Procedural Guideline
Rehabilitation Plan Development

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1. Overview

Procedural Guidelines outline DVA’s requirements and supporting guidance for Rehabilitation Providers (providers) and their Rehabilitation Consultants (consultants) working with DVA clients. Consultants are expected to follow this guideline in developing Rehabilitation Plans for DVA clients. Providers are responsible for ensuring DVA requirements are followed by their consultants.

The development of a Rehabilitation Plan (plan) commences after an Initial Rehabilitation Assessment (assessment) has been completed. It is founded upon the recommendations in the assessment form and will reference this as required. The aim of a plan is to provide:

- an outcome oriented plan that addresses the identified rehabilitation requirements of the client and their rehabilitation goals
- an itemised list of recommended activities aligned with rehabilitation goals specific to the client’s needs, and
- detailed costs of the activities and the proposed timeframes for these to commence and be completed.

2. Rehabilitation Plan requirements

<table>
<thead>
<tr>
<th>Topic</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>Rehabilitation Plan</td>
<td>The plan must:</td>
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<td></td>
<td>- be completed using the <a href="#">D1347 Rehabilitation Plan</a> form</td>
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<td>- address all sections on the form template, and provide sufficiently</td>
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<td>detailed information for the Rehabilitation Delegate (the delegate) to</td>
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<td>make an informed decision</td>
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<td>- NOT be signed by the client or the provider, until the delegate has</td>
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<td>reviewed and signed the draft plan</td>
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<td>- be informed by medical evidence from the client’s medical practitioners</td>
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<td>and other health professionals</td>
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<td>- link directly to the findings of the assessment</td>
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<td>- specify rehabilitation goals and activities that are Specific,</td>
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<td>Measurable, Achievable, Realistic within a given Timeframe (SMART)</td>
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<td>- align itemised activities with specific rehabilitation goals</td>
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<td>- for each activity, provide realistic timeframes for commencing and</td>
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<td>completing the activity, itemised costs, and the rationale, and</td>
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<td>- be uploaded using the Provider Upload Portal.</td>
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<td>Client Welfare</td>
<td>- DVA must be advised immediately where the provider and/or consultant</td>
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<td>becomes aware the client has urgent needs or is at risk.</td>
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<td>Timeframes</td>
<td>- The plan must be submitted within 21 calendar days of the referral</td>
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<td>being issued. Where the plan cannot be submitted within 21 calendar</td>
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</table>
3. Rehabilitation Plan development process

**Figure 1: Rehabilitation plan development overview**

Plan development commences after the assessment has been completed. The plan is submitted to the delegate in draft, together with the assessment and other supporting documents. The plan must **NOT** be signed by the client or the provider before the delegate has been provided with a draft copy and given their agreement to the plan by signing the plan. This is to ensure that the client’s expectations in regards to their plan and associated activities are managed appropriately.

### 3.1. Whole of person rehabilitation approach

DVA’s whole-of-person approach to rehabilitation must always be used to guide decision making. The consultant must ensure that a client’s plan is tailored to their current needs and circumstances and appropriate services are identified to maximise rehabilitation via the most direct route. A client may work towards a combination of vocational, medical management and/or psychosocial goals concurrently, or may initially focus on achieving specific types of goals (i.e. medical management and/or psychosocial) before moving onto others. This will be determined by what is most appropriate for each client given their individual circumstances and needs.

### 3.2. Types of Rehabilitation Plans

Plans fall into two categories: return to work plans, and non-return to work plans. Return to work plans will have a vocational element to them, whereas non-return to work plans focus solely on non-vocational rehabilitation (i.e. psychosocial goals and activities including medical management). Return to work plans are more akin to traditional rehabilitation schemes (e.g. Comcare and Work Cover) where the end goal is to obtain suitable employment.
Where it is reasonable to expect that the client will be able to commence vocational rehabilitation activities to work towards a return to work goal within the next 12 months, then a return to work plan should be prepared. Where it is unlikely that the client will be able to commence vocational rehabilitation activities within 12 months then a non-return to work plan should be prepared.

**Figure 2: Return to work versus non-return to work Rehabilitation Plans**

**Return to work plan**
- May have an initial focus on non-vocational activities (e.g. six months) but must include a vocational goal.
- Medical clearance for work is not needed but there should be a reasonable prospect of medical clearance to work within two years.
- Client is expected to be ready to participate in some vocational activities over the next 12 months
- Client is motivated to work towards vocational goals

**Non-Return to Work plan**
- Only includes non-vocational goals and activities.
- Client is not expected to be able to participate in vocational activities for at least 12 months.
- Client is not motivated to work towards vocational goals, or their participation in vocational goals and activities may harm their rehabilitation.
- Client is not expected to be medically cleared for work within two years.

Even if a return to work plan is proposed for the client, vocational rehabilitation must not be the first, or the only, priority. The plan must be tailored to the client’s current needs, whilst considering the longer term goals of the client. In some cases, this may mean that a client is placed on a return to work plan but there is initially a focus on psychosocial goals (including medical management) until they are ready to participate in vocational rehabilitation activities. In this case a vocational goal may be included on the client’s plan, but vocational activities may not commence straight away (vocational activities may commence several months into the plan).

Further guidance on vocational and non-vocational rehabilitation is covered in the Vocational Rehabilitation Services Provider Procedural Guideline and the Non-Vocational Rehabilitation Services Provider Procedural Guideline. *Note, these guidelines are expected to be released in September 2019.*

### 3.3. Client engagement and communication

A client will be motivated to participate in their plan when they have been actively engaged in planning rehabilitation goals and activities. Therefore, the development of a plan and the goals and activities within it must be a collaborative process that involves the client at every step in the process. This will help ensure that the right activities and services are provided to the client at the right time and enable cost effective service delivery that avoids unnecessary duplication. Where appropriate, the client’s general practitioner (GP), treating specialists, allied health professionals,
family/significant others and employers/work colleagues should also be involved. This may assist in aligning expectations of all key parties and ensure that medical clearance is obtained.

Good communication is key to managing expectations and ensuring the client has a strong understanding of realistic activities and goals that may be included in their plan. It is essential that the client has made a significant contribution to developing the activities and goals of their plan, to ensure that the client is engaged with their rehabilitation, motivated to achieve their identified goals, understands their role and responsibilities in meeting their goals and comfortable when signing their approved plan.

When developing a plan, the consultant must clearly explain the roles and responsibilities of the client, the delegate and the consultant in the rehabilitation process. This helps to ensure that the integrity of the relationship between all parties is maintained.

3.3.1. Expectations Management

Throughout the assessment and plan development process, consultants are expected to proactively manage client’s expectations as to potential interventions and services that may be offered as part of their rehabilitation. It is important that the client is aware that plan goals and activities are subject to negotiation and agreement with the delegate. Consultants should proactively manage client’s expectations as to what interventions meet DVA’s reasonableness criteria and ensure that interventions meet the requirements of the Vocational Procedural Guideline and Non-Vocational Procedural Guideline as relevant. Note, these guidelines are expected to be released in September 2019. This includes ensuring the activities reflect the client’s circumstances and are cost effective.

3.4. Rehabilitation Plan form

The D1347 Rehabilitation Plan form must be used to document the client’s plan. In line with the template, the plan must include:

- the program of activities with clearly defined goals
- expected short-term and longer-term objectives and associated outcome measures
- a start date and an anticipated end date for the plan
- clearly defined timeframes for goals and activities, and
- itemised costs for each recommended activity listed on the plan.

If the plan is not completed to a satisfactory standard, the delegate may reject the plan and send it back to the consultant for revision.

3.4.1. Rehabilitation Plan duration

As a general rule, to assist with the effective management of plans, a client’s first plan with DVA should initially run for a period of six months. After six months, where it is envisaged that more time is needed to implement a plan, a plan amendment or new plan may be proposed that includes longer timeframe depending on the circumstances of the client. Typically, subsequent plans would go for six to twelve months. Regardless of plan duration, there needs to be periodic progress reporting during the duration of a plan at three month intervals or as otherwise agreed with the delegate.
If a client is undertaking study and needs minimal support based on the first six months, further plans may be developed for a longer period with minimal contact from the consultant. Note that for longer spanning plans, plan management costs are expected to be lower than the costs for management of more intensive plans, to reflect the reduced work effort by consultants.

When submitting draft plans to the delegate that are outside of the standard timeframes (six months initially and then six to twelve months thereafter), the consultants should include the rationale for why they have specified a particular plan duration.

DVA does not impose generic timeframes for goals, as goals need to be tailored to the client’s individual circumstances. Consultants should work with the client to ensure that timeframes are appropriate for each goal, and can realistically be achieved by the client. Goal end dates should not exceed the duration of the plan.

### 3.4.2. Procedure for signing a Rehabilitation Plan

Once the plan has been developed in close consultation with the client, a draft plan must be submitted to the delegate for approval PRIOR TO the client or provider signing the plan. The client must not be given a copy of the draft plan until it has been reviewed and approved by the delegate. This is to ensure that the delegate has the opportunity to review the plan for appropriateness, cost-effectiveness and sustainability, and propose any revisions if necessary. The development of a plan involves negotiation and close engagement between the consultant, the delegate and the client to come up with a plan that is satisfactory to all parties.

Once a suitable plan has been negotiated between all parties, the delegate signs the plan first, prior to the plan going back to the client and consultant for signature. The signature of each party (delegate, consultant and client) confirms they have contributed to the plan, and agreed to the goals and activities included in the plan. The delegate’s signature also gives approval for the funding of activities under the plan. A copy of the signed plan must be provided to the client so that they have a record of all activities included in their plan.

**Note:** For high risk or complex clients, it may be beneficial to hold a case conference prior to the plan being signed, so that all parties including the client’s general practitioner, allied health professionals and family/significant others are aware of the proposed activities and rehabilitation goals and are ‘on the same page’.

### 3.4.3. Client refusal to sign their Rehabilitation Plan

A client is not considered to be non-compliant with their rehabilitation program merely because they have refused to sign their plan. If this situation arises, it is important that there is a discussion between the consultant and the client to resolve any concerns that the client has about the focus of the plan or any of the activities detailed within the plan. If the situation cannot be resolved, the delegate must be notified via phone or email so they can assist the consultant and client come to a satisfactory solution.

Where a client still refuses to sign the plan, the reason should be documented by the consultant and recorded on the plan and the plan submitted to the delegate. Work should continue between the consultant, delegate and client to achieve agreement and implement the plan.
3.5. **Provider Upload Page**

It is mandatory that providers upload the plan via the Provider Upload Page (PUP). In the event that the PUP is offline, the consultant should wait several hours and try accessing the portal again. Where upload is still not possible, the consultant should contact the delegate before submitting the documentation via email.

For further information about using the PUP, please consult the PUP user guide and frequently asked questions available through the [PUP home page](#).

4. **Timeframes for completing the plan**

The draft plan must be provided to the delegate within 21 calendar days. There may be situations where the plan cannot be completed in this timeframe, including:

- delays in performing the assessment because:
  - it is not in the client’s best interests to commence or complete the assessment, such as where there are concerns over the client’s wellbeing
  - the consultant is unable to make contact with the client
  - the consultant is unable to organise a suitable time to meet with the client to complete the assessment, or
- the client is unable to obtain reports from their treating medical practitioner in rural and remote areas.

In these situations, the consultant should notify the delegate via email and provide a justification for the delay. This information should also be captured by the provider so that it can be included in six monthly reporting to DVA. Where medical reports could not be obtained within 21 calendar days, the consultant should still submit the draft plan together with the assessment to the delegate within the 21 calendar timeframe. Once medical reports have been obtained the consultant should either:

- confirm with the delegate via email or phone if the assessment and draft plan are consistent with the medical reports and no changes are required to the assessment and plan, or
- submit a revised assessment and/or draft plan to the delegate if medical reports warrant changes or additions to the assessment and/or plan.

5. **Developing meaningful goals**

Goals are what the client wants to achieve, or the desired outcome that they are working towards. Plans are underpinned by meaningful and appropriate goals, which specify the results the client is looking to achieve through their participation in rehabilitation. The consultant must work collaboratively with the client to tailor individual rehabilitation goals and to ensure they are appropriate, and decide what successfully achieving the goal means using expected outcomes. Goals should follow the SMART model (refer Figure 3 below), by being specific, measurable, attainable, relevant and time-based.
Examples of goals include:

- Assist Ms Blogs to manage her pain better so that her sleep patterns can improve and alcohol consumption decrease.
- Assist Mr Blogs to undertake tertiary study so that he can gain employment as a nurse.

Figure 3: SMART model for goal setting

As a general rule, multiple activities will be included under each goal to help the person to reach their goal. For example, the goal of ‘Improvement physical functioning so that Mr Blogs can walk pain free and improve his fitness’ could have the activities of ‘attend physiotherapy appointment 1 time per week and complete all exercises recommended by the therapist’, ‘walk around the block 4 times per week’ and ‘support from XX (eg. family member) to assist with developing a weekly routine’.

5.1. Goal Attainment Scaling and Life Satisfaction Indicators

DVA requires providers to use Goal Attainment Scaling (GAS) to develop personal goals for clients during the development of their plan. This allows goal outcomes to be explored with the client through plan development. To provide a measure for assessing how clients rate their own life satisfaction before, during and after rehabilitation, each client is asked to provide their ratings against Life Satisfaction Indicators (LSI) by completing the D9230 Life Satisfaction Indicators form. Completing the LSI at the outset of rehabilitation provides a baseline for which client’s life satisfaction improvements or deterioration can be measured. This assists with measuring the effectiveness of a client’s rehabilitation.

Using GAS, for each new goal, a scale is developed which describes expected outcomes. Each expected outcome is given a measure of -2 to +2, where:

- -2 means the goal is significantly under-met
- -1 means the goal is slightly under-met
- 0 means the goal is met
- +1 means the goal is slightly over-met
- +2 means the goal is significantly over-met
GAS is aligned with DVA’s rehabilitation best practice philosophy and emphasises the provision of individualised service and maximises client involvement in the development of plans and goals. Scaling formalises the collaborative element of the assessment and plan development process between provider and client. Outcome reporting using GAS and LSI provides DVA with a link between the whole-of-person model of rehabilitation and the measurement of whole-of-person outcomes. Reporting data obtained by GAS and LSI process assists DVA to understand the level of success or otherwise for clients receiving rehabilitation services.

Scaling improves DVA’s rehabilitation program by:

- ensuring all parties have the same understanding of the client’s rehabilitation goals via collaborative development
- ensuring consistent expectations throughout the life of a plan by using well developed formal documentation, and
- assessing and reporting on improvements and changes to life satisfaction and wellbeing.

Consultants work in collaboration with clients to develop relevant rehabilitation goals that link to the assessment using the GAS model. As part of the plan development process, the consultant is required to explain the LSI to clients. This should include the instruction that the client will need to complete the LSI to be best of their ability throughout their plan and at plan closure.

6. **Reasonableness of costs to deliver the Rehabilitation Plan**

The consultant must itemise all costs for the recommended services and activities listed on the plan by completing Attachment A of the plan form.
Consultants are required to ensure that rehabilitation costs are efficient and effective. This includes undertaking due diligence to ensure that activities specified in a plan represent value for money and documenting the justification in Attachment A of the plan form. The Non-Vocational Rehabilitation Services and Vocational Rehabilitation Services Procedural Guidelines should be referenced when determining the cost effectiveness of particular interventions. Note, these guidelines are expected to be released in September 2019.

6.1. Consultant travel costs

Consultants must use all reasonable attempts to minimise travel costs. Where possible and appropriate for the client’s circumstances, consultants are encouraged to utilise telehealth arrangements, including teleconference and videoconference. The exception to this is the initial Rehabilitation Assessment, where an in person meeting would generally be preferable except in situations where the client is very remote or there are safety concerns associated with meeting in person.

Travel costs need to be itemised and justified in the plan, with delegate approval prior to any travel occurring. The following factors should be considered when determining whether consultant travel is appropriate:

- the type of service being delivered
- the location of the appointment
- the timing of the appointment to minimise the need for overnight travel,
- where a consultant’s journey starts and finishes, and
- the stage of the rehabilitation plan.

6.1.1. Allowable travel claims

Consultants are able to claim their travel time under certain circumstances when delivering the following services. These include:

- face-to-face meetings with clients, including but not limited to Initial Rehabilitation Assessments, Vocational Assessments, Work Environment Assessments and Ergonomic Assessments
- work site visits to work trial host employers, and
- case conferences with the treating doctor or specialist. This is only to be used in exceptional circumstances, when case conferencing via teleconference or videoconference is not suitable.

6.1.2. Limitations on travel claims

Limitations to claiming consultant travel time:

- When developing the plan, consideration should be given to the individual client’s needs when quoting travel costs. The need for travel will vary depending on the complexity of the case, the client’s preferences and needs, and the stage of the rehabilitation plan. At initial assessment and plan development meeting in person is important to gain rapport. During plan management and implementation occasional phone calls and videoconferencing can be
considered as viable alternatives to in person meetings, where these delivery modes are agreed to by and appropriate for the client. The frequency of face-to-face meetings and other alternatives should be discussed with, and agreed by, the client as the plan is being drafted. All anticipated travel costs over the life of the plan should be included in the plan (or plan amendment) if required.

- The geographic location of the client will have an impact on the associated travel costs in developing a plan. For clients residing in rural and remote locations as described by the Modified Monash Model zones 4-7, as far as practicable, a provider with an office nearby the client’s location will be allocated the case. Travel in these circumstances will be undertaken by vehicle and billed at an hourly rate, unless other arrangements are negotiated with the delegate.

- In rare situations, for example, for clients who live in remote locations, or have specific requirements, a consultant may require to travel distances that cannot be reasonably serviced by vehicle travel. In such circumstances the consultant may be required to travel by commercial airlines to attend a face-to-face meeting with the client. Air travel must only be undertaken where other communication tools, such as teleconferencing and videoconferencing, are ineffective. Air travel proposals must be forwarded to the delegate for approval and itemised in the draft plan. No air travel is to take place without delegate approval. Reimbursement for costs associated with air travel and overnight accommodation must be in accordance with the Australian Government Domestic Travel Policy (Resource Management Guide No. 404).

6.1.3. Ways to increase efficiency of travel costs

Consultants should consider flexible ways of working to reduce consultant travel time. To increase efficiency, consultants may wish to consider:

- meeting with the client at the provider premises, if appropriate
- scheduling back-to-back appointments for numerous clients in the same geographical locality and splitting travel time over the number of clients they visit, and/or
- helping clients to coordinate the timing of periodic appointments for medical and other services (particularly in remote and regional areas).

7. Completion of additional assessments (including vocational assessments)

Detailed specific assessments such as a Vocational Assessment, Functional Capacity Evaluation, Ergonomic Assessment and Work Environment Assessment should only be undertaken following the recommendation and approval of the delegate. It is a requirement that additional assessments are specified in the draft plan and approved by the delegate before they are undertaken. The client should be at an appropriate point in their rehabilitation before undertaking additional assessments. For some clients, this may be after they have progressed past a period of focus on medical management and/or psychosocial rehabilitation interventions.

For additional information and requirements on completing vocational assessments, providers should consult the Vocational Assessment Procedural Guideline. This also includes information on
Functional Capacity Assessments, Ergonomic Assessment and Work Environment Assessment. *Note, these guidelines are expected to be released in September 2019.*

8. **Invoicing for rehabilitation plan development**

Instructions for invoicing DVA for the costs associated with performing the assessment and plan development are included in the Initial Rehabilitation Assessment Procedural Guideline. Please refer to this guideline for further information.