Exploring the Coordinated Veterans’ Care Program – how it is being implemented and which participants receive the greatest benefits

Discipline of General Practice
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Executive Summary

Overview of the Coordinated Veterans’ Care Program

The Department of Veterans’ Affairs (DVA) Coordinated Veterans’ Care (CVC) Program is a team-based program designed to improve care and reduce unplanned hospital admissions and re-admissions through a coordinated model of care. The program is aimed at those Gold Card holders with chronic conditions, and complex care needs who are most at risk of unplanned hospitalisation.

The underlying premise behind chronic disease care coordination programs is that people with chronic diseases have significantly poorer outcomes and higher health care costs than should be achievable if they received evidence based and coordinated care and they adhered to medication, exercise, diet and self-care regimes.

As at 30 June 2015, there had been approximately 29,700 Gold Card holders enrolled in the CVC Program since its introduction in May 2011. The program targets five conditions where improved coordinated community care has the potential to reduce unplanned hospitalisation. These are:

- congestive heart failure
- coronary artery disease
- pneumonia
- chronic obstructive pulmonary disease
- diabetes.

General Practitioners (GPs) are paid to enrol Gold Card holders onto the CVC Program and to provide ongoing, comprehensive and coordinated care with the assistance of their practice nurse or a community nurse (from a DVA contracted provider).

The scope and aims of the present research

The general aim of the present research project was to explore how the CVC program was being implemented in general practice and identify which participants were receiving the greatest benefits. Specifically the project aimed to:

- Perform a comprehensive literature review of primary care interventions that have sought to reduce health care costs and synthesise this literature to identify the critical elements for success for care coordination programs; and

- Conduct qualitative interviews with a sample of general practices to examine the degree to which care coordination elements for success (identified in the literature review) are present in the CVC Program.

- Integrate the findings from the literature review and the qualitative interviews to provide a summary of the key implications of the present research for DVA.
Literature review of care coordination programs to identify critical elements for success

A comprehensive literature review was performed to examine the evidence base for primary care interventions that improve the management of chronic disease, with a specific focus on the impact of interventions that reduce unnecessary health service use in older patients with chronic disease. In addition, an in-depth case study approach was used to examine a number of care coordination programs, which have been implemented in Australia and US.

Based on an initial review of the literature and in-depth case studies in the context of the Australian health care system, effective care coordination and disease management programs will be characterised by the following:

- High levels of in-person contact between care coordinators and patients;
- High levels of collaboration between care coordinators and general practitioners;
- Careful targeting to patients who are both likely to benefit from care coordination and have high costs that can be moderated;
- A strong emphasis on medication adherence;
- Thorough assessments and care planning;
- Support for patient education and self-management;
- Close attention to transitions between primary and secondary care; and
- A quality improvement approach for program development and refinement.

Qualitative interviews with general practices

Qualitative interviews were conducted with a sample of 20 general practices to examine the degree to which care coordination elements for success (identified in the literature review) were present in the CVC Program. A purposive sampling technique was used, based on the type of community served (regional and urban communities) and numbers of CVC patients. Practices were selected from former Medicare Local regions in South Australia and from regional and urban Queensland regions (Metro North and South Brisbane, Gold Coast, Sunshine Coast, West Morton-Oxley and Wide Bay). The results from the interviews are presented around the key characteristics for successful care coordination programs identified in the literature review.

Targeting correct patients. Patients were most often invited to enrol in the CVC Program where GPs (and care coordinators) believed that the patient would benefit from the program and that they were at risk of poor health outcomes. There was considerable variability between practices with respect to how practices identified which patients would benefit from the program or how “risk” of poor health outcomes was assessed.

In-person interaction between care coordinators and patients. Effective care coordination programs are characterised by high levels of in-person contact between care coordinators and patients. From the interviews it appeared that the majority of contact between care coordinators and patients occurred by telephone and not in-person.

GP engagement and teamwork. GPs needed to be effectively involved and to collaborate with care coordinators for the delivery of care coordination to be successful. Interviewees reported effective communication between care coordinators and GPs. Information regarding patient care was shared via electronic systems (e.g. in notes associated with patient files), via
impromptu meetings or via scheduled appointments with CVC patients. In general, practice nurses were comfortable approaching GPs as required and often worked together to coordinate care for a patient. Regular practice meetings provided a further opportunity for communication.

**Medications.** There is good evidence that poor management and coordination of medications contributes significantly to increased health costs and hospital admission rates. Medication management was identified as an important part of the CVC Program by the majority of interviewees. Coordinating care with a pharmacist who conducts home medicine reviews was one of the most common ways that practices sought to improve medication management.

**Transitional care.** Transitional care interventions are designed to facilitate smoother, safer, and more efficient transitions from hospital to primary care. In the CVC Program, care coordinators are expected to liaise with hospital staff upon learning of an unplanned admission and request discharge information, or be involved in the discharge planning process if appropriate. For the most part there was very little evidence that improved transitional care was being implemented in the CVC Program.

**Evidence based patient education interventions.** There is growing research evidence that patient education and self-management support can improve symptoms of some chronic illnesses. From the interviews it is clear that CVC care coordinators provide self-management support in a relatively unstructured manner and that many care coordinators have received very little formal self-management training.

**GP and care coordinators’ perceptions of CVC Program benefits.** GPs and care coordinators believed that hospitalisations were being prevented because of the CVC Program. This was attributed to early intervention, regular contact with patients, mental health support, care coordination, increased medication compliance and falls prevention. It was believed that information gathered by care coordinators, particularly during home visits and monthly phone calls, differed from the information available to GPs following standard consultations. This information improved the capacity of the practice to provide holistic care and was highly valued.

**Implications of the findings of this research for DVA**

In discussing the implications of this research for DVA it is important to recognise a number of key contextual factors. These are:

- It is widely recognised in Australia and internationally, that the increasing demands placed on health care systems from aging populations with chronic health needs requires better care coordination.

- The DVA CVC Program is a significant care coordination program by Australian and international standards. The model adopted in the CVC Program comprises many of the critical elements for success identified in the research literature.

- Developing cost-effective programs to achieve better care coordination takes experimentation, evaluation and refinement over a period of years. It is only relatively recently that the critical elements for effective programs have been identified.
The present research has found that the CVC Program comprises two key strengths that have been recognised in the literature as being crucial to the success of care coordination programs:

- the design of the CVC Program promotes collaborative teamwork between care coordinators and GPs, and
- the CVC Program model encourages GP involvement and engagement in health assessment and care planning which is crucial if the delivery of care coordination is to be successful.

The presence of these crucial design elements is illustrated by the rapid uptake by older veterans on the program and the broad acceptance of the program in general practice. The results from the present research do however suggest that there are a number of improvements that could be made to the CVC Program to improve its operation.

**Better patient targeting**
The majority of patients enrolled in the CVC Program have been done so on the basis of a GP assessment of likelihood of benefit. Currently this assessment is subjective, unstructured and it appears that there is variation in how GPs are selecting patients for enrollment into the CVC Program. DVA should consider developing a more structured and standardised approach for GPs to use to identify appropriate candidates to the CVC Program.

**More detailed specification of the process of care coordination**
DVA should consider providing a more detailed specification of the process of care coordination to GPs and care coordinators. The desire for practical resources that are more process driven and that detail the CVC Program requirements was expressed by both GPs and care coordinators. This more detailed specification would focus particularly on transitional care planning, patient self management support and medication management. Importantly DVA should also consider increasing the amount of in-person interaction between patients and care coordinators required under the CVC Program.

**More face to face training opportunities for care coordinators**
Further training and support to care coordinators is required if the CVC Program is to be consistently implemented to a high standard; including training in a more detailed specification of care coordination activities. Optimally, this will include face to face training opportunity to ask questions and network with others.

**Assist GPs to improve medication management**
A substantial amount of effort around medication management is taking place especially regarding monitoring adherence and home medications reviews. DVA could consider providing more timely and higher quality information about medications to GPs. The first step however is to better use the information that is already available. This would include improving GP knowledge and access to the Patient Treatment Report (PTR) and making general practices aware they can choose the method of delivery (paper versions, Health Professional Online Services portal or via secure electronic messaging).
**Quality improvement program**
A quality improvement approach for program development and refinement was identified in the literature review as a key element of effective care coordination and disease management programs. Regular review of CVC patients both with regard to the care being received as well as adherence to the CVC program guidelines has the potential to improve the care participants in the CVC program. There are numerous quality improvement models that can be implemented at all levels of the primary health care system, including the federal, state, Primary Health Network and practice level. DVA should consider developing a CVC Program specific quality improvement program.

**Further research**
There are a number of opportunities for further research to contribute to the continuing development of the CVC Program. Two future research projects could be considered by DVA.

- Develop and pilot test an enhanced model of CVC care using the results from the present project. The purpose of this pilot study is to determine whether the changes outlined in the present study are feasible to implement in general practices and lead to better outcomes for CVC program participants.

- Develop and test an improved care transitions package for the CVC Program based around the electronic systems that have been implemented in some Australian health regions to improve information flows between major hospitals in the region and primary care.

**Conclusion**

There is an important need to develop cost effective primary care based care coordination programs for older Australians (both veterans and non-veterans) living with chronic diseases. The CVC Program is highly innovative in how it provides better services to meet the health needs of veterans with chronic diseases. This research has identified that improvements can be made to the CVC Program which will contribute to better health outcomes for veterans including reducing the need for hospitalisations and, potentially, health care savings.