The Coordinated Veterans’ Care Program

What is the program about?
The Coordinated Veterans’ Care Program (CVC Program) is a Department of Veterans’ Affairs (DVA) program to better manage and coordinate primary and community care for Gold Card holders who are most at risk of being admitted or readmitted to hospital. Gold Card holders includes veterans, war widows, war widowers and dependants, hereafter referred to as ‘veterans’.
The Program is targeted only at Gold Card holders most at risk and is only for around 10% of Gold Card holders living in the community. Chronic disease management items are still available for the remainder of Gold Card holders.
The CVC Program is focussed on providing additional support for veterans with one or more chronic diseases or conditions, and who have been identified as having complex care needs.
The key element of the CVC Program is the core team of the participant, the participant’s carer (if applicable), the nurse coordinator and the GP. The team uses care planning, coordination and review as tools to focus on better management and self management of the CVC participants’ health.

What is the GP’s role?
The role of the GP is to provide clinical leadership and oversight to coordinate care for the CVC participant by ensuring the practice is adequately equipped to offer proactive and planned, multidisciplinary care:
• Understanding and commitment from all staff
• The practice needs to appoint a care coordinator who is either:
  – a practice nurse, or
  – an Aboriginal health worker (AHW), or
  – a community nurse from a DVA contracted community nursing provider on referral.
If no suitable nurse coordinator can be secured, the GP may assume the role of care coordinator.
If the practice nurse is the care coordinator, the GP needs to ensure there is:
• a reminder system in place to prompt the nurse to call, visit or make appointments for CVC participants
• a discrete space for the nurse to coordinate care in privacy
• the capability to make home visits to CVC participants where reasonable.
The care planning cycle is continuous and most participants enrolled in the CVC Program will stay on it.
How does the CVC Program work?

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

- **Enrolment phase**
  - Monitor care coordination
  - Commence care coordination
  - Regular review and update Care Plan
  - Regular calls and visits to participant

- **Coordination phase**
  - Participant works with care coordinator to implement Care Plan
  - Maintain regular consultations with participant
  - Feedback to GP

**Participant's actions**
- Gold Card holder asks to go on program
- Contacts GP for appointment
- Consents to CVC Program
- Participant works with care coordinator to implement Care Plan

**GP's actions**
- GP identifies a patient
- Eligibility assessment
- Finalise Care Plan
- Regular review and update Care Plan

**Practice nurse or AHW actions**
- DVA identifies
- Letter to Gold Card holder and GP
- Comprehensive needs assessment
- Assist in preparation of Care Plan
- Regular calls and visits to participant
Only current DVA Gold Card holders are eligible to participate in the CVC Program. To be enrolled the CVC participant must also:

- In the opinion of the GP have one or more chronic conditions that:
  - has resulted, or could reasonably result in frequent hospitalisations
  - has complex care needs
  - requires a treatment regimen that involves complicated ongoing care.

- To the best of the GP’s knowledge none of the following apply to the CVC participant:
  - lives in a residential aged care facility
  - has been diagnosed with a condition that in the opinion of the GP would likely to be terminal within 12 months
  - is participating in any Commonwealth Department of Health and Ageing coordinated care program.

The decision to enrol a participant in the CVC Program is made by the GP – following an assessment against the eligibility criteria and with the informed consent of the veteran.

**Participation in the CVC Program is not mandatory and only those eligible Gold Card holders who consent will be enrolled on the CVC Program.**
Enrolling a participant in the CVC Program

How are CVC participants enrolled in the program?

Participants may be identified to participate in the CVC Program in one of the following ways:
- veteran and GP receive letter from DVA advising they have been identified as a potential participant
- GP identifies veteran as potential participant
- veteran self identifies as potential participant
- other health provider recommends veteran as potential participant.

Once a veteran has been identified as a potential participant and is interested, an appointment is scheduled and the GP conducts an eligibility assessment.

Next steps

If the veteran is eligible and interested, the GP or practice nurse carries out a needs assessment and develops a Comprehensive Care Plan, if one does not already exist. The GP then:
- records the decision to enrol the CVC participant in the program
- records on the Care Plan the CVC participant’s consent to participate
- provides the participant and/or participant’s carer with a patient friendly version of the Care Plan.

If a practice nurse is the nurse coordinator, the practice nurse then:
- monitors Care Plan progress
- provides health coaching and motivational counselling
- liaises with the veteran’s carer to ensure they are kept informed of progress and changes to the Care Plan
- maintains accurate records of all actions and coordination activities
- provides a copy of the Care Plan to all relevant health practitioners and care providers (as agreed with the GP), and monitors actions
- regularly reviews and checks monthly patient reports of treatment and medications as they are received from DVA.

When a participant is being enrolled in the CVC Program, or any time afterwards, the GP may refer socially isolated CVC participants for social assistance. This will be short term (up to 12 weeks) assistance aimed at increasing participation in community activity.
Payments to practitioners

GPs are paid to enrol participants in the CVC Program and to provide ongoing comprehensive coordinated quarterly periods of care.

Payments are made through existing Department of Human Services arrangements, with GPs paid a one-off Incentive Payment for enrolling a CVC participant onto the program, followed by Quarterly Care Payments in arrears. GPs must submit a claim each quarter in order for a payment to be made.

Where a GP uses a practice nurse or an AHW employed by the practice to coordinate the care, payments to the GP are higher than for a GP who does not use a practice nurse. Payments are in addition to existing Medicare Benefits Schedule / Repatriation Medical Fee Schedule items including all existing items relevant to care planning and coordination.

Where can I find more information?

Call 1300 550 597
Email info@cvchelpline.net.au

*Fees as at 1 November 2012.
The Coordinated Veterans’ Care Program is a Department of Veterans’ Affairs initiative, supported by primary service provider, Bupa Health Dialog.

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