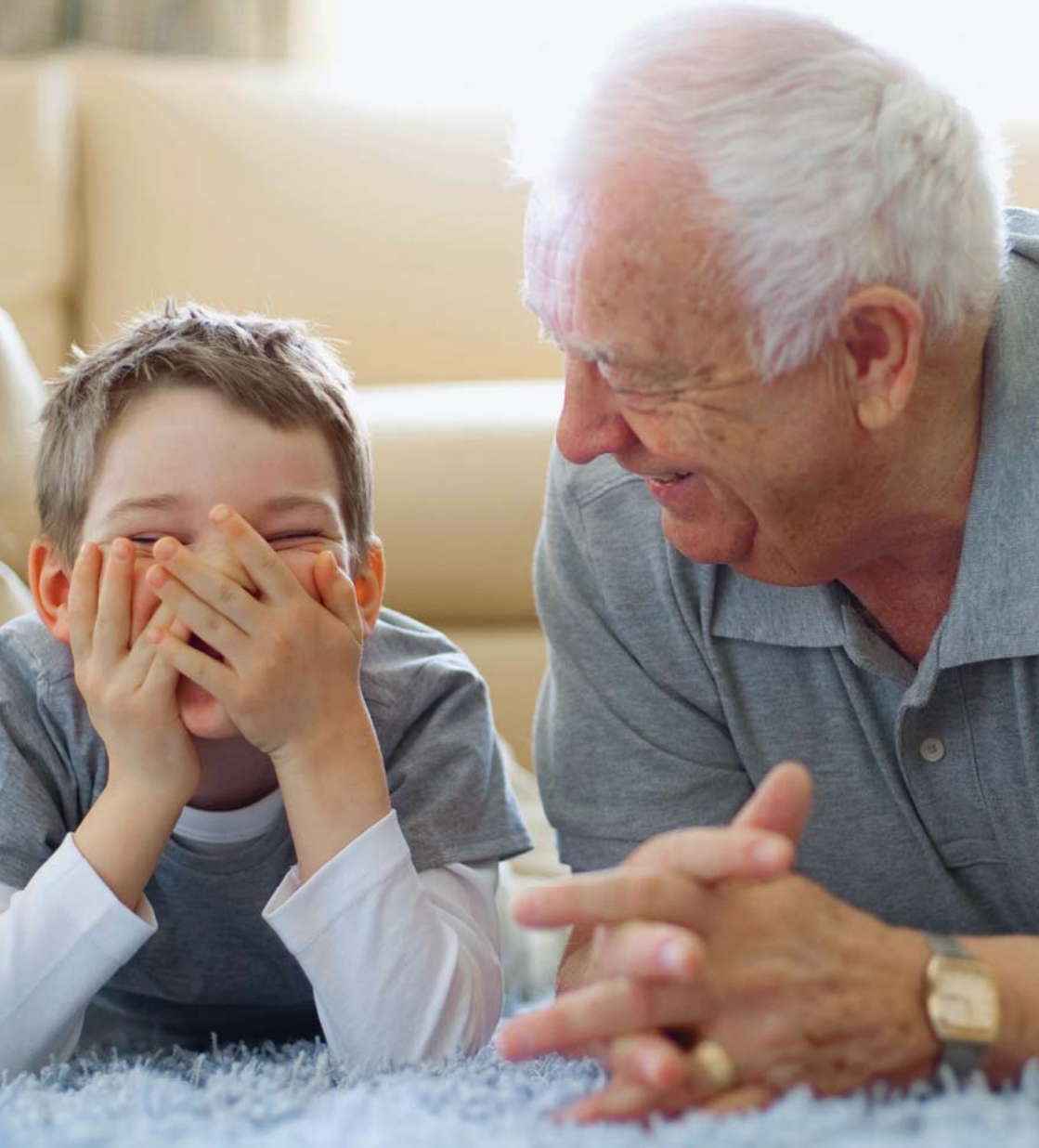
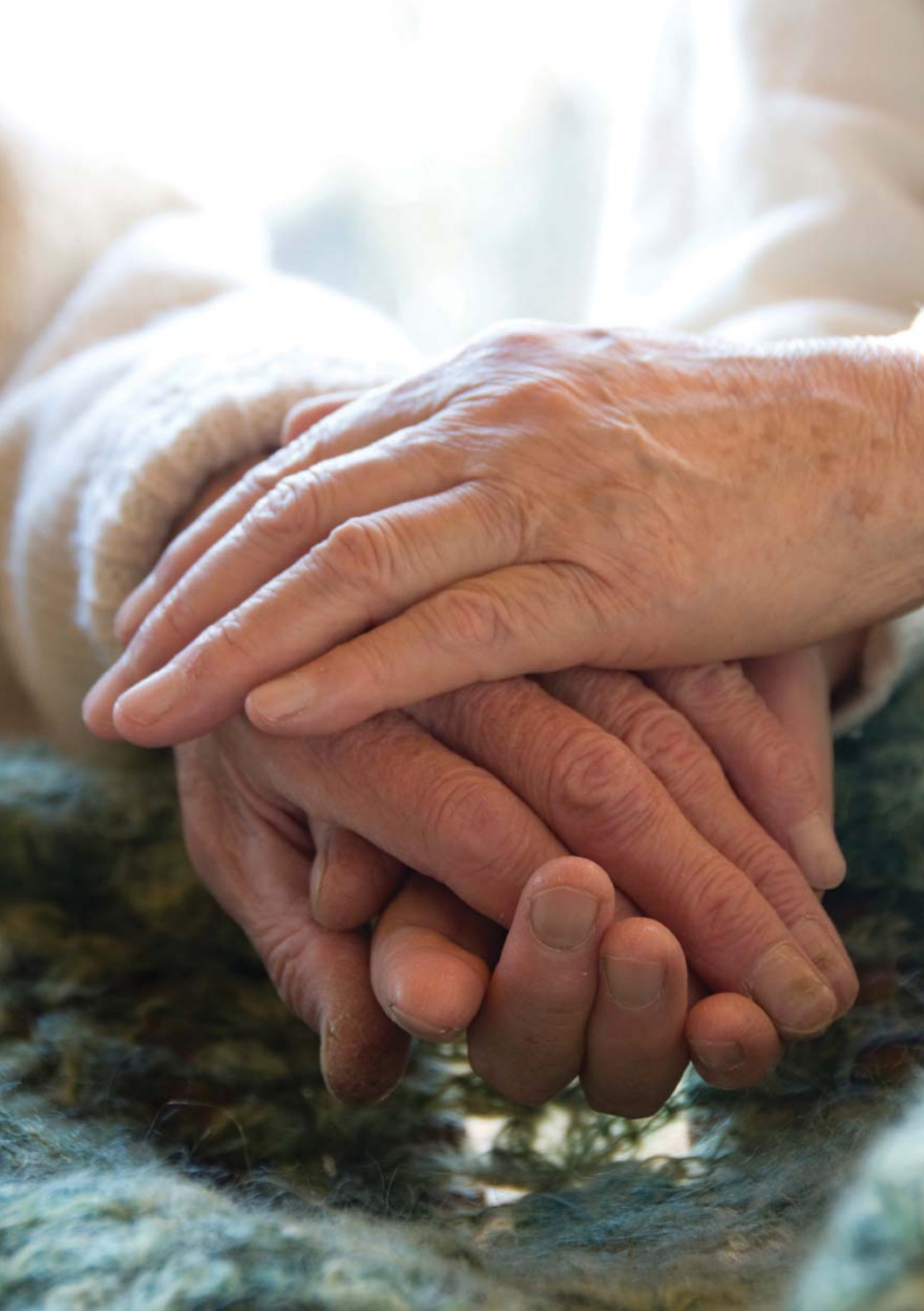
Department of Veterans' Affairs –
Coordinated Veterans' Care Program

Information for Veterans

Australian Government
Department of Veterans' Affairs





The Coordinated Veterans' Care (CVC) Program

What is the CVC Program about?

The CVC Program is a targeted program for Gold Card holders who have health problems that increase their risk of unplanned hospitalisations and have one or more of the following chronic illnesses:

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

CVC is not for all Gold Card holders. The focus of the Program is on prevention and improved management of chronic diseases resulting in improved quality of life and reduced risk of hospitalisations.

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

What does it mean for me?

If you are eligible (see page 3) and enrolled in the CVC Program, your ongoing and planned care will be based on a personalised Care Plan developed by your General Practitioner (GP) along with a nurse coordinator and in consultation with you.

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

All of this will be in your Care Plan.

Your Care Plan will be regularly reviewed and you will be given a patient friendly version of the plan to take home and keep handy as a reminder of your medications, appointments and health goals.

Is the CVC Program for me?

To benefit from this Program, you must have:

- a Gold Card
- one or more chronic conditions
- complex care needs
- high risk of unplanned hospitalisation.

In addition, you:

- must be living in the community (not in Residential Aged Care)
- must not be suffering from a condition likely to be terminal within 12 months
- must not be already participating in a similar coordinated health care program provided by the Commonwealth Department of Health and Ageing.

Your GP will assess your eligibility for the CVC Program in consultation with you.

How do I enrol onto the CVC Program?

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

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

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

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

What happens once I'm on the CVC Program?

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

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

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

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

What is CVC Social Assistance?

CVC Social Assistance is an additional, optional service provided to those participating in the CVC Program who may benefit from more contact with their community.

The CVC Program recognises the importance of well established social support networks and the effect of people's health and well being.

Assistance would generally be short term (up to 12 weeks) and would support and encourage you to participate in community activities through local clubs and associations.

If you are eligible for Social Assistance, your GP will refer you to your local Veterans' Home Care assessment agency.

Jack's* story

Jack – age 70

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

Jack's GP recommends that he enrol in the CVC Program.

The GP conducts an eligibility assessment.

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

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

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

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

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

GP's actions | Practice nurse's actions | Veteran's actions

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

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

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

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

When Jack sees his GP for regular appointments they talk about the Care Plan and how Jack is getting on with the things in the plan he can do for himself.

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

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

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

Where can I find more information?

Call 133 254

Email cvcprogram@dva.gov.au

Visit www.dva.gov.au/cvc.htm