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Department of Veterans' Affairs

CVC

Coordinated Veterans' Care Program

A Guide for General Practice

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OVERVIEW

About the CVC Program

The Department of Veterans' Affairs (DVA) Coordinated Veterans' Care (CVC) Program has been running since 2011.

The CVC Program:

- uses a proactive approach to improve the management of participants' chronic condition/s and quality of care
- involves a core care team which includes a general practitioner (GP), care coordinator and the participant (and their carer if applicable) who work together to manage the ongoing care of the participant
- provides payments to GPs for initial assessment and ongoing care.

GPs who decide to participate in the CVC Program are required to:

- prepare for the program
- enrol participants in the program
- provide ongoing care.

Eligibility

The CVC Program is aimed at veterans who have complex care needs, and who are at risk of unplanned hospitalisation. The program is available to:

- Veteran Gold Card holders who have one or more chronic health condition/s
- Veteran White Card holders who have a mental health condition that has been accepted by the Department of Veterans' Affairs (DVA) (an accepted mental health condition) and is chronic.

GPs can enrol veteran patients in the program if they:

- meet the eligibility requirements
- give their informed consent to be enrolled in the program.

Payments for GPs

By participating in the program, GPs can claim the following payments through existing payment arrangements with Medicare:

- Initial Assessment and Program Enrolment payment for enrolling a participant in the program
- Completion of 90 day Period of Care – Review of Care Plan and Eligibility payment, which can be claimed every 90 days (quarterly) for ongoing care and assessment of ongoing eligibility.

The current schedule of payments is available on the DVA website at www.dva.gov.au/cvc.

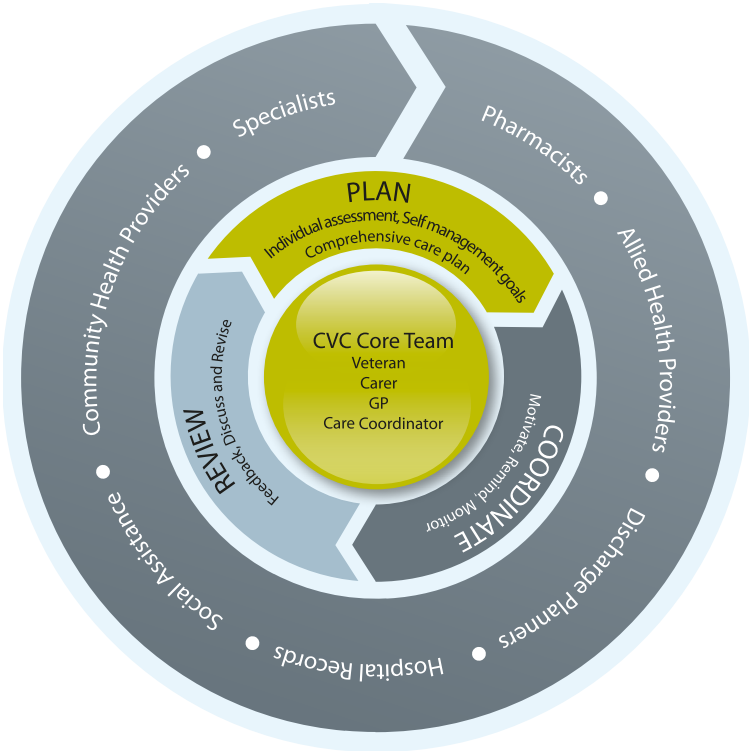
Legislation

The CVC Program is administered under the DVA *Treatment Principles* and the *Notes for Coordinated Veterans' Care Program Providers*.

CVC Program Model of Care

The Model of Care for the CVC Program is based on the core care team, which includes the GP, care coordinator, the participant and the participant's carer (if applicable). The care coordinator can be a practice nurse, Aboriginal and/or Torres Strait Islander Primary Health Worker or community nurse working for a DVA contracted community nursing provider (CN provider).

The core care team undertakes care planning, coordination and review, centred around the health needs of the participant.



Each participant's needs are different, and their comprehensive Care Plan (Care Plan) and coordination needs will be unique to their situation. The CVC Program is about genuine engagement with the participant. The development of a meaningful Care Plan, in collaboration with the participant and other members of the broader care team, is central to the CVC Model of Care.

The broader care team, which includes other health professionals delivering services to the participant, may be multidisciplinary and will be specific to the needs of the participant at that particular time. The sharing of personal health information is a key feature of the CVC Program. The availability of electronic health records and electronic communication assists in sharing health information amongst all health care providers for CVC participants.

Regular communication, empowerment and coaching of the participant are important elements in the success of the team based model. The 90 day (quarterly) review of the Care Plan ensures care remains relevant.

Benefits for participants

As a result of the program, participants are likely to become:

- healthier, with fewer unplanned hospitalisations
- more educated and empowered to self-manage their condition/s.

Benefits for health professionals

As a result of the program, health professionals can benefit in the following ways:

- GPs receive recognition and remuneration for care coordination activities
- health professionals are involved in improving the quality of care of participants
- nurses have enhanced opportunity to work in partnership with the GP
- practices offer more efficient alignment of nursing roles with nursing skills.

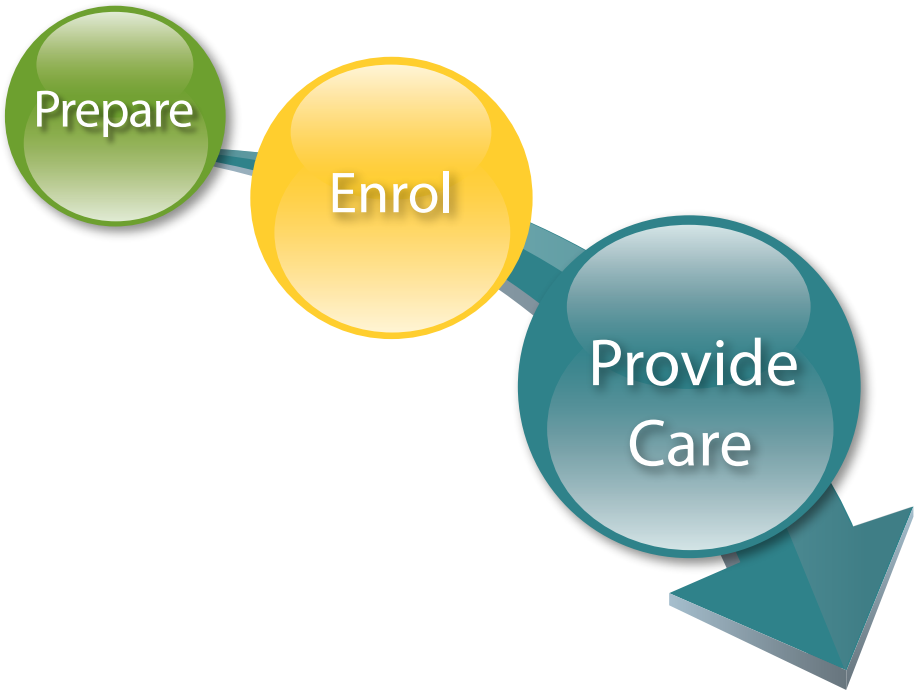
Key roles and stages

GPs play a lead role and are required to commit sufficient time and resources to the program.

The care coordinator can be one of the following:

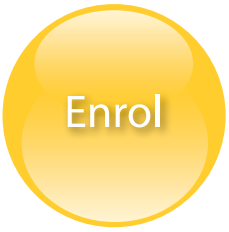
- practice nurse (PN) – this is either a registered nurse (RN) or enrolled nurse (EN), and can be a nurse practitioner
- Aboriginal and/or Torres Strait Islander Primary Health Worker (ATSIPHW)
- community nurse working for a DVA contracted CN provider.

The GP and care coordinator have different roles in the three stages of the CVC Program.



Prepare for the CVC Program

Action		Role
Step 1:	Appoint a care coordinator, i.e. PN, ATSIPHW or community nurse	GP



Enrol participant in the CVC Program

Action		Role
Step 2:	Identify potential participants	GP
Step 3:	Assess their eligibility for the program	GP
Step 4:	Gain participant's informed consent	GP
Step 5:	Conduct an individual assessment	GP/Coordinator
Step 6:	Prepare a comprehensive Care Plan	GP/Coordinator
Step 7:	Finalise the comprehensive Care Plan	GP
Step 8:	Consider the need for social assistance	GP

Provide ongoing care

Action		Role
Step 9:	Coordinate treatment services as per the comprehensive Care Plan and provide education and support	GP/Coordinator
Step 10:	Regularly review, update and renew the comprehensive Care Plan	GP/Coordinator

PREPARE

Coordinated Veterans' Care Program

PREPARE FOR THE CVC PROGRAM

The first stage for GPs involved in the CVC Program is preparation by appointing a care coordinator.

STEP 1: Appoint a care coordinator

Overview

To prepare for delivery of the CVC Program, the GP will appoint a care coordinator, whose role is to coordinate the Care Plan, liaise with the participant and their carer (if applicable) and provide feedback to the GP.

The care coordinator is either:

- a practice nurse (PN)
- an Aboriginal and/or Torres Strait Islander Primary Health Worker (ATSIPHW)
- a community nurse working for a DVA contracted CN provider.

Where there is no RN available:

- an EN or an ATSIPHW may be appointed as the care coordinator
- the GP will play a closer role in care coordination with an EN or ATSIPHW
- the GP can perform the role of care coordinator.

ENROL

Coordinated Veterans' Care Program

ENROL PARTICIPANTS IN THE PROGRAM

The second stage of the CVC Program is for GPs to enrol participants. The key steps are:

Step 2: identify a potential participant

Step 3: assess their eligibility for the program

Step 4: gain the participant's consent

Step 5: conduct an individual assessment

Step 6: prepare a comprehensive Care Plan (Care Plan)

Step 7: finalise the comprehensive Care Plan

Step 8: consider the need for social assistance.

There is no enrolment form to complete and return to DVA. When all steps are completed, the GP records the enrolment and consent on the patient's record. The GP can now claim the Initial Assessment and Program Enrolment payment.

STEP 2: Identify potential participants

Who is the program aimed at?

The program is focused on supporting Veteran Card holders with complex care needs who are at risk of unplanned hospitalisation.

- Veteran Gold Card holders who have one or more chronic condition/s
- Veteran White Card holders who have an accepted mental health condition which is chronic.

Who identifies participants?

Individuals may be identified as potential participants for the program in the following ways:

GP or PN	A GP or practice nurse may identify one of their veteran patients as a potential participant.
Veteran or care provider	A veteran may ask to participate in the CVC Program. A veteran's care provider, such as a carer, specialist, allied health professional, hospital discharge planner or community nurse, may recommend they arrange an appointment with their GP for an assessment for the CVC Program.

Initial screening

When a veteran patient is identified as a potential participant, either the GP or the PN should:

- check the patient's medical record to ensure there are no disqualifying factors - refer to the Eligibility Checklist in step 3
- contact the patient and explain the CVC Program to them
- check the patient's DVA records to ensure their mental health condition is an accepted condition (Veteran White Card holders only – see below information)
- make an appointment to conduct an assessment if the patient is interested in the program.

NOTE: The CVC fee items are claimable in addition to existing Medical Services Fee Schedule items. The assessment appointment is billed as a separate consultation.

Checking Accepted Mental Health Condition/s (for Veteran White Card holders only)

To be eligible for the CVC Program, Veteran White Card holders must have at least one accepted mental health condition. An accepted mental health condition is one that DVA has accepted as being related to a veteran's military service and that DVA funds clinically required treatment (including participation in the CVC Program) for.

Checking the patient's accepted condition/s will ensure only eligible veterans are enrolled in the program. A Veteran White Card holder's accepted conditions can be confirmed by:

- asking the patient for a printed list or letter from DVA
- asking the patient to log into their MyService account and check under the 'Cards' tab, or
- phoning the DVA Health Provider Enquiry Line, with the patient's consent, on 1800 550 457.

STEP 3: Assess eligibility for the program

Eligibility Checklist

During the assessment appointment, the GP assesses the patient to determine whether they are eligible for the CVC Program. The following set of eligibility criteria and disqualifying factors can be used to assess a potential participant's eligibility for the program.

GPs may use the eligibility tool available on the CVC Toolbox website to assist with determining eligibility.

MUST apply

Part A: ALL of the following eligibility criteria must apply to a potential participant:

✓	Are they a current holder of a Veteran Gold Card? Or a Veteran White Card with an accepted mental health condition?
✓	Do they currently live in the community (not in residential aged care)?
✓	Have they been diagnosed with one or more chronic condition/s that have resulted, or could reasonably result, in unplanned hospitalisation? (For Veteran White Card holders the chronic condition must be an accepted mental health condition.)
✓	Do they have complex care needs, being one or more of the following: • multiple comorbidities that complicate the treatment • unstable condition/s with a high risk of acute exacerbation • the condition/s is contributed to by frailty, age and/or social isolation factors • limitations in self-management and monitoring?
✓	Do they require a treatment regimen that involves one or more of the following complexities of ongoing care: • multiple care providers • complex medication regimen • frequent monitoring and review • support with self-management and monitoring?
✓	Are they an Australian resident, and living in Australia?
✓	Have they given their informed consent to participate in the program?

Must NOT apply

Part B: To the best of the GP's knowledge, none of the following disqualifying factors can apply to the potential participant:

✗	Are they currently a resident of a residential aged care facility?
✗	Have they been diagnosed with a condition/s that, in your opinion, would likely be terminal within 12 months? (NOTE: This applies only for initial admission to the program; not where the diagnosis subsequently occurs.)
✗	Are they participating in the Department of Health Transition Care Program?
✗	Are they a Veteran White Card holder without an accepted mental health condition (including being a Veteran White Card holder with only NLHC for mental health care)?

If ALL answers for Part A are Yes and Part B are No, they can now be enrolled.

STEP 4: Gain the participant's consent

Specific consent

In order to enrol a participant in the CVC Program, the GP needs to gain their informed consent to:

- participate in the program
- the use of a care coordinator, and
- the sharing of their relevant health and medical information.

NOTE: This consent is in addition to the standard consents of Veteran Card holders.

Explain consent

In order to gain the patient's informed consent, the GP explains the following:

- what it will mean for them to participate in the CVC Program
- what they are required to consent to:
  - involvement of the nominated care coordinator
  - the Care Plan that will be prepared as part of the enrolment process being shared with other care team members as required
- their relevant health and medical information will be shared with health care providers, who make up their broader care team, as follows:
  - health care providers include specialists, pharmacists, allied health, community nurses, hospital discharge planners, assessors/providers of social assistance and nominated carers
- regular reports on all treatment and medicines will be provided to the GP
- their relevant health and medical information may be shared with DVA contracted organisations from time-to-time for program analysis and improvement activities
- privacy principles and legislation will be observed by all recipients of the information.

TIP: Refer to the suggested script at the end of this Guide for obtaining informed consent.

Ask for their consent

Once the GP has explained the above, ask for the patient's consent to:

- participate in the program
- the use of a care coordinator
- the sharing of their personal information, including relevant health and medical information and data, as outlined above.

TIP: Explain that the patient will also be asked to sign the Care Plan that will be prepared as part of their enrolment in the program to indicate their agreement with this plan.

Substitute consent

If the patient is unable to provide informed consent, a person who is legally authorised to give substitute consent to treatment under state law (e.g. Public Trustee, guardian, holder of an appropriate Special Power of Attorney) may provide consent on their behalf. However, in these cases, please consider if the CVC Program is the most suitable program for the patient.

NOTE: If consent is not obtained, the patient cannot be enrolled in the program.

Once informed consent is obtained, the GP proceeds to the next steps for enrolling a participant in the program. A patient is not considered to be enrolled until all steps have been completed.

STEP 5: Conduct an individual assessment

The GP or care coordinator conducts a comprehensive assessment of the participant's care needs.

DVA recommends that a home visit is conducted as part of the assessment, where it is the participant's preference and the coordinator has capacity to undertake a home visit.

Where a participant is a Veteran White Card holder, the GP or care coordinator should ensure they identify all of the participant's conditions (all accepted conditions, as well as conditions covered under NLHC and those not covered by DVA, in addition to their accepted mental health condition) as part of the comprehensive assessment.

STEP 6: Prepare a comprehensive Care Plan

Once an individual assessment has been conducted, the GP or care coordinator prepares a comprehensive Care Plan (Care Plan), or updates an existing plan, in collaboration with the participant. The GP must be involved in the finalisation of the Care Plan.

To allow flexibility for GPs, there is no mandated Care Plan template. The Care Plan can be developed using the template available on the CVC Toolbox website or any care plan template used by the GP, as long as it is comprehensive, and includes all relevant and necessary care and treatment required by the participant. The Care Plan is tailored to the participant's health needs, preferences and priorities. However, the checklist below provides the minimum requirements for the Care Plan.

Care Plan Checklist

The Care Plan should contain at least the following information:

- a description of all chronic and other health conditions, including:
  - current care arrangements
  - targets
  - red flags
  - background information
  - current management
  - stepped escalation process
  - most recent results
- medication list including dose, frequency and known adherence
- allergies and adverse reactions
- self-management goals and strategies
- any family and/or carer contact details
- significant medical events and results
- other treatment providers and their contact details
- referrals planned and reasons for referrals
- devices being used.

NOTE: There are two Care Plan templates available on the CVC Toolbox website, one for Veteran Gold Card holders and one for Veteran White Card holders. The Care Plan template for Veteran White Card holders enables the GP or care coordinator to identify accepted and non-accepted conditions for Veteran White Card holders. The template also enables the identification of funding options, as not all treatments and health services for Veteran White Card holders are funded by DVA.

Discuss with participant

The GP or care coordinator discusses the Care Plan with the participant to ensure that they understand the following:

- goals of the Care Plan
- interventions and self-management aspects
- methods of monitoring and evaluating the plan
- the need for regular monitoring and review.

When this has been done, the participant is asked to sign the Care Plan to indicate their agreement with this plan.

STEP 7: Finalise the comprehensive Care Plan

Key Steps

When the participant agrees to the Care Plan:

- the GP records the decision to enrol them in the program
- the GP records their consent to participate in the program
- the care coordinator or GP provides the participant (and any carer/family as agreed) with a copy of the Care Plan.

Enrolment and submitting a claim

At this point in the process:

- the participant has now been enrolled in the CVC Program
- the first 90 day (quarterly) period of care has commenced
- GPs can submit a claim for the Initial Assessment and Program Enrolment payment (UP01 or UP02).

NOTE:

- By enrolling a participant in the CVC Program, the GP is accepting the clinical leadership and oversight role for the participant.
- If the care coordinator is a community nurse, it is very important that the GP submits their first claim promptly, as a claim by the community nurse will be rejected if the GP's claim for the Initial Assessment and Program Enrolment payment has not yet been made.

STEP 8: Consider the need for social assistance

Participant's needs

The GP and/or the care coordinator should also consider the participant's need for social assistance. CVC participants experiencing social isolation can receive social assistance under this service. The GP initiates this assistance via a referral to a Veterans' Home Care (VHC) assessment agency, where relevant.

What is CVC Social Assistance?

CVC Social Assistance is a short-term service available to eligible CVC participants to help them re-engage in community life through social contact or accompanying them to a social activity.

CVC Social Assistance aims to address the increasing prevalence of social isolation amongst veterans and its impact on their health. The service provides up to 12 weeks of assistance to encourage longer term socialisation, for example, assistance with participating in community activities or courses.

This service focuses on building the confidence of participants to promote ownership and motivation for their ongoing social health, with a view to establishing and maintaining long-term benefits, such as:

- re-entry into community life
- expanding the type and frequency of social contact
- encouraging the veteran to proactively engage with communities of interest.

The aim is to promote social health and independence.

GP identifies potential participants

When a participant is being enrolled in the CVC Program (or any time thereafter), the GP may determine that they could benefit from CVC Social Assistance.

A GP can refer a CVC participant to a VHC assessment agency for a social assistance assessment, where:

- the participant has a limited or inadequate social support network and could reasonably be at risk of hospitalisation because of that situation
- the risk of the participant being hospitalised for a chronic condition/s may be significantly reduced if they receive social assistance.

The VHC assessment agency will determine whether the CVC participant will be provided with CVC Social Assistance, as well as the amount and type of service/s to be provided.

NOTE: Not all referrals for an assessment will result in social assistance being provided.

VHC assessment agency

To refer a CVC participant for a social assistance assessment:

- call 1300 550 450 to be connected with your local VHC assessment agency
- provide the CVC participant's contact details and any other relevant information.

NOTE:

- When referring to a VHC assessment agency it should be made clear that it is a CVC referral.
- An assessment will generally be arranged within a few days of the referral, although this can be done more quickly if urgent.

Follow-up

The GP and/or care coordinator will follow up on the assessment with the participant and monitor the services supplied and the effect on the participant's wellbeing.

PROVIDE ONGOING CARE

Coordinated Veterans' Care Program

PROVIDE ONGOING CARE

The third stage for the care team involved in the CVC Program is providing ongoing care, which involves:

- coordinating treatment and health services included in the Care Plan
- regularly reviewing, updating and renewing the Care Plan.

During this stage, the care team:

- works with the participant (and their carer if applicable) to manage their ongoing care
- implements agreed actions from the Care Plan
- uses a proactive approach to improve the management of the participant's chronic condition/s and quality of care
- supports the participant to self-manage their condition/s.

The care team supports the participant to self-manage their condition/s on an ongoing basis by providing them with:

- information and resources to improve health literacy, so that they can better understand what will improve their condition/s and what may exacerbate condition/s
- motivational coaching to empower them to follow their self-management goals, e.g. lose weight or do more exercise.

NOTE:

- It is expected that most participants who are enrolled in the program will remain in the program for as long as they remain eligible and continue to benefit from ongoing participation.
- Care provided under the CVC Program is not a replacement of the continued interaction between the GP and the patient. Regular consultations should still occur as necessary.

STEP 9: Coordinate treatment services as per the comprehensive Care Plan

Overview

The care coordinator is responsible for coordinating treatment services for each participant based on their Care Plan.

The GP provides regular advice and guidance to the care coordinator.

NOTE: The duties of the care coordinator vary slightly, depending on whether they are a PN, ATSIPHW or community nurse. This is explained in the following section.

Coordinate treatment services

The care coordinator coordinates treatment and health services for the participant as follows:

- monitors the participant's progress according to the Care Plan
- monitors the participant's physical and mental health condition/s
- maintains regular contact with the participant – at least monthly
- provides the participant with advice and support, e.g. medication, health coaching / education, motivational counselling, health literacy
- liaises with the participant's carer and keeps them informed of progress and changes to the Care Plan (if applicable)
- makes appointments with other care providers, if necessary, and provides a copy of the Care Plan to all specialists, allied health professionals and other care providers (as appropriate and agreed with the GP)
- monitors the actions of all care providers (e.g. prescriptions, tests, referrals and recommendations) through feedback from the participant, carer, consultation reports and calls to other providers
- liaises with emergency departments and/or hospital discharge planners
- provides regular feedback about the participant's condition/s to the GP and alerts the GP where changes occur in the participant's condition/s
- provides feedback to the GP – at least monthly
- maintains up-to-date records of all monitored actions and coordination activities
- considers and addresses ongoing social isolation issues, including advice on their need for social assistance services.

Care coordinator – community nurse

In addition, where the care coordinator is a community nurse, they:

- receive the Care Plan with the referral
- conduct an in-home assessment of the participant
- update the Care Plan in collaboration with the GP and the participant
- receive feedback from the GP
- visit the CVC participant at home – at least once every 28 days.

Role of the GP when the care coordinator is a community nurse:

Where the care coordinator is a community nurse, the GP should:

- send a referral to the CN provider that includes their preferred method of contact, e.g. telephone/fax/email (secure email only)
- send the Care Plan with the referral to the CN provider
- regularly receive feedback from the community nurse on the participant's condition/s and progress against their goals – at least monthly
- maintain frequent dialogue with the community nurse.

NOTE:

- The referral for a community nurse is valid for 12 months, unless it is withdrawn by the GP or a disqualifying event occurs, e.g. participant enters a residential aged care facility.
- There can be only one provider of community nursing services to a participant at one time. If a participant is already receiving community nursing services, the GP withdraws the existing referral and sends a new referral that covers CVC and other nursing services to the CN provider.

Planned hospital admission

Where appropriate, the GP or care coordinator should:

- liaise with the hospital during a planned admission
- follow up with the participant on discharge.

Unplanned hospital admission

On learning of an unplanned admission of a CVC participant to hospital, the GP or care coordinator should contact the hospital and:

- advise that the participant is in the CVC Program and has a Care Plan
- request to be advised of the discharge date
- request a copy of the discharge papers
- ask to be involved in the discharge planning process (if appropriate).

One or two days after the participant is discharged from hospital, the GP or care coordinator should contact the participant and/or carer to:

- arrange for an appointment with the GP either in the surgery or at home
- review the participant's condition/s
- review the Care Plan (as appropriate).

STEP 10: Regular review, update and renewal of the comprehensive Care Plan

Overview

The core care team is expected to review treatment services for the participant on a regular basis. This includes the Care Plan as follows:

- review/update at least every 90 days (quarterly)
- renew at least every 12 months.

GP

The GP is expected to do the following:

- check the participant is still eligible for the program and continuing in the CVC Program is appropriate
- record the decision to approve a subsequent period of care and discuss the need for a review or renewal of the Care Plan with the care coordinator
- arrange appointments for the participant to attend the practice for a review or renewal.

Care coordinator

The care coordinator is expected to do the following:

- provide regular feedback to the GP where a Care Plan needs review
- remind the GP when a period of care is about to expire
- send the new or reviewed Care Plan to other members of the broader care team (as appropriate and agreed with the GP).

OTHER

OTHER

Summary of roles and responsibilities

The core care team – general practitioner (GP), care coordinator, participant (and their carer if applicable) – all work together to manage the participant's condition/s on an ongoing basis. The following provides a summary of the key responsibilities for each of these roles:

Participant

- self-manages their health care according to their Care Plan and in conjunction with the care team.

General practitioner

- provides clinical leadership and oversight for the participant
- ensures all members of the care team understand the basic requirements and roles and are committed to supporting the program
- assesses eligibility of potential participants for the program
- finalises the Care Plan
- monitors the overall provision of care and provides regular advice and guidance to the care coordinator.

Care coordinator – PN or ATSIPHW

- monitors the participant's progress and coordinates treatment services according to the Care Plan
- liaises with the participant and their carer (if applicable)
- educates and motivates the participant
- liaises with and provides a copy of the Care Plan to specialists, allied health professionals and other care providers, including emergency departments and/or hospital discharge planners as appropriate and agreed to by the GP
- provides feedback to the GP on the participant's condition/s and progress against their health goals on a regular basis
- maintains comprehensive clinical records and reminds the GP when the 90 day (quarterly) period of care is about to expire.

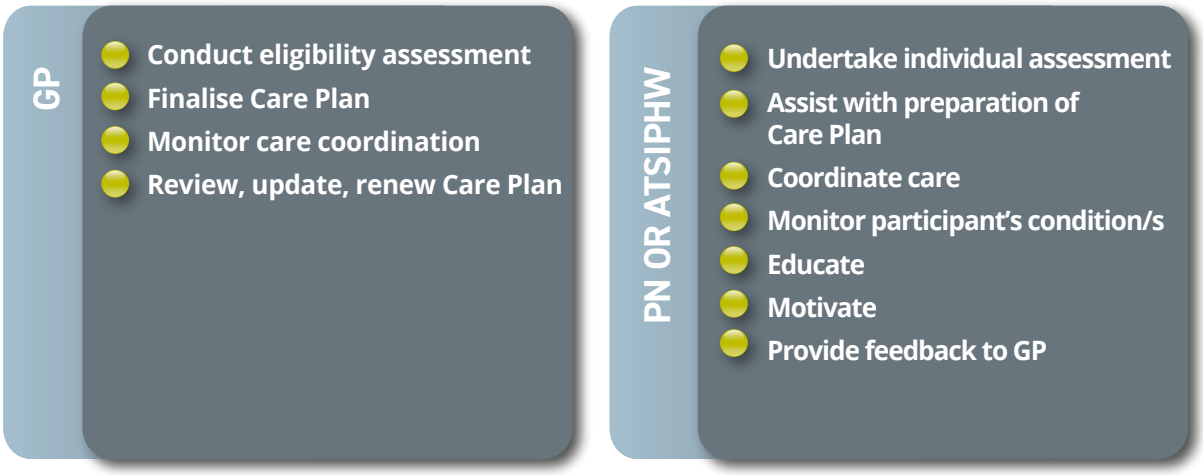
Care coordinator – community nurse

- conducts an in-home assessment of the participant
- collaborates with the GP on the development of the Care Plan
- monitors the participant's progress and coordinates treatment services according to the care plan
- liaises with the participant and their carer (if applicable) – visits the participant at home at least once every 28 days
- educates and motivates the participant
- maintains frequent dialogue with the GP – provides feedback to the GP on the participant's condition/s and progress against the goals in the Care Plan on a regular basis (at least monthly)
- provides a copy of the Care Plan (if agreed to by the GP) to and liaises with specialists, allied health professionals and other care providers, including emergency departments and/or hospital discharge planners.

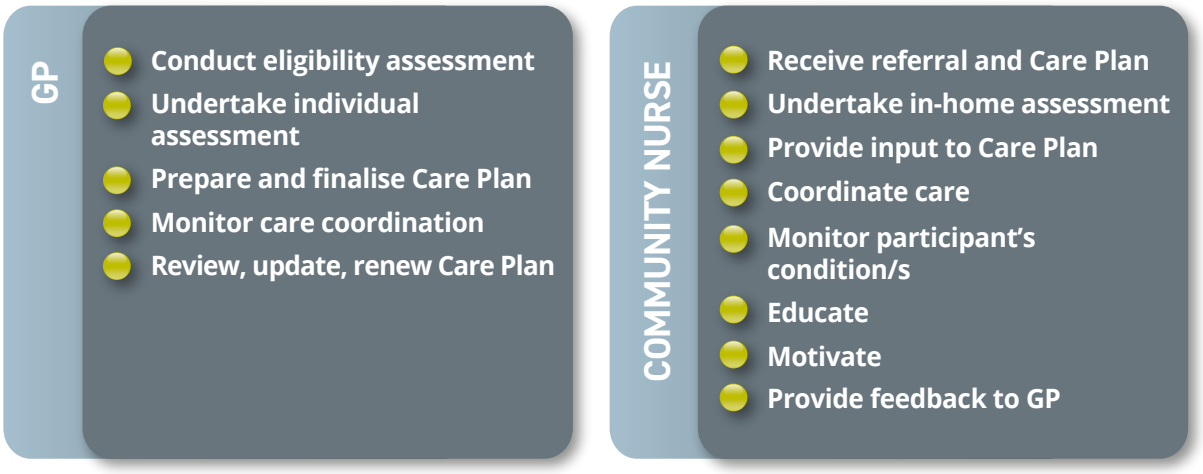
Compare key roles

The diagrams below show how the roles vary, depending on whether the GP uses a PN, ATSIPHW or community nurse.

GP with PN or ATSIPHW



GP with Community Nurse



CVC and DVA funding

The CVC Program does not fund treatment or health services. Veteran Gold Card holders are entitled to receive DVA-funded treatment for all health conditions, whether or not they are related to their military service.

The CVC Program enables the coordination of these treatments for participants.

Veteran White Card holders who have an accepted mental health condition are entitled to receive DVA-funded treatment for all of their accepted health conditions. They may be entitled to receive DVA-funded treatment for other health conditions, for instance under Non-Liability Health Care (NLHC) arrangements. They may also have conditions for which DVA does not fund treatment. The CVC Program enables the comprehensive coordination of treatment for all of their health conditions, regardless of treatment funding source.

For information on the difference between funding for Veteran Gold and White Card holders, see the table on the back page of this Guide.

Payments to general practitioners

General

There are two payments for the CVC Program, an Initial Assessment and Program Enrolment payment, and ongoing Completion of 90 day Care Period of Care – Review of Care Plan and Eligibility payments. Payments are made to GPs using existing Medicare arrangements.

The payments vary as follows:

- A GP who uses a PN or ATSIPHW as the care coordinator uses the item numbers UP01 and UP03.
- A GP who either uses a community nurse as the care coordinator or does the coordination themselves uses the item numbers UP02 and UP04.

Initial Assessment and Program Enrolment Payment

An Initial Assessment and Program Enrolment payment (UP01 or UP02):

- Payment is made to the GP for enrolling a patient in the program and having completed all necessary steps for the enrolment.
- This is a one-off payment and is only paid once per participant, regardless of any change in provider or PN, or where a participant leaves and later re-enters the program.
- UP01 is for a GP with a PN or ATSIPHW care coordinator. UP02 is for a GP with a community nurse or a GP without a care coordinator.

Completion of 90 day Period of Care – Review of Care Plan and Eligibility payments

Completion of 90 day Period of Care – Review of Care Plan and payments (UP03 or UP04):

- Payment is made to the GP for 90 day (quarterly) periods of care as part of ongoing clinical care leadership of a participant in the CVC Program.
- The previous care period must have expired before the commencement of the new 90 day (quarterly) care period.
- UP03 is for a GP with a PN or ATSIPHW care coordinator. UP04 is for a GP with a community nurse care coordinator or a GP without a care coordinator.

Claims

In claiming any item, a GP is confirming either that all steps necessary for the enrolment of a participant have been undertaken or that the ongoing care coordination for a participant has been completed. DVA may conduct post payment audits to monitor compliance.

Date of Service

The date of service for the 90 day (quarterly) period of care is the first day of that period. The claim for payment is made after the last day of the period.

For example, if the period of care runs from 7 May to 5 August (90 days), the date of service is 7 May but the claim for UP03 or UP04 cannot be made until after 5 August (i.e. on or after 6 August).

There is a claim calculator on the CVC Toolbox website and a self-populating ready reckoner on the DVA website that automatically calculate the date of service and the claiming date for each period of care for an enrolled CVC participant, based on the date of service. You can find the claim calculator at cvctoolbox.dva.gov.au/claim-calculator and the ready reckoner at www.dva.gov.au/cvc.

Community nurse

Where the GP uses a community nurse, the GP claims using the UP02 and UP04 codes and the DVA contracted CN provider claims for the care coordination activities through separate item numbers.

Exiting the program

Where a participant exits the program, e.g. the participant dies or moves permanently to a residential aged care facility, the GP is entitled to claim the full amount of the final Completion of 90 day Period of Care – Review of Care Plan and Eligibility payment.

Rules for transfer of provider

If a participant changes GPs after starting the program, the new GP:

- cannot claim the Initial Assessment and Program Enrolment payment
- can only claim for a Completion of 90 day Period of Care – Review of Care Plan and Eligibility payment after the expiry of the previous GP's 90 day (quarterly) care period.

Transfer from PN to community nurse

A change from a PN to a community nurse may occur in the following situations:

- The participant and/or the GP decides that a community nurse is better placed to coordinate the care. In this case, the GP should make all attempts to complete the current period of PN coordinated care before making the change. This will ensure seamless transition to the community nurse who can begin coordinating care straight away and can claim after the first 28 day period has been completed.
- The participant changes GP and the GP does not have a PN or the PN cannot provide the coordination service.

Transfer from community nurse to PN

A change from a community nurse to a PN may occur in the following situations:

- The participant and/or the GP decides that a PN is better placed to coordinate the care, or the GP previously did not have a PN. In this case, the GP should attempt to align the transition with the next care period.
- The participant changes GP and the participant and/or the GP decides that the care will be coordinated by the PN, or the previous GP did not have a PN. In this case, the new GP may choose to commence managing and PN coordination of the Care Plan straight away but will not be entitled to the Completion of 90 day Period of Care – Review of Care Plan and Eligibility payment for the GP with PN until any current period of care expires.

Change of CN provider

Where a participant changes from one CN provider to another, the new provider cannot commence a 28 day billing period of coordinated care until the existing 28 day billing period of care from the previous provider has expired.

NOTE: The new CN provider will require a referral from the GP.

Further information and resources

Enquiries

You can obtain additional information as follows:

General Enquiries	DVA Provider Enquiries DVA website	Phone: 1800 550 457 www.dva.gov.au/cvc cvctoolbox.dva.gov.au
Community Nursing	DVA website	www.dva.gov.au/cn
Social Assistance	Veterans' Home Care assessment agency	Phone 1300 550 450

Script for gaining consent

The GP must explain to an eligible patient what it means to be in the CVC Program, the sharing of their medical and health information and the consents that they will have to make.

The following script is recommended to obtain informed consent from the patient before enrolling them in the program:

> An important part of being in the CVC Program is that your relevant health and medical information is shared with all of your health care providers, including any specialists, pharmacists, allied health professionals, community nurses, hospitals, discharge planners, and nominated carers, in your broader care team.
>
> The sharing of relevant health and medical information allows a common understanding of your condition/s and treatments, your needs and preferences, and allows everyone to operate as a team to improve your health.
>
> DVA may need to access and use Care Plans and other personal information for the purposes of monitoring the quality of services delivered or the performance of the program. All of the people receiving your health and medical information must respect your privacy and comply with all relevant privacy legislation.
>
> Do you consent to participating in the CVC Program and to the sharing of your personal information including relevant health and medical information and data as I have outlined and to the use of a care coordinator? [A yes/no answer is expected and a record made of the response].
>
> You will also be asked to sign the Care Plan we will prepare as part of your enrolment.

Veteran White Card Holder

Veteran Gold Card Holder

Check Eligibility

- Current Veteran Card
- Live in the community
- Chronic mental health condition
- Complex care needs
- At risk of unplanned hospitalisation

Mental health condition is an accepted condition

- Confirm mental health condition is an accepted condition
- Confirm any other accepted condition/s

- Current Veteran Card
- Live in the community
- Chronic health condition
- Complex care needs
- At risk of unplanned hospitalisation

Gain Informed Consent

Conduct Needs Assessment

Develop and Finalise Comprehensive Care Plan

Claim UP01 or UP02 – Initial Assessment and Program Enrolment

- Individual Comprehensive CVC Care Plan
  - Needs Assessment
  - Initial Care Plan development

Deliver Ongoing Care

Claim UP03 or UP04 – Completion of 90 Day Period of Care – Review of Care Plan and Eligibility

- Coordination of Care based on CVC Care Plan and participant requirements – may include, as needed:
  - All health conditions and health care needs regardless of who funds treatment
  - Appointment scheduling
  - Appointment reminders
  - Health literacy
  - Arranging transportation for appointment
  - Engaging with family and community

THE CVC PROGRAM DOES NOT FUND TREATMENT

DVA Funding

- Necessary treatment for accepted mental health condition
- Treatment for any other accepted conditions
- Non-Liability Health Care (NLHC – cancer and tuberculosis, mental health care (different from accepted mental health conditions))

- Funding for treatment for non-accepted conditions **is not funded** by DVA (exceptions including NLHC and PAMJ)
- Alternative funding must be sought for treatment for non-accepted conditions e.g. Medicare, private funding

- Funding for all necessary treatment for all health services

Coordinated Veterans' Care Program