

This Program Logic forms part of the Plan and Evaluate phases of DVA’s Program Management Framework.

Problem Statement / Proposal	Program Objective	Inputs	Outputs	Activities	Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes
			Participants		6 months – 1 year	1 year – 2 years	2 years – 3 years
What is the underlying issue that we are trying to address?	What is the program aiming to achieve?	What resources do we have?	Who will be involved in the program?	What do we do to implement the program or activity?	The difference we make in the short term (generally seen as changes in skills, knowledge, attitudes, awareness or motivation)	The difference we make in the medium term (generally seen as changes in behaviour, practice or systems, or the application of skills and knowledge)	The difference we make in the long term, which resolves the issue identified in the problem statement

The health and wellbeing of veterans may be at risk from posttraumatic stress disorder (PTSD) and common co-morbidities.

To ensure Entitled Persons have access to PTSD treatment, provided through Trauma Recovery Programs (TRPs), that:

1. Is safe and clinically effective (reduction in PTSD symptoms and its common comorbidities over time and improvement in overall wellbeing);
2. Is evidence-based and aligns with best practice industry standards; and
3. Represents value for money (i.e. consideration of program length, cost and treatment outcomes [symptom reduction]). In the future, this may include consideration of whether veterans’ needs are met.

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Assumptions

External Factors

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Approved by:

S 47F

Director, Program Futures Section

4/12/2024

IMPLEMENTATION MANUAL

for Posttraumatic Stress Disorder Trauma Recovery
Programs

Version 2025

CONTENTS

HOW TO USE THIS DOCUMENT	3
INTRODUCTION	3
TRAUMA RECOVERY PROGRAM	3
TREATMENT POPULATION	3
CHANGES TO ACCREDITATION	3
PROGRAM EVALUATION	4
WHAT IS THE CLINICAL DATA USED FOR?	4
WHAT CLINICAL DATA IS COLLECTED?	4
ACCESSING THE DATA	6
SECTION 1: MINIMUM REQUIREMENTS FOR TRPs	7
1. Accreditation against NSQHS Standards.....	7
2. Provide evidence-based treatment for PTSD	8
3. Minimum program requirements.....	10
4. Reporting requirements.....	19
SECTION 2: BEST-PRACTICE GUIDANCE	26

HOW TO USE THIS DOCUMENT

Section 1 of this document outlines the Department of Veterans' Affairs (DVA) minimum program requirements for the delivery of Trauma Recovery Programs (TRPs) and provides information on how to meet these requirements, including a checklist against each requirement.

Section 2 of this document highlights best-practice guidance for improving the quality of TRP services and provides advice on how best-practice can be obtained.

If you have any questions about the TRP, please contact the DVA TRP Program Managers at Mental.Health.Programs@dva.gov.au.

INTRODUCTION

TRAUMA RECOVERY PROGRAM

DVA engages private and public hospitals throughout Australia to provide evidence-based TRPs for entitled persons experiencing Posttraumatic Stress Disorder (PTSD).

The TRPs are not intended to be stand-alone services, nor will they meet all the treatment needs of entitled persons. Rather, they aim to provide highly specialised, time-limited, evidence-based treatment for PTSD and its common comorbidities and form only part of a person's treatment needs.

TREATMENT POPULATION

DVA funds TRPs for entitled persons who hold a current Veteran Gold Card or White Card and have a clinical diagnosis of PTSD. An entitled person includes veterans, ex-serving Australian Defence Force (ADF) personnel and current serving ADF personnel if their treatment is paid for by DVA. For the purpose of this Manual, 'veteran' includes ex-serving ADF personnel.

CHANGES TO ACCREDITATION

Previously, hospitals were required to meet the:

- *National Safety and Quality Health Service (NSQHS) Standards;*
- *DVA's National Accreditation Standards for Trauma Recovery Programmes (2015); and*
- *National Standards for Mental Health Services (2010).*

Since December 2022, hospitals delivering TRPs are now only required to be accredited against the NSQHS Standards. Any requirements from DVA's *National Accreditation Standards for Trauma Recovery Programmes – PTSD (2015)* that are not adequately covered by the NSQHS Standards have been included as a DVA minimum requirement, outlined in Section 1 of this document.

Hospitals can still follow the *National Standards for Mental Health Services (2010)*, however, accreditation to the standards is not mandatory for providers of mental health services as determined by the state and territory Health Departments.

PROGRAM EVALUATION

WHAT IS THE CLINICAL DATA USED FOR?

The clinical effectiveness of the TRPs is evaluated using clinical outcome data from consenting participants. This data is collected by an independent research organisation – Phoenix Australia - Centre for Posttraumatic Mental Health. TRP clinical data collection has two main aims:

1. to describe the population characteristics of participants entering the programs; and
2. to measure change across time of an individual's clinical, social and functional profile that the program is targeting.

All participant data is de-identified and aggregated by Phoenix Australia before it is provided to DVA.

Data is collected through:

- a clinician-administered assessment interview before the group program starts;
- a brief clinician-completed questionnaire at the end of group treatment; and
- a veteran self-report questionnaire at four time points (see Section 3.7 for further details):
 - o before the group treatment starts
 - o after the group treatment ends
 - o 3 months after discharge
 - o 9 months after discharge

At a national level, this can assist DVA to better understand:

1. the types of participants utilising these programs;
2. how effective TRPs are in reducing the severity of PTSD and its comorbid conditions;
3. emerging issues or barriers to effectiveness; and
4. potential program improvements.

At a hospital level, TRP providers can review data for their program in the annual *Hospital Outcome Reports* provided by Phoenix Australia, for quality assurance and continuous improvement purposes.

At a clinician level, participant intake data can be used to develop an individual's case formulation and treatment plan, as well as help develop an understanding of the needs of each TRP cohort as a whole. Discharge and follow-up data can be used to help understand the participant's progress, and remaining clinical or referral needs after they have been discharged from the group component of the program.

The DVA/Defence Human Research Ethics Committee has approved the monitoring of TRP outcomes, including collecting outcome data from TRP participants (i.e. veterans and current serving ADF personnel) (Protocol 828-16 & E096/002).

WHAT CLINICAL DATA IS COLLECTED?

The outcomes being measured through the data analysis are referred to as key indicators. These include:

- a) Clinical indicators; and
- b) Social and functional indicators.

The measures are selected based on considerations including their consistency with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA 2013), comparability with other datasets for benchmarking purposes and psychometric strength.

Demographic and other descriptive information, such as gender, current employment status, military service history and health service usage are also collected.

Clinical Indicators	Measure
PTSD	Posttraumatic Stress Checklist (PCL-5)
Anxiety	Generalised Anxiety Disorder Assessment (GAD-7)
Depression	Patient Health Questionnaire – Depression (PHQ-9)
General distress	Kessler Psychological Distress Scale (K10)
Alcohol use	Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
Anger	Dimensions of Anger Reactions-5 (DAR-5)
Aggression	Two-item measure of violence used in the Transition and Wellbeing Research Program
	Jellinek Inventory for Assessing Partner Violence (J-IPV)
Sleep	Insomnia Severity Index (ISI)

Social and Functional Indicators	Measure
Quality of life	Assessment of Quality of Life instrument – 4 Dimensions version (AQoL-4D)
Potentially traumatic events exposure	Life Events Checklist (LEC-5)
Wellbeing	Personal Wellbeing Index (PWI) preceded by a global life satisfaction question routinely used in Australia and other countries
Relationship functioning	Abbreviated Dyadic Adjustment Scale (DAS-4) – will be completed by veterans who have a current partner
Family functioning	Family Assessment Device (FAD-12)
Disturbances in Self-Organisation (DSO) symptoms of Complex PTSD	International Trauma Questionnaire, disturbances in self-organisation subscale
Combat experiences	Deployment Risk and Resilience Inventory (DDRI-2): Section D. Combat Experiences
Guilt and Moral injury	Moral Injury Outcome Scale (MIOS)
Other addictive behaviours	Gambling - Problem Gambling Severity Index (PGSI) short form
	Licit and illicit drug use (Smith et al., 2010)
	Tobacco use - single item asking if ever or currently use tobacco

ACCESSING THE DATA

To access your own hospital's data, TRP providers can submit a request to Phoenix Australia at phoenix-data@unimelb.edu.au. Note that Phoenix Australia only holds de-identified participant information.

Data cannot be used by TRP providers for research or publication purposes unless ethics approval has been sought from and approved by DVA. TRP providers requiring access to the database for purposes other than quality assurance and clinical purposes should contact DVA's TRP Program Managers at Mental.Health.Programs@dva.gov.au.

SECTION 1: MINIMUM REQUIREMENTS FOR TRPs

This section outlines DVA's minimum requirements for the delivery of TRPs. It provides explanatory support, information and a checklist to help hospitals ensure the requirements are met.

DVA will be requesting information from hospitals through the annual **Program Report** to ensure the programs continue to meet the minimum requirements for TRPs. The report will also support DVA's ongoing work with hospitals to ensure the TRPs continue to benefit participants and that the hospital staff who are developing and facilitating the TRPs are supported. The report template (pages 18-21) is sent to hospitals in the last quarter of each year for completion.

1. Accreditation against NSQHS Standards

Hospitals providing Trauma Recovery Programs must be accredited against the current National Safety and Quality Health Service Standards (NSQHS Standards, second edition), or working towards achieving accreditation.

IMPLEMENTATION SUPPORT

The [NSQHS Standards](#) outline the level of care that is required to be provided by health services and the systems that are needed to deliver care.

For TRPs, the hospital's compliance with the NSQHS Standards will continue to be monitored as part of its usual accreditation processes.

The NSQHS Standards Guide for hospitals (www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-guide-hospitals) has been developed to assist health service organisations to align their patient safety and quality improvement programs using the framework of the NSQHS Standards.

If you have any questions about the NSQHS standards, you can contact the [Australian Commission on Safety and Quality in Health Care](#) at mail@safetyandquality.gov.au or your accreditation agency.

2. Provide evidence-based treatment for PTSD

Trauma Recovery Programs to be delivered to Entitled Persons must provide evidence-based treatment for PTSD and its common comorbidities, consistent with the current 'Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD' (Phoenix Australia, 2020)¹ (the Guidelines), as amended from time to time.

Please complete the implementation checklist below to assess if the group program is consistent with the Guidelines.

Implementation Checklist	(Y/N)
Review the Guidelines that are available from www.phoenixaustralia.org/australian-guidelines-for-ptsd/ to ensure access to the current version	
Individual treatment is consistent with the current Guidelines, and includes:	
> engagement and preparatory work, as required > evidence-based PTSD treatment > relapse prevention, as required	
All, or the majority of, treatment offered in the group program is consistent with the current Guidelines and is evidence-based	
The TRP service has clear policies and procedures around what evidence-based treatment and adjunct therapies can be provided to participants	
The TRP service keeps a record of the treatments their clinicians provide to participants in their individual therapy sessions	
The TRP service has clinician and participant manuals to guide the treatment program. These manuals should be reviewed regularly to reflect best practice for PTSD and associated symptoms ²	
The TRP group sessions run for a minimum of 20 days (or equivalent). This ensures there is sufficient time to cover the program content. Please refer to 'Section 2, During Treatment' for best-practice guidance on program content	
The TRP service offers the requisite number of individual therapy sessions in the program (i.e. 8 to 12 individual sessions) with at least one session offered weekly ¹	
Ideally, a TRP cohort is a minimum of 5 and maximum of 9 total participants ³ (which includes veterans, current ADF personnel and first responders)	
• The suggested minimum and maximum cohort size is intended as a guide to the number of participants that are required for viable	

¹ <https://www.phoenixaustralia.org/australian-guidelines-for-ptsd/>

² Cosio (2015). Replication of a cognitive behavioral therapy for chronic pain group protocol by therapists in training. *Postgraduate Medicine*, 127(2), 242–250.

³ Burlingame, G. M., McClendon, D. T., & Yang, C. (2018). Cohesion in group therapy: A meta-analysis. *Psychotherapy*, 55(4), 384.

group treatment, allowing for a potential late withdrawal after the cohort has been established

Adjunct therapies are not offered as a first-line treatment and should only be a minor component of the program⁴ ⁵ (no more than 30% of program content)

⁴ Phelps, A. J., Lethbridge, R., Brennan, S., Bryant, R. A., Burns, P., Cooper, J. A., Forbes, D., Gardiner, J., Gee, G., Jones, K., Kenardy, J., Kulkarni, J., McDermott, B., McFarlane, A. C., Newman, L., Varker, T., Worth, C., & Silove, D. (2022). Australian guidelines for the prevention and treatment of posttraumatic stress disorder: Updates in the third edition. *Australian & New Zealand Journal of Psychiatry*, 56(3), 230–247.

<https://doi.org/10.1177/00048674211041917>

⁵ Haagen, J. F. G., Smid, G. E., Knipscheer, J. W., & Kleber, R. J. (2015). The efficacy of recommended treatments for veterans with PTSD: A metaregression analysis. *Clinical Psychology Review*, 40, 184–194.

<https://doi.org/10.1016/j.cpr.2015.06.008>

3. Minimum program requirements

Trauma Recovery Programs must meet DVA's minimum program requirements as outlined below.

3.1. Entitled persons must have a clinical diagnosis of PTSD in order to enter the program.

Implementation Checklist	(Y/N)
Before obtaining consent and conducting the clinical assessments, TRP services consider the inclusion and exclusion criteria that may impact on whether an entitled person is accepted into the program	
The following inclusion criterion has been considered:	
> a diagnosis of PTSD according to DSM-5 criteria A–H. Where an assessment of an individual with a history of PTSD falls short of the full diagnostic criteria and the clinician believes they will benefit from the program (based on their PTSD-related symptoms, level of distress and/or impairment), they can be considered for inclusion	
The following exclusion criteria have been considered:	
> acute alcohol or other substance intoxication > strong tendencies to dissociate without adequate strategies for management > acute suicidality or violence > current uncontrolled psychosis > lack of ongoing, repeated symptoms > inability to tolerate or manage high levels of arousal > history of difficulties engaging in group treatment > major current life crises	

3.2. Provision of assessment and treatment of Entitled Persons in Trauma Recovery Programs is to be delivered by a clinical workforce that has completed clinical training in evidence-based treatments (as specified by the current Guidelines) and meets DVA requirements to provide mental health services.

Implementation Checklist	(Y/N)
All clinical staff are trained to deliver evidence-based treatment consistent with the current Guidelines ⁶	
Clinical staff are supervised by senior clinicians with training in evidence-based, trauma-focussed mental health treatments consistent with the current Guidelines ⁷	

⁶ <https://www.phoenixaustralia.org/australian-guidelines-for-ptsd/>

Clinical staff can demonstrate an understanding of the unique nature of military service and the impact it can have on the health and wellbeing of participants⁷

Clinical staff work within a trauma-informed care framework⁸

3.3. Trauma Recovery Programs must have appropriate staffing to adequately deliver the various components of group programs including individual trauma-focussed therapy, facilitation and co-facilitation of therapy groups, program coordination, clinical oversight, and administrative tasks.

Implementation Checklist	(Y/N)
The TRP service ensures that:	
> there is a nominated Psychiatrist or Clinical Psychologist as a Clinical Director to oversee the program > there is a multidisciplinary team supporting the program > there are administrative staff to support the program > there is a nominated program coordinator > there is a minimum of one clinician facilitating the program for every six participants at any given time, with an additional facilitator to be in attendance for groups over six participants	
Individual trauma-focussed therapy is provided by a Psychiatrist, Clinical Psychologist, Psychologist, Social Worker (mental health) or Occupational Therapist (mental health) that:	
> has the relevant experience including competency in trauma-focussed therapy; > has the relevant qualifications, accreditation and national registration with relevant professional organisations; and > has competency in the evidence-based treatment/therapy type provided	
Group facilitators must be either a Psychiatrist, Clinical Psychologist, Psychologist, Social Worker (mental health), Occupational Therapist (mental health) or Mental Health Nurse that:	
> has the relevant experience including competency in trauma-focussed therapy; > has the relevant qualifications, accreditation and national registration with relevant professional organisations;	

⁷ Treichler et al 2023 Military culture and collaborative decision-making in mental healthcare: cultural, communication and policy considerations. *BJPsych Open*. 2023 Aug 14;9(5):e154. doi: 10.1192/bjo.2023.516. PMID: 37578050; PMCID: PMC10486237.

⁸ Herzog, J. R., Whitworth, J. D., & Scott, D. L. (2019). Trauma informed care with military populations. *Journal of Human Behavior in the Social Environment*, 30(3), 265–278. <https://doi.org/10.1080/10911359.2019.1679693>

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- > has experience in facilitating group programs⁹; and
 - > demonstrates competency in delivering the content/modules comprising the group sessions
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3.4. As part of the discharge process, a comprehensive discharge plan is provided to the Entitled Person's external treatment providers/referrers and includes:

- clinical assessment and treatment outcomes;
- risk assessment;
- ongoing treatment requirements; and
- referral to support services.

Implementation Checklist	(Y/N)
Participants are assisted with recovery plans and actively linked with ongoing clinical support, including accessing Open Arms Veterans and Families Counselling (Open Arms) if required at discharge	
The discharge plan includes clinical assessment and treatment outcomes, risk assessment, ongoing treatment requirements, and referral to support services	
The TRP service provides direct clinical contact with the referring agency on the participant's treatment outcomes and the discharge plan	

3.5. Trauma Recovery Programs must implement processes and systems to manage the Entitled Person's care journey, from referral into the service to post-discharge, including the opportunity to attend a group relapse prevention session 1 to 3 months post-discharge.

Implementation Checklist	(Y/N)
The TRP service responds to and prioritises all referrals according to risk, urgency, distress, dysfunction and disability	
The participant must provide informed consent to participate in the program, noting that they are able to withdraw their consent at any time	
The TRP service conducts regular clinical case reviews to monitor treatment progress, and to review treatment outcomes and modify treatment plans	
Adverse events are reported to the appropriate authorities within the prescribed timeline. An adverse event includes: > death of a participant while undertaking the TRP; > patient assault during TRP delivery requiring external involvement e.g. police, external emergency services; > an actual or near miss incident/complaint related to the TRP delivery with serious identified system issues; and/or	

⁹ Finch et al 2020 A systematic review of the clinician related barriers and facilitators to the use of evidence-informed interventions for post traumatic stress, Journal of Affective Disorders, Volume 263, 2020, Pages 175-186, ISSN 0165-0327, <https://doi.org/10.1016/j.jad.2019.11.143>.

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- > incidents related to the TRP which may result in media interest, internal or external investigation, mediation, penalties or compensation.

Further information is available in the Incident Management Guide at www.safetyandquality.gov.au/sites/default/files/2021-12/incident_management_guide_november_2021.pdf

The TRP service offers a group relapse prevention session 1 to 3 months post-discharge that includes an opportunity for consolidation of key information from the program, and discussion of relapse prevention approaches

3.6. Trauma Recovery Programs must offer appropriate information/resources and support to families and carers of Entitled Persons as part of the program (e.g. referral to external psycho-educational services; carer and or veteran co-joint groups; linkages to other agencies as necessary e.g. Housing, Open Arms).

Implementation Checklist	(Y/N)
Program information/resources explicitly identify how the program includes families and/or carers, and what the purposes and benefits of inclusion are	
The TRP service actively invites families and/or carers to engage in the TRP	
The TRP service helps families and/or carers to access external psycho-educational services that can help optimise their wellbeing	

3.7. Trauma Recovery Programs must implement systems to ensure compliance with DVA's TRP data collection protocols at assessment and intake, discharge, and 3 and 9 months post-discharge follow-up (as amended from time to time).

Implementation Checklist	(Y/N)
The TRP service has an effective administrative system to manage data collection at specified time points	
An administrator or liaison person is a contact point for Phoenix Australia, with responsibility for compliance with the program outcome monitoring requirements	
Refer to 'ADMINISTRATIVE SYSTEM' below	
Data is collected through:	
> a clinician-administered assessment interview before the group program starts; > a brief clinician-completed questionnaire at end of group treatment; and > a veteran self-report questionnaire at four time points: ○ before the group treatment starts ○ after the group treatment ends ○ 3 months after discharge ○ 9 months after discharge	
Refer to 'CLINICAL SYSTEM' below	

Consent forms are returned to Phoenix Australia for all participants for whom data is collected

Refer to 'OBTAIN INFORMED CONSENT TO PARTICIPATE IN THE CLINICAL DATA COLLECTION' below

Protocols for data collection at the four time points are met

Refer to the following sections below:

'DATA COLLECTION AT ASSESSMENT AND INTAKE'

'DATA COLLECTION AT DISCHARGE'

'DATA COLLECTION 3 MONTHS POST-DISCHARGE'

'DATA COLLECTION 9 MONTHS POST-DISCHARGE'

The TRP service aims to meet the following optimal return rates for data collection:

- > Clinical assessment questionnaire (CA-PTSD) – 100%
 - > Veteran intake questionnaire (VI-PTSD) – 90%
 - > Clinical discharge questionnaire (CD-PTSD) – 100%
 - > Veteran discharge questionnaire (VD-PTSD) – 90%
 - > Veteran 3-month follow-up questionnaire (V3-PTSD) – 70%
 - > Veteran 9-month follow-up questionnaire (V9 – PTSD) – 40%
-

Protocols for the return of clinical questionnaires are met

Refer to 'CLINICAL QUESTIONNAIRE RETURN PROTOCOLS' below

ADMINISTRATIVE SYSTEM

1) IDENTIFY/APPOINT AN ADMINISTRATOR (or liaison person) as a point of contact for Phoenix Australia, who will be responsible for:

- Setting and retaining login details for their TRP website account (www.phoenixtrp.org.au) provided by Phoenix Australia and requesting accounts for any other staff members that require one.
- Generating a unique consecutive cohort number and Phoenix Australia ID number for each person participating in the cohort (please contact Phoenix Australia if you need to confirm the number you are up to).
- Tracking data, including:
 - Keeping a record of exactly which completed consents and questionnaires have been sent to Phoenix Australia.
 - Following up on outstanding questionnaires and sending them to Phoenix Australia, and/or accounting for outstanding questionnaires (e.g. because a veteran withdrew from the program) so this can be reported to Phoenix Australia.
- Completing the clinical data collection return form each time data is returned to Phoenix Australia.
- Informing Phoenix Australia of changes to the administrator's or liaison person's contact details, and other relevant program changes by emailing phoenix-data@unimelb.edu.au.

Important: The unique ID number for each person participating in the cohort needs to be entered onto all hard copy clinical data collection completed questionnaires. This allows Phoenix Australia to track each person's progress over time without them being identified.

2) **ESTABLISH THE TRAUMA RECOVERY PROGRAM GROUP**

- a) **Assign the cohort number:** the administrator is to assign a cohort number to each TRP cohort. Since October 2014, each hospital's cohorts have been numbered consecutively from 001.
- b) **Allocate a unique participant ID number:** the administrator is to assign a unique participant ID number for all persons eligible to participate in the TRP clinical data collection. Since February 2024, participant ID numbers have been allocated consecutively, irrespective of whether the participant has completed a TRP previously. Each hospital has been provided with a participant ID to start their consecutive numbering.
- c) **Inform Phoenix Australia of new cohort details:** Email Phoenix Australia at phoenix-data@unimelb.edu.au before the start of the group program, and include the cohort number, proposed dates that the group will meet and number of veterans, current serving ADF personnel and other participants in the new cohort. This helps with data management.

CLINICAL SYSTEM

TRP services and participants are to complete a series of participant and/or clinician questionnaires as part of the treatment protocols. Questionnaires can be printed and completed in hard copy.

All hard copy questionnaires have an 'office use only' box on the front page that must be completed (see Figure 1). This enables Phoenix Australia to link a participant's responses across time in a way that does not identify them. Each TRP service is responsible for ensuring that participants and clinicians complete the relevant questionnaires at intake, at discharge, and at 3- and 9-months follow-up.

The questionnaires are available from the TRP website at www.phoenixtrp.org.au

- Clinical assessment questionnaire (CA-PTSD)
- Clinician-administered PTSD supplement (CAPS-5)
- Veteran intake questionnaire (VI-PTSD)
- Clinical discharge questionnaire (CD-PTSD)
- Veteran discharge questionnaire (VD-PTSD)
- Veteran 3-month follow-up questionnaire (V3-PTSD)
- Veteran 9-month follow-up questionnaire (V9-PTSD)

Office use only			
State no.	Provider no.	Cohort no.	Phoenix Australia ID

Figure 1 'Office use only' box on each questionnaire

OBTAIN INFORMED CONSENT TO PARTICIPATE IN THE CLINICAL DATA COLLECTION

Before collecting data from the clinical assessments or related questionnaires, the clinician must obtain informed consent from the participant. This is a requirement of the DVA/Defence Human Research Ethics Committee approval (Protocol 828-16 & E096/002). **Please note, individuals who do not consent to participate in the clinical data collection are still able to participate in the TRP.**

When obtaining consent, be sure to emphasise the following to the participant:

- The information collected will be used to improve treatment for, and understanding of, mental health conditions in veterans, locally and nationally.
- Participation in the clinical data collection involves:
 - Completing questionnaires at the beginning of the program, at discharge and at the scheduled relapse prevention program at 3 months and 9 months post-discharge. These questionnaires include questions about quality of life, wellbeing, and health service use. Each will take approximately 20 minutes to complete.
 - Undergoing a clinical assessment including the clinician-administered PTSD scale (CAPS), alcohol use disorder identification test (AUDIT) and other questions about demographics and psychiatric and medical diagnoses with a clinician before starting the specialised PTSD treatment. This interview may take up to 90 minutes. The clinician will also provide information on the participant's progress upon discharge from the program.
- The information will be kept in the strictest confidence by Phoenix Australia. Identifiable information will not be provided to DVA, and the participant's results will not be used when determining pensions or any other compensation entitlement. Participants can withdraw their consent to provide clinical data at any time.
- Datasets maintained by Phoenix Australia will be kept in such a way that no individual can be identified.

Once participants have read and understood the consent form, and agreed to participate in the clinical data collection:

- Ask the participant to sign the consent form. The signed consent forms are returned to Phoenix Australia.
- Provide the participant with a copy of the consent form to keep.

DATA COLLECTION AT ASSESSMENT AND INTAKE

Before administering the CA-PTSD, clinicians should view the CAPS-5 demonstration videos and read the accompanying document, *Clinician-administered PTSD scale (CAPS-5) information booklet*. The videos and booklet are available online through the website (www.phoenixtrp.org.au).

The CA-PTSD must take place **within the 3 months** before the TRP starts^{10 11}. If there is a delay of more than 3 months before the TRP starts, the CA-PTSD has to be completed again.

¹⁰ The CAPS-5 assessment is considered current for one month. However, for practical reasons when used within the TRP CA-PTSD assessment, the acceptable time period has been extended to "within 3-months" noting that the reliability of the assessment decreases as time passes.

¹¹ Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M. (2013). *The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)*. [Assessment] Available from www.ptsd.va.gov.

The CA-PTSD relates to diagnosis of PTSD and symptom severity and does not replace the need for a full clinical or intake assessment. A full clinical assessment will help identify any comorbid issues and assess the veteran's suitability for the program.

The clinician administering the CA-PTSD will need:

- The CA-PTSD, which needs to be sent to Phoenix Australia once completed; and
- The CAPS-5, which is a supplement to the CA-PTSD and can be kept in the medical files for clinical purposes – **do not return it to Phoenix Australia.**

The clinician needs to:

- Administer the CA-PTSD (demographics, psychiatric and medical diagnoses and AUDIT)
- Administer the CAPS-5 CA-PTSD supplement
 - Score the CAPS-5 using the CAPS scoring sheet at the end of the CA-PTSD supplement, and transfer the summary scores and diagnoses to the CA-PTSD
- Return the hard copy CA-PTSD to Phoenix Australia once it has been completed with the CAPS scores
- Administer the VI-PTSD at the start of the TRP (e.g. at the first group session)

DATA COLLECTION AT DISCHARGE

The clinician must complete the CD-PTSD within 1 week of the end of the TRP. Do not complete this in the presence of the participant.

The participant must complete the VD-PTSD at the end of the TRP (e.g. at the end of the final group session).

Individual therapy may continue past the completion of the group program, and these changes in mental health and wellbeing will be picked up in the 3-month post-discharge assessment.

DATA COLLECTION 3 MONTHS POST-DISCHARGE

The 3-month follow-up questionnaire is to be administered 3 months post-discharge. This can be administered when the cohort is recalled for a group relapse prevention session if it occurs approximately 3 months post-discharge.

The TRP service may choose to (1) mail the questionnaire to the participants, so they can complete it and then return it on the follow-up day; or (2) administer the questionnaires during the follow-up day.

If a participant does not attend, they need to be sent the 3-month follow-up questionnaire (if they have not already), and any questionnaires that are not returned need to be followed-up.

DATA COLLECTION 9 MONTHS POST-DISCHARGE

A group session at 9 months post-discharge is not required.

Each TRP service is responsible for sending out the 9-month follow-up questionnaire to all participants in the cohort, and following up any questionnaires that are not completed and returned.

CLINICAL QUESTIONNAIRE RETURN PROTOCOLS

The clinical data collection returns form must be completed when sending hard copy consent forms and questionnaires at all required time points to Phoenix Australia. The TRP service is to use a separate form for each cohort.

The information required for the form is:

- Name of the service
- Date cohort started
- Number of veterans, serving ADF personnel and other participants, and the total number in the group
- Codes for state, provider and cohort number
- Each participant's Phoenix Australia ID number, regardless of whether their questionnaire is included in the package
- Boxes ticked to indicate which questionnaires and/or consent forms are included in the package being sent to Phoenix Australia
- Reason for any missing assessments (e.g. did not consent to participate in the clinical data collection, treatment dropout due to ill health)

The postal address to return hard copy clinical data collection forms to Phoenix Australia is:

Phoenix Australia
TRP Clinical Data Collection
PO Box 562
Mitcham Shopping Centre SA 5062

This address is also listed on the clinical data collection return form.

Ensure that:

- **Participants' consent forms are not posted in the same envelope as their questionnaires**

4. Reporting requirements

Hospitals delivering Trauma Recovery Programs must submit an annual Program Report to DVA and comply with Phoenix Australia's annual data audit (This is separate to the 'Private Hospital Quality Report' requesting information on each hospital's contract and accreditation status).

Examples for implementation	Checklist (Y/N)
The TRP is reviewed regularly and a Program Report is submitted to DVA annually. The 'Program Report' template is available on the next page	
Program improvements/adjustments to better meet the needs of participants, should consider participant feedback and/or data analysis reports provided by Phoenix Australia	
The TRP service complies with Phoenix Australia's annual data audit	
Refer to 'ANNUAL DATA AUDIT' below	

ANNUAL DATA AUDIT

The TRP service is required to comply with Phoenix Australia's audit by completing and sending the TRP-PTSD clinical data collection data audit form to phoenix-data@unimelb.edu.au when requested. Details include:

- Cohort number
- Total number of group participants
- Number of veterans and serving ADF personnel
- Number of questionnaires sent
- Reason for missing data

Where there are any discrepancies in the data, Phoenix Australia will notify and work with the administrator so that the issues can be resolved.

Trauma Recovery Program (TRP) – Program Report	
Name of Hospital:	
Reporting Period: 20xx	
Program information (Information can be included as an attachment)	
1. Title of TRP	
2. Target population	
3. Target cohort numbers [Noting research evidence that optimal group size is 5-9, please provide clinical justification for larger group sizes and specify whether additional facilitator/s will be present]	_____ OR _____ to _____ (range)
4. Number of group programs per year	
5. Specify the aims and expected outcomes of the TRP	
6. Program format	
Mode of treatment	☐ Face-to-face ☐ Online ☐ Combination/Hybrid
Total number of days	_____ days
Total number of weeks	_____ weeks
Number of days per week	_____ days per week
Number of treatment hours per treatment day	_____ treatment hours per treatment day
Total number of treatment hours	= _____ total treatment hours ¹²
The above totals: ☐ Include individual treatment OR ☐ Exclude individual treatment	

¹² DVA must be advised of any proposed change to total number of contact hours

7. Program design: Individual component	<u>Individual treatment is offered to participants:</u> ☐ More than once per week ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Once during the program ☐ Other (please specify): _____ <u>The following treatments are used in the individual component:</u> ☐ Trauma-focused cognitive behavioural therapy (with prolonged exposure) ☐ Trauma-focused cognitive behavioural therapy (without prolonged exposure) ☐ Cognitive processing therapy ☐ Eye movement desensitisation and reprocessing ☐ Cognitive behavioural therapy ☐ Interpersonal therapy ☐ Other (please specify): _____
8. Program design: Group component	<u>The group component includes:</u> ☐ Cognitive behavioural therapy ☐ Interpersonal therapy ☐ Psychoeducation ☐ Symptom management ☐ Skills acquisition ☐ Skills practice ☐ Relapse prevention ☐ Family / partner day(s)

	☐ Group excursions ☐ Linkages to other services ☐ Other (please specify): _____ <u>The group sessions cover:</u> ☐ PTSD ☐ Anxiety ☐ Depression ☐ Anger ☐ Addictions / substance use ☐ Sleep ☐ Relationships / interpersonal skills ☐ Vocational rehabilitation ☐ Physical health and lifestyle ☐ Moral injury ☐ Other (please specify): _____
9. Timetable	<i>Please provide a timetable, detailing the topic/focus of each session and the facilitator/s for each session</i>
10. Clinical Processes Please include information on: • Intake and assessment procedures • The discharge process including provision of a discharge plan: 1. clinical assessment and treatment outcomes; 2. risk assessment; 3. ongoing treatment requirements; and 4. referral to support services	

- Whether processes and systems are in place to ensure Entitled Persons have the opportunity to attend a group relapse prevention session 1 to 3 months post-discharge

Workforce

11. Clinical workforce and staffing capacity

Please provide a list of all staff involved in program delivery (including Clinical Director, lead facilitator, co-facilitator/s, individual trauma-focussed therapist/s) in the table below

Name	Clinical Role (e.g. Clinical Psychologist)	Mental Health and other Qualifications [including qualifications in evidence-based treatment] (e.g. Master of Applied Psychology, Dip Ed TF-CBT)	Role in Program
			Clinical Director
			Lead facilitator
			Co-facilitator
			Individual trauma-focussed therapist

- All clinical staff are trained to deliver evidence-based treatment consistent with the *Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD (Phoenix Australia, 2020)*, www.phoenixaustralia.org/australian-guidelines-for-ptsd/
- The Clinical Director of the TRP must be a Psychiatrist or Clinical Psychologist
- Individual trauma-focussed therapy is provided by a Psychiatrist, Clinical Psychologist, Psychologist, Social Worker (mental health) or Occupational Therapist (mental health) that:
 - has the relevant experience including competency in trauma-focussed therapy;
 - has the relevant qualifications, accreditation and national registration with relevant professional organisations; and
 - has competency in the evidence-based treatment/therapy type provided
- Group facilitators must be either a Psychiatrist, Clinical Psychologist, Psychologist, Social Worker (mental health), Occupational Therapist (mental health) or Mental Health Nurse that:
 - has the relevant experience including competency in trauma-focussed therapy;
 - has the relevant qualifications, accreditation and national registration with relevant professional organisations;
 - has experience in facilitating group programs; and
 - demonstrates competency in delivering the content/modules comprising the group sessions

12. Staffing changes Have there been any staffing changes this reporting period? If so, please provide processes for handover of TRP knowledge following staff turnover	☐ Yes – Please advise of changes ☐ No
Quality Assurance	
13. Program improvements During this reporting period, have any improvements/adjustments been made to the TRP to better meet the needs of participants? <i>These can be based on participant feedback and/or the annual data analysis reports provided by Phoenix Australia.</i>	☐ Yes – Please list ☐ No
Complaints and Feedback	
14. Have you received any feedback from participants in relation to the TRP this reporting period?	☐ Yes – Please list ☐ No
15. Have you received any complaints from participants in relation to the TRP this reporting period?	☐ Yes – Please list ☐ No
16. Please include any feedback or issues that you would like to raise with DVA	
Contact Details	
<u>Contact person 1</u> Name: Title: Phone number: Email: <u>Contact person 2</u> Name: Title: Phone number: Email:	

Signature of authorised representative

Name and position:

Signature:

Date:/...../.....

SECTION 2: BEST-PRACTICE GUIDANCE

This section highlights best-practice guidance for improving the quality of services to participants and provides advice on how best-practice can be obtained. TRP services are not contractually required to implement or report on compliance with these guidelines to DVA (noting this is independent of any requirements associated with TRP service accreditation).

PROGRAM GOVERNANCE

- > A well-documented and consistently implemented risk assessment and risk management protocol is available
- > The TRP service has clinical and administrative processes that are clearly spelt out for staff and, where appropriate, for participants
- > Regular audit of clinical records by the TRP service indicates the use of evidence-based treatments
- > Regular audit of treatment plans by the TRP service indicates that veterans are provided with information to make decisions based on the best available evidence
- > The TRP service has documented records of referrals, and ongoing communication with external services
- > The TRP service conducts thorough handover processes regarding all aspects of TRP delivery when there are staff changes
- > The TRP service engages in activities that support links with key external services (i.e. attendance at external provider meetings, agency orientations, shared professional development activities)
- > The TRP service engages in the DVA/Phoenix Australia Community of Practice

INFORMATION PROVISION

- > Participants, their families and/or carers can access information that clearly describes the program and addresses frequently asked questions
- > Program information that clearly articulates any options that participants have for accessing flexible treatment times is provided, including any after-hours or weekend access
- > Information is provided to participants about self-care resources, programs or interventions at appropriate stages of the program
- > The TRP service ensures the program information/manual is up to date, accurate and accessible (hard copy and online)
- > Online information can be accessed from a variety of browsers and across different operating system platforms and meets relevant online accessibility requirements (i.e. they are compliant with current Web Content Accessibility Guidelines [WCAG])

PROGRAM ACCESSIBILITY

- > The entry process to the program is clearly documented, including the inclusion and exclusion criteria, and is available to referrers and participants
- > The TRP service actively engages with potential referrers to the program and with organisations that cater to DVA's target TRP population, which is entitled persons with diagnosed PTSD
- > The TRP service has an understanding of the wait time for access to the program (average and maximum), and communicates this to potential participants
- > Systems are in place to meet expected and unexpected spikes in demand, and ensure timely access to the program
- > Systems are in place to ensure that individuals on wait lists are monitored and provided with suitable advice about their enrolment in the TRP (i.e. contact records, provision of preparatory individual therapy and referral to an alternative TRP)
- > Individuals are informed about alternative treatment options, and are assisted in making decisions about program suitability
- > If alternative treatments will be sought, a system is in place to effect referrals to other TRP services, hospital facilities, or community-based providers

PROGRAM PROCEDURES

- > Systems are in place to ensure that any preparatory individual therapy is consistent with the individual's presenting needs and consistent with the TRP goals and content
- > Consideration is given to flexible program delivery e.g. providing programs or program components on weekends, or condensing them into shorter blocks to account for participants with work or care commitments
- > If the TRP service does not provide access to 24-hour acute care, information on how to access 24-hour, non-TRP acute care services is provided to the participant and their carer(s)

SERVICE IMPROVEMENTS

- > Quality improvement activities and program evaluation activities are in place. This includes, but is not restricted to, participation in the TRP Clinical Data Collection processes
- > A system is in place for documenting the effectiveness of the program, including clinical outcomes
- > The TRP service uses clinical outcome data, to improve performance in delivering care and services
- > Regular reports are provided to management/clinical workforce on the qualitative and quantitative outcomes of the program, including recommendations for quality improvement
- > Improvement activities have been implemented and evaluated to maximise quality of care

STAFFING

- > The TRP service has a documented staff induction/orientation policy and/or manual
- > Regular clinical case meetings and clinical supervision is available to staff, on either an individual or a group basis
- > A process is in place for regularly reviewing the performance and professional development goals of each clinician
- > Staff are provided with opportunities for engaging in professional development activities and maintaining currency with best-practice approaches

OBTAIN INFORMED CONSENT TO PARTICIPATE IN THE TRP

- > Potential participants and their carer(s) can attend information sessions before the program starts
- > Processes are in place to ensure that the reasons for involvement of a carer(s) are made clear to all parties before obtaining consent for inclusion or participation
- > Clinical records have copies of signed consent forms from participants and carer(s), including consent to participate in the clinical data collection

INTAKE AND ASSESSMENT

- > The TRP service has clinical records that show nominated next of kin or carer details and their involvement in treatment
- > Participants and their carer(s) (if applicable) understand their rights and responsibilities (e.g. through the intake process/interviews)
- > The TRP service ensures that a coordinating clinician is allocated to each participant at intake, which is documented and made known to the participant and their carer(s) (if applicable)
- > The TRP service facilitates access to alternative care for individuals not accepted by the service
- > Participants and their carer(s) (if applicable) are involved in the development of their treatment, care and recovery plans
- > The treatment plan assesses the participant's current level of self-care and identifies specific skills for development
- > The participant and their carer(s) (if applicable) have received a copy of the current treatment plan, and steps have been taken to ensure that the content of the treatment plan is understood by them
- > The TRP service routinely includes carers (if applicable) and external treatment providers in the participant's treatment

DURING TREATMENT

- > Action is taken to reduce safety risks and improve the quality of care for participants, including conducting regular risk assessments throughout the program

- > Treatment plans are updated to indicate interventions offered in response to changes in clinical need
- > Individual therapy sessions are provided during the program at times agreed with the participant
- > Group sessions should comprise at a minimum:
 - o psycho-education
 - o symptom management and skills training (including practice exercises and reinforcement of learning)
 - o information and links to community-based support services, including Open Arms
- > As a guide, the number of sessions for 'symptom management and skills training' in relation to PTSD and common comorbid problems:
 - o PTSD (8 sessions)
 - o anxiety (8 sessions)
 - o depression (8 sessions)
 - o anger (8 sessions)
 - o addictions, including alcohol and other drugs (6 sessions)
 - o sleep (4 sessions)
- > As a guide, the number of group sessions for 'information and links':
 - o one group session on the importance of support following discharge from the TRP and links to community-based support. This could include inviting representatives from Open Arms and community services to present at the TRP and/or organise a site visit
- > As a minimum, group sessions should ensure that participants understand:
 - o what the symptoms are
 - o the frequency of their symptoms and triggers
 - o symptom management
- > The TRP service reviews the participant's treatment plan when the participant:
 - o requests a review
 - o declines treatment and support
 - o is at significant risk of injury to themselves or another person
 - o is going to exit the program
 - o is observed to be deteriorating in mental state or functioning
- > The TRP service engages with relevant clinicians or services at critical points throughout the program, to ensure continuity of care
- > The TRP service actively engages with participants in accessing vocational, educational and training opportunities, and a vocational, education and training officer is available to provide this service as requested
- > The TRP service engages with key defence and veteran services (ADF mental health, Open Arms), and Ex-Service Organisations at key stages in the participants' involvement in the program
- > The TRP service evaluates effectiveness of the intervention and outcomes with the participant before discharge

POST TREATMENT

- > The TRP service facilitates and documents referral and ongoing communication with external services
- > The TRP service facilitates access to recovery-focused services, vocational support systems, and education and employment programs post-discharge
- > Referral to relevant programs or interventions, with follow-up if indicated, is in clinical records



Trauma Recovery Programs (PTSD) – Clinical Data Collection

Final Report 2024-25

30 August 2025



Acknowledgements

We acknowledge Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of Country throughout Australia and pays respect to all Elders, past and present. We acknowledge the continuing connection of Aboriginal and Torres Strait Islander peoples to land, water and communities – places of age-old ceremonies, of celebration and renewal – and their unique contribution in the life of these lands. We are committed to fostering an environment in which the relationship between Aboriginal and Torres Strait Islander peoples and their fellow Australians is characterised by a deep mutual respect, leading to positive change in our nation's culture and capacity.

Acknowledgement to our military members and veterans

Phoenix Australia acknowledges all Australian Defence Force members, veterans, and their families for their service and their sacrifice.

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on behalf of Phoenix Australia - Centre for Posttraumatic Mental Health.

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Disclaimer

The views and recommendations stated in this report are solely those of Phoenix Australia and do not reflect those of the Department of Veterans' Affairs or the Australian Government.

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Contents

Acronyms	3
Executive summary	4
Project activities	4
Participation in TRPs	4
Clinical effects of TRPs	5
Introduction	7
Purpose and structure of this report	8
Section 1: Project activities	10
Activity 1: Project management	10
Activity 2. Routine support for hard copy data collection, monitoring, and compliance	10
Ongoing data recording and management	10
General administrative support for TRP providers	10
Feedback from TRP hospital staff	11
Routine data compliance audit	11
Clinical Data Collection (CDC) response rates	13
Compliance monitoring	17
Phoenix TRP website	17
Engagement with Community of Practice meetings	17
Ethics updates	17
Manuscripts published from the TRP database	18
Activity 3: Data analysis and reporting	18

Section 2. Participation in TRPs	19
Section 3: Clinical effects of TRPs	22
Part A: Veterans / ex-serving members.....	23
Profile of TRP veteran participants at intake	23
TRP veteran participants' outcome data	25
Profile of the TRP current ADF participants at intake	29
TRP current ADF member participants' outcome data	31
Summary	35
References	37
Appendix 1. Current hospitals and key contacts	38
Appendix 2. List of refreshed measures used across four time points.....	39
Appendix 3. Completed outcome reports	43
Appendix 4. Throughput of TRPs	44
Appendix 5. Veterans' outcomes and T1 to T4 effect size changes	47
Appendix 6. Veterans' effect size estimates between each time point.....	52
Appendix 7. Current ADF members' outcomes and T1 to T4 effect size changes	54
Appendix 8. Current ADF members' effect size estimates across time	59

Acronyms

ADAS	Abbreviated Dyadic Adjustment Scale
ADF	Australian Defence Force
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AQoL-4D	Assessment of Quality of Life instrument
AUDIT	Alcohol Use Disorders Identification Test
CAPS	Clinician-Administered PTSD Scale
CAPS-5	Clinician-Administered PTSD Scale for DSM-5
CDC	Clinical Data Collection
CI	Confidence Interval
DAS-4	Abbreviated Dyadic Adjustment Scale – 4 item
DAR-5	Dimensions of Anger Reactions Scale
DDRI	Deployment Risk and Resilience Inventory
DDVA HREC	The Departments of Defence and Veterans' Affairs Human Research Ethics Committee
DSM-5	Diagnostic and Statistical Manual of Mental Disorders – 5th edition
DSO	Disturbances in Self-organisation
DVA	Department of Veterans' Affairs
ESO	Ex-service Organisation
FAD-12	Family Assessment Device – 12 item
GAD	Generalised Anxiety Disorder
GAD-7	Generalised Anxiety Disorder scale – 7 item
HREC	Human Research Ethics Committee
ICD-11	International Statistical Classification of Diseases and Related Health Problems - 11th Revision
ISI	Insomnia Severity Index
ITQ	International Trauma Questionnaire for ICD-11
ITQ-DSO	International Trauma Questionnaire for ICD-11 (Disturbances in self-organisation)
K10	Kessler Psychological Distress Scale
LB	Lower bound of confidence interval
LEC-5	Life Events Checklist
M	Mean
MIOS	Moral Injury Outcome Scale
PCL-5	Posttraumatic Stress Disorder Checklist for DSM-5
PGSI	Problem Gambling Severity Index
PHQ-9	Patient Health Questionnaire – 9 item (depression)
PTSD	Posttraumatic Stress Disorder
PWI	Personal Wellbeing Index
RAAF	Royal Australian Air Force
RAN	Royal Australian Navy
SD	Standard Deviation
TRP	Trauma Recovery Program
TRP-PTSD	Trauma Recovery Programs – Posttraumatic Stress Disorder
UB	Upper bound of confidence interval

Executive summary

The Department of Veterans' Affairs (DVA) contracts hospital services throughout Australia to provide evidence-based Trauma Recovery Programs (TRPs) for current and ex-serving members of the Australian Defence Force (ADF). It also contracts Phoenix Australia to support Clinical Data Collection for these programs. This report summarises key project activities associated with supporting TRP Clinical Data Collection that Phoenix Australia has undertaken during the current contract period.

Project activities

During this reporting period, key milestones achieved include:

- Ongoing recording and management of hard copy data.
- General administrative support for TRP providers and staff turnover.
- Routine data compliance audit.
- Refreshed data collection and monitoring arrangement.
- Ethics amendments.
- Management and facilitation of Community of Practice meetings.

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Participation in TRPs

Since our 2023/2024 Final Report submitted in August 2024, Phoenix Australia have received data from 27 TRP cohorts that commenced across 9 hospitals. These cohorts included 94 veterans and 45 current ADF members, as well as emergency service personnel who are not included in the Phoenix data collection. This brings the total number of participants since the new Clinical Data Processes were implemented on 30 September 2014 until 30 June 2024, to 378 cohorts across 14 hospitals, comprising 1466 veterans and 505 current ADF members¹.

¹ Note that Phoenix Australia has only received ADF member data since June 2017. However, this total includes all current serving members that have attended a group since 2014.

Highlights of the **past twelve months** at a glance (July 2024– June 2025)

● 9 of 16	hospitals conducted at least one TRP cohort	↓ 27	TRP cohorts commenced
↓ 94	veterans/ex-serving members commenced TRP treatment	↑ 45	current serving members commenced TRP treatment
● 1	ethics progress report approved by DVA HREC	● 2	Community of Practice workshops hosted

Note. Increases/decreases are in reference to the 2024 Final Report.
 Green = increase; Red = decrease; Grey = no change.

Highlights **since 2014²** at a glance

14	hospitals conducted at least one TRP cohort	378	TRP cohorts commenced
1466	veterans/ex-serving members commenced TRP treatment	505	current serving members commenced TRP treatment

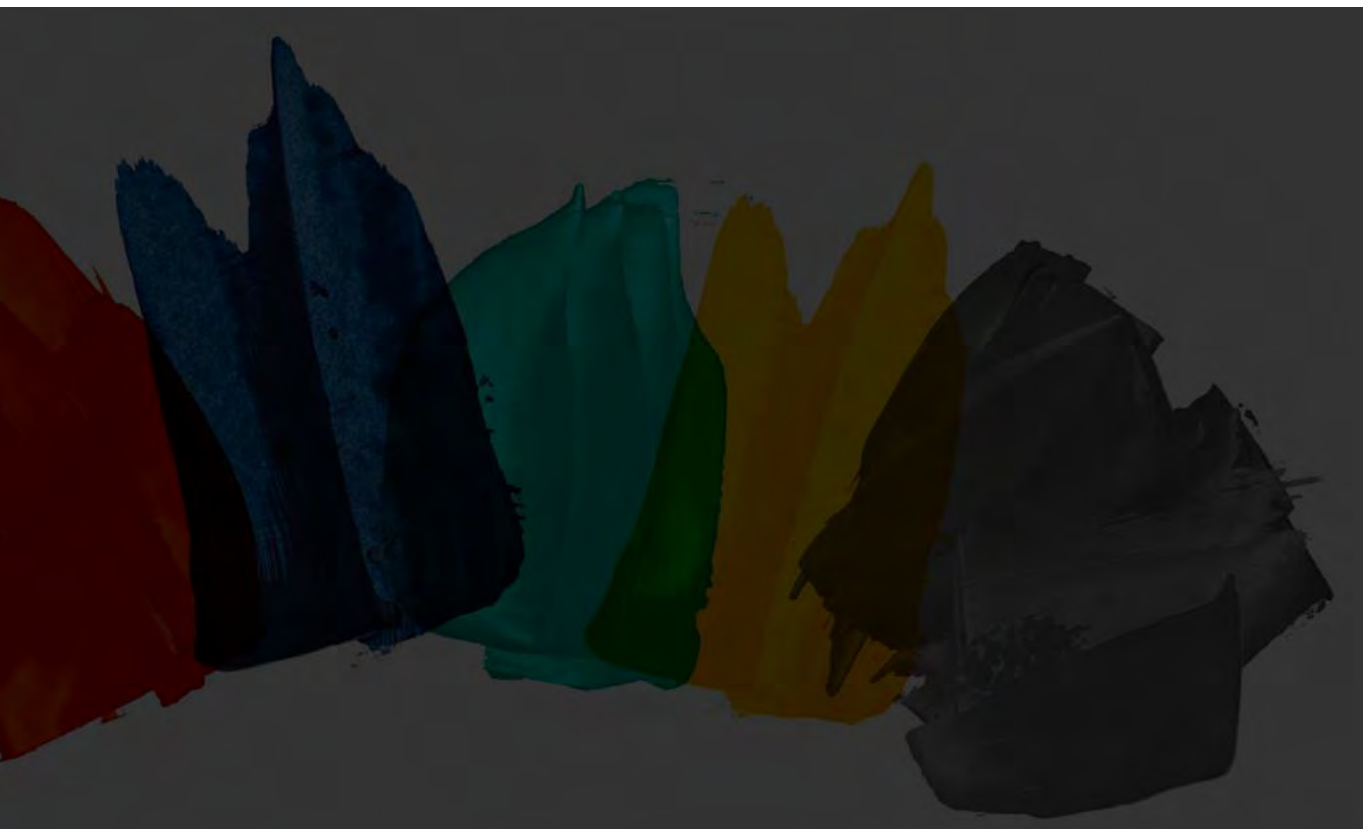
Clinical effects of TRPs

Reported data includes the 2022 refreshed measures. Clinical outcome data indicate that, on average, both **veterans and current serving members typically gain moderate benefit from the programs**. This remains unchanged from the previous year report. Results overall showed:

² In 2014 the TRP Clinical Data Collection was revised to align with the new Diagnostic and Statistical Manual-5 (DSM-5) diagnostic criteria for PTSD.

- For veterans, moderate to large effect size improvements in PTSD (PCL-5) severity scores, all individual PTSD subscales, anxiety, depression, general distress, complex PTSD, and wellbeing from intake to 9-month follow-up.
- For current serving members, moderate to large effect size improvements in PTSD (PCL-5) severity scores, as well as the negative mood & cognitions and arousal subscales, anxiety, depression, general distress and wellbeing from intake to 9-month follow-up.
- Average improvement in PTSD severity score from intake to 9-month follow-up was approximately 10 points, indicating that clinically meaningful changes had been typically achieved and sustained over time.
- For veterans, moderate improvements in insomnia, anger, moral injury – trust and quality of life from intake to 9-months, and small improvements in alcohol use from intake to discharge.
- For current serving members, moderate improvements in insomnia, anger and complex PTSD from intake to 9-months, and small significant decreases in intrusion, avoidance, and aggression from intake to discharge.

While improvements in PTSD, depression and anxiety levels were statistically significant, the data suggests that even at 9-months post-discharge participants on average remain symptomatic, indicating room for further improvement.



Introduction

The Department of Veterans' Affairs (DVA) contracts hospital services throughout Australia to provide evidence-based Trauma Recovery Programs (TRPs) for current and ex-serving members of the Australian Defence Force (ADF). Since 1996, Phoenix Australia Centre for Posttraumatic Mental Health (Phoenix Australia) has been contracted to provide support to these programs, with the nature of that support having varied over time. Currently, Phoenix Australia has the primary role in the management of Clinical Data Collection (CDC), monitoring, analysis, and reporting requirements.

Primary aims of TRP Clinical Data Collection are to:

- Describe the population characteristics of ex-serving members (since 2014)³, and current serving members (as of June 2017)⁴ entering the programs; and
- Measure program outcomes with respect to clinical, social, and functional changes in program participants.

Each hospital is required to collect clinical outcome data from veterans and current ADF members at the following time points: intake (before group treatment starts); discharge (at the end of group treatment); three months post-discharge, and nine months post-discharge.



Clinical (or primary) outcomes include self-reported measures of posttraumatic stress disorder (PTSD), anxiety, depression, general distress, alcohol use, anger and aggression, as well as sleep. Functional (or secondary) outcomes include quality of life, relationship and family functioning, complex PTSD, moral injury and wellbeing. Demographic and other descriptive information is also collected and includes gender, current

³ On 30 September 2014, Phoenix Australia implemented a new quality monitoring process, known as the TRP Clinical Data Collection to coincide with the new Diagnostic and Statistical Manual-5 (DSM-5) diagnostic criteria for PTSD. The significant changes between the pre- and post-September 2014 measures have meant that the post-September 2014 versions are not compatible with the previous versions and therefore cannot be used interchangeably. As such, this report only includes data collected since September 2014.

⁴ Since June 2017 Phoenix Australia has had ethical approval to also collect data received from current ADF members who participate in the TRP-PTSD.

employment status, military service history, health service use and psychiatric diagnoses (please refer to the Implementation Guide for information on the CDC processes). The list of measures used is included in Appendix 2.

Since 1996, the TRP CDC processes have involved paper-based questionnaires which are administered by TRP hospitals and returned to Phoenix Australia via post for data entry, management, and analyses. In 2021/22 during the ongoing COVID-19 pandemic, Phoenix Australia was contracted by DVA to develop and implement a new customised platform to facilitate the transition to online clinical data collection across TRP hospitals, however, during the 2023/24 collection period following a steady decline in hospital compliance and data collection, it was decided following extensive consultation with the TRPs and DVA that the online system would be discontinued and all hospitals would revert to pen and paper methods.

In July 2024, the Phoenix Australia team were informed, based on the recommendation from Dr Peggy Brown's review of the TRPs in 2019 (Brown, 2019), that DVA had formally advised the TRP hospitals in December 2022 that the TRPs:

1. Were no longer subject to separate accreditation based on DVA's Standards, and
2. Must comply with and be delivered in accordance with the current National Safety and Quality Health Service Standards (NSQHS Standards) (Australian Commission on Safety and Quality in Health Care, 2022).

Any requirements not adequately covered by the NSQHS Standards (i.e. evidence-based treatment, program delivery, clinical workforce, quality assurance and data collection requirements) were to be formalised in the Hospital Services Agreement and monitored by DVA. Further, in 2025, Phoenix Australia undertook a review of the Implementation Manual provided to hospitals to ensure evidence relating to the implementation of the TRPs was up to date and streamlined in one single document. This document was released in July 2025 and is available to download from the DVA website: <https://www.dva.gov.au/get-support/providers/programs-services/mental-health-providers/trauma-recovery-program-information-hospitals>

Purpose and structure of this report

This report provides a summary of the TRP Clinical Data Collection project activities since the previous Annual report (Sbisa et al., 2024) and summarises the overall participation in TRPs since September 2014. This report is divided into three sections:

Section 1: Project activities - This section provides a summary of all project activities that occurred during this contract period (1 July 2024 to 30 June 2025).

Section 2: Participation in TRPs - This section provides an overview of the number of cohorts and participants that have taken part in TRP CDC processes since (a) the current form of CDC commenced in September 2014, and (b) the previous TRP CDC Final Report (i.e. covers 1 July 2024 to 30 June 2025).

Section 3: Clinical effects of TRPs - As requested by DVA, this section is divided into two parts: Veteran information and Current ADF member information. For each population, this summarises the data received

from all hospitals since the data collection refresh in June 2022, and descriptions of changes over time for all the outcome measures.

Section 1: Project activities

This section provides a summary of major project activities that have occurred within the current contract period, and is organised in relation to three activity areas:

1. Project management
2. Routine support for hard copy data collection, monitoring, and compliance
3. Data analysis and reporting

Activity 1: Project management

Management of the TRP project has involved the planning and organisation of the data collection (i.e., measures, processes), reporting (e.g., ethics, DVA deliverables), and coordination of internal and external activities including communications with the hospitals and their coordinators. Further, Phoenix Australia held monthly project meetings with the DVA contract manager(s) throughout the year. These have been additional to:

- Weekly meetings of the internal project team across the contract period.
- Monthly financial oversight meetings with senior management at Phoenix Australia.
- Biannual Community of Practice meetings.

Activity 2. Routine support for hard copy data collection, monitoring, and compliance

Ongoing data recording and management

Phoenix Australia continues to receive and store data for paper-based questionnaires. This includes maintaining and updating the relevant SPSS databases and data tracking documents, as well as filing, archiving and secure storage of data hardcopies. Details of the volume of data received and processed in the current contract period are provided in Section 2.

General administrative support for TRP providers

Phoenix Australia has provided ongoing advice and support to TRP hospitals on an ad-hoc basis, and in response to requests including:

- Clarification regarding the TRP Standards and the new Implementation Manual
- Provision of user accounts or reset passwords for access to the TRP website.
- The procedure for returning data to Phoenix Australia.
- Processes for retaining copies of participant data and participant IDs.
- Requests for scientific papers.
- Consultation and advice regarding relationships between TRP hospitals and DVA.

- Induction of new provider staff at existing TRP hospitals, including new staff members at:

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There were no new hospitals that commenced providing TRPs in this reporting period. A list of current hospitals and key contacts are provided in Appendix 1.

Feedback from TRP hospital staff

As per previous annual reports Phoenix Australia continues to receive feedback from several TRP providers regarding the substantial impacts of ongoing staff turnover and extended absences amongst administrative and clinical TRP staff. Within this reporting period, staff changes have been reported at [s 47G](#)

. As a result, numerous locations have experienced difficulties in accurately gathering information, and there have occasionally been delays in sending data to Phoenix Australia, or data missing. We have consistently maintained communication with each hospital site to assess the level of assistance needed for integrating new personnel, and we continue to relay these hospital changes and any associated challenges to the DVA team through regular project meetings.

In an effort to assist the onboarding of new staff and acquainting them with the TRP CDC process, in 2024 Phoenix Australia created a brief document with step-by-step instructions, and any TRP hospitals that have flagged staff changes with the data coordinator have received this document and are directed to the updated Implementation Guide.

Routine data compliance audit

On 23 June 2025, all TRP providers that were expected to have returned participant data in the past 12 months were sent (via email) a routine data compliance audit request that was intended to obtain information about all recent TRP cohorts and participants. The data audit requested information for each cohort, including:

- the number of participants,
- the number of questionnaires returned to Phoenix Australia at each time point, and
- reasons for any missing questionnaires (withdrawal from TRP program, refusal to participate in data collection).

Providers were given 2 weeks to return their data audit form. Information provided was checked against Phoenix Australia's records, and any discrepancies were clarified. Providers were given until the end of July to return any missing surveys. Data received after that date was not included in this report.

The key findings from routine data compliance audit were as follows:

- Eight of the nine hospitals that were active within the current reporting period were sent data audit forms. [s 47G](#)

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The remaining seven hospitals have been inactive for some time and do not have any ongoing cohorts (i.e., cohorts with any data collection time points still outstanding) within this reporting period and were therefore not sent a data audit form.

- All eight hospitals that were sent a data audit form s 47G

returned their form

and clarified discrepancies between what they reported and the data Phoenix Australia received. They were asked to post back all outstanding surveys and consent forms.

- The hospitals (including s 47G reported that they returned 954 surveys to Phoenix Australia for cohorts that were still ongoing in the past 12 months. Phoenix Australia had not received 33 (3%) of these reported surveys. Reasons for this were predominantly failure to post surveys to Phoenix Australia, recording errors (surveys reported as collected that were not), and on rare occasions (n=1), surveys lost in the post. Hospitals are instructed not to include any identifying information (i.e. consent forms, names) with posted surveys, hence, lost surveys contain only de-identified data and cannot be linked to an individual. Further results are presented in Table 2.
- Phoenix Australia has now received 99.4% of surveys reported as collected in the data audit. We are still awaiting 6 surveys (including VI, CA and V3 surveys) from Hollywood Clinic, who have confirmed that these surveys will be posted to Phoenix Australia.

Table 2. Discrepancies in survey return resulting from data compliance audit

Survey	Number of surveys reported to Phoenix by TRPs	Number of surveys Phoenix found missing	% Missing
Clinician intake assessment (CA)	232	14	6%
Intake survey (VI)	234	5	2%
Clinician discharge assessment (CD)	153	1	1%
Discharge survey (VD)	186	8	4%
3-month follow-up survey (V3)	102	5	5%
9-month follow-up survey (V9)	47	0	0%
Total	954	33	3%

Compared to the 23% of surveys not returned to Phoenix Australia at the time of last year's data audit, the 3% missing this year represents a substantial improvement in data return rates. However, it should be noted that last year, a considerable proportion of missing data was attributable to s 47G

As we were unable to complete the data audit with

s 47G their amount of missing data for this reporting period is unknown, and hence, this figure is an underestimation.

There are ongoing challenges with ensuring hospitals send data in a timely manner with both s 47G and the s 47G failing to inform us of or send their data for a recent cohort until they were prompted by the data audit.

In response to the large amount of missing data in the previous final report, Phoenix Australia prepared a Brief Guide to Data Collection document which was sent to all new TRP staff, as well as existing TRP staff with a request to include the document in their handover for new staff. More, recently the DVA Implementation Guide was sent along with the Brief Guide. New staff were also offered a meeting with the Phoenix Australia team to ensure that they understand the requirements of TRP clinical data collection. This appears to have made a difference in reducing the amount of missing data come audit time.

Clinical Data Collection (CDC) response rates

Finalisation of the annual data audit allows CDC response rates for cohorts commencing in this reporting period to be calculated and compared to the benchmarks presented in the TRP Implementation Manual for Posttraumatic Stress Disorder Trauma Recovery Programs (CA, CD: 100%, VI, VD: 90%, V3: 70%, V9: 40%). Table 3 presents CDC response rates among active TRP sites for cohorts commencing in this reporting period. Met targets are highlighted in green, within 20% of target are highlighted in orange and > 21% below target are highlighted in red. Key outcomes are as follows:

- **s 47G** did not have any veterans or ADF members commence in this reporting period.
- All hospitals met the required response rate for the two intake surveys (100% for CA and 90% for VI).
- Four of the eight hospitals met the required response rates for the two discharge surveys (100% for CD and 90% for VD) (**s 47G** and the **s 47G** met the required response rate for the CD survey and came within 20% of the required response rate for the VD survey. **s 47G** and the **s 47G** came within 20% of the required response rate for the VD survey but had poor response rates for the CD survey. **s 47G** may have collected CD surveys for their most recent cohort but have not confirmed either way despite multiple prompts.
- Three hospitals exceeded the required response rates of 70% for the 3-month follow-up survey (V3) **s 47G**. The remaining four hospitals came within 20% of the required response rate for the V3 survey (**s 47G**).
- Many of the cohorts commencing this reporting period were not yet due for their 9-month follow-up survey (V9). Of those that were, response rates were poor. **s 47G** all failed to collect any 9-month follow-up surveys for their cohorts that reached this time point.

Overall, survey response rates were good, mostly meeting expectations or coming within 20%. The 9-month follow-up survey (V9) time point was a problem for all hospitals that had a cohort that reached this time point, and the Clinical Discharge survey (CD) response rates were low for **s 47G** and the **s 47G**.

s 47G and the **s 47G** performed well in terms of survey response rates in this reporting period, meeting or exceeding their required targets. However, both sites did not have a cohort that should have completed their follow-up time points yet. **s 47G** also met

their required intake and discharge response rates and came within 20% of their required response rates for the 3-month follow-up survey. **s 47G** had excellent response rates from intake to 3-month follow-up but did not collect any 9-month follow-up surveys for their single cohort that reached this time point. The remainder of the hospitals (**s 47G**) met required response rates for intake but varied greatly for the surveys following.

Of note is the improvement in response rates for **s 47G** after moving from online to hard copy surveys. As **s 47G** were unable to participate in the data audit, it is difficult to see if they experienced any improvements with a change in data collection mode.

It is also of note that **s 47G** ceased collecting data from non-DVA funded current-serving ADF members as of June 2024 as per their contractual agreement (this is further expanded upon in the Compliance Monitoring section). While their current-serving members are included in the total number in each cohort in Table 3 below, they were removed from the calculated response rates for survey collected after June 2024.

Given the poor data compliance rates from some hospitals for the clinical discharge survey and more generally for the 9-month follow-up survey and the additional administrative load undertaken to remind coordinators to provide Phoenix Australia with data, **we strongly recommend DVA increase communication with the hospitals and remind them of their contractual responsibilities around data monitoring.** In particular, even if the TRPs do not have an in-person 9-month follow-up at the hospital, the surveys should still be posted to the participants and followed up to ensure data collection is completed.

The number of treatment dropouts (withdrawals from the program during treatment) and refusals to participate in CDC were generally low. Withdrawal from treatment can be instigated by the participant or the hospital. At this point in time, there are no guidelines in place regarding when a participant should withdraw from the program (i.e. level of non-attendance), and hence, this is at the hospital's discretion. The hospitals report the dropout and reason to Phoenix Australia, but they do not currently report how much of the program the participant completed. Reasons for withdrawal during this reporting period included:

- Personal circumstances (n=1)
- Unforeseen family stresses (n=1)
- Sudden increase in external appointments (n=1)
- No reason given (n=7)

Table 3. CDC response rates among active TRP sites for cohorts commencing in period 1 July 2024 – 30 June 2025.

Hospital	Cohort	Start date	N	CA	VI	CD	VD	V3	V9	Dropouts	Refusals
				100%	90%	100%	90%	70%	40%		
s 47G	36	22-Jan-25	6	6	6	6	6	6	-	0	0
	37	30-Apr-25	5	3	3	-	-	-	-	1	1
	Total		11	9	9	6	6	6	-	1	1
	Response rate			100%	100%	100%	100%	100%	NA		
	76	8-Jul-24	8	8	8	0	8	6	0	0	0
	77	19-Aug-24	8	7	7	3	3	0	-	4	1
	78	30-Sep-24	9	9	9	9	6	5	-	0	0
	79	11-Nov-24	4	4	4	3	3	3	-	1	0
	80	13-Jan-25	7	7	7	0	6	-	-	0	0
	81	24-Feb-25	9	9	9	0	7	-	-	0	0
	82	7-Apr-25	7	7	7	0	7	-	-	0	0
	Total		52	51	51	15	40	14	0	5	1
	Response rate			100%	100%	33%	87%	61%	0%		
	30	17-Sep-24	3	3	3	3	3	1	-	0	0
	31	9-Jan-25	3	3	3	3	3	3	-	0	0
	32	17-Apr-25	4	4	4	4	4	-	-	0	0
	Total		10	10	10	10	10	4	-	0	0
	Response rate			100%	100%	100%	100%	67%	NA		
	28	9-Jul-24	6	6	6	4	4	3	0	2	0
	29	1-Oct-24	3	3	3	3	3	2	-	0	0
	30	28-Jan-25	5	5	5	4	3	-	-	1	0
	31	22-Apr-25	5	5	5	5	5	-	-	0	0
	Total		19	19	19	16	15	5	0	3	0
	Response rate			100%	100%	100%	94%	71%	0%		
	15	19-Oct-24	8	8	8	8	7	7	-	0	0
	16	5-May-25	9	9	9	0	8	-	-	0	0

s 47G

s 47G

Hospital	Cohort	Start date	N	CA	VI	CD	VD	V3	V9	Dropouts	Refusals
				100%	90%	100%	90%	70%	40%		
	Total		17	17	17	8	15	7	-	0	0
	Response rate			100%	100%	47%	88%	88%	NA		
	21	5-Feb-25	6	6	6	5	5	-	-	1	0
	Total		6	6	6	5	5	-	-	1	0
	Response rate			100%	100%	100%	100%	NA	NA		
	32	15-Jul-24	3	3	3	3	2	2	0	0	0
	32	7-Oct-24	0	0	0	0	0	0	0	0	0
	33	3-Feb-25	1	1	1	1	1	0	-	0	0
	34	28-Apr-25	1	1	1	-	-	-	-	0	0
	Total		5	5	5	4	3	2	0	0	0
	Response rate			100%	100%	100%	75%	50%	0%		
	34	17-Jul-24	3	3	3	3	3	2	0	0	0
	35	28-Apr-25	5	4	4	4	3	-	-	0	1
	Total		8	7	7	7	6	2	0	0	1
	Response rate			100%	100%	100%	86%	67%	0%		

Note. CA = Clinician intake assessment, VI = Veteran intake survey, CD = Clinician discharge assessment, VD = Veteran discharge survey, V3 = Veteran 3-month follow-up survey, V9 = Veteran 9-month follow-up survey.

Benchmark response rates as per the TRP Implementation Manual for Posttraumatic Stress Disorder Trauma Recovery Programs are CA, CD: 100%, VI, VD: 90%, V3: 70%, V9: 40%.

N = number eligible for data collection (i.e. veterans and current-serving members).

*Data not collected from non-DVA funded current-serving ADF members as of June 2024.

Legend: Green = target met; Orange = within 20% of target; Red = > 21% from target.

Compliance monitoring

Following the adoption of recommendations from the 2020 DVA PTSD-TRP Data Collection Refresh report, the TRP measures were refreshed (see Appendix 2). From 1 June 2022, all TRPs running new cohorts were expected to adopt the new versions of the surveys. Except for a small number of returned surveys using the wrong version during the changeover period, and the requirement of the data manager to seek out consent forms for some cohorts, we have not been made aware of any issues regarding the refreshed data collection and monitoring arrangements.

Phoenix TRP website

During this reporting period, TRP hospitals continued to use the www.phoenixtrp.org.au website, which is a secure central hub for the current survey forms, Community of Practice recordings, and other information for hospital coordinators to run the TRPs. Phoenix Australia continues to assist TRPs with this website, where necessary, however we believe streamlining the location of TRP information has been helpful. During this reporting period our activities relating to the website have primarily involved initiating new user accounts when staff turnover occurs.

Engagement with Community of Practice meetings

The Phoenix Australia CDC team have supported and provided information as needed for the TRP Community of Practice meetings. Since the start of the current contract, two Community of Practice meetings have taken place in November 2024 and May 2025.

The first meeting involved a presentation on Moral Injury by s 47G

The second meeting included a presentation by s 47G

Policy & Service Development at Phoenix Australia.s 47G spoke about managing challenging group dynamics in the TRPs and chaired a discussion with hospital representatives in attendance. Both CoPs were well attended and very well received. In addition to DVA and Phoenix Australia representatives, the Community of Practice meeting was attended by representatives from s 47G

A suggested idea for the next Community of Practice meeting includes a discussion regarding the unique topics that hospitals offer within their TRPs, (i.e., those which are not core modules: PTSD, depression, anxiety). For example, topics such as tai chi, sexual functioning, diet, etc., in addition to discussion regarding the utility of these non-core topics within TRPs.

Ethics updates

Two ethics-related activities have occurred since the last reporting period:

- Amendment – Phoenix Australia submitted an amendment to remove the online data collection system (WeGuide) from the approved protocol and Participant Information and Consent Form. This request was approved by DDVA HREC on 19 August 2025.

- Progress report – Phoenix Australia has submitted one scheduled ethics progress report (Protocol Number E096/002) to the DDVA HREC in October 2024. This progress report also requested an extension to the deadline for the project until 31st December 2025. This request was approved by the DDVA HREC Chair out-of-session on the 10th October 2024.

The next annual ethics progress report will be submitted to the DDVA HREC by the 13th October 2025.

Manuscripts published from the TRP database

During this period, no manuscripts based on the TRP database have been published. There is presently no resourcing for research activities in the current funding agreement, and as such, there are no current plans for a manuscript.

Activity 3: Data analysis and reporting

The following sections of the report summarise findings from analyses of data returned to Phoenix Australia during the current contract period including: (1) metrics of participation in TRPs since 1 July 2024 (Section 2); and (2) a quantitative profile of all veterans and current ADF members at intake, as well as change over time (clinical effects) for all outcome measures between 1 June 2022 and 30 June 2025 (since the data collection refresh). These are additional to other data analysis and reporting activities that have been produced over the current contract period, including:

- Brief outcome data spreadsheets and an accompanying interpretation guide that were produced for the 9 active hospitals in the past year, including comparisons between the individual hospital and national data, for all data collected since 1 June 2022. These brief outcome reports will be submitted to DVA along with this report and disseminated to participating hospitals soon after. See Appendix 3 for list of the 9 hospitals that were the subject of a brief outcome report.

S 47G

In addition to these contracted reporting activities, there have been a small number of ad-hoc requests from DVA for clarifying information, targeted analyses and reporting. These include requests for information regarding:

- interim updates on TRP throughput numbers for varying periods by hospital;
- clarification on measures, and;
- updates on active and inactive TRP sites.

Section 2. Participation in TRPs

This section reports on participation data: a) during the current contract period, and b) in total since 30 September 2014. These numbers are based on outcome data returned to Phoenix Australia by 31 July 2025 (inclusive).

As noted in the previous section, a small amount of data for cohorts that commenced in this reporting period was received by Phoenix Australia after the annual report cut-off date of 31 July 2025 (prompted by the routine data audit), and hence, could not be included in the current report. This included intake and 3-month follow-up data.

TRP cohort and participant overview

In this financial year (1 July 2024 – 30 June 2025), there have been 27 cohorts that commenced across 9 hospitals. Active and inactive TRP sites in this reporting period are presented in Table 4, unchanged from our final report from last financial year, submitted in June 2024. Although s 47G has informed us that they will be recommencing cohorts.

Active TRP sites are those that had a cohort commence during this reporting period, and inactive sites are those that did not have a cohort commence in this reporting period. These cohorts have included 94 veterans and 45 ADF members, in addition to emergency service personnel who are not included in the DVA Clinical Data Collection. This brings the total number of TRP participants that have commenced programs since the new Clinical Data Processes were implemented on 30 September 2014 to 378 cohorts across 14 hospitals, comprising 1466 veterans and 505 current ADF members⁵.

Activity highlights since July 2024

- s 47G ran 7 cohorts.
- s 47G each ran 4 cohorts.
- s 47G ran 3 cohorts.
- s 47G each ran 2 cohorts.
- s 47G ran 1 cohort consisting only of first responders.
- s 47G had the highest number of veterans commence the TRP-PTSD with 26, while s 47G had 16.
- s 47G had the highest number of ADF members commence the program with 26 beginning the program, while s 47G had 11 commence.
- Inactive programs are listed in Table 4.

⁵ Phoenix Australia has only received outcome data from ADF members since June 2017. However, the current totals include all current serving ADF members that have attended a group since 2014 (including those that have not provided outcome data which were included in analyses).

Table 4. Active and inactive TRP sites in period 1 July 2024 – 30 July 2025.

Active	Inactive
s 47G	

Treatment dropouts and CDC refusals among active TRP sites in this period are presented in Table 5. There were 10 treatment dropouts in this period, and 3 participants refused consent for clinical data collection (CDC). The number of dropouts was similar to the previous reporting period (n=8 last period), while the number of refusals reduced (n=7 last period). The largest reduction in refusals was from the s 47G who reported four refusals last reporting period, and eighteen refusals in 2022-23. This is likely due to a change in the way data collection was framed to participants, resulting from staff changes. No participants withdrew their consent for CDC this reporting period.

Table 5. Treatment dropouts and CDC refusals among active TRP sites in period 1 July 2024 – 30 June 2025.

Hospital	No. of cohorts	Number participants commenced			Dropout	CDC refusal
		Veterans	ADF	Total		
s 47G	1	0	0	0	0	0
	2	11	0	11	1	1
	7	26	26	52	5	1
	3	10	0	10	0	0
	4	16	3	19	3	0
	2	15	2	17	0	0
	2	4	2	6	1	0
	4	5	11	16	0	0
	2	7	1	8	0	1

Hospital	No. of cohorts	Number participants commenced			Dropout	CDC refusal
		Veterans	ADF	Total		
Total	27	94	45	139	10	3

An update regarding the activity of specific TRP hospitals is as follows:

- s 47G still have not commenced their first cohorts.
- s 47G have been inactive since their last cohorts in 2018/2019.
- s 47G closed at the end of 2021.
- s 47G has not run a cohort since in April 2022, but have informed us that they will be recommencing cohorts.
- s 47G went into receivership in June 2025 and has since closed.

Each hospital's participation data is presented in Appendix 4.

Section 3: Clinical effects of TRPs

This section reports analyses of clinical effects of TRPs for cohorts commencing since new Clinical Data Collection processes were introduced in June 2022 up until 30 June 2025 (data received between 1 June 2022 and 31 July 2025). Consistent with previous reports, the current analyses are divided into two parts:

Part A - Analyses of outcomes among veterans / ex-serving members: This summarises findings based on veteran / ex-serving member data received from TRP hospitals since June 2022. This includes a profile of program participants at treatment intake, as well as changes in outcome measures over time. Key findings are summarised in text, while more detailed results are presented in the appendices. This includes:

- Means and standard deviations on all the measures used across all four time points, as well as effect size changes between intake and 9-month follow-up (see Appendix 5).
- Effect size measures of changes between (a) intake and discharge, (b) discharge and 3-month follow-up, and (c) 3-month and 9-month follow-up (see Appendix 6).

Part B - Analyses of outcomes among current ADF members: This summarises findings based on current serving ADF member data received from TRP hospitals since June 2022. This includes a profile of program participants at treatment intake, as well as changes in outcome measures over time. Key findings are summarised in text, while more detailed results are presented in the appendices. Consistent with the veteran/ex-serving members data, this includes:

- Means and standard deviations on all the measures used across all four time points, as well as effect size changes between intake and 9-month follow-up (see Appendix 7).
- Effect size measures of changes between (a) intake and discharge, (b) discharge and 3-month follow-up, and (c) 3-month and 9-month follow-up (see Appendix 8).

The measures used to evaluate the clinical effectiveness are included in Appendix 2. When interpreting results below it is important to note the following:

- The analyses are based on **treatment completer** rather than “intent to treat” data. This means that the findings relate to those who completed questionnaires at all relevant time points and excludes dropouts (participants who withdrew from the program, and those for whom we have missing data at particular time points).
- In the context of treatment dropout, and the absence of a non-treatment comparison group, it is impossible to draw firm conclusions about reasons for changes observed over time. These may reflect the effect of treatment, as well as spontaneous improvement or worsening of symptoms. It is also possible that mean changes may reflect the effects of dropout; for example, if patients with improving (or worsening) symptoms are less likely to complete treatment or follow-up assessments and are thus less likely to be included in analyses of follow-up data.

Part A: Veterans / ex-serving members

Profile of TRP veteran participants at intake

This section describes the intake characteristic of veterans who have commenced TRP cohorts since June 2022, including features of their demographic and service backgrounds, and clinical status.

Table 6 presents this descriptive profile of veteran participants in TRPs at intake⁶. In summary:

- Females represent 11.2% of the sample.
- The average age of male participants was around 50.2 years (SD = 13.2), and they had served in the military for an average of 13.4 years (SD = 8.7) as a regular and an average of 2.1 years (SD = 4.6) as a reservist.
- The average age of female participants was 49.0 years (SD = 11.2), and they had served in the military for an average of 11.8 years (SD = 8.6) as a regular and an average of 0.7 years (SD = 1.5) as a reservist.
- Over 50% of male and female participants reported serving in the Army (Regular or conscript), with smaller proportions serving in the Royal Australian Navy (RAN) and the Royal Australian Air Force (RAAF). Higher proportions of female participants reported serving in the RAN or RAAF compared to male participants who reported being in those services.
- On average, male veterans discharged around 14 years ago and female veterans discharged 12 years ago.
- Both male and female veterans reported an average of 15-16 past traumatic events (out of a possible 17 presented). This included the event happening to the participant, witnessing it, learning about it and/or it happening as part of their job.
- The average total score on the Clinician Administered PTSD Scale (CAPS-5) was 41.9 for males (SD = 12.3) and 45.1 for females (SD = 9.6), on a scale of 0 to 80 where higher numbers indicate more severe PTSD.
- The average total score for alcohol use (AUDIT) was 11.4 for males (SD = 10.3) and 11.3 for females (SD = 10.3), on a scale of 0 to 40 where higher numbers indicate higher alcohol use.

Table 7 contains the percentage of veterans experiencing comorbid diagnoses (in addition to PTSD) as recorded by clinicians at intake. More than half of participants (64.5% for males, and 74.1% for females) demonstrated a comorbid depressive disorder, which was the most common comorbid diagnosis followed by alcohol or substance use disorder for males (43.0%) and generalised anxiety disorder for females (33.3%).

Intake data on all primary and secondary outcome indicators are presented in Appendix 5.

⁶ Note that the sample size numbers (*n*) in Tables 5 and 6 vary according to the number of people who responded to each question.

Table 6. Clinical assessment profile of veterans at intake

Outcome (measure)	Possible scores	Male (n=214)			Female (n=27)		
		Mean	SD	n	Mean	SD	n
Age at entry into program	N/A	50.2	13.2	178	49.0	11.2	21
Regular	N/A	13.4	8.7	213	11.8	8.6	27
Reservist	N/A	2.1	4.6	213	0.7	1.5	26
Years since discharge	N/A	14.1	12.0	190	14.5	11.7	22
Total number of traumatic events experienced	0-17	16.1	2.1	213	15.4	3.5	27
Clinician-assessed PTSD (CAPS-5) scores							
Total	0 – 80	41.9	12.3	200	45.1	9.6	25
Intrusion	0 – 20	10.5	3.9	200	11.4	3.5	25
Avoidance	0 – 8	5.0	1.8	200	5.2	1.9	25
Negative mood and cognitions	0 – 28	15.1	5.3	200	16.0	3.5	25
Arousal	0 – 24	11.3	4.0	200	12.5	2.7	25
Alcohol use (AUDIT)							
Hazardous Drinking	0 - 12	5.2	4.1	187	4.3	4.1	26
Alcohol Dependence	0 - 12	1.9	2.9	189	2.3	3.1	24
Harmful Drinking	0 - 16	4.2	4.2	191	4.7	4.4	26
Total	0 - 40	11.4	10.3	186	11.3	10.3	24
	Possible scores	n	%	Total n	n	%	Total n
Service							
Army (Regular or conscript)	N/A	154	72.7		15	55.6	
Royal Australian Navy	N/A	27	12.7		4	14.8	
Royal Australian Air Force	N/A	31	14.6	212	8	29.6	27

Table 7. Comorbid diagnoses of veterans at intake (primary diagnosis is PTSD)

Comorbid diagnoses	Male	Female
	% of veterans (n = 214)	% of veterans (n = 27)
Depressive disorders (major & persistent)	64.5	74.1
Alcohol or substance use disorder	43.0	29.6
Generalised anxiety disorder	36.0	33.3
Social anxiety	6.5	3.7
Panic disorder	6.1	3.7
Agoraphobia	1.4	0.0
Other anxiety disorders	3.7	14.8
Other disorders	5.6	11.1

Note: Categories are not mutually exclusive (i.e. more than one comorbid condition can be present for a single individual)

TRP veteran participants' outcome data

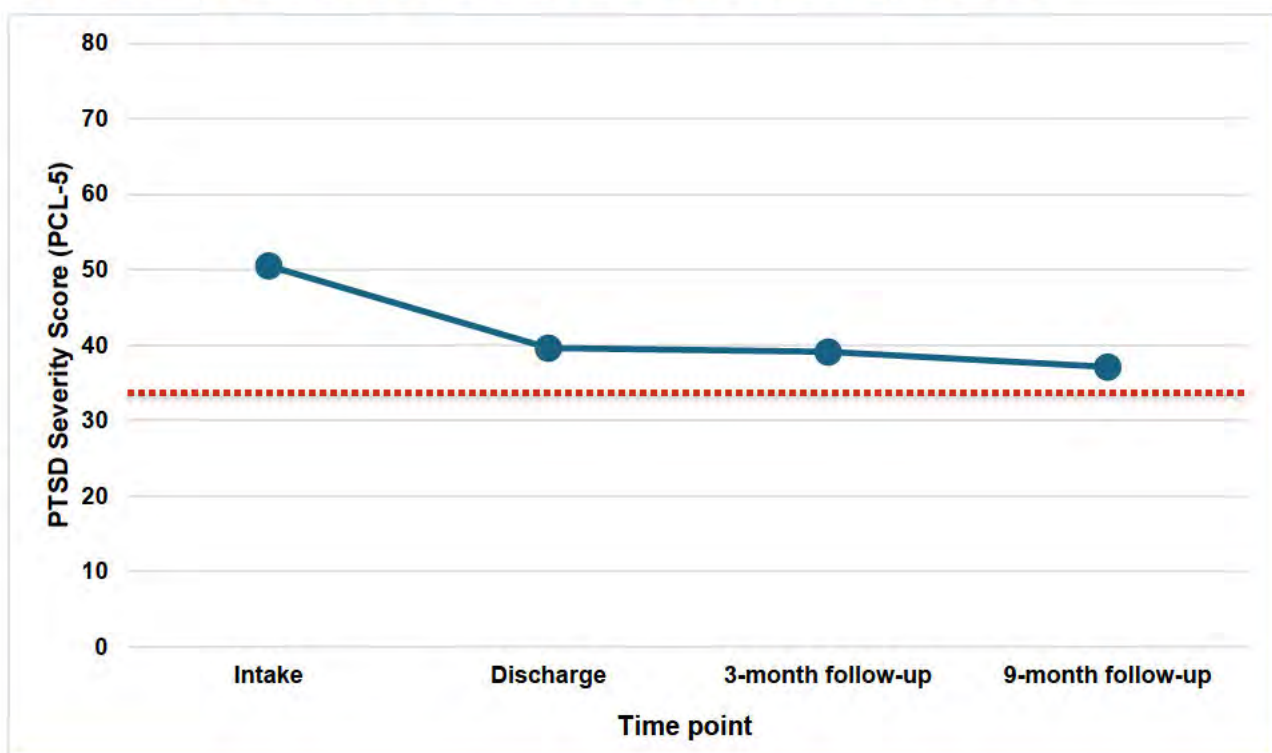
This section provides a summary of TRP outcome data for all veteran and ex-serving members for whom Phoenix Australia received data since June 2022. This includes data at intake, discharge, 3-month, and 9-month follow up time points.

The outcome analyses indicate that when total participants across all hospitals are analysed, the veterans who participated in the TRP cohorts benefited significantly in the context of these programs. Descriptive statistics and effect size measures comparing scores at intake and 9-month follow-up suggested:

- **Moderate to large improvements** from intake to 9-month follow-up for PTSD total scores, the individual PTSD subscales, anxiety, depression, general distress, complex PTSD, and wellbeing.
- **Moderate improvements** for insomnia, anger, moral injury – trust and quality of life.
- No significant changes in aggression, alcohol use, relationship functioning, family functioning, moral injury (shame subscale) at 9-months follow-up. However, there was a small significant decrease in alcohol use from intake to discharge.

The graphs below illustrate changes across time for key clinical outcomes – PTSD, depression, and anxiety. Figure 1 shows that the overall level of PTSD symptom severity, as measured by the PTSD Checklist (PCL-5), improved markedly between intake and discharge ($M = 50.5$ vs. $M = 39.6$) and that this improvement was sustained across the 9 months post-discharge. The improvement in mean PTSD severity scores was greater than 10 points at 9-month follow-up when compared to the intake score, indicating that a **clinically meaningful change had been achieved and sustained over time**. However, while there was significant and clinically meaningful improvement, the average at 9-month follow-up ($M = 37.1$) suggests many participants would still be experiencing significant PTSD symptoms (as evidenced by the red dotted line indicating the threshold for probable PTSD: PCL total 33+).

Figure 1. Change in veterans' PTSD severity over time as measured by the PCL-5



Figures 2 and 3 show that anxiety and depression severity, as measured by the GAD-7 and PHQ-9, improved markedly between intake and discharge and that this improvement was sustained across 3- and 9-months post-discharge. Mean anxiety scores were in the 'moderate' range at intake but fell to the 'mild' range at all 3 follow-up time points. Mean depression scores were in the 'moderately severe' category at intake but fell to the 'moderate' range at all 3 follow-up time points. While there were significant improvements in both anxiety and depression, many participants would still be notably impacted by depression (as evidenced by the mean falling within the moderate symptom range) and/or anxiety, to a lesser degree.

Figure 2: Change in veterans' anxiety severity as measured by the GAD-7

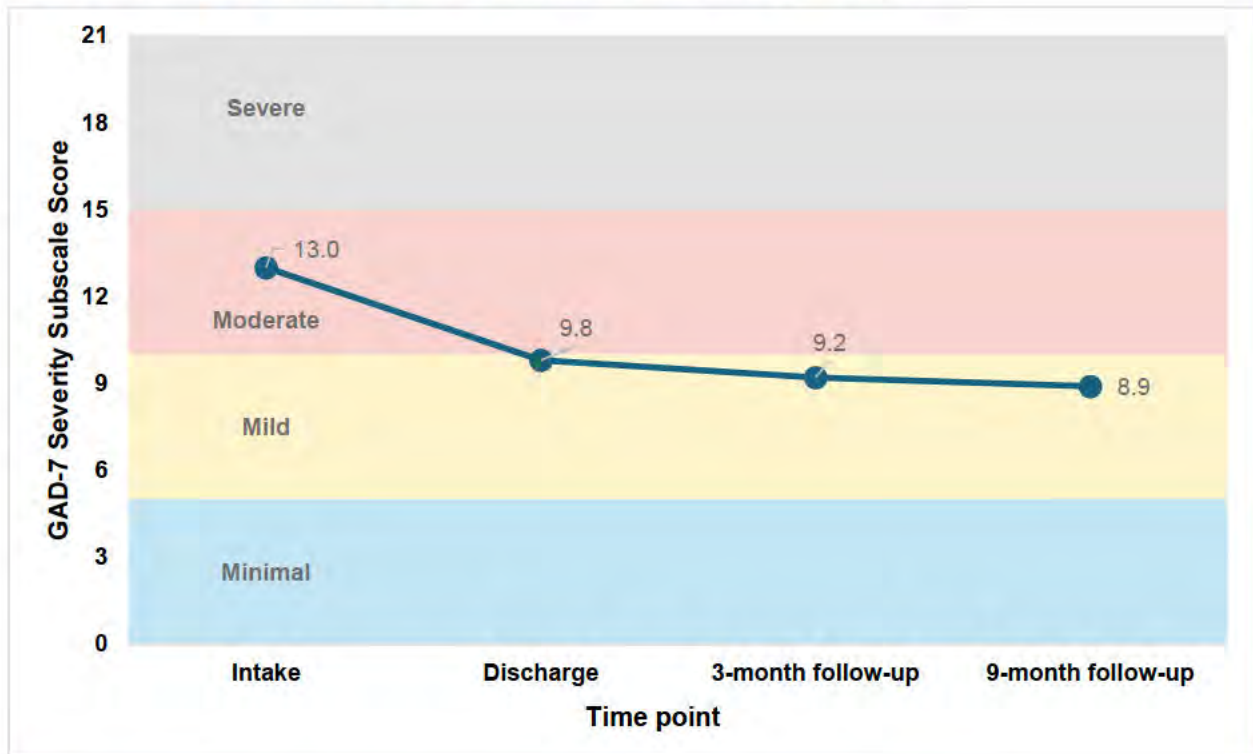
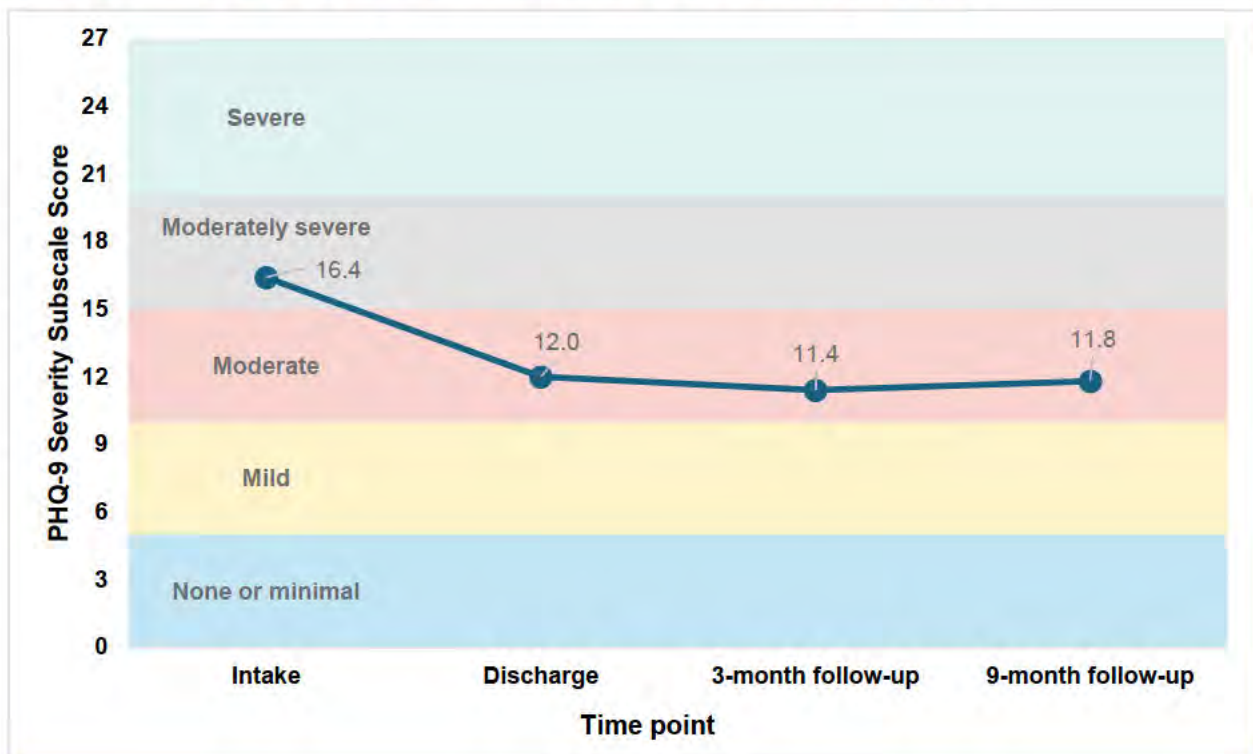


Figure 3: Change in veterans' depression severity as measured by the PHQ-9



Appendix 5 and Appendix 6 contain the descriptive statistics for total scores across outcome measures at intake, discharge, 3-month and 9-month follow-up assessments, as well as effect size estimates of change over time using Cohen's *d* (*d*).

Table 8 shows the rates of PTSD and complex PTSD at intake, 3-month follow-up and 9-month follow-up among veterans. Both the PTSD and complex PTSD groups met criteria for PTSD on the PCL-5 (scores > 33), but the complex PTSD group also met criteria for the disturbances of self-organisation subscale on the International Trauma Questionnaire (ITQ) for ICD-11. Rates of complex PTSD decreased from 38.3% at intake to 14.7% at 3-month follow-up, but increased back to 20.0% at 9-month follow-up. Overall rates of PTSD increased slightly from intake (51.7%) to 3-month follow-up (54.3%), before decreasing to 36.5% at 9-month follow-up. The increase in the proportion of PTSD cases at 3-months likely reflects the movement of those from the complex PTSD group that no longer met DSO criteria into this group. Those with no PTSD increased from 10.0% at intake, to 31.0% at 3-month follow-up and further to 43.5% at 9-month follow-up.

Table 8. Rates of PTSD and Complex PTSD at intake, 3-month and 9-month follow-up among veterans.

Category	Intake		3-month follow-up		9-month follow-up	
	N	%	n	%	n	%
No PTSD	26	10.0	40	31.0	37	43.5
PTSD	135	51.7	70	54.3	31	36.5
Complex PTSD	100	38.3	19	14.7	17	20.0

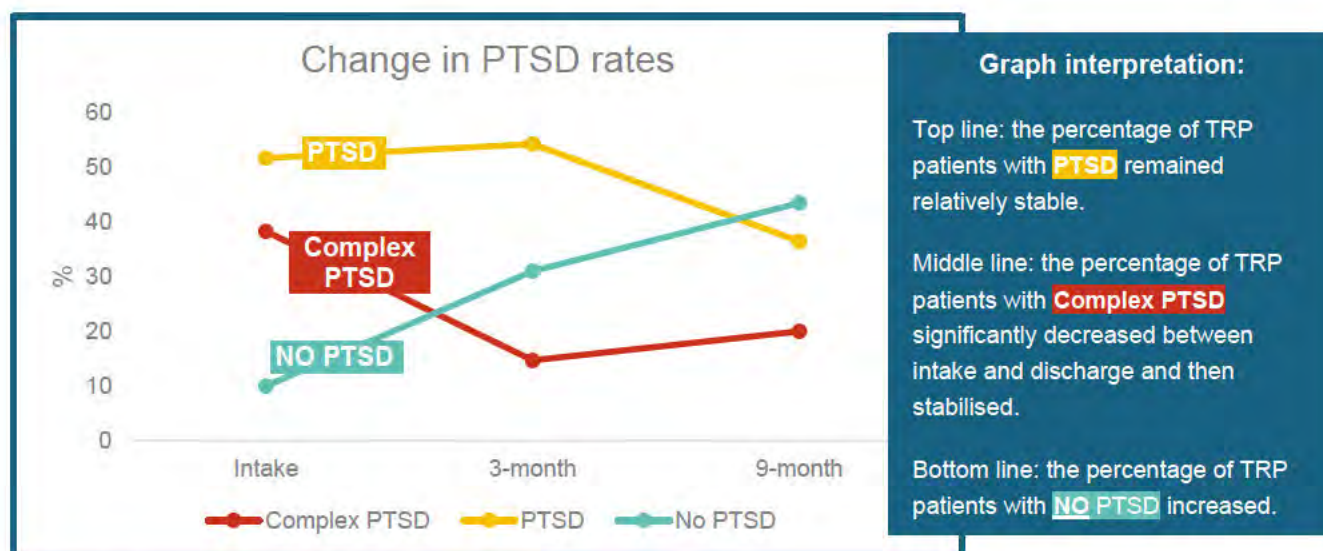


Figure 4. Average change in PTSD rates

Table 9 shows the individual PTSD symptom change on the PCL-5 from intake to discharge, 3-month and 9-month follow-up among veterans meeting PCL-5 threshold (scores 33+) at intake. Overall, around half of the veteran sample showed a response to treatment. This included 25.5% who showed a clinically significant

response to treatment (indicated by a decrease in scores of 10+), but their scores remained above the threshold of 33 indicating probable PTSD, 17.2% whose improvement dropped them below the threshold for probable PTSD, and around 8.9% whose improvement indicated PTSD remission (PCL-5 below 20). The percentage of participants responding to treatment increased from discharge to 9-month follow-up indicating further response to treatment following discharge. Additionally, of the 93 veterans that showed *no response* to treatment (worsening, no change, or change less than 10 on the PCL-5) at discharge, 5 had scores that fell below the threshold of 33 and hence, these participants would be unlikely to meet diagnostic criteria for PTSD.

Table 9. PTSD symptom change on the PCL-5 from intake to discharge, 3-month and 9-month follow-up among veterans.

Category	Discharge		3-month follow-up		9-month follow-up	
	n	%	n	%	n	%
No response	93	48.4	55	47.4	35	47.9
Response but still above threshold for PTSD	49	25.5	33	28.4	9	12.3
Response and below threshold for PTSD	33	17.2	16	13.8	19	26.0
Remission	17	8.9	12	10.3	10	13.7

Note: No response defined as either worsening, no change, or change less than 10 on the PCL-5; Response and above threshold defined as a reduction of 10 or more points but still meeting probable diagnosis for PTSD on the PCL-5 (severity score greater than or equal to 33 on the PCL-5); Response and below threshold defined as response plus no longer meeting probable diagnosis for PTSD on the PCL-5 (severity score <33); Remission defined as severity scores less than 20. Participants with scores below the PCL-5 threshold of 33 (i.e. not meeting probable diagnosis for PTSD) at intake were removed from this analysis.

Part B: Current ADF members

Profile of the TRP current ADF participants at intake

This section describes the intake characteristics of current serving ADF members who have commenced TRP cohorts since June 2022, including features of their demographic and service backgrounds, and clinical status.

Table 10 presents this descriptive profile of current ADF members at intake⁷. In summary:

- Approximately 10% of the sample were female.
- The average age of male participants was around 43.2 years (SD = 7.1), they had served in the military for an average of 21.0 years (SD = 8.0) as a regular and an average of 1.3 years (SD = 4.0) as a reservist.

⁷ Note that the sample size numbers (n) in Tables 9 and 10 vary according to the number of people who responded to each question.

- The average age of female participants was around 41.7 years (SD = 8.6), and they had served in the military for an average of 17.6 years (SD = 9.4) as a regular and an average of 0.9 years (SD = 1.5) as a reservist.
- Over 50% male and female participants reported serving in the Army (Regular or conscript), with smaller proportions serving in the Royal Australian Navy (RAN) and the Royal Australian Air Force (RAAF). No female participants served in the RAAF.
- Higher proportions of female participants reported serving in the Army (Regular or conscript) and RAN compared to male participants.
- Both male and female veterans reported an average of 16 past traumatic events (out of a possible 17 presented). This included the event happening to the participant, witnessing it, learning about it and/or it happening as part of their job.
- The average total score on the Clinician Administered PTSD Scale (CAPS-5) was 47.0 for males (SD = 11.8) and 52.2 for females (SD = 8.0), on a scale of 0 to 80 where higher numbers indicate more severe PTSD.
- The average total score for alcohol use (AUDIT) was 11.1 for males (SD = 9.0) and 13.1 for females (SD = 14.5), on a scale of 0 to 40 where higher numbers indicate higher alcohol use.

Table 10. Clinical assessment profile of ADF members at intake

Outcome (measure)	Possible scores	Male (n=87)			Female (n=10)		
		Mean	SD	n	Mean	SD	n
Age at entry into program	N/A	43.2	7.1	59	41.7	8.6	9
Regular	N/A	21.0	8.0	87	17.6	9.4	10
Reservist	N/A	1.3	4.0	87	0.9	1.5	10
Total number of traumatic events experienced	0-17	16.2	1.8	87	16.4	1.0	10
Clinician-assessed PTSD (CAPS-5) scores							
Total	0 – 80	47.0	11.8	75	52.2	8.0	9
Intrusion	0 – 20	11.8	3.8	75	13.1	2.8	9
Avoidance	0 – 8	5.6	1.6	75	5.7	1.4	9
Negative mood and cognitions	0 – 28	16.7	4.8	75	20.4	5.5	9
Arousal	0 – 24	13.0	3.9	75	13.0	1.9	9
Alcohol use (AUDIT)							
Hazardous Drinking	0 - 12	5.5	4.2	80	5.5	4.3	10
Alcohol Dependence	0 - 12	1.5	2.4	82	2.8	4.3	10
Harmful Drinking	0 - 16	4.0	3.7	82	4.8	6.5	10
Total	0 - 40	11.1	9.0	80	13.1	14.5	10
	Possible scores	n	%	Total n	n	%	Total n

Service							
Army (Regular or conscript)	N/A	60	69.8		8	80.0	
Royal Australian Navy	N/A	13	15.1		2	20.0	
Royal Australian Air Force	N/A	13	15.1	86	0	0.0	10

Table 11 contains the percentage of current ADF members experiencing comorbid disorder (in addition to PTSD) as recorded by clinicians at intake. More than half of males (65.5%) and 40.0% of females had a comorbid depressive disorder, which was the most common comorbid diagnosis followed by alcohol use disorder (27.6% for males, 30.0% for females) and generalised anxiety disorder (27.6% for males, 30.0% for females).

Intake data on all primary and secondary outcome measures are presented in Appendix 7.

Table 11. Comorbid diagnoses of ADF members at intake (primary diagnosis is PTSD)

Comorbid diagnoses	Male	Female
	Percent of current ADF members (n = 87)	Percent of current ADF members (n = 10)
Depressive disorders (major & persistent)	65.5	40.0
Alcohol or substance use disorder	27.6	30.0
Generalised anxiety disorder	27.6	30.0
Social anxiety	2.3	10.0
Panic disorder	2.0	0.0
Agoraphobia	2.3	0.0
Other anxiety disorders	2.3	10.0
Other disorders	1.1	0.0

TRP current ADF member participants' outcome data

This section provides a summary of TRP outcome data for all current serving ADF members from whom Phoenix Australia received data since June 2022. It includes information collected across intake, discharge, 3-month and 9-month follow up time points.

The outcome analyses indicate that when all hospitals and the whole sample of participants are analysed, the members who participated in the TRP cohorts benefited significantly in the context of these programs. Descriptive statistics and effect size measures comparing scores at intake and 9-month follow-up suggested:

- **Moderate to large improvements** from intake to 9-month follow-up for PTSD total scores, the negative mood & cognitions and arousal subscales, anxiety, depression, general distress and wellbeing.

- **Moderate improvements** in insomnia, anger and complex PTSD.
- Changes in the PTSD intrusion and avoidance subscales, aggression, alcohol use, relationship functioning, family functioning, moral injury, and quality of life **did not reach significance** at 9-month follow-up. However, there were small significant decreases in intrusion, avoidance, and aggression from intake to discharge.

The following graphs illustrate the changes across time for key clinical outcomes – PTSD, depression, and anxiety. Figure 5 shows that the overall level of PTSD symptom severity, as measured by PCL-5, improved between intake and discharge. The rate of improvement was sustained at 3 months post-discharge, as indicated by a flattened overall trajectory, and continued improvements (although at a reduced level) were evident at 9-month follow-up.

Figure 5. Change in current serving members' PTSD severity over time as measured by the PCL-5



The improvement in mean PTSD severity scores was approximately 10 points at 9-month follow-up when compared to intake, indicating a clinically meaningful change over time ($M = 51.8$ vs. $M = 38.4$). However, while there was clinically meaningful improvement, the average score at 9-months post-treatment ($M = 38.4$) remained above the threshold for probable PTSD (PCL total 33+) and thus suggests that many participants would still be experiencing clinically significant PTSD symptoms.

Figure 6 shows that overall anxiety severity, as measured by the GAD-7, improved between intake and discharge, while this change continued (although at a reduced level) at 3-month follow-up. The level of improvement was also sustained at 9-months post-treatment. Figure 7 shows that the overall levels of depression severity, as measured by the PHQ-9, demonstrated similar patterns of change. Notwithstanding significant improvements over time, the average scores on the PHQ-9 still fell within the 'moderate' range at 9-months for depression ($M = 12.5$) and average scores on the GAD-7 were just within the 'mild' range at 9-

months for anxiety ($M = 9.8$) This suggests that many current serving members would still be experiencing clinically significant levels of these conditions.

Figure 6: Change in current serving members' anxiety severity as measured by the GAD-7

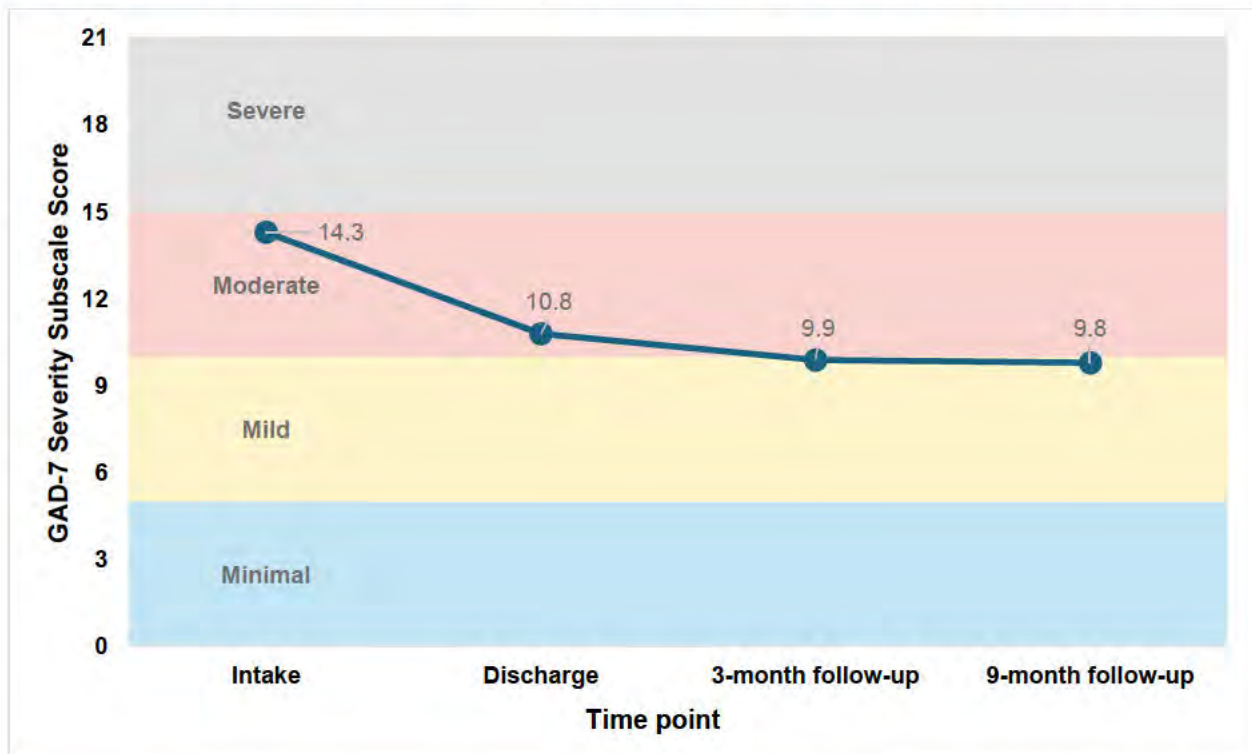
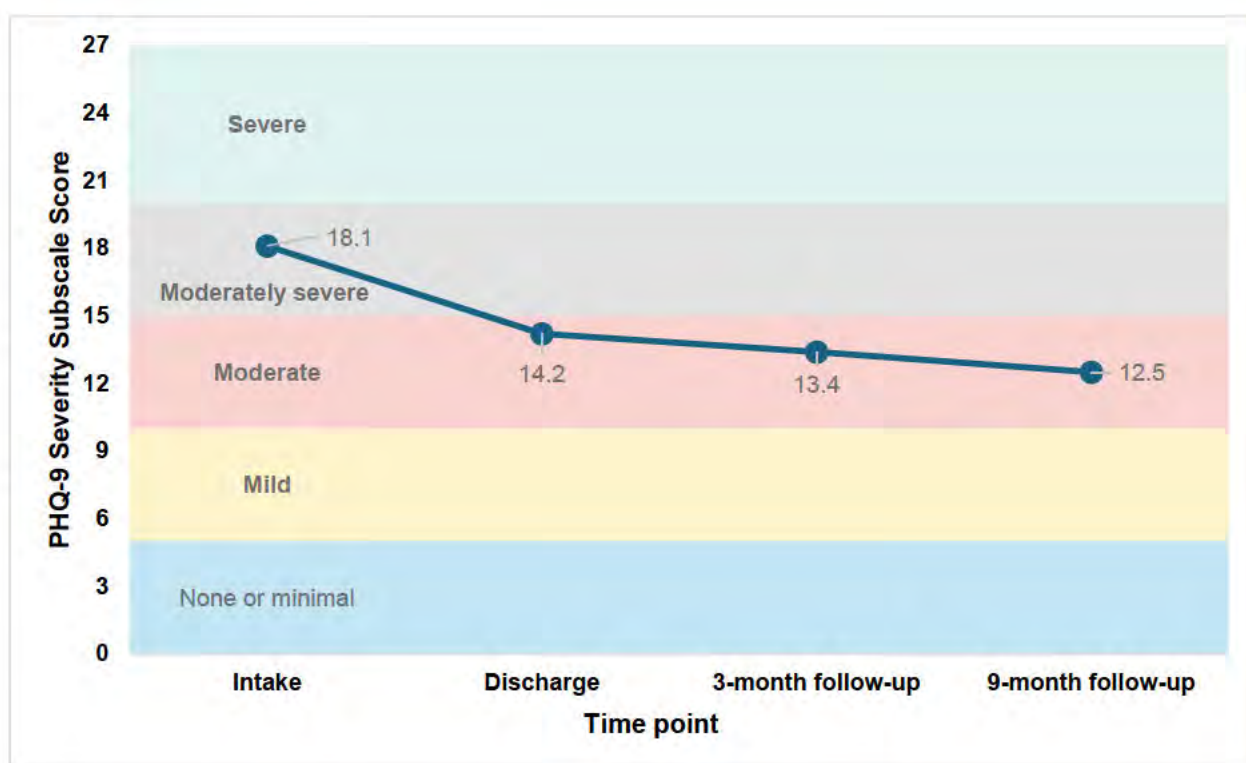


Figure 7: Change in current serving members' depression severity as measured by the PHQ-9



Appendices 7 and 8 contain the descriptive statistics for total scores across outcome measures at intake, discharge, 3-month and 9-month follow-up assessments, as well as effect size estimates of change over time using Cohen's *d* (*d*).

Table 12 shows the rates of PTSD and complex PTSD at intake, 3-month follow-up and 9-month follow-up among current serving members. Both the PTSD and complex PTSD groups met criteria for PTSD on the PCL-5 (scores > 33), but the complex PTSD group also met criteria for the disturbances of self-organisation subscale on the International Trauma Questionnaire (ITQ) for ICD-11. Rates of complex PTSD decreased from 41.7% at intake to 31.0% at 3-month follow-up and further to 26.1% at 9-month follow-up. Overall rates of PTSD decreased from 51.5% at intake to 36.2% at 3-month follow-up, before slightly increasing to 39.1% at 9-month follow-up. Those with no PTSD increased from 6.8% at intake, to 32.8% at 3-month follow-up and further to 34.8% at 9-month follow-up.

Table 12. Rates of PTSD and PTSD with DSO at intake, 3-month and 9-month follow-up among current serving members.

Category	Intake		3-month follow-up		9-month follow-up	
	n	%	n	%	n	%
No PTSD	7	6.8	19	32.8	8	34.8
PTSD	53	51.5	21	36.2	9	39.1
Complex PTSD	43	41.7	18	31.0	6	26.1

Table 13 shows the individual PTSD symptom change on the PCL-5 from intake to discharge, 3-month and 9-month follow-up among current serving members meeting PCL-5 threshold (scores 33+) at intake. Overall, around 50-60% of participants showed a response to treatment at discharge, 3-month and 9-month follow-up. At discharge, 30.4% of the sample showed a response to treatment (indicated by a decrease in scores of 10+), but their scores remained above the threshold of 33 indicating probable PTSD. While 19.0% showed a response to treatment, with scores below the threshold for probable PTSD, and 6.3% of participants had a severity score of less than 20 indicating remission at discharge.

Table 13. PTSD symptom change on the PCL-5 from intake to discharge, 3-month and 9-month follow-up among current serving members.

Category	Discharge		3-month follow-up		9-month follow-up	
	n	%	n	%	n	%
No response	35	44.3	27	50.0	8	40.0
Response but still above threshold for PTSD	24	30.4	11	20.4	5	25.0
Response and below threshold for PTSD	15	19.0	12	22.2	6	30.0
Remission	5	6.3	4	7.4	1	5.0

Note: No response defined as either worsening, no change or change less than 10 on the PCL-5; Response and above threshold defined as a reduction of 10 or more points but still meeting probable diagnosis for PTSD on the PCL-5 (severity score greater than or equal to 33 on the PCL-5); Response and below threshold defined as response plus no longer meeting probable diagnosis for PTSD on the PCL-5 (severity score <33); Remission defined as severity scores less than 20. Participants with scores below the PCL-5 threshold of 33 (i.e. not meeting probable diagnosis for PTSD) at intake were removed from this analysis.

Summary

In summary, the 24-25 report finds:

- 27 TRP cohorts commenced across 9 hospitals in the past year, including 94 veterans and 45 current ADF members.
- Since June 2022, across all programs veterans and current ADF members showed moderate to large improvements in PTSD symptoms, anxiety, depression, distress, and wellbeing from intake to 9-month follow-up.
- Average PTSD severity scores improved by approximately 10 points on the PCL from intake to 9-month follow-up for both groups, indicating clinically meaningful change.
- However, average scores at 9-months still indicated many participants remained symptomatic for PTSD, anxiety and depression.
- With respect to the proportion of veterans and current ADF members who gained clinical benefit, between 50-60% showed a response to treatment (10+ point reduction on the PCL) at discharge and follow-up time points.

Areas for improvement include:

1. Follow-up data collection: There were issues with collecting 9-month follow-up data for many participants, particularly for current ADF members. Improving processes and engagement to increase follow-up response rates would provide more robust long-term outcome data.
2. Sustained symptom reduction: While clinically significant improvements were seen, many participants remained symptomatic at follow-up. Exploring ways to enhance and sustain treatment gains, such as booster sessions, may help address ongoing symptoms.
3. Improved quality assurance: The reports Phoenix Australia have completed in recent years provide quantitative mental health data, veteran qualitative perceptions, and hospital self-report data, which together, have shown variable outcomes in the active TRPs. We recommend DVA reassess quality assurance activities to ensure the TRPs are meeting the minimum requirements according to the Implementation Manual, and the quality of the programs are consistent, and veterans are receiving quality treatment.

References

- Australian Commission on Safety and Quality in Health Care. (2022). *National Safety and Quality Mental Health Standards for Community Managed Organisations*. ACSQHC.
- Baur, J., Cowlshaw, S., Sbisá, A., Madden, K., Dell, L., pham, L., & Phelps, A. (2023). *Trauma Recovery Programs (PTSD) – Clinical Data Collection: Final Report 2022-23*. Report Prepared for Department of Veterans' Affairs. Phoenix Australia - Centre for Posttraumatic Mental Health: Melbourne.
- Brown, P. (2019). *Review of the Trauma Recovery Programs*. Department of Veteran's Affairs and Phoenix Australia - Centre for Posttraumatic Mental Health. P:\DVA\TRP PTSD Clinical Data Collection\3. Project Management and key docs\Dr Brown_DVA workshop Dec2019 and findings

Appendix 1. Current hospitals and key contacts

State	Hospital	Coordinator(s) / Key contacts*
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*Indicates new staff member or staff member in a new role

Appendix 2. List of refreshed measures used across four time points

Completed by	Completed when	Measures included
Clinical Assessment (CA-PTSD): Time 1		
Clinician (with veteran/ ex-serving personnel, or ADF member)	Within three months prior to group commencement	1. Demographic information 2. Pension status 3. Psychiatric and medical diagnoses 4. Alcohol Use Disorders Identification Test (AUDIT) – interview version 5. Clinician Administered PTSD Scale (CAPS-5)
Intake Questionnaire (VI-PTSD): Time 1		
Veteran/ Ex-serving personnel/ ADF member	At program commencement	1. Demographic information 2. Military service history 3. Health service use 4. Personal Wellbeing Index (PWI) 5. Abbreviated Dyadic Adjustment Scale (ADAS or DAS-4) 6. Family Assessment Device (FAD-12) 7. Life Events Checklist (LEC-5) 8. Deployment Risk and Resilience Inventory (DRRI) 9. PTSD Checklist (PCL-5) 10. Patient Health Questionnaire (PHQ-9) 11. Generalized Anxiety Disorder (GAD-7) 12. Moral Injury Outcome Scale (MIOS) 13. ASSIST for alcohol use 14. Gambling - Problem Gambling Severity Index (PGSI) short form 15. Licit and illicit drug use 16. Tobacco use (single question)

Completed by	Completed when	Measures included
		17. Dimensions of Anger Reactions Scale (DAR-5) 18. 2-item measure of violence from TWRP 19. Jellinek Inventory for Assessing Partner Violence 20. Kessler Psychological Distress Scale – Plus (K10+) 21. Complex PTSD - International Trauma Questionnaire for ICD-11 (ITQ) - disturbances in self-organisation (DSO) subscale only 22. Insomnia Severity Index (ISI) 23. Assessment of Quality of Life instrument (AQoL-4D)
Clinical Discharge (CD-PTSD): Time 2		
Clinician (without veteran/ ex-serving personnel, or ADF member)	Within one week of program completion	1. Psychiatric diagnoses 2. Therapy undertaken
Discharge Questionnaire (VD-PTSD): Time 2		
Veteran/ Ex-serving personnel/ ADF member	On last day of program	1. Health service use 2. PTSD Checklist (PCL-5) 3. Patient Health Questionnaire (PHQ-9) 4. Generalized Anxiety Disorder (GAD-7) 5. ASSIST for alcohol use 6. Dimensions of Anger Reactions Scale (DAR-5) 7. 2-item measure of violence from TWRP 8. Kessler Psychological Distress Scale – Plus (K10+) 9. Insomnia Severity Index (ISI)
Three-Month Follow-Up Questionnaire (V3-PTSD): Time 3		

Completed by	Completed when	Measures included
Veteran/ Ex-serving personnel/ ADF member	Approx. three months after program completion (e.g., at 3-month follow-up day)	1. Health service use 2. Personal Wellbeing Index (PWI) 3. Abbreviated Dyadic Adjustment Scale (ADAS or DAS-4) 4. Family Assessment Device (FAD-12) 5. PTSD Checklist (PCL-5) 6. Patient Health Questionnaire (PHQ-9) 7. Generalized Anxiety Disorder (GAD-7) 8. Moral Injury Outcome Scale (MIOS) 9. ASSIST for alcohol use 10. Dimensions of Anger Reactions Scale (DAR-5) 11. 2-item measure of violence from TWRP 12. Kessler Psychological Distress Scale – Plus (K10+) 13. Complex PTSD - International Trauma Questionnaire for ICD-11 (ITQ) - disturbances in self-organisation (DSO) subscale only 14. Insomnia Severity Index (ISI) 15. Assessment of Quality of Life instrument (AQoL-4D)
Nine-month follow-up Questionnaire (V9-PTSD): Time 4		
Veteran/ Ex-serving personnel/ ADF member	Approx. nine months after program completion (e.g., at 9-month follow-up day)	1. Health service use 2. Personal Wellbeing Index (PWI) 3. Abbreviated Dyadic Adjustment Scale (ADAS or DAS-4) 4. Family Assessment Device (FAD-12) 5. PTSD Checklist (PCL-5) 6. Patient Health Questionnaire (PHQ-9) 7. Generalized Anxiety Disorder (GAD-7) 8. Moral Injury Outcome Scale (MIOS) 9. ASSIST for alcohol use

Completed by	Completed when	Measures included
		10. Dimensions of Anger Reactions Scale (DAR-5) 11. 2-item measure of violence from TWRP 12. Kessler Psychological Distress Scale – Plus (K10+) 13. Complex PTSD - International Trauma Questionnaire for ICD-11 (ITQ) - disturbance in self-organisation (DSO) subscale only 14. Insomnia Severity Index (ISI) 15. Assessment of Quality of Life instrument (AQoL-4D)

Appendix 3. Completed outcome reports

State	Hospital	Outcome Report Generated
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Appendix 4. Throughput of TRPs

Table 14. Number of cohorts, and breakdown of participants by hospital.

Hospital (Prov. no.)	Time period (data received)	No. of cohorts	Number participants commenced		
			Veterans	ADF	Total
s 47G	Sept 2014 – 30 June 2023	34	58	24	82
	1 July 2023 – 30 June 2024	3	4	0	4
	1 July 2024 – 30 June 2025	1	0	0	0
	Total	38	62	24	86
	Sept 2014 – 30 June 2023	14	32	1	33
	1 July 2023 – 30 June 2024	0	0	0	0
	1 July 2024 – 30 June 2025	0	0	0	0
	Total	14	32	1	33
	Sept 2014 – 30 June 2023	1	10	0	10
	1 July 2023 – 30 June 2024	0	0	0	0
	1 July 2024 – 30 June 2025	0	0	0	0
	Total	1	10	0	10
	Sept 2014 – 30 June 2023	3	20	0	20
	1 July 2023 – 30 June 2024	0	0	0	0
	1 July 2024 – 30 June 2025	0	0	0	0
	Total	3	20	0	20
	1 July 2023 – 30 June 2025	NOT YET OPERATIONAL			
	Sept 2014 – 30 June 2023	31	163	7	170
	1 July 2023 – 30 June 2024	4	20	0	20
	1 July 2024 – 30 June 2025	2	11	0	11
	Total	37	194	7	201
	Sept 2014 – 30 June 2023	68	316	127	443

s 47G

Hospital (Prov. no.)	Time period (data received)	No. of cohorts	Number participants commenced		
			Veterans	ADF	Total
	1 July 2023 – 30 June 2024	7	27	16	43
	1 July 2024 – 30 June 2025	7	26	26	52
	Total	82	369	169	538
	Sept 2014 – 30 June 2023	28	71	94	165
	1 July 2023 – 30 June 2024	CLOSED			
	1 July 2024 – 30 June 2025	CLOSED			
	Total	28	71	94	165
	Sept 2014 – 30 June 2023	25	106	8	114
	1 July 2023 – 30 June 2024	4	14	1	15
	1 July 2024 – 30 June 2025	3	10	0	10
	Total	32	130	9	139
	Sept 2014 – 30 June 2023	23	99	47	146
	1 July 2023 – 30 June 2024	4	14	7	21
	1 July 2024 – 30 June 2025	4	16	3	19
	Total	31	129	57	186
	1 July 2023 – 30 June 2025	NOT YET OPERATIONAL			
	Sept 2014 – 30 June 2023	12	83	8	91
	1 July 2023 – 30 June 2024	2	14	1	15
	1 July 2024 – 30 June 2025	2	15	2	17
	Total	16	112	11	123
	Sept 2014 – 30 June 2023	6	22	23	45
	1 July 2023 – 30 June 2024	0	0	0	0
	1 July 2024 – 30 June 2025	0	0	0	0
	Total	6	22	23	45
	Sept 2014 – 30 June 2023	17	55	9	64

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Hospital (Prov. no.)	Time period (data received)	No. of cohorts	Number participants commenced		
			Veterans	ADF	Total
	1 July 2023 – 30 June 2024	2	4	2	6
	1 July 2024 – 30 June 2025	2	4	2	6
	Total	21	63	13	76
	Sept 2014 – 30 June 2023	25	149	33	182
	1 July 2023 – 30 June 2024	5	9	12	21
	1 July 2024 – 30 June 2025	4	5	11	16
	Total	34	163	56	219
	Sept 2014 – 30 June 2023	30	72	36	108
	1 July 2023 – 30 June 2024	3	10	4	14
	1 July 2024 – 30 June 2025	2	7	1	8
	Total	35	89	41	130
	Sept 2014 – 30 June 2023	317	1256	417	1673
	1 July 2023 – 30 June 2024	34	116	43	159
	1 July 2024 – 30 June 2025	27	94	45	139
	Total	378	1466	505	1971

Note. Sept 2014 – 30 June 2023 numbers include n=172 current serving members that completed the program but were not eligible for clinical data collection and analysis until July 2017.

Appendix 5. Veterans' outcomes and T1 to T4 effect size changes

Table 15 provides descriptive statistics for total scores across outcome measures at intake, discharge, 3-month, and 9-month follow-up assessments. These statistics include means and standard deviations (SDs) for each measure across time. Table 15 provides effect size estimates of change over time using Cohen's d (d). We will report effect size changes between intake and 9-month follow-up. Effect size values of 0.2 indicate a small effect, 0.5 a moderate effect and 0.8 a large effect.

Table 15. Descriptive statistics for all veterans' data across four time points (since June 2022).

Outcome (measure)	Possible scores	Intake mean (T1)			Discharge mean (T2)			3-month follow-up (T3)			9-month follow-up (T4)		
		n	M	SD	n	M	SD	n	M	SD	n	M	SD
PTSD (PCL-5)													
Total	0 – 80	258	50.5	13.2	212	39.6	15.6	129	39.1	15.3	84	37.1	18.2
Intrusion	0 – 20	262	11.4	4.2	213	9.6	4.4	129	9.1	4.3	84	8.7	5.0
Avoidance	0 – 8	258	5.6	2.0	212	4.4	2.2	129	4.5	2.2	84	4.0	2.4
Negative mood and cognitions	0 – 28	262	18.2	5.4	213	14.2	6.2	129	13.9	6.2	84	12.9	6.7
Arousal	0 – 24	262	15.4	4.5	213	11.5	4.8	129	11.6	4.9	84	11.4	5.7
Anxiety (GAD-7)	0 – 21	255	13.0	4.9	211	9.8	5.1	131	9.3	5.2	86	8.9	5.4
Depression (PHQ-9)	0 – 27	256	16.4	5.4	212	12.0	6.0	131	11.6	5.8	86	11.8	6.2

Outcome (measure)	Possible scores	Intake mean (T1)			Discharge mean (T2)			3-month follow-up (T3)			9-month follow-up (T4)		
		n	M	SD	n	M	SD	n	M	SD	n	M	SD
Insomnia (ISI)	0 – 28	255	17.2	5.9	209	14.2	6.1	136	14.1	6.6	87	14.1	6.8
Anger (DAR-5)	5 – 25	260	13.0	5.0	209	10.8	4.8	135	10.9	4.5	87	11.1	5.1
Aggression	0 – 8	254	0.4	0.9	209	0.3	0.7	130	0.3	0.7	86	0.5	1.1
General distress (K10)	10 – 50	256	31.5	8.1	209	25.9	8.4	136	25.6	7.8	86	25.6	8.5
Alcohol use (ASSIST)	0 – 39	234	15.2	12.4	151	11.9	10.5	104	13.3	11.0	70	12.5	10.6
Relationship functioning (DAS-4) ^{a, b}	0 – 21	183	11.9	4.4	-	-	-	95	13.6	4.4	58	13.7	4.1
Family functioning (FAD-12) ^a	0 - 48	212	27.7	7.3	-	-	-	121	26.6	7.0	76	26.6	6.8
Complex PTSD (ITQ-DSO)	0 - 24	255	15.1	5.1	-	-	-	136	11.2	5.5	86	10.9	5.9
Moral Injury													
Shame	0 – 28	215	15.2	5.4	-	-	-	119	12.0	5.4	76	13.1	5.5
Trust	0 - 28	213	16.7	4.5	-	-	-	119	14.1	5.3	118	14.1	5.3
Wellbeing (PWI) ^b	0 - 70	255	29.7	12.2	-	-	-	131	39.7	11.2	86	39.8	13.2
Quality of life (AQoL-4D) ^b	0 – 1	250	0.3	0.2	-	-	-	134	0.3	0.2	85	0.3	0.2

^a The n for this outcome measure is smaller as only participants meeting a certain criteria complete this measure (those in a relationship for the DAS-4 and those with family for the FAD-12).

^b On these measures a higher number indicates better outcomes i.e., better relationship functioning, wellbeing or higher quality of life.

Table 16. Effect size estimates (Cohen's d) from intake to 9-month follow-up (T1-T4).

Outcome (measure)	Cohen's d comparison		
	T1-T4		
	Cohen's d ^c	95% CI ^d	
		LB	UB
PTSD (PCL-5)			
Total	-0.77	-1.01	-0.53
Intrusion	-0.61	-0.85	-0.38
Avoidance	-0.58	-0.80	-0.34
Negative mood & cognitions	-0.68	-0.92	-0.44
Arousal	-0.77	-1.01	-0.52
Anxiety (GAD-7)	-0.63	-0.86	-0.40
Depression (PHQ-9)	-0.82	-1.07	-0.58
Insomnia (ISI)	-0.52	-0.74	-0.29
Anger (DAR-5)	-0.38	-0.59	-0.16
Aggression	0.15	-0.06	0.37
General distress (K10)	-0.62	-0.85	-0.39
Alcohol use (ASSIST)	-0.07	-0.31	0.18
Relationship functioning (DAS-4) ^{a, b}	0.13	-0.14	0.40
Family functioning (FAD-12) ^a	-0.17	-0.41	0.08
Complex PTSD (ITQ-DSO)	-0.58	-0.81	-0.35
Moral Injury			
Shame	-0.23	-0.46	0.01
Trust	-0.37	-0.60	-0.13
Wellbeing (PWI) ^b	0.74	0.50	0.98
Quality of life (AQoL-4D) ^b	0.41	0.19	0.64

^a The n for this outcome measure is smaller as only participants meeting a certain criteria complete this measure (those in a relationship for the DAS-4 and those with family for the FAD-12).

^b On these measures a higher number indicates better outcomes i.e., better relationship functioning, wellbeing or higher quality of life.

^c Note that a negative Cohen's d (d) indicates a decrease in scores from one time point to the next (i.e., a decrease in scores from T1 to T4). Effect size values of 0.2 indicate a small effect, 0.5 a moderate effect and 0.8 a large effect.

^d Confidence intervals (CIs) that do not include zero indicate significant differences at the $p < .05$ level.

Appendix 6. Veterans' effect size estimates between each time point

Table 17. Veteran participants' effect size estimates (Cohen's d) for each outcome from intake to discharge (T1-T2), discharge to 3-month (T2-T3), and 3-month to 9-month follow-ups.

Outcome (measure)	Cohen's d comparison								
	T1-T2			T2-T3			T3-T4		
	Cohen's d ^c	95% CI		Cohen's d ^c	95% CI		Cohen's d ^c	95% CI	
		LB	UB		LB	UB		LB	UB
PTSD (PCL-5)									
Total	-0.71	-0.86	-0.56	0.05	-0.13	0.22	0.09	-0.15	0.34
Intrusion	-0.42	-0.56	-0.28	-0.08	-0.26	0.10	0.08	-0.16	0.33
Avoidance	-0.51	-0.65	-0.37	0.02	-0.15	0.20	0.05	-0.20	0.29
Negative mood and cognitions	-0.62	-0.77	-0.47	0.06	-0.12	0.23	0.04	-0.20	0.29
Arousal	-0.76	-0.91	-0.61	0.13	-0.05	0.31	0.12	-0.12	0.37
Anxiety (GAD-7)	-0.60	-0.74	-0.45	0.05	-0.13	0.23	0.06	-0.18	0.31
Depression (PHQ-9)	-0.72	-0.87	-0.57	0.11	-0.06	0.29	0.15	-0.09	0.40
Insomnia (ISI)	-0.48	-0.62	-0.33	0.02	-0.16	0.19	-0.05	-0.29	0.18
Anger (DAR-5)	-0.42	-0.56	-0.28	0.07	-0.10	0.25	0.06	-0.18	0.29

Outcome (measure)	Cohen's d comparison								
	T1-T2			T2-T3			T3-T4		
	Cohen's d ^c	95% CI		Cohen's d ^c	95% CI		Cohen's d ^c	95% CI	
		LB	UB		LB	UB		LB	UB
Aggression	-0.13	-0.27	0.00	0.06	-0.12	0.24	0.24	-0.01	0.48
General distress (K10)	-0.70	-0.85	-0.55	0.05	-0.12	0.23	0.16	-0.08	0.39
Alcohol use (ASSIST)	-0.29	-0.45	-0.11	0.31	0.06	0.55	-0.19	-0.49	0.11
Relationship functioning (DAS-4) ^{a, b}	-	-	-	-	-	-	-0.34	-0.65	-0.02
Family functioning (FAD-12) ^a	-	-	-	-	-	-	0.03	-0.25	0.30
Complex PTSD (ITQ-DSO)	-	-	-	-	-	-	0.05	-0.19	0.28
Moral Injury									
Shame	-	-	-	-	-	-	0.24	-0.03	0.50
Trust	-	-	-	-	-	-	0.21	-0.06	0.47
Wellbeing (PWI) ^b	-	-	-	-	-	-	0.05	-0.20	0.29
Quality of life (AQoL-4D) ^b	-	-	-	-	-	-	-0.16	-0.39	0.08

^a The n for this outcome measure is smaller as only participants meeting a certain criteria complete this measure (those in a relationship for the DAS-4 and those with family for the FAD-12).

^b On these measures a higher number indicates better outcomes i.e., better relationship functioning, wellbeing or higher quality of life.

^c Note that a negative Cohen's d (d) indicates a decrease in scores from one time point to the next (i.e., a decrease in scores from T1 to T2, T2 to T3 etc).

Appendix 7. Current ADF members' outcomes and T1 to T4 effect size changes

Table 18 provides descriptive statistics for total scores across outcome measures at intake, discharge, 3-month and 9-month follow-up assessments. These statistics include means and standard deviations (SDs) for each measure across time. Table 18 provides effect size estimates of change over time using Cohen's d (d). We will report effect size changes between intake and 9-month follow-up with values of 0.2 indicating a small effect, 0.5 a moderate effect and 0.8 a large effect.

Table 18. Descriptive statistics for all current serving members' data across four time points (since June 2022).

Outcome (measure)	Possible scores	Intake mean (T1)			Discharge mean (T2)			3-month follow-up (T3)			9-month follow-up (T4)		
		n	M	SD	n	M	SD	n	M	SD	n	M	SD
PTSD (PCL-5)													
Total	0 – 80	103	51.8	12.4	84	40.2	15.6	58	40.6	15.6	23	38.4	16.8
Intrusion	0 – 20	103	11.2	3.9	84	9.3	3.9	58	9.2	4.4	23	8.5	4.3
Avoidance	0 – 8	103	5.5	2.0	84	4.5	2.2	58	4.4	2.1	23	4.6	2.7
Negative mood and cognitions	0 – 28	103	18.8	5.2	84	14.3	6.4	58	14.8	6.2	23	13.0	6.0
Arousal	0 – 24	103	16.3	3.7	84	12.1	4.7	58	12.2	4.8	23	12.3	5.3
Anxiety (GAD-7)	0 – 21	101	14.3	4.5	82	10.8	5.4	55	9.9	5.1	24	9.8	5.5

Outcome (measure)	Possible scores	Intake mean (T1)			Discharge mean (T2)			3-month follow-up (T3)			9-month follow-up (T4)		
		n	M	SD	n	M	SD	n	M	SD	n	M	SD
Depression (PHQ-9)	0 – 27	101	18.1	5.3	83	14.2	7.9	55	13.4	6.5	24	12.5	6.4
Insomnia (ISI)	0 – 28	102	19.1	5.0	83	16.0	5.6	57	16.8	6.1	24	15.7	6.7
Anger (DAR-5)	5 – 25	103	15.1	4.4	83	12.2	4.8	58	12.6	5.2	24	12.5	5.3
Aggression	0 – 8	102	0.5	1.0	83	0.3	0.8	56	0.3	0.8	24	0.5	1.1
General distress (K10)	10 – 50	102	33.5	8.1	83	28.5	9.2	57	29.2	8.9	24	26.4	8.7
Alcohol use (ASSIST)	0 – 39	91	14.6	10.7	60	12.6	10.7	43	13.7	11.2	17	12.0	7.8
Relationship functioning (DAS-4) ^{a, b}	0 – 21	83	12.1	3.9	-	-	-	45	13.8	3.9	21	12.2	4.9
Family functioning (FAD-12) ^a	0 - 48	91	28.5	7.0	-	-	-	52	26.2	7.7	23	27.2	7.0
Complex PTSD (ITQ-DSO)	0 - 24	102	15.5	5.2	-	-	-	58	13.0	6.0	24	11.3	6.3
Moral Injury													
Shame	0 – 28	89	16.0	5.3	-	-	-	50	13.8	6.5	20	13.8	6.9
Trust	0 - 28	89	18.0	4.3	-	-	-	50	14.8	5.4	50	14.8	5.4
Wellbeing (PWI) ^b	0 - 70	101	27.1	11.2	-	-	-	56	35.8	12.3	23	39.5	11.1

Outcome (measure)	Possible scores	Intake mean (T1)			Discharge mean (T2)			3-month follow-up (T3)			9-month follow-up (T4)		
		n	M	SD	n	M	SD	n	M	SD	n	M	SD
Quality of life (AQoL-4D) ^b	0 – 1	102	0.3	0.2	-	-	-	57	0.3	0.2	22	0.3	0.2

^a The n for this outcome measure is smaller as only participants meeting a certain criteria complete this measure (those in a relationship for the DAS-4 and those with family for the FAD-12).

^b On these measures a higher number indicates better outcomes i.e., better relationship functioning, wellbeing or higher quality of life.

Table 19. Effect size estimates (Cohen's d) from intake to 9-month follow-up (T1-T4).

Outcome (measure)	Cohen's d comparison		
	T1-T4		
	Cohen's d ^c	95% CI ^d	
		LB	UB
PTSD (PCL-5)			
Total	-0.71	-1.17	-0.25
Intrusion	-0.41	-0.83	0.02
Avoidance	-0.26	-0.67	0.16
Negative mood & cognitions	-0.74	-1.20	-0.27
Arousal	-0.84	-1.31	-0.35
Anxiety (GAD-7)	-0.82	-1.29	-0.34
Depression (PHQ-9)	-0.84	-1.31	-0.36
Insomnia (ISI)	-0.45	-0.87	-0.02
Anger (DAR-5)	-0.52	-0.95	-0.09
Aggression	-0.06	-0.47	0.35
General distress (K10)	-0.67	-1.12	-0.21
Alcohol use (ASSIST)	-0.44	-0.95	0.08
Relationship functioning (DAS-4) ^{a, b}	-0.11	-0.54	0.34
Family functioning (FAD-12) ^a	0.03	-0.40	0.46
Complex PTSD (ITQ-DSO)	-0.45	-0.87	-0.02
Moral Injury			
Shame	-0.29	-0.75	0.17
Trust	-0.23	-0.69	0.23
Wellbeing (PWI) ^b	0.65	0.19	1.11
Quality of life (AQoL-4D) ^b	-0.14	-0.57	0.29

^a The n for this outcome measure is smaller as only participants meeting a certain criteria complete this measure (those in a relationship for the DAS-4 and those with family for the FAD-12).

^b On these measures a higher number indicates better outcomes i.e., better relationship functioning, wellbeing or higher quality of life.

^c Note that a negative Cohen's d (d) indicates a decrease in scores from one time point to the next (i.e., a decrease in scores from T1 to T4). Effect size values of 0.2 indicate a small effect, 0.5 a moderate effect and 0.8 a large effect.

^d Confidence intervals (CIs) that do not include zero indicate significant differences at the $p < .05$ level.

Appendix 8. Current ADF members' effect size estimates across time

Table 20. Current serving ADF participants' effect size estimates (Cohen's d) for each outcome from intake to discharge (T1-T2), discharge to 3-month (T2-T3), and 3-month to 9-month follow-ups.

Outcome (measure)	Cohen's d comparison								
	T1-T2			T2-T3			T3-T4		
	Cohen's d ^c	95% CI		Cohen's d ^c	95% CI		Cohen's d ^c	95% CI	
		LB	UB		LB	UB		LB	UB
PTSD (PCL-5)									
Total	-0.92	-1.18	-0.66	0.11	-0.15	0.38	-0.19	-0.64	0.27
Intrusion	-0.59	-0.82	-0.35	-0.01	-0.28	0.25	0.00	-0.45	0.45
Avoidance	-0.45	-0.67	-0.22	0.05	-0.22	0.31	0.20	-0.26	0.65
Negative mood and cognitions	-0.86	-1.11	-0.61	0.16	-0.11	0.42	-0.56	-1.04	-0.07
Arousal	-0.94	-1.20	-0.68	0.13	-0.14	0.39	-0.04	-0.49	0.41
Anxiety (GAD-7)	-0.81	-1.06	-0.56	0.05	-0.23	0.32	-0.01	-0.46	0.44
Depression (PHQ-9)	-0.56	-0.79	-0.33	0.03	-0.24	0.31	-0.13	-0.58	0.32
Insomnia (ISI)	-0.55	-0.78	-0.32	0.17	-0.10	0.44	-0.27	-0.72	0.18
Anger (DAR-5)	-0.70	-0.94	-0.46	0.18	-0.09	0.45	-0.15	-0.58	0.30
Aggression	-0.25	-0.46	-0.03	0.07	-0.20	0.34	0.24	-0.22	0.69

Outcome (measure)	Cohen's d comparison								
	T1-T2			T2-T3			T3-T4		
	Cohen's d ^c	95% CI		Cohen's d ^c	95% CI		Cohen's d ^c	95% CI	
		LB	UB		LB	UB		LB	UB
General distress (K10)	-0.80	-1.05	-0.55	0.16	-0.11	0.42	-0.46	-0.91	0.01
Alcohol use (ASSIST)	-0.15	-0.42	0.12	0.14	-0.20	0.49	-0.33	-0.91	0.26
Relationship functioning (DAS-4) ^{a, b}	-	-	-	-	-	-	-0.14	-0.63	0.36
Family functioning (FAD-12) ^a	-	-	-	-	-	-	0.27	-0.22	0.75
Complex PTSD (ITQ-DSO)	-	-	-	-	-	-	-0.37	-0.81	0.09
Moral Injury									
Shame	-	-	-	-	-	-	-0.25	-0.78	0.28
Trust	-	-	-	-	-	-	0.03	-0.50	0.55
Wellbeing (PWI) ^b	-	-	-	-	-	-	0.59	0.08	1.08
Quality of life (AQoL-4D) ^b	-	-	-	-	-	-	-0.17	-0.63	0.30

^a The n for this outcome measure is smaller as only participants meeting a certain criteria complete this measure (those in a relationship for the DAS-4 and those with family for the FAD-12).

^b On these measures a higher number indicates better outcomes i.e., better relationship functioning, wellbeing or higher quality of life.

^c Note that a negative Cohen's d (d) indicates a decrease in scores from one time point to the next (i.e., a decrease in scores from T1 to T2, T2 to T3 etc).

This Program Logic forms part of the Plan and Evaluate phases of DVA’s Program Management Framework.

Problem Statement / Proposal	Program Objective	Inputs	Outputs		Short-Term Outcomes* 6 – 12 months	Medium-Term Outcomes* 1 – 2 years	Long-Term Outcomes* 2+ years
			Activities	Participants			
What is the underlying issue that we are trying to address?	What is the program aiming to achieve?	What resources do we have?	What do we do to implement the program or activity?	Who will be involved in the program?	The difference we make in the short term (generally seen as changes in skills, knowledge, attitudes, awareness or motivation)	The difference we make in the medium term (generally seen as changes in behaviour, practice or systems, or the application of skills and knowledge)	The difference we make in the long term, which resolves the issue identified in the problem statement

Clients with chronic conditions that are not fully managed may be at greater risk of unplanned hospitalisation, and have decreased overall health and wellbeing.

The Coordinated Veterans’ Care (CVC) Program provides planned and coordinated care for DVA clients who have complex care needs, are at risk of unplanned hospitalisation, are living in the community, and who hold either a Gold Card and have one or more chronic conditions, or a White Card and have a chronic DVA-accepted mental health condition. The program aims to improve overall health and wellbeing and reduce unplanned hospitalisations, by improving the management of chronic conditions, and promoting health literacy, self-management and best practice coordination of care through a person-centred approach.

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Approved by:

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Director, Nursing Programs and Operations

21/12/2023

Refer to the Program Management Framework page 15 for Assurance requirements/Sign Off.
When saving this template document please use the following naming convention:
Program Management Framework (PMF) - <insert program name> - Program Logic – <insert month and year, e.g. February 2023>

*Timeframes for the short, medium and long term outcomes for participants and providers are variable as participants and providers may enter and exit the program at any time. Timeframes provided for participants are from enrolment in the program, noting that outcomes will vary at the participant level, based on participants’ individual circumstances. Given the program outcomes and objectives are primarily at the client level, and participation in the program is intended to be for as long as the client is benefitting from participation, the timeframes for outcomes will vary from participant to participant.

BOLD DELIVERS

Department of Veterans' Affairs

24 June 2024

Submitted to:

Health Policy Section
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Executive Summary

In June 2023, the Department of Veterans' Affairs (DVA) commissioned Abt Associates to independently evaluate the Coordinated Veterans' Care Program (CVC Program).

The CVC Program

When established in May 2011, the CVC Program was originally accessible only to eligible Gold Card holders (GCHs). Following expansion in July 2021, CVC became accessible to White Card holders (WCHs) with chronic DVA accepted mental health conditions (eligible WCHs). While initially considering the reduction of hospital admissions an appropriate outcome measure, a more contemporary approach is to focus on participant health and wellbeing outcomes as a more appropriate measure of effectiveness. This occurs through improved management of chronic conditions, promotion of health literacy, provision of self-management support, and coordinated care from the eligible client's usual General Practitioner (GP).

The CVC Program involves a care team consisting of the CVC participant, their carer (if applicable), the GP, and the care coordinator (who can be the treating GP but is most often either a practice nurse [Registered or Enrolled Nurse], Aboriginal and Torres Strait Islander Primary Health Worker, or Community Nurse [CN] from a DVA-approved provider). Specialists and allied health professionals may also join the team as required.

CVC Program implementation, as described in the Notes for CVC Providers, involves a comprehensive health assessment by the GP, the development of a personalised care plan with the GP, and regular follow-up appointments to review and update the plan. Care coordinators play a crucial role in coordinating care, managing administrative tasks, and ensuring effective communication among healthcare providers.

As of 2022, the CVC Program had 21,193 participants, with active engagement from 5,322 providers. DVA's Transport and CVC Programs section oversees program administration, with Medicare processing CVC claims on a 90-day billing cycle. DVA maintains a Program communication strategy to educate stakeholders and promote program compliance through regularly updating DVA website information, development of detailed guidance documents, and stakeholder liaison. As part of the communication strategy, feedback mechanisms and targeted awareness campaigns are intended to facilitate participation by Program care team members. The intent is to demonstrate the Program's positive impact to care team members and external stakeholders, who may then promote the positive Program impact further by encouraging participation with both their peers and eligible patients. This multi-faceted approach seeks to ensure that stakeholders are informed and engaged and are therefore able to contribute to the Program's sustainability.

Evaluation of the CVC Program

DVA's purpose in commissioning this evaluation was two-fold. First, to undertake a programmatic evaluation of the CVC Program across selected evaluation criteria; and second, based on the programmatic evaluation and other available evidence, to identify options to potentially redesign the Program in the context of the contemporary health system (including future directions) and relevant policy, as they relate to the veteran cohort. The three key evaluation questions were:

1. *To what extent has the CVC Program been implemented in line with its intended design?*
2. *To what extent has the CVC Program achieved its intended outcomes?*
3. *How could the CVC Program potentially be redesigned to better meet the needs of current and future DVA clients?*

Evaluation methods and data sources

A comprehensive, mixed methods approach was used to conduct the evaluation including:

- An environmental scan and literature review examined care coordination for veterans in the other Five Eyes countries and contrasted this with Australia's approach. This extensive review (see Section 2.2.1), encompassing academic and grey literature, informed the evaluation's design and provided contextual background that further informed opportunities for CVC Program reform (see Section 5.1).
- Quantitative methods, including program data and cost-efficiency analysis, assessed CVC participant characteristics and program implementation with a view to complement, rather than duplicate routine analytics available through the CVC Program dashboards (see Section 2.2).
- A range of stakeholder consultation processes were undertaken to further inform and enrich the evaluation (Section 2.2.2). This included consultation with and/or written submissions from DVA, other government agencies, health profession peak bodies/associations, ex-service organisations (ESOs), and case studies with general practices. The case studies included consultation with CVC participants, GPs, Practice Nurses and Practice Managers. Additionally, results of the independently facilitated 2023 CVC Participant Survey [1] were incorporated into the evaluation findings.

Key Evaluation Findings

The CVC Program is being managed by DVA in accordance with its intended design and is highly valued by program participants and other key program stakeholders. The scope of the Program and the policy and health system context for its implementation have shifted markedly since program commencement – pressing for adjustment to the Program design and the way in which it is implemented. The evaluation provides a set of recommendations for how the Program can more effectively meet the needs of current and future DVA clients and further demonstrate this effectiveness.

Implementation: To what extent has the CVC Program been implemented in line with its intended design?

The CVC Program has largely been implemented in line with its intended design. Administered and maintained by DVA since its inception, the Program has seen stable participation across the period 2016–2022, reaching 21,193 participants across Australia in 2022. Initially designed for GCHs, the Program was expanded in 2021 to include WCHs with a chronic DVA-accepted mental health condition. While this expansion has been positively received, WCH enrolment remains low due to the complexity of eligibility criteria and the CVC claiming process, and low level of stakeholder awareness. Additionally, there are associated concerns about payment claims, and challenges in marketing the Program to eligible individuals, as most benefits and promotional materials target GCHs.

The establishment of care teams and facilitation of improved care for participants aligns with the CVC Program design. The challenge remains that the capacity to facilitate personalised care for all participants is constrained by a lack of provider expertise, which inhibits the implementation of coordinated care. Most GPs and nurses only perform basic coordination tasks, such as sending written referrals and using practice software notes, with limited case conferencing, multidisciplinary discussions, or other substantive processes of coordinated 'patient-centred' care. To enhance care coordination, DVA could consider providing training for GPs and practice nurses on CVC best practice.

Fundamental to the CVC Program design is long-term participation which supports achieving ongoing improved health outcomes. The Program's results for service utilisation and continuity of participants are mixed. In their first year of enrolment, around half of CVC participants accessed five or six services; however, 19% received two or fewer services. Additionally, 26% of participants disengaged in their first year, and it is estimated that only one-third of exits were due to a participant entering residential care or passing away. There is a suggestion there may be significant instances of non-compliance, whereby some organisations, who are not the usual GPs of relevant participants, are directly marketing their services to

veterans through inducements, and enrolling them in the CVC Program. This involves the provider claiming for both an initial consult and billing (UP01), and for ongoing claiming every 90 days thereafter. DVA are currently investigating this area of non-compliance. Other notable trends in participation for further consideration include the decreasing average age of participants (from 78 years in 2016 to 65 years in 2022), and the increasing proportion of male participants (from 54% in 2016 to 73% in 2022).

The CVC Program's strengths centre on its ability to tailor support to the health care needs of eligible persons, and the specific individuals participating in the Program. Positive feedback was received about the implementation of the CVC Program by practices or GPs that have a military association, and some participants highlighted they felt GPs and practice staff who understood or had lived-military experience provided empathetic, trauma-informed care.

Accessing CVC through their usual GP, veterans feel better understood, trusted, and respected, reducing the need for repetitive storytelling. There is opportunity for an enhanced service in relation to veteran-centric care. DVA could consider: (i) providing and/or supporting (including incentivising) a range of activities (e.g. information, training, education policy, liaison roles) that equip the practice team to deliver more veteran-centric care, and (ii) develop a mechanism that provides formal recognition for practices that have demonstrated that they provide veteran-friendly services to a defined standard.

While establishing GCH eligibility was considered straightforward, a number of challenges to determining WCH eligibility were identified. GP feedback indicated broader uncertainty about WCH entitlements that are wider than the CVC Program. This limited understanding/awareness of Program criteria and business rules for WCHs has led to some reluctance for GPs to enrol eligible WCHs. Feedback noted that providers were hesitant to enrol WCH participants due to the risk of their claim for payment being rejected due to client ineligibility. Specific communication to GPs in relation to WCH eligibility for the Program is warranted.

More general challenges for CVC Program uptake by veterans include low awareness of the Program by entitled persons and insufficient promotion of the Program in the context of transitioning ADF members. For GPs, challenges include low awareness of the Program, inadequate funding support for smaller practices that do not benefit from economies of scale, and perceived significant administrative burden and communication challenges with DVA.

While DVA is already implementing many communication strategies, stakeholders would particularly value improvements in feedback mechanisms for rejected billings and timely communication targeting Nurses and Practice Managers prior to implementation. There would be benefit in using the GP Advisory Group (GPAG) to discuss this issue.

Outcomes: To what extent has the CVC Program achieved its intended outcomes?

Regular communication and follow-up with participants and personalised care from health care professionals underpins very high levels of satisfaction with the Program by CVC participants. As a result of their participation in the Program, participants reported feeling more empowered to manage their health, well supported by their care teams, and confident in their navigation of the health system (Section 4.2).

There has been no identifiable significant impact of the CVC Program on its original intent, reduction of unplanned hospital admissions (Section 4.1). There were no statistically significant differences in use of hospital services by Program participants, as measured by the number of hospital episodes, length of stay, or costs. This finding is consistent with the earlier Program analyses and is not unique within the Australian healthcare context. For example, a robust analysis in NSW showed that after enrolment in a chronic disease management program, significant increases in service utilisation were observed for a range of hospital services [2]. Hospital utilisation is determined by many factors beyond the control of primary care providers, and as such, does not provide a useful policy rationale or outcome measure for care coordination programs such as the CVC Program. Consistent with DVA's decreasing emphasis on

Program cost-savings, improvements such as more robust outcome measures on treatment compliance and outcomes, integrating with other chronic disease management services, and enhancing data integration could be considered.

Program Reform Opportunities: How could the CVC Program potentially be redesigned to better meet the needs of current and future DVA clients?

Any potential redesign of the CVC Program needs to be informed by evidence and lessons learnt from the Program to date, as well as the quickly evolving Australian health system. Recent health policy developments, in particular, the new voluntary patient registration model (MyMedicare), the Australian Primary Health Care 10 Year Plan,[3] the Strengthening Medicare Taskforce Report,[4] and the Medicare Benefits Schedule Review Taskforce,[5-7] are expected to transform the primary care landscape in Australia. In this context, and that of a changing veteran cohort and the evidence for best practice chronic disease management, five areas for program improvement and/or are proposed.

1. Adopting Alternative Funding Models (Sections 5.2 and 5.4): The Productivity Commission Report recommended that the CVC Program adopt a risk-based payer model, in which providers are paid a fee per client based on their risk profile and become responsible for delivering all services required by the client during the year [8]. Similar capitation and bundled payments systems in the UK and the US incentivise early prevention and intervention multidisciplinary teams delivering care integrated across providers and system levels, and efficiency improvements in health outcomes. However, these risk-based, value-added funding mechanisms require transformational practice changes for success, including adopting models of care tailored for multidisciplinary team-based services, altering the composition and roles of practice staff, and supporting digital and business infrastructure. Noting upcoming changes to primary care funding aimed at incentivising continuity of care and service quality, it is recommended that substantial changes to the Program funding mechanism should be considered once more information about new practice incentives and the broader primary care funding landscape matures.

2. Expanding CVC Program Eligibility (Section 5.3): Various stakeholders have identified veteran cohorts currently ineligible for enrolment who would benefit from the Program. Consideration should be given to expanding eligibility, subject to resource availability, with priority given to groups most likely to benefit from early intervention and prevention associated with patient-centred care programs, as well as cohorts with relatively less access to health services. In order of priority, it is recommended that consideration be given to the following groups: medically discharged ADF members, an expanded group of WCHs that includes people with chronic DVA-accepted physical conditions and those with a mental health diagnosis, and GCHs in residential aged care and/or that have a terminal diagnosis.

3. Outcome Measures (Section 5.5): The CVC Program is not well positioned to demonstrate the achievements of outcomes. It is recommended the stated outcomes and associated measures are revised to reflect the reasonably anticipated outcomes of the Program that can drive quality and improvement in a timely way, and that have readily available data. Potential outcome areas and specific measures to consider include Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs), chronic disease markers, and measures of holistic well-being such as improved social support networks, community engagement, enhanced coping mechanisms, and better quality of life.

4. Enhancing Digital Interoperability (Section 5.5): Efficient data utilisation and integration are crucial for optimising healthcare delivery and minimising administrative burden, particularly for time-constrained GPs. By leveraging existing data collections and linking these with mainstream systems, such as electronic health records and patient management platforms, healthcare providers can streamline data collection processes and access comprehensive patient outcome data. However, achieving this relies heavily on the interoperability of systems used by general practices and hospitals, as well as the establishment of appropriate data governance and privacy measures, which were highlighted as significant challenges by peak health providers.

5. Implementing a Stepped-Model of Care Coordination (Section 5.6): It is recommended that reforms to the CVC Program be considered as part of a broader approach to patient-centred and coordinated care for veterans. This broader approach could include: a structured approach to healthcare delivery where the level of care coordination provided to veterans is matched to their individual needs, tailored care plans developed for each individual with specific budgets, and coordination across DVA program, for example, the Wellbeing and Support Program.

Summary of Findings and Proposed Improvements and Reforms

Proposed short-term improvements to the CVC Program are tabulated below, along with key evaluation findings.

Key Evaluation Findings	Short-term Improvement
CVC Program Trends (Section 3.1)	
- Consistent levels of participation from 2016–2022. - Significant drop-out rates in the first year of enrolment. - Average participant age is decreasing. - Proportion of male participants is increasing. - There is overlap between the CVC Program and other chronic disease management services.	- Investigate underlying causes of early drop-out rates and address these through appropriate interventions. - Introduction of additional program controls to prevent and/or mitigate the impact of organisation's enrolling eligible persons in the CVC Program and not providing continuity of care. - The decreasing age of CVC participants is a factor that requires consideration as part of Program improvement and/or reform in the future. - Reinforce communication of WCH eligibility - Provide clarity for GPs about whether concurrent use of GPMP/TCA with the CVC Program is acceptable.
Appropriateness of eligibility criteria (Section 3.2)	
- Stakeholders supported the current GCH eligibility criteria, but determining WCH eligibility was challenging. - Low uptake of WCHs since expansion of eligibility in 2021.	Improve clarity and awareness of WCH eligibility criteria.
Strengths and enablers (Section 3.3)	
- CVC participants valued frequent contact, care coordination, and services tailored to veterans' needs. - Veteran-centric care is highly valued. - Communication strategy is mixed, there is low awareness of the CVC Program and the associated Social Assistance Program.	- Develop a proactive communication strategy and national awareness campaigns targeting GPs, allied health providers, and eligible veterans (particularly WCHs) to promote the CVC Program and associated Social Assistance Program. - Provide and/or support (including incentivise) a range of activities (e.g. information, training, education policy, liaison roles) that equip the practice team to deliver more veteran-centric care. - Investigate the development of a formal mechanism to recognise veteran-centric providers identifiable by veterans and their families.

Key Evaluation Findings	Short-term Improvement
Program challenges and barriers (Section 3.4)	
- Barriers included concerns with use of the CVC Program as intended, administrative burden, lack of awareness, and challenges in identifying eligible veterans. - Low awareness and use of the Notes for CVC Program Providers; need for better integration of clinical care coordination forms with GP software. - Metropolitan practices without dedicated practice nurse coordinators found the funding inadequate, and high administrative burdens were reported.	- Simplify administrative processes, improve communication about necessary forms and rejected billings, and increase awareness campaigns (for GPs and eligible veterans). - Improve support for transitioning ADF members through use of Veteran Support Officers and Transitioning Case Managers. - Simplify and streamline the Notes for CVC Providers and improve interoperability of other forms necessary for clinical care coordination with GP practice software. - Review funding adequacy and consider billing options to reduce administrative burdens through better tools and support. - Further consideration and potential development of guidance on care coordination within the CVC Program and other chronic disease management services. - Review and update the communications strategy to ensure it meets current needs.

Recommendations for long term improvement and or reform of the DVA primary care arrangements.

Long-term Improvements/Reform
- Expanding Eligibility (Section 5.3): Expanding eligibility to include additional groups: transitioning ADF members, WCHs with chronic conditions, and GCHs in residential aged care or with terminal diagnoses. - Emphasising Patient-Reported Outcomes (Section 5.5): Shifting the focus to patient-reported outcomes and experiences (PROMs and PREMs), rather than hospital cost savings could better reflect the CVC Program's value to participants. - Enhancing Digital Interoperability (Section 5.5): Enhancing digital interoperability and data integration would offer an opportunity to streamline care delivery and reduce administrative burdens. - Implementing a Stepped-Model of Care Coordination (Section 5.6): Implementation of a stepped-model of care coordination tailored to individual needs would improve personalised care and overall CVC Program effectiveness.

Conclusion

The evaluation of the CVC Program confirms its positive impact on participants' health and satisfaction. Key strengths include improved healthcare education and trust among veterans. However, challenges such as administrative burdens, funding inadequacies, and limited efficiency gains persist. Short-term improvements should reduce administrative tasks, enhance GP software interoperability, and improve provider communication and education. Long-term strategies should focus on integrated care starting from the transition to civilian life, supported by sustainable funding. Ongoing assessment and adaptation are essential to maintain the program's effectiveness and relevance, ensuring better healthcare for the veteran community. Opportunities for reform in DVA primary health care arrangements should be considered to enhance service delivery.

1. Introduction

Abt Associates were engaged in June 2023 to undertake an evaluation of the Coordinated Veterans' Care Program (CVC Program). This document presents the final report of the evaluation.

1.1 Background

The CVC Program is a flagship DVA program that commenced on 1 May 2011. Originally as a cost-saving budget measure only for eligible Gold Card holders (GCHs), it was expanded to include White Card holders (WCHs) with a chronic DVA-accepted mental health condition from 1 July 2021. The Program aims to improve overall health and wellbeing and reduce unplanned hospitalisations of CVC participants by improving the management of chronic conditions and promoting health literacy, self-management, and best practice coordination of care through a person-centred approach.

1.2 CVC Program Context

The model of care for the CVC Program is based on a care team, which includes the CVC participant, their carer (if applicable), the GP and the care coordinator (who can be the treating GP), but is most often either a practice nurse (Registered or Enrolled Nurse), Aboriginal and Torres Strait Islander Primary Health Worker, or Community Nurse.¹ Care teams may include relevant specialists and allied health practitioners, depending on the care required. The care team works together to develop and regularly review an agreed comprehensive care plan and provide ongoing care coordination within the general practice setting.

1.2.1 Current eligibility criteria

The Notes for CVC Program Providers outline the following participant eligibility criteria:

- a current GCH or WCH with a chronic DVA-accepted mental health condition
- living in the community (i.e. not in a residential aged care facility (RACF))
- not likely to be terminal within 12 months (not terminal on CVC enrolment)
- diagnosed with one or more chronic conditions
- at risk of unplanned hospitalisation
- having complex care needs
- able to give their informed consent to participate in the CVC Program.

An eligibility tool and other tools and resources are available in the CVC Toolbox (available at <https://cvctoolbox.dva.gov.au/Eligibility>) for GPs to use to support their care coordination.

1.2.2 CVC Program implementation

The CVC Program is designed to enhance care coordination for veterans with chronic conditions and complex care needs. Program implementation guidelines are documented in the Notes for CVC Program Providers. General practitioners and care coordinators play a central role in its implementation.

The process begins with a comprehensive health assessment conducted by a GP, who then collaborates with the CVC participant to develop a personalised care plan. This plan outlines specific health goals, management strategies, and necessary interventions. During the health assessment, the entitled person is informed about the CVC Program, its benefits, and what participation entails. They are then asked to

¹From a DVA approved Community Nursing (CN) provider.

provide their informed consent to participate in the Program and to have their health information shared among their healthcare providers for the purpose of care coordination.

GPs and/or care coordinators perform regular follow-up appointments, typically every three months, to review and update the care plan. Monthly reviews, often conducted by the care coordinator by telephone, involve monitoring the participant's progress, addressing any emerging health issues, and providing necessary support and education. This includes discussing medication management, lifestyle modifications, and preventive measures.

Care coordinators also play a crucial role in coordinating care among various healthcare providers, ensuring that all aspects of the CVC participant's health are managed cohesively. They handle much of the administrative workload, such as updating and maintaining the care plan, organising referrals, and facilitating case conferences when required.

The program emphasises proactive management, continuous monitoring, and effective communication among the healthcare team. GPs and the care coordinator (where different personnel) work closely to ensure that CVC participants receive timely, comprehensive, and coordinated care, aiming to improve their overall health outcomes and quality of life and reduce unplanned hospitalisation.

1.2.3 CVC participants and providers

Evaluation program data analytics show stable CVC Program participation, peaking at 21,193 CVC participants in 2022 and a low of 19,275 in 2019. Due to data limitations for the evaluation outlined in Section 2.3.1, provider analysis was not conducted. However, the CVC Program Quarterly Report for April to June 2023 noted 5,322 active providers, including GPs and CN providers, with a median of two CVC participants per GP. Nine GPs had over 100 participants, with the highest being 395.

1.2.4 CVC Program administration and funding

The DVA Transport and CVC (TCVC) Programs section (formerly Nursing and Program Operations) oversees the CVC Program administration. The role of the TCVC Program team is to manage the Program, which includes responsibility for veteran and provider education; issuing the CVC Provider Notes; communication materials, such as brochures and DVA website information; managing client and provider enquiries and complaints; review and analysis of CVC data; and identifying program improvements.

The CVC Program is funded by the Australian Government as a medical service through DVA's portfolio budget. CVC claims are processed by Medicare (Figure 1.1). Providers submit an initial claim through Medicare for the assessment and enrolment of CVC participants and claim at the end of the 90-day care period for the review and coordination services provided during the period. Claims must be lodged after the care period is complete.

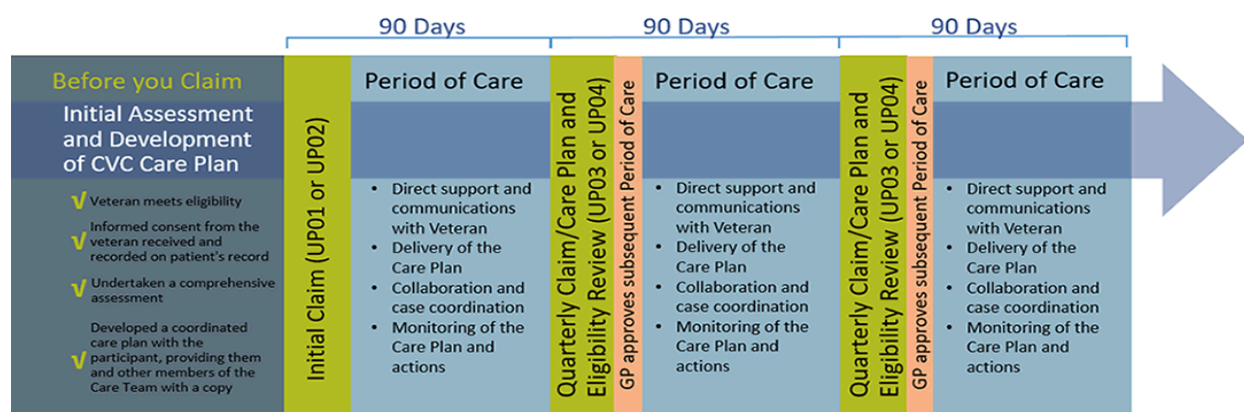


Figure 1.1: Flowchart of CVC Claiming Process for Providers (Source: <https://cvctoolbox.dva.gov.au/Claim-Calculator> last visited 12 June 2024).

1.3 Evaluation of the CVC Program

DVA's purpose in commissioning this evaluation was two-fold. Firstly, to undertake a programmatic evaluation of the CVC program across selected evaluation criteria; and secondly, based on the programmatic evaluation and other available evidence, identify options to potentially redesign the CVC program in the context of the contemporary health system (including future directions) and relevant policy, as it relates to the veteran cohort.

1.3.1 A programmatic evaluation

To understand the benefits of the CVC Program, including its clinical outcomes and impact on wellbeing across appropriateness, effectiveness, and cost-effectiveness domains, this component builds on previous assessments. These assessments include a cost analysis undertaken in the 2019 Bupa cost-shifting analysis[9], and the 2019 Nous review of post-hospital coordination programs [10]. Through examining the past performance of the Program, the programmatic evaluation addresses the first two key evaluation questions (KEQs):

KEQ1: To what extent has the CVC Program been implemented in line with its intended design?

KEQ2: To what extent has the CVC Program achieved its intended outcomes?

1.3.2 A policy focussed review

This review was undertaken to identify potential options to redesign the CVC Program (a forward-looking strategy), particularly with respect to a changing primary care policy and funding landscape and veteran cohort, particularly given the Program's initial design occurred prior to 2011. This component addresses the third KEQ:

KEQ 3: How could the CVC Program potentially be redesigned to better meet the needs of current and future DVA clients?

2. Evaluation approach and methodology

The following approach and methods were used to inform the evaluation of the CVC program including both the programmatic and policy components and the discussion of a forward-looking strategy. A more detailed description of the evaluation approach and methodology is provided in Appendix A.

2.1 Overview

A comprehensive, mixed methods approach was used to conduct the evaluation providing a thorough understanding of the CVC Program's effectiveness and opportunities for improvement and more substantial reform. Methods included a literature review, consultation with a range of key stakeholders, and data analysis focused on participant details, hospital use, and cost savings.

2.1.1 Evaluation design

Activities undertaken to inform the design of this evaluation included:

- a review of the international literature with a focus on the structure/system for and delivery of care coordination and management of chronic diseases for veterans in the Five Eyes countries
- examination of the key policy developments in the Australian primary care sector
- a review of previous CVC Program evaluations and those with relevance to the CVC Program (including the existing, endorsed program logic)
- interviews with key informants
- discussion of and review of available data elements
- weekly discussions on program strategic and implementation considerations with the Project Management Team (PMT) and a co-design workshop to provide DVA the opportunity to discuss the evaluation framework.

2.2 Qualitative Methods

This section provides an overview of the qualitative methods used in the evaluation.

2.2.1 Environmental scan/Literature review

A review of the literature was undertaken with an emphasis on care coordination for veterans in Canada, New Zealand, the UK and the US (Five Eyes) to contrast this with the approach used in Australia for both veterans and the broader population (provided to DVA as an Annex to the evaluation design).

The results of the environmental scan informed the evaluation design and provided background and context to the key findings. Specifically, a lessons-learned rather than a theoretical approach has been used in this report to summarise the main findings of the environmental scan and inform the forward-looking strategy for the CVC Program.

Academic literature (predominantly studies since 2015) and grey literature, including government reports and websites, were extensively searched to ensure the most up-to-date information on care coordination services for veterans was included. Sixty-eight studies, reports and documents were scanned/reviewed. A further 46 documents relating to broader issues of financing and care coordination/integration were also reviewed. Finally, over 64 Australian studies and reports of relevance in Australia, including key policy documents, as well as reports examining a wide range of issues including the challenges of strengthening primary care and reducing hospital costs were identified and scanned/reviewed.

2.2.2 Stakeholder consultations

A broad range of stakeholders were consulted through various processes, including telephone/video interviews, written submissions, and case studies. Those consulted included:

DVA AND OTHER AREAS OF GOVERNMENT

Telephone/MS Teams consultations were undertaken with DVA and other government agencies with respect to the existing CVC Program and/or a forward-looking strategy for the Program in the context of the Australian primary care landscape. This included:

- 11 business areas/sections of DVA
- Department of Health and Aged Care – MyMedicare
- the Australian Digital Health Agency.

EX-SERVICE ORGANISATIONS

Enabling ESOs the opportunity to inform the evaluation, a consultation paper that included key evaluation questions was developed in collaboration with the PMT and distributed to participating ESOs through the National Consultation Framework Secretariat. A written response was provided directly to the evaluators on behalf of their members. Responses were received from:

- Australian War Widows Inc.
- Totally and Permanently Incapacitated (TPI) Federation of Australia.

CASE STUDIES WITH GENERAL PRACTICES

The evaluation was designed to consult with general practices across a range of typologies (to the extent this was feasible given the voluntary nature of the evaluation), examining the effects of location, size and ownership. Targeting general practices to participate also necessitated identifying those practices that had engaged WCHs in the program, particularly given the limited uptake by this cohort.

While the aim was to speak to each of the key personnel (GP, care coordinator, administration officer and CVC participant) from the practice involved in the CVC Program, not always the case that all participated (particularly CVC participants). Table 2.1 and Table 2.2 summarise the consultations conducted with general practices and their participants (see Appendix A for more details).

Table 2.1: Summary of case study sites and general practice CVC participants consulted as part of the evaluation.

ID	Jurisdiction	Geography	GP	PN	Admin/Billing/ Manager	Total
1	ACT	Metro	1	1	1	3
2	QLD	Metro	4	5	3	12
3	QLD	Inner Regional	1	0	1	2
4	SA	Inner Regional	1	5	2	8
5	SA	Metro	3	1	5	9
6	SA	Outer Regional	2	1	1	4
7	NSW	Metro	2	0	0	2
8	NSW	Inner Regional	1	1	2	4
9	VIC	Inner Regional	1	1	0	2
TOTAL	5		16	15	15	46

Table 2.2: Summary of the characteristics of CVC participants interviewed as part of the evaluation.

State/territory	GCH		Total GCH	WCH		Total WCH	Total Veteran Card holders
	Dependent	Veteran		Veteran			
ACT				1	1	1	1
Metro				1	1	1	1
QLD		4	4	1	1	1	5
Metro		4	4	1	1	1	5
SA	3	9	12	2	2	2	14
Inner Regional		3	3				3
Metro		1	1	2	2	2	3
Outer regional	3	5	8				8
TOTAL	3	13	16	4	4	4	20

GENERAL PRACTICE, NURSING AND ALLIED HEALTH COLLEGES/ASSOCIATIONS/PROFESSIONAL BODIES CONSULTED

A broad range of general practice, nursing, and allied health colleges/associations/professional bodies were consulted, either directly by the evaluators, or through a written submission process facilitated via the DVA Health Providers' Partnership Forum (HPPF) Secretariat.

Those consulted and/or who provided a submission included:

- DVA GP Advisory Group (GPAG)
- Royal Australian College of General Practitioners (RACGP)
- Australian College of Rural and Remote Medicine
- Australian Primary Health Care Nurses Association
- Dietitians Australia
- Occupational Therapy Australia
- Exercise & Sports Science Australia
- Australian, New Zealand & Asian Creative Arts Therapist Association
- Australian Association of Psychologists Incorporated
- Australian Physiotherapy Association
- Australian Association of Practice Management
- Primary Health Networks (Country to Coast QLD)

2.3 Quantitative Methods

The following section provides a more detailed summary of the quantitative methods used in the evaluation.

2.3.1 Program data analysis

The key variables of interest for this evaluation related to CVC participant characteristics and their use of the CVC Program and hospital services. The data analytics examined program implementation and cost-efficiency, including impact on hospital savings, with a primary focus on GCHs. Since WCHs represented less than 5% of participants in a given year, it was agreed that a separate analysis for them was not warranted. Additionally, current datasets offered limited opportunities for useful quantitative assessments to inform a forward-looking strategy for this cohort.

Since some standard metadata were not routinely available (e.g. data report specifications), accessing the specifics of the variables and datasets required was not possible. Accordingly, an iterative process with multiple cross-checks and discussions with the DVA Data & Insights (D&I) Team was undertaken.

Analysis was undertaken against 28 datasets, including, but not limited to: chronic condition, hospital episodes, service items, RACF, and geographical location. Challenges in relation to detailed information from private hospitals prevented the use of emergency department data for eligible GCHs to build an indicator of unplanned hospital admissions (and associated costs).

To refine the dataset and create a final version with complete information on unique Veteran Card holders and their chronic conditions, a cross-validation process was undertaken that involved several steps, including examining whether the classification of individuals as CVC Program participants or eligible persons aligned with records of CVC Program treatment in the primary care dataset.

Following comprehensive validation, the final sample of unique individuals in the chronic condition dataset was 116,013. Among non-CVC participants, the final sample was 71,654; all in this group were alive as of September 2023. For Veteran Card holders with at least one CVC Program treatment record in 2016–2023, the final sample was 44,359, with approximately 68% still alive as of November 2023.

Standard data and health economics analytics methods were used, including descriptive statistics and multivariate regression analysis to examine program data and estimate metrics of program implementation and outcomes.

In some instances, the year of enrolment was chosen as the time variable for the analysis, and in others, the fiscal year in which the service was delivered was used. This approach allowed consideration of different time perspectives, providing a comprehensive understanding of the dynamics and patterns within the data.

2.3.2 Cost-efficiency analysis

A cost-efficiency analysis was conducted alongside program data analytics to identify areas for optimising resource use within the CVC Program. This analysis examined service delivery patterns, associated expenditures, participant characteristics, and the availability of other chronic condition management programs like GP Management Plans (GPMP) and Team Care Arrangements (TCA). This comprehensive approach provided actionable insights for potential improvements.

To assess the CVC Program's impact on hospital expenditure, regression analysis was used, comparing entitled persons using GPMP/TCA services who never used the Program as a control group. All costs are reported in constant Fiscal Year 2021 dollars to account for inflation, using health price indexes from the Australian Institute of Health and Welfare (AIHW).[11] For primary services costs, the AIHW's Medicare medical services fee index was applied, and 2022 expenditures were adjusted using the Consumer Price Index (CPI).

2.4 Limitations

The evaluation of the CVC Program faced two key limitations:

- **Data availability.** A time lag in the final recording of data resulted in selection of more limited time frames for analysing data sets. This is described in detail in the relevant sections.
- **Small sample size.** For Practices and CVC participants, the voluntary nature of participating in the evaluation and delays to recruitment (participants), resulted in a smaller and less geographic representation than aimed for. Whilst this may lead to some caution in interpreting findings, it is important to note that responses within and between these two main stakeholder groups were consistent. Additionally, CVC participant feedback was consistent with the themes identified in the 2023 Participant Survey.[1] GP feedback was consistent with issues raised by GPAG members and other key stakeholders.

3. Program Implementation Findings

Chapter 3 describes the evaluation findings as they relate to **KEQ1: To what extent has the CVC Program been implemented in line with its intended design?**

The chapter addresses the four key areas of: (i) Trends in CVC Program uptake and attrition and Integration with other chronic disease management programs, (ii) Appropriateness of the eligibility criteria, (iii) Strengths and enablers and (iv) Program challenges and barriers.

3.1 CVC Program Trends

The effectiveness of chronic disease management services is tied to sustained engagement over extended periods of time [12, 13]. Consistent engagement allows healthcare professionals to monitor and adjust care plans according to the dynamic nature of a patient's condition, fostering a patient-centred approach to their management. Furthermore, the establishment of an ongoing relationship between healthcare providers and patients facilitates the development of trust, encouraging individuals to actively participate in their care and adhere to recommended interventions [12-15]. Therefore, the longevity of service utilisation is intrinsic to achieving sustained improvements in health outcomes and the associated cost savings from reduced hospital utilisation. This issue was underscored by previous CVC Program evaluations, whose findings showed that many years of enrolment were required for the Program to achieve the expected cost savings.

A wealth of indicators focused on CVC Program uptake trends are routinely monitored by DVA. In particular, the Quarterly CVC Program Reports examine socio-demographic characteristics of CVC participants, enrolment status by type of Veteran Card, use of services, and expenditure. Additionally, the program dashboards offer supplementary indicators, enabling management to access the most recent metrics continuously and effortlessly.

The following section details CVC participant characteristics and changes in program uptake over time, using data from Quarterly Reports and program analytics. Stakeholder feedback and academic literature are included to contextualise the trends.

3.1.1 Program uptake

Considering the constraints imposed by the current data landscape and leveraging the insights available from program dashboards, the following section presents an overview of CVC Program uptake trends. This overview serves as a contextual foundation for the remaining data analytics presented in this report.

Table 3.1 illustrates key demographic characteristics of CVC participants for the fiscal years 2016–2022, with the key findings being:

- A stable trend in the number of CVC participants, with a peak of 21,193 in 2022 and a low of 19,275 in 2019. While these numbers are approximately 15% lower than those routinely reported in the program dashboards, this discrepancy is likely attributed to the calculation method used for the evaluation, which only includes participants that received a service during that fiscal year and did not extend to those who received services in the three months prior.
- A discernible trend in the mean age of CVC participants decreasing, from 81 years in 2016 to 74 years in 2022, reflecting a similar trend in the overall veteran population.
- The proportion of male CVC participants is increasing – from 52% in 2016 to 67% in 2022.
- The percentage of CVC participants residing in major city/regional areas has remained stable – ranging from 90% in 2016 to 87% in 2022.

Table 3.1: CVC participants and demographic characteristics by fiscal year (2016–2022).

Fiscal year	CVC participants(N)	Current age (mean)	Male (%)	% Major city/regional area
2016	20,276	81	52%	90%
2017	19,627	81	53%	89%
2018	19,372	80	55%	89%
2019	19,275	79	58%	88%
2020	19,470	78	60%	88%
2021	19,319	76	64%	86%
2022	21,193	74	67%	87%

Table 3.2 illustrates the count of new CVC participants for each fiscal year, average age at enrolment, and sex:

- Despite fluctuations in enrolment trends since 2016, analysis of the data suggests that program uptake remained relatively unaffected by the COVID-19 pandemic, with consistent intake numbers from fiscal years 2019 through 2021.
- Notably, there was a significant surge in the number of new CVC participants for the last fiscal year (2022), marking an increase of 66% over the previous year. The upward trend in CVC Program participation continued, with 2,577 eligible Veteran Card holders joining in the first four months of the 2023 fiscal year. However, qualitative findings (see Section 0) suggest that some new enrollees may not be ‘genuine participants’, with DVA currently analysing this trend.
- In line with age and sex trends for each service year and the overall CVC participant population, when looking at newly enrolled participants:
 - There is a substantial trend of decreasing age, with average age being 78 years in 2016, down to 65 years in 2022.
 - The proportion of males increased from 54% in 2016 to 73% in 2022, this is supported by the 2023 CVC Participant Survey [1].
 - These trends were further investigated employing regression analysis, with both trends found to be statistically significant and seeming to persist in the first four months of 2023.

Table 3.2: New CVC participants and demographic characteristics by fiscal year (2016–2022).

Fiscal year	New CVC participants (N)	Age at enrolment (mean)*	Male (%) **
2016	3,454	78	54%
2017	2,948	77	56%
2018	3,102	76	58%
2019	3,181	74	63%
2020	3,177	72	66%
2021	3,021	66	70%
2022	5,030	65	73%

*Decreasing time trend significant at the 1% level ** Increasing time trend significant at the 1% level

The following section discusses the implications of broader systemic challenges of identifying the target cohort and its general effect on CVC Program uptake and of other DVA services.

SYSTEMIC CHALLENGES IDENTIFYING VETERANS AND THEIR FAMILIES

To assess eligibility (and thus uptake) for the CVC Program, GPs must be aware of their patients' potential eligibility for DVA entitlements. However, this status is not always known to service providers due to veterans and/or their eligible family members being reluctant to disclose it, often due to feelings of shame related to their mental health and well-being. Discussions with general practices in relation to eligibility criteria revealed challenges in identifying patients who may be eligible for DVA entitlements. The key findings were:

- Self-Employed GPs admitted they often did not know whether new patients were veterans or family members of ADF personnel unless patients self-identified or requested to pay with a Veteran Card.
- Larger Corporate Practices commonly understood their patient characteristics, including Veteran Card holder status, using GP practice software (e.g., Best Practice™, MedicalDirector™), and regular segment analysis.
- Veteran-Centric Practices had comprehensive intake systems that included asking new patients whether they or their family had ever served in the Australian Defence Force (ADF). This indirect question was found to be less confronting for those reluctant reveal their status. This approach is also recommended by organisations like AIHW and the Australian Bureau of Statistics (ABS) and used by other non-veteran-specific service providers such as mental health and homelessness services.
- Non-Veteran-Centric Practices acknowledged that the veteran and family population was small and often difficult to determine unless they self-identified.

The degree of veteran focus, practice size, business model, and familiarity with the CVC Program were factors in a practices' awareness of their patients' veteran status. While this issue is not specific to the CVC Program, awareness-raising efforts by the DVA should include promoting initiatives and approaches for mainstream services to identify patients who may have DVA entitlements. Additionally, appropriate referral points for support and information, including DVA and peer support networks, should be included with the patient's consent.

3.1.2 High attrition and service delivery patterns

To contextualise the qualitative findings on implementation of the CVC Program, data pertaining to key service patterns within the broader landscape of chronic disease management services were examined.

Table 3.3 presents a detailed analysis of CVC participants who received only one or two services during their first year of enrolment in the 2016–2020 period, noting five to six would be expected. Analysis was restricted to an end point of 2020 to take potential delays in recording of services into consideration.

- Over the full period analysed, the proportion of new CVC participants receiving only one service averaged 12%, with a range from 10% in 2018 to 17% in 2020.
- The higher percentage observed in 2020 could potentially be an effect of the pandemic. Future monitoring of service usage should examine whether these elevated levels of attrition persist in subsequent years and investigate their underlying cause.
- A further 7% of CVC participants received only two services in their first year of enrolment, indicating that 19% of participants receive two or less services in their first year of enrolment.

These high rates of non-adherence to the expected quarterly services, (a) poses financial challenges for practices (examined below), and (b) will have a significant impact on the overall effectiveness of the CVC Program through limited attendance.

Table 3.3: CVC participants receiving 1 or 2 services only in year one of enrolment by fiscal year (2016–2020).

Service received in Year 1 of CVC enrolment	2016	2017	2018	2019	2020	Total
Total new CVC participants	3,454	2,948	3,102	3,181	3,177	15,862
# receiving one service only	364	361	323	372	526	1,946
% of total CVC participants	11%	12%	10%	12%	17%	12%
# receiving two service only	249	217	218	209	254	1,147
% of total CVC participants	7%	7%	7%	7%	8%	7%
Proportion receiving two or less services	18%	19%	17%	19%	25%	19%

Further analysis of low service usage found that a significant number of CVC participants only stayed in the program for one year or less between 2016 and 2020. In line with the above findings, 26% of participants disengaged within their first year, with the highest rate of disengagement occurring in 2020, as seen in Table 3.4.

Table 3.4: CVC participants enrolled for 1 year or less by enrolment fiscal year.

Number of CVC participants enrolled for 1 year or less	2016	2017	2018	2019	2020	Total
Total new CVC participants	3,454	2,948	3,102	3,181	3,177	15,862
# disengaged in first year of enrolment	853	787	776	774	939	4,129
% of new CVC participants	25%	27%	25%	24%	30%	26%

To investigate whether factors beyond CVC participants' control influenced their decision to leave the CVC Program in the first year of enrolment, the proportion of participants who entered RACF or passed away during their initial year was examined by fiscal year of enrolment (see Table 3.5).

Table 3.5: CVC participants enrolled for 1 year or less by enrolment fiscal year – % that entered RACF or died (low and high scenarios).

Fiscal year of enrolment	2016	2017	2018	2019	2020	Total
Estimate of the # (range) of CVC participants exiting the program due to entering a RACF or passing away	285 – 325	233 - 258	197-203	162- 193	171 - 201	1048 - 1188
% of CVC participants exiting in year 1	33-39%	30-33%	24-26%	21-25%	18-21%	25-29%

In terms of RACF, a substantial number of CVC participants exiting the program in the first year of enrolment recorded multiple aged care entries. For some, the episodes appeared consecutive. It is possible that some of these entries represent multiple occurrences of respite in RACF, which does not preclude participants from remaining enrolled in the CVC Program and are thus recorded as such.

In Table 3.5, a range of estimates based on different criteria for including a CVC participant as having entered RACF are provided. In the lower scenario estimate, an admission of at least six months is included. In the higher scenario, participants with at least one admission without any time parameters is included.

- The first row provides the estimated range (using the low and high scenarios) of the number of CVC participants within each fiscal year who exited the CVC Program due to entering RACF or passing away. The second row shows the percentage range of participants who left the Program in the first year due to these reasons. This is estimated as a proportion of the total participants that exited the program in year 1.

- In the fiscal year 2016, 853 CVC participants exited the CVC Program in year 1 (as shown in Table 3.4). Of these, 33% to 39% of exited due to entering residential care or passing away. On average, in the 2016–2020 period, between 25% to 29% of participants that remained in the Program for one year or less left due to factors beyond their control, such as passing away or entering RACF.
- Accordingly, on average, in the 2016–2020 period, between 71–75% did not continue in the CVC Program after 12 months for other reasons.
- Notably, a decreasing trend was found in the proportion of participants leaving the CVC Program due to factors such as death or entering RACF in both the lower and higher scenarios. Taking the high scenario estimate, it decreased from 39% in 2016 to 26% in 2018 before further declining to 21% in 2020.
- The robustness of this trend was further scrutinised by considering only CVC participants who passed away during their first year of enrolment, since this information is less subject to data recording issues for RACF. The results indicate a similar decreasing trend of participants exiting the CVC Program in their first year of enrolment due to death – from 21% in 2016 to 13% in 2020.

The evidence reviewed here suggests a changing pattern in the reasons for CVC Program exits that likely aligns with a relatively younger cohort of CVC participants. Since attrition rates in year one remain high (as shown in Table 3.4), notwithstanding the decline in the proportion of individuals exiting due to factors beyond their control, it is important to continue monitoring these trends.

OTHER SERVICE PATTERNS FOR SERVICES DELIVERED IN THE FIRST YEAR OF ENROLMENT

Table 3.6 shows new CVC participants have five and six claims annually during 2016–2021. Of note, a relatively high proportion of clients (approximately 29% in their first year of enrolment) have six claims. After cross-validation with the TCVC team, six claims were concluded to be within the business rules.

Table 3.6: Number of CVC participants receiving 5 or 6 CVC Program services in year one of enrolment by fiscal year (2016–2021).

# of CVC participants enrolled for 1 year or less	2016	2017	2018	2019	2020	2021	Total
Total new CVC Program enrolments	3,454	2,948	3,102	3,181	3,177	3,021	18,883
# received five services	1,050	1,005	878	954	867	769	5,523
% of all new CVC Program enrolments	30%	34%	28%	30%	27%	25%	29%
# received six services or more	1,028	763	953	1,023	881	865	5,513
% of all new CVC Program enrolments	30%	26%	31%	32%	28%	29%	29%

COST-EFFICIENCY IMPLICATIONS OF HIGH DROP-OUT RATES IN THE FIRST YEAR OF ENROLMENT

Building on the insights derived from analysis of CVC Program attrition in the first year of enrolment, the cost-efficiency implications are more pronounced.

- The 4,129 CVC participants that left the CVC Program during their first year of enrolment incurred a total cost to DVA of approximately \$5 million. With approximately half of the exiting participants having received two or less services, the benefits of that expenditure with respect to individual and program outcomes in a chronic disease management program context would have been negligible.
- Furthermore, for the 2016–2018 cohort, which represent CVC participants who could have stayed in the CVC Program four years or longer, a further 19 to 20% remained enrolled three years or less, a period insufficient for a key program objective of anticipated cost savings arising from reduced hospitalisations to materialise.

Note that the cost-efficiency implications of these service enrolment patterns apply in all circumstances; that is, including instances where exiting the CVC Program was beyond the control of CVC participants, such as entering RACF or passing away. Moreover, the data suggests high attrition rates continue, even as the proportion of CVC participants entering residential care or passing in year one declines.

LIMITED VOLUNTARY CVC PROGRAM DROP-OUTS

The following section discusses the qualitative findings that supports the notion of voluntary CVC Program drop-out being limited. Only current CVC participants and not those who had exited the Program were interviewed for the evaluation; this would have required an additional layer of ethical clearance requiring additional time that was unavailable. Accordingly, GPs were asked for their experience with participant drop-out and perspectives as to the high drop-out rates observed in the data (see Table 3.4).

Interviewed GPs indicated that to their knowledge, neither Veteran Card holder cohort dropped out voluntarily. The consistent feedback provided was:

- GCHs exited the program mainly for two non-voluntary reasons: entering RACF (per the Program rules) or death, both analysed above.
- Occasionally, GCHs dropped out if they travelled and needed a new regular GP who may not be a current CVC Program provider or have an interest in doing so. However, it was indicated that some GPs were maintaining them in the Program using telehealth, while the CVC patient supplemented their healthcare with a local non-regular GP for non-urgent purposes (coughs/colds). However, a few GPs interviewed indicated that they did not use 'shared care' for this purpose and would exit a participant if they travelled for an extended period.
- A few GPs and CVC participants indicated that access to certain medications that may not be prescribed by their regular treating doctor, or easy to access in certain states (such as cannabinoid oil), may have been the reason for changing GPs (and by extension, dropping out of the CVC Program if the new GP did not use the Program).
- There was a view that some WCHs found the frequency of communication associated with the CVC Program overwhelming, and consequently dropped out, otherwise the reasons outlined above applied to them as well (travel and access to certain treatments).

Many GPs theorised that the recent high drop-out rate was more likely to be reflective of what they considered to be 'non-genuine' CVC Program enrolments by some 'organisations' that were enrolling new patients not in line with the Program's intent, further discussed in the next section. Some GPs indicated there would be benefit in a DVA exit survey to determine the reason for Program drop-out in the future.

RECRUITING PARTICIPANTS IN LINE WITH THE CVC PROGRAM INTENT

Internal stakeholders, health provider peaks and many GPs held a strong view that there were organisations operating in 'veteran compensation and health' that were not using the CVC Program as intended. They were reported to be predominantly accessing newly transitioned patients, enrolling them in the Program via a telehealth consult and billing for the initial consult (UP01) unbeknownst to their regular GP. Allegedly, this included enticements of free medication, including cannabinoid oil. It was reported that continuity in the Program with the enrolling GP did not occur in line with the intent of the Program, potentially a cause of the increasing year one attrition discussed above.

When the regular GP subsequently enrolled an eligible participant in the CVC Program, they would not be aware that this had already occurred until after the 90-day billing cycle had elapsed. Accordingly, they would have a high degree of frustration upon receiving a rejected UP01 claim for significant administration and treatment they had already provided to develop the comprehensive care plan.

It has been suggested that this may be partially mitigated through re-introducing a requirement that GPs obtain written consent from an eligible participant to be enrolled in the CVC Program. Further, that the

business rules be amended to require that this written consent be submitted to DVA with the UP01 claim and a copy be provided to the CVC participant. This requirement may:

- create some reluctance amongst those with no intent to continue offering the CVC Program to enrol an eligible participant; and
- through having the consent, possibly reinforce to the CVC participant their enrolment (many forget the name or specifics of the programs they are on), thereby increasing the chance they will alert their regular GP to the fact they are already enrolled – saving GPs the additional efforts associated with enrolment without payment.

Both GPs and CVC participants voiced the importance of treatment and provider choice; however, also acknowledged that when a provider was offering to pay for all medications and aids (such as orthotics, hearing aids etc), in exchange for signing up to a Program over the phone, that it would seem attractive to participants who did not understand the consequences for themselves (no intent of ongoing care) and their 'regular GP'. One GP noted that patients seemed to assume that they would continue to be the CVC participant's regular doctor and continue to provide CVC treatments/reviews while another provider supplied the patient with their medication and billed for the treatment/reviews. The patient was very distressed that shared care was not an option for them.

Separate to the issues discussed above; however, in the same vein, some CVC participants expressed concerns about ensuring the CVC Program was not just a checkbox exercise by GPs. They emphasised the importance of maintaining integrity within the Program and ensuring that Program resources are used effectively and efficiently to support genuine healthcare needs.

From the data analysis demonstrating high and increasing attrition in year one of CVC Program enrolment and related stakeholder feedback, the DVA should consider a more in-depth investigation of this trend to assess the underlying cause(s) and address them accordingly. This could include:

- Implementing a dashboard indicator to measure drop-out rates, particularly in the first year of CVC Program enrolment. As data architecture improves, this indicator could be disaggregated by major causes such as entering RACF, death, and other factors.
- Conducting a detailed analysis of available internal datasets to identify patterns and trends related to specific GPs or individual characteristics associated with both the drop-out and/or limited service episodes in year one of enrolment.
- Surveying and interviewing veterans who in recent years exited the program in the first year of enrolment to gather qualitative data and insights.

3.1.3 Integration with other chronic disease management services

During evaluation design discussions, the evaluators were requested to examine the extent to which the CVC Program was delivered alongside chronic disease management services, more specifically GP Management Plans (GPMP) and Team Care Arrangements (TCA).

Table 3.7 presents an analysis of the intersection between CVC participants and those concurrently receiving the GPMP/TCA services and the associated costs. The data showed:

- consistent utilisation patterns across fiscal years, with a substantial proportion of CVC participants also receiving chronic disease management services, in the range of 62% (2021) to 67% (2019)
- CVC participants receive a similar average number of services from each of the chronic disease management initiatives every year from GPs, though slightly higher for the CVC Program
- total service costs for CVC participants amounted to \$216 million over the 2016–2022 period, with an additional \$34 million spent on GPMP/TCA services for the same participants.

Further analysis showed that when looking beyond concurrent fiscal year services, a higher percentage (approximately 90%) of CVC participants during the 2016–2022 period also received chronic condition management services at some point in time. This has important implications for evaluating the impact of the CVC Program, since a large proportion of participants have received and benefited from the delivery of both service types. It should be noted from a program cost-efficiency perspective, that those additional resources may be justified if patients receiving both services have more complex needs. GPs tend to enrol patients in the Program with more conditions, higher severity of illnesses or a history of more intensive healthcare utilisation.

Table 3.7: Treatments and costs for CVC participants who received concurrent chronic condition management services (2016–2022).

Fiscal year	CVC participants			CVC participants also receiving GPMP/TCA			
	# of CVC participants	Program Treatments (mean)	Annual Cost	# of CVC Participants	As % of Total	Treatments (mean)	Annual Cost
2016	20,276	3.4	\$32,721,190	13,375	66%	3.2	\$5,248,609
2017	19,627	3.4	\$31,423,730	13,025	66%	3.2	\$5,087,422
2018	19,372	3.4	\$30,851,189	12,972	67%	3.2	\$4,934,982
2019	19,275	3.4	\$30,678,822	12,934	67%	3.2	\$5,002,752
2020	19,470	3.4	\$30,252,739	12,895	66%	3.2	\$4,842,811
2021	19,319	3.3	\$29,439,722	11,957	62%	3.2	\$4,382,089
2022	21,193	3.0	\$30,322,669	13,371	63%	3	\$4,871,000
Total	138,352		\$215,690,060	90,529			\$34,369,666

TIMING OF SERVICES AND CVC PARTICIPANT ‘SELECTION’

To further explore these findings, the analysis focussed on the intermediate years, specifically 2018–2020, enabling an assessment of CVC Program treatment utilisation for CVC participants both prior to and after their enrolment in the Program.

Table 3.8 provides a breakdown of the number of new CVC participants for each fiscal year, categorised by enrolment in GPMP and TCA services between 2016 and 2023. The data underscores a notable trend of a substantial proportion of new participants (ranging from 88% to 90%) also receiving GPMP/TCA services during the study period. For those who received GPMP/TCA services, the timing of their first recorded engagement was explored – whether it occurred before, concurrently with, or after their enrolment in the CVC Program. The analysis showed:

- the majority of CVC participants received their first GPMP/TCA services in the years preceding their CVC Program enrolment, showing an upward trend from 46% in 2018 to 55% in 2020
- a significant portion of CVC participants received their first services in the same year as their CVC enrolment. However, in alignment with the above trend, this percentage decreased from 42% in 2018 to 36% in 2020
- a smaller percentage received their first GPMP/TCA services after their first CVC year of enrolment, a trend of decline from 12% in 2018 to 6% in 2020.

The reviewed evidence suggests a growing trend among providers to leverage the CVC Program for patients engaged in GPMP/TCA, aligning with the earlier observation of a substantial increase in new Program enrolments in recent fiscal years.

Table 3.8: New CVC participants – timing of GPMP/TCA services (2018–2020).

	2018	2019	2020
New CVC participants (N=)	3,102	3,181	3,177
Received GPMP/TCA treatments in 2016-2023?			
No	297 10%	337 11%	397 12%
Yes	2,805 90%	2,844 89%	2,780 88%
If yes, when received their first GPMP/TCA treatment?			
• In the years prior to their CVC Program enrolment	1,303 46%	1,465 52%	1,526 55%
• In their CVC Program year of enrolment	1,169 42%	1,057 37%	1,009 36%
• After their CVC Program year of enrolment	333 12%	322 11%	156 6%

Given this trend of an increasing proportion of CVC participants having already been enrolled in GPMP/TCA, the evaluation examined the extent to which providers channelled more complex patients into the CVC Program. While not having access to the health condition of patients prior to their enrolment in the Program, the chronic conditions dataset held by DVA provided invaluable information to fill this gap for a sub-sample of individuals.

The dataset identified the chronic conditions of CVC participants, as well as those of other GCHs currently alive and not in RACF. These conditions were measured in the second semester of 2023 based on past usage of health care services, including hospital services and primary care. Since there was a significant delay of up to 18 months for some of the treatments/services used for these measurements, it was assumed that they captured the health status prior to 2022 and was not heavily contaminated by their use of services since July 2022. On this assumption, the chronic conditions dataset was used to assess the extent to which providers direct their patients with more complex needs (as measured by the number of chronic conditions identified) towards receiving dual services (GPMP/TCA and the CVC Program).

As shown in Table 3.9, the total sample represents GCHs that enrolled in GPMP/TCA as a new GCH in 2022 (4,200), which included those that received GPMP/TCA services exclusively (3,195) and those concurrently enrolled in the CVC Program that year (1,005).

- Within this sample, logistic regression was applied to estimate the probability of these GCHs receiving dual services. To ensure the robustness of findings, alternative samples were explored, such as including those engaged with GPMP/TCA in the previous years. Notably, the results remained consistent across these alternative specifications.
- The key focus was the number of chronic conditions per GCH. A positive and significant result showed that providers tended to refer more complex patients to the CVC Program. The basic model considered age and sex, while alternative models also included remoteness classification. This additional factor was not significant, and the results remained consistent.

Basic descriptive statistics (mean and standard deviation) are described in Table 3.9 for the total sample and the two cohorts, while Table 3.10 shows the results of the regression analysis. The descriptive statistics in Table 3.9 suggest GCHs with dual services are younger, have a slightly higher average number of chronic conditions, and are more likely to be male than those exclusively receiving GPMP/TCA services. The logistic regression results shown in Table 3.10 show that:

- An additional chronic condition increased the odds of joining the CVC Program by approximately 7.6 %, with the effect being statistically significant. That is, there was a positive association between the number of chronic conditions and Program enrolment, which supported that providers were enrolling more complex patients in the Program.
- Of note, an additional year of age decreased the odds of joining the program by 2.8% and the effect was statistically significant. This appears to align with earlier findings of an increasingly younger profile of CVC participants.
- Being male increased the odds of a CVC Program enrolment, which aligns with earlier results; however, the effect was not statistically significant.

For chronic disease management, prioritising relatively younger cohorts with more complex health needs may be beneficial. Younger individuals may have a longer time horizon for potential health benefits, making this type of intervention more impactful.

Table 3.9: Descriptive statistics – GCH with GPMP/TCA only vs. GCHs also receiving Program treatment (2022).

	Eligible GCH with GPMP/TCA only*		Eligible GCH also joined CVC Program*		Total*	
Sample Size	3,195	76.1%	1,005	23.9%	4,200	100%
Variables	Mean	SD	Mean	SD	Mean	SD
# of chronic conditions	1.99	(1.24)	2.01	(1.21)	1.99	(1.23)
Age	72.1	(14.35)	64.9	(18.01)	70.4	(15.63)
Male	0.60	(0.49)	0.71	(0.454)	0.624	(0.484)
*Mean & (Standard Deviation)						

Table 3.10: Logistic regression results - Probability of a new GPMP/TCA GCH also receiving CVC Program treatment (2022).

Probability of a GPMP/TCA GCH enrolling in the CVC Program in 2022	
Variables	Odds Ratio
Number of chronic conditions	1.076**
Age	0.972*
Male	1.211

* Significant at the one percent (1%) level ** significant at the five percent (5%) level

INFORMAL INTEGRATION OF OTHER CHRONIC DISEASE MANAGEMENT COMPLEMENTARY BILLING CODES

In support of the quantitative findings, many interviewed GPs reported using the CVC Program with chronic disease management items (particularly GPMP and TCA) for very complex patients. Some GPs were confused about whether this practice was allowed under CVC business rules due to the perceived overlap in purpose. Several GPs noted that GCHs were entitled to significant health treatment through the Program, which sometimes led to 'over-servicing'. Team Care Arrangements were less commonly used due to challenges with allied health providers accepting DVA funding, creating billing issues and disincentives. Gap payments were also a barrier for lower socio-economic patients.

The GPMP item was seen as particularly useful for billing and coordinating necessary health services within the CVC Program. Most GPs understood the different purposes of these items. Combining these items ensured regular monitoring of complex patients and provided a billing safety net for issues with CVC Program billing.

Some GPs indicated that the proposed merging of GPMP and TCA items would be beneficial under the upcoming MyMedicare reforms, although many were unsure how these changes would impact or benefit them.

3.1.4 Summary of CVC Program trends

The number of CVC participants remained stable through the period 2016 to 2022. There was a significant increased uptake in 2022 that would partially relate to expansion of the program eligibility criteria in 2021, to include WCH with a chronic DVA-accepted mental health condition. However, feedback from GPs was that some of the recent new enrollees may not be 'genuine participants' and there is a suggestion that contrary to the CVC Program design intent, some organisations (that are not usual GPs of relevant participants) are directly marketing their services to veterans and enrolling them in the CVC Program for the limited purpose of an initial consult and billing (UP01). This assertion is potentially supported by program data analysis of variable service access and relatively high attrition rates in year one of enrolment. While around half of CVC participants accessed five or six services, 19% received two or fewer services in their first year. Additionally, 26% of participants disengaged in their first year, and it is estimated that only one-third of exits were due to a CVC participant entering residential care or passing away. The vulnerability of the program to this capture behaviour is heightened by limited awareness of the CVC Program and the status of patients as veterans by usual GPs (self-employed GPs in particular).

Separately, there is a very high proportion of CVC participants that are concurrently enrolled in other chronic disease management services. Whilst most GPs understood the purpose of the CVC Program, as well as other primary care chronic disease arrangements such as GPMP and TCA, and how they can best be used together, there was some confusion on what was allowable and sensible to avoid overservicing and increased complexity for patients and service providers.

The decreasing age of CVC Participants is a factor that needs consideration as part of Program improvement and/or reform in the future, with the average age being 78 years in 2016 and falling to 65 years in 2022. Additionally, the proportion of males increased from 54% in 2016 to 73% in 2022.

3.2 Appropriateness of the Eligibility Criteria

This section describes the appropriateness of and the ease of determining CVC Program eligibility.

3.2.1 Appropriate eligibility criteria

The current GCH eligibility criteria was widely supported as appropriate by stakeholders, particularly GPs, as targeting the appropriate cohort to meet the aims of the program. All case study participants agreed that the current GCH eligibility criteria was appropriate to reduce unplanned hospitalisations. They noted that regular monitoring of these patients theoretically allowed for early intervention to prevent hospitalisations and also noted the recommendations. Additionally, the Productivity Commission report [8] indicated that earlier enrolment into care coordination programs was a more efficient use of funding. A number of CVC Program participants indicated that regular monitoring of their vital signs kept them accountable and may have prevented complications. However, many GPs also indicated that hospitalisations were very likely for this cohort regardless of their care due to their age, and sometimes it was the best place for them.

The flexibility allowing GPs to use their professional judgment in selecting suitable participants, especially those with complex chronic conditions, was seen as a key advantage. However, some expressed concerns about the risks of non-compliance if audited, questioning whether their assessments of complexity would be sufficient. This compliance concern arose from audits related to non-DVA funded programs.

While establishing GCH eligibility was considered straightforward, a number of challenges to determining WCH eligibility were identified and are discussed in Section 3.4.1.

The benefits of expanding the CVC Program eligibility criteria to include other cohorts was explored with stakeholders and through the literature review. This raised a range of opportunities that would require a relatively major reform of the program and thus is discussed in more detail in Section 5.3.

3.2.2 Summary of the appropriateness of CVC Program eligibility criteria

Stakeholders, especially GPs, generally supported the current eligibility criteria for GCH and there were no concerns of note in establishing that eligibility. Determining WCH eligibility posed challenges for some GPs. Stakeholder feedback and evidence from the literature supports consideration of expanding the CVC Program eligibility criteria to other cohorts who would benefit from a program of care coordination.

3.3 Program Strengths and Enablers

The following section describes CVC Program strengths and enablers identified through stakeholder consultation and the academic literature. These strengths include ease of determining GCH eligibility, the benefits of veteran-centric healthcare, tools and resources for implementation, participant education and information, and high participant satisfaction. Where stakeholder feedback is nuanced by location or general practice business model, it is identified as such.

3.3.1 Gold Card holder eligibility

The evaluation finding was that there are no concerns of note in establishing the GCH eligibility to participate in the CVC Program. Stakeholders attributed this to:

- The CVC Program was originally designed for GCHs in 2011 with limited to no ‘chronic condition’ limitations; thus, their eligibility has had the time (and openness) to be well established.
- Generally, GCHs are an older cohort, and as such, are highly likely to have at least one chronic condition with multiple comorbidities, a degree of complexity and as such at risk of an unplanned hospitalisation – the large group of older GCHs are almost eligible for the program by default.

However, feedback from some practices, in particular, those that are veteran-centric, was that with the changing veteran demographic, the GCH cohort presenting to them was increasingly younger. Accordingly, the previously safe assumption for the vast majority of GCHs that older age equals chronic condition and co-morbidities, and thus, eligibility for the CVC Program no longer stood. These veteran-centric practices (that appear to be attracting younger GCHs than practices for mainstream patients) tended to have a more targeted intake system, knew their patients DVA card holder status, had a greater understanding of their entitlements, and a greater willingness to complete DVA claims paperwork.

3.3.2 Advantage of veteran-centric healthcare

Case study consultation revealed health professionals providing the CVC Program tended to have lived military experience or an understanding and/or personal interest in veteran health and wellbeing. Veteran centric practices with high concentrations of staff with lived military experience tended to be located close to Veterans and Families’ Hubs and current military bases, coinciding with the location of high concentrations of newly transitioned veterans [16]. Data are not available to describe how many GPs/providers that provide the Program are veterans themselves.

Research in relation to veteran-specific barriers for accessing services, including care coordination, demonstrates a key factor being a lack of trust in providers’ understanding of the veteran’s experience [17]. Interviewed CVC Program participants supported that the primary drivers for their sustained enrolment are GPs who are personally motivated and have military backgrounds. GPs and practice staff who understand or have lived-military experience can provide more empathetic, trauma-informed care. Veterans feel better understood, trusted, and respected, reducing the need for repetitive storytelling.

IMPROVING ACCESS TO AN APPROPRIATE HEALTH WORKFORCE

Stakeholders expressed that identifying the location of veteran-centric healthcare providers was crucial; however, it was difficult for entitled persons to identify and/or access these providers if they did not live close to a hub or military base. The high mobility of the veteran cohort often complicated continuous healthcare access and raises challenges of how to ensure access to an appropriate health workforce for all entitled persons, notwithstanding the general workforce access challenges in regional areas.

It is unrealistic to expect that all eligible persons are treated by a GP who is a veteran, and in accordance with the importance of individual choice in provider, not all entitled persons want to be treated by a provider who is affiliated with the military.

Given the improbability of having GPs with military backgrounds available in all regions of Australia providing the CVC Program, it is essential to consider how to achieve veteran-centric care more widely. A strategy could involve enhancing the capabilities of mainstream providers to better understand veterans' experiences, thereby equipping them to manage veterans' needs more effectively.

While accepting that some GPs will not have an interest or consider it overly important to be more veteran-centric, the following strategies could be considered and will likely require CVC Program support and possibly incentivisation (as discussed further below):

- Information provided to all GPs who provide the CVC Program as part of the communication strategy (e.g. how to create a welcoming environment that fosters trust and confidence among veteran patients).
- Education and training of the healthcare team in military culture and the unique needs of veterans and their families. This could include promoting online training modules and encouraging participation in programs that improve the understanding of DVA processes. It is understood that this was previously available through PHNs.
- Developing veteran-specific policies and procedures.
- Incorporating a Veteran Liaison role within practices to help the team navigate DVA administrative processes and coordinate care more effectively, echoing the successful elements of the UK's Veteran-Friendly Practices accreditation.

Some form of incentive is likely to be key to the success of mainstream practices undertaking the more substantive activities that will enable them to be more veteran-centric. This could include:

- exploring opportunities for continuing professional development points (CPD) to be attached to any training programs offered
- payment for completion of substantive activities
- the payment (incentive or a higher rate of UP) attached to a form of recognition that the practice is veteran centric.

A RECOGNISED VETERAN-CENTRIC PRACTICE

A strategy supported by stakeholders and the wider literature involves developing a mechanism that increases the visibility of veteran-centric GPs and practices, that is, it is formally recognised and can be branded as such.

The benefit to veterans and their families is that they are provided with information that allows them to make more informed choices about their healthcare providers. Additionally, they have greater assurances that their interactions with this practice team and the support they obtain will cater to their unique needs, ultimately improving their health outcomes.

The mechanism for recognising a GP or a practice as being veteran-centric would require much greater examination and consideration. It could be relatively simple, with limited criterion being established that if met would facilitate them being recognised as such with an identifier on the National Health Services Directory. Of course, practices could subsequently highlight this recognition in their branding and promotion.

A more extensive mechanism for recognition would be through a more expansive accreditation system such as the 'Veteran Friendly Accreditation scheme' established in the UK. Such a scheme could be broader than the CVC Program and recognise and incentivise businesses, healthcare providers, and educational institutions that demonstrate a commitment to veteran-friendly practices [18].

It should be noted that in the UK, the success of the Veteran Friendly Accreditation scheme, adopted by approximately half of all practices, has been highlighted by a recent survey finding that 63% of veterans would be more inclined to seek help if they knew their GP practice was accredited, which has prompted renewed efforts to encourage more practices to join the scheme [18].

In relation to the CVC Program specifically, an 'extreme' approach would be to make accreditation a condition of eligibility to deliver the Program, albeit this would need to be a long-term strategy. Alternatively, accreditation could be voluntary, with practices motivated to take up accreditation to receive an incentive payment.

Designing and implementing an accreditation system in Australia would require specific consideration and would not be a case of simply 'installing' the UK system. The health and veteran compensation systems in Australia and the UK differ significantly. The structural differences imply that any accreditation scheme in Australia must align with both public and private healthcare providers, potentially complicating implementation compared to the UK's more centralised system.

Additionally, DVA administers various benefits, including pensions, healthcare, and rehabilitation services. Veterans UK, a part of the UK Ministry of Defence, operates compensation schemes such as the War Pension Scheme (WPS) and the Armed Forces Compensation Scheme (AFCS). The UK system's bifurcation based on the date of injury or illness contrasts with Australia's more integrated approach [19]. Thus, the policy framework for a veteran-friendly accreditation scheme in Australia must accommodate a broader range of services and providers, ensuring compatibility with existing DVA programs.

Introducing a veteran-friendly accreditation scheme in Australia involves several policy challenges, including navigating existing regulatory frameworks, securing government support, and ensuring alignment with current DVA policies to avoid duplication. Effective stakeholder engagement is essential, requiring trust-building within the veteran community and clear value propositions for businesses. Substantial initial funding would be required for development, marketing, and administration, with a focus on long-term sustainability through continuous funding. Raising awareness among the veteran community, businesses, and the public is vital, along with providing incentives for participation. Establishing clear, fair accreditation standards and robust quality control mechanisms is crucial for credibility. Addressing cultural and social barriers, ensuring compliance with privacy and anti-discrimination laws, and developing reliable methods for measuring the scheme's impact are necessary for successful implementation and continuous improvement.

To achieve enhanced access to veteran-centric care across the CVC Program, the DVA should consider:

- How they could provide and/or support (including incentivise) a range of activities (e.g. information, training, education policy, liaison roles) that equip the practice team to deliver more veteran-centric care.
- A mechanism that provides formal recognition for practices that have demonstrated to a defined standard that they provide veteran-friendly services.

3.3.3 Tools and resources to support implementation

A range of tools and resources are available for providers on the DVA website.² The one resource that received consistently positive feedback from stakeholders was the DVA Claims calculator. One practice manager stated:

“...without it, it would be impossible to keep track of when it was time for billing.”

However, different practice models used a variety of in-house tools that varied in sophistication to monitor the 90-day billing cycle (such as spreadsheets and calendar reminders). Similarly, ensuring CVC Program compliance varied depending on the practice typology, and included:

- larger corporate practices with hundreds of CVC participants used more automated scheduling tools, and with economies of scale assigning dedicated days for CVC Program review calls by the care coordinator
- smaller, regional general practices more often utilised a spreadsheet – but still blocked out dedicated care coordinator time for CVC participant reviews
- for self-employed GPs that only coordinated a handful of CVC participants, this was completed ad hoc by the care coordinator, if there was one available, or completed themselves.

USE OF TAILORED COMPREHENSIVE CARE PLANS

Consistent with the intended program design, all GPs indicated that they were using a tailored care plan. Those integrating their GPMP reported that the goals were often similar, but the CVC Program structure meant that the patient was more involved in the goal setting. Although GPs indicated that care plan templates were provided by DVA, not one GP interviewed indicated that they were using them, instead they used the care coordination templates found in their existing practice software.

While a range of CVC Program forms are available for GPs to use, there is no mandate for their use. However, it seemed apparent to the evaluators from the GPs interviewed that their perceptions were that they must be used or are highly recommended. With this understanding and a concern for ensuring compliance, GPs provided the following feedback:

- Many GPs indicated that the formats of the templates in the CVC Toolbox did not integrate with the software that they regularly used (i.e. did not auto populate) and this was an immense barrier as the time taken to fill out each section manually for each CVC participant was considerable.
- Most GPs indicated that they modified the templates available to them through their practice software ‘in house’ and there may be benefit from DVA contracting out this role to establish a plan with inter-operability. There was a common view that there would be benefit in providing the DVA care plan in a format that was user friendly and would increase its uptake.
- The DVA referral form was the only template that some GPs indicated was the least cumbersome to modify to integrate into their software and some did not modify it at all.

Most interviewed CVC participants did not mention a ‘comprehensive care plan,’ but many indicated that they did have “*regular discussions about their healthcare and their goals and how they were tracking*” and the program looked very “*structured for the GP but informal for the [CVC participant]*”. Most participants supported that their care plan was discussed thoroughly every three months with their GP and the monthly phone calls ensured that logistics such as referrals were organised prior to their next GP appointment. Their increased health literacy empowered them to make decisions about their own healthcare.

² At the time of report writing (April–May 2024) the Notes for CVC Program Providers were under review by the TCVC team in response to stakeholder feedback about their length and complexity.

The 2023 CVC Participant Survey supported the finding above and found that approximately 67% of respondents actively participated in preparing or reviewing their care plan. Additionally, 83% reported having a care team beyond their GP and care coordinator. Most respondents (85%) maintained regular contact with GPs or the care coordinator, with face-to-face consultations being most common [1].

However, one participant indicated (noting this was not wide-spread feedback) that this did not seem to be the case, as their GP seemed to be using the CVC Program solely to complete DVA claims. The CVC participant expressed:

“[It] makes [me] feel sick when [I] need a doctor’s appointment.... [I want] to have blood tests and pain medication alternatives.... [but it has] opened up conversation with [a] psychiatrist who is very busy, and I can only see once every 6 months [I] need to see a GP to see [about] more scripts and referrals – but [I] have issue getting scripts filled – time seems to be taken up with DVA claims.... [there is] no goal setting, no health checks. – [I] want prostate, blood tests, testosterone tests...”

One general practice (confirmed by their interviewed CVC participants) was using a physical ‘Blue Book’ system that summarised their care plan and what treatments they were currently on that they could take with them to referrals/hospital. The participants at the practice liked having the book with them, as it meant not having to re-tell their story to different health providers and that they had responsibility and accountability for their own health information. Stakeholders and GPs supported that many participants did not trust digital health records and had the right to options.

The DVA should consider a communique to GPs to reiterate that the forms and templates provided in the toolbox are not mandatory.

In the longer term, there could be an advantage in establishing forms, templates and a care plan that have inter-operability with practice software, noting this may be challenging with multiple systems in place. This opportunity could first be raised with the GPAG.

3.3.4 Participant education and information

The thematic analysis of the 20 CVC participant interviews regarding information and education received during the CVC Program by their treating doctor or care coordinator confirmed the following:

- CVC participants received education on managing various health conditions, including blood pressure, cholesterol, pain management, and medication use, to help them understand and manage their health effectively.
- Educational resources such as brochures, emails, and websites were provided covering health conditions, treatment options, wellness, and support services, offering diverse learning opportunities.
- Consultations with healthcare professionals, including GPs and practice nurses, provided personalised education and information about the CVC Program, treatment plans, and ongoing support.
- CVC participants were connected with external resources and support services, like Open Arms – Veterans & Families Counselling and dietitian services, addressing specific needs such as mental health and nutrition.
- The proactive health management approach of the CVC Program, including a comprehensive onboarding process (45–60 minutes), empowered participants to take control of their health and make informed decisions.
- A physical ‘Blue Book’ was valued for its portability, ensuring continuity of care and access to treatments while traveling, though only one practice used it for recording health information.
- Some CVC participants explored alternative treatments like cannabinoid oils, reflecting a willingness to find effective health management approaches, but faced access restrictions in certain jurisdictions.

Overall, CVC participants interviewed highlighted several strengths of the CVC Program including the importance of comprehensive health education, diverse educational resources, personalised support from healthcare professionals, and connections to external support services. Additionally, adopting a proactive approach to health management, ensuring information accessibility, and exploring alternative treatment options were seen as key benefits. These elements demonstrate that the program is being implemented as intended and contribute to its overall effectiveness and participant satisfaction.

3.3.5 Participants are satisfied with the CVC Program

Overall CVC participants, those interviewed or 2023 CVC Participant Survey respondents [1], were generally very satisfied and valued the CVC Program for themselves and other veterans.

CVC participants interviewed highlighted common themes about their experiences with care teams and collaboration within the CVC Program and these themes were supported by the 2023 CVC Participant Survey results. The survey showed strong agreement with GPs referring patients to other healthcare providers and those providers sharing progress updates with the GPs [1]. However, there was lower agreement regarding care coordinator assistance in making appointments and communication with other providers on the patient's behalf. Through the qualitative interviews, CVC participants:

- valued frequent contact with their care teams, particularly through monthly phone calls or in-person appointments, which facilitated ongoing health monitoring and support.
- expressed satisfaction with communication and coordination within their care teams, appreciating check-in calls from nurses and efficient referrals to allied health professionals and specialists.
- benefited from receiving care at veteran-centric medical practices, which offered tailored support and access to veteran-specific services and advocacy.
- Appreciated the accessibility of services, including GPs, allied health professionals, and specialists, and this was particularly the case in regional areas with limited healthcare options.
- noted that initial concerns, such as staff turnover or communication issues, were generally resolved over time, leading to improved experiences with the CVC Program.

A GCH CVC participant said they felt:

"Prioritised. When [I have] bad days – [I] can ring up [my] doctor if [I] need to talk ... and get prioritised straight away. Other doctors will also see you.... [I] don't have to repeat [my] medical history...." The same participant also noted that they: "Got asked a lot of questions initially – [and] wouldn't want to go through that again with a new practice...."

3.3.6 Summary of CVC Program strengths and enablers

The strengths of the CVC Program centre on its ability to tailor support to the health care needs of eligible persons, and the specific individuals participating. This is best demonstrated where the program is implemented through veteran-centric practices or GPs that have a military association. As supported in the relevant literature, these practices are better positioned to understand and build trust with veteran patients and readily understand and address veteran-specific barriers to accessing health services and broader health needs. It is recommended that these types of practices be made more visible to veterans (including potentially through the CVC Program and its requirements), although ready access to GPs of this kind will not be feasible in all regions of Australia. More generally, regular communication and follow-up with participants and personalised care from health care professionals underpinned very high levels of satisfaction with the CVC Program by its participants. Additionally, adopting a proactive approach to health management, ensuring information accessibility, and exploring alternative treatment options were seen as key benefits.

CVC Program tools, including the comprehensive care plans, are fundamental to the program design intent and hold further potential to support tailored care for entitled persons and the specific program participants. Currently however, there appears to be very limited use of the comprehensive care plans and other program tools, other than for administrative purposes such as DVA claims. The primary reasons for limited use of the tools by GPs was the lack of integration with the routine systems of their practices and confusion if they were mandatory for program compliance.

3.4 Program Challenges and Barriers

The following section identifies key program challenges and barriers, primarily derived from stakeholder consultation feedback. These challenges relate to WCH eligibility, low program awareness, care coordination difficulties, funding issues, insufficient promotion, and support for medically discharged ADF members, high administrative burden, and communication challenges.

3.4.1 White Card holder eligibility

The available evidence on the impact of models of care related to coordination and interdisciplinary management suggests that programs with clearly targeted interventions for a well-defined cohort of clients are more likely to improve outcome [20-22]. This seems to be in contrast with the current design of the CVC Program, which has a broad eligibility criteria, providing GPs with flexibility when enrolling eligible persons in the program. However, current evidence may reflect the challenges of measuring outcomes for broader cohorts of clients, which may be under-represented in the current literature.

The following findings reflect themes from the qualitative consultation with a focus on the challenges of determining WCH eligibility. Where findings are nuanced by location or general practice business model, they have been identified as such.

GENERAL WHITE CARD HOLDER CHALLENGES

Many issues highlighted by WCHs and GPs that treated this cohort were broader than the CVC Program and included issues with access to a health workforce, and confusion about their entitlements in general. This evaluation did not attempt to review the entitlements of WCHs, but acknowledge that at the time of report writing (April–May 2024) public consultation was being conducted by DVA regarding harmonisation of Australia’s veterans’ compensation system in response to Recommendation 1 of the Royal Commission’s Interim Report [23].

The evaluation finding in relation to establishing WCHs’ eligibility to participate in the CVC Program is that this was more difficult than for eligible GCHs. Notably:

- Key informants and members of the PMT revealed that there were barriers for GPs to easily establish whether a patient had a chronic DVA-accepted mental health condition and was therefore eligible for the CVC Program.
- Problems with diagnosis coding for accepted conditions prevented the evaluation team from identifying eligible CVC participants from the available data set. This was exacerbated by broader issues related to WCH eligibility for DVA funding for treatment in general.

GP RELUCTANCE TO ENROL WHITE CARD HOLDERS INTO THE CVC PROGRAM

GPs were reluctant to enrol WCHs for three main reasons; (i) poor understanding/awareness of WCH eligibility criteria and CVC Program business rules, (ii) Program claiming for GPs was considered too financially risky for some GPs and (iii) the Program was difficult to promote as the benefits and promotional material targeted GCHs.

A common theme from interviewed GPs included a lack of understanding of WCH eligibility. Specifically, how to determine whether a mental health condition was accepted by DVA (further described below). This was also reflected in a response from a peak health provider that indicated a “...veteran patient of

any age who affected by a mental health condition" (omitting 'DVA-accepted') were eligible for the CVC Program. This omission was particularly evident from GPs that did not work in veteran-centric practices who had a lower familiarity with DVA administrative processes in general, and the assumption that all mental health issues are caused by their service.

GPs who were veterans and owned veteran-centric practices maintained that even though they were experienced in working with DVA for compensation claims, the risk of not being paid for their treatment and the lack of communication about rejected claims was a deterrent. It simply was not "*good business sense*", especially given the high administration load required for CVC Program compliance (see Section 3.4.6). Some of these very experienced GPs/practice managers remained unclear as to why some patients were continually rejected, even if they seemed to meet the Program business rules (see Section 3.4.7).

Another common reason for not using the CVC Program for WCHs was the "*difficulty to sell*" to eligible persons, as it was not clear how it was benefiting them. A number of GPs and practice nurses indicated that the current Program promotional material available through the DVA website targeted the (generally) older GCH, whereas WCHs were much younger and could not relate. There was a sense that the Program was operating two different programs and would benefit from a name change and re-branding as it related to WCHs and supporting the management of mental health.

MENTAL HEALTH DIAGNOSIS AND ACCESS TO TREATMENT

Further to the issues above, most interviewed GPs indicated that the main barrier to determining WCH eligibility was criterion of having a chronic DVA-accepted mental health condition. Many GPs indicated that they had newly transitioned patients whose DVA claims were still being processed, making them ineligible for the CVC Program when they were most at risk and could benefit the most from the Program structure. Some acknowledged that this cohort was eligible for Provisional Access to Medical Treatment (PAMT), [24] but many were not aware of this entitlement. This concern for those awaiting a determination was echoed by a peak health provider. They advocated for a mental health diagnosis being the criterion for eligibility criteria, rather than it being accepted as caused by their military service, especially given the priority of the Royal Commission into Defence and Veteran Suicide. Although many GPs acknowledged that these patients were eligible for some treatments under non-liability health care (NLCH), [25] and Commonwealth funded GP mental health care plans (GP MHCP), a degree of frustration was expressed that the significant administration required to satisfy DVA claims paperwork was not being compensated and negatively influencing CVC Program uptake. No GPs reported utilising other incentive schemes to support these patients, such as the Veterans' Access Payment (VAP) [26].

One peak body suggested that expanding the eligibility to WCHs with a complex mental health diagnosis could mean that some of this claims administration time could be supported by practice nurses who are "*highly skilled, are excellent health promoters and patient advocates and build cumulative trust and long-lasting relationships with patients*". A dedicated practice nurse funding item for this purpose was suggested. Notwithstanding, a number of GPs who treated WCHs also noted that they were undertaking the majority of the care coordination for these patients, with very minimal administration support from any practice nurses except to ensure appointments and scripts were current.

These initial findings support the lower-than-expected uptake of WCHs since the expansion of CVC Program eligibility in 2021 to include WCHs with a chronic DVA-accepted mental health condition.

In summary, establishing GCH eligibility was not considered difficult because the population characteristics of the current cohort meant that they were generally eligible due to age and likely chronic conditions. However, determining eligibility for WCHs, especially regarding establishing if their mental health condition was DVA-accepted, posed challenges. Many GPs hesitate to enrol WCHs due to financial risks and unclear benefits.

Section 5.3 provides further discussion related to the policy ramifications of the current eligibility criteria for both GCHs and WCHs and considerations for how they may be expanded.

3.4.2 Low CVC Program awareness

GPs and entitled but not enrolled persons have low awareness of the CVC Program, including specific supports such as the CVC Social Assistance Program.

LOW AWARENESS OF THE CVC PROGRAM AMONG GENERAL PRACTITIONERS

Stakeholder consultation revealed that many GPs were unaware of the CVC Program. Some GPs came to know of the CVC program through colleagues, while others discovered the Program by chance, such as when researching billing codes. This lack of awareness appears widespread, as confirmed by feedback from health and allied health provider organisations, as well as ESOs and CVC participants.

Increasing the number of GPs who know about and offer the CVC Program, especially in areas where it is less available, could improve access for veterans. Mapping veteran populations against practices offering the Program could help the DVA focus on raising awareness where it is needed most. This would also reduce the reliance on a limited number of providers and enhance options for veterans seeking care.

LOW AWARENESS OF THE CVC PROGRAM BY ENTITLED PERSONS

Despite reminders, 29% of CVC participants surveyed in 2023 were unaware of having a CVC Program care plan [1]. This suggested many participants do not know about the Program or its benefits. Better promotion through veteran networks and ESOs was proposed by stakeholders, who also indicated that many veterans were not aware of their entitlements, particularly contemporary veterans who have recently transitioned out of service. This lack of awareness means they are less likely to ask for the Program, although some veterans may be overusing services compared to others who could benefit but are not eligible. For example, GCHs often use physiotherapy sessions for general wellness, while WCHs are more sparingly prescribed these sessions specifically for treatment. Allied health providers also indicated that they had a role in promotion of the Program to their entitled patients to increase awareness.

CVC PARTICIPANTS WERE NOT RECEIVING SOCIAL ASSISTANCE

A 12-week CVC Social Assistance program is available to CVC participants at risk of becoming socially isolated and/or at risk of unplanned hospitalisation because of social isolation.[27] The CVC Social Assistance Program had very low uptake, with fewer than 10 participants in the last five years. This low uptake seems primarily due to a lack of awareness among both GPs and participants. Many GPs and nurses interviewed were unaware of the Social Assistance Program, and therefore did not offer it to their patients. Some interviewed participants reported that they were not offered support for participating in social activities or groups through the CVC Program and either did not remember if it was offered by their GP or indicated that they did not receive such support.

Instead, GPs and nurses indicated that their CVC participants were using other social supports, such as sporting clubs, RSLs, and social media groups, which were more commonly used by contemporary veterans. Some general practices even explored alternative programs like community gardens and art therapy, though funding for these was a challenge. Many interviewed participants expressed a preference for their own social activities or felt they did not need additional support due to their existing networks. However, some suggested that more organised community engagement activities could improve the social aspect of the CVC Program and enhance their overall wellbeing.

INCREASE UPTAKE OF ELIGIBLE VETERAN CARD HOLDERS WITH A FOCUS ON WHITE CARD HOLDERS

Notwithstanding the recent trend in increasing CVC Program uptake, less than 1,000 WCHs accessed the Program, and they were treated by a small number of specialised GPs. Although some stakeholders commented on the DVA fees-structure for overall health services in general, the general sentiment was that Program fees provided a financial incentive for general practices to participate in the program and that low uptake was probably related to lack of awareness and implementation challenges.

Stakeholders indicated that there would be benefit from improved communication from the DVA to improve participant uptake with the following to be considered:

- re-branding the CVC Program for relevance to the contemporary veteran cohort, combined with
- a national awareness campaign with a focus on any eligibility changes and the benefits of the Program for eligible veterans. The target audience should include providers, allied health, and eligible but not enrolled persons through channels relevant to entitled persons.
- promote the CVC Program Social Assistance Program to providers.

3.4.3 Insufficient promotion and support for transitioning ADF

A number of GPs and external stakeholders, and Royal Commission submissions expressed concern at the level of support received by medically discharged transitioning Australian Defence Force (ADF) members with serious mental health conditions. Suggestions made for better promoting the availability of the CVC Program to this cohort included through:

- Veteran Support Officers on base
- Transitioning Case Managers
- DVA Triage and Connect – that currently accepts external GP and veteran self-referrals.

The limitation of DVA being unable to promote specific treatments or services to their clients is a barrier to promoting the CVC Program, as not all GPs offer the Program. Some stakeholders highlighted the recent research coming from the Royal Commission into Defence and Veteran Suicide, indicating that military service could be a risk factor for suicide [28]. The advantage of this research finding is that it is an opportunity to promote the Program that can manage mental wellbeing and empower new entitled Veteran Card holders who could enquire about it to their GP.

Stakeholders suggested expanding eligibility criteria for WCHs to address equity concerns and noted a service gap for transitioning ADF members (discussed in Section 5.2). The DVA should consider:

- promoting the CVC Program to this cohort through utilising Veteran Support Officers, Transitioning Case Managers and leveraging DVA Triage and Connect; and
- investigating a mechanism to identify 'veteran-friendly' providers, as discussed in Section 3.3.2.

3.4.4 Care coordination challenges

The following challenges related to care coordination were identified by stakeholders.

LACK OF KNOWLEDGE OF CARE COORDINATION MODELS

Many GPs lack training and understanding of care coordination and best practices due to gaps in their curriculum. When asked about care coordination models, many GPs could not identify any and assumed they understood care coordination based on the CVC Program guidelines, which are not frequently reviewed. Most GPs and nurses only perform basic coordination tasks, such as sending written referrals and using practice software notes, with limited case conferencing or multidisciplinary discussions.

Stakeholders suggested that the care coordination program aim should be reframed to be more 'patient-centred'. Key findings included:

- GPs are often not the best at care coordination due to time constraints for case conferencing.
- GPs could refer complex mental health patients to social workers but often do not.

- Coordination of care is mostly done through practice software notes, with care coordinators following up on referrals if available.

GP CARE COORDINATION OF ELIGIBLE WHITE CARD HOLDERS

Interviews with GPs managing WCHs showed that GPs commonly undertook the majority of care coordination, even where a practice nurse care coordinator was available. These CVC participants were typically complex and had strong bonds with their GPs, resulting in frequent contact, sometimes multiple times a day. This intensive involvement was often seen in ex-military GPs or highly veteran-centric practices.

Nurses played a larger role in coordinating chronic disease management for GCHs and less complex WCH patients. However, concerns were raised about practice nurses' lack of mental health experience or training and the potential impact on their mental health and wellbeing. Stakeholders suggested that DVA should provide training, such as Mental Health First Aid, to better equip nurses for these roles.

ALLIED HEALTH BARRIERS IMPACTING CARE COORDINATION SERVICES

Although allied health professionals cannot undertake care coordination under current CVC Program rules, GPs and allied health peaks identified barriers impacting patient care, including:

- exercise physiology and physiotherapy services, beneficial for mental health conditions, cannot be used together due to treatment cycle barriers
- some allied health professionals do not accept DVA funding, preventing GPs from billing the item. The proposed merging of GPMP and TCA under MyMedicare may address this issue
- two-tier rebates for clinical and non-clinical psychologists limit access and equity in treatment
- a lack of time and funding for case conferencing hinders effective care coordination.

Some allied health professionals suggested they could perform care coordination within their scope of practice, especially in large corporate practices.[29] However, most GPs and peak bodies preferred the role remain with practice nurses. There was no support for administrative staff without a clinical background to perform this function. For mental health patients, a social worker or psychologist could potentially undertake the coordinator role.

The DVA could consider the following targeted workforce development opportunities to enhance care for veterans and support mainstream chronic disease management:

- training for GPs and practice nurses in best practice care coordination; and
- Mental Health First aid training for care coordinators with large numbers of WCHs.

3.4.5 CVC Program funding challenges

General practice location and business model influenced the attitude of GPs around the adequacy of remuneration:

- In regional areas, funding was considered adequate as long as there were economies of scale (sufficient nursing support) and an appropriately skilled workforce that understood veterans' needs.
- CVC Program funding was considered sufficient in metropolitan locations for veteran-centric practices if there was a dedicated care coordinator and many DVA clients. Funding was considered sufficient for 'concierge service' and to purchase support staff such as practice nurses and social workers if there were enough regular CVC participants. It enabled no extra appointments to be billed for scripts/referrals for participants – these administration tasks were absorbed by Program payments.

- Funding was considered inadequate in metropolitan locations to compensate GPs without the assistance of a practice nurse care coordinator where only treating a handful of eligible Veteran Card holders. This was particularly true of self-employed GPs where the administrative activity (follow up appointments, etc) was too great to cover the cost of a GP conducting the role. The following feedback was also provided:
 - This model is insufficient to pay for a practice nurse on site if a general practice is small or with low numbers of veterans, especially as the billing cycle is paid in arrears.³
 - RACGP noted that even though the GP fee under the CVC Program is 115% of the normal Medicare Benefits Schedule (MBS) item rebate for the equivalent service, they are unable to charge DVA clients a gap fee. The increased rate is insufficient to compensate the shortfall associated with poor indexation and the increasing reliance on many general practices to move to mixed-billing to support their business needs.[30]
- Some internal stakeholders suggest aligning CVC payments to the date of service, while external stakeholders were concerned about unclear payment processes.

Regardless of case study location or practice type, many GPs were using some CVC Program time to also fill out/follow up DVA claims paperwork, this was considered an incentive to use the Program as a means of getting some compensation for this time if their care coordination aligned with other DVA claims processes. One case was reported by a CVC participant that their doctor was exclusively using Program time for DVA claims, which was not the purpose of the Program, albeit this was not raised by any other participants interviewed.

Proposed considerations regarding reform of the funding mechanism for the CVC Program are discussed in Section 5.2. Whilst noting the recommendation in that section that changes to the funding arrangements should be considered once more information about new practice incentives and the broader primary care funding landscape becomes available, options that the DVA could consider mitigating against the funding challenges described above include:

- Enhancing support for regional practices with sufficient nursing and skilled workforce and increasing funding for metropolitan practices without dedicated care coordinators, especially those with few veteran patients.
- Addressing billing cycles paid in arrears for small practices and improving the indexation of GP fees to match rising costs would support mixed-billing practices.

3.4.6 High administration burden

Practice nurse care coordinators and practice managers reported a significant administrative burden for CVC Program compliance, often viewed as a 'concierge' service. Common feedback included:

- Most case studies indicated that the program forms/templates were customised in-house to integrate with practice software, as the DVA templates for general referrals, Client At Risk and care planning were not user-friendly and did not auto-populate.⁴
- Monthly reviews were time-consuming, involving multiple calls and informal interactions, especially with WCH participants and their GPs, occurring at all hours.
- In addition to the three-monthly in-person consultations and monthly phone calls, CVC participants often had direct access to GPs via private phone and email for healthcare queries.
- Referrals or regular prescriptions were approved without separate billed consultations.

³ NB using DVA contracted practice nurses is available, but none of the case study sites or GPs interviewed used them.

⁴ Stakeholders acknowledged that these were not CVC specific forms, nor were they mandated; however, they were necessary for clinical care coordination and/or access to service/treatment to be coordinated.

- CVC participant consultations were typically longer than usual, sometimes lasting up to an hour.
- Many of these providers were highly passionate about veteran health and wellbeing and seemed to go above and beyond the Program requirements.

Different locations and general practice business models had varying opinions on CVC Program remuneration for Program administration. Metropolitan general practices, both large corporate and self-employed GPs, felt that the fees, though higher than the equivalent MBS rate, were still insufficient to cover the significant administrative burden associated with caring for this vulnerable cohort (see Section 3.4.4). The high administrative load was particularly challenging for practices with fewer CVC participants and part-time care coordinator. One practice nurse coordinator noted, "*administration took time from providing healthcare*".

VARYING USE OF PROGRAM TOOLS BY GPS

Regarding the strengths and weaknesses of the Notes for CVC Program Providers, most GPs interviewed had not reviewed them recently, which is understandable given their long-standing participation in the program. Only one regional practice, new to the Program, had conducted a recent review due to concerns about audit compliance. Key Program documentation and tool findings include:

- Most GPs and care coordinators were unsure where to find the Notes for CVC Program Providers on the DVA website, with some admitting they had never reviewed them and were operating on a general understanding of the program and principles of care coordination.
- A few experienced GPs noted that while the Notes for CVC Program Providers and GP Guide had improved over time and the DVA CVC Toolbox offered Program resources, they lacked time to review extensive documents. They suggested streamlining resources to create more accessible, concise materials for time-pressed GPs, such as a one-page project summary summarising the business rules.

The following improvements were suggested by stakeholders to streamline administrative processes and incentivise general practice to use the CVC program. The DVA should consider:

- simplifying Notes for CVC Program Providers/GP Guide;⁵ and
- improving interoperability of forms/templates necessary for clinical care coordination with common general practice software.

3.4.7 Communication challenges

Many stakeholders indicated that an overhaul of the DVA communication strategy to be more proactive with general practice (and not reliant on care coordinator email/newsletter) rather than reactive regarding CVC Program changes, would be welcomed. However, many stakeholders did not provide explicit suggestions on how it could be improved.

CVC PROGRAM COMMUNICATION STRATEGY

The current CVC Program communication strategy is multifaceted to educate stakeholders and ensure CVC Program compliance. This strategy includes information sessions and training workshops for GPs and practice nurses, supported by detailed guidance documents such as the Notes for CVC Program Providers. Regular updates through newsletters, bulletins, email campaigns, and the program's website promote continuous information dissemination. Clinical resources and patient education materials further aid healthcare providers and CVC participants in understanding and benefiting from the Program.

⁵ NB at the time of report writing, DVA noted that this is currently in progress.

Feedback mechanisms, including CVC Participant Surveys and interviews, gather input and drive continuous improvement. Targeted awareness campaigns highlighted the CVC Program's expansion. These campaigns used case studies and success stories to illustrate the Program's positive impact, encouraging participation and compliance. This approach ensures stakeholders are informed and engaged, contributing to the Program's overall sustainability.

STAKEHOLDER FEEDBACK AND OPPORTUNITIES TO IMPROVE COMMUNICATION

A number of practice managers expressed frustration about the lack of specific communication and feedback and an easy way to communicate with DVA regarding rejected billings and any changes to CVC Program business rules that affected payments.

Internal DVA feedback indicated that in most cases, rejected billings were due to an inappropriate 'date of service' entered and billing before the 90 days had elapsed. However, a number of interviewees suggested that for experienced practices who had submitted claims for many years and understood the billing cycle rules, this was unlikely. Regardless, the perspectives of those interviewed was that getting a response to issues by calling DVA was considered a 'frustrating' process that ultimately had no resolution and resulted in significant unbilled work when it involved many patients. Other feedback included:

- GPs acknowledged that their inbox was often full and promotion to nurses/practice managers was probably a better communication target (especially if it involved changed administration).
- There was varying support of promotion through PHNs from stakeholders due to mixed relationships between general practices and their associated PHNs across Australia.
- Participants suggested that ESOs should be more of a target to promote the program to entitled persons – including that of the Social Assistance Program, but social media/Apps may be more appropriate for contemporary veterans.

Notwithstanding that much of the feedback about communication improvements was directed at DVA, some CVC participants noted that communication with some practices would also improve CVC Program implementation and the experience for participants. Some participants (associated with a particular general practice) reported difficulties in communication or access to services, such as challenges in reaching receptionists or delays in getting appointments due to high demand for popular GPs; however, most participants provided positive interview feedback regarding communication between the care team.

While the DVA is already implementing many communication strategies, stakeholders would particularly value improvements in feedback mechanisms for rejected billings and timely communication targeting nurses and practice managers before implementation. There would be benefit in using the GPAG to discuss this issue.

The DVA should consider investigating or optimising the following strategies:

- Review and update the communications strategy to ensure it meets current needs.
- Digital marketing and website optimisation: Enhance targeted social media, email newsletters, online ads, mobile accessibility, and search engine optimisation of CVC Program information and feedback on DVA website.
- Educational webinars: Conduct regular webinars for GPs and include program information in medical education.
- Community engagement and outreach: Partner with ESOs, Open Arms – Veterans' & Families Counselling, and participate in community events to increase awareness amongst entitled persons.
- Referral incentives: Implement incentives for referrals by GPs and participants.

3.4.8 Summary of CVC Program challenges and barriers

Whereas the strengths of the CVC Program focus on its ability to provide tailored care to veterans that is personalised to the specific individual, the challenges constrain the ability of the Program to achieve this for all participants. In particular, the program does not appear to work as well for WCHs. General practitioners were reluctant to enrol WCHs for three main reasons; (i) poor understanding/awareness of WCH eligibility criteria and CVC Program business rules, (ii) CVC Program claiming for GPs was considered too financially risky for some GPs and (iii) CVC Program was difficult to promote as the benefits and promotional material targeted GCHs. Further, the ability of the Program to facilitate personalised care for all participants appears to be constrained by lack of expertise and/or implementation of coordinated care. Most GPs and nurses only perform basic coordination tasks, such as sending written referrals and using practice software notes, with limited case conferencing, multidisciplinary discussions, or other substantive processes of integrated 'patient centred' care. Care coordination is further constrained in relation to allied health due to various access barriers.

More general challenges for program uptake by veterans include low awareness of the CVC Program by entitled persons and insufficient promotion of the CVC program in the context of transitioning ADF members. Challenges for uptake by GPs include low awareness of the CVC program among GPs, inadequate funding support for non-veteran-centric practices that do not benefit from economies of scale, and significant administrative burdens and communication challenges with DVA.

3.5 Implementation summary and proposed improvements

The following table provides a summary of the key evaluation findings and potential program improvements to enhance CVC Program implementation for the DVA's consideration.

Key Evaluation Findings	Short-term Improvement
CVC Program Trends (Section 3.1)	
- Consistent levels of participation from 2016–2022. - Significant drop-out rates in the first year of enrolment. - Average participant age is decreasing. - Proportion of male participants male is increasing. - There is overlap between the CVC Program and other chronic disease management services.	- Investigate underlying causes of early drop-out rates and address these through appropriate interventions. - Introduction of additional program controls to prevent and/or mitigate the impact of organisation's enrolling eligible persons in the CVC Program and not providing continuity of care. - The decreasing age of CVC participants is a factor that requires consideration as part of Program improvement and/or reform in the future. - Reinforce communication of WCH eligibility - Provide clarity for GPs about whether concurrent use of GPMP/TCA with the CVC Program is acceptable.
Appropriateness of eligibility criteria (Section 3.2)	
- Stakeholders supported the current GCH eligibility criteria, but determining WCH eligibility was challenging. - Low uptake of WCHs since expansion of eligibility in 2021.	Improve clarity and awareness of WCH eligibility criteria.

Key Evaluation Findings**Short-term Improvement****Strengths and enablers (Section 3.3)**

- CVC participants valued frequent contact, care coordination, and services tailored to veterans' needs.
- Veteran-centric care is highly valued.
- Communication strategy is mixed, there is low awareness of the CVC Program and the associated Social Assistance Program.
- Develop a proactive communication strategy and national awareness campaigns targeting GPs, allied health providers, and eligible veterans (particularly WCHs) to promote the CVC Program and associated Social Assistance Program.
- Provide and/or support (including incentivise) a range of activities (e.g. information, training, education policy, liaison roles) that equip the practice team to deliver more veteran-centric care.
- Investigate the development of a formal mechanism to recognise veteran-centric providers identifiable by veterans and their families.

Program challenges and barriers (Section 3.4)

- Barriers included concerns with use of the CVC Program as intended, administrative burden, lack of awareness, and challenges in identifying eligible veterans.
- Low awareness and use of the Notes for CVC Program Providers; need for better integration of clinical care coordination forms with GP software.
- Metropolitan practices without dedicated practice nurse coordinators found the funding inadequate, and high administrative burdens were reported.
- Simplify administrative processes, improve communication about necessary forms and rejected billings, and increase awareness campaigns (for GPs and eligible veterans).
- Improve support for transitioning ADF members through use of Veteran Support Officers and Transitioning Case Managers.
- Simplify and streamline the Notes for CVC Providers and improve interoperability of other forms necessary for clinical care coordination with GP practice software.
- Review funding adequacy and consider billing options to reduce administrative burdens through better tools and support.
- Further consideration and potential development of guidance on care coordination within the CVC Program and other chronic disease management services.
- Review and update the communications strategy to ensure it meets current needs.

4. Program Outcomes Findings

Chapter 4 describes the evaluation findings concerning **KEQ2: To what extent has the CVC Program achieved its intended outcomes?** It includes a discussion on the impact of the CVC Program on accessing health services and cost savings as the key goal of the CVC program, as well as a summary of findings in relation to patient-centredness of care and participant views.

It should be noted that while the CVC Program was initially designed as a cost-saving measure in 2011 and hence a significant focus on hospital savings as an outcome measure, it has shifted to focus on participant health and wellbeing outcomes as a more appropriate measure of effectiveness.

4.1 Hospital Service Impacts

The following section examines the impact of the CVC Program on hospitals, drawing primarily from program and cost data, as well as academic literature. This analysis focuses on the Program's effects on hospital services and cost savings, particularly in relation to hospital efficiency savings, which is a key goal of the Program.

4.1.1 Hospital services and cost savings

Despite widespread agreement on the importance of care coordination and integration, some expected outcomes, such as efficiency gains and reductions in hospital services due to improved care coordination, remain elusive [31]. This was a finding of the earlier Bupa Cost shifting analysis [9], which demonstrated a moderate impact of the CVC Program on hospitalisations and cost savings. The more in-depth analysis showed that this was mostly due to enrolment periods being shorter than the necessary long periods required to attain anticipated savings.

These findings are not unique within the Australian healthcare context. For example, a robust analysis in NSW showed that after enrolment in a Chronic Disease Management Program, significant increases in service utilisation were observed for a range of hospital services [2]. These increases were partly explained by the Program's success in identifying the unmet needs in the target population.[2] Similarly, an evaluation of a care coordination model for older vulnerable people in the Central Coast Local Health District also noted increased hospital services usage [12].

As presented in the early literature review (provided as an annex to the evaluation design), these findings are understandable, as many factors beyond the control of primary care providers are at play, ranging from lifestyle choices to the funding system and associated incentives for hospitals.[32]-[33]

In this context, the evaluators, and many stakeholders, acknowledge that hospital services and the associated cost savings are not ideal metrics for assessing the impact of a primary care program like the CVC Program. However, since this was one of the intended objectives of the Program, the available data have been examined to determine the impact of the Program on hospital costs, as follows:

- The substantial overlap between the CVC Program and GPMP/TCA services makes it challenging to isolate the impact of the Program. To address this, GCHs receiving both services were compared to a control group receiving only GPMP/TCA services. By establishing GPMP/TCA as the base treatment, the specific contributions of the Program were identified.
- Previous evaluations and literature indicate that sustained engagement with chronic disease management programs is necessary to achieve cost savings. Therefore, the sample included GCHs who remained in treatment for at least three consecutive years and were actively enrolled the year prior to the outcome measurement.
- The number of identified chronic conditions was used as a proxy for health complexity, a key determinant of hospital costs. Analysis was restricted to GCHs alive in 2023, as data were only available for them.

- To control for health status, past hospital service usage was used to measure the number of chronic conditions. The analysis focused on hospital costs for 2021, the most recent fiscal year with complete data to reduce confounding risk.
- The model included controls for age, sex, and residence (living in major cities or inner regional areas) to account for demographic factors affecting hospital costs.

Table 4.1 presents the descriptive statistics, mean and standard deviation (in parentheses) for the sample. The dependent variable was hospital expenditure in 2021. The table also includes the number of hospital episodes per individual and the hospital length of stay (days).

The main variable of interest was a binary one indicating whether the eligible GCH received GPMP/TCA exclusively (control group) or both GPMP/TCA and CVC Program services (intervention group). Controls were included for number of chronic conditions, age, sex, and residence (major city/inner regional area).

Table 4.1: Descriptive statistics – hospital episode costs 2021 (GCH with only GPMP/TCA services vs. those also receiving CVC Program treatment).

	GCH with GPMP/TCA only (control)		GCH also receiving CVC Program (intervention)		Total	
Sample size	10,467	65%	5,470	34.8	15,746	100%
Variables	Mean	SD	Mean	SD	Mean	SD
Number of hospital episodes	1.43	(5.4)	1.54	(4.8)	1.47	(5.2)
Number of hospital days	4.44	(13.3)	4.46	(12.3)	4.46	(12.9)
Hospital costs (\$)	6,638	(16,435)	6,947	(16,036)	6,745	(16,297)
Number of chronic conditions*	2.53	(1.4)	2.63	(1.2)	2.56	(1.3)
Male*	62%	(0.49)	64%	(0.48)	63%	(0.49)
Age*	77.9	(10.3)	75.8	(12.7)	77.2	(11.2)
GCHs living in major city/inner regional area	88%	(0.3)	88%	(0.3)	88%	(0.3)
*Differences are statistically significant						

As shown in Table 4.1, when compared against GCH receiving GPMP/TCA services only, there were no statistically significant differences in terms of use of hospital services as measured by the number of hospital episodes, length of stay and costs.

In line with earlier findings (Section 3.1.2), GCH receiving both GPMP/TCA and the CVC Program were younger, had a higher number of chronic conditions and had a larger proportion of males with the observed differences being statistically significant. There were no statistically significant differences in the proportion of GCH living in major city/inner regional areas.

The use of hospital services was investigated through regression analysis, summarised in Table 4.2 and with a focus on hospital expenditure (2021). Based on these results and noting the earlier caveats, the analysis showed that:

- Enrolment in the CVC Program was not associated with hospital expenditure when compared against GCH that received GPMP/TCA services only. Although the coefficient on the key variable of interest was positive (in line with the descriptive statistics associated with hospital episodes), it was not statistically significant.
- Of note, each additional chronic condition increases hospital expenditure by \$1,555 and the effect was statistically significant.

- The coefficient on eligible GCH age was also statistically significant at conventional levels, though relatively modest (a \$31 increase in hospital expenditure for each additional year of age).
- The male coefficient was negative, while the coefficient on residential area was positive, but neither was statistically significant after controlling for other covariates.

Table 4.2: Key regression results for hospital episode costs in 2021.

OLS regression results (hospital episode costs, 2021)	
Variable	Coefficient
Eligible Veteran GCHs with dual service	216
Number of chronic conditions	1,555*
Age	30.7**
Male	-175.5
Eligible Veteran GCHs living in major city/inner regional area	371.6

*Statistically significant at 1% level. ** Statistically significant at 5% level

After interrogating the results against the following alternative specifications, they remained robust:

- alternative years for measuring outcomes, within the constraints of the available data
- different specifications for the sample, including removing the constraint of GCH being active in 2020 or only including eligible GCH that enrolled after 2017
- alternative model specifications, including Poisson regression to account for the large number of zeroes in the outcome variable and results remained robust.

The results, which remained robust even with a sample including only GCHs with at least three years of sustained engagement, suggest that the CVC Program has a limited impact on hospital savings. This aligns with previous evaluations of the program. However, due to data limitations, these findings should be considered as indicative only.

4.1.2 Revisiting hospital efficiency savings as a goal of the CVC Program

In the context of recent literature, the results are understandable. The primary focus of the CVC Program is on care coordination for eligible Veteran Card holders with existing complex needs, rather than on preventing these individuals from reaching a stage where their need for care coordination and hospital services is greater.

Additionally, access to primary care is only one determinant of hospital costs [34]. Although primary care programs like the CVC Program can play a pivotal role in advancing preventive care, managing chronic conditions, and enhancing overall population health, their direct impact on hospital costs may also be constrained by the intricacies of the health financing system. As noted by the recent Australian Health Care Homes Trial, achieving outcomes such as reduced hospital services cannot rely solely on the primary care system and funding architecture; it also requires engagement and incentives for other providers and stakeholders across the health system [35].

Primary care programs like the CVC Program do not operate in isolation. The current activity-based funding system, which reimburses hospitals based on the volume and complexity of services provided, creates financial incentives that often prioritise acute and specialised care over preventive and care coordination services. A recent review of value-based care emphasised that an activity-based funding system oriented towards episodic care sits at odds with the growing share of patients with chronic conditions who require continuous, rather than episodic, engagement with health services.[32]

Since there are limited leverage points for the CVC Program to influence hospital costs for the target population (elderly chronic patients with high and complex needs), it is unrealistic to set such a goal for the Program, especially within the current health funding architecture. This point was stressed by GPs, who highlighted the challenges of reducing hospitalisations for the cohort of older GCHs, while noting the importance of engaging the population at younger ages (i.e. around 50) to realise the many benefits of early intervention and prevention.

The case studies also identified additional practical considerations that make hospital savings an inappropriate outcome for the program, as there are important methodological challenges to measure and attribute such outcome. GPs noted issues such as the choice of hospital metric to capture ‘unplanned’ or ‘preventable’ hospitalisations, the limitations of available data and confounding factors such as access to other primary care and community services.

While hospital savings is a less-than-ideal CVC Program outcome measure, this does not negate the DVA exploring other potential efficiency savings, such as those related to the delivery of Program treatment and integration with other chronic disease management services.

4.2 Patient-centred Outcomes and Experiences

Patient-centred care aims to provide healthcare services in a way that is respectful of and responsive to individual patient preferences, needs, and values. This approach is expected to lead to higher quality care and better outcomes for patients [36]. By involving patients as active participants in their own care, patient-centred care can improve communication and build a stronger provider-patient relationship built on trust. This may encourage patients to share more information, ask questions, and actively participate in developing treatment plans. Patient-centred care is also expected to increase patient satisfaction, adherence to recommended treatments, and self-management of chronic conditions.

The following section includes a sample of quotes from CVC participants about how the CVC Program impacted their general wellbeing and aided in managing symptoms caught early, followed by participants’ perspectives on communication, empowerment, and program satisfaction.

4.2.1 CVC participant perspectives on patient-centred outcomes

Table 4.3 illustrates some of the interviewed CVC participants’ perspectives on their experience of the CVC Program and its benefits, with common themes including hospital avoidance, mental health crisis de-escalation, the benefits of a regular doctor, and peace of mind.

Table 4.3: Quotes from CVC participants on their program experience.

Theme	CVC participant quote
Hospital avoidance	“Discussion of gut health resulted [prompted investigation and resulted] in gall bladder removal.”
Mental health de-escalation/hospital avoidance	“... [I don’t] think [I’d] be here without access to [my GP].”
Trust and rapport	“...if you go in about something else, they know you well enough to not think you’re a hypochondriac.”
Peace of mind	“...It’s essential because it’s keeping me focused – and I don’t need to worry about the medical stuff and I don’t need to worry about the DVA... [it] takes the pressure off, including having to think about when I need to take medication etc; my chemist works closely with the GP/nurse too...”

In addition to, and supporting the findings above, the 2023 CVC Participant Survey reported the highest benefits of participating in the CVC Program were being connected to relevant medical, health, and community services (56%) and receiving assistance with healthcare coordination (53%). However, only 12% reported an impact on social connection, and 23% reported a reduction in unplanned hospital stays [1].

The following sections present evidence from interviewed CVC participants supported by CVC Participant Survey results, demonstrating effective communication and trust with the program. Most participants expressed satisfaction and highly valued the program [1].

4.2.2 Effective communication and trust

CVC participants reported effective communication between healthcare providers and participants fostered trust and confidence in the care received. Participants highlighted the following regarding their communication with care teams:

- Relief at not having to explain their story to different doctors as there was a shared understanding of military culture – this was highlighted in particular by CVC participants of veteran-centric general practices as a major benefit.
- They felt supported by their care teams, who demonstrated a thorough understanding of their medical history and needs, and who communicated well outside of regular appointments to ensure a streamlined program experience.
- They appreciated the continuity of care provided by having the same nurse or doctor regularly and many contrasted this with their experience in the ADF that meant they did not see a regular doctor and they often waited months for appointments.
- CVC participants emphasised the importance of coordination and continuity of care within the program. They appreciated the cohesive approach, where information shared with one provider was communicated to others, improving care coordination and continuity. This streamlined approach reduced the need to repeat their medical history and ensured a holistic understanding of their healthcare needs.

4.2.3 CVC participants felt empowered by the CVC Program

CVC participants revealed the impact of information and education on their healthcare and communication with GPs or care providers. These themes were consistent across various general practice locations and business models and aligned with the CVC Participant Survey results [1]:

- CVC participants felt more confident discussing their health concerns and treatment plans due to improved knowledge and understanding of their conditions, medications, and treatments. This enhanced health literacy empowered them to actively participate in healthcare decisions and advocate for themselves.
- CVC participants reported better communication with their GPs or care providers, feeling more comfortable discussing difficult topics, asking questions, and having open, honest conversations. This improved communication fostered stronger trust between participants and healthcare providers.
- CVC participants felt empowered to take control of their health and set improvement goals. They expressed a desire for more proactive health checks and goal-setting discussions within the CVC Program, contributing to their overall sense of empowerment and well-being.
- Some CVC participants explored alternative treatments, such as cannabinoid oils, meditation, yoga, breathing practices, and art therapy. They discussed these options with healthcare providers and shared experiences with other veterans, indicating a willingness to consider holistic health approaches.

4.2.4 Most CVC participants are satisfied with and value the CVC Program

The 2023 CVC Participant Survey and CVC participant interviews across practice locations supported overall satisfaction was high for both GPs and nurse coordinators, with GPs receiving higher scores. Participants expressed the highest satisfaction with health condition management and understanding their healthcare needs. Although satisfaction with overall health and wellbeing was slightly lower, the CVC Program's contribution remained positive [1]. Key findings from participant interviews included:

- CVC participants felt comfortable and trusted the CVC Program, enabling open communication with healthcare providers without feeling judged.
- Regular check-ups, appointment and medication reminders, and monthly check-ins helped CVC participants stay on top of their healthcare needs and encouraged active health management.
- CVC participants reported better health and wellbeing due to early diagnosis, regular check-ups with familiar doctors, and effective care coordination.
- The CVC Program's personalised approach, including regular check-ups with the same doctor and streamlined processes, reduced stress, and ensured timely care.
- Some CVC participants emphasised the need for better understanding of veterans' experiences and advocated for veteran-specific healthcare hubs.

Overall, the 2023 CVC Participant Survey [1] broadly supported the evaluation qualitative findings that the highest benefits of the CVC Program are connecting participants to relevant medical, health, and community services and assisting with healthcare coordination. Effective communication and trust, rooted in a shared understanding of military culture and support from knowledgeable care teams, are key to the CVC Program's success for CVC participants. While only 12% of survey respondents reported improved social connection and 23% noted fewer unplanned hospital stays, the Program enhances participants' confidence, knowledge, and proactive health management [1]. These factors contributed to improved health outcomes, overall wellbeing, and high Program satisfaction.

4.2.5 Outcomes summary

Evaluation findings regarding the extent to which the CVC Program has achieved its intended outcomes indicate that the program has improved the quality of care and patient centredness of care for participants. Its impact on hospital cost savings remains limited, however, it is noted that DVA no longer consider this the primary intent of the CVC Program. Participants valued the personalised and proactive management approach, which included regular check-ups, medication reminders, and effective care coordination. This fostered a supportive environment of comfort and trust, empowering participants to actively manage their health. While direct financial sustainability and value for money in terms of hospital cost reductions were less clear, the overall health improvements and participant satisfaction suggest the Program provides value. To further enhance the Program's effectiveness consistent with DVA's decreasing emphasis on Program cost-savings, improvements such as more robust outcome measures on treatment compliance and outcomes, integrating with other chronic disease management services, and enhancing data integration could be considered.

4.3 Outcomes Summary and Proposed Improvements

The following table provides a summary of the key evaluation findings and potential program improvements to enhance CVC Program outcomes for the DVAs' consideration.

Key Evaluation Findings	Program Improvements
Hospital Service Impacts (Section 4.1)1)	
- The CVC Program has contributed to improvements in quality of care and health outcomes (per section 4.2) but has a limited impact on hospital costs. - While the direct impact on hospital cost savings is unclear, overall health improvements suggest value for money.	Explore other potential efficiency savings, such as those related to the delivery of CVC Program treatment and integration with other chronic disease management services.
Patient-centred outcomes and experiences (Section 4.2))	
- Outcomes are influenced by factors such as age, sex/gender, risk profile, and practice size. - Improved care coordination and access to necessary treatments through regular check-ups and consistent communication. The proactive approach of the CVC Program helps participants stay on top of their healthcare needs, ensuring nothing falls through the cracks. - The program fosters a supportive environment where participants feel comfortable and trust their healthcare providers. - The CVC Program empowers participants to actively participate in their healthcare decisions and advocate for themselves. - Personalised care including regular check-ups with the same doctor and streamlined processes, reduces stress, and ensures timely care.	Enhance data integration and leverage existing data systems to reduce administrative burden (Section 5.6).

5. Program Reform Opportunities

Chapter 5 addresses **KEQ3: How could the CVC Program potentially be redesigned to better meet the needs of current and future DVA clients?**

This chapter explores major reforms that could enhance DVA primary care arrangements, informed by stakeholder consultations, approaches to veteran care coordination in other Five Eyes countries, experiences within Australia's primary care landscape, and considerations for a younger veteran cohort.

Section 5.1 provides key lessons learned from other Five Eyes countries through a rapid literature review, focusing on best practices for delivering and funding care coordination for veterans. These findings are detailed in an annex to the evaluation design.

Sections 5.2–5.6 outline considerations for a forward-looking strategy for DVA primary care arrangements. The primary emphasis is on how the Program can leverage upcoming policy developments in Australia's primary care sector to improve outcomes for a new cohort of younger veterans. These considerations are exploratory, as details about MyMedicare and other funding reforms were still emerging at the time of writing (April–May 2024). Additionally, the forthcoming report from the Royal Commission into Defence and Veteran Suicide, due in September 2024, is expected to contain recommendations that will impact the design of the CVC Program.

Data sources for this chapter include stakeholder feedback, reviewed literature, and CVC Program data analytics. A summary of key reform considerations concludes the chapter.

5.1 Key Lessons in Veteran Care Coordination across Five Eyes Countries

This section first provides the experiences in other Five Eyes countries, and subsequently, a brief overview of ongoing developments in the Australian primary care landscape that are directly relevant to care coordination programs like the CVC Program, particularly the introduction of MyMedicare.

5.1.1 New Zealand and Canada – Veteran specific care coordination only for complex cases

The limited publicly available information on New Zealand and Canada suggests most health services and their coordinated delivery are funded and delivered through the mainstream health system. A veteran-specific care coordination system exists only for those individuals with complex needs.

In New Zealand, Veterans Affairs covers only service-related injuries or illnesses. When the required treatment exceeds 'usual' care, approval for a treatment plan is required. This plan seemingly functions as both a coordinating and cost-containing mechanism. Recent consultations on broader service coordination indicate ongoing efforts to improve care delivery, recognising the need for more integrated and comprehensive approaches, particularly for veterans with complex needs [37-41].

In Canada, veterans with disabilities or requiring long-term care qualify for additional benefits beyond those offered by mainstream health services and receive a health card. Care coordination services, primarily listed under health benefits, focus on case management for veterans in transition or who were released from service years ago, but are still in need of complex care [42-45].

5.1.2 USA – Team-based approach supported by transformational general practice change and funding

In the United States, the Veteran’s Health Administration (VHA) has implemented the Patient Aligned Care Teams (PACT) model, the largest Patient-Centred Medical Home ‘demonstration’ in the country. The model is funded through a complex blended formula that includes risk-adjusted per capita allocations [46-54]. PACT is recognised as a transformative approach to healthcare delivery, emphasising patient-centred care and coordination across the entire healthcare system, aligning with the primary objectives of coordinated care programs like CVC and broader initiatives such as the Health Care Homes trial in Australia.[35]

The PACT model consists of interdisciplinary ‘teamlets’ that provide ongoing care to enrolled patients within their designated healthcare home. These teamlets typically include:

- GPs or Primary Care Physicians: responsible for overall patient care management, diagnosis, and treatment planning.
- Nurses: who play a vital role in patient education, care coordination, and follow-up.
- Medical Assistants: who assist with administrative tasks, patient intake, and basic medical procedures.
- Clerks: who provide administrative support, schedule appointments, and manage patient records[12, 31, 54-58].

This teamlet composition addresses the wide range of tasks required for delivering integrated care, from health professionals developing and implementing treatment plans, to more mundane, but critical care coordination tasks, such as facilitating timely appointments and referrals and maintaining accurate patient records, undertaken by clerks.

Despite the advantages of teamlets, which optimise the use of highly qualified and scarce professionals such as GPs and nurses, their implementation requires transformational changes in practice operations and funding. A recent report highlighted that significant changes to how Australia funds GPs—potentially involving a mix of fee-for-service and flexible per capita budgets based on need—are necessary to support team care and enable GPs to spend more time on complex clients.[59] Since this seems to be the direction towards which the new MyMedicare scheme is moving (Section 5.1.4), the evaluators recognise the large potential of leveraging MyMedicare to provide improved care coordination to veterans.

5.1.3 The UK – Care coordination outside the NHS only for veterans with complex needs and starting prior to military service discharge

Similar to the USA model, integrated care is at the core of how health services are delivered to the UK population, including veterans.[60-62] Healthcare for veterans is seamlessly integrated within the National Health Service (NHS) Clinical Commissioning and Integration Systems, which prioritise coordination and integration of care services.

According to the 2019 Integrated Personal Commissioning for Veterans (IPC4V)[63], care coordination for veterans with broad health and social care needs is managed and funded through mainstream services - the NHS. Veterans with complex and enduring health care needs are enrolled into the IPC4V program.

The framework emphasises that planning for delivering care and support to veterans should begin before they are discharged from military service. Thus, prior to discharge, veterans’ care coordination needs are identified and matched to the appropriate services and providers, whether through the NHS or the IPC4. [63].

In addition to healthcare, the IPC4V commissioning package includes coordination of services related to accommodation, domestic assistance, transport, carers, finance, family support, social life, and work/education. This comprehensive approach recognises that veterans may require support in various aspects of their lives beyond medical care.[63]

Once a referral to the program is made, a multi-disciplinary, multi-agency steering group oversees the case. The program is implemented through Veterans Welfare Managers, who serve as local area coordinators. These managers support veterans in developing personalised plans, connecting them to community resources, including veteran organisations, and facilitating referrals to health and/or social care services. Funding is provided through personal budgets allocated to individuals based on their personalised care plans.[63]

5.1.4 Australian key primary care developments and care coordination

Recent policy developments, in particular, the new voluntary patient registration model (MyMedicare), the Australian Primary Health Care 10 Year Plan,[3] the Strengthening Medicare Taskforce Report,[4] and the Medicare Benefits Schedule Review Taskforce,[5-7] are expected to transform the primary care landscape in Australia.

Of specific relevance to the CVC Program is MyMedicare, a new voluntary patient registration model aimed at providing a platform for funding reform to incentivise quality of care and improved outcomes for at-risk population groups such as those with complex and chronic conditions who frequently attend hospitals.[64] This scheme aims to formalise the relationship between patients, their, general practice, and primary care teams.

MyMedicare benefits include longer MBS funded telehealth consultations, triple bulk billing incentives for longer MBS telehealth consultations for priority populations, including pensioners and more regular GP visits and better care planning for people living in a residential aged care home. Additional benefits for practices registered with MyMedicare in 2024–2025 include:

- improved access to information about their regular clients
- new blended funding payments for clients living in the community who are frequent users of hospital services
- financial incentives to deliver the new aged care services, including regular health assessments, care plans and regular GP visits
- the linking of patients' registrations to chronic disease management items. This linkage will ensure that for registered patients, only their regular GP (i.e. their registered practice) is able to provide chronic disease management items, as expected with models of care for chronic conditions.

In late April 2024, a large number of practices across the country had registered with MyMedicare and continuing efforts by the Australian Government to achieve full coverage are underway.

At the time of writing this report, details about the frequent hospital users' scheme were still emerging. However, brief discussions with the Department of Health and Aged Care (DOHAC) indicated that the scheme would be piloted with five to nine PHNs and associated general practices in the coming year. Each PHN is likely to have flexibility in how the CVC Program is implemented and assessed, with the pilot informing national rollout.

Additionally, in the coming months, a review of the Practice Incentives Program (PIP) is expected to outline changes to the model, including how incentives are paid.

These potential changes reflect some recommendations from a recent evaluation of the Better Access to Psychiatrists, Psychologists, and General Practitioners through the MBS initiative (Better Access) to promote more care [65]. Details are still to emerge regarding the extent to which items such as GP

Mental Health Plans will be linked to a patient's registration with a specific practice under MyMedicare in the near future.

The requirement under MyMedicare that chronic disease management items only be provided by the practice with which they are registered could be extended to the CVC Program. This would contribute to ensuring the client's regular GP delivers CVC Program services/treatments, and thus, improve outcomes for clients. This measure could also prevent the enrolment of eligible CVC participants solely for financial gain, without having a regular and established relationship with them.

Currently, DVA only has access to information about individual GPs providing services. By implementing this measure, data could also be obtained at the practice level, which would enhance CVC Program performance monitoring. This would include tracking indicators such as the rate of practice clients discontinuing participation.

5.2 Funding Mechanisms

The Productivity Commission Report recommended that the CVC Program adopt a risk-based payer model, in which providers are paid a fee per client based on their risk profile and become responsible for delivering all services required by the client during the year.[8] Similar capitation and bundled payments systems in the UK and the US incentivise early prevention and intervention multidisciplinary teams delivering care integrated across providers and system levels, and efficiency improvements in health outcomes.

At the core of these types of funding mechanisms is a capitation payment adjusted by risk factors, so that the higher the risks and health needs of an individual, the higher the per capita payment the provider receives.

Providers assume the financial risks and rewards of delivering care within the allocated per capita funding, with financial incentives linked to achieving specific outcomes.

Funding agencies play a crucial role in ensuring the actuarial soundness of the allocated funding, supporting system requirements such as data exchange platforms, monitoring outcomes, and using data to drive quality improvements.

However, these risk-based, value-added funding mechanisms require transformational practice changes for success, as highlighted by the recent Health Care Homes trial. These changes include adopting models of care tailored for multidisciplinary team-based services, altering the composition and roles of practice staff, and supporting digital and business infrastructure.[35, 66-68]

This type of transformational change at general practice level requires scale; thus, there are important challenges for the Department to use funding reform to transform the way services are delivered by general practices when veterans and their families represent a minority of practices income and clients.

With the veteran population representing a minority of general practice clients, it is understandable that the qualitative findings revealed higher costs for practices where operating procedures deviated from their usual business models.

In this context, it is likely that relatively high financial incentives are required for practices to adopt risk-based payer funding to deliver the CVC Program and offset those higher costs. This would potentially erode any of the expected efficiency savings that can be theoretically expected. Without these incentives, there is the risk of many practices discontinuing the Program.

Upcoming changes to primary care funding aim to incentivise continuity of care and service quality. Evaluators suggest that substantial changes to the CVC funding mechanism, such as adopting risk-based funding, should be considered once more information about new practice incentives and the broader primary care funding landscape becomes available.

Discussions with the DOHAC also indicated that future approaches to primary care funding may be more aligned with how CVC Program services are currently funded, with payments provided at the end of the service cycle and additional incentives tied to specific outcomes. While the review of primary care incentives is ongoing and implementation of any mainstream funding reform would be a decision for Government, adopting a whole-of-Government approach could address concerns with the current funding mechanism, which lacks linkages to outcomes.

Notwithstanding the way chronic disease management services and CVC Program treatments/services are concurrently delivered, it seems advisable to consider the advantages of formally integrating the delivery and funding of both, bringing current payments in line with Medicare systems. However, the mechanism to do so should consider the new practice funding mechanisms, the details of which are yet to be released. It is advisable to reserve changes to CVC provider funding until more information is available about broader primary care financing reform.

Importantly, a strategic redesign of DVA primary care arrangements in line with best-practice models, such as the UK's IPC4V, should be considered. This would involve various care coordination models tailored to the levels of entitled persons' needs. While some care coordination could be delivered and funded through general practice, other models for complex clients may require different providers supported by new financing models.

5.3 Changes to CVC Program Eligibility

Various stakeholders have identified veteran cohorts currently ineligible for enrolment who would benefit from the CVC Program. This section is organised within the context of resource allocation and budgetary constraints, incorporating stakeholder perspectives and available research evidence. Prioritisation has considered groups most likely to benefit from early intervention and prevention associated with patient-centred care programs, as well as cohorts with less generous access to health services. This is not a value-based judgement on who is more deserving of the Program. This is particularly important, because this evaluation adds to previous evidence of limited to no hospital savings derived from the Program, as described in Section 4.1.1.

This section discusses considerations for first prioritising CVC Program eligibility expansion for transitioning ADF members and WCHs. As a second priority, the expansion considers eligible GCHs in RACF and those with a terminal diagnosis.

5.3.1 Consider prioritising eligibility to medically discharged ADF members

Australian Defence Force members transitioning to civilian life are at risk of poorer mental and physical health outcomes. Recent research from the Royal Commission into Defence and Veteran Suicide indicates that military service may actually be a risk factor for suicide, rather than a protective factor.[28, 69] Accordingly, these individuals may significantly benefit from preventive care and early intervention services, which can prevent the escalation of health issues in the long term.[70, 71]

Care coordination models that emphasise integrated care across providers are well positioned to address the challenges veterans face when navigating from a highly structured military healthcare system to a more complex, unstructured, and unfamiliar mainstream system [17]. Stakeholders and evidence from other jurisdictions support patient-centred and care coordination programs, such as the CVC Program, especially when provided in the early stages of the transitioning process. These programs can offer a stable start, improve integration into civilian life and enhance long-term stability and productivity.

The benefits of early intervention are a key factor behind the UK model, where veterans' care coordination needs are identified prior to discharge from military service [63]. This approach also

underpins the Canadian emphasis on care coordination for recently discharged or transitioning individuals.

Further to the evaluation findings in Section 3.4.3, a number of GPs, external stakeholders, and submissions to the Royal Commission expressed concern about the low level of support for medically discharged transitioning members with serious mental health conditions.

Some stakeholders noted that DVAs limitations on promoting specific treatments or services is a barrier, as not all GPs offered the CVC Program. Promoting the Program and encouraging newly entitled veteran card holders to enquire about it with their GPs could mitigate this issue. The advantage of this approach is to promote the Program and empower newly entitled persons to enquire about it to their GP.

Notwithstanding legal issues related to the treatment principles and eligibility criteria for Veteran Cards in general, and with the caveat of the upcoming Royal Commission report, there is a compelling case for DVA to consider prioritising CVC Program eligibility for transitioning ADF members. Section 5.6 presents a stepped care model approach similar to that used in the UK. This model identifies the need for care coordination during the transition process and customises services and funding to the identified needs of the veteran.

5.3.2 Consider expanding eligibility to existing White Card holders with chronic DVA-accepted physical conditions and those with a mental health diagnosis

The case study interviews highlighted the potential efficacy of a ‘care coordination’ program aimed at reducing hospitalisations through early intervention and regular monitoring of chronic diseases. GPs emphasised the value of engaging with the population earlier, starting at age 50. This approach, also supported by health provider peak bodies, aims to slow the progression of chronic disease, reduce mortality, and alleviate patient complexity. These efforts can ultimately lead to long-term healthcare system savings and improved patient outcomes.

Lowering the age threshold to the 50+ age group aligns with evidence indicating that disease is a leading cause of death in this demographic, particularly among former and current male veterans [30] [72] [73] [74] [75]. Additionally, this age group faces heightened risks of diabetes and chronic obstructive pulmonary disease, which are targeted health conditions for the Program. This approach also aligns with the changing demographic of an increasingly younger veteran population.

Consistent with many of the case study and GP interviews, and peak body written submissions a number of considerations for expanding the current eligibility for WCHs were suggested, including:

- WCHs aged 50+ with a chronic health condition that is not a mental health condition
- functional pain disorders
- musculoskeletal disorders commonly associated with service
- diabetes (as recommended by the diabetes review [KPMG report to DVA]).

Regarding WCHs with non-accepted conditions, stakeholders noted that it seemed incongruous to fund treatment for non-accepted mental health conditions, but not for the integrated and person-centred care benefits targeted by the CVC Program, which are essential to quality mental health care delivery.

WCHs, a cohort with more restricted access to benefits, may be considered as the next priority group for extending CVC Program eligibility under budget constraints. Specific groups, as suggested by stakeholders and supported by research that would benefit from accessing the CVC Program, include:

1. WCHs over the age of 50 with a complex chronic physical or mental health condition accepted by DVA, similar to the current eligibility for GCHs.
2. WCHs with a mental health diagnosis (not DVA-accepted) already eligible for NLHC and PAMT (see Section 3.4.1)

5.3.3 Consider expansion of Gold Card holder eligibility to residential aged care and terminal diagnosis

Under a process of prioritisation, extending coverage to GCHs would then be considered. Specifically, some internal stakeholders suggested extending CVC Program coverage to GCH in residential aged care and under palliative care.

The following themes reflect the perspectives of health provider peaks, internal DVA, and external government stakeholders in relation to CVC Program eligibility ceasing on entering RACF, and/or having a terminal diagnosis:

- peak health providers noted that there was an upcoming expansion of GP accreditation to include aged care facilities, which should encourage GPs to work more with RACF in the future
- plans to extend MyMedicare to aged care from August 2024
- there was feedback that on entering RACF, CVC participants thought that their entitlements for service had been ‘taken away’
- a view that an existing terminal diagnosis should not deem an otherwise eligible GCH from the CVC Program as palliation may take many years and encourage participants to stay at home longer – noting that if a CVC participant was in the Program prior to a terminal diagnosis, that it did not exit them from the Program immediately.

Since ongoing MyMedicare developments are targeting residential aged care residents, including eligible persons, a key consideration would be the extent to which the upcoming MyMedicare reforms would effectively address this gap.

Regarding palliative care for those outside residential aged care, an additional consideration beyond prioritisation and available funding relates to the extent to which additional support would be required for GPs to effectively operate in this role. Unlike chronic disease prevention and management, which are already established as a routine part of general practice, additional supports may be required to empower GPs to provide advance care planning and other care coordination activities related to palliative care.[76, 77]

5.4 Care Team Composition

Integrated care involves the seamless coordination of healthcare services across different providers and settings to ensure patients receive comprehensive and continuous care tailored to their individual needs. This approach prioritises person-centred care, empowering patients to actively participate in their own health management through self-management strategies and decision-making processes.[78] Qualitative interviews found that elements of person-centred care, such as personalised care plans and goals, were salient in the models of care across practices in the case studies. However, as discussed earlier, there is variability in the extent to which practices engaged in pro-actively coordinating the care delivered by

other providers, which is critical to ensure a continuum of care for clients and improved outcomes (see Section 3.4.4).

Notwithstanding the name of the program, the current model of care behind the CVC Program places insufficient emphasis on the role of general practice in facilitating and coordinating care delivered by other providers. This issue points to systemic limitations that need to be addressed in the context of ongoing primary care reforms, as discussed below.

Best-practice models for integrated, veteran-centric care that is coordinated and continuous—rather than fragmented—involves a wide range of clinical and administrative tasks. These tasks include making appointments for referral services, warm handovers to avoid clients having to repeatedly tell their story, pro-active information sharing between providers, and routine follow-up with clients and providers.

Given the spectrum of tasks involved in person-centred and coordinated care, it is understandable that the US teamlets model involves much more than a GP and practice nurse. It operates in a supportive environment that facilitates regular communication, information exchange, and collaboration with other providers.

In this context and supported by Section 3.4.4, the evaluators acknowledge that:

- Important system constraints, including privacy issues, digital platforms interoperability, and organisational culture will have an impact on the extent to which general practices are able to coordinate care with other providers, including allied health professionals and hospitals.
- For less complex clients, the use of practice nurses to undertake many of the administrative tasks required to routinely communicate and exchange information with other providers may not provide good value for money nor be in scope, especially related to the care coordination needs of highly complex mental health patients. Case study interviews also suggested that CVC Program funding has been insufficient to fund the ongoing employment of supporting administrative workers or to employ more practice nurses for care coordination purposes, except in circumstances where general practices were veteran-centric (see Section 3.4.5).

Noting that a wider teamlet is ideal for delivering programs like the CVC, implementing such transformational change requires a ‘whole practice’ approach. Qualitative findings emphasise the high costs for practices to deviate from their ‘Medicare business as usual’ processes. The extent to which upcoming changes to MyMedicare and funding reform will incentivise practices to employ expanded teamlets for delivering integrated care—emphasising both patient-centred care and care coordination, as seen in other countries—remains unknown. In this context, it would be advisable for the Department to wait for further developments in the primary care space before making any changes to the composition of the team delivering CVC. Specific changes to team composition would need to be considered, along with financing incentives.

Stakeholders particularly noted the issue of care coordination of musculoskeletal conditions, common among ex-serving members. Both physiotherapists and exercise physiologists indicated they should be allowed to undertake care coordination for these CVC participants (see Section 3.4.4).

A recent review commissioned by DVA considered extending the CVC Program to include allied health professionals in the care coordination role.[79] The report noted the key challenge of very few practices currently employing an allied health professional. However, providing this option may incentivise practices to hire allied health professionals for care coordination. It should also be noted that the current option exists for the engagement of a DVA-contracted CN to provide the care coordinator role (with a separate UPO billing code). Arguably, a similar sort of external contracted agency could be implemented should another provider be used in care coordination for the CVC Program.

Several critical issues require further consideration before including allied health professionals in a care coordination role for the CVC Program:

- An important aspect of the CVC Program is person-centred care, including nurses' routine monitoring of clients, advice relating to medication, and the management of complex psycho-social issues for some clients. Some of these tasks may be outside the remit of allied health practitioners; thus, given their current scope of practice, they may not be a suitable substitute for nurses.
- If the intention behind including an allied health professional is to incentivise general practices to engage a multi-disciplinary team (GP, nurse and allied health professional) to facilitate the delivery of person-centred care and coordination of services, consideration should be given to other aspects of the model, including funding reform (discussed above) and outcome monitoring.
- Without funding changes, providing practices with the flexibility to substitute a practice nurse with an allied health professional may lead to some practices enrolling less-complex clients that do not need the routine monitoring of a practice nurse. These practices would be receiving the same funding as practices enrolling more complex clients that receive the services of practice nurses. Without monitoring the risk profile of clients enrolled in the CVC Program and their outcomes, it will be difficult for the Department to assess the extent to which providing the same level of funding for practices delivering different models of care is warranted.

In summary, while integrating allied health professionals into the CVC Program's care coordination role has potential benefits, it requires careful consideration of scope of practice, multidisciplinary team integration, and funding mechanisms to ensure the Program continues to deliver high-quality, person-centred care.

5.5 Outcome Measures

The findings in Section 4.2 described how the CVC Program has contributed to continuous and trusting relationships between clients and their healthcare teams, client education, knowledge, and self-management. These outcomes were assessed against relevant issues identified in the literature.[80-83] For example, studies have shown that patient-centred care models that enhance client education and knowledge empower clients to self-manage their conditions. Such models ensure clients understand their needs, are aware of available options, and are actively engaged in the decision-making process.

While hospital cost savings have been considered an outcome of the CVC Program, it may be necessary to reassess this focus. Attributing hospital cost savings directly to a primary care program like the CVC, which serves a large proportion of elderly clients, presents significant challenges (Section 4.1.2).

The upcoming frequent hospital users' pilot by PHNs under DOHAC's guidance may offer valuable insights. This pilot, which targets frequent hospital users specifically, could potentially provide a more realistic approach to achieving hospital cost savings compared to the current CVC design that broadly focuses on clients at risk of hospitalisation.

In recent years, health systems worldwide have increasingly adopted patient-centred approaches, which is at the core of the CVC model of care. The literature underscores the importance of a patient-centred approach in improving client experience and system efficiency through enhanced client empowerment, satisfaction, and increased system responsiveness [80, 84-87]. Consultations with health provider peaks indicated strong support for Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs). These measures are well-documented to support clinician decision-making and shared care planning, and are considered good indicators of overall patient outcomes, particularly for conditions where health and wellbeing levels are more significant than mortality risk. Despite the availability and routine use of metrics for PROMs and PREMs in patient-centred care, they are not routinely collected as part of the CVC Program.

The following considerations regarding CVC Program outcomes were primarily derived from qualitative consultations undertaken for this evaluation. However, they must be examined in the context of upcoming primary care reforms to ensure routine Program outcomes and reporting mechanisms align closely with mainstream systems and incur minimal transaction costs for practices.

5.5.1 Chronic disease markers as a measure of CVC Program effectiveness

Although many case study interviews did not discuss chronic disease markers as a measure of CVC Program success (acknowledging it as a care coordination program and the limitations of health information collection by DVA), some stakeholders indicated that linking chronic disease markers with GPMP or the Program (which were being informally integrated by many general practitioners as described in Section 3.1.2) could enhance their effectiveness in managing chronic conditions and improve patient outcomes especially as this data was already being routinely collected.

There was acknowledgement of many challenges to overcome relating to legislative barriers and privacy concerns in addition to the resistance of further data collection from general practices.

Table 5.1 provides an overview of potential markers for consideration within the constraints of data collection.

Table 5.1: Chronic disease markers to indicate CVC Program effectiveness.

Chronic disease marker	Rationale for inclusion into CVC Program outcomes
Blood pressure	Regular monitoring of blood pressure levels is integral to CVC programs, allowing care coordinators to ensure that patients receive appropriate medication management, lifestyle counselling, and follow-up appointments to control hypertension and reduce the risk of cardiovascular events
Blood glucose levels and HbA1c levels	Chronic disease management programs often focus on optimising diabetes management by monitoring blood glucose levels and HbA1c levels. Care coordinators work with patients to develop personalised care plans, including medication adherence, dietary recommendations, and regular blood glucose monitoring to achieve glycaemic control and prevent diabetes-related complications.
Cholesterol levels	The CVC Program could incorporate lipid management strategies to address dyslipidaemia and reduce cardiovascular risk. Care coordinators collaborate with patients to implement lifestyle modifications and medication regimens aimed at improving lipid profiles and reducing the risk of atherosclerotic cardiovascular disease.
Body Mass Index (BMI)	Care coordinators could assist patients in managing weight through nutrition counselling, physical activity recommendations, and referrals to weight management programs or specialists. Monitoring BMI trends allows for early intervention to prevent obesity-related comorbidities and promote overall health.
Lung function tests:	Pulmonary rehabilitation and smoking cessation interventions for patients with COPD or other respiratory conditions could be coordinated through the CVC Program. Care coordinators could monitor lung function test results to assess disease progression, optimise medication management, and coordinate referrals to pulmonary specialists or rehabilitation services.
Kidney function tests	Kidney health could be improved by monitoring kidney function tests and implementing strategies to slow the progression of chronic kidney disease. Care coordinators could collaborate with nephrologists and dietitians to optimise medication management, blood pressure control, and dietary interventions to preserve kidney function and prevent complications.
Mental health screenings and mental health assessment tools	The importance of addressing mental health needs alongside physical health concerns was also highlighted – in addition to the interplay of both physical and mental health in general. Care coordinators could utilise mental health screenings to identify patients at risk of depression or

**Chronic disease
marker****Rationale for inclusion into CVC Program outcomes**

anxiety and coordinate referrals to behavioural health specialists for counselling, therapy, or medication management.

Validated assessment tools such as the Patient Health Questionnaire (PHQ-9) for depression, the Generalised Anxiety Disorder 7-item (GAD-7) scale for anxiety, or the PTSD Checklist for DSM-5 (PCL-5) for post-traumatic stress disorder could be used to measure changes in symptom severity over time.

Some stakeholders suggested that by integrating these chronic disease markers into care coordination programs, healthcare teams could proactively manage chronic conditions by way of determining a change in health condition over time, improve patient engagement and adherence to treatment plans, and ultimately, enhance overall health outcomes for patients.

5.5.2 PREM/PROM as outcome measures

Most stakeholders supported the involvement of patients in the evaluation of health policies as part of a patient-centred approach to health and health policy and more specifically, the health peaks consulted were supportive of the use of PROMs and PREMs to achieve this goal. PREMs proposed for consideration included patients:

- feeling that they understand their condition/s and how they are being treated
- understanding who they should see about specific health concerns
- knowing how to access support if their health conditions worsen
- identifying supports outside of the health setting
- not feeling stressed or confused about managing appointments, tests and treatment as part of their care plan.

When assessing the appropriateness of these measures for GCHs and WCHs, stakeholders emphasised the differing eligibility requirements and the need for customised outcome measures for both cohorts. WCHs who can only access the CVC Program for mental health conditions, often require access to non-health supports for day-to-day living needs and to help maintain social and emotional wellbeing being. Accordingly, PROMs tailored to mental health and wellbeing, such as the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) and the WHO-5 Wellbeing Index were suggested by a peak health body to capture subjective experiences of mental health and life satisfaction.

5.5.3 Support for more holistic approach to wellbeing

In aligning with the holistic approach advocated by stakeholders, in particular, as they related to the WCH CVC Program cohort, the Program outcomes could be aligned with the DVA Wellbeing Model and the upcoming dual ADF/DVA Mental Health and Wellbeing Strategy. These encompass various dimensions of wellbeing, including physical, psychological, social, and financial aspects. This framework could guide the Program's efforts towards addressing not only immediate healthcare needs, but also the broader factors influencing overall health and quality of life for the WCH cohort [88].

Holistic indicators to gauge CVC Program effectiveness for WCH suggested by stakeholders included:

- metrics such as improved social support networks
- increased community engagement
- enhanced coping mechanisms
- better quality of life measures.

The evaluators were also informed of a collaborative effort between the DVA and the ADF to identify and track wellbeing measures, underscoring the DVA's commitment to comprehensive evaluation and continuous improvement. By integrating such initiatives, the CVC Program aims could be enhanced with an emphasis on the promotion of wellbeing and resilience among the target population; thus, achieving more meaningful and sustainable outcomes.

5.5.4 Data collection for new CVC Program outcomes leveraging mainstream systems

The examination of new CVC Program outcomes must be conducted with careful consideration of routine data collection practices within general practices and the broader healthcare system. This assessment should consider the implementation of new outcomes and performance metrics expected in the upcoming years as part of primary care reforms. It was universally recognised that seamless data integration enables the longitudinal tracking of patient outcomes, which facilitates proactive interventions, and the development of personalised care plans tailored to individual needs.

Efficient data utilisation and integration are crucial for optimising healthcare delivery and minimising administrative burden, particularly for time-constrained GPs. This sentiment was echoed in case study interviews and supported by feedback from external government interviews. By leveraging existing data collections and linking these with mainstream systems, such as electronic health records and patient management platforms, healthcare providers can streamline data collection processes and access comprehensive patient outcome data. However, this relies heavily on the interoperability of systems used by general practices and hospitals, as well as the establishment of appropriate data governance and privacy measures, which were highlighted as significant challenges by peak health providers.

5.6 A New System of Integrated Care

A longer-term reform of the CVC Program, this section proposes an overarching framework for a new system of integrated care that delivers both patient-centred and coordinated care to veterans.

During the transition phase, assessments should be undertaken to clearly identify veterans' care coordination needs as they transition to civilian life. This could involve assessing veterans' physical and mental health needs, as well as identifying any social or logistical challenges they may face.

5.6.1 Adopt a stepped model of care coordination

A stepped model of care would provide a structured approach to healthcare delivery where the level of care coordination provided to veterans is matched to their individual needs. The level of needs and the intensity of support of each veteran would be assessed during the transition process.

- At the lowest step of the model, veterans with relatively straightforward needs may require minimal care coordination, which could be managed within the primary healthcare system.

- As the complexity of their need increases, veterans may step up to higher levels of care coordination, involving specialised services, multidisciplinary teams, and closer collaboration between healthcare providers and support agencies.

This stepped approach would ensure that veterans receive the right level of support at the right time, optimising their health outcomes and enhancing their overall well-being. It would also allow for a more efficient allocation of resources, with additional resources being directed to those veterans who require the most intensive support, while still providing appropriate care to those with less complex needs.

5.6.2 Different needs, different care coordination agents

In a system where care coordination is tailored to veterans' needs, the provider responsible for coordinating care differs between less complex and complex clients. For veterans with less complex needs, general practice often serves as the central hub for managing their care coordination. GPs are well-positioned to oversee the healthcare needs of veterans with relatively straightforward requirements, such as routine check-ups, minor illnesses, and basic mental health support. This could be facilitated through existing mainstream services such as chronic disease management items.

Conversely, veterans with more complex healthcare needs may surpass the expertise or capacity of GPs to effectively manage their care coordination. In such cases, a multidisciplinary team approach involving specialists, allied health professionals, and case managers may be required.

These complex clients may have multiple chronic conditions, complex mental health issues, or significant social support needs that necessitate a more comprehensive and coordinated approach to their care. Specialist providers, such as mental health professionals, rehabilitation specialists, and social workers, may take the lead in coordinating care for these clients. This could involve coordinating care delivered by GPs, working collaboratively to address their diverse needs, and ensuring continuity of care across different healthcare and social settings.

In delivering holistic care coordination for veterans with more complex needs, these services could be provided in-house by dedicated case managers within DVA (such as CCS) or commissioned to external agencies specialising in care coordination and support services. In both cases, their tasks include care planning, coordination of appointments; and assisting veterans in accessing benefits and supports offered by DVA and other agencies.

For example, a number of stakeholders have highlighted the potential benefits of promoting and formalising the integration of the CVC Program with existing case management programs and services offered by DVA. This integration would necessitate further resources but could greatly enhance the support available to veterans, as outlined below.

COORDINATED CLIENT SUPPORT (CCS) CASE MANAGERS ALREADY AVAILABLE TO ELIGIBLE VETERANS WITH COMPLEX NEEDS

These veterans are referred to CCS via DVA Triage and Connect from a referral from DVA support staff, Open Arms – Veterans & Families Counselling and the ADF. The CCS then contacts the individual in need to discuss their circumstances and needs – some that may involve clinical care coordination. It was noted that veterans can self-refer to DVA Triage and Connect. External parties such as representatives from ESOs, doctors and other government agencies can also refer; however, there seems to be minimal GP awareness of the role of Triage and Connect (including linking veterans with advocates) from the case study consultations. The CCS program rules are very clear that CCS does not provide a crisis management service, clinical case management services or counselling, undertake any processing role, or investigate or determine a client's entitlements/claims, nor does participation provide prioritisation of claims, or claims advocacy.

PATHWAYS AND INTEGRATION WITH OTHER DVA PROGRAMS

For example, the 12-month Wellbeing and Support Program (WASP) aims to connect newly transitioned veterans to local services in their community, with the purpose of adjustment to life after service. This service was considered a 'step down', particularly if CVC participants with complex mental health conditions were stabilised, as a way of introducing them to local community supports that they could continue to access.

However, DVA's inability to recommend specific treatments and services due to the separation between health and claims business areas as it relates to data sharing/privacy is a barrier. Some stakeholders noted that while case management alone is not a comprehensive solution, the DVA requires a specific product to offer veterans and their families who require complex psychosocial supports. Common feedback from all stakeholders emphasised the necessity for a simplified pathway to determine veterans' entitlements and for health providers to ensure the best support for the veteran cohort.

Moreover, it is important to acknowledge that the insights and recommendations from the forthcoming Royal Commission Report are expected to significantly influence any strategic considerations for delivering integrated care to younger veterans with complex needs.

5.6.3 Tailored care plans are developed for each client

Given the emphasis on care coordination and patient-centred care in this model, individualised plans that identify client needs and match them with evidence-based treatment options should be developed for each client. These plans are used to monitor progress and should include baseline treatment outcomes, as well as the entitled person's personal goals to assess whether progress has been achieved.

To avoid fragmentation, these plans need to be holistic, encompassing a range of services from social support to physical health services. This comprehensive approach is particularly critical for clients with complex needs and will also facilitate their ability to navigate the available healthcare and social support systems.[81]

5.6.4 Personal budgets linked to tailored care plans for complex clients

For veterans with complex needs, care plans should be developed to outline the services, treatments, and support required to achieve their health and well-being goals. These care plans should be assessed and approved to establish the necessary budget for covering both health and social services. Regular monitoring and review of the care plan and budget allocation would be conducted to ensure that the veteran's needs continue to be met effectively. Adjustments to the care plan and budget may be made based on changes in the veteran's health status, goals, or circumstances. This ongoing review process helps optimise resource use and ensures that the veteran receives the most appropriate and beneficial support over time.

5.7 Summary of CVC Program Reform Opportunities

This chapter addressed how the CVC Program could potentially be redesigned to better meet the needs of current and future DVA clients. The evaluation explored major reforms informed by stakeholder consultations, international practices in veteran care coordination, and changes in Australia's primary care landscape. Key findings indicated that adopting alternative funding models, such as risk-adjusted per capita funding and team-based care approaches, could better meet the needs of DVA clients. Expanding eligibility to include transitioning ADF members, existing WCHs with chronic conditions, and those in residential aged care or with terminal diagnoses could enhance early intervention and long-term health outcomes. Additional supports for providers, such as integrating care coordination roles for allied health professionals and adopting a teamlet approach could improve multidisciplinary care. Emphasising digital interoperability and streamlined data integration could reduce administrative burdens and improve care coordination.

The key improvement for the CVC Program is enhancing data integration to streamline healthcare delivery and reduce administrative burdens. This involves leveraging existing data systems, ensuring interoperability, and adopting a patient-centred approach to care coordination and outcome measurement. Shifting focus from hospital cost savings to patient-reported outcomes and experiences can better capture the Program's impact on health and wellbeing. These proposed reforms aim to make the Program more responsive to the needs of current and future DVA clients, ensuring better health outcomes and more efficient use of resources.

6. Conclusion

The evaluation of the CVC Program has provided valuable insights into its implementation, outcomes, and potential avenues for redesign to better meet the needs of current and future DVA clients. Operating within a complex environment marked by impending policy changes and ongoing reforms, the Program's efficacy and adaptability are critical for ensuring continued support and care for veterans and their families. At the time of report writing, upcoming policy changes affecting the management of mainstream chronic disease under the remit of the DOHAC, in addition to changes to the veteran support system underpinned by the current Royal Commission into Defence and Veteran Suicide, were ongoing.

In evaluating the extent to which the CVC Program aligns with its intended design, several key themes emerged. While the expansion of eligibility criteria to include WCHs has facilitated broader access, challenges persist in determining eligibility and promoting CVC Program awareness among both GPs and entitled Veteran Card holders. The CVC Program model of care exhibits both strengths, such as improved education about healthcare for participants, and challenges, including administrative burdens and funding inadequacies.

Assessing the CVC Program's achievement of its intended outcomes revealed a mixed picture. While improvements in care coordination have fostered trust and proactive management among participants, the anticipated efficiency gains and reductions in hospital services remain elusive. The Program's impact on hospitalisations and cost savings has been limited, with enrolment periods falling short of the necessary duration to realise significant benefits. Nevertheless, the Program's focus on personalised and streamlined care has contributed to improved health outcomes and overall satisfaction among veterans and their families.

Exploring potential redesign strategies highlights opportunities for enhancing the CVC Program's effectiveness amidst evolving health policy and funding landscapes. Drawing lessons from Veteran care coordination models in the Five-Eyes countries, as well as upcoming DOHAC reforms and PHN trials, suggests avenues for expanding eligibility, addressing uptake challenges, and streamlining implementation processes to reduce transaction costs for practices stemming from procedural issues and insufficient integration with mainstream systems. Short-term Program improvement considerations include streamlining administration for providers, improving interoperability with GP software, improving communication with providers, and providing education for providers. Longer-term strategic considerations encompass a holistic approach to integrated care, beginning at transition and tailored to individual client needs, with funding mechanisms aligned to support sustainable Program delivery.

In conclusion, this evaluation underscores the importance of ongoing evaluation and adaptation in ensuring the continued relevance and effectiveness of the CVC Program in meeting the healthcare needs of DVA clients. By addressing implementation challenges, enhancing outcomes, and embracing strategic redesign, the Program can better serve its beneficiaries within an ever-evolving healthcare landscape.

Appendix A: Detailed Evaluation Methodology

As illustrated below (Figure 6.1), the evaluation draws on mixed methods, combining various analytical approaches and data sources to answer the proposed evaluation questions. An environmental scan/literature review was undertaken that informed the evaluation design and that is used here to contextualise findings and provide an evidence-base for recommendations.

The quantitative component is mostly focused on analytics of program data, including a cost-efficiency analysis of various aspects of the program. A cost-efficiency rather than other economic approaches was used to provide practical guidance on programmatic areas where current resources could be more efficiently spent. Additionally, this also allowed extension of the analytics to examine the cost-savings in terms of hospital expenditure, which was an intended objective of the program.

The illustrated qualitative approach in Figure 6.1 is described more technically in the following sections.

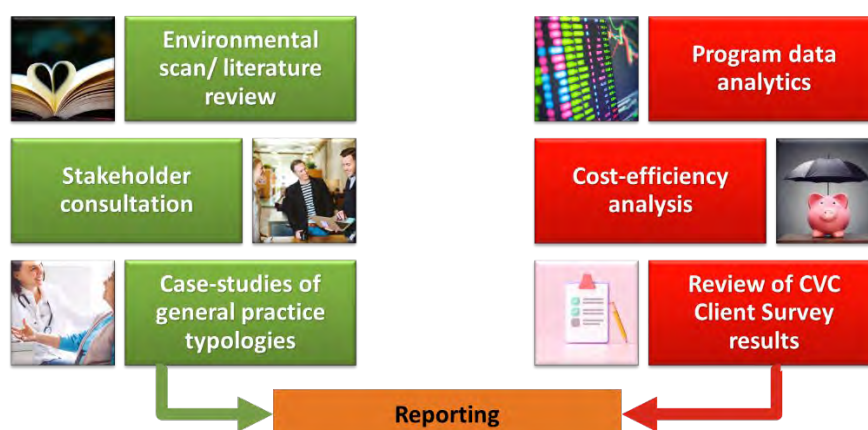


Figure 6.1: Illustrative summary of the mixed methods evaluation.

Environmental Scan /Literature Review

With a view to inform the evaluation framework, a review of the literature was conducted with emphasis on care coordination for veterans in Canada, New Zealand, the United Kingdom and the United States. This was provided as an annex to the evaluation framework and is available from DVA.

Although the academic literature was included, particularly in relation to broader models of care for delivering integrated and patient-centred care, the grey literature, including government reports and websites, were extensively searched to ensure that current and most up-to-date information on care coordination services for veterans was included.

With a few exceptions, only academic studies since 2015 were included. Special care was taken to ensure that the most recent information was available for the grey literature on veterans in the Five Eyes countries. For example, although the 2019 commissioning framework for veterans in England [63] include extensive references to the comprehensive model for personalised care prevalent at the time, this information was triangulated against the most recent developments and the newly revised personalised care operating model supported by personal health and integrated personal budgets was used to draw relevant lessons for the CVC Program [60].

In addition to country specific terms and veterans and defence personnel, search terms included care coordination, health/care integration, patient-centred care, integrated care, chronic disease management, stepped care, funding reform primary health care, case management, personalised care, value-based health care, patient aligned care teams, patient segmentation, and predictive risk modelling. Once key articles or reports were identified, references were examined to further identify relevant additional studies.

In total, 63 studies, reports and documents concerning health services and more specifically care coordination for veterans in Five Eyes countries were scanned/reviewed, in addition to 44 related to broader issues of financing and care coordination/integration. We also identified over 60 Australian studies and reports of relevance in Australia. As noted in the Annexed Power Point Presentation, they include key policy documents, as well as reports examining a wide range of issues including the challenges of strengthening primary care and reducing hospital costs in the country [32, 59, 89-96]

The results of the environmental scan were used to inform the evaluation design and to provide background and context to the evaluation key findings. Specifically, for this report, a lessons-learned rather than a theoretical approach to summarise the main findings of the environmental scan and inform the forward-looking strategy for the CVC Program. This allowed the integration of the literature review findings with the recent primary care developments in Australia. The aim was to present actionable recommendations that leveraged the ongoing system and funding reforms in the country for an improved CVC Program delivering outcomes to patients, providers and taxpayers.

Quantitative Methods

Data analytics examined CVC Program implementation and cost-efficiency, including the impact on hospital savings, with a primary focus on GCH. Since WCH represented less than 5% of CVC participants in a given year, a separate analysis for them was not warranted. Additionally, current datasets offered limited opportunities for useful quantitative assessments to inform a forward-looking strategy for this cohort. White Card holders could be accessing numerous treatments through their Medicare cards, which creates strong biases for data analytics based on their usage of DVA-funded services, which were the only datasets available for the evaluation. This was further complicated by the fact that a large number of accepted condition records had no recorded International Classification of Diseases (ICD) codes (approximate 30%), so this dataset could not be used to identify their need of services.

In this section the datasets available for this evaluation are described, followed by an overview of the main methodological approach used.

Available datasets and the process for assembling the final data for the evaluation

The key variables of interest for this evaluation related to program services, Veteran card holder characteristics and their use of hospital services. Since some standard metadata, such as data report specifications was not routinely available or accessible to allow the identification of variable specifics and datasets needed for this evaluation. An iterative process with multiple cross-checks and discussions with the Data & Insights (D&I) team was undertaken as described below.

The first set of datasets

Twenty-eight datasets were received from the D&I team on 21 August 2023. They included files with variables describing characteristics of Veteran Card holders (i.e. age or sex/gender) and services (i.e. date of hospital admission and separation), as well as files with variables describing the codes (i.e., the remoteness classification of addresses across the country). In total they contained 364 variables, with some of them corresponding to Surrogate Keys that were used to link the various datasets. The smallest dataset had 711 observations and the largest 23,880,692. They covered use of the CVC Program and hospital services since January 2016 to the last date available when the data was extracted.

After receiving the datasets, STATA was used to examine each dataset. In the absence of standard metadata, the variables were mapped under each dataset to identify their content and establish any potential linkages.

To establish potential linkages, the unique identifier was located under each dataset and examined variable names to identify potential matches. The matching and assessment process was subsequently undertaken. If observations in the files describing characteristics of Veteran Card holders or treatments could be matched with the corresponding variables in the metadata files, they were flagged, and confirmation from the D&I team was sought to ensure the correct understanding of the Surrogate Keys. When no matching was possible, alternative variables were sought and when none was found, the D&I team was consulted.

A preliminary review of some Veteran Card holder and treatment datasets with a view to assert the validity of assumptions about what each dataset measures was also undertaken. For example, for Veteran Card holder data, the number of unique Veteran Card holders under key datasets was examined and reviewed if the ballpark estimate of Veteran Card holders was in line with publicly available data. Disparities in those estimates was discussed with DVA and that data was available only for a sub-sample of Veteran Card holders, that is, those with either a recorded hospital episode or a CVC Program treatment item.

Since this data did not include information on any control group, new datasets with a new sample of Veteran Card holders was requested. During these early discussions, the then Nursing Programs and Operations team (now TCVC) suggested the sample should include entitled persons as identified through DVA internal modelling of chronic conditions, based on previous service use data. The TCVC team also requested that we examined potential overlaps with other chronic condition management programs.

As a result, data on a new sample of Veteran Card holders was requested that included those with chronic conditions and/or accessing chronic condition management services including GP Management Plans (GPMP) and Team Care Arrangements (TCA).

In the interim, discussions with DVA staff were held about available hospital data, which indicated there were delays of up to 18 months in the recording of hospital services. They also noted challenges with some detailed information from private hospitals, which prevented the use of emergency department data for eligible GCH to build an indicator of unplanned hospital admissions (and associated costs).

Assembling datasets for a new sample of Veteran Card holders

A second collection of datasets was received on 17 November 2023, which included a new sample of Veteran Card holder data, covering those identified as having a chronic disease based on previous service usage and DVA-accepted conditions as well as those accessing selected primary care services, such as GPMP and TCA.

In the subsequent weeks, the D&I team was consulted to validate linkages between the new datasets. This led to a new suite of datasets with valid linkages on 30 November 2023. Additional data on Veteran Card holders living in residential care, which restricts access to Program treatment services, was provided on 22 December 2023^d. The list of all datasets received to date is shown in Table 6.1.

Table 6.1: Datasets (including codes) received from the D&I team.

Dataset Name	Description
cvc_inlist	Data – Chronic conditions (CVC participants)
cvc_not_enrolled	Data – Chronic conditions (persons)
abt_agedcare	Data – Residential Aged Care
query_for_client_dim.dta	Data – Veteran Card holder demographics
query_for_client_dim2.dta	Data - Veteran Card holder (other)
query_for_client_disability_elig.dta	Data - Veteran Card holder disability
query_for_client_reside_addr_eli.dta	Data - Veteran Card holder address

Dataset Name	Description
query_for_crd_type.dta	Data - Veteran Card
query_for_emergency_dept_patient.dta	Data - Emergency Department Presentations
query_for_hospital_episode_dim.dta	Data - Hospital Episodes
query_for_hospital_episode_fact.dta	Data - Hospital Episodes
query_for_integrated_client_fact.dta	Data - Veteran Card holder, Cards, Episodes, CVC Program
query_for_service_item_dim.dta	Codes - Service Items
service_item_dim.dta	Codes - Service items
remoteness.dta	Codes - Geographical location
ed_misc_detail_dim.dta	Codes - Emergency Department Presentations
hosp_episd_admission_care_dim.dta	Codes - Hospital Episodes
hosp_episd_admission_dim.dta	Codes - Hospital Episodes
hosp_episd_previous_key_map.dta	Codes - Hospital Episodes
hosp_episd_separation_dim.dta	Codes - Hospital Episodes
ic_outpatient_clinic_typ_dim.dta	Codes - Outpatient services
ic_udg_dim.dta	Codes - Emergency Department Presentations
ic_urg_dim.dta	Codes - Emergency Department Presentations
icd_diagnosis_detail_dim.dta	Codes - Diagnosis (ICD)
icd_diagnosis_detail_sq_brdg.dta	Codes -Diagnosis
icd_morphology_detail_dim.dta	Codes - Morphology
icd_morphology_detail_sq_brdg.dta	Codes - Morphology
icd_procedure_detail_dim.dta	Codes - Procedures
icd_procedure_detail_sq_brdg.dta	Codes - Procedures
drg_dim.dta	Codes - Diagnostic Related Groups

A thorough validation of available datasets was undertaken and, whenever possible, findings were cross-checked with the D&I and TCVC teams. Specifically for CVC Program related services, estimated indicator (i.e. number of active CVC participants) were validated against those available through routine program dashboards, which were provided for the evaluation. For other datasets, a rigorous, but pragmatic approach was undertaken.

As shown in the findings section, whenever possible, the robustness of results under alternative scenarios based on a different interpretation of individual variables was assessed. For example, the RACF dataset contained a mix of very short and long stays, and the former did not necessarily preclude access to CVC Program treatment.

After inspecting the data, multiple aged care admissions were registered consecutively for some CVC participants, suggesting that they could potentially be treated as a single admission for the purposes of establishing length of stay. However, for other CVC participants, these multiple entries were short and spaced over time, which seemed to align with respite care, and did not preclude the use of CVC Program treatment.

Estimates were provided under two scenarios, using different criteria to assess whether a record of RACF reflects an admission to aged care that precludes the CVC participant from accessing CVC Program treatment/services.

For other datasets, such as the ones identifying GCH with chronic conditions, the datasets were triangulated against other sources of information to assess the validity of the sample. If this process showed that a GCH was incorrectly identified as a CVC participant, they were reclassified.

Variables were only excluded from this analysis that showed a large proportion of records (well above the accepted rule of thumb of 10%) with invalid or missing information that could not be rapidly addressed. This was the case for example, for data on DVA-accepted conditions, which we found had missing information on primary ICD codes for approximately 30% of records. Along similar lines, out of 857,755 Emergency Department records, 156,942 (18%) had incomplete ICD codes.

To illustrate this process of data cleansing and cross-validation, the example of the chronic conditions' dataset is described below. Similar processes were followed with the various datasets provided to ensure valid samples with valid linkages.

Data validation processes – The example of the chronic conditions datasets

The D&I team leveraged available data on service usage and DVA-accepted conditions to identify Veteran Card holders with likely current diagnoses. The dataset encompassed six major categories of chronic conditions: cardiovascular disease, diabetes, chronic kidney disease, chronic lung disease, cancer, and mental health, and so offers invaluable information about entitled persons, as it is the only source of information on the health status of DVA clients available to the Department.

A dataset for CVC participants encompassing 56,196 unique individuals and another dataset for other entitled persons identified with a chronic condition and not receiving Program treatment encompassing 87,557 records was received.

To refine the dataset and create a final version with complete information on unique Veteran Card holders and their chronic conditions, a cross-validation process was undertaken that involved several steps, including examining if the classification of individuals as CVC Program participants or eligible persons aligned with records of CVC Program treatment in the primary care dataset. Specifically, validation that all CVC participants had at least one recorded CVC Program service during the study period was undertaken and that no individual in the entitled persons group had a recorded CVC Program service.

Validation that all CVC Program participants in the dataset had at least one recorded chronic condition (physical or mental) and that the final combined dataset did not have redundant observations, that is, CVC Program participants with the same unique identification but with multiple records was also undertaken. As a result of this process and bearing in mind that specific numbers vary according to the order of each step:

- Over 7,500 Veteran Card holders identified as CVC Program participants had no recorded Program treatment. Evaluators were unable to ascertain whether these individuals never received a Program treatment or if they belonged to the group of individuals that received all their Program treatment prior to 2016. On these grounds, they were excluded from the analysis.
- Approximately 7,800 Veteran Card holders that were initially categorised as eligible persons in the chronic condition dataset were found to have a Program treatment recorded in the primary care dataset. These individuals were reclassified as CVC participants.
- Between 9,000 to 10,000 redundant observations were removed from the combined dataset and an additional 8,000 individuals who had no recorded chronic conditions (mental or physical), which were also excluded.

The final sample of unique individuals in the chronic condition dataset, stands at 116,013, representing 81% of the initial 143,753 records provided. Among non-CVC participants, the final sample is 71,654, representing an 18% reduction from the original dataset records. All individuals in this group were alive as of September 2023. For Veteran Card holders with at least one Program treatment record in 2016-2023, the final sample is 44,359, with approximately 68% still alive as of November 2023.

Program data analytics

Standard data and health economics analytics methods were used, including, descriptive statistics and multivariate regression analysis to examine program data and estimate metrics of program implementation and outcomes.

In some instances, the year of enrolment as the time variable for the analysis was chosen, and in others the fiscal year in which the service was delivered was used. This approach allowed consideration of different time perspectives, providing a comprehensive understanding of the dynamics and patterns within the data. STATA 18.0 MP Parallel Edition was used for all analyses.

Whenever feasible, the robustness of results were examined by subjecting them to alternative metrics, sample choices, and regression model specifications. For example, the standard Ordinary Least Squares regression alongside Poisson models was conducted, specifically designed to accommodate the substantial number of zeros in the data. Both analyses were also undertaken for alternative samples of Veteran Card holders. This approach allowed the thorough assessment of the robustness of findings regarding the impact of the CVC Program on hospital expenditure.

To provide an understanding of the methodological decisions, the specifics of the methodology are contained in the relevant findings' sections. The complexities surrounding the delivery of the CVC Program treatment/service, along with the intricacies and limitations of the available datasets compelled the discussion of these issues in the context of the actual implementation of the Program. For example, the rationale for the choice of sample to evaluate the extent to which eligible Veteran Card holders enrolled in the CVC Program are likely to show higher levels of need or complexity needs assessment in the context of the CVC Program and earlier findings.

By integrating these methodological discussions into the relevant sections, we offer the reader a more nuanced view of the data available for monitoring and evaluating the CVC Program, while also highlighting the strengths and limitations of analytics based on current datasets.

Cost-Efficiency Analysis

A cost-efficiency analysis was conducted alongside program data analytics to delve into distinct programmatic areas where resource use can be optimised. A focus on examining service delivery patterns and analysing associated expenditure, while considering other aspects such as the characteristics of CVC participants and the availability of other chronic condition management programs, such as GPMP and TCA. This holistic view of the CVC Program provides actionable information, highlighting concrete areas for potential improvements to the program.

Since efficiency gains associated with hospital expenditure reductions are an intended outcome of the CVC Program, we have also used regression analysis to estimate the impact of the CVC Program on hospital expenditure, leveraging the available data and service implementation patterns. Specifically, entitled persons using GPMP/TCA services who have never used the CVC Program were used as a control group and leverage the chronic conditions dataset, to control for the level of needs and complexity of eligible Veteran Card holders.

All costs are reported in constant dollars (Fiscal Year 2021). The use of constant prices removes the inflation effect, so estimates indicate what the equivalent or expenditure would have been had 2021 prices applied in all years. Hospital costs have been adjusted based on the health price indexes for government final consumption expenditure on hospitals and nursing homes as estimated by the

Australian Institute of Health and Welfare (AIHW). For the cost of primary services (the CVC Program and GPMP/TCA), we use the health price index for Medicare medical services fees charged also estimated by the AIHW [97]. For expenditure recorded in 2022, we have extrapolated the expected AIHW price index using information on the Consumer Price Index (CPI).

Review of CVC Participant Survey results

Although, strictly speaking the 2023 CVC Participant Survey [1] does not represent a methodological approach used in the evaluation, it has been used as they are a data source to answer some of the evaluation questions.

Results of the 2021 CVC Participant Survey Report were provided to Abt on 12 July 2023, and the Final Report of the 2023 Participant Survey [1] was provided on 9 April 2024. These survey results were reviewed and used to address the relevant agreed evaluation questions, after triangulation against other sources of data, particularly interviews and focus group discussions with CVC Program participants undertaken in the context of the case studies.

It should be noted that integration of these results have been used with caution for the following reasons:

- many respondents were unsure or unaware that they were on the CVC Program (approximately 1/3)
- there was no reference to other healthcare services that they could have been receiving (particularly relevant as many GPs in consultation were using GPMP and the CVC Program concurrently)
- only current participants were invited.

Qualitative Methods

A range of qualitative consultation processes was used including telephone/video interviews with a broad range of stakeholders, interviews with a sample of general practices and interviews/consults through case studies that would include CVC Program participants. Each of these are discussed in more detail below.

Engagement and consultation with key stakeholders

A key aspect of this evaluation was a broad and comprehensive consultation process. A Stakeholder Engagement Plan that detailed the Who, Why, How and When of the consultation process and included the differentiated consultation tool for each stakeholder group was developed and informed by key informant interviews and discussions with the PMT. Consistent with this Plan, in addition to internal DVA stakeholders, a range of government stakeholders external to DVA were engaged through a combination of snowballing to discuss the broader context of how the CVC Program fits amongst upcoming reforms and how the CVC Program intersects with other areas of government, particularly to explore:

- the upcoming MyMedicare reforms (Department of Health and Aged Care)
- the utility of MyHealth Records for CVC Program management and population outcome measures (Australian Digital Health Agency)

See below for the full consultation list.

Case studies

A case study is a qualitative research or evaluation strategy used to explore and analyse a particular complex phenomenon in-depth. Undertaking a case study involves delving into specific and well-defined 'cases' to unpack the context; examine a broad range of issues, data and variables from various perspectives and generate insights into 'how' interventions/programs work and 'why'. [98].

For the purposes of capturing the breath of experiences across different types of practices and to allow for an in-depth exploration of the various issues affecting the delivery of the program, a multiple embedded case study design was implemented, that is:

- multiple cases: CVC Program delivery by various typologies of General Practices (the units of analysis)
- with sub-units embedded within each 'case'
- These sub-units are: practices within each typology; practice staff including GPs, practice nurses, practice managers and other relevant staff such as receptionists; other health providers involved in delivering care for the veteran and individual CVC participant.

This case study design, explained in more detail below, allowed the evaluators to uncover for each typology how the different pieces of the program fit together, that is, the experience of practice staff, the business model/case for the practice itself, the experience of other health professionals involved, and last, but not the least, the experience of CVC participants themselves.

General practice typologies as the unit of analysis

The unit of analysis for a case study can be an individual, an organisation, or a particular program. For this evaluation, we propose the unit of analysis to be the whole of CVC Program delivery in the context of a particular typology of general practice (illustrated in Figure 6.2).

Discussions with the PMT, the DVA GPAG and the Chief Health Office (CHO) suggested it was important to capture the various typologies of general practice, including those engaged and not engaged with the CVC Program for GCHs and WCHs.



Figure 6.2: Illustrated case study approach to ensure all aspects of the CVC program are considered.

This is echoed by the recent Health Care Homes Trial evaluation, which examined different barriers and enablers of implementation by different types of practices [35]. Although the Health Care Homes trial represents a very different model of care to the CVC Program, their examination of the effects of location, size, and ownership helps to illustrate the type of barriers that can be found, how they may vary by practice typology, and how the various typologies may overlap. This in turn can inform the refinement of the typologies of General Practices to be used as the 'units' of the case studies.

- Practice location: Logistics, challenges to recruit staff and availability of services in general are particular challenges affecting program uptake outside metropolitan areas. However, due to their challenges, rural practices tended to be more holistic, and team oriented in their approach which could provide an incentive to engage with the CVC Program.

- Practice size: Larger practices are less affected by staff turnover and have more resources to implement and deliver new programs. However, one of the potential barriers is having more established processes, which are harder to change and also reduced flexibility to make decisions such as encouraging GPs to engage in a new program.
- Ownership: There is a correlation between practice ownership and size with large practices usually being corporately owned.

Four basic typologies were used as units of analysis to capture the breath of experiences across practices in Australia. They were based on practice location (by ASGS classification) and to allow comparisons of like with like, two separate typologies were included for metropolitan based on ownership (veteran-centric vs. non-veteran centric), which will also cover practice size.

- Inner regional
- outer regional
- metropolitan – veteran centric
- metropolitan - non-veteran centric.

Sampling practices within each typology

The evaluation aimed to include between 2 to 4 practices per case study/typology to capture views from practices engaged and not engaged with Gold Card and White Card holders. As noted in the quantitative findings, community nurses represent less than 1% of CVC services, so the focus is on care coordination undertaken by a practice nurse within the practice. Due to project management delays and challenges with case study recruitment the evaluation was unable to sample a practice that used DVA-contracted community nurses for Care Coordination.

To sample practices within each typology, a purposeful sampling strategy was used to ensure the engagement with practices and capture the nuanced nature of delivering primary care across the country. The evaluation aimed at including practices in Queensland, which is home to the largest proportion of the DVA treatment population [99], and at least two other states.

An initial snowballing approach was intended utilising both the DVA GPAG, and members of the CHO to identify 10 practices that fit in the proposed typology (i.e., 2 per typology), and also include general practices that did and did not participate in the CVC Program. This approach was relatively unsuccessful due to project management delays pushing consultation closer to Christmas when many practice staff were on leave and also delays with internal DVA ethical processes to enable consultation with CVC participants. Consequently, a number of recruitment avenues to encourage general practice engagement and recruitment were employed including:

- a number of unsuccessful recruitment surveys through health/peak bodies (one case study site was recruited in this way)
- cold-calling known general practices that used the CVC Program from a list provided by DVA that detailed practice name, state, and categorised how many CVC participants were recorded by category (to determine practice size). A small number of practices were excluded by DVA from the list.

A practice incentive payment was ultimately offered to general practices of \$500 for case study participation to interview multiple staff (see next section) and \$100 to individual GPs.

Between 12 to 16 practices were estimated to be needed before saturation occurred. For these purposes, after data for a new practice within a specific typology was collected, it was examined and coded to assert if the repetition of themes or patterns became apparent, as an indicator that the richness of the data adequately represented the diversity of experiences within each typology. Saturation was considered adequate at thirteen practices from five jurisdictions.

General practice staff interviews

Key informants interviewed agreed that it was important to capture various perspectives within each practice and that includes not only the General Practitioner and the Practice Nurse, but also the practice manager and even receptionists as relevant.

Practice managers, administration and billing staff provided insights into ‘the ease of doing business’ aspects of the CVC Program, such as issues with processing claims, integration with software practice, the costs of training staff to participate in the program and overall incentives and costs of participating in the CVC Program.

It was assumed initially that for a practice to be considered a case study site that there would be representation from all relevant staff described above, however due to challenges with recruitment, a case study site was considered one where there was participation from at least one GP and one Nurse Coordinator.

General practices that participated in the evaluation received an incentive payment of \$500.

Participating eligible Veteran Card holder interviews and ESOs

On 19 and 20 March 2024, consistent with the agreed DVA-approved ethical process, 11 general practices were encouraged to invite their currently enrolled CVC Program participants to an evaluation interview. On 8 April 2024, two weeks before the consultation period endpoint, general practices that were currently unrepresented by interview bookings were reminded with one email and/or telephone call. It is unknown how many CVC Program participants were invited to participate or if all medical practices contacted their participants. Abt scheduled interviews directly with consenting CVC Program participants following this process.

Table 2.2 summarises their Veteran Card holder status, state/territory and ASGS region that they received their healthcare coordinated through the CVC Program.

Through the NCF Secretariat, ESOs were invited to submit a written response to a paper developed with DVA on the behalf of their members. They were allowed six weeks to input into the evaluation.

Sample representation and bias

Project management and delays in agreement of the recruitment process and advising CVC Program participants about the evaluation by general practices resulted in a non-representative CVC Program sample and potential bias in responses. It should be noted an:

- over representation of veteran-centric general practice experience in the Queensland metropolitan respondents (n = 5) with a heavy reliance on DVA funding and a younger veteran demographic are not representative of most general practice business models operating across Australia
- minimal representation of the inner regional CVC participant experience (n = 3, from the same general practice in South Australia)
- over-representation of outer regional perspectives (n = 8, from two general practices in the Riverland in South Australia).

To minimise the effect of this practice-level bias, thematically analysis focused on ASGS region regardless of state/territory was used to explore the nuances of CVC Program implementation across Australia. Despite the limitations above, there was broad thematic consistency with the feedback obtained through the 2023 CVC Participant Survey [1].

CVC Program participant respondents did not receive evaluation participation incentives.

Other practitioners

Other practitioners (such as allied health) delivering wrap-around care to CVC participants were also identified through interviews with practice staff or CVC participants themselves and were included in the case study analysis as relevant. This allowed the examination of care coordination with other primary care providers, but also to explore issues related to White Card holders who are not engaged with the CVC Program.

Health and allied health provider peaks/professional bodies were also engaged through the DVA HPPF Secretariat to gather the input of their members for the evaluation. Individual online (MS Teams or equivalent) interviews, small focus groups or written submissions captured the input of CVC Program practicing health professionals outside the case study catchments to strengthen the case study approach.

Case study data collection and analysis

Noting the busyness of health professionals in general, Abt offered a number of flexible options relating to timing (including after hours) and focus groups in lieu of individual face to face/telephone/MS Teams modes to maximise evaluation participation that resulted in:

- forty-six general practice staff (case study interviews)
- nine extra individual interviews were conducted with health professionals
- seven health/allied health professional bodies were represented through individual/focus group or written submission.

Abt consultants also interviewed 20 CVC participants by telephone between 25 March - 17 April 2024, that were representatives from five general practices. Telephone (n=19) and video (n=1) interviews ranged from 20 to 45 minutes in length. Due to challenging timeframes and logistics, face to face interviews were only offered to CVC Program participants residing in Brisbane and the Gold Coast, QLD, and this may have impacted evaluation participation. Sixteen eligible GCHs (13 veterans and three dependents) and four eligible WCHs consented to discuss their CVC Program participation from three Australian states/territories (Australian Capital Territory, South Australia and Queensland).

Ex-service organisations were invited to submit a written response on behalf of their members. Two responses were received.

In line with best practice for case studies [98], the contextual and literature reviews extensively informed the evaluation questions, which were organised along relevant themes identified in the literature. Various conceptual frameworks for patient-centred care and care coordination have been used to outline relevant themes that guide the data analysis.

During the analytical stages, patterns in the data were examined and various explanations that emerged from the analysis were explored. Since the views of multiple stakeholders across various case studies were sought, they were triangulated and any rival explanations of a particular phenomenon, such as the expected impact of the program or barriers for program uptake were explicitly addressed.

The evaluation team critically examined the data considering other available evidence and as required, refined questions as the fieldwork progressed to continue unpacking the information and provide nuanced interpretations of findings.

Reporting

The themes and key findings from the quantitative and qualitative analysis were thematically analysed in an integrated way and reported against the key evaluation questions. This included triangulation (cross-verified) of all data to validate the overall evaluation findings and examine the robustness and consistency of results.

Specifically, the initial consultations that took place during the development of the evaluation framework were used to inform the quantitative approach, including the issues examined through data analytics, such as the potential overlap between the CVC Program and other chronic disease management services. Subsequently, discussion occurred with respect to the preliminary quantitative findings with key stakeholders to validate and further unpack the results presented.

Following the completion of the quantitative analysis, iterative refinement of the qualitative instruments occurred, to further validate and explore the implications of the data analytics, ensuring a comprehensive and nuanced understanding of different aspects of the CVC Program. After cross-validating and triangulating results, they were reviewed at a key findings workshop prior to submission of the draft report.

Stakeholders Consulted

Key informant interview participants

Key informant interviews to inform the design of the evaluation framework were conducted between 1 August – 25 August 2023.

DVA Business Area represented and number of participants consulted	Date interviewed
Nursing Programs and Operations, Program Delivery Division (1)	01 August 2023
Veterans' Home Care & Transport Programs Client Programs, Program Delivery Division (2)	02 August 2023
CHO Division and GP (2)	07 August 2023
DVA General Practitioner Advisory Group (10 members)	25 August 2023

Evaluation co-design workshop participants

Three Abt evaluators facilitated a two hour, MS Teams meeting on 13 September 2023:

DVA Business Area	Number of representatives consulted
Nursing Programs and Operations Section	2
Data & Insights Branch	2
Veterans Home Care and Transport Programs Section	2
Program Governance and Evaluation Section	3
Health Policy Section	3
TOTAL	12

Evaluation interviews – Internal and external government stakeholders

More than 30 individual internal and external government stakeholders participate in the evaluation through individual interview, focus group or written response to questions in the agreed Evaluation Framework.

External government	Number of representatives consulted	Date consulted
Australian Digital Health Agency (ADHA)	4	19 April 2024
Department of Health and Aged Care (DOHAC)	3	26 April 2024
Primary Health Network (PHN)	1	27 February 2024
TOTAL	8	

DVA Business Area	Number of representatives consulted	Date consulted
Quality and Safety and Mental Health Programs Mental and Social Health Programs Branch	3	4 October 2023
Data and Insights Branch, Chief Financial Officer Division	8	11 October 2023
Rehabilitation Policy	2	25 March 2024
Rehabilitation and Household Services	1	25 March 2024
Transition Policy	1	20 March 2024
Clinical Policy	1	20 March 2024
Aged & Community Care Taskforce	1	2 April 2024
Residential Aged Care Section	1	2 April 2024
Disability and Wellbeing Section	2	2 April 2024
Program Delivery Division	3	3 April 2024
DVA Triage and Connect	2	9 April 2024
TOTAL	25	

Evaluation interviews – health and allied health peaks

Health and allied health peak bodies inputted into the evaluation through the DVA HPPF Secretariat by written response or individual/focus group interview. Because of their representative nature, DVA GPAG and CHO key informant interviews were considered amongst these responses but have been listed separately due to not having been engaged through the same mechanism.

Health Provider Partnership Forum	Number of representatives consulted	Date consulted/ written submission received
Royal Australian College of General Practitioners	3	Written submission 3 April 2024 Focus group on 11 April 2024
Dietitians Australia	1	27 March 2024
Occupational Therapy Australia	1	Written submission 3 April 2024
Exercise & Sports Science Australia	2	18 March 2024
Australian Physiotherapy Association	2	8 April 2024
Australian Association of Psychologists Incorporated (AAPi)	1	Written submission 3 April 2024
TOTAL	10	

One extra written submission was received from the Australian, New Zealand and Asian Creative Arts Therapists Association (ANZACATA) on 10 April 2024.

General practice consultations

Interviews with individual members of the DVA GPAG, have been included as they were involved in promotion and/or evaluation recruitment through dissemination of recruitment surveys to their networks and individual interviews, yet also provided valuable CVC Program insights in their own right.

GPAG participants were not offered a financial incentive to participate in the evaluation unless participating as a case study.

Individual GPAG consultations	Number of representatives consulted	Date consulted
GPAG member (represented Australian Association of Practice Management)	1	First contact 10 October 2023 (multiple engagements)
GPAG member (non-CVC Program user, represented Australian College of Rural & Remote Medicine)	1	24 October 2023
GPAG member (represented Australian Primary Healthcare Nurses Association)	1	10 October 2023 (multiple engagements)
TOTAL	3	

Nine individuals participated in the evaluation. Individual GPs were compensated \$100 for their participation via telephone/MS Teams and lasted approximately 1 hour.

Individual consultations	Profession represented (location) consulted	Date consulted
Individual GP (non-CVC Program user)	• GP (SA)	29 January 2024
Individual GP (CVC Program user)	• GP (QLD)	6 February 2024
Individual GP (CVC Program user)	• GP (SA)	15 February 2024
Individual GP (CVC Program user)	• GP (SA)	13 March 2024
Individual allied health (CVC Program user)	• Psychologist (WA)	15 March 2024
Individual allied health (CVC Program user)	• Psychologist (QLD)	Written response 2 April 2024
Individual GP (CVC Program user)	• GP (SA)	5 April 2024
Individual practice nurse (CVC Program user)	• Practice Nurse (NSW)	21 March 2024
Open Arms – project with Renmark Medical Centre	• Community Engagement Coordinator at Open Arms SA	26 February 2024

Forty-six individual participants were consulted as part of the evaluation case study consultation from 13 practices across five jurisdictions. Participants role in CVC Program has been referred to in main body of report where relevant.

These practices were compensated \$500 for their evaluation participation of up to two hours' time by telephone/MS Teams. Some practices split this time up over two sessions to accommodate differing participant availability.

Case study sites	ASGS code	Number of representatives consulted	Date consulted
GO2 Health, Brisbane, QLD	Metro	6	29 February 2024
Limestone, Brisbane, QLD	Metro	2	4 March 2024 5 March 2024
Innovative Medicine, Gold Coast, QLD	Metro	4	29 February 2024 1 March 2024
Renmark Medical Centre, Renmark, SA	Outer regional	2	13 February 2024 20 February 2024
Berri Medical Centre, Berri SA	Outer regional	2	21 February 2024
St Agnes Surgery, Ridgehaven, SA	Metro	7	21 February 2024
Windsor Village Medical Centre, Paradise, SA	Metro	2	21 February 2024
Goolwa Medical Centre, Goolwa, SA	Inner regional	8	15 March 2024
Holt Medical Centre, ACT	Metro	3	18 March 2024
The Surgery at Jerra, NSW	Metro	2	5 April 2024
Ashfield Country Practice, QLD	Inner regional	2	27 March 2024
Beach Street Medical Practice, Woolgoolga, NSW	Inner regional	4	18 March 2024 27 March 2024
Bellarine Medical Group, Drysdale, VIC	Inner regional	2	4 March 2024
TOTAL		46	

Ex Service Organisation written submissions

The following ESOs provided written submissions to the evaluation.

Organisation	Written response received
Australian War Widows Inc	8 May 2024
TPI Federation of Australia	28 May 2024

Project Management Team (PMT)

The PMT met fortnightly over the period of the evaluation except over the significant consultation/analysis and report writing period in April – May 2024 when meetings were monthly/as required. The team did experience some turnover over the evaluation due to a DVA restructure and evaluation needs over time. The following participants were present at more than three meetings.

Organisation/DVA Business Area represented	Number of participants
Abt Associates	3
DVA Health Policy Section	5
Nursing Programs and Operations/Transport and CVC Programs	3
Data & Insights Branch	2
Program Governance & Evaluation	2

Appendix B: Reference List

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Lived Experience Workforce Development- Monitoring and Evaluation Plan

This Program Monitoring and Evaluation Plan forms part of the Plan, Implement & Monitor and Evaluate phases of DVA's Program Management Framework.

Purpose	This Monitoring and Evaluation (M&E) Plan will guide the <i>Open Arms – Clinical Governance and Programs Directorate - Lived Experience (LE) Section</i> to manage the process of assessing and reporting progress towards achieving its program outputs and outcomes.
Program Information	The basis for the M&E Plan is the Program Logic, located at HPE Content Manager reference: 24497166E. The Program Logic describes and formulates part of the <i>Open Arms – Clinical Governance and Programs Directorate - Lived Experience Section</i> plan and implementation phasis. Further details about the program, including background and stakeholders can be found in the Lived Experience Workforce Development Strategy, located at HPE Content Manager reference: 24848643E
Scope	<i>Open Arms Lived Experience Section scope of monitoring and evaluation aligns with the Lived Experience Workforce Development Strategy and includes</i> • <i>Open Arms Lived Experience Workforce:</i> ○ <i>Recruitment and retention</i> ○ <i>Position Descriptions, roles and functions across Open Arms</i> ○ <i>Learning and Development</i> • <i>Community and Peer Program:</i> ○ <i>Policies, frameworks, procedures inc. Model of Care</i> ○ <i>Peer support</i> ○ <i>Group programs</i> ○ <i>Community engagement</i> <i>Frequency of monitoring and evaluation activities will vary as the Lived Experience Workforce Strategy is implemented and processes are established as business as usual.</i>
Evaluation Approach	Planned evaluation activity: <i>Lived Experience Workforce Development.</i> Planned evaluation timing: <i>FY 2025/2026</i> Planned evaluation frequency: <i>Quarterly review of outcomes</i>

Sign off: when updates are approved record sign off details in the PMF Document Tracking and Approval at HPE Content Manager: 222500170E.

Final document versions should be saved, dated and stored to enable version control.

Guidance: Monitoring and Evaluation Plan – Guidance available at HPE Content Manager: 222498591E

Program Management Framework is located at: 231046330E

Lived Experience Workforce Development- Monitoring and Evaluation Plan

This Program Monitoring and Evaluation Plan forms part of the Plan, Implement & Monitor and Evaluate phases of DVA's Program Management Framework.

Additional Content for Monitoring Consideration

You may want to consider including additional helpful information such as:

- Stakeholder analysis:
 - *Internal stakeholder review, consultation, feedback*
 - *External stakeholder engagement*
- Communication Strategy:
 - *As identified in the Lived Experience Workforce Development Strategy*
 - *Effective communication of Monitoring and Evaluation activities through various reporting mechanisms to Senior Executive and Workforce*
- Risk Management:
 - *As identified in the Risk Register*
 - *Quality & Safety Committee*
 - *Timely and effective reporting*
- Assurance Planning:
 - *Quality Assurance Plan*

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Guidance: Monitoring and Evaluation Plan – Guidance available at HPE Content Manager: 222498591E

Program Management Framework is located at: 231046330E

Lived Experience Workforce Development - Monitoring and Evaluation Plan

Outcomes & Outputs	Indicator or Measure	Method or Data Source(s)	Collection Frequency	Purpose	Responsibility	Reporting	Data Sensitivities
Program outcomes and outputs should be sourced from the Program Logic	Indicator - a quantitative or qualitative variable that provides reliable means to measure something. Measure - a value that is quantified against a standard.	How are measures collected? Identify the data source e.g. program participants, provider claiming system/s, DoHAC, AIHW, CFMS, surveys	How often does the collection of data occur?	What is the reason we collect this data? Is there a regular purpose/use of data collected?	Who is responsible for collecting the data collection and the associated monitoring activities? Include data SME's/Data Stewards	Who is responsible for reporting? Who is accountable? How often? Reporting format/method	Identify data sensitivities or restrictions/considerations for data publication.
Outcomes							
An Open Arms Lived Experience Workforce with defined governance, roles, positions and functions across Open Arms that provide quality service internally and externally to the Department.	Quantitative – Created, developed and established Lived Experience Workforce Strategy, Procedures, Frameworks and position descriptions, reporting lines aligning with current and best-practices (accreditation, client feedback). Qualitative – Stakeholder and Lived Experience Workforce knowledge of role within Open Arms' through feedback mechanisms, Dashboards and surveys. Through mixed methodologies, it is aimed to have a 60% outcome rate.	Open Arms Clinical Governance Hub: - Model of Care - Frameworks - Procedures This includes DVA broad policies, Enterprise Agreement and relevant legislation. Lived Experience Position Descriptions, APS5, APS6, EL1 and EL2. Establishing the incorporation of co-design with LE Workforce with creating, reviewing and updating key products, including inclusion of LE perspective in working groups and equivalent. LE Workforce feedback mechanisms: - Verbal (meetings) - Email - Surveys (OA led, Pulse) Dashboard Data collection from existing systems: - Client Feedback Management System (CFMS) - Client satisfaction survey (TED)	Collection frequency will vary depending on the activity and reporting requirements. Fortnightly: This will consist of co-design processes with the Lived Experience Workforce and other stakeholders during various activities. Monthly - VERA Dashboard Quarterly - Client satisfaction survey Yearly - The Lived Experience Workforce Development Strategy - Clinical Governance Procedures As required: - LE Workforce feedback mechanisms - Lived Experience Position Descriptions - Lived Experience Feedback mechanisms - CFMS	The purpose of collecting this data is to ensure the Lived Experience Workforce is thriving in a combined APS and mental health service delivery environment. The regular purpose and use of data collected is to: - establish and maintain nationally consistent practices. - Development of stronger cultural and workplace practices to support Open Arms' workforce reputation and retention. - To maintain accreditation against the National Standards for Mental Health Services (NSMHS).	The areas of responsibility for data collection varies depending on the data source. Within Open Arms these are: - Clinical Operations - Business Operations - Clinical Governance and Programs The responsibility of monitoring activities associated is the Lived Experience Section, Clinical Governance and Programs. The data SMEs and Stewards are: - DVA Engagement & co-Design (TED) Branch - Survey, Insights & Community Forums - Feedback Management Team (FMT).	The area responsible for reporting is the Lived Experience Section, Clinical Governance and Programs and is reporting to: - FAS - Open Arms - AS - Clinical Operations - AS - Business Operations - Senior Director - Clinical Governance and Programs - Quality and Safety Committee - National Advisory Committee (NAC) - Lived Experience Workforce - Other; external presentations Frequency is determined based off the collection frequency, data sources and direction of Senior Executive. Reporting formats are variable and may include: - Survey results and feedback. - CFMS reports. - Email. - Minutes. - Reporting templates and summaries	The Identified data sensitivities for data publication includes: - Regional specific, - Identifiable information for Open Arms Clients and Staff The considerations for data publication focuses on reducing risk such as: - Organisational reputation - Privacy of the person - Withdrawal of consent (change of mind or timeframes of consent) Data publications will ensure sensitivities and considerations are factored with the appropriate approvals aligning with relevant DVA policies.

Sign off: when updates are approved record sign off details in the PMF Document Tracking and Approval at HPE Content Manager: 222500170E. Final document versions should be saved, dated and stored to enable version control.

Guidance: Monitoring and Evaluation Plan – Guidance available at HPE Content Manager: 222498591E

Program Management Framework is located at: 231046330E.

Outcomes & Outputs	Indicator or Measure	Method or Data Source(s)	Collection Frequency	Purpose	Responsibility	Reporting	Data Sensitivities
						Quality and Safety - Accreditation reporting.	
A thriving Lived Experience Workforce with access to resources and governance to support roles, clear Learning and Development pathways, professional supervision, career progression in the Lived Experience profession and APS.	Quantitative – Created, developed and established Lived Experience Workforce Strategy, Procedures, and Frameworks aligning with current and best-practices (accreditation, client feedback). Developed and established professional development, including measuring supervision, and learning and development courses, processes and participation. Qualitative – Lived Experience Workforce access, knowledge of resources, governance, learning and development including professional supervision through feedback mechanisms, Dashboards and surveys. Through mixed methodologies, it is aimed to have a 60% outcome rate.	Open Arms Clinical Governance Hub: - Model of Care - Frameworks - Procedures This includes DVA broad policies, Enterprise Agreement and relevant legislation. Open Arms Operational functions, Including: - Training requests and registered - Recognition of Prior Learning - Training completed Establishing the incorporation of co-design with Live Experience Workforce with creating, reviewing and updating key products, including inclusion of LE perspective in working groups and equivalent. LE Workforce feedback mechanisms: - Verbal (meetings) - Email - Surveys (OA led, Pulse) Dashboard Data collection from existing systems: - Client Feedback Management System (CFMS) - Client satisfaction survey (TED) - VERA	Collection frequency will vary depending on the activity and reporting requirements. Fortnightly: This will consist of co-design processes with the Lived Experience Workforce and other stakeholders during various activities. Monthly - VERA Dashboard Quarterly - Client satisfaction survey - Operational functions Yearly - The Lived Experience Workforce Development Strategy - Clinical Governance Procedures As required: - LE Workforce feedback mechanisms - Lived Experience Position Descriptions - Lived Experience Feedback mechanisms - CFMS	The purpose of collecting this data is to ensure the Lived Experience Workforce has access. The regular purpose and use of data collected is to: - Development of national consistent professional supervision and learning and development processes for Lived Experience Workforce to support career progression and retention. - Capture feedback to improve processes and needs of the LE workforce - To maintain accreditation against the National Standards for Mental Health Services (NSMHS).	The areas of responsibility for data collection varies depending on the data source. Within Open Arms these are: - Clinical Operations - Business Operations - Clinical Governance and Programs The responsibility of monitoring activities associated is the Lived Experience Section, Clinical Governance and Programs. The data SMEs and Stewards are: - DVA Engagement & co-Design (TED) Branch - Survey, Insights & Community Forums - Feedback Management Team (FMT). - Reporting and Data Management Section – Business Operations	The area responsible for reporting is the Lived Experience Section, Clinical Governance and Programs and is reporting to: - FAS - Open Arms - AS - Clinical Operations - AS - Business Operations - Senior Director - Clinical Governance and Programs - Quality and Safety Committee - National Advisory Committee (NAC) - Lived Experience Workforce Frequency is determined based off the collection frequency, data sources and direction of Senior Executive. Reporting formats are variable and may include: - Survey results and feedback. - CFMS reports. - Email. - Minutes. - Reporting templates and summaries. - Quality and Safety - Accreditation reporting.	The Identified data sensitivities for data publication includes: - Regional specific, - Identifiable information for Open Arms Clients and Staff The considerations for data publication focuses on reducing risk such as: - Organisational reputation - Safety of person - Withdrawal of consent (change of mind or timeframes of consent) Data publications will ensure sensitivities and considerations are factored with the appropriate approvals aligning with relevant DVA policies.

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Program Management Framework is located at: 231046330E.

Outcomes & Outputs	Indicator or Measure	Method or Data Source(s)	Collection Frequency	Purpose	Responsibility	Reporting	Data Sensitivities
Outputs (including Activities and Participants)					•		
Nationally consistent LE workforce led engagement demonstrating quality service delivery.	Initial development, review and establishment of reporting and data metrics through new monitoring and evaluation activities for the Lived Experience Workforce.	Co-design with Lived Experience Workforce with creating, reviewing and updating key products, including for Open Arms Clinical Governance Hub: - Model of Care - Frameworks - Procedures	Collection frequency will vary to: - As required - Fortnightly - Monthly - Quarterly - Yearly	The purpose of establishing these data metrics, analytical insights and activities is to bring value and ensure the Lived Experience Workforce is thriving in a combined APS and mental health service delivery environment.	The areas of responsibility for data collection varies depending on the data source. Within Open Arms these are: - Clinical Operations - Business Operations - Clinical Governance and Programs	The area responsible for reporting is the Lived Experience Section, Clinical Governance and Programs and is reporting to: - FAS - Open Arms - AS - Clinical Operations - AS - Business Operations - Senior Director - Clinical Governance and Programs - Quality and Safety Committee - National Advisory Committee (NAC) - Lived Experience Workforce	The Identified data sensitivities for data publication includes: - Regional specific, - Identifiable information for Open Arms Clients and Staff
Develop and establish feedback mechanisms for Open Arms clients.	Data metrics will be established to: Measure performance of Lived Experience related activities and processes within Open Arms	This includes incorporating, referencing and utilising DVA broad policies, Enterprise Agreement and relevant legislation.		The regular purpose and use of data collected is to: establish and maintain nationally consistent practices.	The responsibility of monitoring activities associated is the Lived Experience Section, Clinical Governance and Programs.		The considerations for data publication focuses on reducing risk such as: - Organisational reputation - Safety of person - Withdrawal of consent (change of mind or timeframes of consent)
Develop and establish feedback mechanisms for Lived Experience workforce.	- Focus on Open Arms service delivery outcomes - Identify clientele accessing Open Arms Community & Peer Program - Support decision making, strategic planning, Organisational objectives and quality improvement activities	Open Arms Lived Experience Workforce Development Strategy		Development of stronger cultural and workplace practices to support Open Arms' workforce reputation and retention.	The data SMEs and Stewards are: - DVA Engagement & co-Design (TED) Branch - Survey, Insights & Community Forums - Feedback Management Team (FMT). - Reporting and Data Management Section – Business Operations	Frequency is determined based off the collection frequency, data sources and direction of Senior Executive.	
Lived Experience Workforce skilled and utilised to co-facilitate Open Arms group programs with Clinicians.	Report on successful organisational outcomes	Creation of national consistent Lived Experience Position Descriptions: - APS5 - APS6 - EL1 - EL2		To maintain accreditation against the National Standards for Mental Health Services (NSMHS).		Reporting formats are variable and may include: - Survey results and feedback. - CFMS reports. - Email. - Minutes. - Reporting templates. - Quality and Safety - Accreditation reporting.	Data publications will ensure sensitivities and considerations are factored with the appropriate approvals aligning with relevant DVA policies.
Establishing monitoring, evaluation and reporting on Lived Experience workforce.		Dashboard Data collection from existing systems: - Client Feedback Management System (CFMS) - Client satisfaction survey (TED) - VERA					
Open Arms Lived Experience workforce professional identity established through consistent and ongoing Learning and Development.		LE Workforce feedback mechanisms: - Working Groups, Community of Practice, or similar platform - Verbal (meetings) - Email					

Sign off: when updates are approved record sign off details in the PMF Document Tracking and Approval at HPE Content Manager: 222500170E. Final document versions should be saved, dated and stored to enable version control.

Guidance: Monitoring and Evaluation Plan – Guidance available at HPE Content Manager: 222498591E

Program Management Framework is located at: 231046330E.

Outcomes & Outputs	Indicator or Measure	Method or Data Source(s)	Collection Frequency	Purpose	Responsibility	Reporting	Data Sensitivities
		Surveys (OA led, Pulse)					

s 47F

Senior Director – Clinical Governance and Programs

09 April 2025

Approved by

(use TAB key to move to update the Name, Position and Date fields on the right)

Refer to the Program Management Framework 231046330E, page 15 for Assurance requirements/Sign Off.

When saving this template document please use the following naming convention:

Program Management Framework (PMF) - <insert program name> - Monitoring and Evaluation Plan – <insert month and year, e.g. February 2023>

This Program Logic forms part of the Plan and Evaluate phases of DVA's Program Management Framework.

Problem Statement / Proposal	Program Objective	Inputs	Activities	Outputs	Participants	Short-Term Outcomes 0 to 6 months	Medium-Term Outcomes 6 to 18 months	Long-Term Outcomes 18 months onwards
What is the underlying issue that we are trying to address?	What is the program aiming to achieve?	What resources do we have?	What do we do to implement the program or activity?		Who will be involved in the program?	The difference we make in the short term (generally seen as changes in skills, knowledge, attitudes, awareness or motivation)	The difference we make in the medium term (generally seen as changes in behaviour, practice or systems, or the application of skills and knowledge)	The difference we make in the long term, which resolves the issue identified in the problem statement

The Open Arms (OA) Division Lived Experience (LE) workforce operates in a complex mental health service delivery environment leading to impact on staff wellbeing and staffing attrition.

The LE workforce requires consistent program planning with defined workforce structures and professional development frameworks resulting in co-design of military-aware, trauma informed, recovery orientated service provision, aligned to OA strategic objectives.

Nationally consistent outcomes focused LE practices, operating within the Open Arms Model of Care, promoting recovery orientated care through:

- Implementation of clinical governance, strategies and frameworks that promote a thriving LE workforce.
- LE workforce integrated into Multidisciplinary Teams (MDT) providing service delivery across LE practices.
- Workforce capability development of LE specialisations aligned to APS career pathways that are inclusive of ongoing professional development and supervision.

S 47C

Assumptions

External Factors

S 47C

Approved by: S 47C, Open Arms, Clinical Governance Assistant Secretary 12/05/2024

Refer to the Program Management Framework S 47E page 15 for Assurance requirements/Sign Off.
When saving this template document please use the following naming convention:
Program Management Framework (PMF) - <insert program name> - Program Logic – <insert month and year, e.g. February 2023>

DRAFT

Outcome 2

Maintain and enhance the physical and mental wellbeing and quality of life of eligible persons and their dependants through health and other care services that promote early intervention, prevention and treatment, including advice and information about health service entitlements.

Outcome 2 supports the health and wellbeing of veterans and their families by facilitating access to a broad range of physical and mental health services, including general and specialist medical and health care, hospital services, pharmaceuticals, rehabilitation, allied health support, mental health services, and preventative health programs. These services are delivered through arrangements with public and private sector providers and are aligned with the department's Wellbeing Framework, which recognises the interconnected nature of wellbeing across 9 domains.

Outcome 2 contributes particularly to the domains of health, social support and connection, education and skills by promoting early intervention, recovery-focused care, and tailored supports that respond to the unique needs and experiences of veterans and their families. Open Arms – Veterans & Families Counselling (Open Arms) plays a vital role in supporting the mental health and wellbeing of current and former ADF members and families through the provision of free confidential counselling and wellbeing support services. Open Arms provides 24/7 crisis support; individual, couple and family counselling; group programs; care coordination; and lived experience peer support. These services play a critical role in promoting long-term wellbeing and enhance social support networks by encouraging connection through peer support, family counselling and community-based programs. Through this approach, Outcome 2 enhances quality of life and supports long-term, sustainable wellbeing outcomes.

Operational environment

Throughout 2024–25 veterans and their families continued to benefit from access to high-quality healthcare, counselling and rehabilitation services under Outcome 2. The department recognises that health providers are key partners in optimising health and wellbeing outcomes for veterans, through the delivery of quality services. The department is actively engaging with providers to create greater awareness of its services, programs and entitlements available to veterans and families beyond the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme.

The department remains committed to supporting veterans and their families to age well by ensuring they have access to information, services and supports that enable them to live safely and independently at home for as long as possible, and to transition into and live well in residential aged care when needed.

The department is also actively trying to reach members of the veteran community not previously known to the department who would benefit from Open Arms services. The Enhancing Access to Mental Health Services for Veterans and Families Program seeks to reach members of the veteran community who would benefit from support, by establishing partnerships enabling seamless referrals between Open Arms and mental health services.

In collaboration with the Department of Health, Disability and Ageing, Open Arms has incorporated a veteran identifier in the Initial Assessment and Referral Decision Support Tool (IAR-DST), an evidence-based protocol for conducting initial assessment and referral of individuals presenting with mental health conditions in primary healthcare settings.

Working in partnership with Statewide Mental Health Services, Tasmanian Mental Health and Alcohol Directorate, Primary Health Tasmania and the Department of Health, Disability and Ageing, Open Arms has successfully implemented 2 new pilots: the Stress Resilience and Functioning Program to support access for veterans in rural and remote areas, with a total of 5 programs delivered across Devonport, Burnie, Launceston and Hobart; and a Central Intake and Referral Service pilot enabling referrals from Tasmanian Mental Health Services directly to Open Arms.

Outcome 2 performance measures and results

The department's performance under Outcome 2 is measured through the quality, timeliness and client satisfaction results for the services provided.

Timeliness targets are the percentage of claims processed, referrals allocated or assessments completed within a set timeframe. The department uses timeliness measures as proxy tools to assess efficiency. These timeliness measures can give an indication of efficiency over time.

Quality (service) performance measures provide a comparison of the number of complaints recorded about the programs compared to the number of clients accessing services. Details on how to provide feedback or lodge a complaint with the department are provided in the [DVA Service Charter](#) and on the department's [website](#). Feedback and complaints can be lodged via the online portal MyService using an online form, or by email, phone or post. Complaints are registered in the Client Feedback Management System when they are received by the department. Reports from a database of all client feedback identify the number of complaints registered in relation to unmet access and/or quality of service.

This is a proxy measure rather than a direct measure of satisfaction. The indicator focuses on a small cohort of the general population (that is, those who have complained rather than those who may not be satisfied with their service).

Client satisfaction is captured through a survey and considers the experience of individuals when claiming or accessing entitlements.

For Outcome 2, the department achieved all quality measure targets, 2 of the 3 timeliness measure targets, and both of the client satisfaction targets. This reflects the department's successful delivery of programs to maintain and enhance the physical and mental wellbeing of veterans and families.

Program 2.1: General Medical Consultations and Services

The department has arrangements in place with medical and allied health practitioners in both the public and private sectors to deliver a comprehensive range of services throughout Australia, provided in hospitals, in providers’ rooms and in the homes of veterans and families. To ensure that eligible veterans and dependants are able to access necessary services, the department will either pay for travel to the nearest service provider or pay a provider to travel to other locations to provide services to eligible veterans and dependants.

Key activities:

- Work with medical and dental providers throughout Australia to ensure veterans and families have access to a comprehensive range of services

TABLE 17: PROGRAM 2.1 GENERAL MEDICAL CONSULTATIONS AND SERVICES – PERFORMANCE MEASURES AND RESULTS

No	Performance measure	Target	2023-24 actual result	2024-25 actual result	Achieved
2.1-1	Quality of service: The proportion of clients who have registered a complaint in relation to unmet access and/or quality compared to the total number of clients accessing services	<1%	<1%	<1%	Achieved

(PBS p 45, Corporate Plan p 29)

Quality of service

The department achieved the quality target for measure 2.1-1 in 2024–25, with a low percentage of complaints recorded. This measure considers the provision of medical and dental services and enhances the wellbeing of veterans and families by ensuring they receive the health services they require. Recorded complaints are mainly about providers requiring upfront payment. This year’s result is consistent with performance in 2023–24.

Program 2.2: Veterans’ Hospital Services

This program provides access to inpatient and outpatient hospital services for eligible veterans through arrangements with private hospitals, day procedure centres and mental health hospitals, as well as all public hospitals operated by the state and territory governments.

Key activities:

- Make arrangements with public and private hospital service providers throughout Australia to ensure veterans and families have access to a comprehensive range of services.

TABLE 18: PROGRAM 2.2 VETERANS' HOSPITAL SERVICES – PERFORMANCE MEASURES AND RESULTS

No	Performance measure	Target	2023–24 actual result	2024–25 actual result	Achieved
2.2-1	Quality of service: The proportion of clients who have registered a complaint in relation to unmet access and/or quality compared to the total number of clients accessing services ¹	<1%	<1%	<1%	Achieved

¹ As part of quality reporting, contracted private hospitals are required to list complaints received from entitled veterans. Public hospitals are not required to submit any additional quality reporting to the department, beyond what is already managed by state and territory health departments.

(PBS p 46, Corporate Plan p 29)

Quality of service

The target for quality measure 2.2-1 was achieved in 2024–25, with a low percentage of complaints recorded. The majority of services provided by hospitals do not require the department's intervention, as the service is based on clinical need and specialist referral for planned admissions. Veterans can access a wide range of services provided by public hospitals and by over 550 contracted private hospitals and day procedure centres across Australia. The department's comprehensive hospital arrangements, including the need for licensing and accreditation standards, allow veterans to access services when needed, resulting in a low percentage of complaints.

Program 2.3: Veterans' Pharmaceutical Benefits

The Repatriation Pharmaceutical Benefits Scheme provides clients with access to a comprehensive range of pharmaceuticals and wound dressings for the treatment of their healthcare needs, including items available to the broader Australian community under the Pharmaceutical Benefits Scheme.

Key activities:

- Provide eligible veterans with access to a broader range of medicines and wound care items at a concession rate.

TABLE 19: PROGRAM 2.3 VETERANS' PHARMACEUTICAL BENEFITS – PERFORMANCE MEASURES AND RESULTS

No	Performance measure	Target	2023–24 actual result	2024–25 actual result	Achieved
2.3-1	Quality of service: The proportion of clients who have registered a complaint in relation to unmet access and/or quality compared to the total number of clients accessing services	<1%	<1%	<1%	Achieved

(PBS p 47, Corporate Plan p 30)

Quality of service

The department achieved the quality target for measure 2.3-1. As access to the majority of pharmaceuticals does not require the department’s intervention but is supplied directly through the health provider to the pharmacist and then to the client, there are limited points of failure. Recorded complaints are mainly about access to medication and call wait times.

Through the department’s administration of the Repatriation Pharmaceutical Benefits Scheme, the Veterans’ Affairs Pharmaceutical Advisory Centre continued to provide doctors and veterans with 24/7 access to information and approval related to access to subsidised medicines. The clinical appropriateness and conditions of supply of items available on the Repatriation Pharmaceutical Benefits Schedule were regularly reviewed to ensure medicines available are safe, effective and meeting the unique needs of veterans.

Program 2.4: Veterans’ Community Care and Support

The department manages community support and residential aged care programs for clients, including the Veterans’ Home Care program and the Community Nursing Program, which aim to support people to remain independent in their homes and improve their quality of life and health. This program also provides subsidies and supplements for clients living in residential care facilities.

Key activities:

- Provide a range of care and support in the home to assist eligible veterans and families to remain independent at home for longer.

TABLE 20: PROGRAM 2.4 VETERANS’ COMMUNITY CARE AND SUPPORT – PERFORMANCE MEASURES AND RESULTS

No	Performance measure	Target	2023-24 actual result	2024-25 actual result	Achieved
2.4-1	Quality of service: The proportion of clients who have registered a complaint in relation to unmet access and/or quality compared to the total number of clients accessing services	<1%	<1%	<1%	Achieved

(PBS p 48, Corporate Plan p 30)

Quality of service

The department achieved the quality target for measure 2.4-1, with a low percentage of complaints recorded. To maintain and maximise the quality of services for clients using the Veterans’ Home Care program and Community Nursing Program, the department meets and communicates regularly with service providers, which ensures that good relationships are maintained and issues are managed promptly. Regular meetings and communication with providers will continue to ensure the quality of and access to services continues.

Program 2.5: Veterans' Counselling and Other Health Services

This program provides a wide range of mental and allied healthcare services, including counselling and referral services for veterans and their families. The program also supports eligible veterans and their families with funding for aids and appliances, and travel for treatment.

The key activities assess performance in relation to the following subset of the broader program:

- Aids and appliances
- Travel for treatment
- Allied health care services.

TABLE 21: PROGRAM 2.5 VETERANS' COUNSELLING AND OTHER HEALTH SERVICES – PERFORMANCE MEASURES AND RESULTS

Key activities:

- Support veterans with travel for treatment and provide access to aids, appliances and modifications to support independent living.
- Provide veterans with access to allied health services, including access to telehealth services.

No	Performance measure	Target	2023-24 actual result	2024-25 actual result	Achieved
2.5-1	Quality of service: The proportion of clients who have registered a complaint in relation to unmet access and/or quality compared to the total number of clients accessing services	<1%	<1%	<1%	Achieved

(PBS pp 49–50, Corporate Plan p 31)

Quality of service

The quality target for measure 2.5-1 was achieved in 2024–25. The department's close collaboration with service providers supported delivery of high-quality care.

The travel for treatment program helps veterans with transport costs to attend medical treatments. This includes reimbursement of travel expenses, prearranged and prepaid transport to and from medical appointments, and ambulance services funded by the department. Service quality was maintained through rigorous provider vetting, active contract management and a well-established feedback framework. Experienced program managers engaged directly and sensitively with clients and contracted providers to resolve any issues of concern, contributing to overall service quality.

The Rehabilitation and Appliance Program continued to provide veterans with essential support including aids, equipment, and modifications to promote safe and independent living. This success was underpinned by comprehensive contract management, compliance and QA processes that ensured service delivery standards were maintained across contracted suppliers.

The department provides allied health services to support veterans' health and rehabilitation needs. These services involve a range of allied health professionals such as physiotherapists, occupational therapists and podiatrists. The department supports rehabilitation therapy by coordinating care through the allied health treatment cycle. This cycle improves communication and coordination between general practitioners, allied health providers, and veterans to ensure quality care.

The department's programs consistently delivered high-quality care through strong partnerships with providers focused on veteran wellbeing. This success was supported by prompt service delivery and streamlined request processes, ensuring a seamless experience for both veterans and providers.

TABLE 21: PROGRAM 2.5 VETERANS' COUNSELLING AND OTHER HEALTH SERVICES – PERFORMANCE MEASURES AND RESULTS (*continued*)

Key activities

- Support veterans with travel for treatment and provide access to aids, appliances and modifications to support independent living.

(This measure relates to the travel for treatment component only.)

No	Performance measure	Target	2023–24 actual result	2024–25 actual result	Achieved
Travel					
2.5-2	Timeliness: Target percentage of claims for reimbursement processed within 28 days	≥95%	100%	92%	Not achieved

(PBS pp 49–50, Corporate Plan p 31)

Timeliness

The target for timeliness measure 2.5-2 was not achieved. As part of helping veterans with transport costs to attend medical treatments, travel for treatment includes reimbursement of claims for travel expenses. Key factors contributing to the result included claim volumes exceeding processing capacity, and higher call volumes, which delayed claim progression. To address these challenges and improve processing times, targeted initiatives aimed at streamlining the claims process have been established. This includes the introduction of a new claims processing system on 1 July 2025, which is anticipated to improve processing efficiency and reduce delays in the 2025–26 reporting period.

TABLE 21: PROGRAM 2.5 VETERANS' COUNSELLING AND OTHER HEALTH SERVICES – PERFORMANCE MEASURES AND RESULTS (continued)*Key activities:*

- Provide veterans with access to allied health services, including access to telehealth services.
- Provide access to Open Arms including individual and family counselling, after-hours counselling, group program interventions, and peer support.

No	Performance measure	Target	2023-24 actual result	2024-25 actual result	Achieved
Open Arms – Veterans & Families Counselling services					
2.5-4	Percentage of clients allocated to an Open Arms clinician within two weeks of initial intake	≥65%	88%	85%	Achieved
2.5-5	Client satisfaction ^{2, 3}	≥80%	90%	92%	Achieved

2 Client satisfaction is measured by a questionnaire. Satisfaction questionnaires are offered by clinicians at the end of an episode of care. The survey asks clients 'How satisfied are you with the counselling provided to you?' and responses are rated on a scale of 'Very satisfied', 'Satisfied', 'Neutral', 'Unsatisfied' or 'Very unsatisfied'. All clients who answer 'Satisfied' or 'Very satisfied' are counted as satisfied. The questionnaire is not compulsory for clients to complete.

3 Participation in the survey is voluntary. A client questionnaire is not sent when a client does not consent to receiving correspondence, when it is considered unsafe to do so and in other limited circumstances.

(PBS pp 49–50, Corporate Plan p 31)

Timeliness

The Australian Government has been providing veteran mental health support through Open Arms for over 40 years. Founded by Vietnam veterans, Open Arms is a nationally accredited mental health service that provides 24-hour free and confidential mental health support. In 2024–25, 85% of Open Arms clients were allocated to an Open Arms clinician within 2 weeks of their initial intake (measure 2.5-4). This is slightly lower than the previous year's result. Client wait times can fluctuate due to a variety of factors (for example, clients opting to request specific clinicians, such as a male or a female clinician, or a clinician with specific expertise) that may impact ability to allocate. The nationwide shortage of mental health professionals across the sector has impacted the ability of Open Arms to recruit in its intake and triage service, Client Assist. Additionally, Open Arms moved to a contracted panel arrangement with outreach providers, which impacted on the timeliness of referrals during that period.

Client satisfaction

The client satisfaction result confirms that services were successfully delivered and well received. Open Arms achieved a result of 92% in 2024–25, well above the 80% performance target set under measure 2.5-5. This result, based on 496 responses from 9,603 surveys, following 26,046 episodes of care,¹² reflects a strong endorsement of the program. Although participation in the survey is voluntary feedback, it is encouraging that trends remain highly positive.

12 An episode of care is an interval of care for an individual, couple or family encompassing all counselling, treatment and support services provided to a client within an interval of engagement with Open Arms. The episode of care commences at allocation and ends either by mutual agreement that the service is complete; or when the interventions are not achieving the desired change and a new referral is required; or when the client does not wish to continue the episode; or if there is a therapeutic break of more than 3 months.

Program 2.6: Military Rehabilitation and Compensation Acts – Health and Other Care Services

The department arranges for the provision of rehabilitation, medical and other related services under the DRCA, the MRCA and related legislation. The services include payment for medical treatment, rehabilitation services, attendant care and household services.

The key activities assess performance in relation to the following subset of the broader program:

- Rehabilitation services.

Key activities:

- Provide veterans with access to medical management, psychosocial and vocational rehabilitation programs and support for employment.

TABLE 22: PROGRAM 2.6 MILITARY REHABILITATION AND COMPENSATION ACTS – HEALTH AND OTHER CARE SERVICES – PERFORMANCE MEASURES AND RESULTS

No	Performance measure	Target	2023-24 actual result	2024-25 actual result	Achieved
2.6-1	Timeliness: The percentage of rehabilitation assessments completed within 30 days of assessment referral ⁴	≥75%	99%	99%	Achieved
2.6-3	Client satisfaction: An annual survey of client satisfaction with the rehabilitation program ⁵	≥75%	68%	82%	Achieved

4 This measure is a calculation of the percentage of rehabilitation assessments undertaken during 2024–25 that were conducted by rehabilitation providers within 30 days of the assessment being requested by the department. The assessment date is recorded in departmental systems by a delegate based on the assessment date reported by the provider.

5 Client satisfaction is measured through a monthly independent survey by ORIMA Research of departmental clients who have recently completed the rehabilitation program. Client satisfaction for this measure is calculated through the responses to specific questions in the survey, which assess participants' overall views of the program as well as the rehabilitation plan commencement and closure process. The 2024–25 performance result is based on rehabilitation case closures from 1 April 2024 to 31 May 2024 and case commencements and case closures from 1 June 2024 to 31 March 2025. Survey participation is voluntary. Neutral responses do not contribute to the achievement of the measure. The response rate for 2024–25 was 24%.

(PBS p 51, Corporate Plan p 31)

Timeliness

The target for timeliness measure 2.6-1 was achieved, as 99% of rehabilitation assessments were made within 30 days of referral for assessment.

Rehabilitation aims to assist veterans to build skills to enable them to maximise their wellbeing. It involves a rehabilitation assessment to understand the veteran's goals and needs in order to determine if rehabilitation is appropriate. If so, a rehabilitation plan is put in place, progress is monitored and ongoing support is provided to enable the veteran to achieve their goals, whether they relate to medical management, psychosocial or vocational matters.

The target was achieved through continued regular engagement and communication with contracted providers, including ongoing capability development sessions and feedback.

Client satisfaction

In 2024–25 the 75% target for client satisfaction with the rehabilitation program (measure 2.6-3) was achieved. The overall percentage for client satisfaction was 82%.

For the months of April 2024 to May 2024 the survey sample includes clients who completed a rehabilitation plan, and for the months of June 2024 to March 2025 the survey sample was expanded to also include clients who commenced a rehabilitation plan. The full-year 2024–25 result therefore consists of responses received from clients whose rehabilitation plans either started or closed. This is in contrast to the 2023–24 result, which included only clients who had completed their rehabilitation plan. The 2024–25 result considering closures only would be 78%.

There was a marginal improvement in the client satisfaction survey response rate (24%) in 2024–25 following the implementation of a new survey model and of a new contracted rehabilitation model which provides a more structured approach to service delivery. The rehabilitation model includes clearer guidelines on available support and more straightforward procedures for accessing services, resulting in an improvement in client experience as services are being accessed in a more timely and consistent manner.

2024-2025 PPI Methodology and Assurance Document (MAD)

By approving this Methodology and Assurance Document, I acknowledge that all data provided for performance reporting must be based on properly maintained records, accurately reflect the performance of the department, and comply with Section 39(2) of the PGPA Act. For more information, please contact **s 47E**

Ownership & Accountabilities			
Role	Accountable	Signature	Date
Deputy Secretary	Andrew Kefford Policy & Programs		
Senior Responsible Officer (SRO)	Leonie Nowland First Assistant Secretary Open Arms Division		
Responsible Officer	Ben Dalton Assistant Secretary, Business Operations Branch, Open Arms Division	s 47F	12/2/2025
Performance Measure Owner (PMO)	s 47F Governance and Strategic Planning Section, Business Operations Branch, Open Arms Division	s 47F	11/02/2025

Main Contact (if not PMO)	s 47F Strategic Partnerships Section, Business Operations Branch, Open Arms Division	s 47F Signed Electronically	07/02/2025
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Hierarchy					
Outcome		Program		Sub-Program	
Outcome 2		Program 2.5		Open Arms - Veterans & Families Counselling Services	
Key Activities	• Provide veterans and families with access to mental health care services, including primary prevention through counselling and complex care coordination • Provide veterans with access to allied health services, including access to telehealth services • Provide access to Open Arms including individual and family counselling, afterhours counselling, group program interventions, and peer support.				
Performance Measure	2.5-5	Client Satisfaction			
Target	Preceding FY	Current FY	Forward FY		
	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027-2028
	≥80%	≥80%	≥80%	≥80%	≥80%
Business Process	Deliver counselling services				
PPI Reporting Frequency	Tri Annual				

PGPA Classifications		
16EA (d) – Measurement Technique	16EA (e) – Measure Type	16EA (f) – Measurement Timeframe
Qualitative	Effectiveness	Long-term

Measure and Target Selection	
Measure Appropriateness	Open Arms - Veterans & Families Counselling is dedicated to supporting the mental health and wellbeing of the Australian veteran community and their families. Open Arms provides free and

Why was this measure selected as appropriate?	confidential counselling, group treatment programs, community and peer advisors and mental health training. Given the nature of the services Open Arms provides, it is important Open Arms clients are satisfied with the counselling assistance received. To demonstrate whether clients are satisfied, the level of client satisfaction is measured via a client satisfaction questionnaire at the end of an episode of care. This measure correlates specifically to DVA’s key activity “Provide access to Open Arms including individual and family counselling, afterhours counselling, group program interventions, and peer support.”				
Target Appropriateness Why is measuring this target considered appropriate?	Target has been established to assess client satisfaction. A result ≥80% positive feedback result indicates most clients are satisfied with the service they receive.				
Target Rationale Why was the target value selected?	A result ≥80 per cent positive feedback indicates most clients are satisfied with the service they receive. A higher result indicates performance is improving or being maintained. A decrease indicates a reduction in client satisfaction levels to services provided which needs to be addressed. Quality Management in Open Arms is undertaken to achieve and maintain a level of quality which enhances Open Arms services.				
Materiality How does this materially measure the outcomes of the PBS program?	Open Arms delivers high quality mental health assessment and clinical counselling services for Australian veterans and their families. This measure supports Open Arms to continually improve and ensure the effectiveness of its services through measuring client satisfaction with the services provided.				
Timeframe Rationale Is the measure intended for short-term(1 year), medium-term (2-4 years) or long-term (5+ years) use? Why was this timeframe selected?	This measure is intended to exist for the long-term (5+ years), ensuring DVA can track trends in performance on a consistent basis over time.				
Related Measures					
Measure Number	Nil	Relationship	N/A	Description	N/A

S 47E

S 47E

S 47E

S 47E

S 47E

S 47E

2024-25 PPI Methodology and Assurance Document

By approving this Methodology and Assurance Document, I acknowledge that all data provided for performance reporting must be based on properly maintained records, accurately reflect the performance of the department, and comply with Section 39(2) of the PGPA Act. For more information, please contact **s 47E** [@dva.gov.au](mailto:s47E@dva.gov.au).

Approvals & Ownerships			
Role	Accountable	Signature	Date
Deputy Secretary	Andrew Kefford Policy & Programs		
Senior Responsible Officer (SRO)	Leonie Nowland First Assistant Secretary Open Arms Division		
Responsible Officer	Ben Dalton Assistant Secretary, Business Operations Branch, Open Arms Division	s 47F	12/2/2025
Performance Measure Owner (PMO)	s 47F Governance and Strategic Planning Section, Business Operations Branch, Open Arms Division		11/02/2025

Main Contact (if not PMO)	s 47F Assistant Director Governance Business Operations Branch
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Hierarchy					
Outcome		Program		Sub-Program	
Outcome 2		Program 2.5		Open Arms - Veterans & Families Counselling Services	
Key Activities	• Provide veterans and families with access to mental health care services, including primary prevention through counselling and complex care coordination • Provide veterans with access to allied health services, including access to telehealth services • Provide access to Open Arms including individual and family counselling, afterhours counselling, group program interventions, and peer support.				
Performance Measure	2.5-5	Client Satisfaction			
Target	Preceding FY	Current FY	Forward FY		
	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027-2028
	≥80%	≥80%	≥80%	≥80%	≥80%
Business Process	Deliver counselling services				
PPI Reporting Frequency	Tri Annual				

PGPA Classifications		
16EA (d) – Measurement Technique	16EA (e) – Measure Type	16EA (f) – Measurement Timeframe
Qualitative	Effectiveness	Long-term

Measure and Target Selection	
Measure Appropriateness Why was this measure selected as appropriate?	Open Arms - Veterans & Families Counselling is dedicated to supporting the mental health and wellbeing of the Australian veteran community and their families. Open Arms provides free and confidential counselling, group treatment programs, community and peer advisors and mental health training. Given the nature of the services Open Arms provides, it is important Open Arms clients are satisfied with the counselling assistance received. To demonstrate whether clients are satisfied, the level of client satisfaction is measured via a client satisfaction questionnaire at the end of an episode of care This measure correlates specifically to DVA's key activity "Provide access to Open Arms including individual and family counselling, afterhours counselling, group program interventions, and peer support."
Target Appropriateness Why is measuring this target considered appropriate?	Target has been established to assess client satisfaction. A result ≥80% positive feedback result indicates most clients are satisfied with the service they receive.
Target Rationale Why was the target value selected?	A result ≥80 per cent positive feedback indicates most clients are satisfied with the service they receive. A higher result indicates performance is improving or being maintained. A decrease indicates a reduction in client satisfaction levels to services provided which needs to be addressed. Quality Management in Open Arms is undertaken to achieve and maintain a level of quality which enhances Open Arms services.

Materiality How does this materially measure the outcomes of the program?		Open Arms delivers high quality mental health assessment and clinical counselling services for Australian veterans and their families. This measure supports Open Arms to continually improve and ensure the effectiveness of its services through measuring client satisfaction with the services provided.			
Timeframe Rationale Why was the timeframe selected?		This measure is intended to exist for the long-term (5+ years), ensuring DVA can track trends in performance on a consistent basis over time.			
Related Measures					
Measure Number	Nil	Relationship	N/A	Description	N/A

S 47E

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S 47E

S 47E

S 47E

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S 47E

2024-25 PPI Methodology and Assurance Document

By approving this Methodology and Assurance Document, I acknowledge that all data provided for performance reporting must be based on properly maintained records, accurately reflect the performance of the department, and comply with Section 39(2) of the PGPA Act. For more information, please contact **s 47E** @dva.gov.au.

Approvals & Ownerships			
Role	Accountable	Signature	Date
Deputy Secretary	Andrew Kefford Policy & Programs		
Senior Responsible Officer (SRO)	Leonie Nowland First Assistant Secretary, Open Arms Division		
Responsible Officer	Ben Dalton Assistant Secretary, Business Operations Branch Open Arms Division	s 47F	12/2/2025
Performance Measure Owner (PMO)	s 47F Director Governance Business Operations		11/02/2025

Main Contact (if not PMO)	s 47F Assistant Director Governance Business Operations Branch
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Hierarchy					
Outcome		Program		Sub-Program	
Outcome 2		Program 2.5		Open Arms – Veterans & Families Counselling Services	
Key Activities	Provide veterans and families with timely access to counselling support including individual, couples and family counselling.				
Performance Measure	2.5-4	Percentage of clients allocated to an Open Arms counsellor within two weeks of initial intake			
Target	Preceding FY	Current FY	Forward FY		
	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027-2028
	≥65%	≥65%	≥65%	≥65%	≥65%
Business Process	Deliver counselling services				
PPI Reporting Frequency	Tri-Annual				

PGPA Classifications		
16EA (d) – Measurement Technique	16EA (e) – Measure Type	16EA (f) – Measurement Timeframe
Quantitative	Output	Long term

Measure and Target Selection	
Measure Appropriateness Why was this measure selected as appropriate?	This measure indicates the proportion of Open Arms counselling services receiving timely allocation to an Open Arms Counsellor. It is indicative of how well we engage our clients at the initial stages. It is directly related to the DVA key activity Provide access to Open Arms including individual, couples and family counselling.

Target Appropriateness Why is measuring this target considered appropriate?		The higher the percentage the greater number of services that are being allocated to a counsellor in a timely matter. A higher result indicates more counselling services are being allocated to counsellors within 14 days of intake and this is indicative of better service times. Lower percentages could indicate a lack of counsellors available to provide services.			
Target Rationale Why was the target value selected?		The target rationale is determined by National Management and agreed upon by the Executive Management Board as outlined in the PBS.			
Materiality How does this materially measure the outcomes of the program?		Engaging clients early increases trust that our service will provide timely assistance, which supports DVA's mission of being connected, client focussed and responsive.			
Timeframe Rationale Why was the timeframe selected?		This measure is intended to exist for the long-term (5+ years), ensuring DVA can track trends in performance on a consistent basis over time.			
Related Measures					
Measure Number	Nil	Relationship	N/A	Description	N/A

S 47E

S 47E

S 47E

S 47E

2025-2026 PPI Methodology and Assurance Document (MAD)

By approving this Methodology and Assurance Document, I acknowledge that all data provided for performance reporting must be based on properly maintained records, accurately reflect the performance of the department, and comply with Section 39(2) of the PGPA Act. For more information, please contact **s 47E** @dva.gov.au.

Ownership & Accountabilities			
Role	Accountable	Signature	Date
Deputy Secretary	Alison McLaren Deputy Secretary Veteran, Family and Stakeholder Experience		
Senior Responsible Officer (SRO)	Leonie Nowland First Assistant Secretary, Open Arms Division		
Responsible Officer	Amanda Harmer Assistant Secretary, Business Operations Branch Open Arms Division	s 47F	28.11.2025
Performance Measure Owner (PMO)	s 47F Director Business Operations		

Key contact person (business lead)	s 47F Director Governance Business Operations Branch
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Hierarchy					
Outcome		Program		Sub-Program	
Outcome 2		Program 2.1		Open Arms – Veterans & Families Counselling Services	
Key Activities	Providing access to health, rehabilitation, physical and mental wellbeing and care services for veterans and families				
Performance Measure	2.1	Timeliness: Percentage of clients allocated to peer worker, group treatment, or an Open Arms clinician, within two weeks of intake. Client Assist completes the intake over the phone and records a pre-enrolment. The pre-enrolment date is the date used for timeliness reporting.			
Target	Preceding FY	Current FY	Forward FY		
	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028-2029
	Previously “Percentage of clients allocated to an Open Arms clinician within 2 weeks of initial intake with a target of ≥65%”	≥80%	≥80%	≥80%	≥80%
Program Performance Indicator Reporting Frequency	Tri-Annual				

PGPA Classifications		
16EA (d) – Measurement Technique	16EA (e) – Measure Type	16EA (f) – Measurement Timeframe
Quantitative	Output	Long term This measure is intended to exist for the long-term (5+ years), ensuring DVA can track trends in performance on a consistent basis over time.

Measure and Target Selection	
Measure Rationale This is what is published in the Corporate Plan Why was this measure selected as appropriate?	The Department is focused on the provision of high quality and timely mental health services that meet the needs of customers. This measure goes to the core of the department's operations and indicates the department's responsiveness and engagement with its clients at the initial stages through the timeliness of allocation to mental health services provided through Open Arms. This measure is of great public interest, was a focus point for the Royal Commission on Defence and Veteran Suicide and is central to improving veterans' wellbeing. Improving the mental health of veterans and their families is a Government priority. The results from the measure will be used to modify and improve processes.
Target Rationale This is what is published in the Corporate Plan Why is measuring this target appropriate?	≥80% was selected based on historical data and past achievement. Opens Arms has consistently achieved the previous targets. This target will be re-evaluated at the end of the reporting cycle.
Materiality How does this materially measure the outcomes of the Portfolio Budget Statements program?	This measure is key to understanding whether clients can access mental health services in a timely fashion and goes to the heart of whether the department is delivering on Outcome 2 and its purpose. This measure is of great public interest, was a focus point for the Royal Commission on Defence and Veteran Suicide and is central to improving veterans' wellbeing. Improving the mental health of veterans and their families is a key focus for the Government.

S 47E

Are there any Related Measures? If so specify details below					
Measure Number	0.1 and 0.2	Relationship	Correlated	Details	A higher time taken to allocate will impact adversely to the level of client satisfaction and perceived impact on wellbeing.

S 47E

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RESPONSIBLE OFFICER DECLARATION

Processing instructions:

- *Acknowledge any non-compliance*
- *Document any data quality issues*
- *Detail any disclosures to be outlined for the reader in the Annual Performance Statements*
- *Detail any variations or deviances from the endorsed Methodology and Assurance Document (MAD) (changes to calculations methodology, reporting periods, business rules, etc).*

In my opinion, the information presented in the PPI 2 dashboard and content in the annual performance statements is compliant with subsection 39(2) of the PGPA Act, in particular the checklist attached. Any non-compliance has been disclosed as part of this declaration.

As the delegated business owner for the following Strategic Performance Measures, I have reviewed the reporting of these measures as contained in PPI 2:

2.1

In my opinion, all information in PPI 2 relating to the above-mentioned measure(s):

- is accurate, relevant, reliable, and complete
- is based on properly maintained records
- is able to be verified using the source data.

S 47F

Date: 12.03.2026

Amanda Harmer

Assistant Secretary

Business Operations

Comments (if applicable)

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Program Performance Indicator (PPI)
2025-26 Period 2 results – AS Declaration & checklist

Performance Measure – 2.1

PGPA Rule Requirement	Consider	Yes/No	Please include explanations on what processes are in place to address each dot point.
PGPA Act, s37(1)-2	Have records been kept that record and explain the area's performance?	Yes	<i>All allocation records underpinning the PPI are stored as per DVA record keeping standards within TRIM. MADs are stored in TRIM. PPI responses are stored in TRIM once cleared.</i>
PGPA Rule, s16F(1)	Was performance measured and reported as outlined in the 25-26 Corporate Plan and 25-26 PBS?	Yes	<i>There have been no changes to the measures and reporting, therefore data and results align to requirements.</i>
PGPA Rule, s16F(2)	Have you explained in your commentary any changes to activities, capability or environment which may have impacted on the area's performance?	NA	<i>No changes. Processes remain consistent with the MAD and Business Rules, aligned with the prior reporting period.</i>
RMG 134	Have you described factors that contributed to the level of performance in your commentary?	Yes	<i>Identified number of available Outreach Counsellors and In Centre Clinicians as directly contributing to result.</i>
s16EA(a)	Does the measure relate to at least one of the department's key activities?	Yes	<i>Provide access to Open Arms including individual and family counselling, after-hours counselling, group program interventions, and peer support</i>
	Is the relationship clear for each performance measure or does it need to be explained?	Yes	<i>Yes. This measure indicates the timely allocation to an Open Arms clinician for counselling or other mental health support services, reflecting access to Open Arms including individual and family counselling, after-hours counselling, group program interventions, and peer support.</i>



Program Performance Indicator (PPI)
2025-26 Period 2 results – AS Declaration & checklist

PGPA Rule Requirement	Consider	Yes/ No	Please include explanations on what processes are in place to address each dot point.
s16EA(b)	Have the information/ data sources and methodologies used for calculating the results been identified, documented, and agreed by management, through Methodology and Assurance Documents (MADs) and was this procedure followed?	Yes	<i>All information/data sources and methodologies are within the Dep-Sec approved MAD developed for PPI 2.1.</i> <i>These sources and methodologies have been consistently followed.</i>
	Has an assessment been made to confirm that data sources and methodologies are both reliable and able to be verified? I.e. have the results been calculated off evidence that is not open to manipulation and able to be independently verified? If any risks are identified, please indicate in this section	Yes	<i>Quality Assurance steps are included within the PPI 2.1 submission activity, including audits by different members of the team and data sampling to confirm accuracy. Additionally, ANAO audits are conducted that confirm datasets match data embedded on the client management system. Though it is noted that there are limited user logs available due to system limitations.</i>
	Is there a quality assurance process that ensures that the data is complete, and results are accurate etc? ie business rule and script testing documentation from data team to prove data completeness; and sample testing evidence to prove data accuracy.	Yes	<i>As above. Quality assurance steps are implemented within the process of preparing the PPI.</i>
	Are these quality assurance processes documented and followed?	Yes	<i>The information is contained within the MAD document – specifically: sampling the data and controls within the report itself to ensure minimal human interaction.</i>



Program Performance Indicator (PPI)
2025-26 Period 2 results – AS Declaration & checklist

PGPA Rule Requirement	Consider	Yes/ No	Please include explanations on what processes are in place to address each dot point.
s16EA(c)	Is there a risk that the way of calculating the results lead to perceived or actual bias?	No	<i>The methodology within the MAD has been developed to remove or mitigate any identifiable bias.</i>
	Are there controls to prevent and detect the manipulation of data sources?	Yes	<i>Multiple auditing points, and retention of all data included in the results. This allows for auditing at any stage to confirm accuracy of data and results.</i>
	Are processes in place to ensure the source/ underlying data provides a 'complete' and accurate picture and capturing all relevant information (e.g. claim types, cases, client numbers, etc)?	Yes	Supplied with the PPI is the detailed evidence supporting the calculation. This includes all relevant fields.
	Are all relevant exclusions been documented and applied in calculating the result (e.g. non-applicable claim types, cases, client numbers, etc)?	Yes	The report is only altered to reflect the required reporting period and so applies all exclusions documented within the PPI's MAD.
s16EA(f)	Is this measure being applied consistently each period or has there been a change in the calculation?	Yes	The measure is being applied consistently.
	Is the rationale for any changes to performance measures documented and outlined in the corporate plan and annual performance statements.	NA	The performance measures remain unchanged.

OPEN ARMS PPI 2.1 – TIME TAKEN TO ALLOCATE: BUSINESS RULES



A service founded by
Vietnam Veterans, now
for all veterans and
families

Version 1.0

DEPARTMENT OF VETERANS' AFFAIRS

Contents

s 22 - Out of scope

Background	4
Document Purpose	4
Requirement	4
PPI 2.1 – Time to Allocate	4
Overview	4

S 47E

S 47E

s 22 - Out of scope

Background

Document Purpose

The purpose of this document is to set out the business rules and explanation of the methodology used in the Open Arms Time to Allocate PPI 2.1 Reporting solution.

Requirement

PPI 2.1 – Time to Allocate

S 47E

Overview

The Department of Veterans' Affairs (DVA) is focused on the provision of high quality and timely mental health services that meet the needs of customers. This measure goes to the core of the department's operations and indicates DVA's responsiveness and engagement with its clients at the initial stages through the timeliness of allocation to mental health services provided through Open Arms. This measure is of great public interest, was a focus point for the Royal Commission on Defence and Veteran Suicide and is central to improving veterans' wellbeing. Improving mental health is a government priority. The results from the measure will be used to modify and improve processes.

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RESPONSIBLE OFFICER DECLARATION

Processing instructions:

- *Acknowledge any non-compliance*
- *Document any data quality issues*
- *Detail any disclosures to be outlined for the reader in the Annual Performance Statements*
- *Detail any variations or deviances from the endorsed Methodology and Assurance Document (MAD) (changes to calculations methodology, reporting periods, business rules, etc).*

In my opinion, the information presented in the PPI 3 dashboard and content in the annual performance statements is compliant with subsection 39(2) of the PGPA Act, in particular the checklist attached. Any non-compliance has been disclosed as part of this declaration.

As the delegated business owner for the following Strategic Performance Measures, I have reviewed the reporting of these measures as contained in PPI 3:

2.5-4 & 2.5-5

In my opinion, all information in PPI 3 relating to the above-mentioned measures:

- is accurate, relevant, reliable, and complete
- is based on properly maintained records
- is able to be verified using the source data.

I acknowledge that the information contained in the Annual Performance Statements is consistent with the results and information presented in the PPI 3 dashboard.

s 47F

Date: 16 July 2025

Brook Shearer
Acting Assistant Secretary
Business Operations

Comments (if applicable)

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Program Performance Indicator (PPI)
Period 3 results – AS Declaration & checklist

Performance Measure – 2.5-4

PGPA Rule Requirement	Consider	Yes/No	Please include explanations on what processes are in place to address each dot point.
PGPA Act, s37(1-2)	Have records been kept that record and explain the area's performance?	Yes	- All allocation records underpinning the PPI are stored as per DVA record keeping standards within TRIM - MADs are stored in TRIM - PPI responses are stored in TRIM once cleared
PGPA Rule, s16F(1)	Was performance measured and reported as outlined in the 24-25 Corporate Plan and 24-25 PBS?	Yes	There have been no changes to the measures and reporting, therefore data and results align to requirements.
PGPA Rule, s16F(2)	Have you explained in your commentary any changes to activities, capability or environment which may have impacted on the area's performance?	NA	No changes identified, so not reported. Consistent with previous reporting periods.
RMG 134	Have you described factors that contributed to the level of performance in your commentary?	Yes	Identified number of available Outreach Counsellors and In Centre Clinicians as directly contributing to result.
s16EA(a)	Does the measure relate to at least one of DVA's key activities?	Yes	Provide access to Open Arms including individual and family counselling, after-hours counselling, group program interventions, and peer support
	Is the relationship clear for each performance measure or does it need to be explained?	Yes	Yes. This measure indicates the timely allocation to an Open Arms clinician for counselling or other mental health support services, reflecting access to Open Arms



Program Performance Indicator (PPI)
Period 3 results – AS Declaration & checklist

PGPA Rule Requirement	Consider	Yes/ No	Please include explanations on what processes are in place to address each dot point.
			<i>including individual and family counselling, after-hours counselling, group program interventions, and peer support.</i>
s16EA(b)	Have the information/ data sources and methodologies used for calculating the results been identified, documented, and agreed by management, through Methodology and Assurance Documents (MADs) and was this procedure followed?	Yes	- All information/data sources and methodologies are within the Dep-Sec approved MAD developed for PPI 2.5-4. - These sources and methodologies have been consistently followed.
	Has an assessment been made to confirm that data sources and methodologies are both reliable and able to be verified? I.e. have the results been calculated off evidence that is not open to manipulation and able to be independently verified?	Yes	Quality Assurance steps are included within the PPI 2.5-4 submission activity, including audits by different members of the team and data sampling to confirm accuracy. Additionally, ANAO audits are conducted that confirm datasets match data embedded on the client management system. s 47E
	Is there a quality assurance process that ensures that the data is complete, and results are accurate etc?	Yes	As above. Quality assurance steps are implemented within the process of preparing the PPI.
	Are these quality assurance processes documented and followed?	Yes	The information is contained within the MAD document – specifically: sampling the data and controls within the report itself to ensure minimal human interaction.



Program Performance Indicator (PPI)
Period 3 results – AS Declaration & checklist

PGPA Rule Requirement	Consider	Yes/No	Please include explanations on what processes are in place to address each dot point.
s16EA(c)	Is there a risk that the way of calculating the results lead to perceived or actual bias?	No	<i>The methodology within the MAD has been developed to remove or mitigate any identifiable bias.</i>
	Are there controls to prevent and detect the manipulation of data sources?	Yes	<i>Multiple auditing points, and retention of all data included in the results. This allows for auditing at any stage to confirm accuracy of data and results.</i>
	Are processes in place to ensure the source/ underlying data provides a 'complete' and accurate picture and capturing all relevant information (e.g. claim types, cases, client numbers, etc)?	Yes	Supplied with the PPI is the detailed evidence supporting the calculation. This includes all relevant fields.
	Are all relevant exclusions been documented and applied in calculating the result (e.g. non-applicable claim types, cases, client numbers, etc)?	Yes	The report is only altered to reflect the required reporting period and so applies all exclusions documented within the PPI's MAD.
s16EA(f)	Is this measure being applied consistently each period or has there been a change in the calculation?	Yes	- Beginning in FY 2024/25 the process remains unchanged, however the calculation has been altered to better refine the measure based on what is included. - Historically, the date a client was added to the waitlist was used to determine which records were to be included. This has now changed to the date a client is removed in order to ensure the



Program Performance Indicator (PPI)
Period 3 results – AS Declaration & checklist

PGPA Rule Requirement	Consider	Yes/ No	Please include explanations on what processes are in place to address each dot point.
			exclusions within the methodology do not create an unintended gap between reporting periods. This was done in discussion/consultation with ANAO and is reflected in the current MAD. • Please note this particular comment will not appear in subsequent submissions as the change management around this process is now embedded.
	• Is the rationale for any changes to performance measures documented and outlined in the corporate plan and annual performance statements.	NA	The performance measures remain unchanged.



Program Performance Indicator (PPI)
Period 3 results – AS Declaration & checklist

Performance Measure – 2.5-5

PGPA Rule Requirement	Consider	Yes/ No	Please include explanations on what processes are in place to address each dot point.
PGPA Act, s37(1-2)	Have records been kept that record and explain the area's performance?	Y	- All client surveys received are stored as per DVA record keeping standards within TRIM - SOPs are stored in TRIM - PPI responses are stored in TRIM once cleared
PGPA Rule, s16F(1)	Was performance measured and reported as outlined in the 24-25 Corporate Plan and 24-25 PBS?	Y	There have been no changes measures and reporting, therefore data and results align to requirements.
PGPA Rule, s16F(2)	Have you explained in your commentary any changes to activities, capability or environment which may have impacted on the area's performance?	NA	No changes identified, so not reported. Consistent with previous reporting periods.
RMG 134	Have you described factors that contributed to the level of performance in your commentary?	Y	Identified number of closed episodes of care, surveys sent, and response level. All contribute to the level of performance provided in commentary.
s16EA(a)	Does the measure relate to at least one of DVA's key activities?	Y	Maintain and enhance the physical and mental wellbeing and quality of life of eligible persons and their dependants through health and other care services that promote early intervention, prevention and treatment, including advice and information about health service entitlements.



Program Performance Indicator (PPI)
Period 3 results – AS Declaration & checklist

PGPA Rule Requirement	Consider	Yes/No	Please include explanations on what processes are in place to address each dot point.
	Is the relationship clear for each performance measure or does it need to be explained?	Y	<i>Yes – 2.5-5 is Client Satisfaction for Open Arms counselling services, which links directly to the key activities of Program 2.5: Veterans' Counselling and Other Health Services e.g. Provide veterans and families with access to mental health care services, including primary prevention through counselling and complex care coordination.</i>
s16EA(b)	Have the information/ data sources and methodologies used for calculating the results been identified, documented, and agreed by management, through Methodology and Assurance Documents (MADs) and was this procedure followed?	Y	<i>All information/data sources and methodologies are within the AS cleared Standard Operating Procedure documents which have been provided to Performance Reporting and ANAO. These documents provide the framework that is followed throughout this task.</i>
	Has an assessment been made to confirm that data sources and methodologies are both reliable and able to be verified? I.e. have the results been calculated off evidence that is not open to manipulation and able to be independently verified?	Y	<i>Results are calculated from surveys received. Once data is input, it is then randomly audited at 2 additional points within the team. All data is able to be verified, and ANAO do request raw data files each reporting period for additional verification.</i>
	Is there a quality assurance process that ensures that the data is complete, and results are accurate etc?	Y	<i>As above, multiple random audits are completed on both the input of data and calculation of results.</i>



Program Performance Indicator (PPI)
Period 3 results – AS Declaration & checklist

PGPA Rule Requirement	Consider	Yes/ No	Please include explanations on what processes are in place to address each dot point.
	Are these quality assurance processes documented and followed?	Y	<i>As per the OA Feedback SOP and OA Calculations SOP. Both are followed, however due to being an entire manual process, there is a risk of undetected human error.</i>
s16EA(c)	Is there a risk that the way of calculating the results lead to perceived or actual bias?	N	<i>None identified</i>
	Are there controls to prevent and detect the manipulation of data sources?	Y	<i>Multiple auditing points, and retention of all data included in the results. This allows for auditing at any stage to confirm accuracy of data and results.</i>
	Are processes in place to ensure the source/ underlying data provides a 'complete' and accurate picture and capturing all relevant information (e.g. claim types, cases, client numbers, etc)?	Y	<i>Data provided is 'complete', however as the survey is not mandatory, we are only able to provide a result based on those who provide feedback. This is a very small percentage of those accessing our services.</i>
	Are all relevant exclusions been documented and applied in calculating the result (e.g. non-applicable claim types, cases, client numbers, etc)?	Y	<i>Performance Reporting and ANAO have received documentation confirming closures that are not eligible to receive surveys. There are 4 exclusion criteria in place. As these individuals do not receive a survey, they are not included in the 'received survey' numbers, however are included in the 'closed case' numbers.</i>



Program Performance Indicator (PPI)
Period 3 results – AS Declaration & checklist

PGPA Rule Requirement	Consider	Yes/ No	Please include explanations on what processes are in place to address each dot point.
s16EA(f)	Is this measure being applied consistently each period or has there been a change in the calculation?	Y	<i>Remains consistent with previous reporting periods.</i>
	Is the rationale for any changes to performance measures documented and outlined in the corporate plan and annual performance statements.	NA	<i>No changes identified.</i>

Our Plan Open Arms 2025-26

Our Role

Provide access to mental health and wellbeing supports, including individual, couples and family counselling, care coordination, after-hours crisis support, group treatment programs, peer support, and online digital mental health supports to current serving members of the Australian Defence Force, veterans and families of veterans.

Our Priorities

	Key deliverables	Strategic Priorities	External or Inter-Divisional Dependencies	Enterprise Risk Focus Area	Branch Risk Reference	Performance Measure Number	Timeframe (Month)
1	Providing current and former serving members of the ADF and families with timely access to appropriate mental health and wellbeing services.	Deliver quality services	s 47E	Supporting our veterans and their community at all times	s 47E	2.1	s 47C
2	Strengthening service awareness, strategic partnerships and organisational communication.	Deliver quality services		Supporting our veterans and their community at all times		N/A	
3	Embedding a culture of excellence and continuous improvement in service delivery.	Implement Royal Commission and Government priorities		Meeting Government Priorities		N/A	
4	Investing in workforce capabilities, development, and wellbeing	Simplify processes and improved enabling services		Looking after our people		N/A	
5	Enhancing operational integrity, governance and accountability	Simplify processes and improved enabling services		Operational Integrity		N/A	

Our Environment

Our People

We are an accredited mental health and wellbeing support service operating in a competitive mental health service delivery labour market with national shortages, particularly in regional and remote areas. s 47E

Our Clients and Stakeholders

Open Arms provides military aware, trauma informed mental health and wellbeing support for current and former members of the ADF, veterans and families of veterans. Open Arms works with stakeholders and the veteran community to design, deliver and evaluate the effectiveness and safety of programs and supports. This may be through formal governance committees such as the Open Arms' National Advisory Committee and Departmental committees (such as the Chief Health Officer's Clinical Governance Committee), and in consultation with the wider veteran, community and health sectors. We value and utilise the direct feedback to inform service review and design.

Our Systems and Processes

The Model of Care is a dynamic document which defines Open Arms' scope of services. Open Arms is undertaking a Service Planning and Design review to inform the next iteration of the Model of Care to ensure we are meeting the current and future needs of our community. s 47E

Increased quality data will strengthen corporate and clinical governance reporting to support continuous improvement, operational integrity, clinical safety and contribute to quality outcomes.



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OPEN ARMS

Monitoring and Evaluation Framework

September 2025

OPEN ARMS
Veterans & Families Counselling

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Acknowledgement

Open Arms 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.

We respect and give thanks to all who have served in the Australian Defence Force and their families. We acknowledge the unique nature of military service, and the sacrifice demanded of all who commit to defend our nation. We undertake to preserve the memory and deeds of all who have served and promise to welcome, embrace and support all military veterans as respected and valued members of our community. For what they have done, this we will do.

About Open Arms

Open Arms Veterans & Families Counselling (Open Arms) is Australia's leading provider of mental health assessment and clinical counselling services for Australian veterans and their families. Its purpose is to deliver evidence based and informed mental health and wellbeing services which improve the quality of life for veterans and their families, with a specific emphasis on military aware, trauma-informed and recovery focused supports.

Table of Contents

1.	The Purpose	4
2.	Why monitor and evaluate?	4
3.	Definitions.....	5
	<i>Monitoring</i>	5
	<i>Evaluation</i>	6
4.	Guiding Principles	6
5.	Open Arms Evaluation Model	7
6.	Intended users & responsibilities.....	11
7.	Requirements of evaluation activities	11
8.	Types or focus of evaluation.....	12
8.1	Formative Evaluation	12
8.2	Summative Evaluation	12
8.3	Process Evaluation	13
8.4	Outcome Evaluation.....	13
8.5	Impact Evaluation	13
8.6	Economic Evaluation	13
9.	Outcomes Measures.....	14
10.	Quality Measures	14
11.	Methods of data collection	14
12.	Data Analysis	16
13.	Ethical considerations	17
14.	Risks	17
15.	Writing a monitoring and evaluation plan	17
16.	Evaluation reporting and implementation plan	17
17.	Further considerations	18
18.	Glossary of terms	18
	APPENDIX A	20
	Outcome measures	20
	APPENDIX B	21
	Quality Indicators/Measures 2025-2026	21
	APPENDIX C	22
	Timetable for planned evaluation of programs.....	22

1. The Purpose

The Monitoring and Evaluation (M&E) Framework supports Open Arms to assess and improve the mental health and wellbeing, and suicide prevention services it provides to the veteran community. Its purpose is to:

- promote and support high quality and consistent monitoring and evaluation of services
- support evidence-based service design, planning, delivery, decision making and policy
- ensure compliance with government expectations and standards for evaluation.

It will do this by:

- Defining monitoring and evaluation
- Outlining the Open Arms' approach and how it is to be implemented
- Providing guidance on planning evaluation activities
- Defining responsibilities of staff involved in evaluation
- Outlining specific and overarching performance outcomes for Open Arms
- Providing timelines and guidance for evaluation activities

2. Why monitor and evaluate?



Monitoring and evaluating the effectiveness of Open Arms programs is vital to ensure the Division is meeting the mental health and wellbeing needs of the veteran community it is here to support. As an accredited mental health service, Open Arms should be able to demonstrate it is delivering evidence-based interventions safely, effectively, and efficiently, to the people and communities who need them.ⁱ

Evaluations are essential for the assessment of effectiveness and understanding of impact of programs and services. This information is used to determine what works well, where improvements can be made, and outcomes that can be shared with others. It also helps to demonstrate the impact to government and funders. "Understanding what works, why and for whom can enhance the effectiveness, efficiency, and equity of government interventions".ⁱⁱ The Australian Evaluation Society

states, “Evaluation offers a range of powerful tools to make judgments about the value of any set of procedures, activities, strategies, projects, policies, programs, organisations or systems”.ⁱⁱⁱ For ease of use, programs will be the terminology used throughout this document to refer to all the above.

Importantly, the information gained from evaluation can be used to build trust with the veteran community. It allows for Open Arms to demonstrate how and why it makes decisions, which in turn increases its accountability through transparency and supports a sustainable approach.

Purpose of Program Evaluation

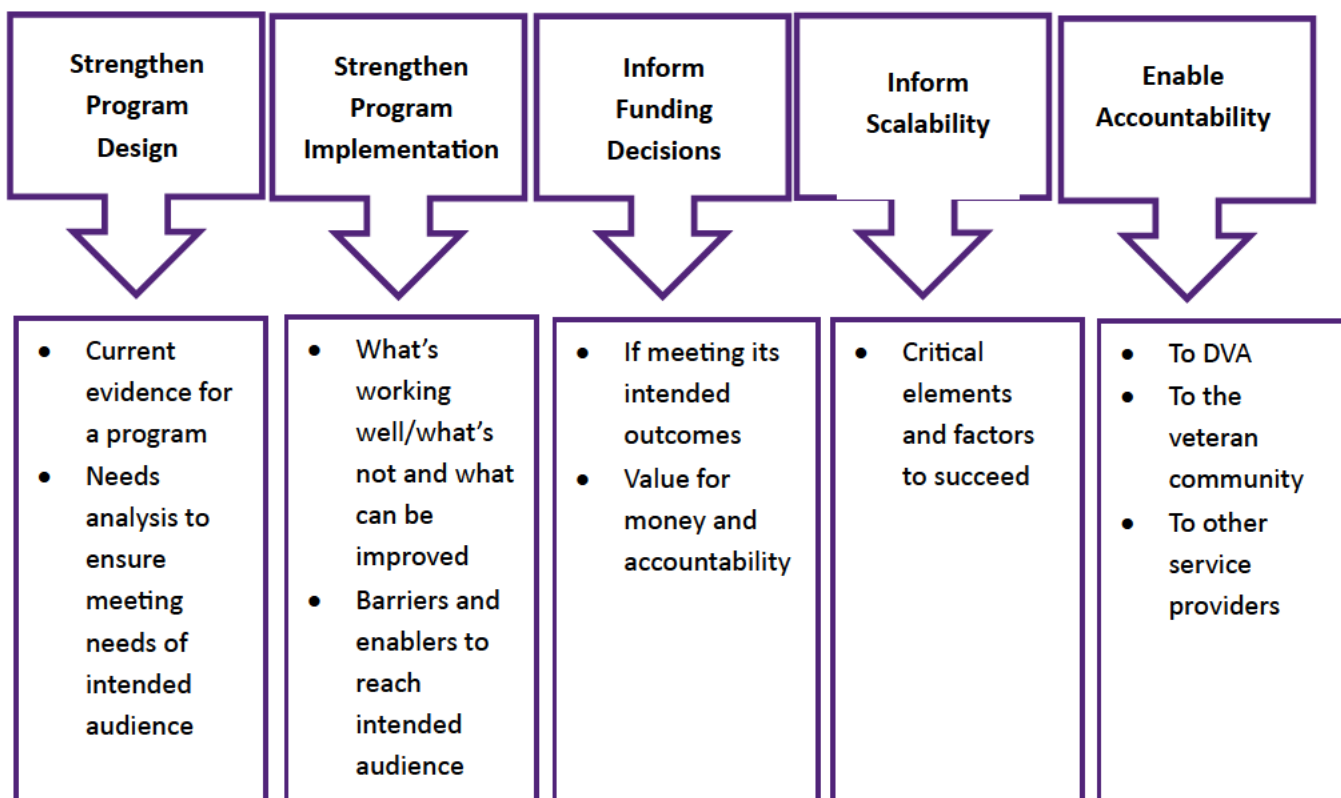


Figure 1. Modified from National Mental Health and Suicide Prevention Evaluation Framework^{iv}

3. Definitions

Clarifying what is meant by monitoring and evaluation will help to ensure consistency of approach and understanding when applying the M&E Framework.

Monitoring

Monitoring is a continuous and systematic collection and analysis of available program information to provide management and key stakeholders with an indication of the extent of progress in implementation against stated objectives^v. In simple terms, monitoring provides an update on progress at any given time.

Monitoring activities include continuous assessment activities of program components to determine whether they are working as planned. These activities:

- Are generally conducted at regular intervals e.g. daily, weekly, monthly, quarterly, six (6) monthly
- Provide stakeholders with regular feedback on program implementation and identify successes and risks, actual and potential
- Allow the collection of performance data supporting program evaluation^{vi}.

Evaluation

Evaluation activities include periodic, in-depth analysis of performance, impact, success, risks and sustainability of a program against its initial strategic intent. These activities:

- inform program improvements and/or scope modifications
- are generally supported by data collected from regular monitoring activities
- involve structured internal and external stakeholder engagement using various methods e.g. workshops, interviews, surveys, desk top reviews.

The National Health and Medical Research Council (NHMRC)^{vii} and the Australian Evaluation Society define evaluation as:

"...the systematic collection and analysis of information to make judgements, usually about the effectiveness, efficiency and/or appropriateness of an activity. The term [evaluation] is used in a broad sense to refer to any set of procedures, activities, resources, policies and/or strategies designed to achieve some common goals or objectives".

4. Guiding Principles

The guiding principles of the M&E Framework are based on Department of Veterans' Affairs (DVA) Program Management Framework and the Australian Evaluation Society's Guidelines for the Ethical Conduct of Evaluations^{viii}. They also align with one of the Commonwealth Evaluation Policy aims to embed an Australian Public Service (APS) culture of evaluation and learning from experience^{ix}.



Respect

Evaluations will be conducted with respect for individuals' rights, privacy and diversity without judgement. This includes but is not limited to age, gender, sexual orientation, religion and cultural background.

Any client data used for the purpose of evaluation should be deidentified.



Risk and safety

During the evaluation process, if risks are identified, these should be reported as soon as possible following the appropriate DVA or Open Arms risk management process.

Where interviews, focus groups and surveys are used to collect sensitive information, risk mitigation processes must be put in place as part of the monitoring and evaluation plan. It is important to maintain confidentiality and that any data used is deidentified.



Useful

Evaluation outcomes are reported accurately and in a way that ensures they are understandable, useful and useable to drive best practice. Where possible, outcomes are made publicly available e.g. through the Open Arms website, publications and the [Evaluation Repository for the Australian Government](#), as this will support building trust in the services provided by Open Arms and assist in sharing outcomes to build the evidence base when working with veteran communities.



Informed

Complete and current information is available to support the monitoring and evaluation process. This enables accurate, high quality and robust evaluations to occur.

5. Open Arms Evaluation Model

The RE-AIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance) model offers a structured yet flexible approach to evaluation, ensuring that assessments are not only methodologically rigorous but also meaningful and applicable across diverse contexts. The model^x is one of the most widely used evaluation frameworks^{xi} in public health^{xii}, that incorporates both quantitative and qualitative methods. It addresses some of the difficulties and delays in translating evidence into policy and practice and has available resources through its dedicated website [RE-AIM – Home – Reach Effectiveness Adoption Implementation Maintenance](#) to support its use.

The RE-AIM model aligns with the evaluation phase of the DVA Program Management Framework (PMF), where the learnings and outcomes from a program and its delivery are captured and as detailed below, is well aligned with the key Commonwealth Evaluation principles.

Fit for Purpose

By using RE-AIM, Open Arms can optimise evaluation efforts, ensuring allocation of the right amount of time and resources according to the program's value, impact, strategic priority, and risk level. The model highlights the most relevant dimensions to guide the evaluation process, while allowing for adjustments based on the program's/activity's scale and scope. It facilitates appropriate, risk-based resource allocation, preventing unnecessary resource use.

The model can be used strategically to customise evaluations based on their purpose. Insights from analysing the key RE-AIM dimensions can support improved program/activity administration, efficient resource allocation and enhanced operational strategies. Furthermore, RE-AIM can contribute to policy-focused evaluations by providing insights into broader, system-level impacts across different communities and contexts.

Useful

RE-AIM supports continuous improvement and accountability by aligning objectives with measurable outcomes, driving data-driven decisions, and refining strategies. By evaluating programs in different contexts, RE-AIM allows for incorporating findings and experience from other jurisdictions to inform decisions and improve program design and implementation. Evaluation findings from each dimension feed back into decision-making allowing for rapid adjustments to improve outcomes.

RE-AIM can help determine whether government policy intent is being met by serving as both a monitoring tool and an input for new programs. As a monitoring tool, the model can track how well a policy is reaching its target population, its actual impact and how widely it is adopted. It also evaluates how policies are implemented and whether they are sustained overtime. When utilised as an input for new programs, RE-AIM leverages insights from past evaluations to guide policy development, helping set realistic objectives and achievable outcomes. In both cases, RE-AIM acts as a structured framework that connects evaluation findings to policy intent, ensuring that government interventions are data-driven, effective and continuously improved.

Robust, Ethical and Culturally Appropriate

RE-AIM ensures that evaluations are well-designed, minimises evaluator bias, and considers the impact of both programs and the evaluation on stakeholders. It emphasises the use of robust data and evidence to drive continuous program improvement. By assessing diverse populations, highlighting real world outcomes and long-term sustainability, and incorporating multiple perspectives, RE-AIM supports a comprehensive and robust assessment that includes broad stakeholder input.

The model promotes ethical evaluation by emphasising equity and inclusion. It ensures that interventions reach diverse populations, particularly those who are underserved, and assesses whether programs and activities lead to meaningful improvements in health and well-being.

RE-AIM recognises the importance of context and adaptation. It encourages tailoring interventions to fit specific cultural and community needs, ensuring that programs are relevant and effective for different populations.

Credible

The RE-AIM framework is widely recognised for its credibility in promoting rigor, transparency, and relevance by ensuring evaluations are technically and culturally sound. Evaluators engaged in the process will possess the necessary cultural competence and technical expertise to accurately reflect the context and complexity of population and settings.

Evidence collection and analysis will be conducted impartially and systematically with careful considerations of diverse stakeholder perspectives. This approach strengthens the reliability and relevance findings, ensuring they meaningfully inform decision-making.

All evaluations will adhere to established standards of integrity and independence, maintaining objectivity and trustworthiness throughout the evaluation process. Through its structured and inclusive approach REAIM supports the generation of high-quality evidence, ensuring that findings are credible, reliable and grounded in real-world evidence.

Transparent

RE-AIM promotes a strong culture of transparency. The model encourages clear reporting of methods, findings, and limitations and fosters clear communication between all stakeholders including researchers, clinicians, leadership and veterans. Findings will be made publicly available by default, unless there are appropriate reasons, such as privacy concerns or ethical considerations, that justify limited disclosure. This commitment to openness supports continuous improvement, accountability, and informed decision-making. Evaluation results will be shared with relevant stakeholders to ensure that insights are accessible, actionable and contribute to the ongoing refinement and effectiveness of programs.

The RE-AIM model suggests that the impact of a program depends on its reach, effectiveness, adoption, implementation and maintenance, with evaluation questions framed around these key criteria after having developed the logic model.

Table 1. Overview of RE-AIM

RE-AIM domain	Definition	Scope	Measurement examples
Reach	The number, proportion and representativeness of people who are willing to participate in a program, and reasons why or why not.	Who is intended to benefit from the program? Who participates or is exposed to the program? Who did not participate in the program, and why?	➤ Number of people receiving the program. ➤ Number (and characteristics) of people not receiving the program. ➤ Characteristics of participants compared to non-participants or to target population.
Effectiveness	The effect of a program on a person's life, including unintended or adverse effects.	What are the most important benefits trying to achieve? What would be a negative outcome?	➤ Self-report rating of health outcome (e.g. quality of life or perceived stress).
Adoption	The number, proportion and representativeness of regions or people delivering the program or who are willing to offer the program.	Where will the program be applied? Who will apply the program?	➤ Percent of regions approached that participate. ➤ Characteristics of organisations or settings that participate compared to either: non-participants or some relevant resource data.
Implementation	The extent to which a program is delivered (by organisations) or used (by participants) as intended.	How consistently is the program delivered? How was the program adapted?	➤ Number and type of changes made to the intervention or program. ➤ If the program was implemented in different contexts or situations, how consistent was the implementation across these contexts.
Maintenance	The [long-term] effect of a program on a person's life (usually six or more months after a program is completed, but this depends on the specific program). Maintenance also applies to the organisation level, and it refers to the extent to which an organisation continues to offer the program, or to incorporate the program, as part of its day-to-day practices.	How long will the program be sustained? How long are the results sustained?	➤ Maintenance or improvement of health outcomes or health behaviours at later time points (individual). ➤ Whether a program is still ongoing at six or more months after project funding.

Evaluation questions are framed around these key criteria after having developed the program logic.

For example, questions used to assess the effectiveness, reach and sustainability of the Open Arms Model of Care (MoC) may be:

- **Reach:** Who is accessing services under the Model of Care? Are all intended populations being reached?
- **Effectiveness:** What are the outcomes for clients (clinical, psychosocial, functional)?
- **Adoption:** To what extent has Model of Care been taken up by staff and outreach providers and partners across the country?
- **Implementation:** Is the Model being delivered as intended, with appropriate training, supervision, and infrastructure?
- **Maintenance:** Is the Model of Care sustainable, adaptable, and integrated into the broader mental health system?

6. Intended users & responsibilities

All Open Arms staff are responsible for implementing the M&E Framework in any evaluation activity.

Position/role	Responsibilities in Evaluation
First Assistant Secretary	Senior Responsible Officer (SRO)
Assistant Secretary/Senior Director	Approval of evaluation reports
Directors	Lead evaluation of activities Approval of M&E plans
Director Programs Assurance and Workforce Capability	Managing M&E Framework and supporting implementation
Assistant Director	Oversight of M&E processes
APS6 staff (Program Officers etc).	Development of M&E plan and conducting evaluation
Program Governance and Evaluation Team	Consultation to support effective monitoring and evaluation
Director Workforce Support	Position detail report
Director Program Insights and Technology	Storage and Maintenance of data

7. Requirements of evaluation activities

Monitoring and evaluation activities can occur across the full cycle of a program from concept to design, piloting, implementation and re-evaluation.

Open Arms' Branches are responsible for planning and managing the monitoring and evaluation of their programs. It is not always feasible or cost effective to fully evaluate everything, so these decisions are made at a Branch level in line with appropriate governance processes. However, when making these decisions, it is important to ensure we are evaluating programs as best we can.

In Open Arms priorities for evaluation include:

- **Pilot projects or programs** seeking renewed or increased funding. In some situations, this evaluation may be conducted by an external provider as part of the procurement process
- Where programs carry high **risks** or where the data is showing that the outcomes are not being achieved or program is not working as intended
- Where program **evidence** is greater than 3 years old, or there is limited existing evidence with the veteran population
- Where there is an aim to **integrate** across regions or improve systems and processes

An agreed timetable for planned evaluation of programs at Open Arms are outlines in **Appendix C**.

All monitoring and evaluation activities at Open Arms must:

- have completed the program management documents including the program logic, program overview and monitoring and evaluation plan available through the [Program Management and Evaluation Resource Hub](#)
- Manage data in accordance with the National Statement on Ethical Conduct in Human Research (2023)
- Be reported on, with the aim of putting evaluation findings into practice.

8. Types or focus of evaluation

To better understand what is working well, where improvements can be made and what is the overall impact of programs, knowing what type (can be more than one) of evaluation to conduct is an important step. To help determine which type of evaluation could be used, the five main ones have been listed below.

8.1 Formative Evaluation

Assesses the progress or effectiveness of a program whilst it is still being implemented. They can often be used to identify potential issues and make early adjustments to improve the program and ensure it aligns with intended goals. This helps with 'starting on the right track' to have a greater chance of achieving outcomes.

Evaluation questions include

- (a) is the program reaching intended audience?
- (b) how are inputs contributing to program function?

8.2 Summative Evaluation

Assesses overall effectiveness of the program and typically occurs at the end of the project/program. These types of evaluations collect information and data from multiple sources over time to be able to demonstrate effectiveness against the stated goals. Summative evaluations can be used when needing to decide whether to continue, expand or end a program as they can be used to measure outcomes over time (e.g. years or number of group program deliveries).

Evaluation questions include

- (a) did participants experience outcomes as intended?
- (b) what changes were made to improve quality of the program?

8.3 Process Evaluation

Incrementally assesses the design and roll-out of a program and considers:

- Implementation - whether being implemented as planned, reaching intended audience, and inputs, activities/processes, and outputs of a program are achieving the intended goals. The key evaluation question is: How (well) is the program being delivered?
- Appropriateness - whether there is alignment between the identified need, activities and outputs, and the intended outcomes. The key evaluation question is: Is this program (still) the right response, or delivery method?
- Administrative effectiveness and efficiency. The key evaluation question is: Could we improve the process by which the program is administered to improve client satisfaction, processing times, or remove unnecessary steps to reduce administrative expenditure?

Process evaluation tends to be completed using quantitative information however can be supplemented by qualitative information.

Evaluation questions include

- (a) how many people participated?
- (b) how many new stakeholders are there?
- (c) were activities delivered on schedule and as intended?

8.4 Outcome Evaluation

Assesses a program's effects in the early or medium-term. This type of evaluation measures the effects or the intended outcomes on participants by assessing whether the program is achieving its intended outcomes.

There are challenges when evaluating outcomes of mental health programs. There are standard outcome measures that Open Arms uses noting that consideration needs to be given to the population group the measure is to be used with.

Evaluation questions include

- (a) did the program increase knowledge and awareness?
- (b) did the program change attitudes and beliefs?
- (c) to what extent has the program achieved its intended outcome?

8.5 Impact Evaluation

Builds on an outcome evaluation to assess a program's impacts in the longer-term. These consider what changes have occurred and to what extent the changes can be attributed to the program, and whether there have been any unintended consequences. They compare these changes or results with what would have happened in the absence of the program.

Evaluation questions include

- (a) what difference/impact is the program making?

8.6 Economic Evaluation

Used to inform decision makers, stakeholders and funders if a program is a cost-effective use of resources. This will allow for decisions to be made about resource allocation and make recommendations to enhance program's efficiency and impact.

Evaluation questions include:

- (a) what is the most cost-effective option?
- (b) is the program the best use of available resources?
- (c) to what extent does the program have benefits that are sustained?

9. Outcomes Measures

There are intrinsic challenges in evaluating the outcomes of mental health and suicide prevention programs, however this shouldn't deter us from identifying ways that this can be done. The Australian National University (ANU) was engaged by Open Arms in 2023 to provide recommendations about the types of measures that can be used in the services it provides. Based on this report (TRIM 23326188E), Open Arms has identified core outcome measures along with additional measures as outlined in **Appendix A**.

Core outcome measures are expected to be completed at a minimum on commencement of an episode or care and again on closure/exit. A mid-point review may also be indicated based on the client goals.

The identified outcome measures are either:

- self-completed (completed by the client); or
- clinician/peer completed with the client present

The way a measure is introduced and its purpose explained to a client is important. It is a useful tool to start a conversation and explain that rationale and when it is likely to be repeated.

It is important that we balance standardised outcome measures with the 'narrative' outcomes for clients using patient rated experience measures (PREMs). PREMs are often administered as questionnaires, either in paper or online formats. These measures will be used to help Open Arms improve a client's experience, use the data to track trends, monitor progress and inform decisions about the way the service is delivered.

10. Quality Measures

Nationally, the [Health Performance Framework](#) and *National Mental Health Performance Framework 2020* define the domains that mental health data is routinely collected. DVA also has a [Corporate Plan 2025-2026](#) that provides performance measures. Open Arms has drawn on these three frameworks to develop its own divisional 'quality' indicators as outlined in **Appendix B**.

All programs, services and initiatives delivered by Open Arms are required to report regularly against the divisional Quality Indicators. The frequency of reporting is determined by the Branch/Directorate.

11. Methods of Data Collection

To answer evaluation questions, we need to be able to access reliable, quality data. These data indicators or measurements will assist understanding if something has changed, progressed or the outcome has been achieved. It is important to gather a range of data to support effective evaluation. This data information can be gathered from a range of sources including:

- People: clients, staff and other stakeholders including external providers

- Information that already exists data bases (Australian Institute of Health and Welfare (AIHW), Australian Bureau of Statistics (ABS), DVA data platform (Tableau), minutes of meetings, reports, client management systems, staff management systems, or client attendance registers
- Direct observation: programs activities and events (workshops), and or client behaviours
- Google analytics: using the data obtained through google analytics to understand more about engagement with the Open Arms website and social media platforms.

Once established where the data will be gathered from, it needs to be decided who will collect that data and how the data will be gathered. In making these decisions, it's important to consider:

- which method is more likely to provide the information needed?
- is it an appropriate way to collect the information?
- is there any inherent or inbuilt biases?
- by whom and what capabilities the person needs to be able to effectively collect the data?
- If using standardised scales such as the DASS, K10, AUDIT and WSAS, provide evidence as to why that scale was used or how a new measure will be developed?

Table 2. Common methods for data collection

Technique	Description	Advantages	Disadvantages
Survey	Information collection through structured questionnaires. Surveys may be mailed, completed online, by telephone or face-to-face ^{xiii} . Surveys can collect quantitative data and be used to collect qualitative (through text) data.	Can be used to collect information from many participants. Participants can complete it on their own and this may save time.	Surveys must be carefully designed for the target population. Survey fatigue therefore may not get a large response. Doesn't get detailed feedback on the story behind a person's response.
Interviews	Information is collected by talking and listening to people (iv). Interviews may be structured, semi-structured or unstructured. Interviews involve asking questions to participants and recording their responses for analysis ^{xiv} .	Provides insight into a topic. Useful for collecting meaningful quotes and stories ^{xv} .	Interviews can be time consuming as it often involves transcribing and analysing text data. Some participants may find interviews intrusive (v). The interviewer may require training (v).
Focus groups	About six to eight participants are interviewed together by a facilitator using open-ended questions around a specific topic (v).	Useful to gather in-depth views or opinions on a topic from several people at one time (v).	During focus groups, one or a few participants may influence or side-track the answers of others (iv, vi). Data analysis may be time consuming.

Technique	Description	Advantages	Disadvantages
Tests and scales	Tests are measurement instruments that collect information about a person's knowledge, skill or performance (16). A scale is a group of related items that have been developed to measure an abstract concept (e.g. attitude, satisfaction) ^{xvi} .	Useful to measure abstract concepts in a standardised way.	There are many tests and scales, but not all of them have good measurement properties. Some require users to be trained before they can be applied.
Document review	Information is collected by reviewing existing files or documents (e.g. via audits). The documents may be internal to a program or organisation (e.g. training attendance records) or external (e.g. AIHW system). Documents may be electronic or hard copy and may include reports, meeting minutes, newsletters or funding proposals (vi).	Can be an inexpensive way of collecting information. Can give valuable background information of a program.	It may be difficult to find the relevant documents because they may not be saved in a standardised way or in a central repository. Information may be incomplete or inaccurate and analysing the documents may be time consuming (vi).
Case study	Is an in-depth examination of a particular case such as a program, site, group of participants, a location or a person (iv).	Provide an intensive analysis of an issue, drawing information from multiple types of data.	The findings may not be relevant to other situations or people.
Observation	Information is collected by direct observation of events, processes, relationships or behaviour (vi). Frequently via video recording events, which makes analysis more practical.	Useful to understand something in its natural setting. Allows direct observation of what people do rather than relying on what people say they did (vi).	Can be difficult to analyse and interpret. Data analysis can be time consuming and may require training. Observer can influence behaviour. Observer bias can influence interpretation of behaviour.

12. Data Analysis

Data analysis aims to make sense of the information that has been collected.^{xvii} It can consist of numbers, documents, recordings of interviews/videos and responses (all de-identified).

Evaluation data and records must be stored and managed in a way that protects privacy and is commensurate with the sensitivity of the data collected as per the [DVA privacy policy](#).

When disposing of data, it should be done so in a way that is safe and secure as per the [DVA privacy policy](#).

13. Ethical Considerations

All evaluation activities must consider whether people involved will be exposed to any harm and that they are not exploited as a result of the activity.^{xviii} Harms can include but are not limited to loss of privacy, social, physical and mental harm. Staff conducting evaluation activities must consider informed consent, privacy, the relevant legislations, professional, is the evaluation justifiable and national standards and if an ethical review is required. To support with this understanding, the *National Health and Medical Research Council (NHMRC)*, *Australian Evaluation Society (AES)* and the *National Statement on Ethical Conduct in Human Research (2023)*^{xix} outline how evaluations are conducted ethically.

14. Risks

The implementation of the M&E Framework may be influenced by a range of risks. Key risks include the limitation in data quality and consistency, including across sites/programs which may affect accuracy of performance reporting. The risk of under-representation of certain veteran community groups (e.g. females, Aboriginal and Torres Strait Islander and those who live in rural and remote areas) may reduce the validity of findings related to reach and equity. Additionally, there may be a reluctance from the veteran community to provide feedback or engage in outcome monitoring which may constrain the access to meaningful data.

Risks will be feasibly managed aligning with the DVA Risk Management Framework 2024-2027 and through workforce training, clear data governance arrangements, monitoring of data quality and the use of multiple pathways to seek client feedback. Current resources relating to risk through DVA are available [here](#).

15. Writing a Monitoring and Evaluation Plan

An evaluation plan is a written document that describes how to monitor and evaluate the program as well as how the results will be used to inform improvements and decision making^{xx}. It is a living document that provides a 'roadmap' to support the process outlining the justification for doing the work, how and when the evaluation will be carried out, and what one expects to produce because of completing the evaluation. The template is available through DVA's [Program Management and Evaluation Hub](#).

16. Evaluation Reporting and Implementation Plan

To support visibility of outcomes, the results of evaluation activities need to be communicated to the relevant Assistant Secretary or Senior Director. The timing of the evaluation report is dependent upon the program being evaluated however all reports must include:

- Report summary,

- Background information of the evaluation, including an overview of the program (or program components) that were evaluated,
- Methods used to answer the evaluation questions,
- Findings, including positive and negative findings,
- Interpretation of the findings, going beyond the data itself and stating what the results mean in relation to the evaluation questions,
- Concluding section, including recommendations to address specific findings and lessons learned to inform the next stages of the project.

To support evaluation reporting, a template can be found [here](#).

It is important to consider how the results of evaluation will be shared with relevant stakeholders including the veteran community. This could include summary report, impact statements, executive summary, presentations at conferences and events, publications, media release and website or social media content.

17. Further Considerations

Additional information may need to be considered such as the need for a communications plan, risk management approach and how these will be managed/mitigated and do any stakeholders need to be involved in the process.

18. Glossary of terms

Term	Definition
Economic Evaluation	Used to inform decision-makers, stakeholders, and funders if a program is a cost-effective use of resources.
Evaluation	Periodic, in-depth analysis of performance, impact, success, risks, and sustainability of a program against its initial strategic intent.
Formative Evaluation	Assesses the progress or effectiveness of a program while it is still being implemented.
Impact Evaluation	Builds on an outcome evaluation to assess a program's impacts in the longer-term, considering what changes have occurred and to what extent they can be attributed to the program.
Monitoring	A continuous and systematic collection and analysis of available program information to provide management and key stakeholders with an indication of the extent of progress in implementation against stated objectives.
Outcome Evaluation	Assesses a program's effects in the early or medium-term, measuring whether the program is achieving its intended outcomes.
Process Evaluation	Incrementally assesses the design and roll-out of a program, considering implementation, appropriateness, and administrative effectiveness and efficiency.
Qualitative	Pertaining to or concerned with quality or qualities, often used to describe data that is not numerical in nature.
Quality Indicators	Quality indicators are metrics used to assess and improve the quality of products, services, or processes. They are used to measure performance, identify areas for improvement, and ensure established standards have been met

Quantitative	Pertaining to or concerned with quantities, often used to describe data that is numerical in nature.
RE-AIM	A model used for evaluation that stands for Reach, Effectiveness, Adoption, Implementation, and Maintenance.
Summative Evaluation	Assesses the overall effectiveness of a program, typically occurring at the end of the project/program.
Veteran Community	An Australian veteran is any current or former member of the Australian Defence Force (ADF) with at least one day of continuous full-time service (CFTS), including Reservists who have rendered any period of CFTS and national servicemen. The term 'veterans' family' includes any person a veteran considers is a member of his/her family. Together these groups form the Australian veteran community.^{xxi}

APPENDIX A

Outcome measures

Domain	Measure
Anger	Dimensions of Anger Reactions (DAR-5)
Composite Measure	Depression, Anxiety and Stress Scale (DASS-10, DASS-21, DASS-Y)
Depression	Patient Health Questionnaire (PH-9)
Generalised Anxiety	Generalised Anxiety Disorder (GAD-7)
Insomnia	Insomnia Severity Index (ISI)
Generalised Psychological Distress	Kessler-10 (K10)
Military transition	M-CARM
Obsessive Compulsive Disorder	Yale-Brown Obsessive Compulsive Scale (Y-BOCS) and Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)
Quality of Life and Functioning	Recovery of Quality of Life 10 (ReQoL)
Substance use	ASSIST-Lite
Traumatic Stress	PTSD Checklist for DSM-5 (PCL-5)
Wellbeing	Personal Wellbeing Index (PWI-A) and Personal Wellbeing Index Children PWI-C)
Moral Injury	Moral Injury Outcome Scale (MIOS)
Relationships (Inclusive)	Couples Satisfaction Index (CSI)
Cognition	Mini Mental State Examination (MMSE)

Intake	Core (entry and exit)	Tailored
DASS10	DASS 21 (18+) and DASSY (Youth)	DAR-5
	ASSIST Lite	GAD-7
		PHQ-9
		PCL-5
		M-CARM
		ISI
		Y-BOCS & CY-BOCS
		Outcome and Session rating scales (ORS and SRS)
		ReQOL-10
		PWI-A & PWI-C
		MIOS
		K10
		CSI
		MMSE
		M-CARM

APPENDIX B

Quality Indicators/Measures 2025-2026

Quality performance demonstrates how Open Arms achieves overarching outcomes it is funded to deliver.

Quality Indicator #	Performance/ Quality Criteria	Target
Outcome 2 of the DVA Corporate Plan 2025 - 2026		
Maintain and enhance the physical and mental wellbeing and quality of life of eligible persons and their dependants through health and other care services that promote early intervention, prevention and treatment, including advice and information about health service entitlements		
QI-01	2.5 - Timeliness: Percentage of clients allocated to peer worker, group treatment, or an Open Arm's clinician, within two weeks of intake (Open Arms specific)	≥80%
QI-02	All - Client Satisfaction: Client satisfaction with delivery and access to key DVA programs	≥80%
QI-03	All - Wellbeing: DVA's contribution to client's physical and mental wellbeing after provision of services	≥80%
Clinical Governance and Programs		
QI-04	Client satisfaction	≥80%
QI-05	Percentage of clinical incident reviews completed within procedural timelines	≥70%
QI-06	Percentage of National Mental Health Standards that are met or partially met through accreditation	≥80%
QI-07	Percentage of DVA Clinical Governance Framework criteria are met or partially met through internal assessment	≥65%
QI-08	Percentage of responses to legal notices and Freedom of Information requests completed within legislated timeframes	≥90%
QI-09	Percentage of regions provided with resources to implement Lived Experience Workforce strategy	≥80%
QI-10	Quarterly reports of client feedback and actions to SES	100%
QI-11	Percentage of staff who have completed mandatory training	100%
Clinical Operations		
QI-12	Percentage of clients with a discharge letter sent to GP following closed episode of care	≥75%
QI-13	Percentage of client's provided with rights and responsibilities brochure prior to or at first appointment	≥90%
QI-14	Proportion of episodes of care with completed clinical outcome measures at baseline and discharge	≥70%
QI-15	Percentage of clients involved provided with a copy of their care plan	≥95%
QI-16	Proportion of episodes of care where significant improvement, significant deterioration or no significant change was identified between baseline and discharge of completed outcome measures	≥70%

QI-17	Percentage of clients with phone call answered by Client Assist within 180 secs	≥80%
QI-18	Percentage of clients who have first appointment within 14 business days of contact with Client Assist	≥70%
Business Operations		
QI-19	Open Arms Compliance to divisional budget	100%
QI-20	Labour hire work orders and variations entered into DOLARS within 42 days	100%
QI-21	OPC work orders and variations executed and entered into DOLARS within 42 days	100%
QI-22	PGPA and CPR non-compliance is reported quarterly to CFO	≥95%
QI-23	Divisional APS Census index scores on <i>Leadership – SES Manager</i> remain within ±5% of prior years' results	100%
QI-24	Divisional APS Census index scores on <i>Leadership – Immediate Supervisor</i> remain within ±5% of prior years' results	100%

APPENDIX C

Timetable for planned evaluation of programs

The table below summarises a forward schedule of Open Arms program evaluations.

*N/A has 2 yearly cycles for review of all policies and procedures

**N/A has own schedule as listed separately

#	Program	*N/A	FY25/26	FY26/27	FY27/28
P01	Open Arms Model of Care	☐	☐	☒	☐
P02	Agreement for Service Schedules (AfS)	☐	☐	☐	☒
P03	Open Arms Lived Experience Workforce Strategy	☐	☐	☒	☐
P04	Open Arms Learning and Development Strategy	☐	☐	☐	☒
P05	Open Arms Clinical Governance Hub*	☒	☐	☐	☐
P06	Open Arms Group Programs**	☒	☐	☐	☐
P07	Digital Mental Health Strategy	☐	☐	☒	☐
P08	Monitoring & Evaluation Framework	☐	☐	☒	☐
P09	Open Arms Lived Experience Learning and Development Framework	☐	☐	☐	☒
P10	Open Arms Digital Mental Health Strategy	☐	☐	☐	☒

Group Programs

#	Group Program Name	Completed	FY25/26	FY26/27	FY27/28
GP01	Stepping Out	☒	☐	☐	☐
GP02	Managing Anger	☒	☐	☐	☐
GP03	Managing Depression	☐	☐	☒	☐
GP04	Open Arms Learning and Development Strategy	☐	☐	☐	☒
GP05	Building Better Relationships	☐	☒	☐	☐
GP06	Relaxation and Stress Management	☐	☒	☐	☐
GP07	Recovery from Trauma	☐	☒	☐	☐
GP08	Understanding Anxiety	☐	☐	☒	☐
GP09	Managing Pain	☐	☐	☒	☐
GP10	Sleeping Better	☐	☐	☒	☐

Version History

Version	Date	Summary of change / reason	Authors and approvals
1	13/02/2025	Review of early draft –first draft of framework by Advisory Group members	s 47F Projects and Programs Assurance Section (PPA Section)
2	05/03/2025	Review of feedback in Advisory group meeting – to include risks, include infographics and update content to align better with DVA PMF	s 47F PPA Section
3	12/05/2025	Advisory group review of second draft of M&E Framework	s 47F PAWC Section
4	May/June 2025	Consultation with branches re: Quality indicators for inclusion	s 47F PAWC Section
5	30/06/2025	Outcome measures – established working group to determine use of Outcome Measures for inclusion in the M&E Framework	s 47F
6	19/08/2025	Advisory group review of final draft of M&E Framework	s 47F
7	September 2025	Branch Heads review & approval	s 47F
8	24/10/2025	FAS endorsed	Leonie Nowland

ⁱ https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-03/nmh_suicide_prevention_agreement.pdf

ⁱⁱ <https://evaluation.treasury.gov.au/publications/australian-centre-evaluation-strategy>

ⁱⁱⁱ <https://www.aes.asn.au/evaluation-resources/talking-about-evaluation>

^{iv} <https://www.health.gov.au/sites/default/files/2025-02/national-mental-health-and-suicide-prevention-evaluation-framework.pdf>

^v Markiewicz A. and Patrick I. Developing monitoring and evaluation frameworks. Thousand Oaks, CA: SAGE publications. 2016

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- vi PMF DVA
- vii National Health and Medical Research Council. Ethical considerations in quality assurance and evaluation activities. National Health and Medical Research Council; 2014.
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- ix [Commonwealth Evaluation Policy and Toolkit | Department of Finance](#)
- x [RE-AIM – Home – Reach Effectiveness Adoption Implementation Maintenance](#)
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- xix [National Statement on Ethical Conduct in Human Research](#)
- xx Lavinghouze SR, Snyder K. Developing Your Evaluation Plans: A Critical Component of Public Health Program Infrastructure. Am J Health Educ. 2013;44(4):237-243. doi: 10.1080/19325037.2013.798216. Epub 2013 Jun 28. PMID: 26442134; PMCID: PMC4592485.
- xxi [Veterans' Health Week 2024 – Frequently asked questions and glossary | Department of Veterans' Affairs](#)



Community Engagement Strategy for Stakeholders: Brisbane Region

Stakeholder Group: Brisbane Region

Period of Primary Engagement: 22/05/2025 to 30/06/2026

Profile/Demographics of group: This is ongoing maintenance of strong relationships built by local staff in Brisbane and Moreton Bay regional council across the veteran and mainstream areas including of ESO's, Stakeholders, Networks, clinical services and community centres.

Region Priorities: During this period, there is a priority to source referral pathways for staff and OPC's across the region, with a strong focus on level 4 and 5 services that support transition from Open Arms services that better align with clients' needs that are beyond Open Arms services. Services of interest include housing vulnerability and homelessness, moral injury, trauma and childhood trauma and NDIS. Specific attention is to be place on family and services for children in these areas.

Key Stakeholders Identified:

S 47F

Structure to engage: Peers and Regional Community Engagement Coordinator (RCEC) to lead veteran focused engagement and local community social supports. Clinicians and Peers with support of RCEC will lead clinical services engagement.

Connection points via:

- **ESO's:** Staff liaison, managers, local events, stakeholder networking.
- **ADF:** Unit Welfare officers
- **Hospitals: Primary:** Social work departments, mental health peer consumers. **Secondary:** Group program coordinators, admission officers, discharge officers.
- **Networks:** Through registered networks on the mental health professional networks, Stakeholder forum invitations – Both community and veteran focused.

Community Engagement Outcomes

1. Promote and raise awareness of Open Arms to enable greater engagement in providing high quality mental health services for Australian veterans and their families.
2. To enhance the Recovery oriented outcomes for complex clients accessing Open Arms services.
3. Empower individuals to be active members of their communities and redefine their identity and contribution in their life.
4. Develop communities understanding of being inclusive of ADF personnel including post service employment, socialisation and contribution to the community.





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Strategy/ Activity to engage	Detail	Benefits
Mapping- All stakeholders	Map out stakeholders, ESOs and networks.	Number of Regular information sessions at hospital, increased referrals to Open Arms
Meet and Greet - All stakeholders	Engage stakeholders within a reasonable drive to connect with stakeholders to provide information about Open Arms services. Build working relationship for ongoing work.	Number of Regular information sessions at hospital, increased referrals to Open Arms Number of Increased referrals to Open arms
Establish discharge referral processes for open arms- All stakeholders	Ongoing referrals with more targeted needs as the process becomes more refined	Number of Increased open communication between stakeholders and open arms
Proactive connection- ESO's and health services	Engage with identified key stakeholders to solidify working relationships and establish referral pathways. Offer training to staff to upskill about supports for veterans and their families	Number of stakeholders where referral pathways have been established to broaden net of people helping veterans
Reactive requests- all stakeholders	Respond to requests to engage from stakeholders to share two way information about services offered.	Maintain good relationships with stakeholders and increase level of knowledge about open arms in the community.

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OPEN ARMS

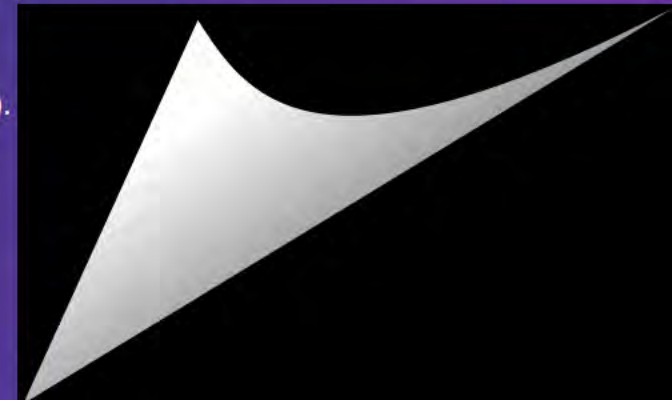
Veterans & Families Counselling

Community and Peer Program Client Satisfaction Survey

12-Month Outcome Evaluation Report (Survey Only)

FOR INTERNAL PURPOSES ONLY

Developed in line with the Open Arms Monitoring and Evaluation Framework (September 2025).



Introduction

Open Arms, in collaboration with the DVA Surveys Team, developed the Community and Peer Program Client Satisfaction Survey. The survey was developed in line with the Open Arms Monitoring and Evaluation Framework (September 2025). Response collection occurs through the Qualtrics survey platform and is ongoing.

This voluntary survey is distributed to Open Arms Community and Peer Program clients by the Lived Experience Professionals (LEPs) at the end of their engagement in Peer Support. [s 47E](#)

[s 47E](#)

The purpose of this 12-month outcome evaluation is to provide a high-level overview of client satisfaction with the Community and Peer Program based on the responses received so far. It provides the following:

- Demographic Data
- Satisfaction Measures
- Client Testimonials
- 12-Month Outcome Evaluation – Key Themes
- Closing Summary

A copy of the survey can be found [here](#).

Data collection through this Survey is collected and stored in accordance with the Australian Privacy Principles. De-identification is undertaken in line with guidance provided by the Office of the Australian Information Commissioner. All personal information is managed carefully in accordance with the DVA Privacy Policy.



12-Month Outcome Evaluation – Client Testimonial Themes

Successes

Themes from Client Responses

- **Trusted and Person-centred Support**
 - Interpersonal connection through understanding and relatability
 - Knowledgeable guidance and advice to ensure continued support after engagement in the program
- **Safe Connection and Belonging**
 - Professionalism, compassion and genuine care
 - Enabled open and honest discussion without judgement
- **Growth and Recovery Outcomes**
 - Improved wellbeing and personal recovery outcomes
 - Influenced connection, social engagement, validation, self-awareness and reflection

Survey Implementation Successes

- **Monitoring and Evaluation of the Community and Peer Program**
 - Implementation of the first nationally consistent Community and Peer Program Client Satisfaction Survey since the program started in 2019.
 - Establishment of Quarterly reports provided to leadership to remain informed on client feedback from the program and to inform future service improvement.
- **Program Knowledge and Awareness**
 - Client testimonials consented for marketing and promotional purposes are provided to Strategic Communications to develop promotional material.
- **Staff Culture**
 - Client testimonials are provided to Regional Leadership for staff recognition to improve workplace culture.

S 47 E

*Note: key themes were extracted from responses to Question 16 and Question 19 in the Client Satisfaction Survey, which permitted respondents to provide qualitative feedback.

Satisfaction Measures



Program Satisfaction continues to remain High

Overall satisfaction with the Community and Peer Program remains high, with a total of **(96%)** of respondents indicating agreement that they were satisfied with the program.

Clients are feeling more Empowered and Hopeful

Most respondents agreed they felt more empowered to manage their future **(89%)** and more hopeful to manage their future **(90%)** because of support provided by their Lived Experience Professional.

Highly Competent Lived Experience Professionals

Most respondents agreed that their Lived Experience Professional was knowledgeable in their role **(97%)**. Most respondents **(96%)** agreed that they were able to work collaboratively with their Lived Experience Professional to identify goals for their personal recovery.

Providing Personalised and Relevant Support

Most respondents agreed that their Lived Experience Professional provided personalised support that suited their needs **(97%)** and helped them to connect with communities and services related to their goals **(95%)**.

A Positive Reputation in the Community

Majority of respondents who completed the survey **(96%)** agreed that they would recommend the Community and Peer Program to others.

S 47F

*Note not all client testimonials in this report have consented for external exposure. This report is for internal use only, it is critical that it is not shared or provided externally to Department of Veterans' Affairs (DVA). For client testimonials have been consented to DVA marketing and promotional purposes, please email: [s 47E](mailto:s47E@dva.gov.au) [@dva.gov.au](mailto:s47E@dva.gov.au)

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Closing Summary

Over the past year, clients have consistently described a positive experience and strong participation, with outcomes reflecting greater confidence, hope, and meaningful progress within the Community and Peer Program.



Clients most value support grounded in relatable lived experience, delivered with non-judgmental understanding and genuine care. Feeling connected and validated has helped clients feel understood and supported in their recovery.



Obtaining the data from veterans and families of veterans through this survey has and will continue to identify areas of success and improvement that will inform processes. Responses are voluntary, de-identified, and for internal use only.



Australian Government
Department of Veterans' Affairs

Corporate Plan **2025–26**



Acknowledgement of Country

The Department of Veterans' Affairs 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.

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Acknowledgement of Service

We respect and give thanks to all who have served in the Australian Defence Force and their families.

We acknowledge the unique nature of military service and the sacrifice demanded of all who commit to defend our nation.

We undertake to preserve the memory and deeds of all who have served and promise to welcome, embrace and support all military veterans as respected and valued members of our community.

For what they have done, this we will do.

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Contents

Secretary's Introduction	2
Purpose	4
Outcomes and key activities	4
Operating context	8
Environment	8
Partnerships and cooperation	10
Capability	15
Risk	20
Performance	24
Performance Reporting Framework	24
Review of the Performance Reporting Framework	24
Measuring performance	27
Our new performance measures	28
Appendices	39
Appendix A: Summary of changes to DVA's Key Activities	39
Appendix B: Summary of changes to DVA's Performance Measures	42
Appendix C: PGPA Act Requirements	47
Endnotes	48

Secretary's Introduction

I am pleased to present the Department of Veterans' Affairs Corporate Plan 2025–26. This plan has been prepared in accordance with section 35(1)(b) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) and sets out the department's objectives for the next 4 years. It is a roadmap for improving the services and support that we provide to veterans and their families and sets performance measures upon which we can benchmark our success.

On 9 September 2024, the Royal Commission into Defence and Veteran Suicide (Royal Commission) handed down its Final Report, marking the culmination of the most significant and comprehensive inquiry ever conducted into suicide and suicidality in Australia's Defence and veteran communities.



The Final Report made 122 recommendations and called for fundamental reform across the Defence and Veterans' Affairs ecosystem focusing on culture and leadership, sexual violence and misconduct, health care, transition supports, data and research.

On 2 December 2024, the Australian Government tabled its response to the recommendations, agreeing or agreeing in-principle to 104 recommendations, noting 17 recommendations and not supporting one recommendation in part.

The Government's response has provided us with clear direction on the priority work for the years ahead and marks the start of a new chapter in how the department supports the veteran community.

Our key priority now, and over the 4 years of this Corporate Plan, is implementing the Government's response and fulfilling the intent of the Royal Commission's recommendations. This will involve comprehensive improvements of the culture, systems and processes supporting Defence personnel, veterans and their families. It is only through undertaking a substantial program of change and listening to the veteran community that we will be able to improve our services to address Defence and veteran suicide and related issues as highlighted by the Royal Commission.

The department is the lead or joint lead for 41 of the recommendations made in the Final Report. We are working towards the establishment of a new agency focused on veteran wellbeing and a national peak body for ex-service organisations. To inform this work, extensive consultation and co-design activities have been undertaken with the veteran community in recent months.

We will continue to work with Defence, the Department of the Prime Minister and Cabinet and other Commonwealth stakeholders, states and territories, ex-service organisations and the veteran community to progress and enact the Government's response.

Our future work will also see the department embed the new streamlined veterans' compensation and rehabilitation legislation — the *Veterans' Entitlements, Treatment and Support (Simplification and Harmonisation) Act 2025* (VETS Act) — which was passed by the Australian Parliament in February 2025.

The main elements of the Act come into effect on 1 July 2026 and mean that from that date, the *Veterans' Entitlements Act 1986* (VEA) and the *Safety, Rehabilitation and Compensation (Defence-related claims) Act 1988* (DRCA) will close to new compensation claims. All claims received from 1 July 2026 will be determined under the enhanced *Military Rehabilitation and Compensation Act 2004* (MRCA).

Consolidating the legislation into one Act will result in a system where it is easier for veterans and families to understand their entitlements. A single Act will also be simpler to administer, benefiting veterans and families over time through claims being processed in a more consistent and timely way.

Implementation of the amendments contained in the VETS Act and the ongoing operation of MRCA will be a priority for the department over the course of this Corporate Plan. We continue to undertake significant work in the lead-up to 1 July 2026 including informing and educating the veteran community, including veterans' advocates, about what the changes will mean for them.

The VETS Act delivers on Recommendation 1 of the Royal Commission's 2022 Interim Report, which called for the simplifying and harmonising of veteran compensation and rehabilitation legislation. In recent times, the department has made significant progress towards implementing other recommendations in the Interim Report, including addressing the backlog of unallocated claims, which was cleared ahead of schedule (Recommendation 2).

During the next 4 years, we will also continue to simplify the department's processes and improve our enabling services so we can better serve veterans and families. The department's efforts to streamline its processes and improve efficiency are particularly important in light of the continuing growth in claims being lodged, and the subsequent impact this is having on downstream services.

As we look to the future, further simplifying our business processes and modernising our technology and data systems will be critical to enhancing the veteran client experience and reducing claim processing times.

Improving technology to provide a more modern digital experience for veterans, including opportunities to automate basic functions and take advantage of Artificial Intelligence (AI) in a considered, safe and responsible way, in consultation with the veteran community. This will support service delivery and pay dividends for both our clients and the department's dedicated staff.

This year, the department has redesigned its performance framework so that it closely reflects its core functions in delivering effective support and services for veterans and their families. The redesign integrates insights from the Royal Commission, aligns departmental priorities, addresses findings from the Australian National Audit Office (ANAO) and is grounded on robust evidence and data. By adopting a more focused and simplified framework, the Department is well-positioned to build its capabilities and better serve the evolving needs of veterans and families.

There is no doubt the department has delivered substantial improvements over the last few years, and this will continue as we implement the significant and long-term reforms called for by the Royal Commission.

It is work I know the entire department is committed to and which will see it better fulfil its purpose and improve outcomes for veterans and their families now and into the future.



Alison Frame

Secretary, Department of Veterans' Affairs

Purpose

For more than 100 years, the Australian Government has committed to repatriate, support, and commemorate the service of veterans to our nation. How we have delivered on this has changed over time, but the purpose of the department is to support the wellbeing of those who serve or have served in the defence of our nation, and their families, by:

- partnering with organisations and individuals to help design, implement and deliver effective policies, programs and benefits, which enhance the wellbeing of veterans and veteran families
- providing and maintaining war graves and delivering meaningful commemorative activities to promote community recognition and understanding of the service and sacrifice of veterans.

Outcomes and key activities

The department will achieve our purpose through 3 outcomes, 4 key activities and 14 programs.

ENHANCE WELLBEING		RECOGNITION AND RESPECT
Outcome 1: Maintain and enhance the financial wellbeing and self-sufficiency of eligible persons and their dependants through access to income support, compensation and other support services, including advice and information about entitlements.	Outcome 2: Maintain and enhance the physical wellbeing and quality of life of eligible persons and their dependants through health and other care services that promote early intervention, prevention and treatment, including advice and information about health service entitlements.	Outcome 3: Acknowledgement and commemoration of those who served Australia and its allies in wars, conflicts and peace operations through promoting recognition of service and sacrifice, preservation of Australia's wartime heritage, and official commemorations.
Key Activity 1. Providing financial support and compensation services for eligible veterans and families.	Key Activities 2. Providing access to health, rehabilitation, physical and mental wellbeing and care services for veterans and families. 3. Supporting transition and employment for veterans and families.	Key Activity 4. Recognise the service of veterans who served in wars, conflicts and peace operations and their families

ENHANCE WELLBEING		RECOGNITION AND RESPECT
Programs	Programs	Programs
1.1 Veterans' Income Support and Allowances	2.1 General Medical Consultations and Services	3.1 War Graves
1.2 Veterans' Disability Support	2.2 Veterans' Hospital Services	3.2 Commemorative Activities
1.3 Assistance to Defence widow/ers and Dependants	2.3 Veterans' Pharmaceutical Benefits	
1.4 Assistance and Other Compensation for Veterans and Dependants	2.4 Veterans' Community Care and Support	
1.5 Veterans' Children Education Scheme	2.5 Veterans' Counselling and Other Health Services	
1.6 Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation	2.6 Military Rehabilitation and Compensation Acts – Health and Other Care Services	

Outcome 1:

Maintain and enhance the financial wellbeing and self-sufficiency of eligible persons and their dependants through access to income support, compensation and other support services, including advice and information about entitlements.

Key activity

1. Providing financial support and compensation services for eligible veterans and families¹.

Programs

Program 1.1 – Veterans' Income Support and Allowance

- » delivers means-tested income support pensions and other allowances to eligible veterans and dependants under the *Veterans' Entitlements Act 1986* (VEA). Income support provides a regular means-tested payment for eligible veterans and their dependants with limited means.

Program 1.2 – Veterans' Disability Support

- » provides compensation in the form of disability compensation payments and ancillary benefits to eligible veterans for the tangible effects of war or defence service.

Program 1.3 – Assistance to Defence Widow/ers and their Dependants

- » provides pensions as part of a compensation package to compensate a widowed partner of a veteran, where there was a connection between the veteran's death and service. Eligible children are also provided with financial support.

Program 1.4 – Assistance and other Compensation for Veterans and Dependants

- » delivers other allowances and assistance to eligible veterans and dependants under the VEA and related legislation, including home insurance, funeral benefits, prisoner of war ex gratia payments, and payments on behalf of Commonwealth and allied countries. Assistance is provided to the ex-service community via Building Excellence in Support and Training grants and the Advocacy Training and Development Program.

Program 1.5 – Veterans' Education Schemes

- » provides education allowances to eligible children of Australian Defence Force (ADF) members who have died or been severely injured as a result of service. The schemes provide financial assistance, student support services, guidance and counselling for eligible students undertaking primary, secondary and tertiary full-time study within Australia.

Program 1.6 – Military Rehabilitation and Compensation Act (MRCA) Payments – Income Support and Compensation

- » provides compensation to eligible veterans and dependants under the *Safety, Rehabilitation and Compensation (Defence-related claims) Act 1988* (DRCA), the MRCA and related legislation. The DRCA (and MRCA for injuries since 1 July 2004) provides coverage for injured ADF members to support their return to health, work and independence. There is also compensation for eligible dependants, and MRCA health care and other ancillary benefits.

Outcome 2:

Maintain and enhance the physical and mental wellbeing and quality of life of eligible persons and their dependants through health and other care services that promote early intervention, prevention and treatment, including advice and information about health service entitlements.

Key Activities

2. Providing access to health, rehabilitation, physical and mental wellbeing and care services for veterans and families.
3. Supporting transition and employment for veterans and families.

Programs

Program 2.1– General Medical Consultations and Services

- » provides, through arrangements with medical and allied health practitioners in both the public and private sectors to deliver a comprehensive range of services throughout Australia, provided in hospitals, in providers' rooms and in the homes of veterans and families.
- » ensures that eligible veterans and dependants are able to access necessary services, by either paying for travel to the nearest service provider or paying a provider to travel to other locations to provide services to eligible veterans and dependants.

Program 2.2 – Veterans' Hospital Services

- » provides access to inpatient and outpatient hospital services for eligible veterans through arrangements with private hospitals, day procedure centres and mental health hospitals, as well as all public hospitals operated by the state and territory governments.

Program 2.3 – Veterans' Pharmaceutical Benefits

- » provides access to a comprehensive range of pharmaceuticals and wound dressings for the treatment of their health care needs, including items available to the broader Australian community under the Repatriation Pharmaceutical Benefits Scheme.

Program 2.4 – Veterans' Community Care and Support

- » manages community support and residential aged care programs for clients, including the Veterans' Home Care program and the Community Nursing program, which aim to support people to remain independent in their own homes and improve their quality of life and health. This program also provides subsidies and supplements for clients living in residential care facilities.

Program 2.5 – Veterans' Counselling and Other Health Services

- » provides access to a wide range of mental and allied health care services, including counselling and referral services for veterans and families.
- » supports eligible veterans and families with funding for aids and appliances, and travel for treatment.

Program 2.6 – Military Rehabilitation and Compensation Acts – Health and Other Care Services

- » provides access to rehabilitation, medical and other related services under the DRCA, the MRCA and related legislation. The services include payment for medical treatment, rehabilitation services, attendant care and household services.

Outcome 3:

Acknowledgement and commemoration of those who served Australia and its allies in wars, conflicts and peace operations through promoting recognition of service and sacrifice, preservation of Australia's wartime heritage, and official commemorations.

Key activity

4. Recognise the service of veterans who served in wars, conflicts and peace operations and their families.

Programs

Program 3.1 – War Graves

- » acknowledges and commemorates veterans' service and sacrifice and promotes an increased understanding of Australia's wartime history. To meet the Australian Government's commitment, the Office of Australian War Graves cares for and maintains official commemorations and sites of collective official commemoration to the standards set by the Commonwealth War Graves Commission.

Program 3.2 – Commemorative Activity

- » delivers activities to enable the community to better understand, acknowledge and commemorate the service and sacrifice of the men and women who have served Australia in wars, conflicts and peace operations.

Operating context

Environment

Royal Commission into Defence and Veteran Suicide Implementation

The Final Report of the Royal Commission into Defence and Veteran Suicide and the lived experience and expertise of Defence members, veterans and their families, that was canvassed over the Royal Commission, underlined the need for the department to significantly reform its systems and processes and the way in which it engages with and supports Defence personnel, veterans and families. In its response of 2 December 2024, the Australian Government accepted the majority of the Final Report's 122 recommendations. The Government agreed or agreed in principle to 104 recommendations, noted 17 recommendations, and did not support one recommendation in part.

Implementing the Government's response is a core strategic priority for the department and involves comprehensive reform of the culture, systems and processes supporting Defence personnel, veterans and families. The recommendations relating to the department are wide-ranging across data and research, healthcare and wellbeing supports, claims processing, transition, the veteran support ecosystem, workforce, culture and service delivery.

Implementing the recommendations of the Final Report will take time. Many of the recommendations intersect with one another and involve complex and long-term reform, for example the multi-year work involved in establishing the National Veterans' Data Asset (Recommendation 107) and the interdependencies between the establishment of a new agency focussed on veteran wellbeing (Recommendation 87) and recommendations related to improving veteran wellbeing and transition supports (e.g. Recommendations 79, 80, 81 and 86). The Royal Commission Implementation Committee (RCIC) within the department is overseeing the overall delivery of DVA's response to the Royal Commission and providing assurance to the Secretary, the Australian Government and relevant external oversight bodies in relation to the implementation of department-related recommendations.

Successful implementation requires consultation and collaboration across the Government, in particular with Defence and the Department of the Prime Minister and Cabinet Royal Commission Implementation Taskforce. It also requires working with state and territory governments through the Commonwealth, State and Territory Committee, and the Defence and veteran community. Engagement with the Defence and Veterans' Services Commission (DVSC) in its capacity as an independent oversight body, will also be critical, with the DVSC's legislation commencing from 29 September 2025.

Key foundational elements outlined below will underpin the department's implementation of the Government's Response and have a central influence on its operating context.

- Subject to the Government's consideration of options arising from the department's consultation and co-design, key initiatives will be the establishment of an agency focused on veteran wellbeing (Recommendation 87) and a national peak body for ex-service organisations (Recommendation 89). Each of these bodies will drive a fundamental shift in how the department interacts with, supports and empowers veterans, families and ex-service organisations. An agency focused on veteran wellbeing would connect veterans and families to appropriate supports and help them navigate both the department's system and the broader veteran services and support system. A peak body would provide a strong, representative voice to Government for large and small ex-service organisations.
- Multiple recommendations seek to improve the collection, sharing and use of data, culminating in the establishment of the National Veterans' Data Asset (Recommendation 107). A more modern data analytics environment will enable the department to improve its analytics, reporting, data science and evidence-based decision-making, and will support implementation of recommendations related to research and data.
- Significant ICT and systems reform is required to implement the new agency, data, structural and service delivery improvements recommended by the Royal Commission, and to fully realise their potential benefits.

Veterans' Entitlements, Treatment and Support (VETS) (Simplification and Harmonisation) Act 2025

Recommendation 1 of the Interim Report of the Royal Commission into Defence and Veteran Suicide was to simplify and harmonise veterans' rehabilitation and compensation legislation.

The passage of the *Veterans' Entitlements, Treatment and Support (Simplification and Harmonisation) 2025* (VETS Act) in February 2025 delivers on this recommendation.

From 1 July 2026, the *Veterans' Entitlements Act 1986* (VEA), and the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) will be closed to new compensation claims and all compensation claims will be determined under a single ongoing Act, an improved *Military Rehabilitation and Compensation Act 2004* (MRCA).

The legislative amendments will:

- Make it easier for veterans and families to understand their entitlements and receive the support they need, when they need it
- Simplify the process for veteran advocates to support veterans making DVA claims
- Streamline claims processing
- Further recognise the enormous sacrifices and contribution made by the families of veterans by increasing access to services such as education schemes, healthcare cards and other financial benefits for the families of veterans who have suffered severe impairment as a result of their service-related injuries and conditions.

Grandparenting arrangements will ensure that current payments received by veterans and families under the VEA and DRCA will continue and be indexed as normal.

During 2025–26, the department will continue to design and implement these changes, working with Defence and veteran communities to transition to the new system. This will include continued communication and, training for advocates and employees, as well as the required changes to ICT systems.

While the main elements of the VETS Act do not come into effect until 1 July 2026, there are 2 provisions that come into effect earlier.

- The harmonisation of external merits reviews for compensation claims, the single review pathway, commenced on 21 April 2025. Veterans appealing determinations made under the DRCA from 21 April 2025 are now able to lodge requests for review directly with the more veteran friendly Veterans Review Board instead of the Administrative Review Tribunal as the first order of external merits review.
- The Defence and Veterans' Services Commission (DVSC), will commence on 29 September 2025. The DVSC will provide independent oversight and evidence-based advice to drive system reform in improving suicide prevention and wellbeing outcomes for serving and ex-serving ADF members (Recommendation 122).

Claims and client expectations

DVA remains focused on actioning the recommendations of the Royal Commission's Final Report and processing outstanding claims.

Of the 41,799 claims originally identified as unallocated in the Royal Commission's interim report, as at 30 June 2025, 99.9 per cent of the claims had been determined.

The department is committed to finalising claims for those veterans that have been waiting the longest and aims to further improve claims processing timeframes with initiatives around online lodgement and more streamlined handling of complex claims.

Partnerships and cooperation



Defence

Leaving the military and transitioning to civilian life can be a challenging time for some ADF members and families. Supporting positive transition outcomes is a shared responsibility between individuals, community, providers and government. The department works with Defence focusing on rehabilitation, income support, employment, physical health and mental wellbeing to support a positive transition. In partnership with the Defence Joint Transition Authority and the Commonwealth Superannuation Corporation, the department works to ensure veterans and families are better prepared and supported through their separation from the ADF and transition to civilian life.

The department has introduced several initiatives to improve and better support the transition journey an individual or family may take. For example, Senior Veteran Support Officers assist veterans who have complex claims with additional assistance in navigating its processes. The Transition Branch coordinates efforts both within the department and across agencies, with a mix of service, policy and program areas. The branch is responsible for the implementation of the Veteran Transition Strategy and Action Plan with Defence and other agencies.

Key research and evaluation partners

The department has a long-term commitment to research that delivers ongoing benefits to the health and wellbeing of veterans and families. To strengthen this commitment, the department has implemented a new research and evaluation model called the Veteran and Families Learning and Innovation Network of Knowledge (VF-LINK). The objectives of the model are to increase the production, use and sharing of evidence to support decision-making and policy, program and service design. The new partners were onboarded in July 2025 following an approach to market in 2024. This initiative builds on, and complements, existing relationships with key research partners, such as the Australian Institute of Health and Welfare, the Australian Institute of Family Studies, Defence, the international Five Eyes Veteran Research Committee, and existing funded partnerships with research institutions. This is an exciting opportunity to ensure evidence informs policy development, decision-making, drives program development, promotes a data-driven culture, facilitates knowledge sharing across the department, fosters collaboration, and translates research and evaluation findings into action.

Partnerships through Grants Programs, including Veterans' and Families' Hubs and Veterans' Acute Housing Program

The department delivers a suite of grant programs designed to support a broad range of veteran and community needs. The grant programs have various purposes including to assist health and wellbeing, the provision of advocacy services, veteran education and employment, and support commemorations.

The department's grant programs, and the partnerships they build, enable organisations to better support the veteran community. For example, the Veterans' and Families' Hubs program provides grants to establish centres which enable the delivery of coordinated support for veterans and families. Each Hub brings together a unique service offering determined by the local veteran community, which is managed and operated by a lead organisation, usually an ex-service organisation. Hub services can include mental and physical health services, wellbeing support, advocacy, employment and housing advice, and social connection. Hubs provide important services and community connection for veterans and families both locally and in the surrounding regions.

As of May 2025, there were 9 established Hubs delivering support to veterans and families in Perth, Townsville, Adelaide, Darwin, Wodonga, Nowra, Caboolture, Burnie and Queanbeyan. Eight new Hubs are being established in areas with significant veteran populations. These are expected to open by mid-2026. Additionally, in 2025–26, the department will work with the Government on its election commitment to establish a Hub in Bendigo, Victoria.

The Veterans' Acute Housing Program is another grant program which is establishing partnerships with organisations to deliver housing and homelessness support to the veteran community. Under this program, \$24 million in capital works grants has been awarded to 8 organisations to increase the supply and ongoing availability of crisis and transitional housing for veterans and families. An additional \$6 million in grants has been awarded to 5 organisations for the delivery of specialist wrap around support services to veterans and families to address the risk of homelessness. In 2025–26, the department will continue working with grant recipients under this program to assist the veteran community.

Royal Australian and New Zealand College of Psychiatrists

The Military and Veterans' Psychiatry Training Program increases veteran access to psychiatrists with specialist training in veteran and military mental health and trauma-focused care by delivering up to 10 psychiatry registrar training places each year. By increasing the number of psychiatrists with training in military and veteran mental health, the psychiatry workforce will be better equipped to address the unique needs of military personnel and veterans. It also recognises the importance of a mental health workforce that has specialist skills and knowledge relating to military service and its impact on veterans. Training placements formally began in February 2022, and the program will run until 30 June 2026.

Defence and Veteran Family Wellbeing Strategy 2025–2030

The joint Defence and Veteran Family Wellbeing Strategy 2025–2030 (the Family Strategy) was released on 20 December 2024 and recognises the pivotal role families play in supporting current and former serving ADF members. The Family Strategy and First Action Plan provides the guiding principles for how support will be delivered to families over the next 5 years and assists in responding to recommendations of the Royal Commission. There are 3 strategic priorities and an action plan which will drive progress.

- Informed and Engaged – Families can find the information they need when they need it, so they can access available supports and make informed decisions. Defence and the department actively engage with families to ensure their perspectives are considered.
- Supported and Secure – Any impacts of service and related life events are managed through appropriate and flexible, fit-for-purpose policies, support, and communication.
- Recognised and Understood – The impacts of military life on Defence and veteran families are recognised with a continued commitment to understand their needs and improve policies through engagement, research and evaluation.

The department will continue to work with Defence and is now focused on implementing the Family Strategy and First Action Plan.

Defence and Veteran Mental Health and Wellbeing Strategy 2025–2030

In 2025–26, the department is prioritising the delivery of the joint Defence and Veteran Mental Health and Wellbeing Strategy 2025–2030 (Mental Health Strategy) and supporting interdepartmental Action Plans.

The Mental Health Strategy outlines how DVA and Defence will work together to promote and support wellbeing through early intervention and prevention, timely access to care and support, and a positive and connected community, while focusing on suicide prevention and using data to drive positive outcomes.

The Mental Health Strategy complements the activities in the Australian Government response to the Royal Commission Final Report including the commitment to transition and wellbeing supports, and the co-design of a new agency focused on wellbeing.

The Mental Health Strategy alongside the Family Strategy and the Veteran Transition Strategy have a shared goal of improving mental health and wellbeing outcomes across the Defence and veteran community.

Advocacy

The department has been collaborating with ex-service organisations to enhance veterans' advocacy through the establishment of the independent Institute of Veterans' Advocacy (the Institute).

The Institute is the national professional association for veterans' advocates, setting and administering professional standards, and providing leadership and support to nationally accredited advocates.

Functions of the Institute include:

- establishing competency standards, a code of ethics and minimum training requirements for veteran advocates
- accrediting veteran advocacy service providers, and monitoring compliance with continuing professional development
- providing members with access to a range of benefits and tools, including improved and nationally consistent training and professional development
- establishing and administering a nationally consistent complaints handling process.

Through these activities the Institute will:

- lift the overall standard of advocacy services nationally
- improve confidence in the veteran community and provide assurance to veterans and their families that services provided from an accredited veterans' advocate are professional, high quality and are provisioned with a contemporary understanding of veteran entitlements
- professionalise veteran advocacy services and enhance the standing and recognition of veteran advocates and advocacy services in the community.

International partnerships

International engagement is focused on bilateral and multilateral engagement, to discuss and progress areas of common interest and opportunities for greater collaboration. The department's approach is based on the mutual exchange of information and learning from one another to improve support and services to veterans and families.

The International Ministerial (Five Eyes) Conference on Veterans' Issues is an important international forum that allows the Minister for Veterans' Affairs to directly engage with his ministerial counterparts from Canada, New Zealand, the United Kingdom and the United States of America. This engagement is supported at agency-head level through the Five Eyes Official Meetings, and at officer level through a range of working groups under the Five Eyes Veteran Research Committee. These forums aim to provide better outcomes for veterans and families through dialogue, research and data sharing. While the committee does not conduct or commission research itself, the department's continued engagement as a member helps to inform domestic policy by facilitating comparison and collaboration with Five Eyes countries in areas of mutual interest.

The department also engages bilaterally with overseas agencies, organisations and individuals through meetings, conferences and hosting international visitors. These engagements all seek to improve the lives of veterans and families through sharing knowledge and experience on policies, programs and initiatives.

The department, through the Office of Australian War Graves (OAWG), represents the Commonwealth War Graves Commission (CWGC) in Australia, Papua New Guinea and the Solomon Islands. The OAWG cares for war cemeteries and war graves, and builds and maintains official Australian memorials overseas, to ensure the service and sacrifice of Commonwealth servicemen and women is never forgotten.

The department manages significant international commemorations annually in Türkiye and France, and supports other local commemorations in Papua New Guinea, Malaysia and Thailand. The department is also responsible for the management and operations of 3 interpretative centres located in France, Thailand and Malaysia, and the care and maintenance of official Australian overseas memorials. This work requires close engagement with the host nations.

There is an ongoing challenge for the department to consider the risks of doing business in each country and ensure appropriate mitigation strategies are in place to maintain operations that reflect Government standards and expectations. The department's close working relationship across the whole-of-government and with the Department of Foreign Affairs and Trade and Defence underpins this work.

Veterans Chaplaincy Program

The Veterans' Chaplaincy Pilot Program is being undertaken in recognition of the vital role ADF chaplains can play in supporting spiritual wellbeing during service and helping address the lack of equivalent services available when transitioning to civilian life.

The pilot program provides counselling and support in a non-clinical setting and pathways for veterans (including those transitioning) and families to access mental health and wellbeing support, as well as foster community connections. The program provides continuity of pastoral care to veterans and families through and after their transition from the ADF.

The 2025–26 Budget extended the pilot program for a further year to enable consideration of the program's future suitability and benefit.

Capability

Our people / capability review

As the department provides support to more veterans and families, the demand for its services has increased and the Government has acknowledged this with an additional \$47.6 million in 2025-26 to maintain resourcing in key service delivery areas. This includes funding to continue supporting service delivery employees in the following areas.

- Claims decision making and health and other service provision
- Veteran Access Network
- Veteran Support Officers
- Complex Case Management teams
- Information Access teams
- Mental health support teams

The department has established enterprise-level workforce planning to position the workforce to deliver its strategic priorities over the next 12 months, with group-level workforce plans supporting capability uplift. The department recognises its middle managers have the greatest impact to change behaviour and lead by example to set the tone for their teams and will invest in its middle manager cohort and build on their capability to create a skilled and confident workforce. Embedding a positive workplace culture while ensuring operational requirements are met, will be a key focus. The Manager Development Program will provide new and existing managers with real-world skills to lead with confidence. New Manager Information Sessions will also provide managers with the opportunity to learn best practice and share information and experiences with a focus on people management.

The department will continue promoting cultural capability and diversity and improving recruitment and mobility. It will focus on bringing core work in-house in line with the APS Strategic Commissioning Framework, and to achieve sustainable outcomes, will strengthen APS workforce capability, reallocating existing APS workforce to deliver core work, and build knowledge transfer requirements into new contracts.

The department will continue to build an inclusive workplace that improves the experience of employees and enhances interactions with clients. Through further enhancements to diversity committee operations, the department aims to better empower its people to share their lived experiences and influence initiatives to support an inclusive workplace culture. The department will continuously strive to achieve higher representation across diversity groups to ensure the workforce reflects the community it serves. It will continue to draw on the capability and ideas of its employees as part of an innovation culture, including through the DVA Innovation Challenge and uptake of employee-proposed initiatives to streamline processes and improve the client experience.

The department provides a range of wellbeing supports for employees, so they are better positioned to support veterans and families. It will continue to implement wellbeing tools and resources to support the maintenance and management of psychosocial safety in the workplace, including the Psychosocial Risks and Hazards Framework. New wellbeing resources that support employee mental, physical and financial wellbeing will continue to be promoted, including the new DVA Connection Sessions that monitor and support wellbeing, and foster connection among front-line employees.

In accordance with the Government's plan for APS Reform, the department will finalise the implementation of the APSC Senior Executive Service (SES) Performance and Leadership Framework to ensure a holistic approach to SES performance and leadership, and to build a culture of transparency and accountability. The Senior Executive will continue to work together to build a consolidated leadership team. Through cross collaboration activities and living the APS Values, senior leaders will actively engage and collaborate with employees, as an opportunity to receive feedback and share ideas and perspectives.

The department is committed to working together to ensure every interaction with the community and each other is conducted with professionalism, kindness, and compassion. It will continue to prioritise workplace culture by aligning its cultural vision with APS frameworks, such as the APS Values and Secretaries Charter of Leadership Behaviours (DRIVE). The department will focus on delivering cultural initiatives such as the Building High Performance Workshop which examines behaviours that enhance team performance, shape culture and boost wellbeing, and the new Respect@Work sessions which define expectations for managers and employees regarding harassment, bullying, and discrimination.

The department will implement the Integrity Action Plan, refresh Aboriginal and Torres Strait Islander cultural training, provide new military service competency training, and enhance the Rewards and Recognition Framework to recognise integrity and contribution to culture. It will reshape processes to support effective change management through consultation with employees and their representatives on the DVA Managing Change Framework. Employees will also benefit from new change management tools and resources.

Digital capability and Artificial Intelligence

The department will continue to invest in the modernisation of its digital ecosystem to deliver services for veterans and their families. This will include further opportunities to automate basic functions, as well as future-focused work that positions the department to take advantage of new technologies.

The department's digital ecosystem continues to be underpinned by legacy ICT systems.

Work is well underway to replace the financial management system in 2025–26. This will provide greater capacity to support timely payments to veterans, families and providers, while providing modern capability to support further operational efficiencies.

The department's new clinical case management solution for Open Arms is also due to be implemented in 2025–26, with the solution providing a modern complex and clinical case management capability to replace the out-dated system.

DVA Digital Strategy

As the department brings these new platforms into its digital ecosystem, the new digital and data strategies will position it to:

- take a user-centred, data driven and digitally enabled approach to meet the needs of veterans and their families, achieve strategic objectives and deliver on the Commonwealth's broader digital and data vision for a simpler, secure and connected public service
- optimise digital capability and technology infrastructure, by steering a pathway to a more connected, efficient, and digitally enabled organisation
- adopt new service delivery models fit for the digital age
- commence consolidation of data platforms into a unified system able to operate advanced analytics
- demonstrate efficiencies by piloting manual workflow processes within new platforms.

Anchored to robust foundations supported by maturing enablers, the Digital Strategy will enable the department to modernise its digital ecosystem and support practical incremental delivery.

Artificial Intelligence

In line with the digital and data strategies, the department is committed to supporting employees and enhancing services by taking advantage of Artificial Intelligence (AI) in a considered, safe and responsible way.

In line with the Commonwealth's Policy for the Responsible use of AI in government the department has published an AI Transparency Statement and during 2025–26, will update this statement periodically as it utilises AI opportunities including:

- a partnership with the Department of Finance, to create an AI prototyping environment separate from core systems, to enable employees to test models and approaches, including future opportunities to take advantage of AI in core service delivery functions
- undertaking a Microsoft Copilot trial
- delivering a new DVA website search (AI) capability, providing an enhanced search result experience to users, with a summarised response to a user's query, with source links to web pages and an option to learn more.

This work will be guided by the department's first AI Policy and Strategy as well as the digital and data strategies.

Communication and engagement will be critical and the department's AI Advisory Board, which includes Government representatives, technical experts and a representative from the veterans' welfare and advocacy community organisation will continue to guide this work and provide feedback.

With a particular focus on the centrality of data to support service delivery to veterans and families, the department will continue to review ways to contemporise its data, analytics and AI capabilities and incorporate analytics tools into its business processes. This will enable contemporary capabilities in areas such as compliance monitoring, as well as program and service delivery.

Data, research and evaluation

In 2025–26, the department will continue to invest in building its data, evaluation and research capabilities to benefit veterans and families.

The department will continue to increase the development and appropriate use and sharing of knowledge and evidence to support policy, program, service design and decision-making. The aim is to improve wellbeing outcomes for veterans and families.

Building a modern enterprise data warehouse (EDW) and analytical capabilities based on curated data assets within the EDW will provide the department with an enhanced and well governed data analytics capability. Actions underway include defining and publishing metadata and data quality, and building data assets designed to support self-service data capability, while maintaining clear data provenance and security requirements.

Several key data-related initiatives are underway to improve our understanding of client needs and to tailor services and programs. These include the Priority Investment Approach, the Data-driven Client Segmentation, the Australian Bureau of Statistics Person Level Integrated Data Asset (PLIDA) and the Defence/DVA Data Sharing and Analytics Solution (DSAS). The department is collaborating with Defence, Australian Institute of Health and Welfare (AIHW) and Australian Bureau of Statistics (ABS) and states and territories around the Royal Commission recommendation to establish the National Veterans' Data Asset and National Veteran Indicator, as well as ways to overcome legislative barriers to improve data-sharing, particularly between the department and Defence, which is critical to facilitating improvements to the provision of services to veterans and families.

With advances in data warehousing and automation, including AI tools, such as machine learning, the department will continue to review ways to modernise its data, analytics and AI capabilities to incorporate into its business processes, in line with the digital and data strategies. This will enable contemporary capabilities in areas such as compliance monitoring, as well as enhanced program and service delivery.

The department will continue to engage with the veteran community around the use and sharing of its data. To support this, the department has initiated a program to uplift data governance, literacy and capability development to ensure it can support the data sharing agenda with robust governance controls that are aligned with key legislative principles set out in the *Data Availability and Transparency Act 2022*.

The department recognises the importance of adhering to our legal obligations including under the *Privacy Act 1988* for handling veterans' and families' information and is committed to handling personal information fairly and lawfully; respecting privacy and keeping information appropriately confidential; and being transparent and open about the kinds of personal information we collect, hold, use and disclose. In 2025–26, the department will continue to focus on improving our practices by implementing consistent protocols and will prioritise a rebuilding of social licence and trust with the veteran and broader community.

The department has a long-term commitment to research and evaluation that delivers ongoing benefits to the health and wellbeing of veterans and families. Further details can be found under '*Partnerships and cooperation*' in the paragraph "Key research and evaluation partners".

Futures and Stewardship

The department is actively investing in long-term integrity and sustainability through a focus on stewardship, strategic foresight and the development of long-term insights. The discipline of Futures Thinking improves the ability to navigate complex and evolving challenges, test preparedness for system shifts and ensures the needs of veterans and families are considered in planning and decision-making. The department uses data analysis and monitoring of demographic, environmental, economic, technology and service delivery trends to develop long-term policy and planning priorities that anticipate change and improve our preparedness to respond client needs. To this end, a dedicated Future Focus Team is in place to mature this work in alignment with the whole of APS Futures Capability uplift program led by the Department of the Prime Minister and Cabinet.

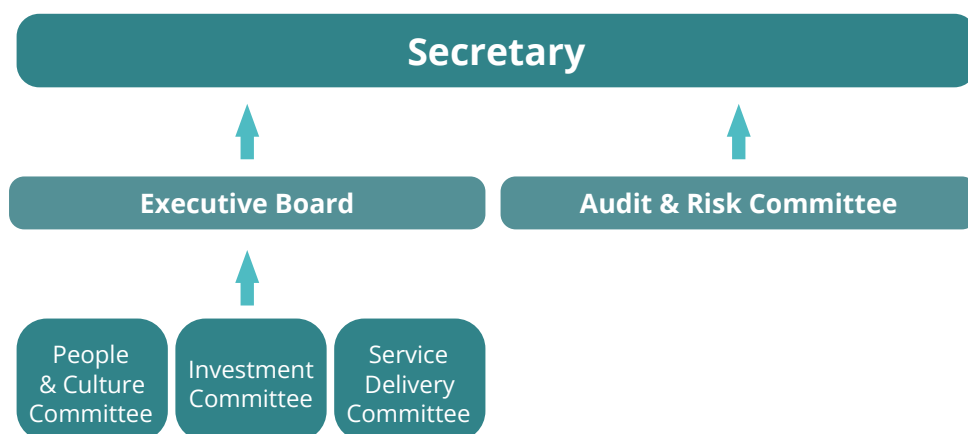
Governance

The department is committed to strong governance that enables strategic oversight, accountability, and robust, evidence-based decision-making. These governance arrangements are essential to delivering quality services, implementing the Australian Government and Royal Commission's priorities, simplifying processes and improving enabling services.

The governance framework is aligned with the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) and supports sound stewardship, transparency and performance across the department. The Executive Board and its sub-committees provide oversight and direction in areas such as resource prioritisation, policy and operational planning, risk management, audit, and compliance to ensure our work remains aligned with the department's purpose and the needs of the veteran community.

The Australian Public Service Commission Capability Review of DVA, which was finalised in October 2024, acknowledged the strength of our current governance arrangements and confirmed that the department is on the right trajectory. It also reinforced the importance of continuing to embed and mature these reforms to achieve lasting impact. In 2025–26, the department will continue to strengthen its governance capability by refining committee structures, enhancing decision-making processes, and embedding consistent operating principles that support clearer accountability, improved transparency, and better outcomes for veterans and their families.

The department's governance continues to evolve to meet expectations, ensuring that diverse perspectives and expertise are reflected in decision-making, and that the department remains agile, accountable, and focused on delivering better outcomes for those it serves.



Risk

Effective risk management is integral to achieving the department's objectives and supporting its purpose. The department is committed to promoting a proactive risk culture that considers threats and opportunities. The department's Chief Risk Officer is responsible for promoting a strong culture of appropriate risk behaviours across all levels of the enterprise. All employees have a responsibility to manage risk as part of their day-to-day activities. Building risk capability and culture is addressed by a range of training and awareness activities. These include mandatory online risk management training and a continuation of the Risk Practitioner's Forum Integration of specialist risks, such as climate risk. Alignment of business continuity, emergency management and disaster response to the Risk Management Framework will be delivered in 2025–26 to improve the department's risk maturity.

Risk Management Framework

The Accountable Authority Instructions and Risk Management Framework provides the foundation and organisational arrangements to nurture risk culture and manage risk across the enterprise. The Framework sets out the systems of risk oversight and management in accordance with section 16 of the PGPA Act and the Commonwealth Risk Management Policy. It is aligned with the International Standard on Risk Management, ISO 31000:2018 Risk management— Guidelines, and Commonwealth best practice guidance. The Framework contributes to the strengthening of management practices, decision-making and innovation across the department.



Management of Key Strategic Risks

In practice, risks are managed at the appropriate level across the department and its business activities. This includes management and oversight of strategic enterprise risks directly by the Executive Board and Enterprise Risk Stewards through to operational-level risks managed by respective divisions and branches. The department regularly scans the operating environment to identify and treat emerging risks and continues to undertake periodic reviews of its risks, critical controls and supporting frameworks to ensure they remain fit-for-purpose. Strategic risk management, described as enterprise risk management in DVA, identifies overarching risk focus areas which, if realised, will affect the department's ability to achieve its purpose and objectives. The department's identification and oversight of strategic risk is captured through a dynamic strategic risk management scan and appointment of Enterprise Risk Stewards. The Executive Board comprehensively review each of the enterprise risks at least annually.

The department's enterprise risk focus areas and mitigation strategies are outlined in Table 1 below. Some of these mitigation strategies span multiple enterprise risk focus areas.

Enterprise Risk Focus Areas – 2025-2026

Enterprise Risk Focus Area	Enterprise Risk Outcomes	Why is this a focus for DVA	Mitigation Strategies
Supporting our Veterans and their community at all times	- Understanding emerging demographics and needs. - Identifying appropriate support in a changing wellbeing landscape. - Embracing sector reform. - Recognise and evaluate global security and economic environmental conditions. - Responding to natural disasters / climate change. - Delivering of relevant services and programs.	So we deliver high quality outcomes that improve the health and wellbeing of veterans and their community	- DVA develops policy and programs based on research, data, wide engagement and evidence. - Plans developed for handling emergencies or crises. - Maintain open communication with stakeholders, demonstrating a commitment to accountability and transparency.

Enterprise Risk Focus Area	Enterprise Risk Outcomes	Why is this a focus for DVA	Mitigation Strategies
Managing claims efficiently and effectively	- Managing of the claims process efficiently. - Identifying innovative solutions to reduce times taken to process. - Meeting the Government Service standards. - Ensuring claims and data integrity. - Building capability through recruitment, skills development and retention. - Modernising and sustaining IT Systems. - Transparency in our dealings with clients.	So we have processes, systems and resources to deliver timely payments	- Implement efficient workflows and automated systems to expedite claims processing and reduce errors. - Reviews of current workforce provisioning and practices to meet the demand of claims processing. - Regularly audit and review claim processes to identify areas for improvement and ensure compliance. - Maintain transparent communication with claimants regarding status of their claims, expectations and any required supporting documentation.
Meeting Government Priorities	- Consolidating legislative reform. - Proactively advising Government and implementing priorities. - Delivering high-quality evidence-based policy advice. - Implementing Government agreed Royal Commission recommendations.	So we deliver the Government's priorities	- Build strong relationships with stakeholders to understand perspectives, gather support and influence the legislative process. - Oversight and monitoring of priorities and outcomes through robust processes. - Timely development and implementation of aligned evidence-based policy advice.

Enterprise Risk Focus Area	Enterprise Risk Outcomes	Why is this a focus for DVA	Mitigation Strategies
Looking after our People	• Management of the safety and wellbeing of employees, to maintain status as employer of choice. • Connection of employees to purpose and vision. • Measurement, detection and response to emerging workforce issues, including effective engagement and communication on issues. • Developing a future workforce (i.e. right people with the right skills at the right time).	So we ensure our people are supported to deliver the best outcomes.	• Prioritise employee health and safety through strategies and initiatives that prevent and manage physical and psychosocial risk and hazards. • Regularly solicit and address feedback from employees. • Invest in developing strong leadership capabilities at all levels. • Develop strategies to attract and retain skilled people in recognition of a changing workforce.
Operational Integrity	• Ensuring privacy and data integrity is maintained. • Being accountable for actions and decisions. • Ensuring compliance with policies, processes and procedures to support delivery. • Delivering robust systems to support the delivery of services and payments. • Delivering internal projects to meet desired outcomes.	So we are trusted by Government and our stakeholders (including veterans and their families, support providers, other government entities, the Parliament, employees and service providers).	• Robust data security measures are developed to protect sensitive information. • Foster a culture of integrity and ethical behaviour by setting clear expectations and leading by example. • Establish strong internal controls to prevent non-compliance. • Implement enterprise solution architecture to ensure strategic and operational objectives are achieved in a way that derives value from technology investments. • Develop and maintain strong relationships with providers to actively manage ICT risks.

Performance

Performance Reporting Framework

The department's Corporate Plan is a key component of the Performance Reporting Framework and aligns closely with its Portfolio Budget Statements (PBS).

The PBS sets out the department's 3 outcomes, the corresponding Budget programs, and the measures the department will use to monitor performance of these programs. The Corporate Plan communicates its strategic priorities for 2025–26 and includes performance measures and targets aligned with the department's purpose and key activities to demonstrate how success will be measured in 2025–26 to 2028–29.

The performance measures in this plan will be reported in the annual performance statements within the DVA 2025–26 Annual Report. The annual performance statements report the department's actual performance for the year against the performance measures and targets in its Corporate Plan and PBS and provide analysis of the extent to which the department has achieved its purpose, including the factors that contribute to the outcomes.

The department's Performance Reporting Framework measures its ability to deliver on its purpose in accordance with the requirements of the PGPA Act.

For information on the Commonwealth Performance Framework, including the relationship between performance information in the PBS, Corporate Plan and annual performance statements, refer to the PBS user guide on page viii, which is available on DVA's website.

The priorities and key activities outlined in this Corporate Plan will flow through to the department's divisional and branch plans, and flow into individual staff performance agreements. This provides a clear line of sight from the department's purpose to the work of individual staff members.

Review of the Performance Reporting Framework

The 2025–26 Performance Reporting Framework has changed to simplify and strengthen the department's performance reporting.

The department's operating environment has changed significantly since last year with the handing down of the Final Report of the Royal Commission into Defence and Veteran Suicide, legislation harmonisation, and the commencement of co-design of a wellbeing agency. This has given the department an opportunity to review its performance measures, consider matters of public interest, Australian Government and departmental priorities, recommendations of the Royal Commission and the breadth of the department's operations. This review has resulted in a reduced, but targeted set of performance measures which support the department's key priorities, improves external reporting and aligns with the approach taken by many other Australian Public Sector agencies.

The revised Performance Reporting Framework ensures the department's key activities and performance measures:

- are purposeful and meaningful from the perspective of veterans and families
- are aligned with current departmental priorities
- are responsive to recommendations from the Royal Commission
- address Australian National Audit Office (ANAO) audit findings, and
- are well supported by evidence and data.

Key Updates to the Performance Reporting Framework

The review of the Performance Reporting Framework resulted in the consolidation of 17 key activities and 44 performance measures, into **4** key activities and **12** performance measures, providing a more focused and meaningful view of the department's performance.

Key activity 1:	Key activity 2:	Key activity 3:	Key activity 4:
Providing financial support and compensation services for eligible veterans and families.	Providing access to health, rehabilitation, physical and mental wellbeing and care services for veterans and families.	Supporting transition and employment for veterans and families.	Recognise the service of veterans who served in wars, conflicts and peace operations and their families.
0.1 Client satisfaction: Client satisfaction with delivery and access to key DVA programs.			
0.2 Wellbeing: DVA's contribution to client's physical and mental wellbeing after the provision of services.			
1.1 Timeliness: Percentage of claims processed within statutory and other timeliness targets. 1.2 Quality: DSHI complies with/meets the requirements of the 2020 General Insurance Code of Practice. 1.3 Quality: Financial support and compensation services are accurate, and provided according to trauma-informed protocols.	2.1 Timeliness: Percentage of clients allocated to peer worker, group treatment, or an Open Arm's clinician, within two weeks of intake. 2.2 Timeliness: Percentage of health, rehabilitation and care services provided within statutory and other timeliness targets. 2.3 Quality: Percentage of clients where rehabilitation goals were met or exceeded.	2.4 Effectiveness and awareness: The percentage of transitioning personnel who have a MyService account set up with DVA.	3.1 Timeliness: Official war graves commemorations are offered to families in a timely manner in recognition of the service and sacrifice of eligible veterans who have served in war, conflict or peace operations. 3.2 Quality: Official war graves commemorations are maintained to recognise the service and sacrifice of eligible veterans who have served in war, conflict or peace operations. 3.3 Awareness: Deliver commemorative events and build community awareness for Anzac Day and significant anniversaries in recognition of the sacrifice of veterans who have served Australia in wars, conflicts and peace operations.

The revised measures are organised into five key thematic categories that reflect the department's strategic priorities and core service outcomes, including two new overarching performance measures centering on veteran wellbeing and client satisfaction.

Client Satisfaction: Determining the level of client satisfaction will identify and explore the effectiveness of engagement with the department by veterans and their families.

Wellbeing: Acknowledging that an individual's wellbeing may be impacted by a multitude of factors, ensuring there is mindfulness about the impact of the department's services on the wellbeing of veterans and families as this is paramount to the department delivering on its purpose *'to support the wellbeing of those who serve and have served in the defence of our nation, as well as their families'*.

Timeliness: Measures the responsiveness of service delivery of key departmental programs against established timeliness targets.

Quality: Examines the accuracy, consistency and adherence to the standards of service required under key departmental programs.

Effectiveness and Awareness: Captures the reach and effectiveness of the department's communication of its services, programs and commemorative events.

Specific performance indicators within these themes are detailed further in the *'Our new performance measures'* section.

These changes support the department's commitment to simplifying and improving processes while delivering high quality services and support to veterans and their families.

Measuring performance

Good performance information demonstrates how the department, in line with its purpose, achieves the overarching outcomes it is funded to deliver through Budget programs.

The Corporate Plan presents a range of key activities against each of the outcomes and Budget programs. How the department performs in undertaking those activities is monitored through performance measures and targets, which are detailed in the *'Our new performance measures'* section.

Achievement against the performance criteria in this Corporate Plan and the PBS, is reviewed by the Executive Board on a triannual basis and will be reported externally in the annual performance statements published as part of the DVA 2025–26 Annual Report.

For a complete overview, performance measures and targets should be read in tandem with program financial and performance information published in the department's PBS.

Approach

The department uses a mix of qualitative and quantitative measures and includes output and effectiveness measures to provide a basis for the measurement and assessment of its performance.

Performance measures identified by the Royal Commission have been incorporated and strengthened. This includes the percentage of health, rehabilitation and care services provided within published service standards, and supporting transition and employment of veterans and families.

Measuring against the 2025-26 Performance Reporting Framework will use a four-point tolerance scale to articulate the department's performance results. This approach better reflects the complexity of the department's administered programs, supports transparency and provides visibility of continuous improvement. Specific tolerance scales for each performance measure are detailed in the *'Our new performance measures'* section.

Performance Targets

Performance measures and targets included in this Corporate Plan apply to each year from 2025–26 through to 2028–29.

All newly created performance measures have been assigned an indicative target of ≥80% (monitored for the first year) based on past performance results, legislative requirements and the data available to support the achievement of the targets going forward. The performance targets may be adjusted after the first year of monitoring.

For claims processing, the department has increased performance targets to >90% to reflect its commitment to meeting and exceeding claims timeframes set out by legislation or recommended by the Royal Commission. The department is well placed to improve the performance of claims processing timeframes as a result of clearing the unallocated claims backlog, increased staff numbers and improvements to processes.

Specific targets for key departmental Programs are detailed in the *'Our new performance measures'* section.

Our new performance measures

Client satisfaction

The department is focused on the provision of high quality and timely services that meet the needs of its clients. This measure goes to the core of the department's operations and provides visibility of clients' level of satisfaction with the accessibility and delivery of DVA's key programs and services, helping to identify and explore the effectiveness of engagements with the department.

Feedback received through a survey will be used to strengthen and modify programs and services.

This is an overarching performance measure and is relevant to all Outcomes.

Programs	All				
Key Activities	All				
Performance Measure	0.1 Client satisfaction: Client satisfaction with delivery and access to key DVA programs.				
Target	Preceding FY	Current FY	Forward FY		
	2024–2025	2025–2026	2026–2027	2027–2028	2028–2029
	New measure includes previous client satisfaction surveys with a target of ≥80%	≥80%	≥80%	≥80%	≥80%
Tolerance Scale	Achieved: ≥80% Substantially achieved: ≥72%-79.9% Partially achieved: ≥60%-71.9% Not achieved: <60%				

Explanatory notes and limitations

- The performance measure is based on the customers' surveyed perceptions of the department and is used to improve the quality of services provided to its customers.
- Customer participation in all surveys is voluntary.
- The integrated survey methodology is being developed in 2025-26.

Wellbeing

The department is focused on the provision of high quality and timely services that meet the needs of clients and enhance their wellbeing. There are 9 factors impacting wellbeing (health, social support and connection, education and skills, employment and meaningful activity, meaning and spirituality, home and housing, income and finance, justice and safety, and recognition and respect) although not all factors are influenced by the department's services. This measure goes to the core purpose of the department and provides visibility of the client's perceived impact on their wellbeing after accessing the department's key programs and services, helping to identify and explore the effectiveness of its programs and services.

Feedback received through a survey will be used to strengthen and modify programs and services.

This is an overarching performance measure and is relevant to all Outcomes.

Programs	All				
Key Activities	All				
Performance Measure	0.2 Wellbeing: DVA's contribution to client's physical and mental wellbeing after the provision of services ⁱⁱ .				
Target	Preceding FY	Current FY	Forward FY		
	2024–2025	2025–2026	2026–2027	2027–2028	2028–2029
	n/a	≥80%	≥80%	≥80%	≥80%
Tolerance Scale	Achieved: ≥80% Substantially achieved: ≥72%-79.9% Partially achieved: ≥60%-71.9% Not achieved: <60%				

Explanatory notes and limitations

- » The performance measure is based on the customers' surveyed perceptions of the department and is used to improve the quality of services provided to its customers.
- » Customer participation in all surveys is voluntary.
- » The integrated survey methodology is being developed in 2025-26.

Outcome 1:

Maintain and enhance the financial wellbeing and self-sufficiency of eligible persons and their dependants through access to income support, compensation and other support services, including advice and information about entitlements.

Timeliness

Claims Processing

The department is committed to ensuring the timely processing of claims to ensure clients receive the correct payment, based on the information provided to the department. The measure provides visibility of the department's performance against its agreed timeliness standards and consolidates a number of previous measures relating to the timeliness of claims processing. The department remains cognisant of processing times and will continue to communicate them for all different claim types monthly on the department website.

Programs	1.1 ,1.6				
Key Activities	Providing financial support and compensation services for eligible veterans and families.				
Performance Measure	1.1 Timeliness: Percentage of claims processed within statutory and other timeliness targets ⁱⁱⁱ .				
Target	Preceding FY	Current FY	Forward FY		
	2024–2025	2025–2026	2026–2027	2027–2028	2028–2029
	New measure includes a number of previous Outcome 1 timeliness measures. The target was previously >50%	>90%	>90%	>90%	>90%
Tolerance Scale	Achieved: ≥90% Substantially achieved: ≥81%-89.9% Partially achieved: ≥67.5%-80.9% Not achieved: <67.5%				

The timeliness of claims processing will be calculated based on the volume of major claim types^{iv} and measured from the point a claim has all the relevant content and is complete providing a more fulsome and accurate view of the department's performance. This also recognises and acknowledges the significant amount of time spent by the department waiting for the provision of information.

Quality

Defence Service Homes (DSH) Insurance

The measure allows users to understand the level of the department's compliance with the General Insurance Code of Practice and how this compares to performance in the wider industry. The measure provides transparency on the timeliness, communication and accuracy of sales and policy, and claims functions provided by Defence Service Homes Insurance and is in place to identify areas of improvement.

Programs	1.4				
Key Activities	Providing financial support and compensation services for eligible veterans and families.				
Performance Measure	1.2 Quality: DSHI complies with/meets the requirements of the 2020 General Insurance Code of Practice.				
Target	Preceding FY	Current FY	Forward FY		
	2024–2025	2025–2026	2026–2027	2027–2028	2028–2029
	≥90%	>90%	>90%	>90%	>90%
Tolerance Scale	Achieved: ≥90% Substantially achieved: ≥81%-89.9% Partially achieved: ≥67.5%-80.9% Not achieved: <67.5%				

Explanatory Note

- » This measure involves completing targeted audits across a wide span of DSHI transactions. The results will help to gauge both department performance and identify potential process deficiencies and improvement opportunities.

Claims Processing

The department is committed to ensuring high quality processing of claims based on information provided to it. This measure provides visibility of the accuracy of the department's claims processing, i.e. whether the department is processing the correct entitlement from the right date to the right person in accordance with trauma-informed protocols and legislation, and whether there are any administrative and processing errors. This measure consolidates a number of previous measures related to the quality of claims processing. Quality assessments are conducted monthly on a random statistical sample by quality assurance officers using assessment criteria relevant to the function (e.g. Initial Liability, Permanent Impairment, Incapacity etc.). Errors are deviations from the entitlements an eligible veteran or family member should or should not have received. Errors may involve both financial and non-financial impacts, including for example, failure to formally notify a veteran of a decision.

Programs	1.1, 1.6				
Key Activities	Providing financial support and compensation services for eligible veterans and families.				
Performance Measure	1.3 Quality: Financial support and compensation services are accurate, and provided according to trauma-informed protocols.				
Target	Preceding FY	Current FY	Forward FY		
	2024–2025	2025–2026	2026–2027	2027–2028	2028–2029
	Includes a number of Outcome 1 quality measures with a target of ≥95%	>95%	>95%	>95%	>95%
Tolerance Scale	Achieved: ≥95% Substantially achieved: ≥85.5%-94.9% Partially achieved: ≥71.3%-85.4% Not achieved: <71.3%				

Outcome 2:

Maintain and enhance the physical and mental wellbeing and quality of life of eligible persons and their dependants through health and other care services that promote early intervention, prevention and treatment, including advice and information about health service entitlements.

Timeliness

Open Arms

The department is committed to providing high quality and timely mental health services that meet the needs of clients and impacts positively on their wellbeing. The department's responsiveness and engagement with its clients at the initial stages, through the timeliness of allocation to mental health services provided through Open Arms is assessed through this measure. The results from the measure will be used to modify and improve processes.

Programs	2.5				
Key Activities	Providing access to health, rehabilitation, physical and mental wellbeing and care services for veterans and families.				
Performance Measure	2.1 Timeliness: Percentage of clients allocated to peer worker, group treatment, or an Open Arm's clinician, within two weeks of intake.				
Target	Preceding FY	Current FY	Forward FY		
	2024–2025	2025–2026	2026–2027	2027–2028	2028–2029
	Previously "Percentage of clients allocated to an Open Arms clinician within 2 weeks of initial intake with a target of ≥65%"	≥80%	≥80%	≥80%	≥80%
Tolerance Scale	Achieved: ≥80% Substantially achieved: ≥72%-79.9% Partially achieved: ≥60%-71.9% Not achieved: <60%				

Veterans' Health and Wellbeing

The department is focused on the provision of high quality and timely access to services that meet the needs of clients and enhance their physical and mental wellbeing. This measure provides visibility to the public of the timeliness of the department's services. Results achieved from the measure will be used to modify processes to increase efficiency.

This measure, in part, responds to the Royal Commission and encompasses Recommendation 100 to improve the transparency of the rehabilitation program.

Programs	2.6				
Key Activities	Providing access to health, rehabilitation, physical and mental wellbeing and care services for veterans and families.				
Performance Measure	2.2 Timeliness: Percentage of health, rehabilitation and care services provided within statutory and other timeliness targets.				
Target	Preceding FY	Current FY	Forward FY		
	2024–2025	2025–2026	2026–2027	2027–2028	2028–2029
	Measure did not exist last year, but new measure covers "The percentage of rehabilitation assessments completed within 30 days of assessment referral with a previous target of ≥75%"	≥80%	≥80%	≥80%	≥80%
Tolerance Scale	Achieved: ≥80% Substantially achieved: ≥72%-79.9% Partially achieved: ≥60%-71.9% Not achieved: <60%				

This is a newly created measure. It is envisaged that the coverage of this measure will increase over time through the addition of significant programs.

Quality

The department is committed to providing high-quality rehabilitation services that meet the needs of clients and impacts positively on their wellbeing. This measure directly addresses recommendation 100 of the Royal Commission to improve the transparency of the rehabilitation program and helps identify and explore the effectiveness of rehabilitation. Feedback received through this measure will be used to strengthen and modify rehabilitation programs.

Programs	2.6				
Key Activities	Providing access to health, rehabilitation, physical and mental wellbeing and care services for veterans and families.				
Performance Measure	2.3 Quality: Percentage of clients where rehabilitation goals were met or exceeded.				
Target	Preceding FY	Current FY	Forward FY		
	2024–2025	2025–2026	2026–2027	2027–2028	2028–2029
	N/A	≥80%	≥80%	≥80%	≥80%
Tolerance Scale	Achieved: ≥80% Substantially achieved: ≥72%-79.9% Partially achieved: ≥60%-71.9% Not achieved: <60%				

Effectiveness and awareness

Ensuring that veterans are supported through their transition to civilian life is key to improving their wellbeing. This measure is an interim measure which provides visibility of the effectiveness of the department's communication with transitioning personnel and demonstrates the level of client engagement and connection with the department. Insights gained will be used to refine interactions with people transitioning. This performance measure will be reviewed once the Wellbeing Agency is established.

Programs	2.4, 2.5, 2.6				
Key Activities	Supporting transition and employment for veterans and families.				
Performance Measure	2.4 Effectiveness and awareness: The percentage of transitioning personnel who have a MyService account set up with DVA.				
Target	Preceding FY	Current FY	Forward FY		
	2024–2025	2025–2026	2026–2027	2027–2028	2028–2029
	N/A	≥80%	≥80%	≥80%	≥80%
Tolerance Scale	Achieved: ≥80% Substantially achieved: ≥72%-79.9% Partially achieved: ≥60%-71.9% Not achieved: <60%				

Outcome 3:

Acknowledgement and commemoration of those who served Australia and its allies in wars, conflicts and peace operations through promoting recognition of service and sacrifice, preservation of Australia's wartime heritage, and official commemorations.

Timeliness

The department and Government are committed to recognising and acknowledging the service and sacrifice rendered by Australians in the wars, peacekeeping and other operations to which the nation has been committed. One of the first steps in fulfilling this commitment is timely communication to families of their entitlement to an official war grave. This measure assesses the responsiveness of the department's communication with families about their entitlement to an official war grave.

Programs	3.1				
Key Activities	Recognise the service of veterans who served in wars, conflicts and peace operations and their families.				
Performance Measure	3.1 Timeliness: Official war graves commemorations are offered to families in a timely manner in recognition of the service and sacrifice of eligible veterans who have served in war, conflict or peace operations.				
Target	Preceding FY	Current FY	Forward FY		
	2024–2025	2025–2026	2026–2027	2027–2028	2028–2029
	N/A	≤ 7 days	≤ 7 days	≤ 7 days	≤ 7 days
Tolerance Scale	Achieved: 100% in ≤ 7 days Substantially achieved: ≥ 90% – 99.9% Partially achieved: ≥ 75% – 89.9% Not achieved: < 75%				

The measure reports the percentage of letters sent within 7 days. The target of ≤ 7 days was selected with reference to existing communication timeframes within the department and is based on public expectations.

Quality

In fulfilling the department and Government's commitment to recognise and acknowledge the service and sacrifice rendered by Australians in the wars, peacekeeping and other operations to which the nation has been committed. The department ensures that official war graves are appropriately maintained at the standards expected by the public. This measure helps to identify and explore the effectiveness of the department's maintenance program. Feedback received through the survey will be used to strengthen and modify the maintenance program.

Programs	3.1				
Key Activities	Recognise the service of veterans who served in wars, conflicts and peace operations and their families.				
Performance Measure	3.2 Quality: Official war graves commemorations are maintained to recognise the service and sacrifice of eligible veterans who have served in war, conflict or peace operations ⁴ .				
Target	Preceding FY	Current FY	Forward FY		
	2024–2025	2025–2026	2026–2027	2027–2028	2028–2029
	Change of measure Previously "Quality – Official commemorations are satisfactorily maintained to recognise the service and sacrifice of veterans"	≥ 80% satisfaction	≥ 80% satisfaction	≥ 80% satisfaction	≥ 80% satisfaction
Tolerance Scale	Achieved: ≥80% Substantially achieved: ≥72%-79.9% Partially achieved: ≥60%-71.9% Not achieved: <60%				

Explanatory notes and limitations

- » The performance measure is based on the customers' surveyed perceptions of the department's maintenance of official war graves commemorations and is used to improve the quality of maintenance of these.
- » Participation in all surveys is voluntary.
- » The integrated survey methodology is being developed in 2025-26.

Awareness

The department is committed to increasing the public's understanding and awareness of the service and sacrifice of veterans and to ensuring that their service and sacrifice is recognised, remembered and honoured through the delivery of commemorative events. This measure provides visibility of the effectiveness of the delivery of the commemorative events and is aligned to the Australian War Memorial's measures. This measure will be used to strengthen and modify the delivery of commemorative events.

Programs	3.2				
Key Activities	Recognise the service of veterans who served in wars, conflicts and peace operations and their families.				
Performance Measure	3.3 Awareness: Deliver commemorative events and build community awareness for Anzac Day and significant anniversaries in recognition of the sacrifice of veterans who have served Australia in wars, conflicts and peace operations ⁴ .				
Target	Preceding FY	Current FY	Forward FY		
	2024–2025	2025–2026	2026–2027	2027–2028	2028–2029
	Change of measure Previously “Commemorative event quality: Commemorative events are conducted to commemorate veterans’ service in a dignified, solemn and respectful manner” and “Increase the public’s understanding and awareness of the service and sacrifice of those who have served Australia in wars, conflicts and peace operations”	Delivered as scheduled	Delivered as scheduled	Delivered as scheduled	Delivered as scheduled
Tolerance Scale	Delivered as planned/not delivered as planned				

This measure indicates whether the department is delivering commemorative events as planned.

Appendices

Appendix A: Summary of changes to DVA's Key Activities

Outcome 1:

Maintain and enhance the financial wellbeing and self-sufficiency of eligible persons and their dependants through access to income support, compensation and other support services, including advice and information about entitlements.

Key Activities 2024–2025	Key Activities 2025–2026
Provide income and financial support and compensation payments to eligible veterans and families	1. Provide financial support and compensation payments to eligible veterans and families
Provide disability support and compensation payments to eligible veterans	
Provide income and financial support and compensation payments to eligible dependants	
Enable veterans and families to access housing-related support via the Defence Home Ownership Assistance Scheme and Defence Service Homes (DSH) Insurance	
Provide eligible children of veterans and families with financial assistance and support to access education and skills development	

Outcome 2:

Maintain and enhance the physical and mental wellbeing and quality of life of eligible persons and their dependants through health and other care services that promote early intervention, prevention and treatment, including advice and information about health service entitlements.

Key Activities 2024–2025	Key Activities 2025–2026
Work with a range of medical, dental, hearing and allied health providers throughout Australia to ensure veterans and families have access to a comprehensive range of services	2. Providing access to health, rehabilitation, physical and mental wellbeing and care services for veterans and families
Make arrangements with public and private hospital service providers throughout Australia to ensure veterans and families have access to a comprehensive range of services	
Provide eligible veterans with access to a broader range of medicines and wound care items at a concessional rate	
Provide a range of care and support in the home to assist eligible veterans and families to remain independent for longer	2. Providing access to health, rehabilitation, physical and mental wellbeing and care services for veterans and families and 3. Supporting transition and employment for veterans and families
Provide veterans and families with access to mental health care services, including primary prevention through counselling and complex care coordination	
Support veterans with travel for treatment and provide access to aids, appliances and modifications to support independent living	
Provide veterans with access to allied health services, including access to telehealth services	
Provide access to Open Arms, including individual and family counselling, after-hours counselling, group program interventions and peer support	
Provide veterans with access to medical management, psychosocial and vocational rehabilitation programs and support for employment	

Outcome 3:

Acknowledgement and commemoration of those who served Australia and its allies in wars, conflicts and peace operations through promoting recognition of service and sacrifice, preservation of Australia's wartime heritage, and official commemorations.

Key Activities 2024–2025	Key Activities 2025–2026
Provide and maintain war cemeteries, war plots, gardens of remembrance and memorials to the missing, and other individual official commemorations for those eligible veterans who have died as a result of their service to Australia in wars, conflicts and peace operations.	4. Recognise the service of veterans who served in wars, conflicts and peace operations and their families
Deliver domestic and international commemorative events to enable the community to better understand, acknowledge and commemorate the service and sacrifice of those who have served Australia in wars, conflicts and peace operations	
Provide online resources to enable the community to better understand, acknowledge and commemorate the service and sacrifice of those who have served Australia in wars, conflicts and peace operations.	

Appendix B: Summary of changes to DVA's Performance Measures

Client Satisfaction

Client satisfaction with delivery and access to key programs.

Performance Measures 2024–2025	Performance Measures 2025–2026
1.1–5 Client Satisfaction: The percentage of clients satisfied with the level of customer service they received when accessing their entitlements (Veterans' Income and Support Allowances)	Client satisfaction is an overarching performance measure and is relevant to all Outcomes, Key Activities and: • Programs 1.1-1.6 • Programs 2.1-2.6 • Programs 3.1-3.2
1.2–3 Client Satisfaction: The percentage of clients satisfied with the level of customer service they received when accessing their entitlements (Veterans' Disability Support)	
1.3–3 Client Satisfaction: The percentage of clients satisfied with the level of customer service they received when accessing their entitlements (Assistance to Defence Widow/ers and their Dependents)	
1.4–3 Client Satisfaction: The percentage of clients satisfied with the level of customer service they received when accessing their entitlements (Funeral Benefits)	
1.6–13 Client Satisfaction: The percentage of clients satisfied with the level of customer service they received when accessing their entitlements (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation).	
2.1–1 Quality of Service: The proportion of clients who have registered a complaint in relation to unmet access and/or quality compared to the total number of clients accessing services (General Medical Consultations and Services)	
2.2–1 Quality of Service: The proportion of clients who have registered a complaint in relation to unmet access and/or quality compared to the total number of clients accessing services (Veterans' Hospital Services).	
2.3–1 Quality of Service: The proportion of clients who have registered a complaint in relation to unmet access and/or quality compared to the total number of clients accessing services (Veterans' Pharmaceutical Benefits)	
2.4–1 Quality of Service: The proportion of clients who have registered a complaint in relation to unmet access and/or quality compared to the total number of clients accessing services (Veterans' Community Care and Support)	
2.5–1 Quality of Service: The proportion of clients who have registered a complaint in relation to unmet access and/or quality compared to the total number of clients accessing services (Veterans' Counselling and Other Health Services)	
2.5–5 Client Satisfaction (Open Arms – Veterans and Families Counselling Services)	
2.6–3 Client Satisfaction: An annual survey of client satisfaction with the rehabilitation program (Military Rehabilitation and Compensation Acts – Health and Other Care Services)	

Wellbeing

DVA's contribution to client's physical and mental wellbeing after provision of services.

Performance Measures 2024–2025	Performance Measures 2025–2026
N/A	The wellbeing of individuals and families is paramount through all departmental engagements. This is a new overarching performance measure which ensures there is mindfulness about the impact of the department's services on the wellbeing of veterans and families and is relevant to all Outcomes and Key Activities and: • Programs 1.1–1.6 • Programs 2.1–2.6 • Programs 3.1–3.2

Outcome 1

Maintain and enhance the financial wellbeing and self-sufficiency of eligible persons and their dependants through access to income support, compensation and other support services, including advice and information about entitlements.

Timeliness

Performance Measures 2024–2025	Performance Measures 2025–2026
1.1–1 Timeliness: The percentage of claims processed within 30 days (Veterans' Income and Support Allowances)	1.1 Timeliness: Percentage of claims processed within statutory and other timeliness targets
1.6–1 Timeliness: The percentage of DRCA liability claims processed (determined) within 100 days (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation – DRCA Liability)	
1.6–2 Timeliness: The percentage of DRCA permanent impairment claims processed (determined) within 100 days (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation – DRCA Permanent Impairment)	
1.6–3 Timeliness: The percentage of DRCA incapacity claims processed (determined) within 50 days (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation – DRCA incapacity)	
1.6–7 Timeliness: The percentage of MRCA liability claims processed (determined) within 90 days (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation – MRCA liability)	
1.6–8 Timeliness: The percentage of MRCA permanent impairment claims processed (determined) within 90 days (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation – MRCA permanent impairment)	
1.6–9 Timeliness: The percentage of MRCA incapacity claims processed (determined) within 50 days (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation – MRCA incapacity).	

Quality

Performance Measures 2024–2025	Performance Measures 2025–2026
1.4–4 Quality: DSHI complies with/meets the requirements of the 2020 General Insurance Code of Practice (Defence Service Homes (DSH) Insurance)	1.2 Quality: DSHI complies with/meets the requirements of the 2020 General Insurance Code of Practice (Defence Service Homes (DSH) Insurance)
1.1–3 Quality: Correctness rate of processed new claims (Veterans' Income Support and Allowances)	1.3 Quality: financial support and compensation services are accurate and provided according to trauma-informed protocols
1.6–4 Quality: Correctness rate of processed DRCA liability claims (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation – DRCA liability)	
1.6–5 Quality: Correctness rate of processed DRCA permanent impairment claims (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation – DRCA permanent impairment)	
1.6–6 Quality: Correctness rate of processed DRCA incapacity claims (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation – DRCA Incapacity claims)	
1.6–10 Quality: Correctness rate of processed MRCA liability claims (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation – MRCA liability)	
1.6–11 Quality: Correctness rate of processed MRCA permanent impairment claims (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation – MRCA permanent impairment)	
1.6–12 Quality: Correctness rate of processed MRCA Incapacity claims (Military Rehabilitation and Compensation Acts Payments – Income Support and Compensation – MRCA incapacity)	

Outcome 2

Maintain and enhance the physical and mental wellbeing and quality of life of eligible persons and their dependants through health and other care services that promote early intervention, prevention and treatment, including advice and information about health service entitlements.

Timeliness

Performance Measures 2024–2025	Performance Measures 2025–2026
2.5–4 Percentage of clients allocated to peer worker, group, treatment, or an Open Arm's clinician, within two weeks of intakes	2.1 Timeliness: Percentage of clients allocated to peer worker, group, treatment, or an Open Arm's clinician, within two weeks of intakes
2.6–1 Timeliness: The percentage of rehabilitation assessments that were made within 30 days of assessment referral (rehabilitation)	2.2 Timeliness: Percentage of health, rehabilitation and care services provided within statutory and other timeliness targets

Quality

Performance Measures 2024–2025	Performance Measures 2025–2026
N/A	2.3 Quality: Percentage of clients where rehabilitation goals were met or exceeded

Effectiveness and Awareness

Performance Measures 2024–2025	Performance Measures 2025–2026
N/A	2.4 The percentage of transitioning personnel who have a MyService Account set up with DVA.

Outcome 3

Acknowledgement and commemoration of those who served Australia and its allies in wars, conflicts and peace operations through promoting recognition of service and sacrifice, preservation of Australia's wartime heritage, and official commemorations.

Timeliness

Performance Measures 2024–2025	Performance Measures 2025–2026
3.1.1 New official commemorations are completed within published timeframes (War Graves)	3.1 Timeliness: Official War Graves commemorations are offered to families in a timely manner in recognition of the service and sacrifice of eligible veterans who have served in war, conflict or peace operations

Quality

Performance Measures 2024–2025	Performance Measures 2025–2026
3.1-3 Quality: Official commemorations are satisfactorily maintained to recognise the service and sacrifice of veterans (War Graves)	3.2 Quality: Official War Graves commemorations are maintained to recognise the service and sacrifice of eligible veterans who have served in war, conflict or peace operations

Awareness

Performance Measures 2024–2025	Performance Measures 2025–2026
3.2-1 Commemorative events quality: Commemorative events are conducted to commemorate veterans' service in a dignified, solemn and respectful manner (Commemorative activities)	3.3 Awareness: Deliver commemorative events and build community awareness for Anzac Day and significant anniversaries in recognition of the sacrifice of veterans who have served Australia in wars, conflicts and peace operations
3.2-2 Increase the public's understanding and awareness of the service and sacrifice of those who have served Australia in wars, conflicts and peace operations.	

Appendix C: PGPA Act Requirements

The Corporate Plan has been prepared in accordance with the requirements of:

- subsection 35(1) of the PGPA Act; and
- subsection 16E(2) of the PGPA Rule 2014.

The Department of Veterans' Affairs has no subsidiaries as defined by the PGPA Act.

Endnotes

- i The description of this key activity has changed since the publication of the 2025-26 PBS.
- ii The description of this performance measure has changed from the 2025-26 PBS to better define how wellbeing will be measured and reported.
- iii The description of this performance measure has changed from the 2025-26 PBS to provide a clearer definition of how timeliness will be calculated and reported.
- iv This measure consolidates information for major claim types and considers the following claim types: Income Support, Veterans Payment, Service Pension, MRCA and DRCA Initial Liability and Permanent Impairment, as well as MRCA and DRCA Incapacity.
- v The description of this performance measure has changed from the 2025-26 PBS to provide a clearer definition of how awareness will be measured and reported.







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SENATE ESTIMATES JUNE 2026
VFSE GROUP – BACK POCKET BRIEF
Open Arms Division

EC25-00-2602

OPEN ARMS KEY PERFORMANCE MEASURES

KEY ISSUES

- Open Arms – Veterans & Families Counselling (Open Arms) report against two Key Performance Indicators (KPIs) in the Department of Veterans' Affairs (DVA) 2024-25 Annual Performance Statements.
- Open Arms exceeded targets for both KPIs in 2024-25.
- Open Arms' performance measure has been updated to better reflect the services the Division provides to its clients. The measure is now the percentage of clients allocated to a peer worker, group treatment, or an Open Arms clinician within two weeks of intake. The new target is $\geq 80\%$.

FY 2024-25 Measures

Measure	FY 2023-24	FY 2024-25
2.5.4 Percentage of clients allocated to an Open Arms clinician within two weeks of intake assessment. ¹	87.00% <i>Target > 65%</i>	86.18% <i>Target > 65%</i>
2.5.5 Client satisfaction surveys identify service improvements and quality outcomes for individuals and their families. ²	90.87% <i>Target > 80%</i>	93.37% <i>Target > 80%</i>

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¹ This measure indicates the timely allocation to an Open Arms clinician for counselling or other mental health support services and is an indication of how well we engage with our clients in their initial engagement with our service.

² Client satisfaction is measured by a questionnaire. Satisfaction questionnaires are offered by clinicians at the end of the counselling episode of care. All clients who answer 'satisfied' or 'very satisfied' to the question 'How satisfied were you with the counselling provided to you?' will be measured as satisfied. The questionnaire is not compulsory for clients to complete.

FY 2025-26 Measure

Measure	FY 2025-26 FYTD as at 30 April 2026
2.1 Percentage of clients allocated to a Peer Worker, Group Treatment, or Open Arms clinician within two weeks of intake assessment. ¹	89.26% Target > ≥80%

BACKGROUND

- The KPI 2.5.4 'Percentage of clients allocated to an Open Arms clinician within two weeks of intake assessment' was amended in June 2020, based on advice from the ANAO.
- The KPI required amendment due to the implementation of the Client Assist Contact Centre (Client Assist) that provides 24-hour telephone support for clients, where they also undertake their initial intake assessment.

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Historical Data

Measure	2022-23	2023-24	2024-25	2025-26 (as at 30 April 2026)
Number of total unique clients	43,173	42,481	38,554	33,719
Number of services provided	325,351	339,882	300,388	235,040
Client satisfaction	90.67%	90.87%	93.37%	92.25%
Percentage of clients allocated to a clinician within two weeks of intake assessment	89.54%	87.00%	86.18%	89.21%

Clearance

Date Created:	06/05/2026
Division & Branch:	Open Arms Business Operations
Contact Officer:	Kerry McKenna, A/g Assistant Secretary
Phone:	s 47F

Date Cleared:	12/05/2026
Division:	Open Arms
Clearance Officer:	Amanda Harmer, A/g First Assistant Secretary
Phone:	s 47F

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