailed description of the methodology is given in Appendix 8.

Our preferred model included five months of data before the treatment cycle arrangements and five months of data afterwards to avoid the period affected by COVID-19.

As indicated in Appendix 8, the estimate for the interaction between allied health services and the treatment cycle arrangements period is –$13.00 (95% CI: [–$14.547, –$11.452]), suggesting that the treatment cycle arrangements were associated with a mean monthly reduction of $13 in spending per client. In this cohort of 94,612 clients, it can be extrapolated that under pre-COVID-19 conditions, this would amount to an annual saving of $14,759,472.

Conclusion

There was a substantial reduction in total cost after the treatment cycle arrangements were implemented (2019 Oct – 2020 Sep) compared with the two previous years. This reduction was repeated in mean annual appointments, mean annual spending and the total number of appointments per client. The lockdowns imposed since March 2020 due to COVID-19 may have affected the service utilisation of allied health services. When interpreting the trendlines observed since implementing the treatment cycle arrangements, it is important to consider the effect of COVID-19 since March 2020. Multivariable analysis indicated that treatment cycle arrangements are cost-saving compared to previous practice.

SECTION 4: LIMITATIONS

Project limitations

Our findings and conclusions are drawn from the materials collected through the course of the evaluation. Given DVA's broad range of services, the complicated nature of health care provision to such a diverse client group, and the impact of COVID-19 on research activities, the evaluation contained some limitations. The evaluation team have used the totality of information collected to identify the common themes, insights and experiences of those who deliver and receive services within the treatment cycle arrangements.

While we have been mindful of the intricacy of veteran health care provision, we acknowledge there may be areas where additional considerations may be required, given the complexities of DVA and veterans' service systems. Some of these additional considerations are outlined below.

Methodological limitations

Representative samples

There is always a risk when relying on self-reported data for research. While a high number of responses for the survey were collected, there is no way of proving or disproving that people were indeed who they claimed to be: that is, a DVA client, an AHP or a GP. The internal consistency of responses indicate that respondents were honest in their self-allocation, but there is no way to prove this.

As the survey was mainly promoted and totally completed online, there is a bias towards responders who have access to and are comfortable accessing information online. This may lead to certain groups being under-represented, such as older veterans, people who have low IT skill levels or literacy, or time-limited AHP or GP populations. There is consistent evidence that the reading level necessary for most health information materials is above the average adult's reading ability (Australian Commission on Safety and Quality in Health Care, 2013). This limitation could be addressed by extending the evaluation research questions in an offline platform.

Further, all methodology responses were from a self-selected sample. Self-selecting samples are inherently biased, as people who have a negative issue with the content of the survey are much more likely to respond than those who do not experience negative issues surrounding the content of the evaluation. This issue can be mitigated through research that is compulsory for all of the relevant research population, but this is outside the scope of this project.

There is likely an element of responder bias in the results, given the relatively small number of interviews and apparent reliance on commentary from Queensland-based occupational therapists, who were over-represented in the AHP respondents.

Low levels of GP engagement may affect the generalisability and reliability of the findings. GPs are a notoriously difficult cohort to engage, and the research team feel that all reasonable options were exhausted in the available timeframe. Further input from GPs would strengthen the report findings.

SECTION 5: DISCUSSION

The treatment needs of the veteran population in Australia are complex and changing. DVA has estimated that the current treatment population consists of 257,211 veterans, and this population will increase to 300,500 by 2023 and 310,900 by 2030 (DVA, 2019a). The demographics of the Australian veteran population are also changing, with the number of older veterans declining and the nature of recent military conflicts resulting in differing treatment needs compared to those in earlier conflicts (Productivity Commission, 2019). Therefore, the needs of older veterans (who are more likely to require independent living assistance, aged care and health services) need to be balanced with the needs of contemporary veterans, who are more likely to require rehabilitation, ongoing wellness care and assistance with transition to work (Productivity Commission, 2019). As the veteran population changes over time, DVA recognises the importance of access, relevance, efficiency and effectiveness in delivering its programs to ensure good quality health outcomes for clients requiring assistance and support. The treatment cycle arrangements were implemented in October 2019 to support improved collaboration between providers and maximise the quality of care for clients of the system by providing a framework for better coordination and communication between GPs, AHPs and clients. Further, the treatment cycle arrangements intended to position DVA clients as the centre of care and the GP as the primary care provider working with other providers to achieve high-quality health care outcomes (DVA, 2019c).

This evaluation was commissioned to determine the outcomes of the first 12 months of this initiative by exploring three key lines of inquiry:

- how well treatment cycle arrangements have been implemented
- the extent to which stakeholders have engaged with the new arrangements
- the client outcomes achieved, specifically, quality of care and GP engagement, care coordination, access to services and the efficacy of the At Risk Client Framework.

SECTION 5: DISCUSSION

As described in the previous chapters, a mixed-method strategy has been applied to engage the experiences and opinions of all key stakeholders in the new arrangements. Both qualitative and quantitative data were collected and analysed to reach the conclusions and recommendations described here. Recommendations will be made throughout this section and then summarised in list format at the end of this report.

How well have the treatment cycle arrangements been implemented?

Awareness of the new arrangements before implementation

Implementing any new service arrangement requires effective communication of program intentions and new processes to both providers and client end-users. In the lead up implementing the treatment cycle arrangements in October 2019, DVA developed a comprehensive series of communications and resources for all relevant stakeholders. These resources were distributed using the department's usual communication channels from May 2018 onwards and included a variety of formats, such as the VetAffairs newspaper, fact sheets on the DVA website, letters and face-to-face meetings.

The 'DVA treatment cycle communications plan' document emphasised the importance of the role of GPs in the establishment and ongoing effectiveness of the treatment cycle arrangements, noting the importance of GPs in care coordination for veterans. The communications plan highlighted the importance of ensuring that GPs and general practice teams are 'aware of the intent and benefits of the treatment cycle, and their role in the new referral arrangements' ('DVA treatment cycle communications plan' document, 2019).

At the time of implementation of the treatment cycle arrangements, less than 50% of the GPs who responded to the survey (49%, n = 73) reported awareness of the treatment cycle arrangements. Of those aware of the program, 39% recalled having received information directly from DVA and 28% from their DVA client group. Despite the emphasis on GP knowledge of the treatment cycle arrangements in the DVA communications plan, GPs reported relatively low awareness of the arrangements

compared to AHPs and DVA clients. GPs reported that professional associations were the most common channel of communication, which is consistent with the DVA communications plan. Despite these moderate awareness rates, 87% (n = 128) of GPs reported they had consulted DVA clients under the treatment cycle arrangements. By comparison, close to two thirds (72%; n = 316) of AHPs were aware of the treatment cycle before October 2019. Of these, 41% (n = 181) of AHPs recalled receiving information directly from DVA about the treatment cycle arrangements before October 2019, and 37% (n = 164) of AHPs reported that they were informed about the treatment cycle arrangements from their professional association. Further emphasis on GP understanding of the treatment cycle arrangements, particularly on communication methods and ongoing consultation with GP roles, will benefit the ongoing treatment cycle outcomes.

Further, the moderate rates of GP treatment cycle arrangements awareness, coupled with high rates of utilisation reported by GPs, may indicate an opportunity for errors to be made in the early stages of treatment cycle implementation. While there is no current evidence of this possibility (and this was not an area addressed by the data collection in this project), structured monitoring of GP knowledge and compliance is advisable. It is essential that monitoring highlights and addresses areas of common noncompliance via mechanisms to improve communication and feedback from stakeholders. It will also be important to ensure continual quality improvement regarding the operational processes of the treatment cycle arrangements.

General awareness of the treatment cycle arrangements was reasonably high among DVA clients, with 62% (n = 250) of clients reporting awareness. Forty per cent (n = 161) of DVA clients reported receipt of this information directly from DVA. A further 35% (n = 138) of clients reported that they were informed about the treatment cycle by their GP. During interviews, clients emphasised the importance of dissemination of new arrangements through veteran-to-veteran communications, such as social media via veteran advocate and support groups. While awareness was moderate to high at the time of the evaluation data collection, clients did report some difficulties accessing the information when the treatment cycle arrangements were implemented in October 2019.

Information was reported to be hard to find or required more investigation by clients. However, overall, slightly more than half of the client respondents reported that the information they did receive was:

- easy to understand (53%; n = 210)
- relevant to their needs (50%; n = 201)
- prepared them for the changes (57%; n = 229)
- helped them to understand the changes (62%; n = 245).

Effectiveness of the DVA communication strategy

The DVA's pre-implementation communication strategy has achieved moderate levels of reach across the three stakeholder groups (DVA clients, GPs and AHPs). The materials have been generally assessed as easy to understand and fit for purpose; however, there is some room for improvement in client comprehension of the changes. This is, of course, not unusual, and experience with navigating a new program will improve comprehension over time. However, ongoing support will be required to support veterans using the treatment cycle arrangements.

At the time of implementation, DVA acknowledged that 'there are some misconceptions about the treatment cycle among providers and clients which need to be addressed' ('DVA treatment cycle communications plan' document, 2019). DVA noted in the communication plan that there was extensive consultation with key stakeholders about the budget measures for the treatment cycle arrangements. A co-design workshop for the treatment cycle arrangements was held in March 2019, facilitated by Macquarie University and attended by multiple allied health and GP associations. This was in addition to internal health policy DVA workshops and working groups, as well as the treatment cycle arrangements being presented to the Ex-Service Organisation Round Table (ESORT) in May 2019.

Despite this comprehensive communication plan at the outset of the treatment cycle arrangements, ongoing communications from DVA have so far appeared to be ad hoc and reactive. An ongoing plan for DVA communications and consultation with key

stakeholder groups (such as the RACGP and Australian Medical Association [AMA] for GPs and ESOs for DVA clients and professional associations) would improve stakeholder understanding of and engagement with the treatment cycle arrangements. Further, while it may be more time- and resource-intensive, more in-depth and ongoing engagement in feedback relating to the treatment cycle arrangements may help address the sentiment that the treatment cycle arrangements are a cost-saving measure rather than a health care improvement strategy. During both survey and interview data collection, participants expressed their relief in being listened to and provided the opportunity to 'have a say' in the treatment cycle arrangements, which may indicate that ongoing opportunities for feedback from stakeholders (in the form of forums, short-form surveys or a DVA feedback email address) would improve stakeholder perception of the treatment cycle arrangements.

Client survey respondents reported hearing about the treatment cycle arrangements via a variety of sources (more than one option could be selected), including:

- 49% from GP sources (advertisements in clinic, the GP themselves, GP website or GP social media)
- 78% from DVA sources
- 27% from ESO sources
- 3% from 'other sources', including veteran-to-veteran communication (e.g., Facebook groups and social contact)
- 19% from AHP sources.

It was interesting to note the role of professional associations and ESOs in improving awareness rates among all three end-user groups. This result reinforces the importance of the department's multichannel approach to end-user engagement and the particular utility of professional and client associations, generally considered 'trusted agents' in ensuring awareness of program change.

The evaluation notes that DVA client respondents aged 50 years of age or less were more were likely to be positive towards communications about treatment cycle arrangements. Sixty-three per cent (n = 82) of this client group found the information

easy to understand compared to 47% (n = 127) of DVA clients aged over 50 years old. This finding highlights an opportunity for stratification of communications as a function of age and needs profile and the importance of trusted agents (such as professional associations) to assist with messaging reach.

The DVA 'Improved Dental and Allied Health Communications Plan' (2018), which we acknowledge outlined the communications strategy for the whole budget measure, not just the treatment cycle arrangements, states that one of the communications principles was to 'make use of existing channels wherever possible'. This strategy may need to be reviewed or supplemented in light of the data reported here concerning the limited reach of messaging about treatment cycle arrangements. In particular, diversification of communication channels, along with age stratification of the treatment cycle arrangement messaging, would improve communication effectiveness.

While the limitations of retrospective recall are acknowledged, there does appear to be room for improvement in strategies to raise awareness and comprehension of new treatment initiatives and associated administrative changes before their implementation. Advertising and information tailored to the communication mediums most frequently accessed by different age groups are likely to improve uptake and comprehension. This target group segmentation strategy ensures that information is shared via the platforms most likely to be accessed by the target subgroups. There is an opportunity to implement targeted strategies in the first instance with veterans aged 50 years and older, who appear to have experienced reduced exposure to the information offered by the DVA communication plan.

Usefulness and clarity of the provider notes and clinical resources

In the 18 months (May 2018 – October 2019) before implementation, DVA developed and distributed a range of information and resources to assist practitioner groups to comprehend and implement the treatment cycle arrangements. These included:

- web content from the DVA website
- notes and letters sent to GPs and AHPs
- outlines of treatment cycle arrangements
- clinical resources
- fee schedules
- templates for AHP and GP use.

The evaluation reviewed 78 documents and communications and assessed their understandability and actionability using PEMAT-P. This analysis indicated that the document contents were generally considered easy to understand but difficult to implement. The analysis also indicated that the use of visual aids and infographics could improve understandability scores. The actionability of the documents could be improved by providing tangible tools such as checklists to help the user take specific actions. The overall scores for the Health Literacy Checklist were good and congruent with the higher PEMAT-P understandability ratings of the documents.

Operational impact of the treatment cycle arrangements on GPs and AHPs

The operational impact of the treatment cycle arrangements on the three stakeholder groups was outlined in the DVA documents assessed as part of the document analysis. The documents prepared and distributed to practitioners detailed the expected operational impact of the treatment cycle arrangements, including more GP involvement in ongoing care, change in patient care actions for AHPs and general operational changes in the way DVA clients and health care providers access the treatment cycles. These documents outlined the actions required of GPs and AHPs to ensure compliance with the new treatment cycle arrangements.

Surveys conducted with health practitioners indicated that opinions about the intended outcomes of the treatment cycle arrangements were mixed and suggested that sufficient time may not have passed to adequately assess its effects. However, an examination of the experience of AHPs found some small improvements in both the quantity and quality of interactions with GPs in support of their clients' treatment plans. Twenty-four per cent (n = 104) of AHPs indicated that the quality of interactions between themselves and their DVA clients' GPs' have improved, and 30% (n = 132) reported that they have more opportunities to discuss and review DVA clients' health care needs with GPs. Despite these improvements, there also remains considerable room for improvement.

Almost half of GP respondents reported the treatment cycle arrangements to be more time-consuming. Further, close to a third of GPs reported that the treatment cycle arrangements were more expensive and complex. Similarly, GPs noted increased time spent each week to complete referrals and paperwork related to the treatment cycle arrangements and that much of this work was completed in their own time, resulting in unpaid work. Within interviews and surveys, providers also indicated concerns about the length and usability of certain forms. Similar sentiments were echoed by the AHPs, with close to 80% reporting that the treatment cycle is now more time-consuming. More than half of AHPs surveyed reported that the treatment cycle arrangements were more complex than previous DVA health care, and more than a third noted it was more expensive, less effective and worse than the previous arrangements.

The most commonly reported operational impacts reported by both GPs and AHP's included:

- the amount of time required for GPs to see their clients
- the time-consuming nature of the treatment cycle arrangements
- the need for greater clarity on the required process from GPs
- the impact on GP clinic capacity due to administrative load, sometimes needing additional staff to manage administration

- concern over management of chronic conditions under the restriction of the treatment cycle arrangements, which may indicate a lack of comprehension of the provisions of the Risk Framework
- some positive impacts on communication and quality of notes from AHPs
- concern over the cost to clients of seeking additional referrals (personally and on the health system).

The findings described above indicate opportunities to streamline the administrative load associated with the treatment cycle arrangements. The evaluation recommends a review of the current administrative burden of the treatment cycle arrangements to ensure that the arrangements are not unnecessarily adding to the administration loads of health care providers. While the treatment cycle arrangements only add limited paperwork to existing administration requirements in the form of End of Cycle reports or the At Risk Client Assessment Form, it is important to recognise that provider perception of an increased administration load was significant. The tension between the slight increase in administration activities intended by the treatment cycle arrangements and the reported impact of actual administration undertaken by health care providers should be investigated, in order to ensure that there is not unintended impacts on the time of health care providers within the treatment cycle arrangements. While we recognise that there are guidelines for clinical communications outside the context of DVA involvement, a working group or forum for feedback from health care providers on the efficacy and efficiency of the current administration needs of the treatment cycle arrangements and subsequent amendments made to the requirements may alleviate the administrative load currently reported by health care providers.

Further, the implementation of End of Cycle reports consistently raised some challenges. In general, while the intended purpose of the reports is understood, AHP and GP respondents both reported concerns regarding:

- the time required to complete reports
- the manual nature of the reports
- restrictive formatting

- perceived duplication of other usual forms of communication
- lack of benefit to clients
- time delays in receiving the reports from AHPs.

Regrettably, GPs noted they rarely had time to read the reports. These findings provide clear opportunities to revisit and revise the application, efficiency and relevance of End of Cycle reports for AHP and GP implementation and ensure they fit the best DVA client health care outcomes.

Despite the perception of an increased administrative load, health care providers also reported improvements in care coordination and communication due to the treatment cycle arrangements. Overall, 64% (n = 94) of GPs reported having more opportunities to discuss and review their DVA clients' health care needs with their AHP, and 30% (n = 132) of AHPs reported increased opportunities to discuss and review clients' health care needs with GPs.

Impact of the treatment cycle arrangements on DVA clients

DVA clients reported mixed responses relating to the impact of the treatment cycle arrangements on their health care. Twenty-two per cent (n = 89) of DVA clients surveyed reported being positively impacted, 41% (n = 164) of clients reported being negatively impacted, and 37% (n = 147) of clients reported not being impacted by the treatment cycle arrangements.

Despite these mixed responses, DVA clients reported consistent concerns about the increased number of GP appointments required under the new arrangements, as well as the quality and purpose of the visit. Many clients (almost 75%) reported seeing their GP to complete paperwork for the additional referrals rather than to discuss their care needs. Cost concerns noted by DVA clients included the perceived increased cost to Medicare due to consultation billing for additional or more frequent referrals; however, analysis of the economic data and client usage data does not indicate this. Health economic analysis indicates overall savings for the DVA per client, although it is important to note that this may be at the cost of increased personal expenses for DVA

clients and a higher administrative burden for GPs and AHPs. Further rolling analysis of the economic impact of the treatment cycle arrangements to stakeholders should be undertaken to monitor any potential cost shifts to clients.

DVA clients reported that they did not have better access to services under the changes to the treatment cycle arrangements. Seventy per cent (70%; n = 279) of clients reported the treatment cycle to be more time-consuming, and 44% (n = 176) noted it was more complex. Close to one third (35%; 140) noted it was more expensive for them, which related to costs associated with additional GP appointments for referrals and administration. The extra expenses included travel, additional child care and taking time off work. Some psychosocial impacts were reported from clients, which should guide further consideration for the future of the treatment cycle arrangements. Pressure and perceived self-coordination of care were common themes, especially relating to the need to track the number of sessions with their AHP to ensure their referral was current.

Despite this, 34% (n = 137) of clients reported that they are more engaged in how their health care needs are met, and 40% (n = 157) reported that they discuss and review their health care needs more often and in more detail with their GP. This was consistent with client perspectives on increased opportunity to discuss and review their health care needs in increased detail (39%; n = 156) with their AHP. Twenty-nine per cent (n = 117) of DVA clients also reported that their health care needs are better met by the treatment cycle arrangements. Slightly over a quarter of clients (26%; n = 104) reported that they have better access to necessary services and that they receive better quality health care overall. Complementing this, 30% (n = 118) of clients reported they receive better, targeted support based on their health care needs.

Overall, administrative burden and cost increases were reported by all respondent groups, with DVA clients noting the challenges of attending additional appointments. DVA clients also noted having to keep track of their referral and health care requirements due to the limitations of the treatment cycle arrangements. These negative impacts need to be balanced with the improvements from the changed treatment cycle arrangements. Addressing the administrative burden on both DVA clients and their

health care providers through initiatives such as financial remuneration for administrative tasks tied to the treatment cycle arrangements may ensure that the treatment cycle arrangements have maximal benefit for all stakeholder groups.

How well have stakeholders engaged with the new arrangements?

Change in utilisation patterns and health care expenditure

More than half of DVA client respondents (54%) reported seeing their GP more frequently, and 71% (n = 283) reported requiring more referrals to meet their health care needs. This is reflected in similar statistics from GPs; 46% (n = 68) of GPs reported that they see their DVA clients more, 15% (n = 22) reported seeing their DVA clients less, and 37% (n = 55) reported seeing their DVA clients the same amount. By comparison, only 9% (n = 39) of AHPs reported that they see their DVA clients more, 23% (n = 101) of AHPs reported seeing their DVA clients less, 63% (n = 276) of AHPs reported seeing their DVA clients the same amount.

Following the implementation of the treatment cycle arrangements, a general downward trend in the daily expenditure for osteopathic, physiotherapy, podiatry and speech pathology services was noted. This trajectory continued after the intervention in October 2019. By contrast, an upward trend of the daily expenditure, which continued after the intervention, was observed in the following services: diabetes educators, dietetics, exercise physiologists and psychology. A sharp upward trend in the cost of psychology was noted, increasing further after the intervention. This could be attributed to related DVA policy initiatives, such as expanding non-liability mental health care for veteran white card holders, although this cannot be confirmed through the current dataset. The upward trend of expenditures in orthotists was not sustained following treatment cycle arrangement implementation. Physiotherapy (approximately 35% of the total cost), exercise physiology (approximately 24% of the total cost) and podiatry (approximately 17% of the total cost) accounted for nearly 76% of the total cost. The total expenditure was AUD 10 million less in October 2019 – September 2020 compared to the previous year (October 2018 – September 2019).

The total number of allied health service appointments in October 2019 – September 2020 was lower than in the two previous years (254,878 fewer than October 2018 – September 2019, and 191,332 fewer than October 2017 – September 2018). The estimate for the interaction between AHP services and the treatment cycle arrangement period is –$13.00 (95% CI: [–$14.547, –$11.452]), suggesting that the treatment cycle arrangements were associated with a mean monthly reduction of $13 in spending per client. In this cohort of 94,612 clients, it can be extrapolated that under pre-COVID conditions, this will amount to an annual saving of $14,759,472.

GEE regression was used to evaluate the reduction in spending associated with the treatment cycle. The results demonstrated a substantial reduction in total cost after the treatment cycle was implemented (2019 Oct – 2020 Sep) compared with the two previous years. This reduction was repeated across mean annual appointments, mean annual spending and the total number of appointments per client. It is likely that public health measures put in place to manage COVID-19 since March 2020 may have affected the service utilisation of allied health services. When interpreting the trendlines observed since implementing the treatment cycle, it is important to consider the effects of COVID-19 since March 2020.

What outcomes have been achieved by the new arrangements?

Improved quality of care

Overall, both GPs and AHPs reported improvements in client communication and care coordination. Younger clients (50 years of age or less) were more likely to report that their health care needs are better met under the new arrangements (48%, n = 62); they have better access to necessary services (44%, n = 57); they receive better, targeted care (50%, n = 64); and they receive a better quality of health care overall (46%, n = 59) compared to the older cohort.

Consistent with feedback from clients, just over half of GPs noted they issued more referrals to their clients since the change to the treatment cycle arrangements, and just over half of GPs agree that their clients' needs are better met. However, AHPs

expressed concern regarding DVA clients' health care needs being met by the treatment cycle arrangements. Of the AHPs, 52% (n = 230) disagreed that their DVA clients' have better access to necessary services to meet their health care needs. Similarly, 46% (n = 201) of AHPs disagreed that their DVA clients receive better, targeted support based on their health care needs and that they receive better quality health care overall. This group reported confusion and stress among clients about the rules and pressures associated with perceived increased self-responsibility for care coordination.

Care coordination

Coordination of care was an interesting finding that emerged from the evaluation data. While DVA clients reported increased communication between themselves and their GP, they also reflected that they felt that most of the burden for care coordination rested on themselves rather than their treatment team. Fifty-six per cent (n = 223) of DVA clients reported that they coordinate their health care needs compared to 25% (n = 98) reporting that their GP coordinates their health care needs and 12% (n = 47%) reporting that their health care needs are jointly coordinated by their GP and AHP. This is at odds with the perspectives of health care practitioners, who reported increased responsibility for care coordination. Seventy per cent (n = 104) of GPs reported that they coordinate their clients' health care needs, and 57% (n = 251) of AHPs reported that they coordinate their clients' health care needs. Despite this, half of the clients surveyed by the evaluation also reported that they had a PCP developed collaboratively with their health care providers. This indicates that there may be a disconnect between the perceived coordination of care and the practice of DVA client care coordination between the three groups.

As a related issue, concern was expressed by DVA clients about the perceived additional pressure of self-coordination of care. This concern was frequently expressed by reports of stress associated with keeping track of the number of sessions with their AHP to ensure their referral was current. DVA clients reported feeling as though they coordinated their own health care, which may be influenced by the apparent increase in

management and tracking of referrals and the number of visits to AHPs. This should be balanced with positive improvements, such as some DVA clients reporting improved communication between their GP and AHP and improved knowledge of treatment options by their GP. Consistent with this, the majority of DVA clients reported more contact and discussion with their GP before starting a treatment cycle and increased regularity of visits to GPs to follow the 12-session structure. Results also indicated that clients perceived benefits regarding the communication between GPs and AHPs; half of the clients indicated that they now had a PCP with their AHP.

An important exception to this improvement was interview and survey data collected from DVA clients, which found that the treatment cycle arrangements negatively impacted their health care coordination and quality of care. Survey responses reported that 36% (n = 143) of DVA clients disagreed that their health care needs are better met by the treatment cycle arrangements, 41% (n = 162) disagreed that they have better access to necessary services to meet their health care needs, and 37% (n = 147) disagreed that they receive better quality health care overall as a result of the treatment cycle arrangements. This was also highlighted within interviews among DVA clients who work full-time or have chronic conditions, with the increased frequency of referrals required being a significant inconvenience. DVA clients also expressed concerns within interviews that they were an 'inconvenience' to AHPs and GPs by requiring more appointments.

All three stakeholder groups reported that they felt they were responsible for the coordination of DVA clients' health care, and it is important to note that all groups feel that they have taken on significant responsibility in care coordination as a result of the treatment cycle arrangements. If the implementation of the treatment cycle arrangements is to remain consistent with the aims of establishing the GP as the primary care provider working with other providers (DVA, 2019c), the burden of care coordination for AHPs and DVA clients may need to be reviewed. Within interviews, AHPs indicated that they were aware that it should be the GPs taking on the role of health care coordination; despite this, they are involved in suggesting referrals, coordinating with families and other forms of patient care. AHPs reported the belief that

GPs are time-poor and unable to take on the role of care coordination. Further review and communication of the intended care coordination structure among GPs, AHPs and DVA clients, along with a clearer outline of the responsibilities of care for the treatment cycle arrangements, is recommended to address these concerns. The opportunity exists for improved clarity about the role of each stakeholder group to minimise duplication and maximise efficiency.

Access to required treatment

Analysis of health usage data demonstrated differences in access to health care treatment as a function of location, as well as a predictable impact on service utilisation due to the impacts of the COVID-19 pandemic. The evaluation identified an increasing trend in total daily spending in major cities and inner and outer regional areas since October 2016, continuing until the first quarter of 2019. Perhaps predictably, this trend reversed during the pandemic, and a decreasing trend in access to treatment continued until September 2020. Interestingly, total daily spending in very remote areas gradually increased after implementing the treatment cycle arrangements. Given known challenges associated with access to services in remote and rural areas, this positive change in access to services may be the result of improved service-related communication and referral to AHP providers by GPs. Monitoring this change over time may help determine whether this is the case.

Efficacy of the At Risk Client Framework

The At Risk Client Framework was developed for a proportion of clients who may require more tailored plans over longer periods (up to 12 months) to achieve the desired quality of care. The DVA communication plan acknowledged that health care providers and DVA clients had expressed concerns that the treatment cycle arrangements would make it difficult for clients with complex health conditions to maintain continuity in their treatment (‘DVA treatment cycle communications plan’ document, 2019). Data collected in this evaluation indicated that these concerns are still present. DVA clients with chronic and severe health conditions expressed dissatisfaction with the 12-session requirement of the treatment cycle arrangements but did not express awareness or

utilisation of the At Risk Client Framework, indicating that some eligible clients may not be accessing it.

The evaluation found that self-reported knowledge of the At Risk Client Framework among GPs is moderate. Less than 60% of GPs thought they had sufficient knowledge about the framework (57%; n = 84) and understood it (58%; n = 86). Despite this, 63% (n = 94) of GPs reported applying the framework, and 62% (n = 92) were satisfied with the framework criteria. Just over half of GP respondents (54%; n = 80) agreed that the framework meets complex health care needs, and 60% (n = 89) believed the framework ensures quality primary coordinated care. Just over half the GP group (53%; n = 79) agreed that few DVA clients require the framework. DVA client interviews indicated that there might be uneven awareness of the framework among clients and GPs, with DVA clients reporting that they had bought the framework to the attention of their GP after hearing about it elsewhere.

The evaluation recommends that the At Risk Client Framework is reviewed to ensure its aims are being met and that DVA clients and GPs are aware of and able to apply the framework where appropriate. A review of the current number of DVA clients accessing the framework may indicate whether it is currently appropriately accessed, although these data were not available for this project. The application of the framework may be improved by more effective communication of the framework to GPs.

Data regarding AHP and DVA client knowledge of the framework were not collected within this project as DVA policy outlines that the framework is only applied by GPs. Despite this, AHPs and DVA clients mentioned the framework during interviews. Interview data collected from occupational therapists and podiatrists highlighted the opportunity for AHPs with ongoing interactions with clients to be able to contribute to discussions of client health conditions, psychosocial factors and functional impairments as a result of the treatment cycle arrangements, and that a dialogue between AHPs and GPs would improve both the quality of care provided to the client and the application of the framework to at-risk clients. Further research regarding AHP knowledge and possible contribution to the application of the At Risk Client Framework is

recommended, as it was outside the scope of this evaluation but is an opportunity for improved patient care outcomes.

SECTIONS 6: CONCLUSIONS AND NEXT STEPS

The evaluation has identified multiple instances of good practice and positive outcomes as a result of the implementation of the treatment cycle arrangements, although the COVID-19 pandemic has undoubtedly had an impact on access and coordination of services. Many strong views have been expressed across each of the participant groups, which indicates the need for ongoing monitoring of stakeholder outcomes and continual improvement in streamlining the administrative requirements of the treatment cycle arrangements. Some DVA clients and health care providers doubted whether the objectives of the treatment cycle arrangements relating to improved coordination and access to services are being met. However, the 12-session structure was generally accepted as being suitable for acute conditions.

Concern was raised by GPs and AHPs about managing clients with chronic conditions. This may indicate a limited understanding of the At Risk Client Framework in the wider practitioner group and requires ongoing monitoring to ensure that clients requiring services under this system are being appropriately identified.

Additionally, further clarity about coordination responsibilities under the treatment cycle arrangements is required but may develop with longer experience of the program and targeted communication about responsibilities for client coordination. Client care coordination requires additional focus and strategies to maximise service efficiency and facilitate desired outcomes. A combination of factors, from the need for increased referrals and additional or new administration, may have overshadowed any potential improvement in care coordination at the time of the evaluation.

Clients who have accessed DVA-funded allied health treatment reported their experience of services was typically very good or excellent from AHPs. Additionally, many clients expressed their gratitude towards DVA for recognising their service, injuries and need for treatment. However, clients have reported that some GPs and AHPs refuse to treat DVA clients due to bureaucracy, administrative requirements, insufficient remuneration and the complexity of DVA client care.

In light of the above findings and conclusions, this evaluation has made the following recommendations for the ongoing monitoring and implementation of the treatment cycle arrangements. These recommendations have been discussed in the previous section but have been summarised here for ease of action. These recommendations are designed to be actionable and to meet the original intentions of the treatment cycle arrangements.

Next steps

Communication

- **Improved, better-targeted GP communication:** This report recommends that more emphasis is placed on the DVA improving the GP understanding of and participation in the treatment cycle arrangements. This includes ongoing communication and consultation with GP-specific channels (such as the RACGP and AMA) with emphasis on GP roles within the referral arrangements. This should include specific information regarding the At Risk Client Framework.
- **Communication with AHPs and clients regarding the purpose of the treatment cycle arrangements:** This evaluation recommends more in-depth and ongoing engagement of veteran's groups and AHP associations regarding feedback about the treatment cycle to improve understanding of and engagement with the treatment cycle arrangements. Ongoing opportunities for stakeholder feedback relating to the treatment cycle arrangements and for targeted communications from DVA to stakeholders about the improved quality of care outcomes may help address the sentiment that the treatment cycle arrangements are a cost-saving measure rather than a health care improvement strategy.
- **Tailored communication methods:** Information tailored to the communication mediums most frequently accessed by different age groups is likely to improve uptake, positive perceptions and comprehension of the treatment cycle arrangements. This targeted group segmentation strategy will ensure that information is shared via the platforms most likely to be accessed by the target

stakeholder subgroups. There is an opportunity to implement a targeted strategy in the first instance with veterans aged 50 years and older who appear to have experienced reduced exposure to the information offered by the DVA communication plan.

- **Improved written communications:** Actionability of DVA-provided documents relating to the treatment cycle arrangements should be improved by including tangible tools for readers, such as checklists, to ensure that the user takes specific actions to implement and comply with the treatment cycle arrangements.

Quality of care

- **Treatment cycle compliance monitoring:** This evaluation recommends that a structured monitoring program of GP knowledge and compliance be implemented to ensure GP understanding of treatment cycle arrangements. It is essential that compliance monitoring highlights and addresses areas of common noncompliance via mechanisms to improve communication and feedback from stakeholders. Monitoring should also ensure the continuous improvement of operational processes of the treatment cycle arrangements.
- **Review and communication of coordination of care responsibilities:** Pressure and perceived self-coordination of care was a common theme among DVA clients, especially relating to feeling the need to track the number of sessions with their AHP to ensure their referral was current. These psychosocial impacts should guide further communication of the treatment cycle arrangements. Further review and communication of the intended care coordination structure among GPs, AHPs and DVA clients, along with a clearer outline of the responsibilities of care coordination for the treatment cycle arrangements, is recommended to address these concerns. For example, if the intended outcome of the treatment cycle is for AHPs to track the 12-session allowance, this may need to be better communicated to DVA clients and health care providers. If the 12 sessions are intended to be tracked by DVA clients, a document or diary outline could be published and provided to clients to assist in their health care coordination.

- **End of Cycle report review:** The findings of this evaluation provide an opportunity to revisit and revise the application, efficiency and relevance of End of Cycle reports for AHP and GP implementation and ensure they are fit for the best DVA client health care outcomes. A working group or similar to review the current uses and applicability of End of Cycle reports is recommended to improve the reports for improved veteran quality of care and health provider communication.
- **Access to required treatment:** Data indicated that total daily spending in very remote areas gradually increased after implementing the treatment cycle arrangements. The evaluation notes the opportunity for monitoring this change over time and investigating the impact of the treatment cycle arrangements in remote areas.
- **At Risk Client Framework review:** The evaluation recommends that the At Risk Client Framework is reviewed to ensure the aims of the framework are being met and that DVA clients and GPs are aware and able to apply the framework where applicable. A review of the current number of DVA clients accessing the framework may indicate whether it is currently appropriately accessed. Considering the inclusion of specific AHP types, such as occupational therapists and podiatrists, who deal with long-term conditions and care, may improve the application of the framework and the effectiveness of veteran care.

Economic impacts

- **Analysis of the economic impact of the treatment cycle for stakeholders:** While health economic analysis indicated that the treatment cycle arrangements resulted in overall savings for the DVA per client, it is important to note that this may be at the cost of increased personal expenses for DVA clients and a higher administrative burden for GPs and AHPs. Further rolling analysis of the economic impact of the treatment cycle arrangements on stakeholders should be undertaken to monitor any potential cost shifts to clients.

- **Ongoing financial savings:** This evaluation recommends that DVA further analyse the financial impact of the treatment cycle arrangements to track ongoing trends and patterns. This could be achieved by analysing the next available financial year of data to track ongoing trends and see if estimated savings have remained consistent with the findings of this evaluation.
- **The impact of COVID-19:** The conclusions made by this evaluation regarding the financial savings made as a result of the treatment cycle arrangements should be further tested and consolidated with additional data to account for the impact of COVID-19. While the analysis accounted as much as possible for the impact of the pandemic, further analysis of health usage data will improve our understanding of the impact of COVID-19 on health care access and financial savings concerning the treatment cycle arrangements.
- **Financial remuneration for health care providers:** The administrative burden and cost increases reported by health care providers was an important finding of this evaluation. Addressing the administrative burden on DVA clients and their health care providers through initiatives such as financial remuneration for administrative tasks tied to the treatment cycle arrangements may ensure maximal benefits for all stakeholder groups.

SECTION 7: REFERENCES

Allied Health Professions Australia. (n.d.). *Access to allied health services.* Allied Health Professions Australia. https://ahpa.com.au/access-to-allied-health-services/

Anderson, R. (2020). *QUT's new 'Welcome to Country' and 'Acknowledgement of Country' videos*. Queensland University of Technology. https://qutvirtual4.qut.edu.au/group/qut/news?mode=VIEW&id=2602

Australian Bureau of Statistics. (2018). *Australian Statistical Geography Standard (ASGS): Volume 5—Remoteness Structure, July 2016* (Cat. No. 1270.0.55.005). Australian Bureau of Statistics. https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/1270.0.55.005Main+Features1July%202016?OpenDocument

Australian Commission on Safety and Quality in Health Care. (2013). *Consumers, the health system and health literacy: Taking action to improve safety and quality.* Australian Commission on Safety and Quality in Health Care. https://www.safetyandquality.gov.au/sites/default/files/migrated/Consumers-the-health-system-and-health-literacy-Taking-action-to-improve-safety-and-quality3.pdf

Australian Diabetes Educators Association. (2019). *Annual Report 2018–19.* Australian Diabetes Educators Association. https://www.adea.com.au/wp-content/uploads/2020/07/AR_Booklet_2018-19-FINAL.pdf

Australian Orthotic Prosthetic Association. (2012). *Australian Orthotist/Prosthetist Workforce Snapshot and Trend (2007–2012)*. Australian Orthotic Prosthetic Association. https://www.aopa.org.au/documents/item/212

Biggs, A. (2016). *Medicare: A quick guide.* Parliament of Australia. https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1617/Quick_Guides/Medicare

Burnard, P., Gill, P., Stewart, K., Treasure, E. & Chadwick, B. (2008). Analysing and presenting qualitative data. *British Dental Journal, 204*(8), 429–32. https://doi.org/10.1038/sj.bdj.2008.292

SECTION 7: REFERENCES

Chiropractic Board Australian Health Practitioner Regulation Agency. (2020). *Chiropractic Board of Australia registrant data*. *Reporting period: 01 April 2020 to 30 June 2020*. Australian Health Practitioner Regulation Agency Chiropractic Board Australia. https://www.chiropracticboard.gov.au/About-the-Board/Statistics.aspx

DeJonckheere, M. & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health*, *7*(2). https://doi.org/10.1136/fmch-2018-000057

Deloitte. (2016). The registration of social workers in Australia. *Australian Association of Social Workers Limited.* Deloitte Access Economics. https://www.aasw.asn.au/document/item/8806#:~:text=It%20was%20estimated%20that%20there,workers%20in%20Australia%20in%202016

Dempsey, L., Dowling, M., Larkin, P. & Murphy, K. (2016). Sensitive interviewing in qualitative research. *Research in Nursing & Health*, *39*(6), 480–490. https://doi.org/10.1002/nur.21743

Department of Health. (2021). *Total Medicare statistics, 2020–21 Jul–Mar YTD.* Australian Government Department of Health. https://www1.health.gov.au/internet/main/publishing.nsf/Content/32CC6EB4BCC0BB1CCA257BF0001FEB92/$File/Medicare%20%20Year%20to%20Date%20Dashboard.pdf

Department of Veterans' Affairs Data and Insights Branch. (2020). *Treatment population statistics* (Quarterly report—December 2020. Data extracted as at 1 January 2021). Australian Government Department of Veterans' Affairs. https://www.dva.gov.au/sites/default/files/files/publications/datastatistical/treatmentpop/tpop-dec2020.pdf

Department of Veterans' Affairs. (n.d.-a). *Acknowledgment of Country*. Australian Government Department of Veterans' Affairs. https://www.dva.gov.au/acknowledgment-of-country

Department of Veterans' Affairs. (n.d.-b). *Australian Defence Veterans' Covenant*. Australian Defence Veterans' Covenant. https://recognition.dva.gov.au/

Department of Veterans' Affairs. (n.d.-c). *Coordinated Veterans' Care program.* https://cvctoolbox.dva.gov.au/

Department of Veterans' Affairs. (n.d.-d). *Allied health treatment cycle TPI clients.* https://www.dva.gov.au/sites/default/files/files/providers/healthcycle/treatmencycle-for-tpi-clients.pdf

Department of Veterans' Affairs. (2019a). *Veteran numbers—backgrounder*. Australian Government Department of Veterans' Affairs. https://www.dva.gov.au/newsroom/media-centre/record/veteran-numbers-backgrounder

Department of Veterans' Affairs. (2019b). *DVA treatment cycle: At Risk Client Framework.* Department of Veterans' Affairs. https://www.dva.gov.au/sites/default/files/files/providers/healthcycle/atrisk-client-framework.pdf

Department of Veterans' Affairs. (2019c). *DVA treatment cycle: Guide to the treatment cycle for GPs and allied health providers*. Australian Government Department of Veterans' Affairs. https://www.dva.gov.au/sites/default/files/files/providers/healthcycle/guide-to-the-treatment-cycle.pdf

Department of Veterans' Affairs. (2020a). *The cards available to you and your family.* Australian Government Department of Veterans' Affairs. https://www.dva.gov.au/health-and-treatment/veteran-healthcare-cards/cards-available-you-and-your-family

Department of Veterans' Affairs. (2020b). *Veteran Mental Health and Wellbeing Strategy and National Action Plan 2020–2023*. https://www.dva.gov.au/documents-and-publications/veteran-mental-health-and-wellbeing-strategy-and-national-action-plan

Department of Veterans' Affairs. (2020c). *Allied health treatment cycle*. Australian Government Department of Veterans' Affairs. https://www.dva.gov.au/health-and-treatment/injury-or-health-treatments/health-services/allied-health-treatment-cycle

Department of Veterans' Affairs. (2020d). *Treatment population statistics, quarterly report 2020.* Australian Government Department of Veterans' Affairs. https://www.dva.gov.au/sites/default/files/files/publications/datastatistical/treatmentpop/tpop-dec2020.pdf

Dietitians Association of Australia. (n.d.). *Response to 'The Health Workforce' Issues Paper.* Dietitians Association of Australia. https://www.pc.gov.au/inquiries/completed/health-workforce/submissions/sub061/sub061.pdf

Farmer, C.M., Hosek, S.D. & Adamson, D.M. (2016). Balancing demand and supply for Veterans' health care. *RAND Health Quarterly, 6*(1), 12. https://www.rand.org/pubs/periodicals/health-quarterly/issues/v6/n1/12.html

Guest, G., Bunce. A. & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Hennink, M.M., Kaiser, B.N. & Marconi, V.C. (2017). Code saturation versus meaning saturation: How many interviews are enough? *Qualitative Health Research, 27* (4), 591–608. https://doi.org/10.1177/1049732316665344

Macri, J. (2016). Australia's health system: Some issues and challenges. *Journal of Health & Medical Economics, 2*, 2. https://health-medical-economics.imedpub.com/australias-health-system-some-issuesand-challenges.php?aid=8344

Medical Board Australian Health Practitioner Regulation Agency. (2020). *Medical Board of Australia Registrant Data*. *Reporting period: 01 April 2020 to 30 June 2020*. Australian Health Practitioner Regulation Agency Medical Board. Miller, W.L. & Crabtree, B.F. (1999). Clinical research: A multimethod typology and qualitative road map. In W.L. Miller & B.F. Crabtree (Eds.), *Doing qualitative research* (2nd ed., pp. 3–30). Sage Publications. https://www.medicalboard.gov.au/news/statistics.aspx

Moynihan, R., Sanders, S., Michaleff, Z.A., Scott, A.M., Clark, J., To, E.J., Jones, M., Kitchener, E., Fox, M., Johansson, M., Lang, E., Duggan, A., Scott, I. & Albarqouni, L. (2021). Impact of COVID-19 pandemic on utilisation of healthcare

services: A systematic review. *BMJ Open, 11,* e045343. https://doi.org/10.1136/bmjopen-2020-045343

National Disability Insurance Agency. (2020). *The NDIS market—31 December 2020.* National Disability Insurance Agency. https://data.ndis.gov.au/media/2758/download

National Disability Insurance Agency. (2021a). *Plan review reports.* NDIS. https://www.ndis.gov.au/providers/working-provider/allied-health-providers/plan-review-reports

National Disability Insurance Agency. (2021b). *Price Guide 2020–21, version 2.1.* National Disability Insurance Agency. https://www.ndis.gov.au/media/2968/download

North Western Melbourne Primary Health Network. (2014). *Health Literacy Checklist for Written Consumer Resources*. PHN North West Melbourne. https://nwmphn.org.au/wp-content/uploads/2020/12/PD003Health-Literacy-Checklist.pdf

Occupational Therapy Board Australian Health Practitioner Regulation Agency. (2020). *Occupational Therapy Board of Australia Registrant Data*. *Reporting period: 01 April 2020 to 30 June 2020.* Australian Health Practitioner Regulation Agency Occupational Therapy Board. https://www.occupationaltherapyboard.gov.au/about/statistics.aspx

Osteopathy Board Australian Health Practitioner Regulation Agency. (2020). *Osteopathy Board of Australia Registrant Data*. *Reporting period: 01 April 2020 to 30 June 2020*. Australian Health Practitioner Regulation Agency Osteopathy Board Australia. https://www.osteopathyboard.gov.au/about/statistics.aspx

Physiotherapy Board Australian Health Practitioner Regulation Agency. (2020). *Physiotherapy Board of Australia Registrant Data. Reporting period: 01 April 2020 to 30 June 2020.* Australian Health Practitioner Regulation Agency Physiotherapy Board Australia. https://www.physiotherapyboard.gov.au/about/statistics.aspx

Podiatry Board Australian Health Practitioner Regulation Agency. (2020). *Podiatry Board of Australia Registrant Data*. *Reporting period: 01 April 2020 to 30 June*

2020. Australian Health Practitioner Regulation Agency Podiatry Board Australia. https://www.physiotherapyboard.gov.au/about/statistics.aspx

Prime Minister of Australia. (2021). *Establishment of a Royal Commission into defence and veteran suicide.* https://www.pm.gov.au/media/establishment-royal-commission-defence-and-veteran-suicide

Productivity Commission. (2019). *A better way to support veterans: Productivity commission inquiry report* (Vol. 1, No. 93). https://www.pc.gov.au/inquiries/completed/veterans/report/veterans-volume1.pdf

Psychology Board Australian Health Practitioner Regulation Agency. (2020). *Psychology Board of Australia Registrant Data*. *Reporting period: 01 April 2020 to 30 June 2020*. Australian Health Practitioner Regulation Agency Psychology Board Australia. https://www.psychologyboard.gov.au/about/statistics.aspx

Qualtrics. (n.d.). *Determining sample size: How to make sure you get the correct sample size*. Experience Management. https://www.qualtrics.com/au/experience-management/research/determine-sample-size/

Roy Morgan. (2020). *Defence census 2019 (public report).* Australian Government Department of Defence. https://www1.defence.gov.au/sites/default/files/202101/Defence-Census-2019-Public-Report.pdf

Shoemaker, S.J., Wolf, M.S. & Brach, C. (2014). Development of the Patient Education Materials Assessment Tool (PEMAT): A new measure of understandability and actionability for print and audiovisual patient information. *Patient Education and Counseling, 96*(3), 395–403. https://doi.org/10.1016/j.pec.2014.05.027

The Royal Australian College of General Practitioners. (2018). *General Practice: Health of the Nation 2018*. The Royal Australian College of General Practitioners Ltd: Melbourne. https://www.racgp.org.au/download/Documents/Publications/Health-of-the-Nation-2018-Report.pdf

Tune, D. (2019). *Independent review into the TPI payment*. Commonwealth of Australia. https://www.dva.gov.au/sites/default/files/independent_review_into_the_tpi_payment_-_mr_david_tune_ao_psm_a.pdf