



Australian Government
Department of Veterans' Affairs

DVA treatment cycle

Guide to the treatment cycle for
**GPs and allied
health providers**



October 2019

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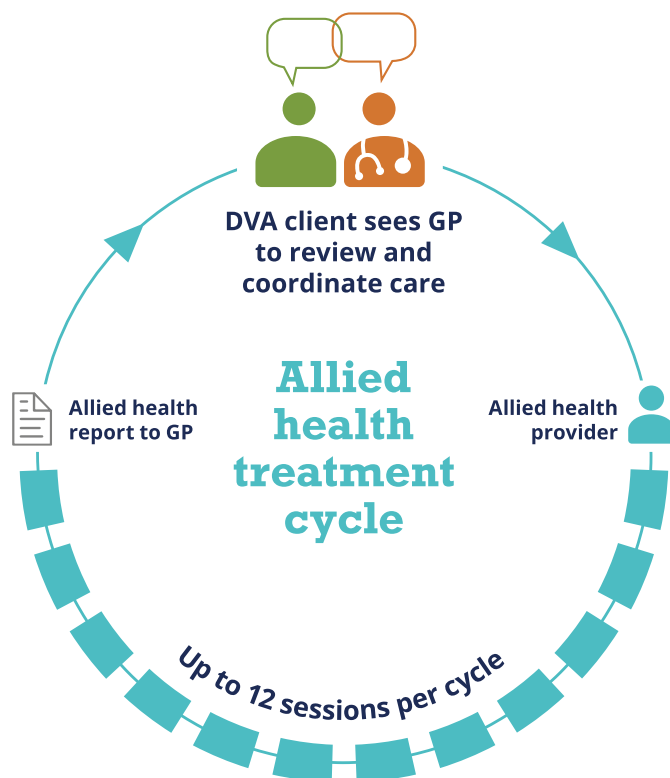
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Overview of the treatment cycle

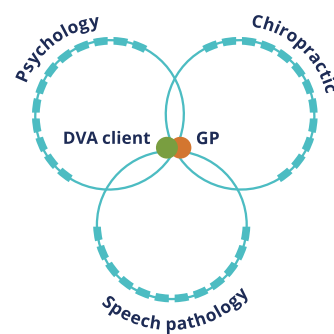
A treatment cycle is up to 12 sessions or one year of allied health treatment – whichever ends first – that a Department of Veterans' Affairs (DVA) client receives from an allied health provider as a result of a general practitioner (GP) referral.

At the end of the treatment cycle, the allied health provider reports back to the DVA client's usual GP, and the GP discusses progress and outcomes with the client. If further sessions are clinically necessary, the GP can provide a referral for another treatment cycle.

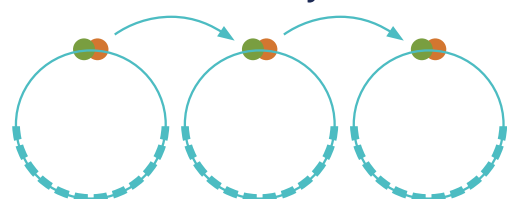
DVA clients may have as many treatment cycles as their GP determines to be clinically necessary. This includes having a treatment cycle with different allied health providers during the same period. It also includes having subsequent treatment cycles with the same



Multiple allied health treatment areas at the same time



No limit to the number of cycles that are clinically necessary



provider. These arrangements allow DVA clients to continue to receive the allied health services they require.

Who needs to use it?

Three groups of people will use the treatment cycle:

- DVA clients who hold a Gold Card or a White Card will use the treatment cycle when accessing allied health services. DVA clients who hold a Totally and Permanently Incapacitated (TPI) Gold Card are excluded from the treatment cycle for exercise physiology and physiotherapy services **only**, but will use the treatment cycle for other allied health services.
- GPs will refer their DVA clients to allied health providers using the treatment cycle.
- Allied health providers will provide services to DVA clients using the treatment cycle. Dental and optical service providers do not require GP referrals for DVA clients and will not be subject to the treatment cycle.

What is the aim?

The treatment cycle aims to support a more collaborative approach to the care of DVA clients. It provides a framework for better coordination and communication between GPs, allied health providers and clients. The treatment cycle reinforces the role of the client as the centre of care and the GP as the primary care provider working with other providers to achieve a better quality of care.

Are there any exceptions for clients?

DVA clients with a TPI Gold Card do not use the treatment cycle for exercise physiology and physiotherapy services. They can use annual or, in some circumstances, indefinite referrals to access these services. Exercise physiology and physiotherapy services for TPI clients must still be clinically necessary, evidence based and goals orientated.

GPs may consider tailored arrangements for clients whose circumstances would benefit from more flexible requirements.

How to use this guide

Allied health providers and GPs should use this guide to help them implement the treatment cycle and deliver best-practice health care to DVA clients.

It can be read as a whole document or in separate sections. Tips and ideas from practising clinicians are included, to help providers implement the treatment cycle.

Related resources

Read this guidance in conjunction with:

- [Notes for Allied Health Providers](#) and [Notes for General Practitioners](#)
- [Patient Care Plan template for allied health providers](#)
- [End of Cycle Report for allied health providers](#)
- leaflets and other resources on the [DVA website](#).

Introduction

DVA is committed to supporting clients to access high-quality health care. The treatment cycle was introduced after a review of dental and allied health funding arrangements for DVA clients, including analysis of service utilisation data. This review identified that coordination and communication between allied health providers and GPs could be improved.

The treatment cycle supports a more collaborative approach to the care of DVA clients through better coordination and communication between GPs, allied health providers and the DVA client. The treatment cycle reinforces the role of the client as the centre of care and the GP as the primary care provider, resulting in better quality of care.

Principles of the treatment cycle

Patient-centred care

The DVA client should always be at the centre of care. This means that health professionals inform and involve clients in decisions about their health care, and are respectful and responsive to their needs and values. When care is patient centred, health professionals provide clients with comprehensive support for all their clinically assessed needs.

See [Additional resources to support patient-centred care](#) for examples of guidance and programs for health professionals and clients about veterans' health.

Care coordination and communication

Collaboration between GPs and allied health providers ensures that care is well coordinated and relevant to the client's clinical needs. This is particularly important for clients with an ongoing, complex or chronic condition.

Coordinated models of care:

- encourage and support clients to self-manage
- improve clients' self-efficacy (their belief that they can achieve their goals)
- give access to clinically required monitoring in a patient-centred way.

GPs are ideally placed to coordinate the client's primary care. Regular communication with the client's allied health providers ensures that treatment is relevant to the client's needs and goals over time.

Collaborative goal-setting

When health professionals work with clients to set realistic and achievable goals, it ensures that care aligns with the things that matter most to the client. When clients have clearly defined goals, they can feel more motivated to achieve those goals. Goals should be SMART – specific, measurable, achievable, relevant and timely.

Standardised outcome measures

Measuring outcomes of treatment provides the client and their health professionals with information about effectiveness of treatment and progress against the client's goals. Standardised outcome measures provide objective information about treatment effectiveness. This informs decisions about whether to continue, change or stop treatment.

Regular review

Regular review helps to ensure that the client receives the most effective form of treatment for their needs. It facilitates clinical accountability and management that responds to the client's circumstances, and ensures that care is clinically appropriate.

Benefits of the treatment cycle

The treatment cycle will benefit DVA clients, GPs and allied health providers through:

- improved treatment planning
- increased coordination of care
- increased communication between providers
- stronger clinical accountability
- periodic review of the appropriateness of clinical care so the client receives the most effective form of treatment for their needs.

The DVA client is at the centre of care, and the GP coordinates care with the allied health providers



Allied health services that the treatment cycle applies to

The treatment cycle applies to referrals to the following allied health services:

- chiropractic
- diabetes education
- dietetics
- exercise physiology
- neuropsychology
- occupational therapy
- occupational therapy (mental health)
- orthotics
- osteopathy
- physiotherapy
- podiatry
- psychology (general and clinical)
- social work
- social work (mental health)
- speech pathology.

Allied health services that the treatment cycle does not apply to

The treatment cycle does not apply to the following:

- Dental services, including dentists, dental specialists and dental prosthetists. DVA clients do not require a referral to dental services.
- Optical services, including optometrists, orthoptists and optical dispensers. DVA clients do not require a referral to optical services.
- Hearing services. Most hearing services for veterans are provided through the Australian Government Hearing Services Program, but DVA clients can also access some hearing services and devices through the DVA Rehabilitation Appliances Program.
- Open Arms – Veterans & Families Counselling, which provides free and confidential counselling to anyone who has served at least one day in the Australian Defence Force and the veteran community. Clients can call Open Arms on 1800 011 046 to access free and confidential counselling, group treatment programs, suicide prevention training, and Open Arms' community and peer network to support mental health and wellbeing.
- Approved allied health services provided to support a DVA Rehabilitation Program.

The treatment cycle also does not affect referrals from GPs for specialist medical services such as psychiatry or surgery.

DVA clients with a TPI Gold Card are excluded from the treatment cycle for exercise physiology and physiotherapy only

Veterans who hold a Totally and Permanently Incapacitated (TPI) Gold Card from DVA are excluded from the treatment cycle for exercise physiology and physiotherapy services.

TPI clients are identified by the TPI icon on their Gold Card. Not all Gold Card holders are TPI veterans.

TPI clients can receive physiotherapy and exercise physiology services under annual or indefinite referrals. Best practice and the principles of the treatment cycle should still apply to these clients, including patient-centred care, collaborative goal-setting, use of standardised outcome measures and regular review. Professional best practice is to ensure that the services provided are appropriate for the client, are not excessive or unnecessary, and promote self-management.



How the treatment cycle works

The treatment cycle supports the coordination of care between the DVA client, their usual GP and allied health providers. The treatment cycle will help ensure that the client receives care that is clinically necessary and helps them achieve their goals.

DVA client visits GP

The client visits their usual GP to discuss their health, including new or existing conditions or issues. This may be part of a regular consultation, or a comprehensive assessment such as the [Veteran Health Check](#).

The client's 'usual GP' is:

- the GP who has provided the majority of care to the client over the previous 12 months, or
- the GP who will be providing the majority of care to the client over the next 12 months, or
- a GP who is located at a medical practice that provided the majority of services to the patient in the past 12 months or is likely to provide the majority of services in the next 12 months.

As is normal best practice, the GP and the client consider options to manage health issues. This may include referral to allied health services. The GP is the client's care coordinator and oversees all the care that the client receives from other health professionals.

Tips

- A regular health check-up provides an opportunity to review existing referrals to allied health services.
- Where a client holds a DVA Gold Card and has a chronic condition, they may be eligible to be enrolled in the [Coordinated Veterans' Care Program](#) to access more care coordination support.

GP refers DVA client to allied health provider

If the client needs allied health services, the GP writes a referral for up to 12 sessions or one year, whichever ends first – this is one treatment cycle.

DVA requires specific information to be included in referrals for allied health services, including under the treatment cycle. It is important that the GP includes all the required elements because allied health providers should not provide treatment to DVA clients without a valid referral.

For example, the referral must state the condition(s) to be treated by the allied health provider or the reason for the referral, rather than the service to be provided (e.g. 'osteoarthritis of right knee', not 'rehabilitation'). Allied health providers will assess the client's needs and develop a treatment plan based on the range of therapy and interventions within their scope of practice.

If the client has multiple conditions that require treatment from the same allied health profession (e.g. chronic lower back pain and reduced limb function after stroke, which can both be managed by a physiotherapist), the GP should write a single referral. All conditions will be managed under the same treatment cycle.

The client can have as many treatment cycles as their GP considers to be clinically necessary. The client can also have treatment cycles with multiple allied health professions (e.g. psychology, chiropractic and speech pathology) at the same time.

The GP can refer the client to a particular individual allied health provider, or to a practice or clinic. DVA expects clients to be referred to the closest suitable allied health provider.

Tips

- Allied health providers deliver a broad range of diagnostic, technical, therapeutic and direct health services to improve the health and wellbeing of DVA clients. More information on allied health professions is available from [Allied Health Professions Australia](#) or the relevant professional association.
 - In the referral, the GP should include information about the other health treatments the client is receiving, including referrals to specialists and other allied health providers.
-

Related resource

DVA's [Notes for General Practitioners](#) lists the specific information to be included in the referral to support collaborative care.

Allied health provider treats DVA client

The allied health provider:

- assesses the client
- develops a Patient Care Plan (PCP) with client goals
- delivers the allied health services
- uses standardised outcome measures to monitor effectiveness.

Patient Care Plan

As part of normal best practice and usual DVA requirements, the allied health provider develops a PCP in consultation with the client. The PCP must include the condition(s) to be treated, the type and frequency of sessions, the goals and outcomes expected, and strategies for self-management. Current evidence suggests that better health outcomes are achieved when a person has a role in selecting their treatment.

Allied health providers who deliver services to DVA clients will already be familiar with the requirement to develop a PCP. The [Patient Care Plan template for allied health providers](#) includes all the necessary elements of a PCP. Although the development of a PCP is mandatory, the use of this template is optional.

The PCP should be shared with the client's usual GP at the start of the treatment cycle. This will help the GP to coordinate the client's health care. In some circumstances, the allied health provider may identify conditions or concerns that were not included in the referral. Sharing a copy of the PCP with the client's usual GP is particularly important in these circumstances.

Related resources

DVA's [Notes for Allied Health Providers](#) lists the specific information to be included in the PCP.

The [Patient Care Plan template for allied health providers](#) can be used to prepare a treatment plan and meet the requirements of the PCP.

Client goals

Patient-centred care includes collaborative goal-setting between the client and their health care team. When health professionals work with clients to set goals, it ensures that the care aligns with the things that matter most to the client. When clients have clearly defined goals, they can feel more motivated to achieve those goals and to manage their own care. It is best practice for health professionals to work with their clients to empower them and support self-management.

Goals should be SMART – specific, measurable, achievable, relevant and timely:

- specific – state what you will do; use action words
- measurable – use metrics or data targets to evaluate progress
- achievable – within scope and possible to accomplish
- relevant – makes sense considering previous goals and where the client is in their life
- timely – specific date or timeframe to achieve the goal.

Standardised outcome measures

Measuring the effectiveness of health treatment provides the treating provider, the client and the client's GP with information on the rate (and direction) of change. For example, is the client's health status improving, being maintained or worsening? It also informs and justifies decisions to continue, change or stop treatment, or to refer the client to another health care professional or service.

Treatment effectiveness should be measured with standardised outcome measurement tools that are relevant to your profession, reliable, valid and sensitive to change. Standardised outcome measures may be supplemented with customised measures of aspects of health or function that are relevant to the client. However, the reliability, validity and responsiveness of customised outcome measures are generally not known. Therefore, these should only be used when there is no suitable standardised measure available, or in addition to a standardised measure.

Practice example: Collaborative goal-setting

Kevin was referred by his GP to a social worker. The social worker undertook a psychosocial assessment with Kevin, and explored Kevin's presenting needs in the context of his social situation. This included consideration of Kevin's physical and mental health; level of social engagement; access to informal help and formal services; and areas of resilience, strengths, hopes and fears.

Following the assessment, the social worker and Kevin agreed that they should explore ways for Kevin to meet up with old friends and expand opportunities to interact with others. The social worker worked with Kevin to identify specific tasks and timeframes. The goals agreed were that:

- the social worker and Kevin would gather information about the community activities that Kevin can participate in
- Kevin and the social worker would make a plan to attend one activity within two weeks
- if required, the social worker would advocate for Kevin and assist him to overcome transport or access issues.

Allied health providers must select relevant and appropriate standardised outcome measures to monitor treatment effectiveness. Standardised outcome measures can be general (e.g. quality of life) or condition specific, and should be relevant to the client.

DVA does not specify which standardised outcome measures should be used. Allied health providers should use their clinical judgement to determine the most appropriate outcome measures for the client. The measures used should align with the client's goals. This means that the results of outcome measures are not necessarily required to show improvement during the course of treatment. This is particularly relevant where the goal is to maintain status or to delay deterioration, rather than to improve.

Standardised outcome measures should be used at the start and end of the treatment cycle, and at any time it is reasonable to expect change.

Frequency and duration of treatment

The allied health provider can provide treatment for up to 12 sessions or one year, whichever ends first.

The allied health provider should use their clinical judgement to determine how many sessions are required, and the frequency of those sessions. This should be based on the client's clinical needs and the principles of the treatment cycle. The focus is on providing clinically necessary treatment, and encouraging and supporting self-management, to deliver the best outcomes for the client.

Allied health providers should have a system in place to monitor the validity of referrals, as well as duration and frequency of treatment.

Tips

This checklist will help ensure that the treatment notes reflect DVA requirements:

- Have SMART goals been set in consultation with the client?
 - Have you selected outcome measures that are relevant, reliable and sensitive?
 - Have you recorded the baseline outcome measures?
 - Have you identified any factors that will adversely affect the outcomes? If so, have you taken appropriate action to address these?
 - Have you outlined the agreed frequency and likely duration of treatment?
 - Is the effectiveness of your intervention reflected in the outcome measures and the treatment goals?
 - If you are unable to achieve the agreed treatment goals, have you included a recommendation for other treatment options in your End of Cycle Report to the GP?
 - Have you remained objective about when your intervention should stop, and decided on what action should be taken at that time?
-

Practice example: Using standardised outcome measures

John is a White Card holder who lives alone. He is a 65-year-old veteran who has been diagnosed with lumbar spondylosis and osteoarthritis of both knees.

His GP refers him to an occupational therapist because John recently had a fall at home when standing up from his chair. He also reports feeling unsteady when transferring and moving, which is affecting his independence. The occupational therapist sees on the referral that the GP has also referred John to a physiotherapist for a mobility assessment and gait aid review.

Since John is a White Card holder, the occupational therapist contacts DVA to confirm his eligibility for the assessment.

The occupational therapist assesses John using a Canadian Occupational Performance Measure and establishes agreed treatment goals with him. The agreed SMART goals are used to establish a PCP, which includes specific outcomes, and the number and

frequency of treatment sessions anticipated to achieve them. The agreed plan includes:

- the capacity to contact help if John falls, by having a personal response system in place within one week
- safe transfers and mobilisation achieved by providing and installing trialled aids and minor home modifications within two weeks.

Cessation of treatment is included in the plan, and promotion of self-management and independence are included as outcomes. The PCP is forwarded to the GP to promote coordinated care with the physiotherapist who is also treating John.

The occupational therapist monitors John's progress and finds that John has achieved his goals after six treatments. The occupational therapist reassesses using the Canadian Occupational Performance Measure and finds a measurable improvement in activities of daily living. An End of Cycle Report is sent to John's usual GP.

Communication with the GP during the treatment cycle

Communication and collaboration are key aspects of the treatment cycle. They help ensure that the care provided is patient centred and clinically appropriate. The GP is the primary care coordinator in the treatment cycle.

The allied health provider and the GP should communicate with each other as required during the treatment cycle. This two-way communication helps ensure that treatment is relevant to the DVA client's needs and goals

over time. Time points for communication could include:

- at the start of the treatment cycle, when the allied health provider shares the PCP with the GP and, if required, discusses the number of sessions needed
- during the treatment cycle, if the client's condition changes or a new condition arises
- at the end of the treatment cycle, if further treatment is needed.

Gaps in treatment

If there is an unplanned gap in treatment (e.g. if the client attends for three sessions, then stops for six months before returning), the allied health provider should use their clinical judgement to decide whether the client needs a new referral or whether they can continue their current treatment cycle. Factors that may affect this decision include whether the client presents with the same condition or a related condition, and the client's wishes.

The allied health provider should communicate with the client's usual GP about these decisions.

Practice example: Managing gaps in treatment

Sandra, aged 55, was referred to physiotherapy to treat neck pain and headache. Sandra and the physiotherapist agree that treatment will be weekly for four weeks, then fortnightly, then monthly. After six sessions, Sandra cancels an appointment and doesn't make a new appointment. Four months later, Sandra makes another appointment. When Sandra comes to the appointment, she tells the physiotherapist that her condition has flared up. The physiotherapist assesses Sandra and agrees that the symptoms are due to the condition she was initially referred for.

The physiotherapist discusses with Sandra the outcomes she would like to achieve from treatment. The physiotherapist explains that, once the condition has stabilised, Sandra will need to continue the prescribed exercise program at a specific frequency to prevent further flare-up. The physiotherapist also reminds Sandra about the previously established 'go to' exercises and other management strategies to address a flare-up. The physiotherapist updates the PCP and sends the revised plan to Sandra's GP.

Changes in condition

The referral must specify the condition(s) to be treated, not the service to be provided. White Card holders are entitled to clinically necessary treatment for accepted conditions only – see the DVA website for information on [DVA health cards](#).

If the client presents with a new condition, or their condition changes, it is important that the allied health provider communicates this to the client's usual GP. If the client is a White Card holder, the allied health provider will need to check if DVA arrangements cover treatment of a new condition. Allied health providers should use their clinical judgement to determine whether the client should visit their GP to discuss the new or changed condition, or whether treatment should continue under the current treatment cycle.

The PCP must be updated to reflect the new or changed condition, and shared with the client's usual GP.

At any one time, an allied health provider should only have one treatment cycle per client, not one treatment cycle per condition per client. If a client has multiple conditions, these should all be covered under a single treatment cycle.

Related resource

See the DVA website for information on [DVA health cards](#).

Allied health provider reports back to GP

Regular review helps to ensure that the client receives the most effective form of treatment for their needs. As the care coordinator, the client's usual GP needs regular information from allied health providers about the client's treatment and progress, including standardised outcome measures. This helps ensure that the client is receiving effective treatment to achieve their goals.

Practice example: Managing the presentation of a new condition during a treatment cycle

Angela was referred to occupational therapy to treat rheumatoid arthritis affecting her hands.

At the third session, Angela reveals she has noticed some memory changes and recently overcooked a meal when reheating it in the microwave. The occupational therapist asks if there are other recent examples of memory changes or forgetfulness. The occupational therapist explains that the symptoms could be related to a low-grade infection and advises Angela to discuss the symptoms with her usual GP as soon as possible, but reassures Angela that there are many useful strategies and aids to help with this if required.

The occupational therapist updates the PCP, sends the revised plan to the usual GP and continues to treat the rheumatoid arthritis. However, the occupational therapist also includes treatment for immediate safety and management, as appropriate, around memory changes, including marking the two-minute spot on the microwave to help with correct timing for reheating meals. This is recorded in the clinical notes and included in the End of Cycle Report to the GP.

- after 12 sessions, if the client has attended 12 sessions in less than one year
- after one year, if the client has attended fewer than 12 sessions in one year.

If the client is likely to need more than 12 sessions, the allied health provider can discuss the need for a GP review with the client before the end of the treatment cycle. This will help the client plan a GP visit to coincide with the end of the treatment cycle and avoid a break in treatment. It will also help the allied health provider plan to send the End of Cycle Report to the GP before the client's appointment.

If continuity of care is needed and treatment frequency is high, the allied health provider can provide the report to the client's usual GP after eight sessions, but before the 12th session. This should be done with agreement of the client and their usual GP. For example, this might be necessary if the DVA client lives in a rural area where their GP only visits once a month. The GP needs to receive the allied health provider's report and discuss it with the DVA client before considering a new treatment cycle.

Using the End of Cycle Report template

DVA, in consultation with allied health provider associations, has developed a report template to support good clinical practice and communication – [End of Cycle Report for allied health providers](#). The template is designed to ensure that relevant and appropriate information is shared between the allied health provider, the client's usual GP and the DVA client.

The End of Cycle Report template includes the minimum information required for the GP to determine if further sessions or other allied health provider input are clinically necessary. Allied health providers may also choose to attach additional information (e.g. reports from practice software) to the template if required, but this is not expected.

When to send the report

The allied health provider must provide a report to the client's usual GP at the end of the treatment cycle. This may be:

- when treatment is complete, if the condition was treated in fewer than 12 sessions
- after eight sessions, if the GP, allied health provider and client agree that continuity of care may be needed (depending on the recommendations in the End of Cycle Report)

Practice example: Working towards self-management

Robert is coming to the end of a second treatment cycle with his physiotherapist. The first cycle of treatment occurred over eight weeks. The second cycle was spread over four months to enable and measure behaviour change.

Throughout the course of the cycle, the physiotherapist and Robert reflect on progress and goals, incorporating strategies for self-management early so they have been tested and are ingrained before the end of the cycle. This included a home exercise program, regular activity such as swimming, and joining a local community tai chi class. By the end of the cycle, Robert is well rehearsed in his 'go to' strategies to use when he has a bad day.

The physiotherapist assesses Robert against the relevant outcome measures at the 12th visit and records them in the End of Cycle Report. Robert agrees that he has almost achieved his goals and feels empowered to manage independently. The physiotherapist reinforces the need to incorporate the home exercise program and other strategies into Robert's routine so that he can continue to improve.

The physiotherapist explains that they will recommend to the GP that Robert doesn't need another treatment cycle because he can self-manage his condition.

The End of Cycle Report facilitates communication between the allied health provider and the client's usual GP. It is not sent to DVA.

Practice example: Maintaining continuity of care

Roy lives in a rural area and sees his podiatrist several times a week for a foot wound that is slow to heal. Roy explains to his podiatrist that the GP is only available one day a week in his town and he is concerned that there will be a gap in treatment while he waits for a new referral. The podiatrist explains to Roy that continuity of care is important. The podiatrist says that they will complete the End of Cycle Report after eight sessions so that Roy can seek a new referral without a break in treatment.

After the eighth session, the podiatrist completes the End of Cycle Report and faxes it securely to the GP. The report outlines the need for continued review, re-dressing and debridement.

Roy has an appointment with his GP the following week. The podiatrist sees Roy three more times before his next GP appointment. When Roy goes to the GP, he has had 11 podiatry sessions and the GP has the report (completed at the eighth session). The GP agrees that Roy requires further treatment and provides a new referral to the podiatrist for another 12 sessions.

Related resource

The template [End of Cycle Report for allied health providers](#) includes the minimum information that GPs need from allied health providers. It must be completed at the end of each treatment cycle.

How to send the report

The allied health provider should send the report to the client's usual GP by their normal processes (e.g. fax, secure messaging, post). A copy can also be given to the DVA client.

Claiming the item for the End of Cycle Report

Allied health providers can claim a DVA fee item for completing the End of Cycle Report. The item number for this report is not linked to a patient consultation, which means the allied health provider can claim for the report in the absence of a session with the DVA client.

If the client is being treated for multiple conditions, all the conditions should be:

- included on a single referral
- treated under a single treatment cycle
- reported in a single report to the GP.

The End of Cycle Report item cannot be claimed by exercise physiologists or physiotherapists for the treatment of TPI veterans.

GP reviews allied health report with client

Regular review helps to ensure that the client receives the most effective form of treatment for their needs. It facilitates clinical accountability and treatment that responds to the client's circumstances, and ensures that care is clinically appropriate.

At the end of the treatment cycle, the client returns to their usual GP to review outcomes and progress. As the care coordinator, the GP receives End of Cycle Reports from all the client's allied health providers. This regular review ensures that treatment is appropriate for the client's needs at that time.

It is important that the usual GP reviews progress with the client before stopping or continuing treatment. The GP should support, encourage and empower the client to take ownership of their own condition with a self-managed program where possible.

Under the treatment cycle, the GP (with the DVA client, and informed by the allied health provider's recommendations in the End of Cycle Report) may determine that:

- further sessions are not clinically necessary
 - the client's condition has resolved, they can self-manage, or progress/maintenance has plateaued and the client is no longer benefiting from this form of treatment
- further sessions are clinically necessary, which may be
 - another treatment cycle with the same allied health provider or a different provider in the same profession
 - a new treatment cycle with an allied health provider from a different profession
 - another health care option such as diagnostic tests, medicines or referral to a specialist.

If further sessions are clinically necessary, the GP writes a referral to the allied health provider, which starts a new treatment cycle of up to 12 sessions or one year, whichever ends first.

The DVA client can have as many treatment cycles as are clinically necessary, with as many different allied health professions as are clinically necessary.

Managing and coordinating treatment cycles

Clients who regularly see multiple allied health professionals may need help to coordinate their treatment cycles and GP appointments. GPs may wish to schedule multiple future appointments to coincide with the anticipated end of each treatment cycle, to ensure adequate and timely review. In general practice clinics, nurses can help by contacting allied health services, managing referral processes, and providing information and feedback between services, clients and GPs.

Practice example: Coordinating multiple allied health services

John is an 84-year-old non-TPI veteran who was discharged from hospital after a suspected transient ischaemic attack. John's GP has ordered a number of tests, prescribed new medicine, and referred him to a cardiologist, a dietitian and an exercise physiologist. His GP asks the practice nurse to help John manage these arrangements.

The practice nurse schedules the first appointment for John with the cardiologist, the dietitian and the exercise physiologist. The nurse, with permission from John and the GP, provides the dietitian and the exercise physiologist with information about test results. When the nurse makes the appointments with the dietitian and the exercise physiologist, the nurse asks them to send a copy of the PCP and the dates of planned future appointments to the general practice.

The practice nurse follows up with John regularly and books him appointments with the GP as he reaches the end of his treatment cycle with the exercise physiologist and the dietitian.

If further sessions are clinically necessary, the next referral must be from the client's usual GP.

Clients referred from a health professional as part of a hospital discharge

If the referral is from a hospital discharge team, the allied health provider should send the End of Cycle Report to the client's usual GP.

If further sessions are clinically necessary, the next referral must be from the client's usual GP.

Clients in residential aged care

Access to DVA-funded allied health services in residential aged care will depend on the client's care classification. DVA clients in residential aged care facilities who are classified as 'lower level care' can access DVA-funded allied health services with a GP referral. The treatment cycle arrangements will apply to these services.

Allied health providers should check with DVA before providing services to clients in residential aged care facilities. See [Notes for Allied Health Providers](#) for more details.

Clients who are receiving therapies that have existing treatment limits

Established therapies for which endorsed clinical practice guidelines state that either less or more than 12 sessions are needed are exempt from the treatment cycle. Refer to the [Notes for Allied Health Providers](#) and the relevant fee schedule for service limits and conditions, and for details of specific therapies that are exempt from treatment cycle arrangements.

Referrals from other sources

Clients referred from medical specialists

If the referral is from a medical specialist, the allied health provider should send the End of Cycle Report to both the specialist and the client's usual GP. This ensures that the GP remains at the centre of primary care coordination for the client.

Putting it into practice

The following case studies illustrate the principles of the treatment cycle:

- patient-centred care
- care coordination and communication
- collaborative goal-setting
- standardised outcome measures
- regular review.

Case study 1

Purpose: To illustrate collaborative goal-setting and SMART goals

Michael is a 92-year-old non-TPI veteran living in regional New South Wales. He is a Gold Card holder. He is a widower with four children who live about two hours away.

Michael has high blood pressure, cataracts in both eyes and osteoarthritis in both shoulders. He was fitted with a pacemaker in 2002. Michael lost 10 kilograms after his wife died three years ago and has become unsteady on his feet.

Six weeks ago, Michael was grocery shopping. He stepped up onto the gutter when crossing the street and fell onto his right shoulder (his 'better' shoulder). He tried to manage by himself for a week, but his shoulder and neck pain were not getting better, and he was having trouble cooking and cleaning for himself because he could not lift his arm without pain.

Michael visited his GP, and together they discussed treatment options.

The GP referred Michael to a physiotherapist, a dietitian, an occupational therapist and a podiatrist.

Each allied health provider worked with Michael on collaborative goal-setting at the initial consultation. Michael's goals with each allied health provider were as follows:

- Physiotherapist
 - to be able to reach above his head to cupboards with a pain rating of no more than 2 out of 10 in five weeks, and to be able to complete 15 steps of a 30-second stair test in three months (one session per week)
 - to improve his tandem balance stance from 3 seconds to 20 seconds with eyes open, aiming for eyes closed
 - to assess his gait and teach him to use a single-point stick.
- Dietitian – to gain 2 kilograms in two months.
- Occupational therapist – to consider alternative management techniques for daily living activities, such as dressing and showering independently, until he has regained his previous range of movement. Some smaller equipment items may be prescribed to help him to meet these goals.
- Podiatrist – to wear supporting, enclosed shoes when grocery shopping for the rest of the year.

By receiving reports about Michael's treatment plans and progress towards his goals from every allied health provider, Michael's GP can ensure that the treatments being offered are clinically necessary, and that the goals transition Michael back to a position where he can maintain his own health independently, in a timely manner. Through regular review, Michael's GP can determine:

- whether Michael is being supported to reach his goals
- whether the treatments being offered are effective
- whether Michael needs more or different support such as a falls prevention program, Veterans' Home Care to assist with heavy housework, and orthopaedic specialist review.

Case study 2

Purpose: To illustrate treatment cycles of less than 12 sessions

Mary has type 2 diabetes. At a recent visit to her GP, the GP was concerned about her blood glucose levels.

Mary explained to her GP that she is finding it hard to manage making herself meals in the kitchen because she has to reach high cupboards, and sometimes finds the kettle and full saucepans hard to lift. The GP refers Mary to an occupational therapist for an assessment. The occupational therapist visits Mary at home and suggests some aids that could assist Mary to manage cooking and food preparation tasks more easily. The occupational therapist orders the aids and, over another two visits, helps Mary learn to use the aids. The occupational therapist sends an End of Cycle Report to the GP.

Mary was referred to a diabetes educator several years ago when she was diagnosed with diabetes. The GP suggests that a diabetes educator could help her again. Mary agrees to see the diabetes educator, and the GP gives her a referral. At the first visit, the diabetes

educator assesses Mary's symptoms and talks to her about how she is managing her diabetes. The diabetes educator suggests some lifestyle changes and activities that could help. Mary is reluctant but agrees to try a group activity. The diabetes educator sees Mary twice over the next two months, to monitor and help Mary with the new activities and changes. After the third visit, the diabetes educator suggests Mary come back every three months. After almost a year from the first appointment, the diabetes educator prepares an End of Cycle Report and recommends to the GP that Mary continue to see her two or three times a year.

Case study 3

Purpose: To illustrate allied health referrals for TPI veterans

Harry is a TPI veteran. He is seeing his usual GP for his annual review. He has a history of bilateral knee osteoarthritis, and reports increasing knee pain on waking and stiffness in his knees. He currently self-manages his knee osteoarthritis at home with a combination of strategies, including cold therapy, visiting the local hydrotherapy pool in his own time and a home exercise program previously prescribed by an exercise physiologist. He last saw an exercise physiologist six months ago for a review of his home program, and wonders if he should go back. The assessment also identifies that Harry's weight has increased to an unhealthy level since his last review, and the blood test results show an increase in triglycerides and cholesterol.

Harry and the GP agree his knee management requires review by the exercise physiologist. The exercise physiologist can also assist him with weight loss. The GP gives Harry a new annual referral to the exercise physiologist.

Because Harry is a TPI veteran, his referral to the exercise physiologist is not subject to the treatment cycle. However, the principles of the treatment cycle still apply, including adopting a patient-centred care approach with

collaborative goal-setting, using standardised outcome measures and delivering evidence-based treatment. Professional best practice includes ensuring that the services provided are appropriate for the client, are not excessive or unnecessary, and promote self-management.

The GP also refers Harry to the dietitian for an assessment and advice on his diet. The referral to the dietitian is under the treatment cycle.

Case study 4

Purpose: To illustrate the use of outcome measures to support goal-focused treatment

Bob lives in Townsville and has been diagnosed with posttraumatic stress disorder (PTSD), alcohol abuse and depression, as well as thoracic spondylosis and tinnitus, which are accepted conditions under his White Card. He sees his physiotherapist and psychiatrist regularly. He has recently been hospitalised due to mental health concerns after a breakdown of his relationship. As part of his hospital discharge, Bob has been referred to a psychologist for treatment of his alcohol misuse, PTSD and depression. Bob has engaged with the psychologist after initial hesitation, and has been referred to Open Arms for peer support and case management.

Bob is living in transition accommodation because he does not have a permanent home. His peer worker liaises with the psychologist to ensure that he is connected to appropriate services, including housing. Bob's goal is to have access to his children. The psychologist engages with Bob to clarify the steps needed to achieve this goal.

It requires a number of sessions for trust to build and for the goals of therapy to be clearly defined. Bob has responded to treatment and has engaged in a number of stabilisation activities, such as learning emotional regulation techniques and engaging with Mates4Mates, and is using the Right Mix app.

He has worked with the psychologist on emotion regulation and behaviour modification techniques with the aim of securing access visits with his children. This has been achieved. The Depression Anxiety Stress Scales pre- and post-treatment scores have indicated that his depression, stress and anxiety have improved. The Alcohol Use Disorders Identification Test indicates that his drinking is in the low-risk range. In relation to treatment for PTSD, Bob contends that he is not yet ready to undertake trauma-focused cognitive behaviour therapy.

The psychologist completes an End of Cycle Report to Bob's usual GP. The psychologist includes the outcome measures used and recommends another 12 sessions to continue to stabilise, work with the Open Arms peer worker and begin therapy for the treatment of PTSD. The psychologist explains to Bob that the report will give the GP an update on the progress of treatment and include information so that the GP can also support Bob towards his goals.

The treatment cycle arrangements will provide ongoing psychological assistance, as well as physiotherapy, with the support of Mates4Mates and Open Arms peer workers.

Appendix

Additional resources to support patient-centred care

It is important that GPs and allied health providers recognise the psychosocial needs of DVA clients, and support them to meet those needs.

For some DVA clients, their regular visit to their allied health provider may be the only time they leave the house or interact with other people, and they may be reluctant to stop these visits if their GP determines they are not clinically necessary. Even if the sessions are clinically necessary, the DVA client may have other unmet psychosocial needs that the GP and allied health providers should consider.

Examples of guidance and programs for health professionals include the following:

- [Clinical Framework for the Delivery of Health Services](#) outlines a set of guiding principles to achieve the best possible health outcomes.
- DVA's [Veteran Health Check](#) aims to help GPs identify and diagnose the early onset of physical or mental health problems among former serving members of the Australian Defence Force.
- DVA's [Coordinated Veterans' Care Program](#) is a team-based program where the participant, their GP and a nurse coordinator work together as a core team to develop a plan to meet the participant's health needs and manage their ongoing care.
- DVA's [At Ease](#) website has resources for health professionals managing veterans with common mental health disorders, including professional development, recommended assessment and management plans. It also has information for veterans.
- DVA's [eLearning courses for health providers](#) help providers understand veterans' health and how to work with DVA.
- [Mental Health Professionals' Network](#) aims to improve interdisciplinary and collaborative mental health care practices.
- DVA's [Veterans' MATES](#) (Veterans' Medicines Advice and Therapeutics Education Services) project aims to improve the use of medicines and related health services in the veteran community. It has information for health professionals and veterans.

- [Open Arms – Veterans & Families Counselling](#) provides free and confidential counselling to anyone who has served at least one day in the Australian Defence Force and their families. Clients can call Open Arms on 1800 011 046 to access free and confidential counselling, group treatment programs, suicide prevention training, and Open Arms' community and peer network to support mental health and wellbeing.
- [Men's Health Peer Education](#) program raises awareness about men's health issues and encourages men to share responsibility for their own health and wellbeing.
- [Men's Sheds](#) are community-based organisations that provide a safe and welcoming environment for men to work on projects and advance their wellbeing.

Support is also available through ex-service organisations, including services to assist with housing, employment, social and community activities, and advocacy.

Glossary

Term	Definition
allied health profession	Refers to the field or discipline in which an allied health provider works (e.g. physiotherapy, chiropractic).
allied health provider	An allied health professional who provides allied health services to DVA clients. In this guide, this term does not include allied health professionals providing dental or optical services.
clinically necessary treatment	A service that is generally accepted by the relevant profession as being necessary for the appropriate treatment of the patient to whom it is rendered.
DVA client	The person who is entitled to receive benefits through DVA. For treatment under the treatment cycle, the DVA client must hold a Gold or White Card. See Notes for Allied Health Providers for more details about clients' eligibility.
Gold Card	Department of Veterans' Affairs (DVA) Health Card – All Conditions
GP; usual GP	<p>The client's general medical practitioner. It is preferable that the client has a usual GP, to facilitate continuity of care. The 'usual GP' is:</p> <ul style="list-style-type: none"> the GP who has provided the majority of care to the client over the previous 12 months, or the GP who will be providing the majority of care to the client over the next 12 months, or a GP who is located at a medical practice that provided the majority of services to the patient in the past 12 months or is likely to provide the majority of services in the next 12 months.
medical specialist	<p>A medical practitioner who:</p> <ul style="list-style-type: none"> is registered as a specialist under state or territory law, or holds a fellowship of a specified specialist college and has obtained a relevant qualification from a relevant college and has formally applied and paid the prescribed fee; may be recognised by the Minister for Health as a specialist or consultant physician for the purposes of the <i>Health Insurance Act 1973</i>. <p>This definition includes GPs because general practice is a recognised specialty.</p>
TPI client	A person who holds a Gold Card that indicates they receive a Totally and Permanently Incapacitated (TPI) pension from DVA. This is shown by the TPI icon on the Gold Card.
treatment	Refers to both treatment and management of health conditions, being the services provided by allied health professionals. DVA recognises that some conditions cannot be treated, but they can be managed. In this document, 'treatment' covers both treatment and management.
White Card	DVA Health Card – Specific Conditions

