Notes for community nursing providers

Effective February 2019
# Contents

1. **Introduction** ................................................................................................................. 7

1.1 SERVICES AND PAYMENTS ......................................................................................... 7

1.1.1 Changes to service delivery areas or sites ................................................................. 7

1.1.2 Subcontracting ............................................................................................................. 8

1.2 PROVIDER NUMBER/S ................................................................................................. 8

1.3 ACCESS TO THE NOTES .............................................................................................. 8

1.4 CONTACTING DVA ....................................................................................................... 9

1.5 COMPLAINTS MECHANISM ......................................................................................... 9

2. **Aims of the Community Nursing Program** .................................................................. 9

2.1 DVA HEALTH SERVICES ........................................................................................... 9

2.2 DVA COMMUNITY NURSING PROGRAM ................................................................... 9

2.3 OUT OF SCOPE/EXCLUSIONS ..................................................................................... 9

3. **Accessing the Community Nursing Program** .............................................................. 11

3.1 ELIGIBILITY ................................................................................................................. 11

3.1.1 White Card ............................................................................................................... 12

3.1.2 Orange Card ............................................................................................................. 12

3.1.3 Entitled persons without a DVA Health Card ............................................................ 12

3.2 REFERRALS ................................................................................................................ 13

3.2.1 Nearest suitable provider ........................................................................................ 13

3.2.2 Ongoing referral ........................................................................................................ 14

3.2.3 Written referral ......................................................................................................... 14

3.2.4 Verbal referral .......................................................................................................... 14

3.2.5 Informal enquiry ....................................................................................................... 14

3.2.6 Acceptance of a referral ........................................................................................... 14

3.3 TRANSFER OF AN ENTITLED PERSON .................................................................... 15

3.4 INFORMED CONSENT ............................................................................................... 15

3.5 DATE OF ADMISSION ................................................................................................. 15

4. **Care environment** ...................................................................................................... 16

5. **Personnel** .................................................................................................................. 17

5.1 REGISTERED AND ENROLLED NURSES ................................................................. 17

5.2 NURSING SUPPORT STAFF (NSS) ........................................................................... 17

5.3 QUALIFICATIONS AND COMPETENCIES ................................................................ 17

5.3.1 Registered Nurses (RN) and Enrolled Nurses (EN) .................................................. 17

5.3.2 Nursing Support Staff (NSS) ................................................................................... 18

5.3.3 First Aid and CPR requirements .............................................................................. 18

5.3.4 Delegation of care .................................................................................................... 18

5.3.5 Continuing education for personnel ......................................................................... 19

6. **Assessment** ................................................................................................................. 20

6.1 REGISTERED NURSE ASSESSMENT ......................................................................... 20

6.2 PERSONAL CARE ASSESSMENT ................................................................................. 20

7. **Classification** .............................................................................................................. 22

7.1 MAJORITY OF CARE PRINCIPLE ................................................................................. 22

7.2 COMBINATIONS OF CARE ........................................................................................ 22

7.3 CLINICAL CARE SCHEDULE ....................................................................................... 22

7.3.1 Clinical Support ....................................................................................................... 23

7.3.2 Clinical (Short or Long) ........................................................................................... 24

7.3.3 Post-operative eye drops .......................................................................................... 24

7.4 PERSONAL CARE SCHEDULE .................................................................................... 25

7.4.1 Personal Care – Mix of visit lengths ........................................................................ 25

7.4.2 Assistance with Medication .................................................................................... 25

7.4.3 Personal Care – What can be included and out of scope care .................................. 26
7.5 **THREE TIMES DAILY (TDS) VISITS** ............................................................................ 27
7.6 **OTHER ITEMS SCHEDULE** .................................................................................... 27
   7.6.1 **Assessment** ........................................................................................................ 28
   7.6.2 **Palliative Care** .................................................................................................. 28
   7.6.3 **Overnight Nursing Care** ................................................................................... 30
   7.6.4 **More than one worker assisting per visit (Second Worker)** ............................... 31
7.7 **NURSING CONSUMABLES** ..................................................................................... 31
   7.7.1 **Bereavement Follow-up** .................................................................................... 31

8 **Review of care** .......................................................................................................... 36
   8.1 **7 DAY REVIEW** .................................................................................................... 36
   8.2 **28 DAY REVIEW** ................................................................................................. 36
      8.2.1 **Personnel undertaking review** ....................................................................... 36
   8.3 **3 MONTHLY REVIEW** ......................................................................................... 36
   8.4 **COMMUNICATION WITH LMO OR GP** ............................................................. 37
   8.5 **REVIEW OF CARE SUMMARY** ......................................................................... 38

9 **Discharge from community nursing services** ............................................................ 39
   9.1 **ABSENCES FOR 28 DAYS OR LESS** ................................................................. 39
   9.2 **READMISSION AFTER DISCHARGE** .................................................................. 39

10 **Policies and care documentation** ............................................................................. 40
    10.1 **CLINICAL AND ADMINISTRATIVE POLICIES** ................................................ 40
    10.2 **CARE DOCUMENTATION** ................................................................................ 40
    10.3 **PRIVACY, DOCUMENTATION AND RECORD KEEPING** ................................ 40
    10.4 **DVA’S RIGHT TO ACCESS RECORDS AND PREMISES** ................................... 41
    10.5 **REFUSAL OF SERVICES** ..................................................................................... 41
    10.6 **ENTITLED PERSON NOT RESPONDING** ........................................................... 42
    10.7 **RIGHTS OF CARERS** ........................................................................................ 43

11 **Claiming** .................................................................................................................. 44
   11.1 **28-DAY CLAIM PERIOD** .................................................................................... 44
      11.1.1 **Changes in care needs during the 28-day claim period** ................................. 44
      11.1.2 **Two providers in a 28-day claim period** ....................................................... 44
   11.2 **MINIMUM DATA SET AND MULTIPLE ITEM NUMBERS** ................................. 45
   11.3 **GOODS AND SERVICES TAX (GST)** ............................................................... 45
   11.4 **TIMEFRAME FOR CLAIMING** .......................................................................... 45
   11.5 **SUBMITTING A CLAIM FOR PAYMENT** ............................................................ 45
   11.6 **RETENTION OF CLAIMS** ................................................................................... 46
   11.7 **PAYMENT METHOD** .......................................................................................... 46
   11.8 **QUERIES ABOUT CLAIMS** ................................................................................. 46
   11.9 **UNSUCCESSFUL CLAIM/S FOR PAYMENT** ....................................................... 46
   11.10 **RESUBMITTING A CLAIM/S FOR PAYMENT** .................................................. 46
   11.11 **ADJUSTMENTS TO A CLAIM/S FOR PAYMENT** ............................................ 46
   11.12 **INCORRECT PAYMENT/S** ............................................................................... 46
   11.13 **INAPPROPRIATE CLAIMING** ............................................................................ 47
   11.14 **RECOVERY OF OVERPAYMENTS** .................................................................. 48

12 **Continuous Improvement, Innovation and the DVA Quality Framework** .............. 49
   12.1 **CONTINUOUS IMPROVEMENT AND INNOVATION** ....................................... 49
   12.2 **PERFORMANCE MONITORING AND THE QUALITY FRAMEWORK (QF)** ....... 49
   12.3 **QF STRUCTURE** ................................................................................................ 49
   12.4 **RECOGNITION OF ACCREDITATION** ................................................................. 50

13 **Interaction with other health and community support service providers** ........... 51
   13.1 **VETERANS’ HOME CARE (VHC) PROGRAM** .................................................. 51
      13.1.1 **Short term clinical intervention** ................................................................. 51
   13.2 **REHABILITATION APPLIANCES PROGRAM (RAP)** ......................................... 52
   13.3 **DVA-CONTRACTED DIABETES EDUCATORS** ................................................... 52
13.4 OPEN ARMS - VETERANS AND FAMILIES COUNSELLING (FORMERLY VVCS) .......................... 52
13.5 HOME CARE PACKAGES PROGRAM ................................................................. 53
  13.5.1 Home Care Level 1 and Level 2 packages ......................................................... 54
  13.5.2 Clinical Nursing services ..................................................................................... 54
  13.5.3 Personal Care services ......................................................................................... 54
  13.5.4 Clinical Nursing and Personal Care services ....................................................... 54
  13.5.5 Cessation of clinical nursing services ................................................................. 54
  13.5.6 Home Care Level 3 and Level 4 packages ........................................................... 55
  13.5.7 Commonwealth Home Support programme ....................................................... 55
  13.5.8 Transition Care .................................................................................................... 56
  13.5.9 Short-Term Restorative Care ............................................................................... 56
  13.5.10 State or local based community services ............................................................ 56
  13.5.11 Communication with community support services ............................................. 57

Attachment A - Exceptional Case process ................................................................. 58
  1 Exceptional Case Unit ............................................................................................... 58
    1.1 POTENTIAL EXCEPTIONAL CASE STATUS ......................................................... 58
       1.1.1 Clinical Care ................................................................................................. 59
       1.1.2 Personal Care ............................................................................................... 59
       1.1.3 Combination of Care ..................................................................................... 59
    1.2 ECU FORMS ...................................................................................................... 59
       1.2.1 Timeframes for submitting ECU Forms ........................................................... 60
       1.2.2 ECU Form/Documentation Requirements ...................................................... 60
       1.2.3 Submitting ECU Forms .................................................................................. 61
    1.3 APPLICATION ASSESSMENT ............................................................................. 61
       1.3.1 Application approved .................................................................................... 61
       1.3.2 Acceptance or rejection of an approval ............................................................ 62
       1.3.3 Application not approved .............................................................................. 62
    1.4 NOTIFICATION OF INTERRUPTION TO CARE .................................................. 62
    1.5 VARIATION ....................................................................................................... 63

2 Appeals process ................................................................................................. 64
  2.1 CLINICAL REVIEW ............................................................................................... 64
  2.2 OUTCOME OF APPEAL ..................................................................................... 64

3 Other ECU Items............................................................................................... 65
  3.1 NURSING CONSUMABLES EXCEEDING $1,000 ............................................... 65

Attachment B – Additional Travel ................................................................. 66
  1.1 NEAREST SUITABLE PROVIDER ................................................................. 66
  1.2 SITUATIONS WHERE TRAVEL MAY BE CLAIMED ........................................ 66
  1.3 CLAIMING FOR TRAVEL .............................................................................. 67
  1.4 CLAIMING ....................................................................................................... 67

Attachment C - Palliative Care Phases ............................................................... 68
  1 Palliative Care ..................................................................................................... 68
     1.1 PHASE 1: STABLE ......................................................................................... 68
     1.2 PHASE 2: UNSTABLE ............................................................................... 68
     1.3 PHASE 3: DETERIORATING ................................................................. 68
     1.4 PHASE 4: TERMINAL ............................................................................ 69
     1.5 PHASE 5: BEREAVED ........................................................................ 69
     1.6 PSYCHOSOCIAL ASPECTS OF NURSING CARE IN THE PALLIATIVE PHASES 70

Attachment D –Nursing Consumables ............................................................... 71
  1 Overview ........................................................................................................... 71
     1.1 REPATRIATION PHARMACEUTICAL BENEFITS SCHEME ............................ 71
     1.2 REHABILITATION APPLIANCES PROGRAM ............................................ 71
     1.3 CLAIMING FOR CONSUMABLES $1,000 AND UNDER ................................. 71
1.4 CLAIMING FOR NURSING CONSUMABLES EXCEEDING $1,000........................................... 71
1.5 CLAIMING RULES................................................................................................. 72
1.6 NURSE’S TOOLBOX............................................................................................... 72

Attachment E – Community Nursing and the Coordinated Veterans’ Care Program........................................... 73

1 Overview .................................................................................................................... 73
1.1 COMMUNITY CARE COMPONENT................................................................. 73
1.2 CVC PROGRAM SERVICE PARTNERS...................................................... 73

2 Referral ....................................................................................................................... 74

3 Care Coordination ..................................................................................................... 74

4 Payments ..................................................................................................................... 81

Attachment F – Submitting Minimum Data Set (MDS)...................................................... 83

1 DVA Community Nursing MDS .................................................................................. 83

NOTES FOR COMMUNITY NURSING PROVIDERS
EFFECTIVE JANUARY 2019

5
1 Introduction

*The Notes for community nursing providers* (Notes) is Annexure A to the Terms and Conditions.

These Notes form part of a legally binding Agreement setting out the conditions and accountability requirements under which community nursing (CN) providers may provide services to entitled persons under DVA’s health care arrangements. The CN provider and all personnel delivering community nursing services to entitled persons must read, understand and comply with the Notes, and are non-negotiable.

The DVA Community Nursing Schedule of Fees (Schedule of Fees) are Annexure B to the Terms and Conditions. The set fees within the Schedule of Fees compensate a CN provider for the costs associated with the provision of community nursing services during a 28-day claim period. The cost components covered by the fees for the provision of community nursing services are:

- face-to-face time;
- travel time;
- general time;
- labour on-costs;
- overheads;
- profit margin; and
- ‘nurse’s toolbox’ consumables.

DVA has a commitment to innovation and continuous improvement of its activities and consults with a broad range of organisations within the community nursing industry.

To remain contemporary with changes in the community nursing industry the Notes may be amended from time to time. DVA will update amendments on AusTender and the DVA website: [www.dva.gov.au/providers/community-nursing](http://www.dva.gov.au/providers/community-nursing).

1.1 Services and Payments

DVA will only pay for community nursing services delivered to a DVA Health Card (Gold or White) holder (entitled person) by an approved CN provider. There may be occasions where a CN provider will be asked to provide services to an entitled person without Health Card Eligibility. See section 3.1.3 *Entitled Persons without a DVA Health Card* for more information.

1.1.1 Changes to service delivery areas or sites

A CN provider will supply DVA with information related to changes to service delivery areas or sites within a reasonable timeframe. This is considered part of administrative information required by DVA. See clause 12 *Provision and Disclosure of Provider Information* in the Terms and Conditions for more information.
1.1.2 Subcontracting
CN providers intending to utilise the services of subcontractors are required to:

- notify DVA by completing the subcontracting template within 14 days in the event of any subcontractor being used in performing community nursing services for entitled persons, the template can be found at https://www.dva.gov.au/sites/default/files/files/providers/cn/cnsubtemp.docx
- identify subcontractors by providing their legal name, ABN, ACN and registered or principal place of business;
- allow DVA to view and authorise the terms of any subcontract as requested;
- ensure that subcontractors employ suitably qualified personnel to deliver the services;
- ensure that subcontractors have access to the Notes and any other DVA material required for them to deliver services;
- inform subcontractors about obligations outlined in the Agreement with DVA. In providing services, subcontracted service providers are expected to be made aware of and comply with the DVA Service Charter and Australian Public Service Values;
- ensure the continuing suitability of subcontractors, including compliance with law generally and anti-discrimination laws;
- ensure that no subcontract restricts DVA’s legal rights; and
- appropriately pay or reward subcontractors under any relevant subcontract, including accounting properly for all tax-related issues.

1.2 Provider number/s
DVA allocates CN providers with a provider number/s for claiming and monitoring purposes. Generally provider number/s are allocated as follows:

- one provider number will be allocated if all services are delivered within the same State or Territory; or
- a provider number will be allocated for each State or Territory if services are delivered in multiple States or Territories.

Organisations requiring additional provider numbers for specific sites for organisational business purposes are requested to email the DVA contract manager at NMBCN@dva.gov.au.

1.3 Access to the Notes
A CN provider must ensure that all of its personnel and subcontractors delivering community nursing services to entitled persons have access to, and a working knowledge of, the current Notes, including any amendments made to the Notes over time.
1.4 Contacting DVA
A CN provider can contact DVA on the following telephone numbers:
- 1300 550 466 - Community Nursing;
- 1800 550 457 - Provider Enquiry Number

Once connected, you will be transferred to the appropriate team member.

Written enquiries can be emailed to:
For general interpretation/clarification of program policies contained in these Notes: CMBNURPRO@dva.gov.au
For matters relating to contract management issues: NMBCN@dva.gov.au
For requests relating to advertisements, see section 3.2 Referrals: CMBPHPROPART@dva.gov.au.

Information on the DVA Community Nursing program can be located online at: https://www.dva.gov.au/providers/community-nursing.

1.5 Complaints mechanism
The DVA Community Nursing program includes a complaints mechanism. A CN provider can make a complaint about any aspect of the DVA Community Nursing program by emailing: CMBNURPRO@dva.gov.au.gov.au.

DVA will inform the CN provider of the outcome of the complaint.

2 Aims of the Community Nursing Program

2.1 DVA health services
DVA provides entitled persons with access to a range of quality health care and related services, including community nursing services, at DVA’s expense.

Information on all of DVA’s services, including the DVA Community Nursing program, can be found online: www.dva.gov.au/.

2.2 DVA Community Nursing Program
The aim of DVA’s Community Nursing program is to enhance the independence and health outcomes of an entitled person by avoiding early admission to hospital and/or residential care by providing access to community nursing services to meet an entitled person’s assessed clinical and/or personal care needs.

These community nursing services are delivered by a skills mix of registered nurses (RN), enrolled nurses (EN) and nursing support staff (NSS).

2.3 Out of scope/Exclusions
The Community Nursing program does not fully fund entitled persons living in Private Aged Care communities where the CN providers offer an
entitled person a consumer directed care type model approach. CN providers operating under this model of care are required to contact DVA to establish how services should be claimed prior to commencing care for an entitled person.
3 Accessing the Community Nursing Program

3.1 Eligibility
An entitled person is a person who DVA has issued a:
- DVA Health Card — All Conditions within Australia, or Totally &
  Permanently Incapacitated (TPI) (Gold Card); or
- DVA Health Card — For Specific Conditions (White Card).

In the majority of cases, to be eligible to receive community nursing services for an assessed clinical and/or personal care need, an entitled person must hold either a Gold Card or a White Card.

There may be instances where an entitled person is approved for community nursing services but they are not eligible for a DVA Health Card. See section 3.1.3 Entitled persons without a DVA Health Card for more information.

Gold Card
The Gold Card is gold in colour and includes the words: “DVA Health Card – All Conditions within Australia”

A Gold Card enables an entitled person to receive health care and related services to meet all of their assessed clinical and/or personal care needs, regardless of whether they are war or service related.
3.1.1 White Card
The White Card is white in colour and includes the words “DVA Health Card – Specific Conditions”.

For all White Card holders, the CN provider must contact DVA to determine eligibility to receive community nursing services for an assessed clinical and/or personal care need prior to the commencement of community nursing services. See section 1.4 Contacting DVA.

3.1.2 Orange Card
The Orange Card is orange in colour and includes the words “DVA Health Card – Pharmaceuticals Only”.

The Orange Card is for use only for pharmaceuticals and wound dressings through the Repatriation Pharmaceutical Benefits Scheme (RPBS) for Commonwealth and allied veterans and mariners.

It cannot be used to access any DVA community nursing services.

3.1.3 Entitled persons without a DVA Health Card
In some cases, a CN provider may be required to provide care to an entitled person with multiple or complex needs and who does not have a DVA Health Card.

Before services are put in place, the Department will contact a CN provider with prior approval. This will be in the form of a formal letter outlining the services required for that entitled person and agreed method of payment.

If a CN provider has any concerns, they should contact DVA. See section 1.4 Contacting DVA.
3.2 Referrals

A CN provider cannot deliver community nursing services to an entitled person without a valid referral from an authorised referral source.

A referral for an entitled person must be received from one of the following five authorised referral sources:

- Local Medical Officer (LMO) or other General Practitioner (GP);
- Treating doctor in a hospital;
- Hospital discharge planner;
- Nurse Practitioner specialising in a Community Nursing field; or
- Veterans’ Home Care (VHC) Assessment Agency.

Note: the Department considers the entitled person’s LMO/GP as the case manager.

If DVA establishes that a CN provider has given or offered financial or other inducement to any authorised referral source to generate referrals, it may terminate its Agreement with the CN provider and take any further action available under the Terms and Conditions of the Agreement.

As such, a CN Provider cannot:

- Represent itself in any way as a DVA preferred provider; or
- Refer to DVA in any of its advertisements without obtaining prior written permission from DVA via email to CMBPHPROPART@dva.gov.au. The email should include a copy of the proposed advertisement. Even with written permission, the CN Provider may only state that it can deliver community nursing services to entitled persons.

3.2.1 Nearest suitable provider

An authorised referral source should refer an entitled person to the nearest suitable CN provider, i.e. the CN provider nearest to an entitled person’s place of residence. The nearest suitable provider can be identified from the panel located on the DVA link below:


The panel is arranged by Service Delivery Areas and Local Government Areas for each State and Territory.

In special circumstances the nearest suitable provider may not be the closest geographic provider, for example the entitled person may require specialist care such as palliative care. In this case the nearest suitable CN provider is the nearest available provider that offers the required specialised nursing care. A CN provider who is not the nearest provider must contact DVA for clarification.
3.2.2 Ongoing referral
A valid referral is ongoing through the entitled person's episode of care, from admission to discharge. A new referral from the LMO or GP will be required if an entitled person is transferred to another CN provider or discharged.

3.2.3 Written referral
The authorised referral source should provide a written referral for the entitled person. The written referral should be on one of the following:
- DVA's Request/Referral Voucher (D0904 form);
- the referral source's official letterhead; or
- CN provider's official referral form.

The written referral must include the referral source’s provider number. For a written referral from a discharge planner or treating doctor in a hospital, the hospital's provider number must be used.

3.2.4 Verbal referral
A CN provider may receive a verbal referral for an entitled person from an authorised referral source. A verbal referral can be accepted and community nursing services commenced to an entitled person as long as a written referral is received from the authorised referral source within 7 days.

CN providers should use the verbal referral date as the date of referral for the entitled person when making a claim for payment. The processes to make a claim for payment are outlined in section 11 Claiming.

3.2.5 Informal enquiry
An informal enquiry may be received from a number of sources, such as a verbal enquiry from an entitled person, a family member or a concerned neighbour.

If an informal enquiry is received, the CN provider must advise the person to contact the entitled person’s LMO or GP to obtain a written referral. In this case, the written referral should be received prior to commencing community nursing services.

3.2.6 Acceptance of a referral
A CN provider cannot pick and choose the entitled persons to whom they deliver community nursing services. The economic viability of caring for an entitled person is not a criterion for refusing a referral.

A CN provider should accept a referral for an entitled person from an authorised referral source, including the transfer of an entitled person.

A referral cannot be refused by a CN provider without first notifying DVA and indicating the reasons for refusal. DVA will determine if the referral can be refused.
3.3 Transfer of an entitled person
A CN provider cannot transfer an entitled person to another CN provider once services have commenced unless approval is granted by DVA.

An agreed transfer plan must be in place before any transfer - including agreed wording and approach for notification to the entitled person. The CN provider is required to support a smooth transfer without disruption to an entitled person.

A new referral from the LMO or GP will be required if an entitled person is transferred to another CN provider.

3.4 Informed consent
A CN provider must obtain written informed consent from the entitled person before commencing community nursing services. If the entitled person is unable to sign their consent, a person who is legally authorised to give substitute consent to treatment under State law (e.g. The Public Trustee, Guardian, a holder of an appropriate Enduring/Special Power of Attorney, etc.) may sign on their behalf.

To ensure the entitled person has enough information to make an informed choice about the proposed community nursing services, the CN provider must inform them of:

- the proposed community nursing services to be delivered in written format, and supported by a verbal explanation;
- their rights and responsibilities as the entitled person;
- the role of the CN provider’s personnel, and that different personnel may be providing community nursing services, as clinically appropriate;
- the possibility that the CN provider’s personnel may be required to disclose personal information about them to other health providers, as clinically appropriate, and in some instances without seeking the entitled person’s consent prior to the disclosure;
- the right of DVA, or any person or organisation authorised by DVA, to access all of the records held by the CN provider, including their care documentation; and
- the process for providing feedback or making a complaint about the community nursing services that they receive.

3.5 Date of admission
The date of admission is the first face-to-face contact visit between a CN provider’s personnel and the entitled person. This first face-to-face contact visit must be undertaken by an RN and take place in the entitled person’s place of residence.
4 Care environment

A CN provider must:

- deliver all community nursing services in a 28-day claim period to an entitled person in their place of residence and in accordance with the care plan;
- deliver community nursing services in line with industry recognised evidence based best practice and community nursing industry standards;
- provide, at a minimum, a contact for an entitled person for emergency purposes 24 hours a day, 7 days a week;
- deliver community nursing services in an environment that promotes dignity, integrity and a respect for cultural and linguistic diversity and social differences; and
- assist an entitled person to develop, increase or maintain their independence, health and well-being.

A CN provider cannot deliver community nursing services, to an entitled person in any of the following locations:

- an acute facility (including hospital in the home programs);
- a residential aged care facility;
- a multi-purpose centre;
- a community centre; and/or
- a clinic in any location.

If an entitled person chooses to access, or a CN provider chooses to deliver, services in a facility or clinic other than the entitled person’s place of residence then the CN provider cannot claim for payment for these services from DVA, unless prior approval is granted in extraordinary circumstances.
5 Personnel
A CN provider may use a mix of personnel to deliver community nursing services. These personnel include:
- Registered Nurse (RN);
- Enrolled Nurse (EN); and
- Nursing Support Staff (NSS)

When delivering community nursing services, all personnel must work within the framework of the relevant national standards and meet all State and Commonwealth statutory requirements.

CN providers must maintain current registration and continuing education documentation for all their personnel, and ensure that all personnel and sub-contractors who have access to entitled persons have had a national police check within the last three years.

5.1 Registered and Enrolled Nurses
The national standards developed by the Nursing and Midwifery Board of Australia (NMBA) provide the framework for professional nursing practice in Australia.

All community nursing services delivered by RNs and ENs must be in accordance with the national standards. Information on the national standards for RNs and ENs can be accessed online through the ‘Profession Codes and Guidelines’ tab, at:

5.2 Nursing Support Staff (NSS)
The Community Services Training Package developed by the Community Services and Health Industry Skills Council forms the training and assessment framework for the certification of NSS.

All community nursing services provided by NSS must be in accordance with the relevant standards and qualifications set out in the Community Services Training Package.

Information on the Community Services Training Package can be accessed online at: https://training.gov.au/Training/Details/CHC

5.3 Qualifications and competencies
5.3.1 Registered Nurses (RN) and Enrolled Nurses (EN)
The minimum required qualifications and experience for an RN delivering community nursing services to an entitled person are:
- National Registration; and
- having practiced as an RN or EN within the last three years; or
- completion of a recognised refresher course in the last three years, and
- manual handling; and
• Cardiopulmonary Resuscitation (CPR).
The minimum required competencies for an EN include:
• manual handling competency; and
• Cardiopulmonary Resuscitation (CPR).

These competencies must be maintained annually and recorded in personnel files.

5.3.2 Nursing Support Staff (NSS)
The minimum required qualifications and experience for NSS delivering community nursing services to an entitled person are:
• a Certificate III in Home and Community Care, Aged Care or Disability (pre December 2015); or Certificate III in Individual Support (post December 2015); and
• experience working in a NSS role in the last five years; and
• manual handling competency; and
• Cardiopulmonary Resuscitation (CPR) and
• a current Applied First Aid certificate (refer below).

These competencies must be maintained annually recorded in personnel files.

5.3.3 First Aid and CPR requirements
Personnel’s First Aid certificates must be:
• current;
• from a registered training organisation; and
• the CPR component of the First Aid certificate must be maintained on an annual basis through a recognised training organisation. Refer to the Australian Resuscitation Council link: http://resus.org.au/.

5.3.4 Delegation of care
A CN provider must ensure that all community nursing services delivered by an EN and/or NSS are planned, delegated, supervised and documented by an RN. All delegated care must be appropriately documented in clinical records and kept on the entitled person’s file.

The RN must recognise the differences in accountability and responsibility between RNs, ENs and unlicensed care workers (i.e. NSS). An RN must delegate aspects of care to others according to their competence and scope of practice. This includes:
• delegation of aspects of care according to role, functions, capabilities and learning needs;
• monitoring aspects of care delegated to others and provides clarification/assistance as required;
• recognising own accountabilities and responsibilities when delegating aspects of care to others; and
• delegation to and supervision of others consistent with legislation and organisational policy.
More information on the delegation of care can be found in the Registered nurse standards for practice:

5.3.5 Continuing education for personnel
The CN provider must ensure its personnel have access to, and undertake, appropriate continuing education and professional development, particularly in relation to the provision of community nursing services, on a regular and ongoing basis.

The CN provider must maintain current education and professional development records for all its personnel. This is in line with the Australian Health Practitioner Regulation Agency (AHPRA) Standards for Nursing. More information can be found at the following link: www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.
6 Assessment
After receiving a referral from an authorised referral source, on a 12 month anniversary (if there has been 13 consecutive 28-day claim periods), or with a transfer from another CN provider, an RN must assess/review the clinical and/or personal care need/s of an entitled person through a comprehensive assessment prior to commencing the provision of community nursing services. The outcomes of each comprehensive assessment must be recorded on a new care plan and communicated to entitled person’s LMO or GP.

A comprehensive assessment includes the use of validated assessment tools based on current community nursing industry best practice standards. Where an assessment is undertaken and no ongoing care needs are identified, the CN provider must use the Assessment only – no ongoing services item number (NA99) for claiming.

6.1 Registered Nurse Assessment
A comprehensive assessment must be undertaken by an RN who is required to identify and document within a care plan:

- the entitled person’s clinical and/or personal care need/s;
- the goal/s of care;
- the expected outcomes of care;
- the issues identified or the community nursing services required;
- the delegation of care;
- the agreed days and approximate timeframes that services will be provided; and
- a referral for the LMO/GP to arrange any other allied health service and/or referrals to other community service if required e.g. occupational therapist, delivered meals, etc.

Clinical nursing notes and assessment documentation must remain up-to-date and be based on current community nursing industry best practice standards.

The RN must report the outcomes of each comprehensive assessment to the original referral source and the entitled person’s GP if the GP was not the original referral source.

6.2 Personal Care Assessment
When an entitled person is assessed as requiring low level personal care services up to, and including, 1.5 hours per week and the entitled person does not have a clinical need for any other community nursing services, the personal care services should be provided through VHC program.

When an entitled person is assessed as requiring low level personal care services up to, and including, 1.5 hours per week and the entitled person has a clinical need for community nursing services, all of the personal care services required should be provided through the DVA Community Nursing program.
When an entitled person is assessed as requiring higher level personal care services (more than 1.5 hours per week), regardless of whether the entitled person also has a clinical need, the personal care services should be provided through the DVA Community Nursing program.
7 Classification
A CN provider must classify an entitled person under the appropriate Classification System.

The Classification System is based on:
- an episode of care model where a provider retrospectively claims for payment at the end of the 28-day claim period; and
- groupings of visit types and in three separate schedules:
  - Clinical Care;
  - Personal Care; and
  - Other Items.

Figure 7.1 on page 31 demonstrates some examples of core, opposing schedule and other items add-ons.

7.1 Majority of Care Principle
A CN provider will classify an entitled person into either the Clinical Care schedule or the Personal Care schedule, whichever is the core care requirement (majority of care principle).

Majority of care is generally based on visit count, although there are situations when time may represent the majority of care.

Where equal time and visits has been spent on personal and clinical care, the entitled person should be classified under the Clinical Care schedule.

7.2 Combinations of Care
The Classification System allows for combinations of care, for example:
- if the majority of care classification is from the Clinical Care schedule – a Personal Care Schedule add-on can also be claimed if personal care was delivered; or
- if the majority of care classification is from the Personal Care schedule – a Clinical Care schedule add-on can also be claimed if clinical care was delivered.

If any other community nursing services or nursing consumables are also provided, item numbers from the other items schedule may also be claimed.

7.3 Clinical Care Schedule
Clinical care is defined as the clinical nursing care required to treat medical conditions.

The goal of clinical care is to maintain the entitled person’s optimal health status through interventions that have a clinical purpose, including regular review of care needs to determine if improved outcomes have occurred. Clinical care must be delivered by RNs or ENs (based on their qualifications and experience).
DVA expects that once the goal/s of care has/have been achieved and the entitled person’s condition/situation is stable there will be a discharge plan implemented.

There are three classifications in the Clinical Care schedule. They are:
- Clinical Support;
- Clinical (Short or Long); and
- Post-Operative Eye Drops.

7.3.1 Clinical Support
The Clinical Support visit type is used when the entitled person requires no direct treatment for a medical condition, however, there are nursing interventions. These could include coordination, education and goal setting, monitoring and carer support, based on an identified clinical need that is definable and has expected health outcomes.

Clinical Support aims to prevent health complications and/or deterioration in health status by providing services such as:
- coordination of care between allied health and LMO or GP to ensure all required appropriate services and equipment are in place;
- education including clinical advice related to self-management of medical conditions (medication use, safety and falls risks, chronic disease management), goal setting, self-monitoring, risk management and early recognition of deterioration;
- monitoring of an unstable health condition requiring reporting to the LMO or GP (reportable levels from the LMO or GP must be obtained if performing short term Blood Glucose Levels (BGL) or Blood Pressure (BP) monitoring);
- support for the carer where carer stress has been identified until necessary support services have been implemented; and/or
- psychosocial/emotional support - identification of mental health symptoms or developing cognitive impairment issues requiring referral to LMO, GP or other relevant and appropriate services.

The Clinical Support visit type is not to provide a check visit for an entitled person who is:
- stable in health (including has a stable BGL/BP);
- self-reporting (entitled person or carer able to contact/visit LMO or GP if issues arise); or
- independent.

If an entitled person is a participant of the Coordinated Veterans’ Care (CVC) Program, and a practice nurse is the care coordinator, CN providers must ensure there is no duplication of services.

If an entitled person is a CVC Program participant and care coordination is being delivered via a CN provider, Clinical Support cannot be claimed while the entitled person remains enrolled in the CVC Program.
Clinical Support is a short-term classification and can only be claimed for a maximum of 3 x 28-day claim periods per 6 months of continuous care.

7.3.2 Clinical (Short or Long)
There are 2 Visit Lengths in the Clinical visit type. An entitled person can be classified as:
- Clinical Short (20 minutes or less) with 9 categories of Visit Range, or
- Clinical Long (21 minutes or more) with 6 categories of Visit Range.

The Clinical item number must correspond with the Visit Length and the Visit Range (number of visits provided) in the 28-day claim period.

7.3.2.1 Mix of short and long visits
Where there is a mix of long and short visits provided in the 28-day claim period, the CN provider would calculate the total minutes of clinical care and divide this by the number of clinical care visits provided to determine the correct classification (Short or Long) to be claimed.

7.3.2.2 Medication Administration – Clinical Care
The entitled person must be classified under the Clinical Care Schedule and the care must be provided by an RN or EN with an approved qualification in administration of medications if the entitled person requires the administration of:
- prescribed medications (Schedule 4 and above);
- Schedule 8 drugs if dispensed from a bottle/packet, including Schedule 8 transdermal patches;
- cytotoxic drugs or creams;
- prescribed medicated eye drops (Schedule 4 and above); and/or
- prescribed creams.

7.3.2.3 Symptom Management
When an entitled person is referred to the Community Nursing program for Symptom Management for an unstable disease/condition they must be classified under the Clinical visit type (NL03 to NL17 in the schedule of fees) – not clinical support.

Symptom Management requires an LMO, GP or specialist to give a diagnosis, orders regarding a treatment plan and medication orders.

If an entitled person is stable in their condition/chronic disease or palliative care phase, they must be classified under Clinical Support with a plan to discharge.

7.3.3 Post-operative eye drops
This visit type is specifically for eye drop administration, prescribed by a specialist, following eye surgery. There must be 85 or more visits within the claim period to claim this item number.

The Post-Operative Eye Drops visit type:
- can be claimed only once per eye, for 1x28-day claim period per 365 days; and
- is based on a minimum of over 3 visits a day for the 28-day claim period.
Any prescribed eye drops of a continuous nature (i.e. longer than 1 x 28-day claim period) must be classified in the Clinical or Personal Care schedules, depending on the type of eye drops required and any other clinical and/or personal care intervention/s provided to the entitled person.

NSS cannot provide Post-Operative Eye Drops services but can be used to deliver personal care services, if this intervention is also required.

7.4 Personal Care Schedule
A CN provider will classify an entitled person into the Personal Care visit type when personal care is the core care requirement for community nursing services.

The goal of personal care is to support the clinical, health and wellbeing outcomes of an entitled person so that they can remain independently at home as long as possible.

Personnel used to deliver Personal Care services include RNs, ENs and NSS. However, the CN provider must ensure that all community nursing services delivered by ENs and NSS are planned with delegation and supervision, documented by an RN within the Care Plan, see section 5.3.4 Delegation of care.

An entitled person will be classified within the Personal Care schedule according to the Visit Range and, if applicable, the Visit Length. There are 3 Visit Lengths that apply to the Personal Care Schedule for number of visits over 35. The Visit Lengths are:
- Short - up to 30 minutes per visit;
- Medium - 31 to 45 minutes per visit; and
- Long - 46 minutes or more per visit.

7.4.1 Personal Care – Mix of visit lengths
It is possible that an entitled person may require a mix of Short, Medium and Long Personal Care Visit Lengths in a 28-day claim period.

Where there is a mix of Short, Medium and Long visits in a 28-day claim period, the CN provider calculates the total minutes of personal care provided and divides this by the number of personal care visits provided to determine the correct classification (Short, Medium or Long).

7.4.2 Assistance with Medication
An entitled person can be physically assisted with self-administered medication by NSS under the following criteria:
- the entitled person’s medical condition/s are stable; and
- there is an established medication regime; and
- there is a comprehensive care plan in place which includes medication contraindications (interactions and side-effects) and emergency contacts; and
there is a blister pack filled by a registered Pharmacist which meets the DVA Dose Administration Aid Service Procedure Manual; or
it is over-the-counter medication, or prescribed/non-prescribed cortisone cream; and

- the NSS;
  - has completed the required assistance with medication administration competencies; and
  - adheres to the relevant National and State Drug Acts; and
  - adheres to the CN provider's Medication Administration/Prompting Policy or Policies; and

- personnel adhere to the Delegation of Care principles (see section 5.3.4 Delegation of care), and any change in health status is reported immediately to the RN; and

- the RN (or an EN with an approved qualification in administration of medication) conducts a face-to-face visit and reviews the entitled person on a weekly basis if assistance with the self-administration of Schedule 8 drugs are involved, see section 8.1 7 day review.

If the entitled person does not fall within these criteria, they must be classified under the Clinical Care schedule, see section 7.3.1.3 Medication Administration – Clinical Care for more information.

**Note:** DVA does not support NSS assisting with the self-administration of cytotoxic drugs under any circumstances.

NSS can administer over-the-counter medication and apply prescribed or non-prescribed cortisone cream.

The CN provider must ensure that the assistance with self-administration of medication, and the administration of over-the-counter medications/creams, by an EN and/or NSS is planned, appropriately delegated, supervised and documented by an RN, see section 5.3.4 Delegation of Care.

The CN provider must also ensure that assistance with self-administration of medication meets the legislative requirements of the State or Territory where the services are delivered.

7.4.3 Personal Care – What can be included and out of scope care

Personal Care activities which support a person’s overall health, wellbeing and clinical outcomes can be included under Personal Care. For example, where a person requires assistance with meal preparation, cooking or assistance with eating to ensure that they meet their nutritional requirements to maintain their health; or where laundry or cleaning is required to ensure poor hygiene does not contribute to clinical deterioration. General domestic assistance which is not directly related to a person’s assessed clinical and health needs is out of scope for DVA’s community nursing program and
Schedule of Fees. Other specific activities that are out of scope for personal care include:

- transport; and
- companionship.

7.5 Three Times Daily (TDS) Visits
There are occasions where a client requires visits from a provider three times a day (TDS). Where a client required TDS visits, this can be claimed through the Schedule of Fees using the appropriate item number from the TDS item range.

Where the TDS visits are only required for part of a 28 day claim period and the client has once or twice daily visits for the remainder of the claim period, the appropriate item code from the personal or clinical care core schedule may be claimed.

TDS visits cannot be claimed on the same day as personal or clinical core care is provided.

Clinical and Personal add-on items cannot be claimed with TDS visits.

Other items may also be claimed as appropriate.

TDS is a composite fee weighted to take account of clinical and personal care that may be provided. The fee is designed to be utilised for clinical and personal care delivered TDS.

7.6 Other Items Schedule
The Classification System includes an Other Items schedule which is comprised of add-on options for the provision of other community nursing services.

Most of these Other Items classifications can be added onto a core Personal Care or Clinical Care core item number when a further combination of care or services are provided in the 28-day claim period.

The Other Items schedule classifications that can be claimed are:

- assessment (ongoing or non-ongoing);
- palliative care phases (stable, unstable, deteriorating, terminal);
- nursing consumables;
- bereavement follow-up (can only be claimed once);
- second worker;
- additional travel (see Attachment B Additional Travel); and
- palliative care – overnight nursing.

NB: Palliative Stable is the only palliative care add-on item that can be claimed with a PC Core Schedule item where there is no requirement for an add-on from the Clinical Care Schedule.
7.6.1 Assessment
This visit type is used to claim the initial comprehensive assessment undertaken by an RN of an entitled person with ongoing or non-ongoing care needs, and at every 12 month anniversary (if there has been 13 consecutive 28-day claim periods) for entitled persons with ongoing care needs.

If an entitled person has been discharged from the Community Nursing program, and there is a break in services for more than 1 x 28-day claim period, the Assessment item number can be claimed if the entitled person is readmitted to the program.

7.6.1.1 Ongoing community nursing services required
The Assessment classification for ongoing services can be claimed following the completion of a comprehensive assessment:

- once at the beginning of an episode of care; and
- after each 12 month period of ongoing care.

This classification can be claimed in conjunction with:

- core, TDS and add-on item numbers from the Clinical Care and/or Personal Care schedules; or
- item numbers from the Exceptional Case Schedule only when the Exceptional Case claim is at the beginning of the episode of care and not when an entitled person moves from the Schedule of Fees into the Exceptional Case subcategory within an existing 12 month assessment.

The CN provider must communicate the outcomes following any comprehensive assessment with an entitled person’s LMO or GP.

7.6.1.2 No ongoing community nursing services required
An Assessment where no ongoing community nursing services are required can be claimed only once per entitled person within 3 consecutive 28-day claim periods (84 days).

The CN provider must contact the entitled person’s LMO or GP to provide information on the outcome of the comprehensive assessment, including any requests for referrals to allied or other health service/s, if these are required.

If the entitled person requires a community support service, the CN provider must obtain the entitled person’s consent and refer the entitled person to the appropriate community support service for an assessment.

The only other item number that can be claimed in conjunction is Other Items – Additional Travel item number (if appropriate).

7.6.2 Palliative Care
Palliative care add-ons are used for an entitled person who has a diagnosis of a life-limiting illness and requires a palliative approach.
Palliative care focuses on the psychosocial aspects of the care for the entitled person and their family and/or carers and reflects the resulting increase in care required.

Clinical aspects of palliative care, such as symptom control, will be claimed under a core clinical care visit type. If an entitled person diagnosed with a life limiting illness requires only personal care services, these can be claimed under a core personal care visit type.

Examples of life-limiting illnesses include:
- metastatic cancers;
- local reoccurrence of cancer;
- end-stage organ failure, such as cardiac, renal or liver failure;
- end-stage dementia;
- acquired immunodeficiency syndrome; and
- neurodegenerative disorders such as Huntington’s Disease or Motor Neurone Disease.

Personnel used to deliver palliative care services include RNs or ENs, based on their qualifications and experience.

7.6.2.1 Palliative care phases
There are 4 Other Items - Palliative Care classifications which encompass the palliative care phases of:
- stable;
- unstable;
- deteriorating; and
- terminal.

For further details see Attachment C Palliative Care Phases.

7.6.2.2 Specialist Palliative Care Teams
DVA understands that the primary care team (the CN provider) usually provides the majority of the care under a palliative approach.

In general, a specialist palliative care team would not be directly involved in the ongoing care of entitled persons who have uncomplicated needs associated with a life-limiting illness.

Specialist palliative care teams may be required to provide ongoing or episodic care when the problems experienced are complex, or beyond the capabilities of the primary care team. This scenario may vary depending on the State or Territory which the CN provider operates.

If a CN provider has any concerns regarding palliative care, the CN provider or palliative care specialist should call the ECU on 1800 636 428.
7.6.2.3 Mix of Palliative phases
It is possible that an entitled person may move between two or more palliative care phases during a 28-day claim period.

The CN provider would claim the Palliative Care phase that reflects the majority of care (based on number of visits provided or time spent) in that 28-day claim period.

7.6.2.4 Palliative Care - claiming
Other Items – palliative care stable, unstable, deteriorating and terminal visit type item number can be claimed with the following:
- a Clinical Care Schedule item number (excluding Post-Operative Eye Drops); and
- a Personal Care Schedule item number (when there is an add-on from the opposing Clinical Care Schedule).

The Other Items - palliative care stable, is the only palliative care item number that can be claimed with a Personal Care Schedule item number (when there is no requirement for an add-on from the opposing Clinical Care Schedule).

The Other Items - palliative care terminal item number:
- can only be claimed once for an entitled person;
- can only be claimed after the death of an entitled person; and
- cannot be claimed with any another Other Items - palliative care phase.

7.6.3 Overnight Nursing Care
A CN provider may provide overnight care for an entitled person in a number of situations, including to provide palliative care, when overnight support is required following a hospital admission, or to support the primary carer.

Overnight care may be provided by an RN or EN where clinical care is required, or by a NSS where this is the appropriate level of care.

Overnight care may be classified as active or inactive. Active overnight care involves the provision of continuous active support throughout the night. The care provider (RN, EN or NSS) does not have a designated sleep time and provides assistance when required. Inactive overnight care occurs where overnight support is needed, but the care provider can sleep when not required to provide support.

Overnight nursing care should be claimed in the same 28 day claim period as other services provided to the entitled person.

Palliative care may be provided in the terminal palliative care phase of a client’s disease, where this care is required in the short term and the entitled person meets the criteria to receive overnight nursing care.

Overnight care may be provided when overnight care is required in the period following discharge from hospital.
An entitled person cannot access overnight respite care and overnight nursing care concurrently. Any overnight care that a respite worker would provide can be provided by the nurse, in addition to providing the clinical care. For example, the nurse will be able to attend to repositioning, toileting or mouth care as these form part of the clinical duties of end of life care.

7.6.4 More than one worker assisting per visit (Second Worker)
There may be situations where an entitled person requires more than one worker to assist the primary worker for some, or all, of the scheduled visits for community nursing care.

For example, over a 28-day claim period, an entitled person has the following care profile:
- Core care requirement - Personal Care - Medium 56 visits.
  (E.g. Non-weight bearing person - the personal care provided is comprised of the Primary Worker for 56 visits, who is assisted by a Second Worker for 28 of these visits for transfer and shower in AM.)

In these situations, a second worker add-on code may be claimed for the delivery of services where the care plan requires a second worker to provide services to an entitled person during the same visit for the same task.

To claim for the provision of second worker services, utilise the relevant add-on code from the schedule of fees.

7.7 Nursing Consumables
Nursing consumables items are claimed by CN providers to be reimbursed for products used (excluding items contained the nurse’s toolbox) during the provision of clinical care to an entitled person in a 28-day claim period.

There are nursing consumables item numbers available in the Schedule of Fees with a set dollar amount attributed to each item number. The CN provider would claim the Other Items - nursing consumables item number that is closest in value to the actual cost (excluding items contained the nurse’s toolbox) within the listed range for consumables provided to the entitled person in the 28-day claim period.

The CN provider must not include any nurse’s toolbox or GST component when calculating which nursing consumable item number to claim. Payments made to CN providers automatically add the GST component prior to payment.

For further information, including the Schedule of Fees, see Attachment D – Nursing Consumables.

7.7.1 Bereavement Follow-up
The Bereavement Follow-up add-on is used for visit/s to a bereaved family member or carer following the death of an entitled person who recently
received community nursing services. The entitled person must have been a current entitled person of the CN provider at the time of death.

The visit/s to the bereaved family member or carer should preferably not occur on the same day as the entitled person’s death, but can be made within three months of the date of death.

The goal of care is to assess the bereaved family member or carer and, if required, refer them for further bereavement counselling and support.

Personnel used for a Bereavement Follow-up visit must be an RN or EN, based on their qualifications and experience.

7.7.1.1 Bereavement Follow-up - Claiming
Bereavement Follow-up can only be claimed once the entitled person has died. The claim date for this item number must be the same start date as the final claim for payment regardless of when the bereavement visit/s actually occur.
### Figure 7.1: Core Schedule and potential add-ons

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Core Item</th>
<th>Opposing Schedule add-on</th>
<th>TDS</th>
<th>Potential Other Items Schedule add-ons if required</th>
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</thead>
<tbody>
<tr>
<td><strong>Personal Care</strong></td>
<td><strong>CORE</strong> Personal Care item number</td>
<td>ADD-ON from Opposing Schedule for Clinical Care</td>
<td>TDS</td>
<td>Assessment (NA02)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Bereavement Follow-up (NA03)</td>
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<td></td>
<td></td>
<td>Palliative Care Stages (NA04-NA07)</td>
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<td>Nursing Consumables (NC10 – NC70)</td>
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<td></td>
<td>Additional Travel (NA10)</td>
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<td>Palliative Care – Overnight Nursing</td>
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<td>CVC UP05 and UP06 (if applicable)</td>
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<td>Second Worker</td>
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<tr>
<td><strong>Clinical Care</strong></td>
<td><strong>CORE</strong> Clinical Care item number</td>
<td>ADD-ON from Opposing Schedule for Personal Care</td>
<td>TDS</td>
<td>Assessment (NA02)</td>
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<td></td>
<td>Bereavement Follow-up (NA03)</td>
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<td>Palliative Care – Overnight Nursing</td>
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<td></td>
<td>CVC UP05 and UP06 (exception – where NL01 or NL02 have been claimed)</td>
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<td>Assessment (NA02 – only first 28-day claim period)</td>
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<td>Bereavement Follow-up (NA03)</td>
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<td>Palliative Care – Overnight Nursing</td>
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Figure 7.2 - Common Community Nursing Activities by Interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Clinical nursing activities</th>
<th>Clinical Support activities</th>
<th>Personal care activities</th>
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<tbody>
<tr>
<td>Hygiene</td>
<td></td>
<td></td>
<td>Shower/sponge/bath</td>
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<td></td>
<td></td>
<td></td>
<td>Dress/groom</td>
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<tr>
<td>Mobility</td>
<td></td>
<td></td>
<td>Transferring</td>
</tr>
<tr>
<td>Output</td>
<td>Lymphoedema (if undertaken by an RN with a qualification from a recognised lymphoedema course)</td>
<td></td>
<td>Observation and/or assistance with toileting and/or showering</td>
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<tr>
<td></td>
<td>Peritoneal dialysis</td>
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<td></td>
<td>Bowel management</td>
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<td></td>
<td>Enema ordered by LMO/GP/Specialist</td>
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<td></td>
<td>Bladder care</td>
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<tr>
<td></td>
<td>Suppository/ microenemas</td>
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<td></td>
<td>Venipuncture</td>
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<td></td>
<td>Urinary catheter insertion</td>
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<td></td>
<td>Urinary stoma care</td>
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<td>Flip flow valve change</td>
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<td></td>
<td>Nephrostomy care</td>
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<td>Stoma therapist visit</td>
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<td>Stoma assistance where entitled person unable to maintain responsibility for care</td>
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<td>Perineal care</td>
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<td>Input</td>
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<td>Naso gastric/lavage feeding</td>
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<td></td>
<td>Parenteral feeding/PEG feeds</td>
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<td></td>
<td>Central/peripheral venous device management/IV therapy &amp; line management</td>
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<tr>
<td>Aids/ Appliances</td>
<td>Fitting aids &amp; appliances e.g. splints, callipers, compression garments/stockings</td>
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<tr>
<td>Respiratory Care</td>
<td>Tracheostomy care</td>
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<td>Assist with self-care administration of oxygen</td>
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<td>Oxygen/inhalation therapy</td>
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<tr>
<td>Intervention</td>
<td>Clinical nursing activities</td>
<td>Clinical Support activities</td>
<td>Personal care activities</td>
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<tr>
<td><strong>Care Coordination</strong></td>
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<td>Care coordination</td>
<td>Reporting – delegation by RN/EN</td>
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<tr>
<td><strong>Wound Management</strong></td>
<td>Simple/Complex wound dressing</td>
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<td>Basic first aid treatment</td>
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<td>Pressure area care/prevention</td>
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<td>Ulcer care</td>
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<td>Wound assessments and clinical interventions</td>
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<td>Removal of sutures</td>
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<td>Central/peripheral venous device management</td>
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<td>Compression bandaging</td>
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<td><strong>Assessment &amp; Monitoring</strong></td>
<td></td>
<td>Comprehensive needs assessment</td>
<td>Maintenance of skin integrity</td>
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<td>Assessment</td>
<td>Assess/supply equipment needs</td>
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<td>Planning/review</td>
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<td>Support</td>
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<td>Monitor/surveillance</td>
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<td>Carer support</td>
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<td>Health</td>
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<td>education/teaching</td>
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<td>Vital signs/observations</td>
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<tr>
<td><strong>Medication</strong></td>
<td>Insulin injection</td>
<td>Short term assistance with self-management of vital signs/Blood glucose (BGL)</td>
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<tr>
<td>Cytotoxic Injection</td>
<td>Administration of optical/oral/rectal/vaginal/aural/ IMI/ IV/ SC medication</td>
<td>Management/Education for self-administration of medications</td>
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<tr>
<td>Syringe driver/pump management</td>
<td></td>
<td>Prompting self-management of medication from a DAA (Dose Administration Aid)</td>
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<tr>
<td>Application of Cytotoxic creams</td>
<td></td>
<td>Non-prescribed eye drops/ointment Eye toilet</td>
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<tr>
<td>Application of prescribed topical medication (other than cortisone cream)</td>
<td></td>
<td>Assist self-administration of medication</td>
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<tr>
<td>Compliance problems</td>
<td>Application of non-prescribed skin cream or lotion Application of cortisone cream (either prescribed or non-prescribed)</td>
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</tbody>
</table>
8 **Review of care**

The CN provider must conduct a review of the care needs of an entitled person, as a minimum, at the following times throughout the entitled person’s episode of care. Each review *must* be recorded in the entitled person’s documentation, even where the care continues unchanged, and will include the reviewer’s name, signature, designation and date.

8.1 **7 day review**

An entitled person classified in the Personal Care Schedule who requires assistance with self-administered medication of Schedule 8 drugs from a Dose Administration Aid, must be reviewed by an RN (or an EN with an approved qualification in administration of medicines) at the end of every 7 days.

All entitled persons with Exceptional Case status for personal care only, must be seen by an RN at least once per week.

8.2 **28 day review**

The CN provider will review the care provided to the entitled person at the end of the 28-day claim period.

The purpose of this review is to review the care plan and existing documentation to verify that the classifications and care delivered reflect the item number/s claimed, including the:

- core Schedule visit type classification;
- opposing Schedule visit type add-on (if required); and
- other care and service/s provided from the Other Items schedule (if required).

8.2.1 **Personnel undertaking review**

If the entitled person is classified under the Clinical Care schedule (either as a core or add-on), the review at the end of each 28-day claim period *must* be conducted by an RN.

The review at the end of each 28-day claim period of entitled persons receiving community nursing services under the Personal Care schedule (with no Clinical Care add-on) *must* be conducted by either an RN or an EN.

8.3 **3 monthly review**

The 3 monthly review *must* occur prior to the end of every third 28-day claim period by an RN, regardless of the type of community nursing services being delivered. A file note *must* be placed on the entitled person’s care documentation when the review is completed. All delegated care details must be appropriately documented in clinical records and kept on the entitled person’s file.

In undertaking the review, the RN will identify any changes required to the community nursing services, document and implement those changes in consultation with the entitled person.
If the review identifies a change is required, the CN provider must either:

- reclassify the entitled person within the Classification System; or
- identify the need for the entitled person to be assessed through the Exceptional Case process; or
- discharge the entitled person from community nursing services.

For an entitled person classified as Palliative Care Stable phase, the RN will identify whether claiming the Palliative Care Stable add-on continues to be appropriate.

If the change to care needs results in a reduction in personal care services to 1.5 hours or less per week, and there is no clinical need for community nursing services, the CN provider should consider discharging the entitled person and refer them to VHC for an assessment for personal care services, see section 6.2 Personal Care Assessment.

8.4 Communication with LMO or GP
The CN provider must communicate with an entitled person’s LMO or GP on a regular basis, and record the communication on the entitled person’s care documentation. This should occur:

- on admission following a comprehensive assessment of care needs;
- following a review when the assessed care needs change;
- every 12 months following a comprehensive assessment of care needs; and
- on discharge from community nursing services.

The CN provider must identify:

- any significant change to clinical and/or personal care needs; and
- the need for an allied or other community health service and request a referral for this service/s.
### 8.5 Review of care summary

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Activities</th>
<th>Personnel Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 days for Personal Care with Schedule 8 drug assistance</td>
<td>Review medication management and ensure the delegations are still appropriate. A clinical care add-on may be claimed for this review.</td>
<td>RN; or EN with an approved qualification in administration of medication.</td>
</tr>
<tr>
<td>7 days for entitled persons with Exceptional Case status</td>
<td>Review all clinical and personal care needs. There is no clinical care add-on that can be claimed. The review is included in the ECU funding.</td>
<td>RN</td>
</tr>
<tr>
<td>28-day claim period</td>
<td>Includes a review of the care plan and existing documentation to verify that the classifications and care delivered reflect the item number/s claimed.</td>
<td>RN; or EN if only personal care is being delivered</td>
</tr>
<tr>
<td>Every 3 months</td>
<td>Includes but not limited to:  1. identification of any changed care needs  2. review of care plan and all documentation relevant to the care needs  3. update of care plan where necessary  4. consultation with the entitled person re care plan updates  5. any relevant assessment tools.  6. verification the classifications and care delivered reflect the item number/s claimed.  For information regarding the Palliative Care Stable 3 Monthly review, refer to section 8.3 3 monthly review.</td>
<td>RN</td>
</tr>
<tr>
<td>At any time if care needs change</td>
<td>Review and update all assessment documentation and care/treatment plan/s relevant to the changed care needs.</td>
<td>RN</td>
</tr>
</tbody>
</table>

**Note:** It is expected that, wherever possible, the review occurs in the same visit as the visit for the provision of clinical/personal care.
9 Discharge from community nursing services

An entitled person must be discharged from community nursing services if the entitled person:

- is absent from community nursing care more than 28 days;
- has been permanently admitted to an aged care facility;
- transfers to another community program where nursing services are included, e.g. the Home Care Package program, Transition Care etc.;
- transfers to another CN provider (with DVA’s approval);
- moves permanently to another location;
- no longer requires community nursing services; or
- passes away.

The date of discharge from community nursing services is the date of the last face-to-face visit. The entitled person’s episode of care ends on the date of discharge.

A discharge should not occur if the entitled person is:

- absent from community nursing care for 28 days or less, for any purpose, e.g. from residential respite care, hospitalisation, holiday;
- absent for short periods which does not interrupt planned community nursing services; or
- visited regularly, but infrequently, over a period longer than 28 days and which is considered one continuous delivery of community nursing services (e.g. 6 – 8 weekly indwelling or supra pubic catheter change).

9.1 Absences for 28 days or less

Absences from community nursing services may be due to admission to an acute facility or hospice, a period of rehabilitation, residential respite, or going on a holiday.

If an entitled person is absent from community nursing services for 28 days or less, and still requires community nursing services, they should recommence their community nursing services with the same CN provider within the 28-day claim period. This ensures continuity of care.

If the care needs have changed, the CN provider must update all assessment and care plan documentation. Item numbers must also be updated to reflect the type of care being provided.

Outcomes of the assessment must be reported back to the entitled person’s LMO or GP.

9.2 Readmission after discharge

If community nursing services are required again after being discharged, regardless of the period of time since the discharge, the CN provider must obtain:

- a new referral prior to admission back into the DVA Community Nursing program; and
- a new comprehensive assessment and care/treatment plan.
10 Policies and care documentation

10.1 Clinical and administrative policies
A CN provider must have written clinical and administrative policies in place which adhere to the provisions contained in the relevant State or Territory legislation and which are appropriate for a community nursing setting.

At a minimum, these policies must include:
- Work Health and Safety;
- Incident, Accidents and Dangerous Occurrence Management;
- Infection Control;
- Medication Management;
- Entitled person not responding; and
- Delegation of Care.

All policies must be reviewed at a minimum of every three years, to take into account industry changes to clinical practices.

10.2 Care documentation
A CN provider must develop and maintain an appropriate care documentation framework for a community nursing setting, based on the principles of the community nursing industry recognised evidence based best practice.

An entitled person’s care documentation must be developed in conjunction with the entitled person and, if applicable, the carer and the family. The entitled person must be provided with, or be able to access in a timely manner, an up-to-date copy of the care documentation. The entitled person, and if applicable the carer and family, must sign the care plan. The care documentation must be updated regularly at review and assessment, as changes occur and when additional information becomes available. All services must be delivered in accordance with the care plan.

As a minimum, care documentation must include a care plan that must be developed and completed by an RN. A care plan must include the:
- Clinical and Personal Care activities identified from the assessment;
- Goal/s of care (short and long term);
- Nursing intervention/s;
- Desired outcome/s;
- Delegation of care;
- Review dates; and
- Agreed days and approximate timeframes that services will be delivered.

10.3 Privacy, documentation and record keeping
All CN providers must develop, maintain and store appropriate documentation relating to the claiming, administrative, and clinical aspects of the entitled person’s episode of care. This includes having the following clearly identified and documented:
- valid referrals; and
- assessments; and
- treatment/care plans; and
CN providers must ensure the storage and security of personal information regarding an entitled person is in accordance with the Australian Privacy Principles that can be accessed through the Office of the Australian Information Commissioner’s link: www.oaic.gov.au/privacy-law/.

The Office of the Australian Information Commissioner’s Guide to Information Security provides guidance on information security, specifically the reasonable steps entities are required to take under the Privacy Act 1988 (Privacy Act) to protect the personal information they hold. CN providers must not do an act, or engage in a practice under the agreement or a subcontract, that would breach an Australian Privacy Principle under the Privacy Act.


The CN provider must retain any documents relating to the care of an entitled person, or documentation relating to payments claimed for the entitled person, in accordance with legislation regarding the retention of medical records in their State or Territory.

Where records include personal information about entitled persons (such as name, address, age and services received) their confidentiality must be protected. CN providers must ensure that records are stored securely and only accessible by personnel that has undergone appropriate security checks, and will access only information as is required for the personnel to perform their duties.

10.4 DVA’s right to access records and premises
The CN provider must make the care, administrative and/or claiming documentation (copies or electronic) available to DVA, or any person or organisation authorised by an authorised DVA delegate, and provide reasonable access to the documentation upon request. This administrative information will be provided on request from DVA. DVA will ensure that reasonable timeframes are allowed for the supply of administrative information.

As a component of the Community Nursing program’s Quality Framework (QF) or Performance Monitoring processes DVA may request copies of the care, administrative, and/or claiming documentation to be sent to DVA to enable these processes to occur. DVA will retain copies of this documentation where required.

10.5 Refusal of services
An entitled person has the right to refuse either some or all of the proposed community nursing services. A legally authorised person under State law (e.g. The Public Trustee, Guardian, a holder of an appropriate Special Power of Attorney, etc.) can also refuse some or all of the proposed community nursing services on behalf of the entitled person.
If community nursing services are refused, the CN provider must:

- inform the entitled person of the expected consequences of refusal;
- notify the entitled person’s LMO or GP of the refusal; and
- document the refusal and the actions undertaken as a result of the refusal.

An entitled person’s refusal of community nursing services on a previous occasion does not exclude the entitled person from accessing community nursing services in the future.

10.6 Entitled person not responding

The *Commonwealth Home Care Standards* (CHCS), which CN providers are subject to, require community care service providers to develop, where agreed with the entitled person, an individual plan of action to be implemented as part of their policy and procedures in the event that an entitled person does not respond when the care worker arrives to deliver the scheduled service visit.

Where an entitled person does not want an individual plan of action, community care service providers are required to have a generic plan in place to ensure the safety of all entitled persons without an individual plan.

Any occasions where the entitled person not responding plan has been implemented/activated, a summary of events should be documented in the entitled person’s care documentation.

CN providers should have processes in place to minimise situations where an entitled person forgetting about a service visit (e.g. contacting the entitled person or carer to remind them of the upcoming service visit). Where the CN provider has not activated an individual or generic entitled person not responding plan to check the entitled person’s safety, the CN provider must not claim a visit.

More information on the *Commonwealth Home Standards* can be found at the following link:

10.7 Rights of Carers
The Carer Recognition Act 2010 aims to increase recognition and awareness of carers and to acknowledge the valuable contribution they make to society. The Carer Recognition Act 2010 provides a Statement for Australia’s Carers that outlines principles and obligations for Australian Government agencies and organisations that they contract.

As a contracted organisation, CN providers should take all practicable measure to ensure that its officers, employees and agents:

- have an awareness and understanding of the Statement for Australia’s Carers; and
- take action to reflect the principles of the Statement in developing, implementing, providing or evaluating care supports.

11 Claiming

A CN provider claims for payment for the delivery of community nursing services to an entitled person through the Department of Human Services (Medicare). All claims for payment must be submitted to Medicare Australia within six (6) months of service delivery for payment.

DVA recommends Medicare’s online claiming services as they provide a number of efficiencies and cost-savings for health care providers. The Community Nursing program intends to move towards online claiming as the only method for CN providers to claim for community nursing services.

DVA will accept financial responsibility for the provision of community nursing services to meet the clinically assessed needs of entitled persons. The community nursing services must be delivered in accordance with these Notes.

An entitled person must never be asked to provide additional payment for the delivery of community nursing services by a CN provider.

11.1 28-day claim period

DVA pays CN providers retrospectively for the delivery of all the community nursing services to an entitled person in a 28-day claim period.

11.1.1 Changes in care needs during the 28-day claim period

If an entitled person’s care needs change during a 28-day claim period, the CN provider must reassess the classification/s:

- according to the core community nursing service provided (based on the majority of care principle);
- if required, adding an add-on from the opposing schedule (based either on lesser visit count or lesser time, whichever is applicable; and/or
- if required, adding any add-ons from the Other Items schedule (based on additional services or nursing consumables provided).

If an entitled person under the Exceptional Case process changes care needs during a 28-day claim period, the CN provider must undertake the Exceptional Case status variation or interruption to care process as outlined in Attachment A – Exceptional Case process.

11.1.2 Two providers in a 28-day claim period

Where an entitled person requires services from two CN providers in a 28-day claim period, services may be claimed directly through Medicare.

Situations where the entitled person may require services from two providers include when an entitled person:

- goes on a holiday in the 28-day claim period and has care delivered by two providers (e.g. has CN services at their holiday destination); or
- is referred to another community nursing provider (e.g. post hospital admission)
However, some services can only be claimed once in a 28 day claim period per entitled person. These are:

- Assessment only – no other services required;
- Exceptional case status;
- Overnight care;
- Second worker;
- Additional travel; and
- Coordinated Veterans Care items.

11.2 Minimum Data Set and multiple item numbers
The Minimum Data Set (MDS) is required for most item numbers in the:

- clinical care schedule;
- personal care schedule; and
- other items schedule.

However the following items do not require MDS:

- additional travel;
- nursing consumables; or
- CVC – UP05 and UP06.

For more information, see Attachment F Submitting Minimum Data Set.

11.3 Goods and Services Tax (GST)
The fees in the Schedule of Fees and for the Exceptional Case process are exclusive of GST, GST will be added (where appropriate) when the claim for payment is processed by Medicare, regardless of the claiming method used. Medicare will produce a GST compliant Recipient Created Tax Invoice (RCTI) on behalf of DVA at the time of payment.

11.4 Timeframe for claiming
A claim for payment for community nursing services, regardless of the claiming method used, must be forwarded to Medicare for processing within six months of the first day of the 28-day claim period.

11.5 Submitting a claim for payment
A CN provider must ensure that the details on their claim for payment are correct prior to submitting to Medicare.

In submitting a claim for payment for community nursing services provided to an entitled person, the CN provider certifies that the community nursing services:

- were delivered by the CN provider or a subcontractor;
- were provided under an approved treatment/care plan for the entitled person; and
- are a true representation of the community nursing services actually provided.
11.6 Retention of claims
CN providers must retain their claims in a storage system which is able to be accessed for review purposes.

A CN provider must be compliant with the Australian Privacy Principles, see section 10.3 Privacy, documentation and record keeping.

11.7 Payment method
CN providers are paid directly into a nominated bank account. For a CN provider to be paid directly into a nominated bank account, these details should be provided to Medicare on 1800 700 199. For information on this payment method, or access the online claiming information and forms at: https://www.humanservices.gov.au/organisations/health-professionals/forms/hw052

11.8 Queries about claims
If a CN provider has any queries about the status of a claim for payment/s please contact Medicare on 1300 550 017 (option 2).

11.9 Unsuccessful claim/s for payment
A claim for payment may be unsuccessful in full or in part. Medicare will inform the CN provider if a claim for payment has been unsuccessful and the reason/s why. Depending on the reason/s the claim for payment has been unsuccessful, Medicare may return either part or all of the claim documentation to the CN provider.

11.10 Resubmitting a claim/s for payment
If appropriate, a claim for payment or a component of a claim for payment should be corrected and resubmitted to Medicare. If only part of the claim for payment has been unsuccessful, it can be corrected and included in the next claim for payment made to Medicare.

11.11 Adjustments to a claim/s for payment
An adjustment may need to be made to a claim/s for payment and may occur for one of the following reasons:
- an incorrect payment has been made; or
- changes have occurred to the community nursing services delivered to an entitled person with Exceptional Case status. For further details, see Attachment A – section 1.5 Variation.

11.12 Incorrect payment/s
An incorrect payment may involve either an overpayment or an underpayment. An incorrect payment may be identified by DVA or the CN provider. If an incorrect payment is identified by DVA, Medicare will contact the CN provider and manage the adjustment process.
If a CN provider identifies an incorrect payment, it must request an adjustment from Medicare. The request must be in writing and include the following information:

- the reason for the adjustment;
- the provider number;
- the claim number/s; and
- the details of the entitled person/s involved.

All requests for adjustments should be sent to Medicare.

When an adjustment is made, a GST-compliant Recipient Created Adjustment Notice (RCAN) is provided to the CN provider. The RCAN replaces the RCTI previously provided with the incorrect payment.

11.13 Inappropriate claiming
DVA has systems in place to monitor and report on the servicing and claiming patterns of services provided under the DVA Community Nursing program. These systems are aimed at detecting and preventing fraud and non-compliance.

**Over-servicing** is defined as providing an entitled person with health care services that, when viewed objectively, are not required for the person’s health and well-being. This includes services that, despite being provided at normal levels, is provided without a clear clinical or personal care need.

**Under-servicing** is defined as providing an entitled person with a lower level of health care services than is clinically required to meet the desired clinical or personal care health objectives. It is a part of the goals of DVA and the DVA Community Nursing program to provide entitled persons with quality and appropriate health care services.

The Resource Management Guide No. 201 *Preventing, detecting and dealing with fraud* 2014 defines fraud against the Commonwealth as “dishonestly obtaining a benefit, or causing a loss, by deception or other means”.

Fraud against the Commonwealth may include (but is not limited to):

- theft;
- accounting fraud (false invoices, misappropriation etc.);
- misuse of Commonwealth credit cards;
- unlawful use of, or obtaining property, equipment, material or services;
- causing a loss, or avoiding and/or creating a liability;
- providing false or misleading information to the Commonwealth, or failing to provide it when there is an obligation to do so;
- misuse of Commonwealth assets, equipment or facilities;
- cartel conduct;
- making, or using false, forged or falsified documents;
- wrongfully using Commonwealth information or intellectual property; and
- any offences of a like nature to those listed above.
DVA has an obligation to meet Fraud Control arrangements under the *Public Governance, Performance and Accountability Act 2013*, failure to meet the obligations to conduct business with the Commonwealth in an honest manner may result in provider education, recovery of monies or prosecution.

11.14 Recovery of overpayments

DVA will recover any overpayments identified during regular contract management performance monitoring processes and take appropriate action as required. Action may include:

- offsetting any overpayment against future payments; and/or
- recovering, as a debt due to the Commonwealth, any money owing to DVA (plus reasonable interest) in a court of competent jurisdiction.
12  **Continuous Improvement, Innovation and the DVA Quality Framework**

12.1  Continuous improvement and innovation

CN providers must work within a framework of continuous improvement and innovation to deliver industry recognised evidence based best practice community nursing services.

CN providers must have a continuous improvement framework in place. A continuous improvement framework is made up of quality systems and at a minimum, includes systems for:

- the management of risk, including health and safety risks to an entitled person; and
- the management of feedback to other health professionals; and
- the management of complaints and feedback from entitled persons and other individuals; and
- the evaluation of continuous improvement outcomes; and
- the management of records to ensure maintenance and appropriate access.

12.2  Performance monitoring and the Quality Framework (QF)

All CN providers are subject to performance monitoring processes. The aim of the performance monitoring processes is to measure compliance with the contractual requirements, including both the administrative and clinical requirements, and determine the quality of community nursing services being delivered.

Performance monitoring utilises claiming data to validate assessment and classification within the Schedule of Fees.

The QF uses a risk-based scoring process to assess CN providers’ compliance with requirements of these Notes.

The key objectives of the QF are to:

- ensure compliance with these Notes;
- monitor the appropriateness and quality of community nursing care being provided to entitled persons; and
- minimise the risk of errors or fraud.

12.3  QF structure

The QF may include:

- a Contractor Questionnaire completed by CN providers; and/or
- a Contractor Risk Assessment completed by DVA based upon the Contractor Questionnaire and additional reporting and data analysis.
Following completion of the Contractor Questionnaire and Contractor Risk Assessment processes, further assessment may include:

- **Desk Review**: DVA will request copies of all care and claiming; documentation for selected entitled persons from the CN provider; and/or
- **Contractor Performance Review**: an on-site visit; and/or
- **Clinical Performance Review**: a review of the community nursing care being provided to entitled person/s if concerns regarding care provision is detected in other performance monitoring activities or through DVA's complaints processes.

The mix of activities undertaken by DVA to monitor CN providers’ performance, and the frequency with which these activities are undertaken, will be based on a CN provider’s business structure, business processes, service delivery claiming patterns, data analysis, random selection, and any issues which may arise over time.

### 12.4 Recognition of accreditation

In determining the mix and frequency of performance monitoring activities, DVA will recognise a CN provider’s achievement of specific types of accreditation through the recognised Australian accreditation agencies for health care services.

This recognition is based on the similarities between the compliance measures of these specific accreditation processes and DVA’s Performance Monitoring process. However, the achievement of accreditation does not replace DVA’s Performance Monitoring process.

The recognised Australian accreditation agencies for health care services, and the specific types of accreditation they provide which DVA will recognise, are:

- **Quality Improvement Council (QIC)** whose accreditation program is delivered under license by the Institute for Healthy Communities Australia Ltd (IHCA), Quality Management Services Inc (QMS) and Quality Improvement and Community Services Accreditation Inc (QICSA) - QIC Standards.

Accreditation organisations recognised by DVA are reviewed over time, as required.
13 Interaction with other health and community support service providers

13.1 Veterans’ Home Care (VHC) Program

A CN provider can deliver community nursing services to an entitled person receiving domestic assistance, home and garden maintenance or respite services under the VHC. All referrals for VHC services must be made to a VHC assessment agency. The contact number for VHC Assessment Agencies is 1300 550 450.

When an entitled person is assessed as requiring low level personal care services (up to and including 1.5 hours of personal care services per week) and the entitled person does not have a clinical need for community nursing services, the personal care services should be provided through VHC.

An entitled person must not receive ongoing personal care services under VHC while they are also receiving community nursing services for a clinical and/or personal care need. All of the required personal care services must be delivered as a part of the community nursing services, see section 6.2 Personal care assessment.

13.1.1 Short term clinical intervention

When an entitled person receiving personal care services under VHC requires a short term clinical intervention, an exemption may be approved by DVA to allow the personal care to continue through VHC at the same time as the clinical intervention is provided through the Community Nursing program. Contact DVA to request this exemption, see section 1.4 Contacting DVA.

Requests for an exemption will be assessed on a case-by-case basis, depending on the circumstances and an agreement for a limited number of 28-day claim periods may be given.

An exemption may also be given in the following circumstances:

- where an entitled person has received long term personal care services through VHC and requires some level of community nursing services through the Community Nursing program but the prospect of receiving these personal care services from a different provider through the Community Nursing program causes a high level of stress and anxiety; or
- where the entitled person is located in an area where the only CN provider is unable to deliver any level of personal care services and the provision of personal care services through VHC is the only option for the entitled person.

The overlap of services for these circumstances may only occur if the provision of personal care services is not duplicated under both programs and the health and safety of the entitled person is not put at risk.

The CN provider must also ensure they regularly discuss the provision of these personal care services with the relevant VHC service provider to ensure...
that the personal care services do not impact on the treatment outcomes of the community nursing services.

There are also circumstances where an entitled person has previously received high level personal care services under the DVA Community Nursing program and then requires a low level of personal care services. Consideration should be given to the entitled person’s care needs, situation and past history to determine whether the VHC program or the DVA Community Nursing program provides the personal care services.

13.2 Rehabilitation Appliances Program (RAP)
Other aids and equipment can be obtained through the Rehabilitation Appliances Program (RAP). Supplies and aids for continence, stoma care, palliative care and diabetes care can be obtained through the National Schedule of RAP Equipment (RAP Schedule). The RAP Schedule and referral details can be accessed online through the DVA link: www.dva.gov.au/providers/provider-programs/rehabilitation-appliances-program-rap.

13.3 DVA-contracted diabetes educators
An entitled person may access diabetes education services from a DVA-contracted diabetes educator. However, a DVA-contracted diabetes educator must not claim payment for diabetes education services provided to an entitled person who is receiving community nursing services, as the cost of diabetes education services is included in the fee paid to CN providers.

13.4 Open Arms - Veterans and Families Counselling (formerly VVCS)
Open Arms provides free and confidential, nation-wide counselling and support for war and service-related mental health conditions, such as posttraumatic stress disorder (PTSD), anxiety, depression, sleep disturbance and anger. Support is also available for relationship and family matters that can arise due to the unique nature of military service.

Open Arms counsellors have an understanding of military culture and can work with clients to find effective solutions for improved mental health and wellbeing.
Open Arms provides the following services:
- individual, couple and family counselling and support for those with more complex needs;
- services to enhance family functioning and parenting;
- after-hours crisis telephone counselling through Veterans Line;
- group programs to develop skills and enhance support;
- information, education and self-help resources; and
- referrals to other services or specialist treatment programs.

The gold and white card holders can seek assistance from Open Arms by calling 1800 011 046. More information can be found at the following link: https://www.openarms.gov.au/.
13.5 Home Care Packages Program
The Home Care Packages Program provides four levels of home care options covering basic home care through to complex home care.

These four levels of home care will provide a continuum of care options:
- Home Care Level 1 - Basic care package;
- Home Care Level 2 - Low level care package;
- Home Care Level 3 - Intermediate level care package; and
- Home Care Level 4 - High level care package.

All package levels will have access to nursing and allied health services, if a need for these services is identified.

In addition, approved providers who provide Home Care packages at any level will also be able to receive a ‘Veterans’ Supplement in Home Care’ or ‘Dementia and Cognition Supplement’ if the care recipient meets certain eligibility requirements.

A ‘Veterans’ Supplement in Home Care’ is available for entitled persons with an accepted service-related mental health condition. This supplement will be automatically paid after consent to disclose their eligibility for the Veterans’ Supplement in Home Care is received from the entitled person.

While entitled persons may be eligible for both the ‘Dementia and Cognition Supplement’ and the ‘Veterans’ Supplement in Home Care’, the approved provider may claim only one supplement for an entitled person.

To receive a Home Care package, an entitled person, as any other member of the community, must have an assessment by an Aged Care Assessment Team.

Entitled persons have the same right of access to Home Care packages, and other forms of packaged care, as any other member of the community. Specifically, entitled persons should not be discriminated against when accessing services through a Home Care package on an assumption that DVA will provide for all their care needs.

A Home Care package recipient, including an entitled person, may be asked to pay a fee for their home care services. DVA will pay this fee for entitled persons who are former Prisoners of War or Victoria Cross recipients.

All Home Care Packages are delivered on a Consumer Directed Care (CDC) basis. CDC packages give older people greater say and control over the design and delivery of community services provided to them and their carers.

Under CDC, clients will determine the level of involvement they would like to have in managing their own package. They will be provided with a personalised budget so that they can see how much funding is available for services and how the money is being spent.
**Note:** It is not proposed that CDC will be a component of DVA Community Nursing program or other DVA home care programs at this time.

For further information on CDC, visit [www.myagedcare.gov.au](http://www.myagedcare.gov.au).

13.5.1 Home Care Level 1 and Level 2 packages
The Home Care Level 1 and Home Care Level 2 packages (equivalent to low level residential care) are not intended to provide comprehensive clinical services, but some nursing services may be provided.

13.5.2 Clinical Nursing services
A CN provider *may* deliver community nursing services to an entitled person on a Home Care Level 1 or 2 package where there is assessed clinical need.

Where an entitled person is in receipt of a Home Care Level 1 or 2 package, the Home Care provider and CN provider must ensure there is no duplication of community nursing services where there is assessed clinical need.

13.5.3 Personal Care services
A CN provider should not deliver community nursing services to an entitled person on a Home Care Level 1 or 2 package who requires personal care services only. All of the personal care services should, where possible, be provided by the Home Care package.

13.5.4 Clinical Nursing and Personal Care services
Where an entitled person on a Home Care package requires one-off, temporary, infrequent or irregular community nursing services (e.g. short term wound care or a catheter change), these clinical nursing interventions can be provided through the Community Nursing program. However, all of the personal care services should, where possible, be provided by the Home Care package.

Where an entitled person with an assessed clinical need for regular ongoing community nursing services also requires personal care services, the CN provider should liaise with the provider of the Home Care package to determine which service will provide all the personal care services.

**Note:** There must not be a duplication in the delivery of any clinical or personal care services, nor should the clinical or personal care services be shared between a Home Care package provider and a CN provider.

13.5.5 Cessation of clinical nursing services
When an entitled person on a Home Care package no longer requires regular ongoing clinical nursing services, all of the personal care services should, where possible, be provided by the Home Care package. In such situations, the CN provider may need to liaise with the Home Care package provider to ensure a smooth transition of personal care services from the DVA Community Nursing program to the Home Care package. The CN provider must not cease providing personal care services to the entitled person until the arrangements with the Home Care package are in place.
There may be situations where a Home Care package provider is unable to deliver personal care services to an entitled person with no assessed need for clinical nursing services. In such situations, the CN provider must continue to provide the personal care services until the Home Care package is in a position to do so.

The CN provider should also liaise with the Home Care package provider to ensure that the personal care services are put in place in a timely manner, noting that entitled persons have the same right of access to the Home Care package services as other members of the community, and that entitled persons should not be discriminated against for the Home Care package services on an assumption that DVA will provide for all their care needs.

13.5.6 Home Care Level 3 and Level 4 packages
The Home Care Level 3 and Home Care Level 4 packages (equivalent to higher level residential care) should provide for all assessed clinical and/or personal care needs.

A CN provider must not deliver community nursing services to an entitled person who receives Home Care services through a Home Care Level 3 - Intermediate level care or Home Care Level 4 - High level care package, except in exceptional circumstances. If a CN provider believes that exceptional circumstances exist, they should contact DVA for prior approval. If prior approval is granted, CN provider must ensure there is no duplication of community nursing services.

13.5.7 Commonwealth Home Support programme
On 1 July 2015, the transition to the Commonwealth Home Support programme (CHSP) began. The CHSP is one of the changes being made to help older people stay independent and in their homes and communities for longer. The CHSP is being implemented under the Aged Care Reforms and brings together the services currently providing basic home support services, including the Commonwealth Home and Community Care programme for older people, the National Respite for Carers Programme and the Day Therapy Centres program, into one program. Consolidating these programs will provide a comprehensive basic home support program for older people to continue to live in the community.

Information can be accessed online at: www.myagedcare.gov.au/help-home/commonwealth-home-support-programme.
13.5.8 Transition Care
A CN provider cannot deliver community nursing services to an entitled person that is currently receiving Transition Care.

Transition Care provides goal oriented, time limited and therapy focused care to help older people at the conclusion of a hospital stay and is for older people who may otherwise be eligible for residential aged care.

To enter Transition Care, clients may require an assessment by an Aged Care Assessment Team (ACAT) while they are still an in-patient of the hospital. This can be organised through the hospital where the client has received their acute/sub-acute care. A transition care client can only enter transition care directly upon discharge from hospital.

More information on Transition Care can be found at the following link: www.myagedcare.gov.au/after-hospital-care-transition-care.

13.5.9 Short-Term Restorative Care
The Short Term Restorative Care (STRC) Program is a new form of flexible care administered by Department of Health. It is being established to increase the care options available to older people and improve their capacity to stay independent and living in their homes.

The CN provider should work with the STRC provider to ensure that all care needs required are provided to the entitled person and that there is no duplication between the services. Any existing care plans should be coordinated between the STRC and CN providers so that the most appropriate services are provided according to the entitled person’s individual needs.

Both the CN provider and the STRC provider will seek consent from the entitled person to coordinate their care and ensure the entitled person receives a seamless continuity of care.

More information on STRC can be found at the following link: www.myagedcare.gov.au/short-term-restorative-care.

13.5.10 State or local based community services
A CN provider can deliver community nursing services to an entitled person with an assessed clinical need who is receiving State or local based support services, provided these support services do not include the provision of community nursing services. If the State or local based support services do include community nursing services, the CN provider cannot also deliver community nursing services.

If the CN provider is delivering community nursing services to an entitled person who has a clinical need and requires personal care services, the provider must liaise with the provider of the support services to ensure there is no duplication or sharing in the delivery of personal care services.
13.5.11 Communication with community support services
A CN provider must undertake, as a part of their community nursing role, the identification of an entitled person’s need or changing need for other community support services.

If a CN provider identifies an entitled person’s need for a community support service/s, it must refer the entitled person to the appropriate service/s for an assessment.

When making a referral to a community support service the CN provider must:
- obtain the entitled person’s consent for the referral;
- explain the reason for the referral;
- explain the type of service that the entitled person is being referred to for an assessment; and
- explain to the entitled person that making the referral does not guarantee that this service will be provided, as many of these services, including VHC, are resource limited and may have waiting lists.
Attachment A - Exceptional Case process

A small number of entitled persons will have care needs that fall significantly outside the Schedule of Fees. To ensure these entitled persons receive the community nursing services they require, they are assessed through the Exceptional Case process by the Exceptional Case Unit (ECU).

The assessment of an entitled person’s care needs is based on their identified clinical needs at a specific point in time. As care needs change over time, entitled persons are not expected to retain Exceptional Case status indefinitely and many will return to the Schedule of Fees.

All ECU forms are available online at the following link: www.dva.gov.au/providers/community-nursing/exceptional-case-unit.

1 Exceptional Case Unit

The ECU is an independent unit of Clinical Nurse Consultants contracted by DVA.

The ECU operates Monday to Friday from 8:30 am to 5:00 pm (AEST and AEDT), excluding recognised public holidays in Canberra and DVA’s Christmas/New Year shut down period.

The preferred method of contacting the ECU is by secure email, Ambecu@dva.gov.au, see section 1.2.3 Submitting ECU forms. The ECU can also be contacted by:

- telephone: 1800 636 428.

1.1 Potential Exceptional Case status

To assist CN providers in identifying entitled persons who may have Exceptional Case status, the following can be used as a guide.

DVA recommends that, if appropriate, any entitled person who has complex care needs and has potential Exceptional Case status should undergo an assessment by an ACAT.

More information on ACAT can be found at the following link: www.myagedcare.gov.au/eligibility-and-assessment/acat-assessments.
1.1.1 Clinical Care
If an entitled person falls under any of the following categories for their clinical care needs, they may require assessment under the Exceptional Case process. This includes if an entitled person has:

- an intensive level and/or increased frequency of visits after discharge from an acute facility or medical attention, who may otherwise remain hospitalised for an acute medical condition;
- a complex health condition, a combination of complex health conditions and/or a combination of clinical interventions which require long or multiple daily visits;
- multiple and/or complex wound/s; and/or
- intensive level of medication administration requiring significantly more visits in a 28-day claim period than allowed in the clinical care schedule.

1.1.2 Personal Care
An entitled person who requires more than three daily visits for personal care interventions may require assessment under the Exceptional Case process.

All entitled persons with Exceptional Case status for personal care only, must be assessed by an RN at least once per week to ensure the needs identified in the care documentation are being met. RN documentation must include elements as outlined in Section 6.1 Registered Nurse Assessment.

1.1.3 Combination of Care
An entitled person who requires a high level combination of Clinical Care, Personal Care, and/or Palliative Care will be assessed accordingly and classified as an Exceptional Case.

If a CN provider is unsure, they should contact the ECU in the first instance and discuss the entitled person on 1800 636 428.

1.2 ECU forms
The Exceptional Case process is managed through a set of ECU forms. If the CN provider identifies an entitled person as having potential Exceptional Case status they must submit an application to the ECU using the Application for Exceptional Case Status (D1004 - Application).

Specific information, where required, must be included with the application. The attachments to the application are:
- D1004A - Attachment 1 - Dementia/Short term Memory Loss/Confusion;
- D1004B - Attachment 2 - Mental Health;
- D1004C - Attachment 3 - Palliative Care; and
- D1004D - Attachment 4 - Wound Care.

The other ECU forms are as follows:
- D1307 Exceptional Case Status Variation or Interruption to Care
- D9297 Exceptional Case Unit Request for Funding of Consumables over $1,000
1.2.1 Timeframes for submitting ECU Forms

The application (or a variation form) must be submitted to the ECU before the end of the 28-day claim period where funding is required to commence.

An Application for Exceptional Case Status is a legal document and will only be approved for the current, or if necessary, the previous 28-day claim period when Exceptional Case status is required. Exceptional Case status funding can only be backdated for 1 x 28-day claim period.

Note: The Department will not accept forms received that do not meet the above criteria and the CN provider may be required to take on the cost of providing the additional service/s.

A CN provider must not claim a Schedule of Fees item number whilst awaiting the outcome of an application for Exceptional Case status (including variations or interruption to care). If a Schedule of Fees item number is claimed, the ECU will reject the application for Exceptional Case status.

1.2.2 ECU Form/Documentation Requirements

An application (or a variation form) submitted to the ECU must:

- be completed and signed by the RN who has conducted the assessment;
- include the current treatment/care plan and any relevant attachments; and
- be legible and completed in full.

If a form or attachment is incomplete or current treatment/care plan and is not considered industry recognised evidence based best practice, the ECU will make contact by secure email or telephone with the CN provider for completion/rectification. The CN provider will be asked to submit the required information within 7 days.

If the requested information is not provided within 7 days, or there is a lack of sufficient information to identify the care required, the CN provider will be notified in writing that the application has lapsed.

In this situation, the onus is on the CN provider to supply the required information in accordance with the requirements of these Notes. A new application for Exceptional Case status can be made, if required, once all the required information is available.

If an entitled person is identified as having potential Exceptional Case status, the CN provider must maintain the existing 28-day claim date cycle for that entitled person, rather than using a different start date in the application. Recording a different start date will result in delays in the assessment of the application and/or rejected claims for payment, as the 28-day claim cycle has not been maintained.
1.2.3 Submitting ECU Forms
ECU forms must be submitted through secure email. A CN provider is required to register an email address in order to submit their ECU forms through secure email. The Contractor’s Representative (as recorded on the Agreement held with DVA) is first required to email the ECU with the following information regarding the person who will be submitting the ECU forms:
- Contact name;
- Contact phone number; and
- Email address used to submit the ECU forms.
This information should be emailed to Ambecu@dva.gov.au.
DVA will respond to the email providing information on how to use secure email. Completed and signed forms can be sent by secure email.

1.3 Application assessment
The ECU assesses an application to determine whether an entitled person meets the requirements for Exceptional Case status. The assessment will take approximately 10 working days from receipt of a complete application.

An ECU Clinical Nurse Consultant (CNC) may contact the CN provider to clarify and/or discuss the application.

In some cases, a clinical assessment of the entitled person’s care needs in their home may be a part of the ECU assessment process. The clinical assessment will be undertaken by an independent health professional contracted by DVA.

In assessing an application, the ECU will determine:
- the entitled person’s care needs;
- if the entitled person’s care needs exceed the scope of the Schedule of Fees;
- the appropriateness of the entitled person’s care regime, including the skills mix of the personnel delivering the care; and
- whether the entitled person’s care regime will achieve realistic outcomes which include, as much as possible, a return to care needs which can be met under the Schedule of Fees.

1.3.1 Application approved
The ECU will notify the CN provider in writing by secure email if the application has been approved. The confirmation letter will include the:
- number of 28-day claim periods within the period of Exceptional Case status, for up to 12 months unless there is a variation;
- number of community nursing visits per 28-day claim period covered by the approval, for each level of personnel providing the assessed care;
- item number to be claimed for each 28-day claim period covered by the approval; and
- fee to be paid for each 28-day claim period covered by the approval.

The first payment made for an entitled person with Exceptional Case status may include a component of Schedule of Fees as well as Exceptional Case funding.
If the ECU identifies the community nursing services being delivered do not meet industry recognised evidence based best practice, the approval will include recommended changes to these services. The CN provider must implement the ECU’s recommendations.

CN providers should read the confirmation letter carefully and check all details. If details are incorrect the ECU must be notified within 7 days, to make any amendments to the approval. After 7 days have passed no changes will be made.

1.3.2 Acceptance or rejection of an approval
A CN provider will be deemed to have agreed to the approval unless a CN provider contacts the ECU in writing, detailing the reasons for not agreeing within 7 days.

If the CN provider has additional relevant information about the entitled person they wish to provide, they should discuss this information with the ECU CNC. The ECU CNC may reconsider the approval in light of the additional information. During this time, the CN provider must continue to deliver the clinically appropriate community nursing services to the entitled person.

1.3.3 Application not approved
The ECU will notify the CN provider in writing if it has determined that the entitled person’s care needs should be managed within the Schedule of Fees, rather than as an Exceptional Case.

If the CN provider has additional relevant information about the entitled person which they wish to provide, they should contact the ECU CNC to discuss this information. The ECU CNC may reconsider the application in light of the additional information.

1.4 Notification of Interruption to Care
The ECU must be notified of an entitled person’s interruption to care, return to the Schedule of Fees, discharge from community nursing services or death using the Exceptional Case Status Variation or Interruption to Care form.

An interruption to care is an absence from community nursing services of seven or more consecutive days of care and may require an adjustment to the Exceptional Case funding for the 28-day claim periods where the interruption occurred. An interruption to care includes absences from home due to admission to an acute facility or hospice, a period of rehabilitation or residential respite, or going on a holiday.

A return to Schedule Fee is when an entitled persons returns to care levels within a 28-day claim period that can be managed in the Classification System and Schedule of Fees. In these cases the CN provider must also provide the DVA Classification System item number the entitled person has returned to.
A discharge or death requires an adjustment to the Exceptional Case funding for the 28-day claim period when the return to Schedule Fee, discharge or death occurred.

The *Exceptional Case Status Variation or Interruption to Care* form must be completed and sent to the ECU within 7 days of the commencement date of the interruption to care, return to Schedule Fee, discharge, or death of the entitled person.

The ECU will notify the CN provider by letter with details of the adjustment/s following the interruption to care, return to Schedule Fee, discharge, or death of an entitled person.

1.5 *Variation*
The ECU must be notified if an entitled person’s care needs change using the *Exceptional Case Status Variation or Interruption to Care* form.

A variation request submitted to the ECU must be completed and signed by the RN who has conducted the assessment and must include the current treatment/care plan.

If the entitled person’s care needs change significantly, a new *Application for Exceptional Case Status* can be submitted.
2 **Appeals process**
The Exceptional Case process includes an appeals mechanism. In considering an appeal the CN provider must note that:
- a CN provider cannot appeal on financial grounds;
- an appeal can only be made when the ECU has accepted that the entitled person has Exceptional Case status;
- an appeal only assesses an entitled person’s care needs and does not consider the fee being offered to provide the community nursing services; and
- an appeal can only be made after negotiations between the ECU and the CN provider has resulted in the CN provider rejecting the third offer made by the ECU.

To lodge an appeal, the CN provider should forward in writing the reason for the appeal.

An appeal must be lodged within 14 days of the date of the CN provider’s rejection of the approval. The appeal should be lodged with:

The Director – Nursing Programs and Operations  
CMBNURPRO@dva.gov.au

When making an appeal, the CN provider must continue to deliver the required community nursing services to the entitled person.

2.1 **Clinical review**
DVA’s assessment of an appeal includes a clinical review to compare the entitled person’s care needs with the ECU’s approval. The clinical review may be undertaken by an independent health professional contracted by DVA.

The clinical review will include, as a minimum, a documentation-based review. The clinical review may also include an in-home clinical assessment of the entitled person’s care needs. If required, the in-home clinical assessment will be arranged by the DVA Health Programs Section.

2.2 **Outcome of appeal**
DVA will inform the CN provider of the outcome of the appeal within 28-days of receipt of the appeal. The appeal outcome is final.

If the appeal is upheld in full or in part, DVA will instruct the ECU to process a new approval based on the revised care needs.

A letter detailing the new approval will be forwarded to the CN provider by the ECU.

A CN provider will be deemed to have agreed to the new approval unless a written response to the ECU detailing the reasons for non-acceptance is received within seven days.
If the appeal is disallowed the original approval stands. The CN provider must accept or reject the original approval again in writing to the ECU within seven days. If the CN provider rejects the original approval, the ECU will inform DVA of this decision.

If the CN provider rejects the new approval, the ECU will inform DVA of this decision. If an alternative CN provider is available DVA may transfer the entitled person. If an alternative CN provider is not available or DVA chooses not to transfer the entitled person, the CN provider must continue to deliver the clinically appropriate community nursing services to the entitled person.

3 Other ECU Items

3.1 Nursing consumables exceeding $1,000
The following process replaces the need for CN providers to submit invoices to the Department for items over $1,000 and up to $1,500. The *nursing consumables exceeding $1,000* form is available online through the DVA link: [Exceptional Case Unit Request for Funding of Nursing Consumables over $1,000 (D9297)](https://example.com).

CN providers will need to email the completed form and relevant attachment/s to the ECU for processing. The ECU will email confirmation of the approved amount for NC70 item number to be claimed through DHS.

CN providers must not claim products that are contained in the nurse’s toolbox on this form. Any form that includes nurse’s toolbox products will automatically be rejected and the CN provider will not be reimbursed until a correct form is submitted.
Attachment B – Additional Travel

All Schedule of Fees and ECU classification item numbers already have a built-in component for travel, including travel for multiple daily visits.

There are some circumstances where CN providers are providing community nursing care to a small number of entitled persons living in regional or remote areas who require an exceptional amount of travel that may not be covered by the Schedule of Fees (including Exceptional Case status).

To ensure that CN providers are adequately compensated for the travel to deliver community nursing services to these entitled persons in regional or remote areas, an additional kilometre-based travel payment may be paid in certain circumstances.

1.1 Nearest suitable provider
A CN provider may not claim for travel for an entitled person under the Travel requirements if they are not the nearest suitable CN provider.

For Travel purposes the nearest suitable provider also includes the location of its personnel. For example, one of the CN provider’s personnel may live closer to the entitled person than the CN provider’s head office, in this case the CN provider’s personnel living closest to the entitled person must be utilised to provide the care.

1.2 Situations where Travel may be claimed
A kilometre-based travel payment is only paid when the following criteria are all met:
- to the nearest suitable provider;
- for travel only in regional or remote areas, classified as regions MMM4 to MMM7 in the Modified Monash Model; and
- for distances of 20 kilometres or more from the community nurse’s final departure point to the entitled person’s home.

A kilometre-based travel payment is not paid:
- if the CN provider is already receiving additional travel for another entitled person in the same region who is visited on the same day; or
- if there is another suitable provider closer to the entitled person’s residence; or
- if the distance is less than 20 kilometres from the community nurse’s final departure point.
1.3 Claiming for Travel
Travel can be claimed with the fee schedule items for the relevant 28 day claim period.

Travel is funded retrospectively. Claims should be submitted after the end of the relevant 28-day claim period, and within two 28-day claim periods of the end of the relevant 28-day claim period.

The CN provider should submit claims for payment to Medicare for the 28-day claim periods.

1.4 Claiming
The Other Items – Additional Travel item number (NA10) will be used for reimbursement of the travel component only.

The Additional Travel item number must be claimed in conjunction with an item number/s from either the Clinical or Personal Care schedules.
Attachment C - Palliative Care Phases

1 Palliative Care

Palliative care phases provide a clinical indication of the level of care required and have been shown to correlate strongly with survival within longitudinal, prospective studies.

The palliative care phase is a stage of the person’s illness. Palliative care phases are not sequential and a person may move back and forth between phases.

An entitled person in the:
- Palliative - Stable phase of their disease, should not be requiring high levels of interventions in this phase;
- Palliative - Unstable phase of their disease, requires high levels of interventions in the short term in this phase;
- Palliative - Deteriorating phase of their disease, requiring high levels of interventions to enable them to remain at home in this phase; or
- Palliative - Terminal phase of their disease, requiring interventions aimed at physical and emotional issues, and/or requiring overnight nursing care in the short term and meeting the criteria to receive this overnight care.

REFERENCE DOCUMENT: Palliative Care Outcomes Collaboration (PCOC) University of Wollongong.

Phases are defined in terms of the following criteria as these highlight the essential issues to be considered when assigning phase.

1.1 Phase 1: Stable
Symptoms are adequately controlled by established management. Further interventions to maintain symptom control & quality of life have been planned. The family/carers situation is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

1.2 Phase 2: Unstable
The person experiences the development of a new unexpected problem or a rapid increase in severity of existing problems, either of which require an urgent change in management or emergency treatment.

The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multidisciplinary team.

1.3 Phase 3: Deteriorating
The person experiences a gradual worsening of existing symptoms or development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment.
The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling, as necessary.

1.4 Phase 4: Terminal
Death is likely in a matter of days and no acute intervention is planned or required. The use of frequent, usually daily, interventions aimed at physical, emotional & spiritual issues is required.

The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement.

1.5 Phase 5: Bereaved
Death of a patient has occurred and the carers are grieving. A planned bereavement support program is available including referral for counselling as necessary.

These phases are aligned with Palliative Care Australia’s national standards. Further information can be found on the Palliative Care Australia website at: [http://palliativecare.org.au/](http://palliativecare.org.au/).

**Source:** Education Handout. Palliative Care Outcomes Collaboration (PCOC) University of Wollongong.

1.6 Psychosocial aspects of nursing care in the Palliative Phases

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<th>PHASE</th>
<th>COMMON PSYCHOSOCIAL ASPECTS OF ADDITIONAL COMPONENTS</th>
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<tr>
<td><strong>STABLE</strong></td>
<td>• Care plans/advanced care plans</td>
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<td>• Referrals for appropriate services/home supports</td>
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<td>• Explore goals of care/treatment options</td>
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<td>• Identify family/carer situation</td>
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<td>• Assessment of psychosocial status</td>
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<td>The symptoms are adequately controlled by an established plan of care and further interventions to maintain symptom control and quality of life have been planned and the family/carer situation is settled.</td>
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<td><strong>UNSTABLE</strong></td>
<td>• Management of psychosocial crisis such as suicidal ideation or severe depression</td>
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<td>• Family or carer crisis</td>
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<td>• Care plan reviews to address unstable phase</td>
</tr>
<tr>
<td></td>
<td>• Referrals to appropriate services</td>
</tr>
<tr>
<td></td>
<td>The development of a <em>new or unexpected problem</em> or a <em>rapid increase</em> in the severity of existing problems requiring an <em>urgent</em> change in management or emergency treatment. The family/carers experience a sudden change in status requiring urgent intervention.</td>
</tr>
<tr>
<td><strong>DETERIORATING</strong></td>
<td>• Care plan review to address deteriorating phase</td>
</tr>
<tr>
<td></td>
<td>• Counselling for family/carers</td>
</tr>
<tr>
<td></td>
<td>• Referrals to appropriate services</td>
</tr>
<tr>
<td></td>
<td>A <em>gradual worsening</em> of existing symptoms or the development of a <em>new but anticipated problem</em> that requires a specific care plan. <em>No urgent or emergency treatment is required.</em> The family/carers have gradually worsening distress that impacts on the person’s care and may require planned support/counselling.</td>
</tr>
<tr>
<td><strong>TERMINAL</strong></td>
<td>• Increased support and counselling for family and carers</td>
</tr>
<tr>
<td></td>
<td>• Care plan review to address terminal phase</td>
</tr>
<tr>
<td></td>
<td>• Increase in home visits</td>
</tr>
<tr>
<td></td>
<td>• Referrals to appropriate services</td>
</tr>
<tr>
<td></td>
<td>Death is likely in a matter of days. No acute interventions are planned.</td>
</tr>
</tbody>
</table>

Source: *University of Wollongong – Palliative Care Outcomes Collaboration – The Palliative Care Phase:*
Attachment D – Nursing Consumables

1 Overview
The following outlines the methods and processes that CN providers can use to obtain nursing consumables for entitled persons.

1.1 Repatriation Pharmaceutical Benefits Scheme
There are range of medications and wound dressings available through the RPBS. RPBS items require a prescription or authority prescription from a doctor for wound management consumables.

The RPBS can be accessed online at www.pbs.gov.au/browse/rpbs.

1.2 Rehabilitation Appliances Program
The Rehabilitation Appliances Program (RAP) provides access to a range of aids or appliances to assist entitled persons to maintain their independence at home. Aids or appliances prescribed through RAP can include for example:
- continence products;
- mobility and functional support aids;
- Personal Response Systems;
- home medical oxygen;
- diabetic supplies; and
- Continuous Positive Airways Pressure (CPAP) supplies.

Further information on RAP can be found on the DVA website at: www.dva.gov.au/providers/provider-programs/rehabilitation-appliances-program-rap.

1.3 Claiming for consumables $1,000 and under
A range ($10 to $1,000) of Other Items - nursing consumables item numbers, is available through the Schedule of Fees. These item numbers are exclusive of GST and are not subject to annual indexation.

1.4 Claiming for nursing consumables exceeding $1,000
All reimbursements for entitled person’s whose nursing consumables total cost exceeds $1,000 (exclusive of GST) in a 28-day claim period must be claimed via the Exceptional Case process see Attachment A section 3.1 Nursing Consumables Exceeding $1,000. There is an upper limit of $1,500 for consumables.

Substantiation of items used, number supplied and cost in the 28-day claim period for each entitled person must accompany the ECU form.
1.5 Claiming Rules
1. The CN provider claims the item number that is closest in value to the actual cost (excluding nurse’s toolbox items) within the listed range for nursing consumables provided to the entitled person in the 28-day claim period.
2. The CN provider must not include any GST component when calculating which nursing consumables item number to claim. Payments made on behalf of DVA automatically add the GST component prior to payment.
3. The GST law allows a supplier and a recipient to agree to treat as GST-taxable any item listed in Schedule 3 that would otherwise be GST-free under the GST Act [subsection 38-45(3)]. To give effect to this arrangement, a CN provider that uses any of the nursing consumables item numbers will be taken to have accepted the GST-taxable status of these item numbers and to have agreed to the treatment of Schedule 3 items under subsection 38-45(3) of the GST Act. Schedule 3 items in supplies over $100 will continue to be GST-free.
4. DVA does not pay for the cost of delivery of nursing consumables to an entitled person.
5. CN providers agree not to add any dollar amount or percentage or ‘mark-up’ on to the actual cost of the nursing consumables prior to claiming a nursing consumables item number
6. CN providers agree not to claim for items that:
   • the entitled person should purchase through a pharmacy or supermarket for ongoing non-clinical self-management of conditions (for example moisturiser, over-the-counter medication etc.);
   • the entitled person has obtained via the RPBS;
   • the entitled person has been supplied via RAP; and
   • items which are covered in the cost of the visit, including the ‘nurse’s toolbox’.
7. A nursing consumables item number can be claimed in conjunction with a clinical care item number or as a stand-alone item.
8. Only one nursing consumables item number can be claimed in a 28-day claim period per entitled person.
9. MDS is not required for nursing consumables item numbers.
10. The CN provider must retain nursing consumables records on the entitled person’s file to be able to substantiate any payment of nursing consumables item numbers for future QF review or Performance Monitoring review requests or processes.

1.6 Nurse’s toolbox
The ‘nurse’s toolbox’ consumables are:

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adhesive remover wipes</td>
<td>Individual use lancing device</td>
</tr>
<tr>
<td>Alcohol wipes</td>
<td>Non-sterile gloves</td>
</tr>
<tr>
<td>Boot protectors</td>
<td>Non-sterile scissors</td>
</tr>
<tr>
<td>Disposable hand towels</td>
<td>Normal saline</td>
</tr>
<tr>
<td>Emergency use sharps container</td>
<td>Plastic apron/gown</td>
</tr>
<tr>
<td>Face masks</td>
<td>Sanitising hand wash</td>
</tr>
<tr>
<td>Gauze swabs</td>
<td>Skin protection wipes</td>
</tr>
<tr>
<td>Goggles</td>
<td>Tape</td>
</tr>
</tbody>
</table>
Attachment E – Community Nursing and the Coordinated Veterans’ Care Program

1. Overview

The aim of the Coordinated Veterans’ Care (CVC) Program is to better manage and coordinate primary and community care for Gold Card holders (Veterans, War Widows/ers and Dependents) who are most at risk of unplanned hospitalisation. Participation in the CVC Program is not mandatory and requires the Gold Card holder’s consent.

LMOs and GPs (in this attachment are collectively referred to as the LMO/GP), will enrol a Gold Card holder in CVC and provide ongoing comprehensive coordinated care with the assistance of either a Practice Nurse/Aboriginal Health Worker or a Community Nurse from a DVA CN provider.

An entitled person must be diagnosed by an LMO/GP as having one or more of the targeted chronic conditions – congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes or pneumonia to be eligible for enrolment onto the CVC Program.

Further information on the broader CVC Program is available at: https://www.dva.gov.au/providers/provider-programs/coordinated-veterans-care

1.1 Community care component

Access to CN Care Coordination within the Community Nursing program is limited to those Gold Card holders who are participants in the CVC Program and have been determined by their LMO/GP as needing CN Care Coordination through a CN provider.

If a CN provider identifies that a Gold Card holder could benefit from CN Care Coordination and is not participating in the CVC Program, they should recommend the Gold Card holder visit their LMO/GP to determine their eligibility.

1.2 CVC Program Service Partners

DVA has contracted external providers (known as CVC Program Service Partners) to assist with aspects of the CVC Program, including:
- provider assistance and support through a CVC helpline; and
- accredited online training and resources for the CVC Program.

CN providers may be contacted from time to time by the CVC Program Service Partners. This may take the form of:
- offering CVC Program training for Chronic Disease Management;
- requests for data and sampling of care plans and records to facilitate evaluation and post payment monitoring; and/or
- participating in surveys to assist in evaluating the CVC Program.
2  Referral
A Gold Card holder must be referred by an LMO/GP to a CN provider for CN Care Coordination. The referral from the LMO/GP should include a copy of the CVC Comprehensive Care Plan (CVC CCP) and any supplementary Notes, if relevant. If the referral does not include a CVC CCP the CN provider must request a copy before accepting the referral.

The CVC CCP should include the LMO/GP’s expectations (e.g. for initial set-up, contact preference [by telephone, fax etc.], medical appointment schedule/s including dates, and CN Care Coordination recommendations). The LMO/GP should also provide a patient-friendly copy of the CVC CCP to the Gold Card holder.

Some Gold Card holders may already be receiving clinical and/or personal care services through the DVA Community Nursing program. If the Gold Card holder is already a client of a CN provider, it is anticipated that the LMO/GP referral for CN Care Coordination will be made to the existing CN provider. There can be only one provider of Community Nursing services and CN Care Coordination services to a Gold Card holder at any one time.

Referrals are valid for a 12 month period and the referral period remains valid:
- regardless of whether a Gold Card holder moves in and out of the DVA Community Nursing program (e.g. is discharged from DVA funded clinical and/or personal care for any reason, apart from permanent entry into a residential aged care facility or is enrolled in a similar Government coordinated care program, for example, Home Care packages levels 3 or 4); and
- providing the LMO/GP is satisfied the Gold Card holder meets CVC eligibility and continues to claim the period of care every quarter.

3  Care Coordination
3.1 Overview
The CN Care Coordinator has responsibility for coordinating the ongoing care needs and self-management support as set out in the CVC CCP. The CN Care Coordinator records the outcomes of their comprehensive assessment based on the CVC CCP in the Community Nursing Management Plan (CNMP). The CNMP complements the CVC CCP and details the CN Care Coordination services required.

All Gold Card holders in the CVC Program require a minimum of one (1) face-to-face visit by a registered nurse per 28-day claim period. The initial face-to-face assessment must be undertaken by a registered nurse.

The CN Care Coordinator works with the Gold Card holder and health providers nominated in the CVC CCP to ensure:
- services are provided;
- the CNMP is carried out; and
- the CNMP reflects the Gold Card holder’s current CVC CCP.
The CN Care Coordinator is responsible for providing the LMO/GP with information on treatments and maintaining integrated and up-to-date care documentation. Where a Gold Card holder’s condition changes, the CN Care Coordinator is responsible for contact with the LMO/GP for possible changes to the CVC CCP and updating the CNMP, if required.

3.1.1 Community Nurse Care Coordination
Within the DVA Community Nursing program, CN Care Coordination is separate from, and for some Gold Card holders in addition to, DVA’s requirements for clinical and/or personal care services which are set out in the Notes.

The CNMP is a separate plan which is specific to the CVC Program and details the activities for CN Care Coordination. The CNMP will take a holistic approach to the Gold Card holder’s health and wellbeing. The CN Care Coordinator has responsibility for providing the LMO/GP with a copy of the CNMP, ensuring that the registered nurse and the Gold Card holder agrees to and signs the CNMP.

CN Care Coordination should give a Gold Card holder responsibility and empowerment through the setting of goals and self-management of their medical condition/s and lifestyle. CN Care Coordination should complement, assist and support a Gold Card holder by providing appropriate clinical and self-management information and goal setting assistance.
CN Care Coordination may include, but is not limited to, the following activities:

**Empowerment**
Empower the Gold Card holder (and carer - where applicable), by:
- encouraging goal setting;
- providing information on medical condition/s;
- assisting self-monitoring and recording of vital signs;
- developing a checklist to assist with reminders (e.g. appointments, medication, exercises etc.);
- providing information on emergency warning signs - what to avoid, who and when to contact (e.g. nursing hotlines, 000); and
- providing information and support for carer (if appropriate).

**Appointments**
Assist the Gold Card holder in relation to appointments, by:
- providing reminders, including what to take to appointments (e.g. x-rays) or restrictions (e.g. fasting on day of appointment) etc.;
- arranging for post-appointment report from specialist/LMO/GP;
- assisting to make appointments (where appropriate – consider empowerment);
- assisting in arranging transport (e.g. through Repatriation Transport or State Taxi Vouchers system, if used).

**Liaison**
Provide a liaison role by:
- undertaking home visits and assessments at least once every 28 days;
- keeping in regular contact with Gold Card holder/carer (by telephone or home visit), especially if social assistance is being provided;
- written contact with the Gold Card holder (if required), LMO/GP, specialist/s*, other allied health provider/s* etc. (*including information contained in the CVC CCP where appropriate);
- following up on appointments to establish clinical information;
- assessing suitability of, or arranging for, in-home appliances and aids to daily living (e.g. through RAP);
- communicating with other community nursing staff within your organisation, if the Gold Card holder is also receiving clinical/personal care community nursing services;
- attending Hospital Discharge Planning meetings;
- communicating with:
  - Emergency Department/Outpatients;
  - Allied Health services (pre/post appointment to discuss clinical outcomes);
  - other community-based services;
  - other DVA services where appropriate, e.g. VHC and RAP; and
  - LMO/GP for CVC social assistance services where a registered nurse believes Gold Card holder has become socially isolated and has not received social assistance.
Education
Provide information in relation to:
- self-management – goals/tools/monitoring;
- warning signs – checklist/s;
- emergency contacts and procedures;
- clinical information;
- health literature;
- carer education and support; and
- general observation of wellbeing.

Monitoring
Monitor the Gold Card holder (and carer where applicable) in relation to:
- general health status;
- self-management status;
- medication compliance;
- deterioration reporting; and
- self-management of vital signs with reportable levels from LMO/GP.

Carer Support
Support the carer by providing:
- warning signs – checklist/s;
- emergency contacts and procedures; and information on:
  - carer support networks;
  - community based services; and
  - in-home and residential respite services.

Regular review
Providing a regular review process by ensuring:
- ongoing observation (a minimum of one face-to-face visit by a registered nurse in the home in the 28-day claim period);
- ongoing and regular contact;
- Gold Card holder is coping with self-management knowledge / processes (with carer where appropriate);
- goals are achievable and reset (with carer where appropriate);
- a regular review process and reporting to LMO/GP – every 28 days or more often if significant change to health status occurs;
- referrals to other allied health providers through LMO/GP;
- referrals to community based services;
- reminder to LMO/GP when quarterly period of care is about to expire; and
- reminder to LMO/GP when 12 month referral is about to expire and discuss the need for a review of the GP Care Plan.

3.1.2 The Community Nursing Management Plan
The CN provider will arrange for a registered nurse to conduct a face-to-face comprehensive assessment and develop a CNMP and update the Treatment/Care Plan for community nursing services, if required.
When the CVC Program comprehensive assessment is completed and a CNMP and schedule are developed, the CN Care Coordinator will report to the LMO/GP the outcomes in the CNMP including any additional CN Care Coordination identified in the comprehensive assessment and not stated in the CVC Program referral or CVC CCP. The LMO/GP will provide comments or additional information, if required. All the outcomes of the CVC Program comprehensive assessment must be recorded in the final CNMP and a copy forwarded to the LMO/GP.

The CN Care Coordinator has responsibility for coordinating the ongoing care needs and self-management support as set out in the CNMP, based on the CVC CCP. The CN Care Coordinator also has responsibility for ensuring the registered nurse and the Gold Card holder agree to and sign the CNMP, providing the LMO/GP with a copy of the CNMP, and providing ongoing regular feedback to both the LMO/GP and Gold Card holder.

The CNMP will contain appointment reminders, self-monitoring requirements/information, emergency contacts and any other information specific to the CN Care Coordination or wellbeing of the Gold Card holder.

The CNMP is monitored regularly to check the progress of the Gold Card holder's self-monitoring participation and improved health status. If practicable, the CN Care Coordinator will ensure that the carer is involved in the process and is informed of any changes to the CNMP.

The CN provider will report to the LMO/GP on a regular basis:
- every 28 days after a face-to-face visit by the care coordinator;
- as required if care or CN Care Coordination needs change;
- after the 3 monthly review of the CNMP; and
- at 12 months, with a request for an ongoing CVC Program referral, if applicable.

3.1.3 Personnel
CN Care Coordination provided under the CVC Program:
- must be delivered by either a registered nurse or an enrolled nurse;
- in providing CN Care Coordination services under the CVC Program, the CN provider must ensure that the services are delivered by personnel with appropriate qualifications and experience;
- all community nursing services, including CN Care Coordination delivered by an enrolled nurse must be appropriately delegated, supervised and documented by a registered nurse; and
- requires a minimum of 1 face-to-face visit to the Gold Card holder by a registered nurse per 28 day claim period to monitor the Gold Card holder’s CN Care Coordination needs.

3.1.4 Record Keeping
The CN provider must keep comprehensive clinical records in accordance with existing requirements in the Notes section 10.2 Care documentation. This should include a copy of the CNMP signed by the registered nurse and the Gold Card holder.
Full details of all CN Care Coordination and contact activities with the Gold Card holder or any third party (e.g. LMO/GP, hospital nursing staff or discharge planner, allied health provider, etc.) are required to be recorded and placed on the Gold Card holder’s file.

3.1.5 Exit from the CVC Program
A Gold Card holder is no longer eligible to participate in the CVC Program if they:
- Enter a Residential Aged Care Facility permanently; or
- Enrol in a similar Government coordinated care program e.g. Home Care packages, levels 3 or 4.

A Gold Card holder may choose to voluntarily exit the CVC Program at any time, in this instance the Gold Card holder may be eligible to reenrol at a later date.

3.1.6 Hospitalisation
Where a Gold Card holder is hospitalised, the following rules apply:
- claims for Community Nursing – Subsequent Care Coordination services are still payable provided that CN Care Coordination activity has taken place in a 28-day claim period; or
- claims for Community Nursing – Subsequent Care Coordination services are not payable if CN Care Coordination activity has not taken place in a 28-day claim period.

During hospitalisation, the CN Care Coordinator must:
- as a minimum, contact the hospital to advise that the Gold Card holder is participating in the CVC Program and request to be advised of the Gold Card holder’s expected discharge date;
- liaise with the LMO/GP to:
  - be informed of the discharge date and participate if possible in the hospital discharge planning process; and
  - request a copy of the discharge papers from the LMO/GP;
- once discharged, contact the Gold Card holder to review the CNMP;
- document all CN Care Coordination activity in accordance with the existing requirements in the Notes section 10.2 Care documentation.

3.1.7 Transition Care
A Gold Card holder receiving Transition Care cannot be enrolled in CVC or admitted to the Community Nursing program until Transition Care has ceased.

If a Gold Card holder in CVC is admitted to Transition Care after a stay in hospital, claims for Community Nursing – Subsequent Care Coordination services are not payable if CN Care Coordination activity has not taken place in a 28-day claim period.
3.1.8 Death of a Gold Card holder
Where a Gold Card holder dies partway through a claim period, the CN provider can claim the Community Nursing – Subsequent Care Coordination item number for the 28-day claim period in which the death occurred, provided some CN Care Coordination activity has taken place in the 28-day claim period.

3.1.9 Entry into an Aged Care Facility
The CVC Program is not available for permanent residents of an aged care facility. Where a Gold Card holder becomes a permanent resident of an aged care facility partway through a 28-day claim period, the CN provider can claim the Community Nursing – Subsequent Care Coordination item number for the 28-day claim period in which the Gold Card holder entered residential care.

3.1.10 Temporary entry into an Aged Care Facility
Where a Gold Card holder enters an aged care facility as a temporary resident for residential respite for all of a 28-day claim period a Community Nursing – Subsequent Care Coordination item number cannot be claimed for this 28-day claim period.

3.1.11 Transfer of Provider
Situations may occur where the responsibility for care coordination services under the CVC Program need to be transferred.

This section covers situations when care coordination is transferred from:
- a Practice Nurse to a CN provider;
- from a CN provider to a Practice Nurse; or
- from one CN provider to another CN provider.

3.1.11.1 From Practice Nurse to CN provider
A change from Practice Nurse to CN provider may occur where:
- the LMO/GP decides that a Community Nurse is better placed to coordinate the care. In this case, the LMO/GP should make all attempts to complete the current quarterly period of Practice Nurse Care Coordination treatment before making the change. This will ensure seamless transition to the CN provider who can commence CN Care Coordination services immediately and claim after the first 28-day claim period has been completed; or
- the Gold Card holder changes LMO/GP and the new LMO/GP does not have a Practice Nurse or the Practice Nurse cannot provide care coordination services.

3.1.11.2 From CN provider to Practice Nurse
A change from a CN provider to Practice Nurse may occur where:
- the LMO/GP decides that a Practice Nurse is better placed to coordinate the care, or the LMO/GP previously did not have a Practice Nurse; or
- the Gold Card holder changes LMO/GP and the new LMO/GP decides the care will be coordinated by the LMO/GP’s Practice Nurse.
3.1.11.3 From one CN provider to another
Where there is a change in the CN provider for whatever reason, the new CN provider cannot commence a 28-day claim period of CN Care Coordination until the existing 28-day claim period of CN Care Coordination from the previous CN provider has expired.

4 Payments
All claims for payment for CN Care Coordination services provided to a Gold Card holder in the CVC Program are paid by Department of Human Services (DHS) on behalf of DVA.

Once the LMO/GP assesses the Gold Card holder and enrolls them in the CVC Program, the LMO/GP’s quarterly care period commences and the LMO/GP Initial Incentive Payment is claimed through DHS. After this claim is processed by DHS it enables subsequent claims for Practice Nurse Care Coordination treatment or CN Care Coordination services to be made.

4.1.1 Item Numbers
The two CVC Program item numbers in the Schedule of Fees are:

1. UP05 - Community Nursing - Initial Care Coordination is a one-off payment for the initial 28 day claim period** in which the CN provider receives the CVC Program referral, appoints the CN Care Coordinator, sets up the CNMP and commences the CN Care Coordination services. **This item must have a claim start date which is later than the date the Gold Card holder was enrolled in the CVC Program by the LMO/GP; and

2. UP06 - CVC Subsequent Care Coordination is claimed for the provision of all subsequent 28 day CVC Program CN Care Coordination services.

4.1.2 Item numbers which cannot be claimed with CVC Program item numbers
The item numbers in the Community Nursing Schedule of Fees that cannot be claimed with a CVC Program CN Care Coordination item number by the same CN provider are:

- NA02 – Assessment;
- NA99 – Assessment Only;
- NL01 – Clinical Support; and
- NL02 – Clinical Support.

All other item numbers in the DVA Community Nursing Schedule of Fees can be claimed in conjunction with the CVC Program Item Numbers, if appropriate.

4.1.3 New clients
A Gold Card holder referred to a CN provider for CN Care Coordination under the CVC Program who has no clinical and/or personal care needs can be admitted to the Community Nursing program for CVC Program CN Care Coordination treatment only. A referral is valid for 12 months, and the LMO/GP must make a new referral when the 12 month period has elapsed.
When claiming the CVC Program Community Nursing – Initial Care Coordination item number the CN provider would use the date of the first face-to-face assessment performed by a registered nurse as the claim start date.

4.1.4 CVC Program Community Nursing – Initial Care Coordination
The Community Nursing – Initial Care Coordination payment is made only once per Gold Card holder in the life of the CVC Program.

It is not payable if a claim has already been made for the initial incentive payment for a Practice Nurse or CN provider (i.e. there is only one initial payment paid for Care Coordination services, whether provided by a Practice Nurse or Community Nurse).

If a Gold Card holder changes CN providers, changes from a Practice Nurse to a CN provider, or ceases to be eligible and later re-enters the CVC Program, the Community Nursing – Initial Care Coordination payment will not be payable.

After the Gold Card holder has been enrolled in the CVC Program and referred by the LMO/GP to the CN provider the Community Nursing – Initial Care Coordination item number is claimed after the Registered Nurse has undertaken a comprehensive assessment. This item number is claimed at the end of the first 28-day claim period for CN Care Coordination services.

A claim for the Community Nursing - Initial Care Coordination will be rejected if:
- the date of service i.e. the first day of the 28 day claim period, is earlier than the date the Gold Card holder was enrolled in the CVC Program; or
- the LMO/GP has not claimed the payment to enrol the Gold Card holder in the CVC Program.

4.1.5 CVC Program Community Nursing – Subsequent Care Coordination
When claiming the CVC Program Community Nursing – Subsequent Care Coordination item number, the CN provider should use the same 28 day claim period start date for all item numbers claimed for the same 28 day claim period for a Gold Card holder.

A claim for the Community Nursing - Subsequent Care Coordination will be rejected if:
- the LMO/GP has not claimed the payment to enrol the Gold Card holder in the CVC Program.

4.2 DVA’s right to access records
The CN provider must make all documentation for CN Care Coordination, the CNMP, administrative and claiming documentation available to DVA, or any person or organisation authorised by an authorised DVA delegate, and provide reasonable access to the documentation upon request.
Attachment F – Submitting Minimum Data Set (MDS)

1  DVA Community Nursing MDS
DVA requires CN providers to submit data on all the community nursing services delivered to an entitled person. This data is referred to as the Minimum Data Set (MDS).

The MDS is used by DVA to monitor the appropriateness of the provision of community nursing services and ensure that an entitled person receives quality health outcomes.

The MDS collects information on:
- **Claim Details:**
  - entitled person’s name, file number and claim start date; and
  - item numbers claimed.
- **Staffing Resources Used (in the 28-day claim period):**
  - level of personnel delivering community nursing services to the entitled person; and
  - visits/occurrences and hours of care provided by each level of personnel delivering community nursing services.

The MDS data is collected at the level of the individual entitled person receiving community nursing services.

A CN provider must complete the MDS for every 28-day claim period that it delivers community nursing services to an entitled person.

1.1 Why does DVA require MDS data?
DVA uses MDS data to:
- monitor the appropriateness of the provision of community nursing services;
- substantiate community nursing claims;
- ensure that an entitled person receives quality health outcomes; and
- assist in research into program development (for example, MDS data was used in the development of the current Schedule of Item Numbers and Fees).

1.2 What item numbers require MDS?
All item numbers except nursing consumables (NC10 – NC70), Travel (NA10) and CVC Initial and Subsequent Care Coordination (UP05-UP06) require MDS.

1.3 How is MDS recorded when a Registered Nurse undertakes both clinical and personal care in the one visit when a core and add-on are claimed?
In instances where an RN/EN delivers clinical and personal in the same visit and a CN provider claims a core and add-on item, each component of the care
delivered must be counted and recorded in the MDS as a separate occurrence. There is possibility in one visit there may be multiple occurrences of services being delivered, e.g.:

- clinical care (core item);
- personal care (opposing schedule add-on); and
- palliative care (other items add-on).

or vice versa:
- personal care (core item);
- clinical care (opposing schedule add-on); and
- palliative care (other items add-on).

1.4 Submitting MDS data
MDS data must be submitted at end of each 28-day claim period either:

- online to Department of Human Services (Medicare) as part of the Medicare claim (preferred); or
- manually by secure email to DVA, using the MDS Collection Tool.

If the CN provider has multiple sites with multiple provider numbers, each site must submit its own MDS data.

1.4.1 Online
CN providers are able to lodge claims for payment and MDS through Medicare’s online claiming, this is the preferred method for claiming and submitting MDS. CN providers who use online claiming to submit their claims include the MDS along with their submission.

1.4.2 Manual
The MDS Collection Tool is an Excel spreadsheet that is used to collect MDS Data manually.

If MDS data is not submitted in the format used by the MDS Collection Tool, or is incomplete, it will be returned to the CN provider for correction and resubmission.

1.5 The MDS Collection Tool Process
Step 1: Open the MDS Collection Tool.

Step 2: Once the MDS Collection Tool is open, save the MDS Collection Tool on your computer using your CN provider name* and the date that you commence completing it.
For example: If your provider name is “Tower Nursing Services”, and the MDS is completed on 1 November 2014, you would name the file as follows.

**Note:** There is a 35-character limit for MDS file names (including spaces). Please ensure each file name complies with the limit.

Once you have saved the MDS Collection Tool you can enter data.

1.5.1 Entering Information
The MDS Collection Tool is pictured below:

First, the following sections that need to be completed are:

- Provider Details;
- Claim Details; and
- Staffing Resources Used.

1.5.2 Provider Details
The Provider Details section collects information which allows DVA to:
- identify the CN provider and site submitting the data;
- seek further information (if required) from the CN provider’s MDS contact officer; and
- return data for resubmission if necessary.

1.5.3 Information required for Provider Details

Provider Business Name
This field requires you to enter your Provider Business Name as it appears on your DVA Community Nursing Agreement, however in some cases you may need to shorten the length to comply with the 35 character limit (including spaces).

Site Name (if applicable)
If CN providers have more than one site, enter the name of the relevant site, otherwise leave this field empty.

Provider Number
Enter the CN provider number for the site.

Contact name
Enter the name of the person who can assist with questions about the completed MDS Collection Tool.

Contact Phone Number
Enter the Phone Number for the contact person above.

1.5.4 Claim Details
Claim Details are recorded in the first four columns of the MDS Collection Tool, as shown below:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Claim Details section identifies the entitled person, item number/s and the claim period to which the data relates. It is used to match MDS data to a claim.

If details are entered incorrectly, the data provided cannot be matched to a claim. The CN provider is not considered to have met their contractual obligations until data has been correctly matched to a claim.
1.5.4.1 Information required for Claim Details
All fields in the Claim Details section need to be completed for each row of data.

**NOTE:** A separate row of data must be entered for an entitled person for each item number used during a 28-day claim period.

**File Number**
This field must contain the entitled person’s file number written in exactly the same way as it appears on the entitled person’s Gold or White Card.

**Veteran Surname**
This field must contain the entitled person’s surname entered exactly the same way as it appears on the entitled person’s Gold or White Card.

**Item Number**
The item number(s) must be recorded exactly as it was on the claim for the 28-day claim period.

The item number field includes a drop down menu that restricts entries to valid item numbers. CN providers can either enter a valid item number or use the drop down menu.

Where an entitled person has more than one item number in a 28-day claim period, each item number must be recorded on a separate row.

*Error Message: Item Number*
If an invalid item number is entered into this field, the error message below will appear. Click on Retry and choose the correct item number from the drop down list.
Completing Claim Period From

Dates must be entered in the DD/MM/YYYY format. This column requires the commencement date of the entitled person’s 28-day claim period. This must be the same date as recorded on the claim.

Where there is more than one item number for the 28-day claim period, the Claim Period From date entered must be the same for all item numbers claimed.

The template has been formatted to prevent an entry that is not in a date format, the message below will appear if an invalid date entry is made:

If this message appears, click on Retry and re-enter the correct date.

1.5.5 Staffing Resources Used (28-day claim period)
The Staffing Resources Used (28-day claim period) section records the number of visits and hours of service provided by each of the following personnel:

- Clinical Nurse Consultants (CNC);
- Registered Nurses (RN);
- Enrolled Nurses (EN); and
- Nursing Support Staff (NSS).

This data is used to inform Community Nursing policy decisions including the setting of future item number fee levels and future directions for DVA’s Community Nursing program. It is therefore important that the data provided is accurate.

1.5.5.1 Information required for Staffing Resources Used

Visits/occurrences - data for each type of personnel
CN providers are required to complete the number of visits/occurrences made by each type of personnel to an entitled person within the 28-day claim period.

Minutes and Hours - data for each type of personnel
CN providers are required to enter the total number of minutes and hours of care provided by each type of personnel within the 28-day claim period.

Data must be entered in DECIMAL HOURS, for example:

- 5 minutes must be entered as 0.1 hours, 15 minutes must be entered as 0.25 hours and 150 mins as 2.5 hours. To assist, a conversion calculator is also included with the MDS Data Collection Tool.

For example:

During a 28-day claim period, an entitled person receives:

- One 20 minute visit from a CNC:
  - 20 minutes divided by 60 minutes = 0.33 hours;

- Two visits from a RN, one takes 35 minutes and the other 45 minutes:
  - Add visits to get a total of 80 minutes; and
  - 80 minutes divided by 60 minutes = 1.33 hours.

- Three visits per week from a NSS which take 45 minutes each:
  - This makes 12 visits in the 28-day claim period;
  - 12 times 45 minutes = 540 minutes; and
  - 540 minutes divided by 60 minutes = 9 hours.
The correct entry for this example would be as follows:

<table>
<thead>
<tr>
<th>Nursing Visits/Occurrences</th>
<th>CNC Hours</th>
<th>RN Visits/Occurrences</th>
<th>RN Hours</th>
<th>EM Visits/ occurrences</th>
<th>EM Hours</th>
<th>NSS Visits</th>
<th>NSS Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.33</td>
<td>2</td>
<td>1.33</td>
<td></td>
<td>12</td>
<td>9.00</td>
<td></td>
</tr>
</tbody>
</table>

Error messages
If an invalid number is entered into these fields, an error message will appear. Click on Retry and enter the correct number.

---

1.5.5.2 Information not required for Staffing Resources Used

The MDS Collection Tool indicates when an item number does not require Staffing Resources Used to be entered, a message appears as shown below:

<table>
<thead>
<tr>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>CNC Visits/Occurrences</th>
<th>CNC Hours</th>
<th>RN Visits/Occurrences</th>
<th>RN Hours</th>
<th>EM Visits/Occurrences</th>
<th>EM Hours</th>
<th>NSS Visits</th>
<th>NSS Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>WVC</td>
<td>NC37</td>
<td>01/10/2014</td>
<td>No Nursing Hours/Visits Required for this Item</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1.6 Scenarios when claiming a core and add-on

Scenario 1
Mr Brown is admitted to the nursing service on 1/10/14. The RN conducted the comprehensive assessment on the first home visit which took 1.5 hrs and Mr Brown receives clinical care nine times (this includes the comprehensive assessment) and personal care eight times in a 28-day claim period.

Example A
The provider delivers community nursing services to Mr Brown using an RN for seven visits for clinical care (including the comprehensive assessment), EN for two visits/occurrences (delivers both the clinical and personal care) and a NSS for six visits. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>Clinical Visits / Occurrences</th>
<th>Clinical Hours</th>
<th>RN Visits / Occurrences</th>
<th>RN Hours</th>
<th>EN Visits / Occurrences</th>
<th>EN Hours</th>
<th>NSS Visits</th>
<th>NSS Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>BROWN</td>
<td>Core, Clinical</td>
<td>NL13</td>
<td>01/10/2014</td>
<td></td>
<td>6</td>
<td>3.00</td>
<td>2</td>
<td>1.09</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BROWN</td>
<td>Other</td>
<td>NA02</td>
<td>01/10/2014</td>
<td></td>
<td>1</td>
<td>1.50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BROWN</td>
<td>AddOn, Personal</td>
<td>NT02</td>
<td>01/10/2014</td>
<td></td>
<td>2</td>
<td>1.00</td>
<td>6</td>
<td>3.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Example B
The provider delivers community nursing services to Mr Brown using an RN (nine visits in total) to deliver all the care. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>Clinical Visits / Occurrences</th>
<th>Clinical Hours</th>
<th>RN Visits / Occurrences</th>
<th>RN Hours</th>
<th>EN Visits / Occurrences</th>
<th>EN Hours</th>
<th>NSS Visits</th>
<th>NSS Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>BROWN</td>
<td>Core, Clinical</td>
<td>NL13</td>
<td>01/10/2014</td>
<td></td>
<td>8</td>
<td>4.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BROWN</td>
<td>Other</td>
<td>NA02</td>
<td>01/10/2014</td>
<td></td>
<td>1</td>
<td>1.50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BROWN</td>
<td>AddOn, Personal</td>
<td>NT02</td>
<td>01/10/2014</td>
<td></td>
<td>8</td>
<td>4.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Example C
The provider delivers community nursing services to Mr Brown using an RN to conduct the comprehensive assessment, an EN to deliver the remaining clinical care and a NSS to deliver all the personal care. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>Staffing Resources (Totals for 28 day Claim Period)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>BROWN</td>
<td>Core Clinical</td>
<td>NL13</td>
<td>01/10/2014</td>
<td></td>
<td>[CNC Visits/ Occurrences]</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>[RN Visits/ Occurrences]</td>
<td>4.00</td>
</tr>
</tbody>
</table>

Scenario 2
Mrs White is a war widow who requires daily personal care. She sustained a skin tear on day 18 of the 28-day claim period and required a combination of clinical (2nd daily) and personal care for the remaining period. Mrs White receives clinical care six times and personal care 28 times.

Example A
The provider delivers community nursing services to Mrs White using an RN for the all clinical care clinical care and an NSS for all the personal care. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>Staffing Resources (Totals for 28 day Claim Period)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITE</td>
<td>Core Personal</td>
<td>NPO6</td>
<td>01/10/2014</td>
<td></td>
<td>[CNC Visits/ Occurrences]</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>[RN Visits/ Occurrences]</td>
<td>14.00</td>
</tr>
</tbody>
</table>

| WHITE           | AddOn Clinical | NS02      | 01/10/2014|                   | [Nursing Hours/ Visits Required for this Item]      |  |
|                 |                |           |          |                   |                                                    | 6    |
|                 |                |           |          |                   |                                                    | 3.00 |
Example B
The provider delivers community nursing services to Mrs White using an RN to deliver both the clinical care and personal care on the visits where both services are required, the remaining personal care is delivered by an NSS. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>Claim Period From</th>
<th>CVC Visits/Occurrence</th>
<th>CVC Hours</th>
<th>RN Visits/Occurrence</th>
<th>RN Hours</th>
<th>EN Visits/Occurrence</th>
<th>EN Hours</th>
<th>NSS Visits</th>
<th>NSS Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITE</td>
<td>Core Personal</td>
<td>NP06</td>
<td>01/10/2014</td>
<td></td>
<td></td>
<td>5</td>
<td>3.60</td>
<td>22</td>
<td>11.60</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHITE</td>
<td>Additional Clinical</td>
<td>NS02</td>
<td>01/10/2014</td>
<td></td>
<td></td>
<td>5</td>
<td>3.60</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHITE</td>
<td>WC</td>
<td>NC11</td>
<td>01/10/2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No Nursing Hours/Visits Required for this Item</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Example C
The provider delivers community nursing services to Mrs White using an RN to assess and deliver the wound care in one visit as well as personal care, for the remaining visits where both clinical and personal care is required an EN delivered both, the remaining personal care is delivered by an NSS. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>Claim Period From</th>
<th>CVC Visits/Occurrence</th>
<th>CVC Hours</th>
<th>RN Visits/Occurrence</th>
<th>RN Hours</th>
<th>EN Visits/Occurrence</th>
<th>EN Hours</th>
<th>NSS Visits</th>
<th>NSS Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITE</td>
<td>Core Personal</td>
<td>NP06</td>
<td>01/10/2014</td>
<td></td>
<td></td>
<td>1</td>
<td>0.60</td>
<td>5</td>
<td>2.60</td>
<td>22</td>
<td>11.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHITE</td>
<td>Additional Clinical</td>
<td>NS02</td>
<td>01/10/2014</td>
<td></td>
<td></td>
<td>1</td>
<td>0.60</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHITE</td>
<td>WC</td>
<td>NC11</td>
<td>01/10/2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No Nursing Hours/Visits Required for this Item</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scenario 3
Mr Gray is a veteran who requires twice a day visits for assistance with personal care. He has a Buprenorphine transdermal (e.g. Norspan) patch changed once a week.

Example A
The provider delivers community nursing services to Mr Gray using an RN to change the Norspan patch and an NSS to deliver all the personal care. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>Claim Period From</th>
<th>CVC Visits/Occurrence</th>
<th>CVC Hours</th>
<th>RN Visits/Occurrence</th>
<th>RN Hours</th>
<th>EN Visits/Occurrence</th>
<th>EN Hours</th>
<th>NSS Visits</th>
<th>NSS Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITE</td>
<td>Core Personal</td>
<td>NP06</td>
<td>01/10/2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>36</td>
<td>37.33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHITE</td>
<td>Additional Clinical</td>
<td>NS02</td>
<td>01/10/2014</td>
<td></td>
<td></td>
<td>4</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Example B
The provider delivers community nursing services to Mr Gray using an RN to change the Norspan patch and deliver personal care in the same visits/occurrences and an NSS to deliver all the remaining personal care. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>Staffing Resources (Totals for 20 day Claim Period)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Core Personal</td>
<td></td>
<td>NP15</td>
<td>01/10/2014</td>
<td>4 2.67 52 34.66</td>
</tr>
<tr>
<td></td>
<td>AddOn Clinical</td>
<td></td>
<td>NS01</td>
<td>01/10/2014</td>
<td></td>
</tr>
</tbody>
</table>

Scenario 4
Mr Black has a deteriorating palliative condition and is receiving daily visits for a combination of personal care, medication administration (via a syringe driver), symptom management and psychosocial aspects of care. Personal care services take approximately 30 minutes per day. Clinical care including medication administration and symptom management 30 minutes per day and psychosocial care 15 minutes per day.

Example A
The provider delivers community nursing services to Mr Black using an RN for the clinical and psychosocial care and an NSS delivers all the personal care. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>Staffing Resources (Totals for 28 day Claim Period)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Black</td>
<td>Core Clinical</td>
<td>NL17</td>
<td>01/10/2014</td>
<td>28 14.00 28 14.00</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>AddOn Personal</td>
<td>NT14</td>
<td>01/10/2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>Other</td>
<td>NA06</td>
<td>01/10/2014</td>
<td>28 7.00</td>
</tr>
</tbody>
</table>
Example B
The provider delivers community nursing services to Mr Black using an RN to deliver all Mr Black’s care needs. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>CNC Visits/Occurrences</th>
<th>RN Hours</th>
<th>RN Visits/Occurrences</th>
<th>EN Hours</th>
<th>EN Visits/Occurrences</th>
<th>NSS Hours</th>
<th>NSS Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>Core Clinical</td>
<td>NL17</td>
<td></td>
<td>01/10/2014</td>
<td>28</td>
<td>14.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>AddOn Personal</td>
<td>NT14</td>
<td></td>
<td>01/10/2014</td>
<td>28</td>
<td>14.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>Other</td>
<td>NA06</td>
<td></td>
<td>01/10/2014</td>
<td>28</td>
<td>7.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.7 Checking MDS Collection Tool is complete
The MDS Collection Tool indicates if a row of data is missing a field by showing the font as red.

The example below is missing the “Claim Period From” and “CNC Hours (total)” data.

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>CNC Visits/Occurrences</th>
<th>CNC Hours</th>
<th>RN Visits/Occurrences</th>
<th>RN Hours</th>
<th>EN Visits/Occurrences</th>
<th>EN Hours</th>
<th>NSS Visits</th>
<th>NSS Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>NX</td>
<td>SMITH</td>
<td>Core_Personal</td>
<td>NP01</td>
<td></td>
<td>0.87</td>
<td>3.00</td>
<td></td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When data has been entered correctly, the font will change to black:

DVA Community Nursing - Minimum Data Set (MDS)

<table>
<thead>
<tr>
<th>Vendor File No.</th>
<th>Vendor Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>CNC Visits/Occurrences</th>
<th>CNC Hours</th>
<th>RN Visits/Occurrences</th>
<th>RN Hours</th>
<th>EN Visits/Occurrences</th>
<th>EN Hours</th>
<th>NSS Visits</th>
<th>NSS Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>FX123456C</td>
<td>SMITH</td>
<td>Core_Personal</td>
<td>NP01</td>
<td>01/10/2014</td>
<td>1</td>
<td>0.87</td>
<td></td>
<td>4</td>
<td>3.00</td>
<td>4</td>
<td>5.00</td>
<td></td>
</tr>
</tbody>
</table>

Once all the data has been entered the MDS can be submitted.
1.8 Submitting finalised data for manual MDS

1.8.1 SENSITIVE email

DVA’s Secure Mail Facility (Sensitive email) has been introduced to enable the secure communication of sensitive information between DVA and external parties over the internet.

Sensitive emails sent via this facility are encrypted to ensure the information within each email remains private and secure. Encrypting the email means the contents are scrambled/encoded to minimise the risk of an unauthorised person being able to read it if is intercepted.

1.8.2 Registering an email address

A CN provider is required to register an email address in order to submit their MDS through Sensitive email. The Contractor’s Representative (as recorded on the Agreement held with DVA) is first required to email the following information regarding the person who will be submitting the MDS (MDS contact):

- MDS contact name;
- Contact phone number; and
- Email address used to submit the MDS.

This information should be emailed to mds@dva.gov.au.

DVA will respond to the MDS contact/s providing information on how to use Sensitive email. Once the MDS contact/s have read the information and replied to DVA, arrangements will be made to commence communication via Sensitive email.

The first time you receive a Sensitive email, you will asked to:

1. Open the attachment to the email; and
2. Follow the instructions.

Open the attachment to the email that is called ‘SecureMessageAtt.html’:

A new browser window will open. Click the ‘Read Message’ button (the button is in the middle of the page):
You will then be prompted to register:

- enter your first and last name;
- create a password and re-confirm the password; and
- enter a ‘Password Recovery Question’. The recovery question will assist you if you forget your password.

Email Address: MDS@dlva.gov.au

First Name: Joe
Last Name: Blogs
Password: ********
Confirm Password: ********

Question: Father's middle name
Answer: Burt

Continue
Passwords must meet certain conditions:

- Passwords must be 8-20 characters long.
- At least one digit (0-9) is required.
- At least one symbol character is required.
- Your username may not appear in the password.

An example password is: Pa55w@rd

Upon successful login, the Sensitive email will be displayed in the browser window.

1.8.3 Emailing the MDS Collection Tool
Open the Sensitive email from DVA that will appear in your mailbox with a ‘from’ address mds@dva.gov.au and will have a classification of DLM=Sensitive:Personal.

Open the Sensitive email from your mailbox and the attachment to the email that is called ‘SecureMessageAtt.html’:
A new browser window will open, click the ‘Read Message’ button:

Read Message

You have received a secure message from the Department of Veterans’ Affairs. To read the secure message, click the button above. If you are a first time user, you may have to take additional steps.

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Click the ‘Reply’ button (the button is located at the top left) to reply only to the address that sent you the email:

Subject: CH Provider MCS [LM-Sensitive Personal]

Digital Signature is VALID

Click here to View Image
When replying to a Sensitive email, please ensure the subject field is not changed. To attach the MDS Collection Tool spreadsheet click on ‘Attach a File’ as below:

Locate the MDS Collection Tool spreadsheet in your records and attach the MDS Collection Tool spreadsheet by highlighting and clicking on the ‘+ ADD’ button, and tick ‘Send me a copy’:

---

**From:** MDS@dva.gov.au  
**Sent:** Fri, 5 Oct 2012 05:03:02 +0000  
**To:** MDS@dva.gov.au  
**Cc:**  
**Subject:** CN Provider MDS [DLM=Sensitive:Personal]  

---

**From:** MDS@dva.gov.au  
**Sent:** Fri, 5 Oct 2012 05:03:02 +0000  
**To:** MDS@dva.gov.au  
**Cc:**  
**Subject:** test[DLM=Sensitive:Personal]
Once the MDS Collection Tool spreadsheet has been located, click on the ‘Upload’ button:
The uploaded MDS Collection Tool spreadsheet will be displayed:

Repeat the previous steps if there is more than one spreadsheet to be uploaded. Once all files are attached click on the ‘Send’ button:
Once the Sensitive email has been sent, the following message will appear:

![Message Sent](image)

Click the ‘Logout’ button, this will securely log you out of the secure session:

![Logged Out](image)

Note: The MDS contact must keep the original Sensitive email sent by the DVA to reply to DVA each month.

All MDS submissions to DVA must be sent DLM=Sensitive:Personal to ensure compliance with the Commonwealth Information Privacy Principles Legislation.

1.8.4 Who do I contact if I have a problem?
If this information is unable to assist you, and the problem or question is technical in nature, you can send an email to secure.services@dva.gov.au. Please let DVA know how to contact you regarding your query.

Do not disclose your password or password recovery answer in this email. DVA will not ask you for your password or password recovery answer.

1.8.5 Password resets
If you cannot remember the answer to your ‘Recovery Question’ you will need to contact DVA on either 1300 301 575 or secure.services@dva.gov.au to reset the password.

1.8.6 Resubmits
If MDS data is submitted incorrectly, it will be returned via an email identifying the issues. CN providers are required to correct and resubmit the data within 28 days. When resubmitting data, the CN provider is required to mark the data clearly as resubmit.