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Overview
Overview

About the CVC Program

The Department of Veterans’ Affairs (DVA) Coordinated Veterans’ Care (CVC) Program commenced on 1 May 2011. The CVC Program:

● uses a proactive approach to improve the management of participants’ chronic diseases and quality of care
● involves a care team of a general practitioner (GP) plus a nurse coordinator who work with the participant (and their carer if applicable) to manage their ongoing care
● provides payments to GPs for initial and ongoing care.

GPs who decide to be involved in the CVC Program are required to:

● prepare for the program
● enrol participants in the program
● provide ongoing care.

Eligibility

The program is aimed at Gold Card holders who are at high risk of unplanned hospitalisation. The CVC Program is primarily targeted at patients with one or more specific chronic conditions, i.e. congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes or pneumonia.

GPs can enrol participants in the program if they:

● pass an eligibility assessment
● have given their informed consent to be involved in the program.

Payments for GPs

By participating in the program, GPs can claim the following payments through existing payment arrangements with Medicare:

● Initial Incentive Payment for enrolling a participant in the program
● Quarterly Care Payments for ongoing care.

The current schedule of payments is available on the DVA website at www.dva.gov.au/cvc.htm

Legislation

The CVC Program is administered under the Treatment Principles – Coordinated Veterans’ Care Program, the Notes for Providers for the Veterans’ Entitlements Act 1986, and the Military Rehabilitation and Compensation Act 2004.
CVC Program Model of Care

The Model of Care for the CVC Program is based on the core team, which includes the veteran, the veteran's carer (if applicable), the GP and the nurse coordinator, who is either a practice nurse, Aboriginal health worker or community nurse.

The team uses care planning, coordination and review as the tool to focus on better management and self management of the participant’s health and to incorporate the multidisciplinary team.

The sharing of health information is a key feature of the CVC Program. The availability of electronic health records and electronic communication assist in sharing health information amongst all providers of health care for CVC participants.

Regular communication, empowerment and coaching are important elements in the success of the team based model.

The care planning cycle is continuous and most participants entering the program will remain on the program.
Benefits for participants

As a result of the program, participants are likely to become:

- healthier, with less need to be admitted to hospital
- more educated and empowered to self manage their conditions.

Benefits for health professionals

As a result of the program, health professionals can benefit in numerous ways:

- GPs receive recognition and remuneration, for non face-to-face time spent in providing comprehensive care to eligible participants
- help improve the quality of care of participants
- enhanced opportunity for nurses to work in partnership with the GP
- efficient alignment of nursing roles with nursing skills
- receive training and resources for chronic disease management.

Key roles and stages

GPs play a lead role and are required to commit sufficient time and resources to the program.

The nurse coordinator (NC) can be one of the following:

- practice nurse (PN) – this is either a registered nurse or enrolled nurse, and can include a nurse practitioner
- Aboriginal health worker (AHW)
- community nurse from a DVA community nursing provider (CN provider).

The GP and nurse coordinator have different roles in the three stages of the CVC Program.
Prepare for the CVC Program

<table>
<thead>
<tr>
<th>Action</th>
<th>Role</th>
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<tbody>
<tr>
<td>1. Appoint a NC, ie PN, AHW or CN provider.</td>
<td>GP</td>
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<tr>
<td>2. Prepare your practice for the CVC Program.</td>
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Enrol participant in the program

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<th>Action</th>
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<tr>
<td>3. Identify potential participants.</td>
<td>DVA/GP</td>
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<td>4. Assess their eligibility for the program.</td>
<td>GP</td>
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<td>5. Gain the participant’s informed consent.</td>
<td>GP</td>
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<tr>
<td>6. Conduct a needs assessment.</td>
<td>GP/PN</td>
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<tr>
<td>7. Prepare a Care Plan.</td>
<td>GP/PN</td>
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<tr>
<td>8. Finalise the Care Plan.</td>
<td>GP</td>
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<tr>
<td>9. Consider the need for social assistance.</td>
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Provide ongoing care

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<th>Action</th>
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<tr>
<td>10. Coordinate treatment services as per the Care Plan.</td>
<td>GP/NC</td>
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<tr>
<td>11. Regularly review, update and renew the Care Plan.</td>
<td>GP/NC</td>
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Training & Resources in Chronic Disease Management

DVA provides free comprehensive training and resources in chronic disease management for GPs and nurses participating in the CVC Program. The training is available online and comprises four modules:

Module One – Coordinated Veterans’ Care: Is your service ready?
Module Two – Care Planning and Coordination
Module Three – Managing Care Plans with disease-specific elements
Module Four – Veterans’ social isolation, mental health and wellbeing

To access the training and resources material, visit http://cvceducationresources.dva.gov.au
Prepare
Prepare for the CVC Program

The first stage for GPs involved in the CVC Program is preparation. There are two key steps:

- appointing a nurse coordinator
- preparing your practice for the CVC Program.
1. Appoint a Nurse Coordinator

Overview

In implementing the CVC Program, one of your first actions is to appoint a nurse coordinator, whose role is to coordinate the Care Plan, liaise with the participant and their carer, if they have one, and provide feedback to the GP.

The nurse coordinator is either:

- a practice nurse (PN)
- an Aboriginal health worker (AHW)
- a community nurse from a CN provider.

Qualifications

A registered nurse is preferred as the nurse coordinator.

However, where there is no registered nurse:

- An enrolled nurse (EN) or, if appropriate, an AHW, may be appointed as the nurse coordinator.
- The EN or AHW is expected to complete the CVC training modules within a reasonable period of time of commencing care coordination.
- The GP will play a closer clinical role in care coordination with an EN or AHW.

2. Prepare your practice for the CVC Program

Set-up and procedures

While many practices have already shifted towards proactive, planned, multidisciplinary care, you may need to make some changes to your practice set-up and procedures prior to enrolling participants in the CVC Program.

Preparation checklist

The following checklist will help you to prepare your practice for the CVC Program:

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<tr>
<th>Check</th>
<th>Action</th>
<th>Role</th>
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<tbody>
<tr>
<td>✔️</td>
<td>Do all members of the care team understand the basic requirements and roles and are they committed to supporting the program?</td>
<td>GP</td>
</tr>
<tr>
<td>✔️</td>
<td>Have you appointed a nurse coordinator?</td>
<td>GP</td>
</tr>
<tr>
<td>✔️</td>
<td>If a PN or AHW is the nurse coordinator, have you set up:</td>
<td>GP</td>
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<tr>
<td></td>
<td>- a reminder system to prompt the PN to call/visit/make appointments for CVC patients</td>
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<td></td>
<td>- a discrete space for the PN to coordinate care in privacy</td>
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<td></td>
<td>- home visit capability for the PN to visit CVC patients who live within a reasonable time and distance?</td>
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Enrol
Enrol participants in the program

The second stage of the CVC Program is for GPs to enrol participants. The key steps are:

- DVA and GPs identify potential participants
- assess eligibility for the program
- gain the participant’s consent
- conduct a needs assessment
- prepare a Care Plan
- finalise the Care Plan
- consider the need for social assistance.

There is no enrolment form to complete and return to DVA. When all steps are completed, the GP records the enrolment and consent on the patient’s record. The GP can now claim the Initial Incentive Payment and this will automatically inform DVA that the patient is now a participant of the CVC Program.
3. Identify potential participants

Who is the program targeted at?

The CVC Program targets veterans, war widows, war widowers and dependants who hold a DVA Gold Card and are at risk of unplanned hospitalisation.

The program is focussed on Gold Card holders with one or more of the following chronic conditions:

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

Who identifies participants?

Individuals may be identified as potential participants for the program in the following ways:

| DVA | DVA identifies potential participants using predictive modelling to analyse the health care data of Gold Card holders. |
| GP  | A GP may identify one of their patients as a potential participant. |
| Patient or care provider | A patient may ask to participate in the CVC Program. A patient’s care provider, such as a carer, specialist, allied health worker, hospital discharge planner or community nurse, may recommend they arrange an appointment with their GP for an assessment for the CVC Program. |

Initial screening

When a Gold Card holder is identified as a potential participant, either the GP or the practice nurse (PN) should:

- check the patient’s medical record to ensure there are no disqualifying factors (e.g. terminal condition or lives in a residential aged care facility - refer to the Eligibility Checklist on the next page)
- contact the patient and explain the CVC Program to them
- make an assessment appointment if the patient is interested in the program.

Note: The CVC items are in addition to existing LMO Fee Schedule items. The assessment appointment is billed as a separate consultation.
4. Assess eligibility for the program

Eligibility Checklist

During the assessment appointment, the GP assesses the person to determine whether they are eligible for the CVC Program. The following set of eligibility criteria and disqualifying factors are used to assess a potential participant’s eligibility for the program.

A. MUST apply

Part A: ALL of the following eligibility criteria must apply to a potential participant:

- Are they a current holder of a DVA Gold Card?
- Do they currently live in the community (not in residential aged care)?
- Have they been diagnosed with one or more chronic diseases or conditions that have resulted, or could reasonably result, in frequent hospitalisation?
- Do they have complex care needs, being one or more of the following:
  - multiple comorbidities that complicate the treatment
  - unstable condition with a high risk of acute exacerbation
  - the condition is contributed to by frailty, age and/or social isolation factors
  - limitations in self management and monitoring?
- Do they require a treatment regimen that involves one or more of the following complexities of ongoing care:
  - multiple care providers
  - complex medication regimen
  - frequent monitoring and review
  - support with self management and self monitoring?
- Have they given their informed consent to go on the program?

B. Must NOT apply

Part B: To the best of the GP’s knowledge, none of the following disqualifying factors can apply to the potential participant:

- Are they currently a resident of a residential aged care facility?
- Have they been diagnosed with a condition that, in your opinion, would be likely to be terminal within 12 months? (Note: This applies only for initial admission; not where the diagnosis occurs after admission to the program.)
- Are they a participant in any Department of Health coordinated care program or in receipt of a home care package?

If ALL answers for Part A are Yes and Part B are No, they can be enrolled in the program.
5. Gain the participant’s consent

Separate consent

In order to enrol a participant in the CVC Program, the GP needs to gain their informed consent to participating in the program, the use of a nurse coordinator, and the sharing of their relevant health and medical information.

Note: This consent is in addition to the standard consents of DVA Gold Card holders.

Explain consent

In order to gain the participant’s informed consent, the GP explains the following:

- What it will mean for them to be on the CVC Program.
- What they are required to consent to:
  - the sharing of their relevant health and medical information
  - the involvement of the nominated nurse coordinator
  - the Care Plan that will be prepared as part of the enrolment process.
- Their relevant health and medical information will be shared with their health care providers as follows:
  - health care providers include specialists, pharmacists, allied health, community nurses, hospital discharge planners, assessors/providers of social assistance and nominated carers
  - regular reports on all DVA paid treatments and medicines will be provided to the GP
  - this will allow a shared holistic understanding of their condition
  - privacy principles and legislation will be observed by all recipients of the information.

Tip: Refer to the suggested script on page 32 for obtaining their informed consent.

Ask for their consent

Once the GP has explained what they will be consenting to, ask for their consent to:

- participate in the program
- the use of a nurse coordinator
- the sharing of their personal information, including relevant health and medical information and data, as outlined.

Explain that they will also be asked to consent to the Care Plan that will be prepared as part of their enrolment in the program.

Substitute consent

If the person is unable to provide informed consent, a person who is legally authorised to give substitute consent to treatment under state law (e.g. Public Trustee, guardian, holder of an appropriate Special Power of Attorney) may consent on their behalf. However, please consider if the CVC Program is the most suitable program for the person.

Note: If consent is not obtained, they cannot be enrolled on the program.

Once informed consent is obtained, the GP proceeds to the next steps for enrolling a participant in the program. A participant is not considered to be enrolled until all steps have been completed.
6. Conduct a needs assessment

Conduct a needs assessment

The GP or PN conducts a comprehensive needs assessment of the participant.

Where the PN is the nurse coordinator, it is recommended that they conduct the needs assessment – preferably in the patient’s home.

It is strongly recommended that the GP or PN use the questionnaires available at the CVC Training and Resources website at http://cvceducationresources.dva.gov.au/ to assist with assessing a person’s current self management of their health, a person’s current mental health and a person’s management of their current lifestyle.

7. Prepare a Care Plan

Prepare a Care Plan

Once a comprehensive needs assessment has been conducted, the GP or PN prepares a comprehensive Care Plan (or updates an existing plan). The GP must be involved in the finalisation of the Care Plan.

The Care Plan is a comprehensive version of a General Practitioner Management Plan, which is an existing LMO Fee Schedule item and is billed as a separate service to the CVC items. The Care Plan is tailored to the participant’s health needs, preferences and priorities. To allow flexibility for GPs, there is no mandated Care Plan template. However, the checklist below provides the minimum requirements expected in the Care Plan.

Care Plan Checklist

The Care Plan should contain at least the following information:

- a description of all chronic and other health conditions, including:
  - current care guide
  - targets
  - red flags
  - background information
  - current management
  - stepped escalation process
  - most recent results
- medications list including dose, frequency and known adherence
- allergies and adverse reactions
- self management goals and strategies
- any family and/or carer contact details
- significant medical events and results
- other treatment providers and their contact details
- referrals planned and reasons for referral
- devices being used.

Discuss with participant

The GP or PN discusses the Care Plan with the participant to ensure that they understand the following:

- goals of the Care Plan
- interventions and self management aspects
- methods of monitoring and evaluating the plan
- the need for regular monitoring and review.

When this has been done, the participant is asked to give their consent to the Care Plan.
8. Finalise the Care Plan

Key steps

When the participant gives their consent to the Care Plan:
- the GP records the decision to enrol them in the program
- the GP records their consent to participate in the program
- the PN or GP provides the participant (and any carer/family as agreed) with a patient friendly version of the Care Plan.

Patient friendly version of Care Plan

A patient friendly version of a Care Plan should:
- be in large type and use simple language
- include dates for review
- remind the participant to take medications, observe dietary restrictions, participate in appropriate physical activity, monitor physiological parameters such as weight and blood pressure and to follow-up with other health professionals where required
- provide symptoms and situations where the participant or carer should contact the practice or an after hours service and provide contact details for these.

Enrolment and submitting a claim

At this point in the process:
- The participant has now been enrolled in the CVC Program.
- The first quarterly period of care has commenced.
- GPs can submit a claim for the Initial Incentive Payment.

Note:
- By enrolling a participant in the CVC Program, a GP is accepting the clinical leadership and oversight role for the participant.
- If the nurse coordinator is a community nurse, it is very important that the GP submits their first claim promptly, as a claim by the community nurse will be rejected if the GPs Initial Incentive Payment has not yet been made.
9. Consider the need for social assistance

Participant’s needs

The GP and/or the PN should also consider the participant’s need for social assistance and the GP can provide a referral to a Veterans’ Home Care (VHC) assessment agency, where relevant. The most socially isolated CVC participants will receive social assistance under this program.

What is CVC Social Assistance?

CVC Social Assistance is a short-term service available to eligible CVC participants to help them re-engage in community life through social contact or accompanying them to a social activity.

CVC Social Assistance aims to address the increasing prevalence of social isolation amongst veterans and its impact on their health. The service provides up to 12 weeks of assistance to encourage longer term socialisation, for example, assistance with participating in community activities or courses.

These services focus on building the confidence of participants to promote ownership and motivation for their ongoing social health, with a view to establishing and maintaining long-term benefits, such as:

- re-entry into community life
- expanding the type and frequency of social contact
- encouraging the veteran to proactively engage with communities of interest.

The aim is to promote social health and independence, rather than dependency.

GP identifies potential participants

When a participant is being enrolled in the CVC Program (or any time thereafter), the GP may determine that they could benefit from CVC Social Assistance.

A GP can refer a CVC participant to a VHC assessment agency for a social assistance assessment, where:

- the participant has a limited or inadequate social support network and could reasonably be at risk of hospitalisation because of that social situation
- the risk of the participant being hospitalised for a chronic condition may be significantly reduced if they receive social assistance.

The VHC assessment agency will determine whether the CVC participant will be provided with CVC Social Assistance, as well as the amount and type of service to be provided.

Note: Not all referrals for an assessment will result in social assistance being provided.
VHC assessment agency

To refer a CVC participant for a social assistance assessment:

- call 1300 550 450 to be connected with your local VHC assessment agency
- provide the CVC participant’s contact details and any other relevant information.

Note: When referring to a VHC assessment agency it should be made clear that it is a CVC referral.

An assessment will generally be arranged within a few days of the referral, although this can be done more quickly if urgent.

Follow-up

The GP and/or the nurse coordinator will follow up on the assessment with the participant and monitor the services supplied and the effect on the participant’s social isolation.
Provide Ongoing Care
Provide ongoing care

The third stage for the care team involved in the CVC Program is providing ongoing care, which involves:

- coordinating treatment services as per the Care Plan
- regularly reviewing, updating and renewing the Care Plan.

During this stage, the care team:

- works with the participant (and their carer if applicable) to manage their ongoing care
- uses a proactive approach to improve the management of participants’ chronic diseases and quality of care
- supports participants to self manage their conditions.

The care team supports the participant to self manage their conditions on an ongoing basis by providing them with:

- information so that they better understand what will improve their condition and what will make their condition worse
- motivational counselling to empower them to follow their self management goals, e.g. lose weight or do more exercise.

Note:

- It is expected that most participants who are enrolled in the program will stay on the program. However, if a participant moves permanently to a residential aged care facility providing or receives a home care package, or participating in a Department of Health coordinated care program they must be taken off the program.
- Care provided under the CVC Program is not a replacement of the continued interaction between the GP and the patient. Regular consultations should still occur as necessary.
10. Coordinate treatment services as per the Care Plan

Overview

The nurse coordinator is responsible for coordinating treatment services for each participant based on their Care Plan.

The GP provides regular advice and guidance to the nurse coordinator.

Note: The duties of the nurse coordinator vary slightly, depending on whether they are a practice nurse (PN), Aboriginal health worker (AHW) or community nurse. This is explained in the following sections.

Coordinate treatment services

All nurse coordinators coordinate treatment services for the participant as follows:

- monitor the participant's progress according to the Care Plan
- monitor the participant's physical and mental condition
- maintain regular contact with the participant – at least monthly
- provide the participant with advice, e.g. medication, health coaching, motivational counselling
- liaise with a participant's carer and keep them informed of progress and changes to the Care Plan
- make appointments with other care providers, if necessary, and provide a copy of the Care Plan to all specialists, allied health practitioners and other care providers (as appropriate and agreed with the GP)
- monitor the actions of all care providers (e.g. prescriptions, tests, referrals and recommendations) through feedback from the participant, carer, consultation reports and calls to other care providers
- liaise with emergency and/or hospital discharge departments
- consider and address ongoing social isolation issues
- provide regular feedback about the participant's condition to the GP, including advice on their need for social assistance services and alerts where changes occur in their condition
- provide feedback to the GP – at least monthly
- maintain up-to-date records of all monitored actions and coordination activity.

Nurse coordinator – PN or AHW

In addition, where the nurse coordinator is a PN or AHW, the following applies:

- They should review the regular patient reports from DVA, crosscheck with practice records and information, and alert the GP to any discrepancies or deviations from the Care Plan.
- Contact with the participant may be by telephone, in rooms or through home visits. However, where the participant lives within a reasonable distance and time from the practice, at least one home visit should be conducted per year. Where an initial in-home assessment was not conducted, at least one home visit should be undertaken within the first month of entering the program.

Nurse coordinator – community nurse

Where the nurse coordinator is a community nurse, they:

- receive the GP Care Plan with the referral
- conduct an in-home assessment of the participant
- forward a copy of the Community Nurse Management Plan to the GP for their review
- receive feedback from the GP
- visit the CVC participant at home – at least once every 28 days.
Role of the GP when nurse coordinator is a community nurse:

Where the nurse coordinator is a community nurse, the GP should:

● send a referral for the CN provider that includes their preferred method of contact, e.g. telephone/fax/email (secure email only)
● send the Care Plan with the referral to the CN provider
● regularly receive feedback from the community nurse on the participant’s condition and progress against the goals – at least monthly
● maintain frequent dialogue with the community nurse
● review the regular patient reports from DVA, crosscheck with practice records and information, and note any discrepancies or deviations from the Care Plan.

Note:

● The referral for a community nurse is valid for 12 months, unless it is withdrawn by the GP or a disqualifying event occurs, e.g. participant enters a residential aged care facility.

● There can be only one provider of community nursing services to a participant at one time. If a participant is already receiving community nursing services, the GP withdraws the existing referral and sends a new referral that covers CVC and other nursing services to the CN provider.

Planned hospital admission

Where appropriate, the GP or nurse coordinator should:

● liaise with the hospital during a planned admission
● follow up with the participant on discharge.

Unplanned hospital admission

On learning of an unplanned admission of a CVC participant to hospital, the GP, PN or community nurse should contact the hospital and:

● advise that the participant is on the CVC Program and has a Care Plan
● request to be advised of the discharge date
● request a copy of the discharge papers
● ask to be involved in the discharge planning process (if appropriate).

One or two days after the participant is discharged from hospital, the GP, PN or community nurse should contact the participant and/or carer to:

● arrange for an appointment with the GP either in the surgery or at home
● review the participant’s condition
● review the Care Plan (if appropriate).
11. Regularly review, update and renew the Care Plan

Overview

The care team is expected to review treatment services for the participant on a regular basis. This includes the Care Plan as follows:

- review / update at least every three months
- renew at least every 12 months.

GP

The GP is expected to do the following:

- check the participant is still eligible for the program and continuing on the CVC Program is appropriate
- record the decision to approve a subsequent period of care and discuss the need for a review or renewal of the Care Plan with the nurse coordinator
- arrange appointments for the participant to attend the practice for a review or renewal.

Nurse coordinator

The nurse coordinator is expected to do the following:

- provide regular feedback to the GP where a Care Plan needs reviewing
- remind the GP when a quarterly period of care is about to expire
- send new or reviewed Care Plans to other care providers (as appropriate and agreed with GP).
Other
Other

Summary of roles and responsibilities

The care team – general practitioner (GP), nurse coordinator, participant (and their carer if applicable) – all work together to manage the participant’s conditions on an ongoing basis. The nurse coordinator may be either a practice nurse (PN), Aboriginal health worker (AHW) or a community nurse. The following provides a summary of the key responsibilities for each of these roles:

Participant

- self manages their health care according to their Care Plan and in conjunction with the care team.

General practitioner

- provides clinical leadership and oversight role for the participant
- assesses eligibility of potential participants for the program
- finalises the Care Plan
- monitors the overall provision of care and provides regular advice and guidance to the nurse coordinator

Nurse coordinator – PN or AHW

- monitors the participant’s progress and coordinates treatment services according to the Care Plan
- liaises with the participant and their carer
- educates and motivates the participant
- liaises with and provides a copy of the Care Plan to specialists, allied health practitioners and other care providers, including emergency and/or hospital discharge departments as appropriate and agreed by the GP
- provides feedback to the GP on the participant’s condition and progress against their health goals on a regular basis
- maintains comprehensive clinical records and reminds the GP when a quarterly period of care is about to expire.

Nurse coordinator – community nurse

- receives the GP Care Plan and conducts an in-home assessment of the participant
- prepares a Community Nurse Management Plan [CNMP] and forwards a copy to the GP for their review
- liaises with the participant and their carer – visits the participant at home at least once every 28 days, and educates and motivates the participant
- maintains frequent dialogue with the GP – provides feedback to the GP on the participant’s condition and progress against the goals in the GP Care Plan on a regular basis (at least monthly)
- provides a copy of the GP Care Plan (if agreed by GP) to and liaises with specialists, allied health practitioners and other care providers, including emergency and/or hospital discharge department(s).
Comparing key roles

The diagrams below show how the roles vary, depending on whether the GP uses a PN/AHW or a community nurse.

GP with PN or AHW

- Eligibility Assessment
- Finalise Care Plan
- Monitors care coordination
- Reviews, updates, renews Care Plan

Practice Nurse

- Comprehensive needs assessment
- Assist with preparation of Care Plan
- Patient friendly Care Plan
- Coordinates care
- Monitors participant's condition
- Educates
- Motivates
- Feedback to GP

GP with community nurse

- Eligibility Assessment
- Comprehensive needs assessment
- Care Plan prepared and finalised
- Patient friendly Care Plan
- Monitors care coordination
- Reviews, updates, renews Care Plan

Community Nurse

- Receives referral and Care Plan
- In-house assessment
- Prepares CNMP
- Coordinates care
- Monitors participant's condition
- Educates
- Motivates
- Feedback to GP

Payments to general practitioners

General

Payments are made to GPs using existing Medicare arrangements.

The payments vary as follows:

- A GP who uses a PN or AHW as the nurse coordinator is paid at the higher rate.
- A GP who either uses a community nurse as the nurse coordinator or does the coordination themselves will be paid the lesser amount.
Initial Incentive Payment

An Initial Incentive Payment is:

- made to the GP for enrolling a person in the program and having done all things necessary for the enrolment
- a one-off payment and only paid once per participant, regardless of a change in provider or PN, or where a participant ceases to be a participant and later re-enters the program.

Quarterly Care Payments

Quarterly Care Payments are made to the GP:

- for quarterly periods of care as part of ongoing clinical care leadership of a participant in the CVC Program
- once they submit a claim upon completion of each quarter (90 days). The previous quarter must have expired before the commencement of the new quarter.

Claims

In claiming any item, a GP is confirming that all steps necessary for the enrolment of a participant or for the ongoing coordination of care have been completed. DVA may conduct post payment audits to ensure compliance.

Date of service

The date of service for the quarterly period is the first day of that quarterly period. The claim for payment is made after the last day of the quarterly period.

For example, if the period of care runs from 7 May to 5 August (90 days), the date of service is 7 May but the claim for UP03 or UP04 cannot be made until after 5 August (i.e. on or after 6 August).

There is a self-populating ready reckoner on the DVA website that automatically calculates the date of service and the claiming date for each CVC enrolled patient. You can find the ready reckoner at: www.dva.gov.au/cvc.htm

Community nurse

Where the GP uses a community nurse, the GP is paid the lesser amount and the DVA community nursing provider is paid for the nurse coordination activity.

Exiting the Program

Where a participant exits the program, e.g. the person dies or moves permanently to a residential aged care facility, etc, the GP is entitled to claim the full amount of the final Quarterly Care Payment.
Rules for transfer of provider

Although a participant in this program can change providers, multiple claims cannot be made from different providers in the one claim period. Rules apply to the transfer of care under this program for a patient:

Transfer from GP to GP

Where a participant changes GPs after starting the program, the new GP:

- cannot claim the Initial Incentive Payment
- can only claim for a Quarterly Care Payment where the quarter commenced after the expiry of the previous GP's quarterly care period.

Transfer from PN to community nurse

A change from a PN to a community nurse may occur in the following situations:

- The participant and/or the GP decide that a community nurse is better placed to coordinate the care. In this case, the GP should make all attempts to complete the current quarterly period of PN coordinated care before making the change. This will ensure seamless transition to the community nurse who can begin coordinating care straight away and can claim after the first 28 day period has been completed.
- The participant changes GP and the GP does not have a PN or the PN cannot provide the coordination service.

Transfer from Community nurse to PN

A change from a community nurse to a PN may occur in the following situations:

- The participant and/or the GP decide that a PN is better placed to coordinate the care, or the GP previously did not have a PN. In this case, the GP should attempt to align the transition with the next quarterly care period.
- The participant changes GP and the participant and/or the GP decide that the care will be coordinated by the PN, or the previous GP did not have a PN. In this case, the new GP may choose to commence managing and PN coordination of the Care Plan straight away but will not be entitled to the Quarterly Care Payment for the GP with PN until any current quarterly care period expires.

Change of CN provider

Where a participant changes from one CN provider to another, the new provider cannot commence a 28 day billing period of coordinated care until the existing 28 day billing period of care from the previous provider has expired.

Note: The new CN provider will require a new referral from the GP.
Further information and resources

Enquiries
You can obtain additional information as follows:

<table>
<thead>
<tr>
<th>General Enquiries</th>
<th>DVA Provider Helpline</th>
<th>Phone: 1300 550 457 [metropolitan areas] or 1800 550 457 [non-metropolitan areas] Email: <a href="mailto:cvcprogram@dva.gov.au">cvcprogram@dva.gov.au</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Nursing</td>
<td>DVA website</td>
<td><a href="http://www.dva.gov.au/providers/community-nursing">www.dva.gov.au/providers/community-nursing</a></td>
</tr>
<tr>
<td>Social Assistance</td>
<td>Veterans' Home Care assessment agency</td>
<td>Phone 1300 550 450</td>
</tr>
<tr>
<td>Training and Resources</td>
<td>DVA website</td>
<td><a href="http://www.cvceducationresources.dva.gov.au">www.cvceducationresources.dva.gov.au</a></td>
</tr>
</tbody>
</table>

Training and resources
Information about training and resources for the CVC Program is available at:
www.cvceducationresources.dva.gov.au

This website contains links to training modules specifically designed for the CVC Program. You will also find templates, questionnaires and other resources to help you conduct comprehensive needs assessments and develop Care Plans for new CVC Program participants.

Script for gaining consent
The GP must explain to an eligible person what it means to be on the CVC Program, the sharing of their medical/health information and the consents that they will have to make.

The following script is recommended to obtain informed consent from the person before enrolling them on the program:

An important part of being on the CVC Program is that your relevant health and medical information is shared with all of your health care providers, including any specialists, pharmacists, allied health, community nurses, hospitals, discharge planners, and nominated carers.

The sharing of relevant health and medical information allows a common understanding of your condition and treatments, your needs and preferences, and allows everyone to operate as a team to improve your health.

In addition, DVA has contracted an external provider to produce regular monthly reports on all of the treatments and medications that you are receiving from DVA. This allows us to see the whole picture of your care. This provider will also report to DVA on the progress of the program.

DVA may need to access Care Plans and other personal information for the purposes of monitoring the quality of services delivered or the performance of the program. All of the people receiving your health and medical information must respect your privacy and comply with all relevant privacy legislation.

Do you consent to participating in the CVC Program and to the sharing of your personal information including relevant health and medical information and data as I have outlined and to the use of a nurse coordinator? [A yes/no answer is expected and a record made of the response].

You will also be asked to consent to the Care Plan we will prepare as part of your enrolment.
CVC Program roles for a GP with a practice nurse

Identification phase

- Gold Card holder asks to go on program
  - Contacts GP for appointment
    - Consents to CVC Program
      - GP identifies a patient
        - DVA identifies
          - Letter to Gold Card holder and GP
            - Contact patient to make an appointment
              - Eligibility assessment
                - Eligible
                  - Informed consent obtained
                  - Finalise Care Plan
                    - Explain Care Plan to patient
                      - Enrolment complete

Enrolment phase

- Participant works with care coordinator to implement Care Plan
  - Monitor care coordination
    - Commence care coordination
      - Regular calls and visits to participant
        - Feedback to GP
          - Regularly review and update Care Plan
            - Maintain regular consultations with participant
              - Monitor care coordination

Coordination phase

- Participant works with care coordinator to implement Care Plan
  - Monitor care coordination
    - Commence care coordination
      - Regular calls and visits to participant
        - Feedback to GP
          - Regularly review and update Care Plan
            - Maintain regular consultations with participant
              - Monitor care coordination

Participant’s actions: Green boxes
GP’s actions: White boxes
Practice nurse or AHW actions: Blue boxes
Coordinated Veterans’ Care Program