The Coordinated Veterans’ Care (CVC) Program

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

The focus of the program is on prevention and improved management of chronic conditions resulting in improved quality of life, and reduced risk of hospitalisations.

The program is voluntary and is in addition to any existing DVA services.

What does it mean for me?
If you are eligible (see page 2) and enrolled in the CVC Program, your ongoing and planned care will be based on a personalised Care Plan developed by your General Practitioner (GP) along with a nurse coordinator and in consultation with you.

The GP and the nurse coordinator will work closely with you to help you understand your health needs, assist you in managing your conditions and to coordinate the various aspects of your care.

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

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

You must have a Gold Card and cannot be:

• permanently living in a residential aged care facility
• diagnosed with a condition that is likely to be terminal within 12 months or
• participating in any similar Commonwealth program, for example Department of Social Services coordinated care program.

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

How do I enrol in the CVC Program?

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

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

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

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

What happens once I’m in the CVC Program?

Once you are in the CVC Program, you will receive a patient friendly version of your Care Plan, and your GP will arrange for a nurse coordinator to help you implement the plan. The nurse may:

• help you make appointments with other health professionals involved in your care
• remind you of appointments
• monitor your conditions and address any concerns
• coach and assist you in achieving your health goals.

The nurse will provide any feedback to your GP, and may also be in contact with your appointed carer or family member, if suitable and if you agree.

Your GP will regularly review your Care Plan to monitor your progress, make any necessary changes and make sure your care is ongoing and planned. You will still have regular appointments with your GP.

Social assistance

The program recognises the benefits of social inclusion in supporting good health.

In some circumstances your GP may identify a need for help with social activities. This help would generally be short-term (up to 12 weeks) and would encourage and help you to participate in community activities through local clubs and associations.
Jack’s story*

Jack – age 70
- Gold Card veteran
- Diabetes
- Hypertension
- Congestive heart failure
- Forgets medications
- Poor diet
- Has been hospitalised twice within the last 6 months

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

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

The GP conducts an eligibility assessment.

The GP explains that Jack, the practice nurse and the GP are now a care team working together to improve Jack’s health.

The GP or practice nurse schedules an appointment for Jack at the surgery, or visits Jack at home to talk about how he is coping with his conditions and how they affect his daily life.

The GP or practice nurse develops the Care Plan for Jack.

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

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

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

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

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

Jack stays on the program and enjoys being healthier and happier.

Where can I find more information?
Call 133 254
Email cvcprogram@dva.gov.au

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