Australian Government
Department of Veterans' Affairs

Notes for Community Nursing Providers

Effective December 2023

* This version of the Notes include two temporary provisions that are in place to 30 June 2025

COMMUNITY NURSING

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1 Introduction

The *Notes for Community Nursing Providers* (the Notes) is **Annexure A** to the *Terms and Conditions for the Provision of Community Nursing Services* (Terms and Conditions).

The Notes form part of a legally binding Agreement, comprising the Terms and Conditions, the Notes, and the Schedule of Fees, setting out the conditions and accountability requirements under which Community Nursing (CN) providers may provide services to clients under Department of Veterans' Affairs (DVA) health care arrangements. The CN provider and all personnel delivering CN services to clients must read, understand and comply with the Notes, which are non-negotiable.

The *DVA Community Nursing Schedule of Fees* (Schedule of Fees) is **Annexure B** to the Terms and Conditions. The set fees within the Schedule of Fees compensate a CN provider for the costs associated with the provision of CN services during a 28-day claim period. The cost components covered by the fees for the provision of CN services are:

- face-to-face time
- travel time
- general time
- labour on-costs
- overheads
- profit margin
- 'nurse's toolbox' consumables.

Changes applied to the Schedule of Fees, including indexation, take effect for claim periods commencing on or after the date the change is applied.

DVA has a commitment to innovation and continuous improvement of its activities and consults with a range of organisations within the CN field as required.

To remain contemporary, the Notes will be amended periodically. DVA will publish updated versions of the Notes on AusTender, and on the DVA website at Information for community nursing (CN) providers.

This version of the Notes includes two temporary provisions (Section 6.4.1 – Remote Delivery of Clinical Wellbeing Checks and Section 8.2.1 – Temporary changes to 28 day reviews) that are in place until 30 June 2025.

1.1 SERVICES AND PAYMENTS

DVA provides clients with access to a range of quality health care and related services, including CN services, at DVA's expense.

Information about all of DVA's services can be found online at https://www.dva.gov.au.

DVA will fund CN services delivered to eligible DVA Veteran Gold or White Card holders by an approved CN provider.

For the purposes of the Notes, eligible DVA Veteran Card holders will be referred to as clients.

1.2 PROVIDER NUMBER/S

DVA allocates CN providers with a provider number/s for claiming and monitoring purposes. Generally provider number/s are allocated as follows:

- one provider number will be allocated if all services are delivered within the same State or Territory, or
- a provider number will be allocated for each State or Territory if services are delivered in multiple States or Territories.

Organisations requiring additional provider numbers for specific sites for organisational business purposes can email the DVA contract manager at NMBCN@dva.gov.au.

1.2.1 Changes to service delivery areas or sites

A CN provider will supply DVA with information related to changes to service delivery areas or sites within 30 days. This is considered part of administrative information required by DVA. See clause 12 *Provision and Disclosure of Provider Information* in the Terms and Conditions for more information.

1.3 SUBCONTRACTING

CN providers intending to utilise subcontractors to provide CN services are required to:

- notify DVA within 30 days in the event of any subcontractor being used to deliver CN services to clients by completing the subcontracting template. The template can be found at Information for community nursing (CN) providers
- identify subcontractors by providing their legal name, ABN, ACN and registered or principal place of business
- allow DVA to view and authorise the terms of any subcontract as requested, and supply DVA with a signed copy on request
- ensure that subcontractors employ suitably qualified and competent personnel to deliver services, as per the requirements set out in *Section 4 – Human Resources*
- ensure subcontractors have an employee code of conduct that personnel adhere to

- ensure subcontractors have access to the Notes and any other DVA material required for them to deliver services in accordance with DVA requirements
- inform subcontractors of the obligations and the conditions and accountability requirements contained in the Agreement between DVA and the CN provider, as relevant
- ensure that, in providing their services, subcontracted service providers are made aware of and comply with the DVA Service Charter
- inform subcontractors that DVA has the right to request and review documentation related to services provided to clients under the subcontract, including as part of any audit process undertaken by DVA of the CN provider
- ensure the continuing suitability of subcontractors, including compliance with law generally and anti-discrimination laws
- ensure no subcontract restricts DVA's legal rights
- appropriately pay or remunerate subcontractors under any relevant subcontract, including accounting properly for all tax-related matters
- ensure every subcontract contains clauses that impose obligations on the subcontractor and grant rights to DVA (either directly or through the CN provider) that are the same as those obligations imposed on the CN provider and those rights granted to DVA under these Notes and the Terms and Conditions applicable to the part of the services being provided by the subcontractor
- none of the following reduce or limit the CN provider's obligations under the Agreement:
    - the CN provider subcontracting any part of the services delivered under this agreement
    - an act or omission of a subcontractor.

1.4 ACCESS TO THE NOTES

A CN provider must ensure that all of its personnel and subcontractors delivering CN services to clients have access to, and a working knowledge of, the current Notes, including any amendments made to the Notes over time.

1.5 CONTACTING DVA

A CN provider can contact the DVA Provider Enquiry Line by telephone on 1800 550 457.

Written enquiries can be emailed to:

- for general CN program information including interpretation/clarification of program policies contained in the Notes: nursing@dva.gov.au
- for Exceptional Cases: exceptional.cases@dva.gov.au
- for matters relating to the contract: NMBCN@dva.gov.au
- for client eligibility checks: health.approval@dva.gov.au (or via phone on the provider enquiry line above)
- for enquiries about CN audits: CN.program.quality@dva.gov.au.

Information about the CN program can be found online at Community Nursing services and providers.

1.6 FEEDBACK / COMPLAINTS MECHANISM

A CN provider can provide feedback, including complaints, about any aspect of the CN program by emailing nursing@dva.gov.au or online at Complaints, compliments and other feedback.

DVA will review all feedback and complaints and inform the CN provider of the outcome of their complaint.

As DVA is not a registration or regulatory authority, there may be instances where DVA will need to refer the complaint to the one of the following bodies due to the nature of the complaint:

- the Australian Health Practitioner Regulation Agency
- a relevant peak professional body
- a state / territory health complaints organisation.

2 Aim and scope of the Community Nursing program

The aim of DVA's CN program is to enhance the independence and health outcomes of a client and avoid early admission to hospital and/or residential care through the provision of CN services that meet the client's assessed nursing needs. Nursing services include both clinical and personal care services required to meet a defined health outcome. DVA contracts CN providers to deliver these nursing services to clients in their own homes.

CN services are delivered by Registered Nurses (RN), Enrolled Nurses (EN), and Personal Care Workers (PCW).

A CN provider must:

- deliver CN services in line with industry recognised evidence based practice and quality standards
- assist a client to develop, increase or maintain their independence, health and wellbeing.

2.1 CARE ENVIRONMENT

The care environment for DVA funded CN services is the client's own home.
A CN provider must:

- deliver all CN services to a client face-to-face in their place of residence. Where face-to-face services cannot be delivered and it is clinically appropriate to do so, these services may be delivered remotely, such as by telephone or online. Services that are delivered remotely can be claimed using the normal Schedule of Fees items
- conduct an assessment of any environmental risks to the safety of the CN provider personnel or client in the delivery of services in the client's home. If any environmental risks are identified, the CN provider must discuss the risks and options to mitigate those risks with the client and/or their carer, and note in the care documentation
- deliver CN services in a safe, effective and responsive manner to facilitate positive outcomes for the client, and in a manner that promotes privacy, dignity and respect for the client, including taking into account the client's culture and diversity
- deliver CN services in accordance with the nursing care plan
- provide a contact for clients for emergency purposes 24 hours a day, 7 days a week.

2.2 SCOPE OF THE COMMUNITY NURSING PROGRAM

The CN program provides a primary care service that aims to support the general health of a patient with low risk, simple clinical interventions. It is not designed to deliver a high level of nursing interventions, nor be a substitute for a

fulltime carer or a respite service. Similarly, the CN program is not a hospital substitution service or part of a hospital substitution service.

A person with significant care requirements, for example requiring 24 hour care, may not be considered independent. Many of the tasks and activities required to meet significant care needs are not classified as nursing services and are instead performed by a carer or for the purposes of respite (giving the carer a break or relief from caring responsibilities).

Where a client is identified as having significant care needs, for example through an Activities of Daily Living (ADL) assessment, the most appropriate care setting should be considered, particularly if carers are not available to provide the necessary care. Clients with a high level of nursing care needs long term may not be suitable for CN services. Consideration should include whether the person is most appropriately cared for in a health care or residential aged care setting, where a range of therapeutic services can be provided, ultimately resulting in better health and wellbeing outcomes for the client.

2.3 OUT OF SCOPE

A CN provider *cannot* deliver CN services to a client in any of the following locations as they are out of scope for the CN program:

- an acute care facility (including hospital in the home programs)
- a residential aged care facility
- a multi-purpose centre
- a community centre
- a clinic in any location.

If a client chooses to access, or a CN provider chooses to deliver, services in a facility or clinic instead of the client's place of residence, then the CN provider cannot claim for payment for these services from DVA.

Hospital substitution services, including Hospital in the Home, are out of scope for the CN program.

The CN program does not provide in-home respite care or supervision, or provide services to meet needs associated with Instrumental Activities of Daily Living (IADLs). These services are out of scope for the CN program. Where ADLs and IADLs are assessed through one tool, only the identified ADLs should be supported through CN services. IADLs can be supported through DVA's Veterans' Home Care (VHC) Program, or another suitable program.

If a care need relating to an IADL is identified, the client can be referred to a Veterans' Home Care (VHC) Assessment Agency for assessment. Additional care needs outside the scope of the CN program may also be covered under another suitable program such as the Department of Health and Aged Care funded Home Care Packages (HCP) Program or Commonwealth Home Support

Programme (CHSP). The client can be referred to My Aged Care for an Aged Care Assessment.

IADLs include:

- companionship and emotional support
- transportation
- cleaning/dishwashing
- routine laundry
- shopping
- childcare in some short-term and crisis care circumstances
- lawn mowing
- gardening
- cleaning gutters
- meal preparation
- arranging for medications and filling prescriptions
- communicating with others
- managing finances.

Where services are out of scope for the CN program (for example respite care and/or supervision), a CN provider should not misrepresent to a client what can be provided under the CN program even if this does not align with the client's expectations. The CN provider could discuss alternative service options with the client as required and/or refer to the GP or alternative services.

CN services are to maintain a person's independence at home, and should complement rather than replace services that are more appropriately delivered through another program or by a carer. Additionally, where clients are receiving similar services through another program, there must be no duplication of services between the programs.

3 Access to the Community Nursing program

3.1 ELIGIBILITY

A client is a person to whom DVA has issued a:

- Veteran Gold Card (clinically required treatment for all medical conditions) or
- Veteran White Card (medical treatment for accepted service-related injuries or conditions).

In the majority of cases, to be eligible to receive CN services for an assessed nursing care need, a client must hold either a Veteran Gold Card or a Veteran White Card.

3.1.1 Veteran Gold Card

The Veteran Gold Card is gold in colour and includes the words:
"Veteran – All Conditions within Australia".

A Veteran Gold Card enables a client to receive health care and related services to meet all of their assessed clinical nursing and/or personal care needs.

3.1.2 Veteran White Card

The Veteran White Card is white in colour and includes the words:
"Veteran – Specific Conditions".

For all Veteran White Card holders, the CN provider must contact DVA to determine eligibility to receive CN services for an assessed clinical nursing and/or personal care need prior to the commencement of CN services. See *Section 1.5 – Contacting DVA*.

CN services can only be provided to meet clinically required care needs associated with a client's eligibility to receive treatment, including for an accepted condition, or under Non-Liability Health Care (NLHC) or Provisional Access to Medical Treatment (PAMT).

If a client is receiving services under Provisional Access to Medical Treatment (PAMT) and their claim is declined, their eligibility to receive services will end.

See the Veteran White Card page on the DVA website for further information about Veteran White Card holder eligibility to receive services.

3.1.3 Veteran Orange Card

The Veteran Orange Card is orange in colour and includes the words
"DVA Health Card – Pharmaceuticals Only".

The Veteran Orange Card is for use only for pharmaceuticals and wound dressings through the Repatriation Pharmaceutical Benefits Scheme (RPBS) for eligible Commonwealth and Allied veterans and mariners.

It cannot be used to access any CN services.

3.2 REFERRALS

A CN provider must receive a valid written referral for an eligible client before the commencement of services, from one of the following authorised referral sources:

- General practitioner (GP)
- Treating medical practitioner in a hospital
- Hospital discharge planner
- Nurse practitioner specialising in a CN field.

Note: The client's GP is to have ongoing clinical oversight of the person's care. See *Section 8.5 – Communication with the client's GP* for expectations around communication between the CN provider and GP.

Referrals should outline necessary services to meet an assessed nursing care need for a medical condition. The clinically required nursing and personal care interventions should be included in the referral.

Referrals from GPs and nurse practitioners are valid for 12 months, at which time a new referral is required.

Referrals from hospitals are valid for six weeks, see *Section 3.2.2 – Referrals from Hospitals* section below for more information.

A Veterans' Home Care (VHC) Assessment Agency may identify a need for CN services and refer the client to their GP for a CN referral.

A CN provider cannot represent itself in any way as a DVA preferred provider.

If DVA establishes that a CN provider has given or offered financial or other inducement to any authorised referral source to generate referrals, it may terminate its Agreement with the CN provider and take any further action available under the Terms and Conditions of the Agreement.

3.2.1 Written referral requirements

The authorised referral source must provide a written referral for a client to a DVA contracted CN provider to request CN services. The referral should be on either the referral source's official letterhead, the CN provider's official referral form, or the DVA Community Nursing referral form, and be sent directly to the CN provider.

The referral must include the following information:

- authorised referral source details, including provider number (for a referral from a discharge planner or treating medical practitioner in a hospital, the hospital's provider number must be used)
- the medical condition/s the client requires CN services for, and clinical details of the condition/s including recent illnesses and injuries
- if medication administration or assistance is required, a medication authority or signed current medication chart/list that includes medication information
- a measure of the person's level of independence. If the level of independence has not been included in the referral, the RN should assess this as part of the initial comprehensive assessment, using an industry recognised measure of assessing independence. The tool should include ADLs such as showering, grooming, dressing, bowel and bladder care, transfers and mobility. If assistance with eating to meet a clinical need is determined, a nutritional assessment must also be conducted to determine the nutritional risk
- other health / support services the client is receiving
- whether an aged care assessment has been conducted by an Aged Care Assessment Team (ACAT) assessor, and the outcome of any assessment.

3.2.2 Referrals from hospitals

Where a referral is received from a hospital (treating medical practitioner or discharge planner) following a client's stay in hospital, the referral is valid for a period of six weeks post discharge. An updated referral is required from the client's GP to cover care needs beyond the six week period.

As a person may have higher care needs in the post-hospitalisation period, consideration should be given to whether the client's care needs immediately following discharge could be better met through a program such as DVA's convalescent care program, or the Department of Health and Aged Care's (DHAC) Transition Care Programme. A CN provider should discuss the most appropriate program/service for a client with the hospital discharge planner prior to accepting a referral. Information about DVA's convalescent program is available on the DVA website at Convalescent care. See *Section 12.4.1 – Transition Care Programme* for further information about the Transition Care Programme.

3.2.3 Referral to a CN provider

An authorised referral source should refer a client to a suitable CN provider in the same geographic region as the client's place of residence. Providers can be identified from the panel located on the DVA website at
Panel of Community Nursing providers

The panel is arranged by Service Delivery Areas and Local Government Areas for each State and Territory.

3.2.4 Referral period

Hospital referrals are valid for six weeks, following which time an updated referral from the client's GP will be required to cover ongoing care needs.

A referral from a GP or nurse practitioner specialising in community nursing is valid for a period of 12 months, or if a client is admitted for less than 12 months is ongoing through the client's episode of care from admission to discharge.

A new referral from the client's GP or nurse practitioner specialising in community nursing will be required if a client is transferred to another CN provider, discharged and later readmitted, and at the end of every 12 month period where ongoing services continue to be required.

3.2.5 Informal enquiry

An informal enquiry or request for services may be received from a number of sources, such as a client, a family member/carer or a concerned neighbour.

If an informal enquiry is received, the CN provider must advise the person to contact the client's GP (or another authorised referral source), to obtain a written referral. The written referral is required prior to the commencement of CN services.

3.2.6 Acceptance of a referral

A CN provider should accept a referral for a client from an authorised referral source, including on the transfer of a client.

Where a referral is unable to be accepted, the CN provider must immediately notify the referrer verbally and in writing advising the referral will not be accepted and why.

3.3 TRANSFER OF A CLIENT

A CN provider cannot transfer a client to another CN provider due to capacity or other contractual reasons once services have commenced unless approval is granted by DVA. Where this is the case, the contract manager should be contacted – see *Section 1.5 – Contacting DVA*.

An agreed transfer plan must be in place before any transfer, including agreed wording and approach for notification to the client. The CN provider is required to support a smooth transfer without disruption of CN services to a client.

Where a client transfers to another CN provider, e.g. due to client choice or moves to another location, the transfer can take place with the oversight of the client's GP, and without disruption to the client's CN services. DVA does not need to be advised of a transfer where it occurs due to client choice.

A new referral from the client's GP will be required if a client is transferred to another CN provider.

3.4 INFORMED CONSENT

A CN provider must obtain written informed consent from the client before commencing CN services. If the client is unable to give their consent, a nominated representative (i.e. a person authorised to represent the client, including a guardianship or administration order, Power of Attorney, legal representative etc.) may consent on their behalf.

To ensure the client can make an informed choice about the proposed CN services, the CN provider must discuss and provide the client with information including:

- a verbal explanation of the proposed CN services to be delivered, in a way the client understands (including a written version/format)
- their rights and responsibilities as a client
- the role of the CN provider's personnel, and that different personnel may be providing CN services depending on clinical requirements and staff availability
- the possibility that personal information about them may need to be disclosed to other health providers, as clinically appropriate, by the CN provider, and in some instances without seeking the client's consent prior to the disclosure
- the right of DVA, or any person or organisation authorised by DVA, to access all of the records held by the CN provider, including their care documentation
- the process for providing feedback or making a complaint about the CN services they receive.

3.5 DATE OF ADMISSION

The date of admission to the CN program is the date of the first face-to-face contact visit between a CN provider's personnel and the client. This first face-to-face contact visit must include a comprehensive assessment undertaken by an RN, in the client's home.

4 Human Resources

4.1 PERSONNEL

A CN provider may use a mix of personnel to deliver CN services. These personnel include:

- Registered Nurses (RN)
- Enrolled Nurses (EN)
- Personal Care Workers (PCW).

All personnel must be considered fit and proper persons to work with DVA clients.

CN providers are responsible for the appropriate supervision, training and support of all personnel delivering services to clients, and must ensure all personnel have the required qualifications, experience and competencies.

When delivering CN services, all personnel must work within the framework of the relevant national standards and meet all State/Territory and Commonwealth statutory requirements.

CN providers must ensure all personnel have relevant qualifications, current registration, competencies, experience and screening checks, and continue to meet continuing education requirements. This information must be maintained by CN providers for all their personnel, including current registration and continuing education documentation.

CN providers must ensure that *all personnel and sub-contractors* who have access to clients have had either:

- a national police check within the last three years or
- if working for a provider accredited to deliver services under the National Disability Insurance Scheme (NDIS), an NDIS worker screening check in the last three years.

Staff must also hold a working with vulnerable people registration / clearance or State/Territory equivalent, where this is a requirement for the delivery of services to adults in the State / Territory in which services are being delivered.

CN providers must have systems and processes in place for the orientation and induction of new staff. DVA has training and resources for CN providers available on the DVA website: Training and resources for Community Nursing providers.

4.2 REGISTERED NURSES (RN)

The national standards developed by the Nursing and Midwifery Board of Australia (NMBA) provide the framework for professional nursing practice in Australia.

Information on the national standards for RNs and ENs and Code of conduct for nurses can be accessed online through the '*Professional Codes & Guidelines*' tab, at: www.nursingmidwiferyboard.gov.au/.

RNs providing CN care and services must have:

- current registration with the Australian Health Practitioner Regulation Agency (Ahpra), with no restrictions to practice
- while a minimum of two years' post graduate experience including wound management is recommended, a minimum of one year supervised post-registration practice will be accepted
- completed infection prevention and control training
- medication management competency
- current manual handling competency
- current Basic Life Support (BLS) certification.

Qualifications and competencies must be maintained and recorded in personnel files.

RNs are responsible for:

- comprehensively assessing client nursing care requirements, face-to-face in the client's home including the client's level of independence, memory, mood, mobility and skin integrity
- reporting the outcomes of the assessment to the client's GP
- development of a tailored nursing care plan informed by the comprehensive assessment
- delegating aspects of client care to ENs and PCWs according to their respective role, scope of practice, competencies and capabilities
- monitoring, supervising and providing assistance as and when required to ENs and PCWs
- ensuring clinical nursing notes and assessment documentation are legible, current, based on industry best practice standards and including delegation of care, are documented in the client's clinical records
- providing CN care and services in accordance with the position description and the *Registered Nurse standards for practice* developed by the Nursing and Midwifery Board of Australia (NMBA), which can be found at NMBA – Registered Nurse Standards for Practice.

4.2.1 Delegation of care

A CN provider must ensure that all CN services delivered by an EN and/or PCW are planned, delegated, supervised and documented by an RN. All delegated care must be appropriately documented in clinical records and kept on the client's file.

The RN must recognise the differences in accountability and responsibility between RNs, ENs and unlicensed care workers (i.e. PCWs). An RN must delegate

aspects of care to others according to their competence and scope of practice. This includes:

- delegation of aspects of care according to role, functions, capabilities and learning needs
- monitoring aspects of care delegated to others and providing clarification/assistance as required
- recognising own accountabilities and responsibilities when delegating aspects of care to others
- delegation to and supervision of others consistent with legislation and organisational policy.

More information about delegation of care can be found in the *Registered Nurse standards for practice*
NMBA – Registered Nurse Standards for Practice.

4.3 ENROLLED NURSES (EN)

The national standards developed by the Nursing and Midwifery Board of Australia (NMBA) provide the framework for professional nursing practice in Australia.

Information on the national standards for RNs and ENs and Code of conduct for nurses can be accessed online through the '*Professional Codes & Guidelines*' tab, at: www.nursingmidwiferyboard.gov.au/.

ENs providing CN care and services must have:

- current registration with the Australian Health Practitioner Regulation Agency (Ahpra), with no restrictions to practice
- while a minimum of two years' post graduate experience including wound management is recommended, a minimum of one year supervised post-registration practice will be accepted
- completed infection prevention and control training
- current manual handling competency
- current Basic Life Support (BLS) certification
- medication management competencies (where applicable) and
- provide CN care and services as delegated by an RN and in accordance with the position description
- care and services should also be provided in line with the *Enrolled Nurse standards for practice* developed by the Nursing and Midwifery Board of Australia (NMBA), which can be found at NMBA - Enrolled nurse standards for practice.

4.4 PERSONAL CARE WORKERS (PCW)

The Community Services Training Package developed by the Community Services and Health Industry Skills Council forms a training and assessment framework for the certification of PCWs. Information about the Community Services Training Package can be accessed online at: https://training.gov.au/Training/Details/CHC.

All CN services provided by PCWs must be in accordance with the relevant standards and qualifications included in the Community Services Training Package, or equivalent training.

The minimum required qualifications for PCWs delivering CN services to a client are:

- one of the following qualifications:
    - a Certificate III in Home and Community Care, Aged Care or Disability (pre December 2015); or
    - a Certificate III in Individual Support (post December 2015). This includes a medication module for PCWs to provide assistance with medication that is recognised by the Community Services Health Industry Skills Council; or
    - a Certificate III in Health Services Assistance; or
    - a student in the second or third year of Bachelor of Nursing degree at an Australian university or accredited higher education provider;
- completion of infection prevention and control training
- medication assistance competency (where applicable)
- current manual handling competency
- current Basic Life Support (BLS) certification
- current Applied First Aid certificate.

These competencies must be maintained and recorded in personnel files.

CN providers must ensure all personnel employed as PCWs are appropriately skilled and experienced to deliver CN services, and receive appropriate training and support.

All care delivered by an EN and PCW must be delegated in line with the requirements set out under 4.2.1– Delegation of care.

4.5 COMPETENCIES AND TRAINING

4.5.1 First Aid and BLS competency requirements

Personnel's First Aid and BLS certificates *must* be:

- current
- completed annually
- from a registered training organisation.

4.5.2 Medication management competency

Where applicable, personnel administering and/or assisting with medications must also maintain medication management competency.

4.5.3 Infection prevention and control training

Providers are responsible for ensuring all personnel are trained in infection prevention and control and can determine which course should be completed. Further information and recommended courses on COVID-19 and infection prevention and control can be found at:

- Department of Health and Aged Care – COVID-19 resources and training
- Australian Commission on Safety and Quality in Health Care:
    - Infection prevention and control for aged care eLearning modules
    - Infection prevention and control – advanced education eLearning modules.

4.5.4 Continuing education and performance management for personnel

The CN provider must ensure its personnel have access to, and undertake, appropriate continuing education and professional development, particularly in relation to the provision of CN services, on a regular and on-going basis.

The CN provider must have a training system in place that ensures personnel maintain the necessary skills and competencies to effectively perform their role, and applicable training is documented in personnel records.

The CN provider must maintain current education and professional development records for all its personnel. This is in line with the Australian Health Practitioner Regulation Agency (Ahpra) Standards for Nursing. More information can be found at the following link: www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.

Personnel should be kept informed and maintain awareness of all current applicable organisational policies and procedures.

In addition, CN providers must have a system and processes in place for ensuring there is regular assessment and review of the performance of personnel, with outcomes recorded as appropriate in personnel records.

5 Assessment and care documentation

Care documentation, including clinical nursing notes and assessment documentation, must remain up-to-date and be based on contemporary CN industry best practice standards.

5.1 COMPREHENSIVE ASSESSMENT

An RN must assess the nursing care need/s of a client through a comprehensive assessment. Assessments must occur face-to-face in the client's home and be undertaken:

- upon receiving a referral from an authorised referral source
- following transfer from another CN provider
- on a 12 month anniversary from the commencement of care (if there have been 13 consecutive 28-day claim periods).

A comprehensive assessment includes the use of validated assessment tools based on current CN industry best practice standards.

Where an assessment of the person's level of independence has not been included in the referral, this should be conducted as part of the initial comprehensive assessment using an industry recognised measure including ADL tool.

For CN services to be provided to a client, there must be an assessed clinical need for nursing care. Where an assessment is undertaken and no services provided and no ongoing care needs are identified, the CN provider must use the *Assessment only – no ongoing services* item number (NA99) for claiming.

The outcomes of each comprehensive assessment will inform the development of a new nursing care plan. The RN must report the outcomes of each comprehensive assessment to the client's GP. Where the GP is not the original referral source and ongoing services are required, an updated referral will need to be provided by the GP. See *Section 3.2 – Referrals* for further information.

The assessment should also identify any allied health or community services that are required, for example occupational therapy, delivered meals, etc., and a request be made to the GP to arrange referrals as appropriate.

The outcome of any assessment should be clearly communicated to the client, and to their carer if appropriate.

5.1.1 Assessment of personal care needs

When a client is assessed as requiring low level personal care services and the client does not have a clinical need for any other CN services, the personal care services should be provided through the Veterans' Home Care (VHC) Program. The CN provider should refer the client to a VHC Assessment Agency on

1300 550 450, and advise the authorised referrer of the outcome. As a guide, if a client is assessed as requiring above 1.5 hours of personal care services per week this may not be considered low level personal care, and services may need to be provided through the CN program.

When a client is assessed as requiring personal care services as well as having a clinical need for CN services, all of the personal care services required should be provided through the CN program.

5.2 CARE DOCUMENTATION

A CN provider must develop and maintain an appropriate care documentation framework for a CN setting, based on the current principles of the CN industry recognised evidence based best practice.

A client's care documentation must be developed in conjunction with the client and, if applicable, the carer and family. The client must be provided with, or be able to access in a timely manner, an up-to-date copy of their care documentation. The client, and if applicable the carer / family, must sign the nursing care plan. The care documentation must be updated regularly at assessment and review, as changes occur and when additional information becomes available. All services must be delivered in accordance with the nursing care plan.

5.2.1 Nursing care plan

As a minimum, care documentation must include a nursing care plan that must be developed and completed by an RN following the comprehensive assessment.

Care plans are individualised and reviewed regularly, including when:

- the client's needs, goals or preferences change
- the client's ability, mental health, cognitive or physical function, capacity or condition deteriorates or changes
- the care that can be provided by a client's carer changes
- risks emerge or change or there is an incident that impacts the client
- all or part of the client's care is transferred between others involved in the client's care.

A nursing care plan must include:

- clinical and personal care needs and associated activities identified from the comprehensive nursing assessment
- client's level of/capacity for independence
- client's goal/s of care and agreed actions (short and long term), including their cultural needs
- clinical care/nursing intervention/s consistent with best practice and evidence
- clinical and personal care interventions consistent with best practice and evidence

- desired outcome/s of care
- delegation of care within Scope of Practice as per *Section 4.2.1 – Delegation of care*
- review dates
- agreed days and approximate timeframes that services will be delivered
- supports for the client's wellbeing and quality of life, maximising the client's independence and supporting their reablement
- information about the risks associated with care and service delivery and how staff can support clients to manage these risks.

Where an ACAT assessment has not been conducted, the CN provider should facilitate one within the first 28-day claim period for eligible clients.

Care plans must be accessible by the client. The CN personnel must ensure the current care plan is referenced in delivery of services to the correct client.

6 Community Nursing Fees Classification

A CN provider must appropriately classify a client under the Classification System, as set out in the Community Nursing Schedule of Fees.

The Classification System is based on:

- an episode of care model where a provider retrospectively claims for payment at the end of each 28-day claim period
- groupings of visit types in separate schedules:
  - Clinical Care (core, add-on, second worker and overnight)
  - Personal Care (core, add-on, second worker, and overnight)
  - Other Items.

Table 1 demonstrates some examples of core, opposing add-on schedule and other items.

Clinical and personal care core, add-on and second worker items may be claimed for up to 84 visits per claim period, where a client requires up to three visits per day throughout a 28-day claim period.

6.1 MAJORITY OF CARE PRINCIPLE

A CN provider will classify a client into either the Clinical Care schedule or the Personal Care schedule, whichever is the core care requirement (majority of care principle).

Majority of care is generally based on visit count, although there are situations when time may represent the majority of care.

Where time and the number of visits have been equally spent on clinical and personal care, the client should be classified under the Clinical Care schedule.

6.2 COMBINATIONS OF CARE

The Classification System allows for combinations of care, for example:

- if the majority of care classification is from the Clinical Care core schedule, a Personal Care schedule add-on can also be claimed if personal care is delivered; or
- if the majority of care classification is from the Personal Care core schedule, a Clinical Care schedule add-on can also be claimed if clinical care is delivered.

If any other CN services or nursing consumables are also provided, item numbers from the Other Items and/or Nursing Consumables schedule may also be claimed.

6.3 CLINICAL CARE SCHEDULE

Clinical care is defined as clinical nursing care required to treat *medical* conditions.

The goal of clinical care is to maintain the client's optimal health status through interventions that have a clinical purpose, including regular review of care needs to determine if improved outcomes have occurred. Clinical care *must* be delivered by RNs or ENs (based on their qualifications and experience).

Where a client is in a palliative phase, palliative care add-ons may be claimed to support the psycho-social elements of care being provided under the Clinical Care schedule. Palliative care provided by a CN provider should be under the supervision of the relevant specialist palliative care team, where clinically required.

DVA expects that once the goal/s of care has/have been achieved and the client's condition/situation is stable, a discharge plan will be implemented.

There are three classifications in the Clinical Care core schedule. They are:

- Clinical Support (short term)
- Clinical (Short or Long)
- Post-Operative Eye Drops.

6.3.1 Clinical Support

The Clinical Support visit type is used when the client requires no direct treatment for a medical condition, however there are nursing interventions required to support health outcomes for a short term period. These could include coordination, health education and goal setting, or monitoring, and be based on an identified clinical need that is definable and has expected health outcomes.

The Clinical Support classification is short term and can only be claimed for a maximum of three 28-day claim periods per six months of continuous care.

Clinical Support aims to prevent health complications and/or deterioration in health status by providing services such as:

- coordination of care between allied health professionals and the GP to ensure all required appropriate services and equipment are in place
- education including clinical advice related to self-management of medical conditions (medication use, safety and falls risks, chronic disease management), goal setting, self-monitoring, risk management and early recognition of deterioration
- monitoring of an unstable health condition requiring reporting to the GP (reportable levels from the GP must be obtained if performing short term Blood Glucose Levels (BGL) or Blood Pressure (BP) monitoring).

The Clinical Support visit type is *not* to provide a check visit for a client who is:

- stable in health (including has a stable BGL or BP); or
- self-reporting (client or carer able to contact/visit GP if issues arise).

If a client is a participant of the Coordinated Veterans' Care (CVC) Program, and a practice nurse is the care coordinator, CN providers must ensure there is no duplication of services with the Clinical Support visit banding.

If a client is a CVC Program participant and care coordination is being delivered via a CN provider, Clinical Support cannot be claimed while the client remains enrolled in the CVC Program.

6.3.2 Clinical (Short or Long)

There are two visit lengths in the Clinical Care visit type. A client can be classified as:

- Clinical Short (20 minutes or less) with 12 categories of visit range; or
- Clinical Long (21 minutes or more) with 11 categories of visit range.

The Clinical Care item number must correspond with the visit length and the visit range (number of visits provided) in the 28-day claim period.

6.3.2.1 Mix of short and long visits

Where there is a mix of short and long visits provided in a 28-day claim period, the CN provider calculates the total minutes of clinical care and divides this by the number of clinical care visits provided to determine the correct classification (short or long) to be claimed.

6.3.2.2 Medication administration

The client must be classified under the Clinical Care schedule and the care must be provided by an RN or EN with an approved qualification in administration of medications if the client requires the administration of:

- prescribed medications (Schedule 4 and above)
- Schedule 8 drugs if dispensed from a bottle/packet, including Schedule 8 transdermal patches
- prescribed medicated eye drops (Schedule 4 and above)
- prescribed creams.

Where a client requires medication administration or assistance with medication, the care interventions are to be documented in the medication management section of the nursing care plan for each prescribed dose and time of administration. A medication authority or signed medication chart must be provided by the prescribing/referring medical practitioner.

6.3.2.3 Symptom management

When a client is referred to the CN program for symptom management for an unstable disease/condition, those visits must be classified under the Clinical Care visit type in the Schedule of Fees, not Clinical Support.

Symptom management requires a GP/specialist medical practitioner to provide a diagnosis, orders regarding a treatment plan, and medication orders.

6.3.3 Post-Operative Eye Drops

This visit type is specifically for eye drop administration, prescribed by a specialist medical practitioner, following eye surgery. There must be 85 or more visits within the claim period to claim this item number.

The Post-Operative Eye Drops visit type:

- can be claimed only once per eye, for one 28-day claim period per 365 days
- is based on a minimum of more than three visits a day for the 28-day claim period.

Any prescribed eye drops of a continuous nature (i.e. longer than one 28-day claim period) must be classified under the Clinical or Personal Care schedule, depending on the type of eye drops required and any other clinical and/or personal care intervention/s provided to the client.

PCWs cannot provide Post-Operative Eye Drops services but can be used to deliver personal care services, if this intervention is also required.

6.4 PERSONAL CARE SCHEDULE

A CN provider will classify a client into the Personal Care visit type when personal care is the core care requirement for CN services.

The goal of personal care is to support the clinical outcomes of a client so that they can remain independently at home for as long as possible.

Personal care is generally considered a time limited (for example following surgery) or specific intervention to provide assistance with ADLs. ADLs include:

- personal hygiene (bathing, grooming, oral and hair care)
- continence management
- dressing
- assistance to eat (which may include heating a meal). This must meet a clinical need if provided through the CN program, and a nutritional assessment would be required to identify nutritional risk
- mobility / transfer (walk with assistance / move from one position to another manually or with assistance, e.g. mechanical lifter).

If the person's level of independence has not been included in the GP referral, the level of independence should be assessed using an industry recognised, validated tool in the initial comprehensive assessment by the RN.

Where there is a hygiene related risk to a client's health status, essential assistance with laundry to mitigate the clinical risk may be provided.

Where a client is in a palliative phase, personal care requirements to meet clinically required care needs can be provided under the personal care schedule, in conjunction with any clinical care requirements provided through the clinical care schedule.

Personnel used to deliver personal care services include RNs, ENs and PCWs. However, the CN provider must ensure that all CN services delivered by ENs and PCWs are planned, delegated and supervised, and documented by an RN in the nursing care plan, in line with requirements in *Section 4.2.1 – Delegation of care*.

A client will be classified within the Personal Care schedule according to the visit range and, if applicable, the visit length. There are three visit lengths that apply to the Personal Care schedule where the number of visits is over 35. The visit lengths are:

- Short – up to 30 minutes per visit
- Medium – 31 to 45 minutes per visit
- Long – 46 minutes or more per visit.

6.4.1 Remote Delivery of Clinical Wellbeing Checks

The provision of Remote Delivery of Clinical Wellbeing Checks has been extended until 30 June 2025.

CN providers are able to claim for remote clinical wellbeing checks, initially introduced as a temporary measure in April 2020. DVA recognises monitoring clients' clinical wellbeing occurs naturally through regular face-to-face services. Where face-to-face visits cannot occur, including as a result of workforce shortages or a client refusing services, this monitoring should continue, where clinically appropriate. Where CN providers deliver clinical wellbeing checks remotely, this can be claimed through the regular Schedule of Fees under the personal care classification.

During the extended period that clinical wellbeing checks can be delivered, DVA will monitor usage of this type of service, to enable evaluation of the level of use and effectiveness of this measure.

6.4.2 Personal care – mix of visit lengths

A client may require a mix of short, medium and long Personal Care visit lengths in a 28-day claim period.

Where there is a mix of short, medium and long visits in a 28-day claim period, the CN provider calculates the total minutes of personal care provided and divides this by the number of personal care visits provided to determine the correct visit length classification (short, medium or long).

6.4.3 Assistance with medication

A client can be assisted with self-administered medication by PCWs when the following criteria are met:

- the client's medical condition/s is/are stable
- there is a medication authority or medication chart signed by the prescribing medical practitioner
- there is a nursing care plan in place which includes medication contraindications (interactions and side-effects) and emergency contacts; and
- there is a blister pack filled by a registered Pharmacist which meets the DVA Dose Administration Aid service requirements; or
- it is over-the-counter medication, or prescribed/non-prescribed cortisone or topical cream;
- if assisting with a sub-cutaneous injection this must be pre-filled
- the PCW:
- has completed the required assistance with medication administration competencies recognised by the Health Industry Skills Council
- adheres to the relevant Commonwealth and State/Territory Drug Acts
- adheres to the CN provider's Medication Administration/assistance Policy/ies
- the PCW is working under the delegation of an RN (see *Section 4.2.1 – Delegation of care*), and any change in health status is reported immediately to the RN
- the RN (or an EN with an approved qualification in administration of medication) conducts a face-to-face visit and reviews the client on a weekly basis if assistance with the self-administration of Schedule 8 drugs is involved, see *Section 8.1 – Seven day review*
- the provider conducts annual medication competencies for the relevant PCWs and keeps individual PCW records for auditing and safety requirements.

If the above criteria cannot be met by a PCW, the care must be provided by an RN or EN and classified under the Clinical Care schedule, see *Section 6.3.2.2 – Medication Administration – Clinical Care* for more information.

The CN provider must ensure that the assistance with self-administration of medication, and the administration of over-the-counter medications/creams, by an EN and/or PCW is planned, appropriately delegated, supervised and documented by an RN, see *Section 4.2.1 – Delegation of care*.

The CN provider must also ensure that assistance with self-administration of medication meets the legislative requirements of the State or Territory where the services are delivered.

6.5 OTHER ITEMS AND ADD-ONS SCHEDULES

The Classification System includes Other Items and Add-ons schedules which include additional options for the provision of CN services.

Most Other Items and Add-ons schedule items can be claimed in conjunction with a Clinical or Personal Care core item number when the services are provided in the 28-day claim period.

The Other Items and Add-ons schedule items that can be claimed are:

- assessment (ongoing or no other services)
- palliative care phases (stable, unstable, deteriorating, terminal)
- bereavement follow-up (can only be claimed once)
- additional travel (see *Attachment B Additional Travel*)
- overnight care
- second worker
- nursing consumables (see *Attachment D Nursing Consumables*).

NB: Palliative Stable is the only palliative care add-on item that can be claimed with a Personal Care Core schedule item where there is no requirement for an add-on from the Clinical Care schedule.

6.5.1 Assessment

This visit type is used to claim the initial comprehensive assessment undertaken by an RN for every client, and at each 12 month anniversary (if there have been 13 consecutive 28-day claim periods) for clients with ongoing care needs.

If a client has been discharged from the CN program, and there is a break in services for more than one 28-day claim period, the Assessment item number can be claimed if the client is readmitted to the program. Where a client requires more than three assessment visits in a 12 month period, for example where the client is discharged from the CN program and re-admitted on more than one occasion, prior approval from DVA will be required to claim a fourth (or more) assessment item.

6.5.1.1 Assessment – ongoing community nursing services required

The Assessment classification for ongoing services can be claimed following the completion of a comprehensive assessment:

- once at the beginning of an episode of care
- after each 12 month period of ongoing care (13 consecutive claim periods).

This classification can be claimed in conjunction with:

- core and add-on item numbers from the Clinical Care and/or Personal Care schedules; or
- item numbers from the Exceptional Case schedule only when the Exceptional Case claim is at the beginning of the episode of care and not when a client moves from the Schedule of Fees into the Exceptional Case schedule within an existing 12 month period of care.

The CN provider must communicate the outcomes from each comprehensive assessment to the client's GP.

6.5.1.2 Assessment only – no ongoing community nursing services required

An Assessment where no ongoing CN services are required can be claimed only once per client within three consecutive 28-day claim periods (84 days).

The CN provider must contact the client's GP to provide information about the outcome of the comprehensive assessment, including any requests for referrals to allied or other health service/s or community support services, if these are required.

The only Other Items number that can be claimed in conjunction with this item is the Other Items – Additional Travel item number (if appropriate).

6.5.2 Palliative care

Palliative care add-ons can be used for a client who has a diagnosis of a life-limiting illness and requires a palliative approach.

Palliative care focuses on the psychosocial aspects of the care for the client and their family and/or carers and reflects the resulting increase in care required.

Clinical aspects of palliative care, such as symptom control, will be claimed under a clinical care visit type. If a client diagnosed with a life limiting illness requires only personal care services, this can be claimed under a personal care core visit type.

Examples of life-limiting illnesses include:

- metastatic cancers
- local reoccurrence of cancer
- end-stage organ failure, such as cardiac, renal or liver failure
- end-stage dementia
- acquired immunodeficiency syndrome
- neurodegenerative disorders such as Huntington's Disease or Motor Neurone Disease.

Palliative care services, including clinical interventions, should be coordinated and provided in conjunction with the specialist palliative care team, including the treating specialist medical practitioner, the client's GP and any other health providers involved in the client's care.

Personnel used to deliver palliative care services include RNs, ENs or PCWs, based on their qualifications and experience.

6.5.2.1 Palliative care phases

There are four Other Items - Palliative Care classifications which encompass the palliative care phases of:

- stable
- unstable
- deteriorating
- terminal.

For further details see *Attachment C Palliative Care Phases*.

6.5.2.2 Mix of palliative phases

It is possible that a client may move between two or more Palliative Care phases during a 28-day claim period.

Where this occurs, the CN provider should claim the Palliative Care phase that reflects the majority of care (based on number of visits provided or time spent) in that 28-day claim period.

6.5.2.3 Palliative care – claiming

The four palliative care item numbers can be claimed with the following:

- a Clinical Care schedule item number (excluding Post-Operative Eye Drops); and
- a Personal Care schedule item number (when there is an add-on from the opposing Clinical Care schedule).

The Other Items - Palliative Stable is the only palliative care item number that can be claimed with a Personal Care schedule item number when there is no requirement for an add-on from the opposing Clinical Care schedule.

The Other Items - Palliative Terminal item number:

- can only be claimed once for a client
- can only be claimed after the death of a client, using the start date of the final claim period in which services were delivered
- cannot be claimed with any other Palliative Care Items.

6.5.3 Bereavement follow up

The Bereavement follow up item is used for visit/s to a bereaved family member or carer following the death of a client who recently received CN services. The

client must have been receiving CN services from the CN provider at the time of death.

The visit/s to the bereaved family member or carer should preferably not occur on the same day as the client's death and should be made within three months of the date of death.

The goal of care is to assess the bereaved family member or carer and, if required, refer them for further bereavement counselling and support.

Personnel used for a Bereavement follow up visit must be an RN or EN, based on their qualifications and experience.

6.5.3.1 Bereavement follow up – claiming

Bereavement follow up can only be claimed once the client has died. The claim date for this item number must be the same start date as the final claim for payment regardless of when the bereavement visit/s actually occur.

6.5.4 Overnight care

A CN provider may provide overnight nursing care for a client where there is a clinical or personal care need.

Overnight nursing care is not for the purpose of providing respite or supervision, or to replace or establish the role of a carer.

Overnight care is classified as active or inactive:

- Active overnight care involves the provision of continuous active care throughout the night. The personnel (RN, EN or PCW) delivering care do not have a designated sleep time and provide assistance when required.
- Inactive overnight care occurs where overnight care is required, however the personnel delivering care can sleep when not required to provide care. During inactive overnight care, the personnel is available to provide assistance up to two times, for 30 minutes each time. If the personnel is up three or more times during the night, making a total of over one hour active duty per night, the overnight care visit can be claimed as active overnight.

Overnight nursing care should be claimed in the same 28-day claim period as other required services provided to the client.

6.5.5 Second Worker

There may be situations where a second worker is required to assist the primary worker for some, or all, of the scheduled visits for CN services.

For example, over a 28-day claim period, a client has the following care profile:

- Core care requirement - Personal Care - Medium 56 visits.

Non-weight bearing person - the personal care provided is comprised of the primary worker for 56 visits, who is assisted by a second worker for 28 of these visits for transfer and shower in the morning.

In these situations, a second worker item may be claimed for the delivery of services where the nursing care plan requires a second worker to provide services to a client during the same visit for the same task.

To claim for the provision of second worker services, utilise the relevant second worker code from the Schedule of Fees.

6.5.6 Nursing Consumables

Nursing Consumables items can be claimed by CN providers for reimbursement for products used, excluding items contained in the 'nurse's toolbox', during the provision of clinical care to a client in a 28-day claim period.

Each of the Nursing Consumables item numbers available in the Schedule of Fees have a set dollar amount attributed to them. The CN provider should claim the Nursing Consumables item number that is closest in value to the actual cost (excluding items contained the nurse's toolbox) within the listed range for nursing consumables used in the provision of care to a client during a 28-day claim period.

The CN provider *must not* include any nurse's toolbox or GST component when calculating which Nursing Consumable item number to claim. Payments made to CN providers automatically add the GST component prior to payment.

There is an upper reimbursement limit of $1,500 (excluding GST) for nursing consumables per client per 28-day claim period.

For further information, including the Schedule of Fees and claiming, see *Attachment D Nursing Consumables*.

Table 1: Core Schedule and additional items

Schedule	Core Item	Add-Ons (Opposing Schedule)	Other Items (Assessment)	Other Items	Other Items (Palliative Care)	Other Items	Other Items (CVC)	Second Worker	Overnight Care	Nursing Consumables
Personal Care	CORE Personal Care item number	ADD-ON from opposing Schedule for Clinical Care	Assessment (NA02)	Bereavement Follow-up (NA03)	Palliative (Stable, Unstable, Deteriorating, Terminal) (NA04-NA07)	Additional Travel (NA10)	CVC UP05 and UP06 (if applicable)	Second Worker	Overnight care	Nursing Consumables (NC10 – NC70)
Clinical Care	CORE Clinical Care item number	ADD-ON from opposing Schedule for Personal Care	Assessment (NA02)	Bereavement Follow-up (NA03)	Palliative (Stable, Unstable, Deteriorating, Terminal) (NA04-NA07)	Additional Travel (NA10)	CVC UP05 and UP06 (exception – where NL01 or NL02 have been claimed)	Second Worker	Overnight care	Nursing Consumables (NC10 – NC70)
EC Status	Assessed EC item number	N/A	Assessment (NA02 – only first 28-day claim period)	Bereavement Follow-up (NA03)	N/A	Additional Travel (NA10)	N/A	N/A	N/A	Nursing Consumables (NC10 – NC70)

7 Claiming

A CN provider claims for payment for the delivery of CN services to a client through Services Australia (Medicare).

DVA recommends CN providers use Medicare's online claiming services as they provide a number of efficiencies and cost-savings for health care providers. The CN program intends to move towards online claiming as the only method for CN providers to claim for services.

DVA will accept financial responsibility for the provision of CN services to meet the clinically assessed needs of eligible clients. The CN services must be delivered in accordance with the Notes and the Terms and Conditions.

A DVA client must never be asked to provide payment for the delivery of CN services by a CN provider.

7.1 28-DAY CLAIM PERIOD

DVA pays CN providers retrospectively for the delivery of all required CN services to a client in a 28-day claim period.

7.1.1 Changes in care needs during the 28-day claim period

If a client's care needs change during a 28-day claim period, the CN provider must reassess the classification/s:

- according to the core CN service provided (based on the majority of care principle)
- if required, utilising an add-on from the opposing schedule (based either on lesser visit count or lesser time, whichever is applicable) and/or
- if required, including any Other Items from the schedule (based on additional services or nursing consumables provided).

7.1.2 Two providers in a 28-day claim period

Where a client requires services from two CN providers in a 28-day claim period, services may be claimed directly through Medicare by both providers.

Where a client receives services from two providers, there must be no duplication of services delivered by the providers. It is expected the providers will liaise with each other to ensure there is no duplication, and that the client's full clinical needs are met.

Where one provider is delivering clinical care and one is delivering personal care, approval is required from DVA to claim opposing core schedule items. This approval needs to be sought from DVA at the end of the claim period, by the second provider to submit a claim to Medicare.

Where there are two providers delivering the same core service but at different times, e.g. on different days or one in the morning and one in the afternoon, the same core care type would be claimed by both providers, based on number and length of visits by each provider.

A client may require services from two providers when:

- they are referred to another CN provider (e.g. post hospital admission); or
- when one provider is not able to provide all the required care, and two providers are required to fully meet a client's clinical and personal care needs.

However, some services can only be claimed once in a 28-day claim period per client. These are:

- Assessment only – no other services required
- Exceptional Case status
- Coordinated Veterans' Care (CVC) Program items.

7.2 MINIMUM DATA SET

DVA requires CN providers to submit data on all the community nursing services delivered to a client. This data is referred to as the Minimum Data Set (MDS).

The MDS is used by DVA to monitor the appropriateness of the provision of community nursing services and ensure that a client receives quality health outcomes.

The MDS collects information on:

- Claim Details:
    - client's name, file number and claim start date
    - item numbers claimed.
- Staffing Resources Used (in the 28-day day claim period):
    - level of personnel delivering community nursing services to the client
    - visits/occurrences and hours of care provided by each level of personnel delivering community nursing services.

The MDS data is collected at the level of the individual client receiving community nursing services.

A CN provider must complete the MDS for every 28-day claim period that it delivers community nursing services to a client.

7.2.1 Why DVA requires MDS data

DVA uses MDS data to:

- monitor the appropriateness of the provision of community nursing services
- substantiate community nursing claims
- ensure that a client receives quality health outcomes and

- assist in research into program development (for example, MDS data was used in the development of the current Schedule of Item Numbers and Fees).

7.2.2 Items that require MDS

All item numbers except nursing consumables (NC10 – NC70), Travel (NA10) and CVC Initial and Subsequent Care Coordination (UP05-UP06) require MDS.

7.2.3 Recording MDS when an RN provides both clinical and personal care

In instances where an RN/EN delivers clinical and personal care in the same visit and a CN provider claims a core and add-on item, each component of the care delivered must be counted and recorded in the MDS as a separate occurrence. There is possibility in one visit there may be multiple occurrences of services being delivered, e.g.:

- clinical care (core item)
- personal care (opposing schedule add-on) and
- palliative care (Other Items add-on).

or vice versa:

- personal care (core item)
- clinical care (opposing schedule add-on) and
- palliative care (Other Items add-on).

7.2.4 Submitting MDS data

MDS data must be submitted at the end of each 28-day claim period either:

- online to Services Australia (Medicare) as part of the Medicare claim (preferred) or
- manually by secure email to DVA, using the MDS Collection Tool.

If the CN provider has multiple sites with multiple provider numbers, each site must submit its own MDS data.

7.2.5 Online

CN providers are able to lodge claims for payment and MDS through Medicare's online claiming, this is the preferred method for claiming and submitting MDS. CN providers who use online claiming to submit their claims include the MDS along with their claim submission.

7.2.6 Manual

The MDS Collection Tool is an Excel spreadsheet that is used to collect MDS Data manually. If MDS data is not submitted in the format used by the MDS Collection Tool, or is incomplete, it will be returned to the CN provider for correction and resubmission.

For more information on the MDS Collection Tool process for manual claiming, refer to the MDS Collection Tool - Quick Reference Guide on the DVA website at Information for Community Nursing providers.

7.3 GOODS AND SERVICES TAX (GST)

The fees in the Schedule of Fees and for Exceptional Case status are exclusive of GST, GST will be added (where appropriate) when the claim for payment is processed by Medicare, regardless of the claiming method used. Medicare will produce a GST compliant Recipient Created Tax Invoice (RCTI) on behalf of DVA at the time of payment.

7.4 TIMEFRAME FOR CLAIMING

A claim for payment for CN services, regardless of the claiming method used, must be forwarded to Medicare for processing within six months of the first day of the 28-day claim period.

7.5 SUBMITTING A CLAIM FOR PAYMENT

A CN provider must ensure that the details on their claim for payment are correct prior to submitting to Medicare.

In submitting a claim for payment for CN services provided to a client, the CN provider certifies that:

- the services were delivered by the CN provider or their subcontractor
- the services were provided under an agreed nursing care plan for the client
- the claim is a true representation of the CN services provided.

7.6 CANCELLED VISITS

Where a visit is cancelled at short notice or the nurse or PCW arrives for a visit and the client is not home, the visit that would otherwise have been made can be claimed. Less than 24 hours' notice of cancellation of a visit is considered short notice. This includes when an individual or generic client not responding plan has been actioned, and the outcome documented in the client's care documentation.

7.7 RETENTION OF CLAIMS

CN providers must retain their claims in a storage system which is able to be accessed for review purposes.

A CN provider must be compliant with the Australian Privacy Principles, see *Section 10.5 – Privacy, documentation and record keeping.*

7.8 PAYMENT METHOD

CN providers are paid directly by Medicare into a nominated bank account. A CN provider should contact Medicare on 1800 700 199 to provide these details. For information about the payment method, or to access online claiming information and forms, visit Services Australia - Banking details online claim form (HW052).

7.9 QUERIES ABOUT CLAIMS

If a CN provider has any queries about the status of a claim/s for payment they are required to contact Medicare on 1300 550 017 (option 2).

7.10 UNSUCCESSFUL CLAIM/S FOR PAYMENT

A claim for payment may be unsuccessful in full or in part. Medicare will inform the CN provider if a claim for payment has been unsuccessful and the reason/s why. Depending on the reason/s the claim for payment has been unsuccessful, Medicare may return either part or all of the claim documentation to the CN provider.

7.11 RESUBMITTING A CLAIM/S FOR PAYMENT

If appropriate, a claim for payment or a component of a claim for payment should be corrected and resubmitted to Medicare.

7.12 ADJUSTMENTS TO A CLAIM/S FOR PAYMENT

An adjustment may need to be made to a claim/s for payment and may occur for one of the following reasons:

- after a claim has been submitted, if an incorrect payment has been made or
- prior to a claim being submitted, if changes have occurred to the CN services delivered to a client with Exceptional Case status. For further details, see *Attachment A Exceptional Cases – Exceptional Case Variation Form*.

7.13 INCORRECT PAYMENT/S

An incorrect payment may involve either an overpayment or an underpayment. An incorrect payment may be identified by DVA or the CN provider. If an incorrect payment is identified by DVA, Medicare will contact the CN provider and manage the adjustment process.

If a CN provider identifies an incorrect payment, it must request an adjustment from Medicare. The request must be in writing and include the following information:

- the reason for the adjustment
- the provider number
- the claim number/s and
- the details of the client/s involved.

All requests for adjustments should be sent to Medicare, using Services Australia's Voluntary acknowledgement of incorrect payments (MO057) form.

When an adjustment is made, a GST-compliant Recipient Created Adjustment Notice (RCAN) is provided to the CN provider. The RCAN replaces the RCTI previously provided with the incorrect payment.

7.14 INAPPROPRIATE CLAIMING

DVA has systems in place to monitor and report on the servicing and claiming patterns of services provided under the CN program. These systems are aimed at detecting and preventing fraud and non-compliance, and include post payment monitoring, which may be conducted as a stand-alone activity or as part of a Quality and Safety audit.

Over-servicing is defined as providing a client with health care services that, when viewed objectively, are not required for the person's health and wellbeing. This includes services that, despite being provided at normal levels, are provided without a clear clinical or personal care need.

Under-servicing is defined as providing a client with a lower level of health care services than is clinically required to meet their clinical or personal care needs. DVA is committed to providing clients with quality and appropriate health care services through the CN program.

The Resource Management Guide No. 201 *Preventing, detecting and dealing with fraud* (2017) defines fraud against the Commonwealth as "dishonestly obtaining a benefit, or causing a loss, by deception or other means".

Fraud against the Commonwealth may include (but is not limited to):

- theft
- accounting fraud (false invoices, misappropriation etc.)
- unlawful use of, or obtaining, property, equipment, material or services
- causing a loss, or avoiding and/or creating a liability
- providing false or misleading information to the Commonwealth, or failing to provide it when there is an obligation to do so
- misuse of Commonwealth assets, equipment or facilities
- cartel conduct
- making or using false, forged or falsified documents;
- wrongfully using Commonwealth information or intellectual property
- any offences of a like nature to those listed above.

DVA has an obligation to meet Fraud Control arrangements under the *Public Governance, Performance and Accountability Act 2013* and the *National Anti-Corruption Commission Act 2022* (NACC Act). Failure to meet obligations to conduct business with the Commonwealth in an honest manner may result in provider education, recovery of monies or prosecution.

7.15 RECOVERY OF OVERPAYMENTS

DVA will advise Medicare of any overpayments and they will initiate a process to recover any overpayments that are identified during regular contract management performance monitoring processes and take appropriate action as required. Action may include:

- offsetting any overpayment against future payments and/or
- recovering, as a debt due to the Commonwealth, any money owing to DVA (plus reasonable interest) in a court of competent jurisdiction.

Medicare will write to the provider to explain the overpayment and ask them to issue a refund within 30 days.

8 Review of care

The CN provider must conduct a review of the care needs of a client, as a minimum, at specified times throughout the client's episode of care noted below, depending on the type of care the client receives. Each review *must* be recorded in the client's care documentation, even where the care continues unchanged, and include the reviewer's name, signature, designation and date.

This should include a review of the person's capacity/level of independence, as documented in the GP referral and/or initial comprehensive assessment undertaken by the RN.

8.1 SEVEN DAY REVIEW

A client classified in the Personal Care schedule who requires assistance with self-administered medication of Schedule 8 drugs from a Dose Administration Aid must be reviewed by an RN (or an EN with an approved qualification in administration of medication) every seven days.

All clients with Exceptional Case status must be reviewed by an RN at least once per week.

8.2 28 DAY REVIEW

The CN provider will review the care provided to a client at the end of the 28-day claim period:

- if the client is classified under the Clinical Care schedule (either as a core or add-on), the review at the end of each 28-day claim period *must* be conducted by an RN
- if the client is classified under the Personal Care schedule (with no Clinical Care add-on), the review at the end of each 28-day claim period *must* be conducted by either an RN or an EN.

The purpose is to review the nursing care plan and clinical documentation to verify that the classifications and care delivered reflect the item number/s claimed, including the:

- core schedule visit type classification
- opposing schedule visit type add-on (if required)
- other care and service/s provided from the schedule (if required).

8.2.1 Temporary changes to 28 day reviews

CN providers are able to claim for remote delivery of 28 day reviews, initially introduced as a temporary measure in April 2020. For the period until 30 June 2025, CN providers may conduct the 28 day review by telephone, where clinically appropriate, to alleviate the need for an RN or EN to travel to a client's house if the sole purpose of the visit is to conduct this review. The client's progress notes / file should be updated following the review.

For the period that 28 day reviews can be delivered remotely where clinically appropriate, usage of this measure will be monitored to provide information in support of evaluating the usage and effectiveness of the measure.

8.3 THREE MONTHLY REVIEW

The three monthly review *must* be conducted prior to the end of every third 28-day claim period by an RN, regardless of the type of CN services being delivered. A file note *must* be entered into the client's care documentation when the review is completed. All delegated care details must be appropriately documented in clinical records and kept on the client's file.

In undertaking the review, the RN will identify any changes required to the CN services, and document and implement those changes in consultation with the client or their nominated representative.

If the review identifies a change to services is required, the CN provider must notify the client's GP where relevant and either:

- reclassify the client within the Classification System if there is a change to the majority of care, or
- identify the need for the client to be assessed through the Exceptional Case process, or
- discharge the client from CN services.

For a client classified as Palliative Stable, the RN will identify whether claiming this item continues to be appropriate.

If there is no clinical need for CN services and the client requires non-clinically necessary personal care services, the CN provider should discharge the client and refer them to VHC for an assessment for personal care services, see *Section 6.1.1 – Assessment of Personal Care Needs* and *Section 13.1 – Veterans' Home Care*.

8.4 REVIEW OF CARE SUMMARY

Time Period	Activities	Personnel Level
Seven days for Personal Care with Schedule 8 drug assistance	Review medication management and ensure the delegations are still appropriate. A clinical care add-on may be claimed for this review.	RN; or EN with an approved qualification in administration of medication
Seven days for clients with Exceptional Case (EC) status	Review all clinical and personal care needs There is *no* clinical care add-on that can be claimed. The review is included in the EC funding.	RN

28-day claim period	Includes a review of the nursing care plan and existing documentation to verify that the classifications and care delivered reflect the item number/s claimed.	RN; or EN if only personal care is being delivered
Three monthly	Includes but not limited to: • identification of any changed care needs; • review of nursing care plan and all documentation relevant to care needs • update of nursing care plan where necessary • consultation with the client about nursing care plan updates • any relevant assessment tools • verification of classifications and that care delivered reflects the item number/s claimed.	RN
At any time if care needs change	Review and update all assessment documentation and the nursing care plan to reflect the changed care needs.	RN

Note: It is expected that, wherever possible, the review occurs in the same visit as a visit for the provision of clinical/personal care.

8.5 COMMUNICATION WITH THE CLIENT'S GP

DVA expects the client's GP to have ongoing clinical oversight and management of the client's care. As such, the CN provider must communicate with a client's GP on a regular basis, and record the communication in the client's care documentation. This should occur:

- on admission following a comprehensive assessment of care needs
- following a review when the assessed care needs change
- every 12 months following a comprehensive assessment of care needs
- where a client and/or nominated representative decline services or issues arise preventing the delivery of services
- on discharge from CN services. When a client is discharged from CN services, a summary of the care provided during the episode of care, reason for discharge, and any additional services the client may require should be documented.

The CN provider must identify:

- any significant change to clinical and/or personal care needs
- the need for an allied or other community health or support service and request a referral for service/s.

9 Discharge from Community Nursing services

A client must be discharged by a CN provider if the client:

- is absent from CN services for more than 28 days
- has been permanently admitted to a Residential Aged Care Facility
- transfers from the existing provider to another CN provider (with DVA approval if required)
- moves permanently to another location (not serviced by the current CN provider
- no longer requires CN services.

The date of discharge from CN services is the date of the last face-to-face visit. The client's episode of care ends on the date of discharge.

A client's GP should be notified verbally and in writing of the client's discharge, including if a client self-discharges, and any recommendation for other services the client may require.

A discharge should not occur if the client is:

- absent from CN services for 28 days or less, for any purpose, e.g. for residential respite care, hospitalisation, holiday
- absent for short periods which do not interrupt planned CN services
- visited regularly, but infrequently, over a period longer than 28 days and which is considered one continuous delivery of CN services (e.g. for six – eight weekly indwelling or supra pubic catheter change).

9.1 ABSENCES FOR 28 DAYS OR LESS

Absences from CN services may be due to admission to an acute facility or hospice, a period of rehabilitation, residential respite, or going on a holiday.

If a client is absent from CN services for 28 days or less, and still requires CN services, they should recommence services with the same CN provider within the 28-day claim period to ensure continuity of care.

If the care needs have changed, the CN provider must update all assessment documentation and the nursing care plan. Item numbers must also be reviewed to ensure they reflect the type and level of care being provided.

The client's GP must be notified of the outcome of the assessment.

9.2 READMISSION AFTER DISCHARGE

If CN services are required again after a client is discharged, regardless of the period of time since discharge, the CN provider must:

- obtain a new referral prior to admission back into the CN program; and
- conduct a new comprehensive assessment and develop a new nursing care plan.

10 Systems, policies and continuous improvement

CN providers must ensure they have systems, policies and procedures in place to deliver safe and quality care to clients, in line with contractual arrangements and quality standards.

While not all CN providers are aged care providers, the CN program aligns with the strengthened Aged Care Quality Standards.

10.1 CN PROVIDER SYSTEMS

CN providers must be able to demonstrate they have systems and processes in place to support the delivery of quality and safe care to clients. These systems include but are not limited to:

- clinical governance
- partnering with clients
- quality and safety
- accountability and quality
- risk management
- incident management
- feedback and complaints
- information management, including requirements under *Section 10.5 – Privacy, documentation and record keeping*
- workforce planning
- human resource management
- emergency management.

10.2 CLINICAL AND ADMINISTRATIVE POLICIES

A CN provider must have written clinical and administrative policies and procedures in place which adhere to the provisions contained in the relevant State or Territory legislation and which are appropriate for a CN setting.

At a minimum, these policies and procedures must include:

- work health and safety
- incident, accidents and dangerous occurrence management
- infection control
- medication management
- care documentation
- client not responding
- delegation of care.

All policies must be reviewed regularly (at a minimum of every three years or in line with relevant legislation), informed by contemporary evidence-based practices, align with quality standards and contractual agreements, and be accessible and understood by all personnel.

10.3 CONTINUOUS IMPROVEMENT

CN providers must have and work within a framework of continuous improvement and innovation to deliver industry recognised, evidence based CN services.

A continuous improvement framework is made up of quality systems and at a minimum, includes systems for:

- the management of risk, including health and safety risks to a client
- the management of feedback to other health professionals
- the management of complaints and feedback from clients and other individuals
- the evaluation of continuous improvement outcomes
- the management of records to ensure maintenance and appropriate access.

10.4 COMMUNICATION

The CN provider must have a system for communicating information about clients and their care that ensures critical information is effectively communicated to personnel and others involved in the client's care, including at the following times:

- the client commences receiving services
- the client's care needs change
- risks emerge or change or there is an incident that impacts the client
- handover or transfer occurs between personnel or others involved in the client's care.

The CN provider must have strategies for supporting staff to:

- recognise risks or concerns related to a client's health, safety and wellbeing
- identify and report deterioration or changes to a client's health status and/or care needs
- respond to and escalate risks and/or incidents in a timely manner.

The CN provider and personnel ensure clients are correctly identified, and matched to their care and services.

10.5 PRIVACY, DOCUMENTATION AND RECORD KEEPING

All CN providers must develop, maintain and store appropriate documentation relating to the claiming, administrative and clinical aspects of the client's episode of care. This includes having the following clearly identified and documented:

- valid referrals
- assessments
- nursing care plans
- clinical nursing notes
- dated reviews of care and the outcomes
- related care documentation
- claiming history.

CN providers must ensure the storage and security of personal information regarding a client is in accordance with relevant State or Territory and Commonwealth privacy laws, including the *Privacy Act 1988* (Cth) and the Australian Privacy Principles (**APPs**) (which are at Schedule 1 to the Privacy Act).

Information about privacy, the Privacy Act and the APPs can be accessed through the Office of the Australian Information Commissioner (**OAIC**) website at www.oaic.gov.au/privacy.

The OAIC's "Guide to securing personal information" provides guidance on information security, specifically the reasonable steps entities are required to take under the Privacy Act to protect the personal information they hold: www.oaic.gov.au - Guide to securing personal information. CN providers must not perform an act, or engage in a practice under the agreement or a subcontract, that would breach an Australian Privacy Principle under the Privacy Act.

The CN provider must retain any documents relating to the care of a client, or documentation relating to payments claimed for the client, in accordance with legislation regarding the retention of medical records in their State or Territory.

Where records include personal information about clients (such as name, address, age and services received) their confidentiality must be protected. CN providers must ensure that records are stored securely and only accessible by personnel that have undergone appropriate security checks, and will access only information that is required for the personnel to perform their duties.

10.6 DVA'S RIGHT TO ACCESS RECORDS

The CN provider must make the care, administrative and/or claiming documentation (hard copies or electronic) available to DVA, or any person or organisation approved by an authorised DVA delegate, and provide reasonable access (either by desk top review or on site review) to the documentation upon request. This information will be made available by a CN provider on request from DVA. DVA will ensure that reasonable timeframes are allowed for the supply of the requested information.

To facilitate Quality and Safety Audits or Performance Monitoring processes, DVA may request copies of the care, administrative, and/or claiming documentation. DVA will collect, use, access, disclose and store the documentation it receives in accordance with relevant Commonwealth laws, including the Privacy Act, the *Freedom of Information Act 1982*, the *Veterans' Entitlements Act 1986*, the *Safety Rehabilitation and Compensation (Defence-related Claims) Act 1988*, and the *Military Rehabilitation and Compensation Act 2004*.

10.7 REFUSAL OF SERVICES

A client has the right to refuse either some or all of the proposed CN services. A nominated representative (i.e. person authorised to represent the client including a guardianship or administrative order, Power of Attorney, legal representative etc.) can also refuse some or all of the proposed CN services on behalf of the client.

If CN services are refused, the CN provider must:

- inform the client of the expected consequences of refusal
- notify the client's GP and nominated representative (where relevant) of the refusal and
- document the refusal and the actions undertaken as a result of the refusal in the client's care documentation.

A client's refusal of CN services on a previous occasion does not exclude the client from accessing CN services in the future.

10.8 CLIENT NOT RESPONDING

The CN provider should develop, together with the client, an individual plan of action to be implemented as part of their policies and procedures in the event that a client does not respond when the CN provider staff member arrives for a scheduled service visit. The plan of action should include a contact person and phone number for a welfare check of the client to be conducted.

Where a client does not want an individual plan of action, providers are required to have a generic plan in place to ensure the safety of all clients without an individual plan.

For any occasions where the client not responding plan has been implemented/activated, a summary of events should be documented in the client's care documentation.

CN providers should have a reminder system in place to minimise situations where a client forgets about a service visit. Where the CN provider has not activated an individual or generic client not responding plan to check the client's safety, the CN provider must not claim a visit. For further information about claiming for visits in this situation, see *Section 7.6 – Cancelled Visits*.

10.9 RIGHTS OF CARERS AND HEALTH CARE RECIPIENTS

'Carers' refers to family or regular unpaid carers providing the majority of support for a client. A carer may or may not live with the client.

Where required or requested by the client, the CN provider must ensure carers are recognised as partners in the client's care and are involved in the coordination of services.

The *Carer Recognition Act 2010* aims to increase recognition and awareness of carers and to acknowledge the valuable contribution they make to society. The *Carer Recognition Act 2010* provides a Statement for Australia's Carers that outlines principles and obligations for Australian Government agencies and organisations that they contract.

As a contracted organisation, a CN provider should take all practicable measures to ensure that its personnel and any subcontractors have an awareness and understanding of:

- the Statement for Australia's Carers
    - and take action to reflect the principles of the Statement in developing, implementing, providing or evaluating care supports
- the Aged Care Charter of Rights
- the Aged Care Quality Standards
- the Australian Charter of Healthcare Rights, which lists rights and responsibilities for everyone receiving health care in Australia.

The *Carer Recognition Act 2010* is available at: https://www.legislation.gov.au/Details/C2010A00123.

11 Performance monitoring

All CN providers are subject to performance monitoring processes. The purpose of performance monitoring is to measure compliance with contractual requirements, including both administrative and clinical requirements, and determine the quality of CN services being delivered. Performance monitoring will include a combination of contract management activities, quality and safety audits and post payment monitoring processes.

11.1 QUALITY AND SAFETY AUDITS

Quality and safety audits are conducted to assess the quality and safety of nursing services delivered by CN providers.

The purpose of quality and safety audits is to review compliance with DVA requirements as outlined in the Notes, and to ensure the provider continues to deliver high quality, safe and person-centred CN services to DVA clients.

As part of the quality and safety audit process, CN providers will be asked to provide evidence of compliance with relevant quality standards and adherence to the Notes and contractual arrangements.

Assessment will be undertaken through a desktop review or onsite visits. It is intended providers will be audited on a three yearly cycle, however this is subject to change based on a number of factors, including service delivery claiming patterns and any issues which may arise over time.

DVA will notify the provider ahead of the audit, with the notification including the documentation requested as part of the audit. Audits will include a post payment monitoring component.

11.2 RECOGNITION OF ACCREDITATION

DVA will recognise a CN provider's accreditation with the Aged Care Quality and Safety Commission (ACQSC) (www.agedcarequality.gov.au). This recognition is based on the adaption of the aged care quality standards for DVA's CN program, similarities between the compliance measures, and DVA's performance monitoring process. The achievement of accreditation does not replace any performance monitoring process.

While DVA recognises CN providers utilise other quality and accreditation frameworks (healthcare and non-healthcare focused), these are not currently recognised in the quality and safety audit process.

11.3 POST PAYMENT MONITORING

Post payment monitoring utilises claiming data to validate assessment and classification within the Schedule of Fees. The key objectives are to:

- ensure compliance with the Notes and CN Schedule of Fees

- monitor the appropriateness of claims relating to the services provided to clients
- minimise the risk of claiming errors or fraud.

12 Interaction with other health and community support service providers

12.1 VETERANS' HOME CARE (VHC) PROGRAM

A CN provider can deliver CN services to a client receiving domestic assistance, home and garden maintenance, or respite services under the VHC Program. All referrals for VHC services must be made to a VHC Assessment Agency. The contact number for VHC Assessment Agencies is 1300 550 450. Further information about the VHC Program can be found on the DVA website at Veterans' Home Care.

When a client is assessed as requiring low level personal care services and the client does not have a clinical need for CN services, the personal care services should be provided through VHC.

As a guide, if a client is assessed as requiring above 1.5 hours of personal care services per week this may not be considered low level personal care, and services may need to be provided through the CN program.

A client must not receive ongoing personal care services under VHC while they are also receiving CN services for a clinical and/or personal care need. All of the required personal care services must be delivered as a part of the CN services, see *Section 5.1.1 – Assessment of Personal Care Needs*.

12.1.1 Short term clinical intervention

When a client receiving personal care services under VHC requires a short term clinical intervention, an exemption may be approved by DVA to allow the personal care to continue through VHC at the same time as the clinical intervention is provided through the CN program. To request an exemption, providers should contact DVA, see *Section 1.5 – Contacting DVA* for contact details.

An exemption may be considered in the following circumstances:

- where a client has received long term personal care services through VHC and requires some level of CN services through the CN program but the prospect of receiving these personal care services from a different provider through the CN program causes a high level of stress and anxiety or
- where the client is located in an area where the only CN provider is unable to deliver the required level of personal care services and the provision of personal care services through VHC is the only option for the client.

Requests for an exemption will be assessed on a case-by-case basis, depending on the circumstances. An agreement for a limited number of 28-day claim periods may be given.

The overlap of services in these circumstances may only occur if the provision of personal care services is not duplicated under both programs and the health and safety of the client is not put at risk.

Where an exemption is granted, the CN provider must ensure they regularly communicate with the relevant VHC service provider to ensure that the personal care services do not impact on the treatment outcomes of the CN services.

12.2 CREDENTIALED DIABETES EDUCATORS

A client may access diabetes education services from a credentialed diabetes educator, where this service cannot be delivered by the CN provider. This scenario would typically arise when a CN provider does not have any credentialed diabetes educators as part of their personnel.

Where a CN provider does have credentialed diabetes educators as part of their personnel, a credentialed diabetes educator not employed by the CN provider must not claim payment for diabetes education services provided to a client who is receiving CN services, as the cost of diabetes education services is included in the fee paid to CN providers.

12.3 OPEN ARMS – VETERANS AND FAMILIES COUNSELLING

Open Arms provides free and confidential, nation-wide counselling and support for a range of mental health conditions, such as post-traumatic stress disorder (PTSD), anxiety, depression, sleep disturbance and anger for current and ex-serving (veteran) defence force personnel and their families. Support is also available for relationship and family matters that can arise due to the unique nature of military service.

Open Arms counsellors have an understanding of military culture and can work with clients to find effective solutions for improved mental health and wellbeing.

Open Arms provides the following services:

- individual, couple and family counselling and support for those with more complex needs
- services to enhance family functioning and parenting
- after-hours crisis telephone counselling
- group programs to develop skills and enhance support
- information, education and self-help resources and
- referrals to other services or specialist treatment programs.

Veterans and their families can seek assistance from Open Arms by calling 1800 011 046. More information can be found on the Open Arms website: https://www.openarms.gov.au/.

12.4 HOME CARE PACKAGES PROGRAM, COMMONWEALTH HOME SUPPORT PROGRAMME AND SHORT-TERM RESTORATIVE CARE PROGRAMME

The Department of Health and Aged Care (DHAC) Home Care Packages (HCP) Program provides a continuum of four home care options covering basic home care through to high level home care:

- HCP Level 1 - Basic care
- HCP Level 2 - Low level care
- HCP Level 3 - Intermediate level care and
- HCP Level 4 - High level care.

All package levels will have access to nursing and allied health services, if a need for these services is identified.

Clients have the same right of access to HCPs, and other forms of packaged care, as any other member of the community. Specifically, clients should not be discriminated against when accessing services through a Home Care Package on an assumption that DVA will provide for all their care needs. To receive a HCP, a client, as any other member of the community, must have an assessment by an Aged Care Assessment Team (ACAT) assessor.

A HCP recipient, including a DVA client, may be asked to pay a fee for their home care services. DVA will pay this fee for clients who are former Prisoners of War or Victoria Cross recipients.

Information can be accessed online at:
Home Care Packages Program | Australian Government Department of Health and Aged Care

The DHAC Commonwealth Home Support Programme (CHSP) aims to help older people remain independent and in their homes and communities for longer. The CHSP works with clients to maintain independence, and is an entry-level support service.

Information can be accessed online at:
Commonwealth Home Support Programme (CHSP) | Australian Government Department of Health and Aged Care

The Short-Term Restorative Care Programme (STRC) Programme is early intervention to reverse or slow 'functional decline' in older people.

'Functional decline' is when a person is having difficulty performing their day-to-day activities, including:

- bathing
- dressing

- feeding
- shopping
- driving

The STRC Programme provides services to older people for up to 8 weeks (56 days) to help them delay or avoid long-term care. A client can access 2 episodes of STRC within a 12-month period.

More information on STRC can be found at the following link:
About the Short-Term Restorative Care (STRC) Programme | Australian Government Department of Health and Aged Care

Under the no duplication of care policy, eligible persons are able to access services through both DVA funded CN and the DHAC funded HCP, CHSP and STRC providing there is no duplication in the services being delivered. Where a client is in receipt of both DVA funded CN and a HCP and/or CHSP and/or STRC, the providers delivering the two programs must liaise to coordinate the care being delivered.

12.4.1 Transition Care Programme

A CN provider *cannot* deliver CN services to a client who is receiving Transition Care services administered by DHAC.

Transition Care provides goal oriented, time limited and therapy focused care to help older people at the conclusion of a hospital stay, and who may otherwise be eligible for residential aged care.

To enter Transition Care, clients may require an assessment by an Aged Care Assessment Team (ACAT) assessor while they are still an in-patient of a hospital. This can be organised through the hospital where the client has received their acute/sub-acute care. A client can only enter transition care directly upon discharge from hospital

More information on Transition Care can be found at the following link:
www.myagedcare.gov.au/after-hospital-care-transition-care.

See Section 3.2.2 – Referrals from hospitals for information relating to referrals to CN following a hospital stay.

12.4.2 State/Territory or local based community services

A CN provider can deliver CN services to a client with an assessed clinical need who is receiving State/Territory or local based community services, provided these services do not duplicate the provision of CN services. Where a client is in receipt of CN services as well as State/Territory or local based services, the providers must liaise to coordinate the care being delivered.

Attachment A – Exceptional Case process

A small number of clients will have care needs that fall significantly outside the CN Schedule of Fees. To ensure these clients receive the CN services they require, they are assessed through the Exceptional Case (EC) process.

Prior approval must be sought from DVA through the EC process and approval given before the commencement of care outside the Schedule of Fees. EC applications may be reviewed by DVA nursing advisers. DVA is not liable to pay for any services that have been delivered before prior approval has been given.

As prior approval is required for all EC applications (including increases to EC care), it is recommended that the application is submitted at least one week prior to the requested commencement date to allow time for processing of the application. EC applications cannot be backdated.

Where urgent circumstances apply in regard to the commencement of care, the CN provider must contact DVA via secure email to exceptional.cases@dva.gov.au to outline the special circumstances prior to the commencement of services. At DVA's discretion, interim approval can be granted for a short period of time to provide EC care without an EC application, for example to provide end of life care. DVA will provide interim approval in writing via secure email to the CN provider. Where interim approval is granted, the CN provider is required to submit the full EC application within the timeframe specified on the interim approval letter to enable processing of the EC application by DVA.

The assessment of a client's care requirements is based on their identified clinical needs at a specific point in time and approval will be given accordingly, up to a maximum of 12 months. If further EC funding is required after 12 months, a new EC application must be submitted 28 days prior to the expiry of the current EC approval. As care needs change over time, where appropriate the funding will return to the Schedule of Fees. DVA is not liable to pay for any services that have not been given prior approval through the EC process.

The CN provider should facilitate an aged care assessment by an ACAT assessor for any client over 65 years with complex care needs. More information about ACAT assessments can be found at the following link: www.myagedcare.gov.au/eligibility-and-assessment/acat-assessments.

1 Exceptional Case applications

It is the responsibility of the CN provider to submit a complete EC application signed by the RN conducting the assessment, including all required attachments as detailed in the relevant EC form/s. If this information is not included with the application, a delay in processing the application will occur.

All applications must include:

- a copy of the current nursing care plan which must be signed by the RN and the client or their nominated representative
- a GP health summary and referral, or a referral from a treating medical practitioner in a hospital, or a hospital discharge planner.

The nursing care plan must detail:

- the specific interventions required for each nursing need including frequency and whether the care is provided by an RN, EN or PCW
- all medication interventions including if medication is being administered by an RN/EN or assisted by a PCW. A current medication authority and/or medication chart signed by the treating medical practitioner must be attached for administration of medications
- any aids and appliances
- the short and long term goals and objectives to successfully resolve and manage each identified nursing need
- nursing equipment required to successfully complete interventions
- level of personnel needed to successfully complete each planned intervention
- referrals to allied health and other health professionals as clinically indicated
- frequency and length of time needed for visits
- agreed visit days and approximate timeframes
- planned review dates as per *Section 8 – Review of Care* requirements, and any additional requirements as identified from the nursing assessment
- nursing care plans must be signed by the RN and the client or their nominated representative.

If a client is identified as having potential EC status, the CN provider must maintain the existing 28-day claim cycle start date for that client, rather than using a different start date in the application. Recording a different start date will result in delays in the assessment of the application and/or rejected claims for payment, as the 28-day claim cycle has not been maintained.

Where a CN provider delivers services under the Schedule of Fees whilst awaiting the outcome of an application for EC status, services delivered will be taken into consideration when assessing the EC application.

Application submission is via DVA secure email. Please email exceptional.cases@dva.gov.au to set up secure email facilities and refer to the information about secure email on the DVA website at Sensitive emails.

Enquiries relating to EC status can be emailed to exceptional.cases@dva.gov.au.

1.1 EXCEPTIONAL CASE FORMS

The EC forms (listed below) are available on the DVA website at Exceptional Cases.

Forms should be completed electronically where possible. If forms are completed manually, black pen should be used.

D1004 - Application for Exceptional Case status – this form is used for new EC applications, and applications to continue care beyond the end of an existing EC approval period.

D1004A - Attachment 1 – Dementia – this form is to be used as an attachment to an EC application where the client has been diagnosed with dementia.

D1004B - Attachment 2 – Mental Health – this form is to be used as an attachment to an EC application where the client has been diagnosed with a mental health condition.

D1004C - Attachment 3 – Palliative Care – this form is to be used as an attachment to an EC application where palliative care is being provided. It must include evidence of the involvement and oversight of the specialist palliative care team.

D1004D - Attachment 4 – Wound Care – this form is to be used as an attachment to an EC application where wound care is being provided, or as an attachment to a Nursing Consumables over $1,000 form containing consumables required for wound care.

D9384 - Exceptional Case Interruption to Care – this form is to be used to notify DVA of an interruption to a client's EC care. This notification must be received within seven business days of the date the interruption to care commenced.

An interruption to care includes absences from home due to admission to an acute facility or hospice, a period of rehabilitation or residential respite, or going on a holiday.

If a client has an interruption to care during an agreed period of EC status, an adjustment may be made to the fee paid for the 28-day claim period during which the interruption to care occurred. If the client has been absent from care for more than 28 days, for whatever reason, they must be discharged from CN services. See *Section 10 – Discharge from Community Nursing Services*.

D1307 - Exceptional Case Variation Form – this form is used to request a variation to a client's approved EC care. This notification must be received prior to the request for increased care or within seven business days of the date the decrease to care commenced.

D9297 - Request for Reimbursement of Nursing Consumables over $1,000 – this form is used to apply for reimbursement of nursing consumables over $1,000 which cannot be claimed via the Schedule of Fees. See *Attachment D Nursing Consumables*. There is an upper limit of $1,500 per claim period for nursing consumables.

The application should include relevant attachment/s including itemised evidence of expenditure. If the consumables claim is in relation to wound care, the *D1004D Attachment 4 – Wound Care* form and current wound images must also be provided.

CN providers must not claim products that are contained in the 'nurse's toolbox' on this form. GST must not be included in the application. Any form that includes nurse's toolbox products or GST will automatically be rejected and the CN provider will not be reimbursed until a correct form is submitted.

1.2 APPLICATION PROCESSING TIMEFRAMES

DVA will endeavour to process EC applications within ten business days of receipt of a complete application, to prevent unnecessary delays to the commencement of care.

Where applications are not completed in full, including necessary relevant attachments and other documentation, DVA will be unable to complete the assessment of the application. DVA will make contact with the CN provider by secure email to notify them that the application is unable to be processed. An Unable to Process letter requesting the necessary information including any timeframes will be sent to the CN provider.

If the requested information is not provided within the requested timeframes, the existing application will be closed and the provider will need to submit a new EC application.

It is the responsibility of the CN provider to supply a complete application with all relevant attachments in accordance with the requirements of the Notes. A new application for EC status can be made, if required, once all the required information is available.

1.3 APPLICATION ASSESSMENT

As part of processing an application, DVA will assess whether a client meets the requirements for EC status. A DVA representative may contact the CN provider to clarify and/or discuss the application.

In assessing an application, DVA will review:

- the client's care needs
- if the client's care needs exceed the scope of the Schedule of Fees

- the appropriateness of the client's care regimen, including the skills mix of the personnel delivering the care
- whether the client's care regimen will achieve realistic outcomes which include, as much as possible, a return to care levels which can be met under the Schedule of Fees.

1.4 APPLICATION OUTCOME

DVA will notify the CN provider by secure email of the outcome of the EC application.

1.4.1 Application not approved

If the application is not approved, a reason will be provided. Where DVA has determined that the client's care needs can be managed within the Schedule of Fees, the EC application will not be approved.

If the CN provider has additional relevant information about the client which they wish to provide, they should contact DVA to discuss this information. DVA may reconsider the application in light of additional information.

1.4.2 Application approved

Where the application is approved, the approval letter will include:

- approved care period dates
- the number of 28-day claim periods within the period of EC status, up to a maximum of 12 months (13 claim periods)
- number of CN visits per 28-day claim period covered by the approval, for each level of personnel providing the assessed care
- item number to be claimed for each 28-day claim period covered by the approval for the current calendar year
- fee to be paid for each 28-day claim period covered by the approval.

The first payment made for a client with EC status may include a component of Schedule of Fees as well as EC funding.

CN providers should read the approval letter carefully and check all details. If there are any issues identified, the provider should contact DVA immediately. Any issues or queries must be notified to DVA in writing within five business days, otherwise the provider is deemed to have accepted the approval.

If DVA identifies the CN services being delivered do not meet contemporary evidence based practice, DVA may request further supporting information and/or make recommendations in relation to the care provided.

Following the application of indexation to CN fees, a subsequent approval letter will be sent for each existing EC approval that extends beyond the indexation

date, detailing funding information for the remaining claim periods covered by the approval.

2 Appeals process

The EC process includes an appeals mechanism. In considering an appeal, the CN provider must note that:

- a CN provider cannot appeal on financial grounds and
- an appeal can only be made when DVA has accepted that the client has EC status and that the required care falls outside the Schedule of Fees.

To lodge an appeal, the CN provider should forward in writing the reason for the appeal. The appeal should be lodged with the Assistant Director - Operations via secure email to exceptional.cases@dva.gov.au.

As part of reviewing an appeal, a clinical review may be conducted. The clinical review may include a documentation-based review and/or an in-home assessment of the client's care needs. If required, the in-home assessment will be undertaken by a health professional contracted by DVA.

2.1 OUTCOME OF APPEAL

DVA will inform the CN provider of the outcome of the appeal within ten business days of receipt of the appeal. The appeal outcome is final.

If the appeal is upheld in full or in part, DVA will process a new approval based on the reviewed care needs. A letter detailing the new approval will be forwarded to the CN provider by DVA.

If the appeal is disallowed the original decision stands.

If the CN provider does not want to continue to deliver services to the client on the basis of the funding decision, the provider must inform DVA so that consideration can be given to alternative provider options.

Attachment B – Additional Travel

1 Overview

All Schedule of Fees and Exceptional Case (EC) classification item numbers have a built-in component for travel, including travel for multiple daily visits.

Where CN providers undertake an exceptional amount of travel to deliver required CN services to clients living in regional or remote areas, this travel might not be covered by the Schedule of Fees and EC classification item numbers.

To ensure that CN providers are adequately compensated for the travel to deliver CN services to these clients in regional or remote areas, an additional kilometre-based travel payment may be paid in certain circumstances.

1.1 NEAREST SUITABLE PROVIDER

A CN provider may not claim for travel for a client under the Additional Travel item if they are not the nearest suitable CN provider.

For Additional Travel purposes the nearest suitable provider also includes the location of its personnel. For example, one of the CN provider's personnel may live closer to the client than the CN provider's head office, in this case the CN provider's personnel living closest to the client should be considered in providing the care.

1.2 SITUATIONS WHERE ADDITIONAL TRAVEL MAY BE CLAIMED

A kilometre-based travel payment is only paid when the following criteria are all met:

- the nearest suitable provider delivers the care
- for travel only in regional or remote areas, classified under the Modified Monash Model (MMM) as regions MMM4 to MMM7
- for distances of over 20 kilometres from the community nurse's final departure point to the client's home.

A kilometre-based travel payment is not paid:

- if the CN provider is already receiving additional travel for another client in the same region who is visited on the same day
- if there is another suitable provider closer to the client's residence
- if the distance is 20 kilometres or less for each segment of the community nurse's journey.

1.3 CLAIMING FOR ADDITIONAL TRAVEL

Additional travel can be claimed with the Schedule of Fees and EC items for the relevant 28-day claim period.

The Additional Travel item number must be claimed in conjunction with an item number/s from either the Clinical Care or Personal Care schedules or EC status.

Additional travel is funded retrospectively. Claims should deduct the first 20 kilometres of each segment one of the nurse's journey, and be submitted after the end of the relevant 28-day claim period, and in line with claiming timeframes.

The CN provider should submit claims for payment of Additional Travel to Medicare for the impacted 28-day claim periods, using the Other Items – Additional Travel item number (NA10) for reimbursement of the additional travel component, in conjunction with the item number/s for services provided during the claim period.

Attachment C – Palliative Care Phases

1 Palliative Care

The primary care team (including the CN provider) usually provides the majority of the care under a palliative approach. Generally, a specialist palliative care team would not be directly involved in the ongoing care of clients who have uncomplicated needs associated with a life-limiting illness.

Specialist palliative care teams may be required to provide ongoing or episodic care when the symptoms or issues experienced are complex, or beyond the capabilities of the primary care team. This scenario may vary depending on the State or Territory in which the CN provider operates or the client resides.

The palliative care phase is a stage of the client's illness and can provide a clinical indication of the level of care required. Palliative care phases are not sequential and a client may move back and forth between phases. Phases are defined in terms of the following criteria as these highlight the essential issues to be considered when assigning a phase.

1.1 PHASE 1: STABLE

A client will not usually require high levels of interventions in this phase. Symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned. The family/carer situation is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

1.2 PHASE 2: UNSTABLE

A client generally requires high levels of interventions in the short term in this phase.

The person experiences the development of a new unexpected problem or a rapid increase in severity of existing problems, either of which require an urgent change in management or emergency treatment.

The family/carer experience a sudden change in their situation requiring urgent intervention by members of the palliative care team.

1.3 PHASE 3: DETERIORATING

A client may require high levels of interventions to enable them to remain at home in this phase.

The person experiences a gradual worsening of existing symptoms or development of new but expected problems. These require the application of specific plans of care and regular review but *not* urgent or emergency treatment.

The family/carer experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling, as necessary.

1.4 PHASE 4: TERMINAL

A client will usually require interventions aimed at physical and emotional issues, and/or requires overnight nursing care in the short term.

Death is likely in a matter of days and no acute intervention is planned or required. The use of frequent, usually daily, interventions aimed at physical, emotional and spiritual issues is required.

The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement.

1.5 BEREAVEMENT

The death of a client has occurred and the family/carer are grieving. A planned bereavement support program is available including referral for counselling as necessary.

These phases are aligned with Palliative Care Australia's national standards. Further information can be found on the Palliative Care Australia website at: http://palliativecare.org.au/.

Additional information and educational resources can be found at: Palliative Care Outcomes Collaboration (PCOC) University of Wollongong. https://ahsri.uow.edu.au/pcoc/index.html.

Attachment D – Nursing Consumables

1 Overview

The following information outlines the methods and processes that CN providers can use to obtain nursing consumables for clients. Where products are available through either the Repatriation Pharmaceutical Benefits Scheme or Rehabilitation Appliances Program, a CN provider cannot claim for these items under Nursing Consumables.

1.1 REPATRIATION PHARMACEUTICAL BENEFITS SCHEME

There are a range of medications and wound dressings available through the Repatriation Pharmaceutical Benefits Scheme (RPBS). RPBS items require a prescription or authority prescription from a medical practitioner.

The RPBS can be accessed online at www.pbs.gov.au/browse/rpbs.

1.2 REHABILITATION APPLIANCES PROGRAM

The Rehabilitation Appliances Program (RAP) provides access to a range of aids and equipment to assist clients to maintain their independence at home. Aids or equipment prescribed through RAP can include for example:

- continence products
- mobility and functional support aids
- Personal Response Systems
- home medical oxygen
- diabetic supplies and
- Continuous Positive Airways Pressure (CPAP) supplies.

Further information on RAP can be found on the DVA website at Rehabilitation Appliances Program.

1.3 CLAIMING FOR NURSING CONSUMABLES $1,000 AND UNDER

A range of Other Items - nursing consumables item numbers ($10 to $1,000) is available through the Schedule of Fees. These item numbers are exclusive of GST and are not subject to annual indexation.

1.4 CLAIMING FOR NURSING CONSUMABLES EXCEEDING $1,000

All reimbursements for clients whose nursing consumables' total cost exceeds $1,000 (exclusive of GST) in a 28-day claim period must be claimed via the EC process. See *Attachment A – Request for Funding of Nursing Consumables Over $1,000*. There is an upper limit of $1,500 for consumables per 28-day claim period.

Substantiation of items used, number supplied and cost in the 28-day claim period for each client must accompany the EC form.

1.5 CLAIMING RULES

a. The CN provider claims the item number that is closest in value to the actual cost (excluding 'nurse's toolbox' items) within the listed range for nursing consumables provided to the client in a 28-day claim period.
b. The CN provider *must not* include any GST component when calculating which nursing consumables item number to claim. Payments made on behalf of DVA automatically add the GST component prior to payment.
c. The GST law allows a supplier and a recipient to agree to treat as GST-taxable any item listed in Schedule 3 that would otherwise be GST-free under the GST Act [subsection 38-45(3)]. To give effect to this arrangement, a CN provider that uses any of the nursing consumables item numbers will be taken to have accepted the GST-taxable status of these item numbers and to have agreed to the treatment of Schedule 3 items under subsection 38-45(3) of the GST Act. Schedule 3 items in supplies over $100 will continue to be GST-free.
d. DVA does not pay for the cost of delivery of nursing consumables to a client.
e. CN providers agree not to add any dollar amount or percentage or 'mark-up' on to the actual cost of the nursing consumables prior to claiming a nursing consumables item number.
f. CN providers agree not to claim for items that:
   - the client should purchase through a pharmacy or supermarket for ongoing non-clinical self-management of conditions (for example moisturiser, over-the-counter medication etc.)
   - the client has obtained via the RPBS
   - the client has been supplied via RAP
   - items which are covered in the cost of the visit, including the 'nurse's toolbox'.
g. A nursing consumables item number can be claimed in conjunction with a clinical care item number.
h. Only one nursing consumables item number can be claimed per 28-day claim period for a client.
i. MDS is not required for nursing consumables item numbers.
j. The CN provider must retain nursing consumables records on the client's file to be able to substantiate any payment of nursing consumables item numbers for future performance monitoring review or quality and safety audit requests or processes.

1.6 NURSE'S TOOLBOX

Adhesive remover wipes	*Individual use lancing device*
Alcohol wipes	*Non-sterile gloves*
Boot protectors	*Non-sterile scissors*
Disposable hand towels	*Normal saline*
Emergency use sharps container	*Plastic apron/gown*
Face masks	*Sanitising hand wash*
Gauze swabs	*Skin protection wipes*
Goggles	*Tape*

Attachment E – Community Nursing and the Coordinated Veterans' Care (CVC) Program

1 Overview

The Coordinated Veterans' Care (CVC) Program is for Veteran Gold Card holders, including veterans, war widows/widowers and dependants who have one or more chronic conditions, and for Veteran White Card Holders with a mental health condition for which DVA has accepted liability (a DVA-accepted mental health condition) which is chronic. To be eligible, clients must have complex care needs and be at risk of unplanned hospitalisation.

The CVC Program is delivered in a general practice setting and can involve just the GP, or in most cases the GP and a care coordinator. The care coordinator may be a Practice Nurse, Aboriginal and/or Torres Strait Islander Primary Health Care Worker or community nurse working for a DVA contracted CN provider. The GP and care coordinator work together with the client and their carer if applicable and other members of the Care Team including other health care providers who are delivering services to the client.

Enrolled participants will receive support through the provision of comprehensive, coordinated and ongoing care with the assistance of a care coordinator. The CVC Program involves a proactive approach to improve the management of participants' chronic conditions and quality of care.

Care Teams use a person centred approach to care planning, coordination and review as the model to support better outcomes and self-management of the client's health. The program emphasises a coordinated approach, partnering and utilising a multidisciplinary team to provide tailored and flexible support based on the participant's individual goals.

Through the CVC Program and the coordination of a participant's comprehensive Care Plan (Care Plan), participants can receive coordination of a wide range of health services to assist in the management of their chronic conditions. The sharing of health information amongst partnering health care providers enables better health outcomes for participants. Regular communication, empowerment and coaching are key to the Care Team successfully managing all aspects of the program for a participant.

Further information about the CVC Program is available at: www.dva.gov.au/cvc.

1.1 NOTES FOR COORDINATED VETERANS' CARE PROGRAM PROVIDERS

The *Notes for Coordinated Veterans' Care Program Providers* define the parameters for coordinating health care treatment under the CVC Program for program participants and describe the relationship between DVA, the GP, the CVC Program

participant and their carer (if applicable).

The Notes provide information about the delivery of the CVC Program for:

a) General practitioners (GP)
b) Registered Nurses (RN)/Enrolled Nurses (EN) employed by the GP practice (Practice Nurses)
c) Aboriginal and/or Torres Strait Islander Primary Health Care Workers
d) Community nurses employed by DVA contracted Community Nursing providers.

1.2 COMMUNITY NURSING CARE COORDINATION COMPONENT

If a CN provider identifies that a Veteran Gold Card holder or Veteran White Card holder with a DVA-accepted mental health condition could benefit from enrolment in the CVC Program and is not participating in the CVC Program, they should recommend the client visit their GP to determine their eligibility.

1.2.1 Personnel

Care coordination provided under the CVC Program:

- must be delivered by either an RN or an EN
- in providing care coordination services under the CVC Program, the CN provider must ensure that the services are delivered by personnel with appropriate qualifications and experience
- CVC care coordination activities delivered by an EN must be appropriately delegated, supervised and documented by an RN.

1.2.2 Record keeping

The CN provider must keep comprehensive clinical records in accordance with existing requirements in *Section 5.2 – Care Documentation*. This should include a copy of the CVC Care Plan signed by the participant, GP and care coordinator.

Full details of all care coordination and contact activities must be recorded and placed on the participant's file.

1.2.3 Claiming

All claims for payment for CVC care coordination services provided to a CVC participant are paid by Services Australia (Medicare) on behalf of DVA.

Once the GP enrols an eligible patient in the CVC Program, the GP's quarterly care period commences and the GP *Initial Assessment and Program Enrolment Payment* is claimed through Medicare. After this claim is processed by Medicare, subsequent claims for CN care coordination services can be made.

1.2.4 Item numbers

There are two CVC Program item numbers in the CN Schedule of Fees:

1. UP05 – *CVC Community Nursing – Initial Care Coordination* is a one-off payment for the initial 28-day claim period in which the CN provider receives the CVC Program referral, appoints the CVC care coordinator, works with the GP to develop the comprehensive Care Plan and commences the CVC care coordination services.

   This item must have a claim start date which is later than the date the Veteran Gold Card holder or Veteran White Card holder with a DVA-accepted mental health condition was enrolled in the CVC Program by the GP, and can only be claimed once in the life of a participant; and

2. UP06 – *CVC Community Nursing – Subsequent Care Coordination* is claimed for the provision of all subsequent 28 day CVC care coordination services.

   When claiming the *CVC Community Nursing – Subsequent Care Coordination* item number, the CN provider should use the same 28-day claim period start date for all item numbers claimed for the same 28-day claim period for a Veteran Gold Card holder or a Veteran White Card holder with a DVA-accepted mental health condition, where the participant is also receiving CN services.

Where a CVC participant is hospitalised during a claim period, the following rules apply:

- claims for Community Nursing – Subsequent Care Coordination services are still payable provided that some care coordination activity has taken place in the 28-day claim period
- claims for Community Nursing – Subsequent Care Coordination services are not payable if care coordination activity has not taken place in the 28-day claim period.

During hospitalisation, the care coordinator must:

- as a minimum, liaise with the GP to:
  - contact the hospital to advise that the Veteran Gold Card holder or Veteran White Card holder with a DVA-accepted mental health condition is a participant in the CVC Program and request to be advised of the expected discharge date
  - participate if possible in the hospital discharge planning process;
- request a copy of the discharge papers from the GP
- once discharged, contact the Veteran Gold Card holder or Veteran White Card holder with a DVA-accepted mental health condition to review the comprehensive Care Plan
- document all care coordination activity in accordance with the existing requirements in *Section 5.2 – Care Documentation*.

1.2.5 Death of a CVC participant

Where a CVC participant dies partway through a claim period, the CN provider can claim the Community Nursing – Subsequent Care Coordination item number for

the 28-day claim period in which the death occurred, provided CVC care coordination activity has taken place in the 28-day claim period.

1.2.6 Entry into a Residential Aged Care Facility

The CVC Program is not available for permanent residents of an aged care facility. Where a CVC participant becomes a permanent resident of an aged care facility partway through a 28-day claim period, the CN provider can claim the Community Nursing – Subsequent Care Coordination item number for the 28-day claim period in which the participant entered residential care, provided CVC care coordination activity has taken place in the 28-day claim period.

1.2.7 Temporary entry into a Residential Aged Care Facility

Where a CVC participant enters an aged care facility as a temporary resident for residential respite for all of a 28-day claim period, a Community Nursing – Subsequent Care Coordination item number cannot be claimed for this 28-day claim period.

1.2.8 Item numbers which cannot be claimed with CVC Program item numbers

The item numbers in the CN Schedule of Fees that cannot be claimed with a CVC Coordination item numbers are:

- NA02 – Assessment;
- NA99 – Assessment Only; and
- NL01 and NL02 – Clinical Support.

All Other Item numbers in the CN Schedule of Fees can be claimed in conjunction with the CVC Program Care Coordination Item Numbers, if appropriate.