Australian Government

Department of Veterans' Affairs

NOTES FOR COORDINATED VETERANS' CARE PROGRAM PROVIDERS

Effective July 2021

The Notes are applicable to the following health care providers under the Coordinated Veterans' Care Program:

- general practitioners
- practice nurses
- Aboriginal and/or Torres Strait Islander Primary Health Workers
- community nurses

I, Jenny Cotton, Assistant Secretary Client Programs Branch in the Client Engagement and Support Services Division of the Department of Veterans' Affairs (DVA) hereby:

(a) revoke the Notes for Coordinated Veterans' Care Program Providers February 2021; and

(b) approve the Notes for Coordinated Veterans' Care Program Providers July 2021.

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(Jenny Cotton CSC)

Dated this 11th day of June 2021

These Notes take effect on 1 July 2021

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Purpose and Status of the Provider Notes

Purpose of the Notes

1. The Notes for Coordinated Veterans' Care Program Providers (the Notes) define the parameters for providing health care treatment under the Coordinated Veterans' Care (CVC) Program to the veteran community and describe the relationship between the Department of Veterans' Affairs (DVA), the CVC Program participant (the participant) and the provider.

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

   a) general practitioners (GPs)

   b) registered nurses (RNs)/enrolled nurses (ENs) employed by the GP practice (practice nurses)

   c) Aboriginal and/or Torres Strait Islander Primary Health Workers

   d) DVA contracted Community Nursing Providers.

Status of the Notes

3. The CVC Program is administered under the *Treatment Principles* for both the *Veterans' Entitlements Act 1986* (VEA) and the *Military Rehabilitation and Compensation Act 2004* (MRCA).

4. Under 6A.9.9 of the *Treatment Principles*, when providing treatment under the CVC Program, a general practitioner, a practice nurse, a DVA contracted Community Nursing provider (community nurse), and an Aboriginal and/or Torres Strait Islander Primary Health Worker are to comply with the requirements in the *Treatment Principles* as well as any requirements set out in the Notes.

5. In the event of an inconsistency between the Notes and the *Treatment Principles*, the *Treatment Principles* prevail.

6. Health providers must ensure that all personnel and Care team members involved in delivering the CVC program to entitled persons have access to, and a working knowledge of, the current version of the Notes.

7. Any breach of the Notes may lead to an action in accordance with the *Treatment Principles*, such as non-payment of claims or recovery of monies from claims previously paid.

Definitions for the purpose of the Notes

8. The following definitions have been used for the purpose of the Notes:

Term / Acronym	Definition
general practitioner (GP)	A GP who has been given a provider number by Medicare in respect of being a medical practitioner, which has not been suspended or revoked.
Aboriginal and/or Torres Strait Islander Primary Health Worker	An Aboriginal and/or Torres Strait Islander Primary Health Worker is a person who is qualified as an Aboriginal and/or Torres Strait Islander Primary Health Worker after undertaking a course in Aboriginal and/or Torres Strait Islander Primary Health, provided by an institution recognised by the *Aboriginal and Torres Strait Health Islander Practice Board of Australia* as suitable for providing a course of that nature, and who obtained a Certificate Level III (or higher) under the course.
Practice nurse	A registered nurse (RN) or enrolled nurse (EN) who is employed by the GP or the GP's practice.
Practice	The General Practice in which the GP and practice nurse work.
Coordinator	A nurse (practice nurse, RN or EN employed by a DVA contracted CN provider or Aboriginal and/or Torres Strait Islander Primary Health Worker) who forms part of the Care team and works with the GP to coordinate a participant's care.
Care team	The core Care team consists of the GP, Coordinator, participant and their carer if applicable, and other health care professionals as required to be involved in the participant's care. Nominated carers may form part of the core Care team as required. The broader care team may include other health care professionals: specialists, pharmacists, allied health, DVA contracted Community Nursing provider, hospital discharge planners and supporting community members.
Participant	An entitled person who meets the eligibility criteria for the CVC Program and is enrolled in the program.

Amendment of the Notes

9. The Notes may be amended from time to time by DVA, consistent with any legal obligations and to remain contemporary with changes in the health care industry. Any amendments to the Notes will be dated and DVA will undertake to advise health providers of changes to the Notes prior to them taking effect.

Treatment of entitled persons under the Coordinated Veterans' Care Program

The Coordinated Veterans' Care Program

10. The objective of the CVC Program is to help eligible participants manage their chronic condition and avoid unplanned hospitalisations.

11. Entitled persons are Gold Card holders who have one or more chronic condition/s. Entitled White Card holders are those with a mental health condition for which DVA has accepted liability (an accepted mental health condition) which is chronic. All participants will have complex care needs and will be at risk of hospitalisation.

12. The CVC Program is a team-based program encouraging partnership and collaboration between the participant, GP, Coordinator and their treating health professionals and community/informal supports. The CVC Program involves a proactive approach to improve the management of participants' chronic conditions and the quality of care for participants.

13. 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 veteran'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.

14. Through the CVC Program assessment and the coordination of their Care Plans, participants can access a wide range of health services to assist in the management of their chronic conditions. The sharing of health information amongst partnering health professionals enables better health outcomes for participants. Regular communication, empowerment and coaching of participants are key to the Care team successfully managing all aspects of the program for a participant.

Prepare your practice for the Coordinated Veterans' Care Program

15. The CVC Program is delivered in a General Practice setting and can involve just the GP, or in most cases, the GP and a Coordinator. The Coordinator may be a practice nurse (PN), Aboriginal and/or Torres Strait Islander Primary Health Worker or an RN/EN employed by a DVA contracted community nurse provider.

16. Where a GP uses a PN as the Coordinator, it is recommended the practice has capability for the PN to make home visits to participants living within a reasonable time and distance from the practice.

17. Where the GP plans to use a PN who is an EN or an Aboriginal and/or Torres Strait Islander Primary Health Worker to coordinate the care, the GP must play a closer clinical role than if an RN is undertaking this role.

18. The GP must ensure that all nursing and other practice staff understand, and are committed to, the program's intent to improve the management of chronic

conditions and reduce unplanned hospitalisations, the requirements of the CVC Program and their role in the program.

19. Resources are available on the DVA website for health professionals involved in the delivery of the CVC Program.

Coordinated Veterans' Care Program Delivery Overview

20. The following table (Table 1) provides an overview of the steps involved in delivering the CVC Program. All steps must occur to ensure compliance with the Notes and the intent of the program.

    Steps one to seven must occur before the participant is considered enrolled in the CVC Program and the initial period of care commences.

    A period of care for the purpose of the CVC Program is a period 90 days.

    Steps eight to ten outline the requirements for ongoing participation and what must occur in order to claim quarterly CVC payments.

21. More detail is provided on each step later in this document.

Table 1 - CVC Program Process and Responsibilities	Responsibility
1. **Identify the Coordinator** (practice nurse, Aboriginal and/or Torres Strait Islander Primary Health Worker, or RN/EN employed by a DVA contracted community nurse). The GP may act as the Coordinator if there is not an available or suitable Coordinator.	GP
2. **Identify potential participants**. The GP leads the process of identifying potential participants.	GP
3. **Check eligibility**. A patient must meet eligibility requirements to be enrolled in the CVC Program. Information and an eligibility tool are available on the DVA website	GP
4. **Gain informed consent**. If a patient is eligible they must also provide their informed consent to participate in the CVC Program.	GP
5. **Undertake an individual assessment** with the participant to understand the person's health condition/s, needs and goals; either in the surgery or the person's home, based on participant preference and capacity of the Coordinator to undertake a home visit.	GP and Coordinator
6. Prepare a comprehensive Care Plan (Care Plan) using the information from the initial assessment process the	GP and Coordinator

participant, GP and Coordinator. Identify other health professionals who will be members of the broader Care team.	 GP
7. **Record Enrolment**. The GP is responsible for both of the following: a) **recording** the enrolment information, the participant's consent and Care Plan in the patient file b) providing the participant and/or carer with a copy of their Care Plan. Once these steps have been completed the patient is considered enrolled in the CVC Program.	GP
8**. Claim** a) An initial UP01 or UP02 claim can be made once steps one to seven have been completed. b) UP03 or UP04 claims can be made at 90 day intervals after this initial claim date.	GP or Coordinator
9. **Provide Ongoing Care** as per the Care Plan. The Care Plan should be implemented throughout the period of care, with care coordination and engagement occurring as required by the participant. The participant will remain enrolled in the program for as long as they can benefit from participation. The GP should provide oversight of the participant's care while enrolled in the CVC Program, and regularly advise and guide the Coordinator.	GP and Coordinator GP
10. **Review the Care Plan** at the end of the 90 day (also known as quarterly) care period ahead of confirming eligibility for continued enrolment in the program. The GP must review the value of participation in the CVC Program prior to the commencement of the next claim period.	GP and Coordinator GP
11. **Consider benefit of additional DVA Services** Under the CVC Program, participants may benefit from the inclusion of other DVA initiatives and programs to meet their ongoing care: a) CVC Social Assistance which is a short term additional service available to CVC participants focussed on building confidence to promote ownership and motivation for their ongoing social health	GP or Coordinator

b) Veterans' Home Care (VHC) which provides a range of home care services designed to maintain the health, wellbeing and independence of eligible veterans and/or war widows/widowers c) The Community Nursing (CN) Program which provides community nursing services for entitled persons in their home to meet their assessed nursing care needs d) Open Arms which is Australia's leading provider of high quality mental health assessment and clinical counselling services for Australian veterans and their families. The DVA website has further information on the above initiatives and programs as well as a comprehensive list of all services and programs available to entitled persons www.dva.gov.au.	

Coordinated Veterans' Care Program Overview – Detail

1. Identify the Coordinator

22. The GP determines whether the Coordinator role will be performed by a practice nurse, Aboriginal and/or Torres Strait Islander Primary Health Worker or an RN/EN employed by a DVA contracted Community Nurse provider. Where there is not a suitable Coordinator available, the GP may perform the coordination role.

23. Where the GP performs the coordination role, the GP must observe all the requirements of the Coordinator as stated in the Notes.

24. Where the GP performs the coordination role, the GP is not entitled to any 'GP with practice nurse' payments.

25. If the GP is using a DVA contracted Community Nursing provider, the GP sends the referral, care plan template and any supplementary notes to the DVA contracted Community Nursing provider. The comprehensive Care Plan should be developed collaboratively between the GP, the DVA Community Nursing contracted provider and the participant. The referral documentation should include the GP's expectations for initial set-up, communication preferences e.g. telephone/fax/email (secure email only), medical appointment schedule including dates and care coordination recommendations. The GP and Coordinator will establish an agreed approach to ensure ongoing and regular communication with each other and the participant and any other members of the Care team.

    Note: The DVA contracted Community Nursing provider referral is valid for 12 months unless withdrawn by the GP or a disqualifying event occurs e.g. participant enters a residential aged care facility. If the participant is already receiving CN services, the existing referral should be withdrawn and a new referral covering the CVC Program and other nursing services must be sent to the DVA contracted Community Nursing provider. There must be only one provider of CN services to any participant at any one time.

    Records of all communications with the DVA contracted Community Nursing provider need to be maintained, including regular feedback from the provider. **Communication should be at least monthly and recorded on the participant's file.**

    The Panel of DVA contracted Community Nursing providers is available on the DVA website.

2. Identify potential participants

26. Identifying potential CVC Program participants is the responsibility of the GP with assistance from the Coordinator. Practices should proactively identify potential program participants through engagement with patients who are Gold Card holders or White Card holders who have an accepted mental health condition.

27. Veterans may also self-nominate to participate in the CVC Program. As with other patients, the GP would check eligibility before enrolment.

3. Check Eligibility

28. All of the eligibility criteria must apply to a potential participant before enrolment in the CVC Program. All of the following must be true for a potential CVC Program participant:

    a) be a current DVA Gold Card or a White Card holder with an accepted mental health condition holder

    b) be living in the community (not in a residential aged care facility)

    c) be diagnosed with one or more chronic conditions

    d) be at risk of unplanned hospitalisation

    e) have complex care needs

    f) have given their informed consent to participate in the CVC Program.

29. Gold Card holders are entitled to receive DVA funded treatment for all health conditions, whether they are related to war/military service or not. The CVC program enables these treatments to be comprehensively coordinated for the entitled person.

30. White Card holders who have an accepted mental health condition are entitled to receive DVA-funded treatment for all their accepted health conditions. They may be entitled to receive DVA funded treatments for other health conditions, for instance under Non-Liability Health Care or Provisional Access to Medical Treatment arrangements. They may also have conditions for which DVA does not fund treatment. The CVC Program enables the treatments for all their health conditions to be comprehensively coordinated for the entitled person.

31. Complex care needs include one or more of the following:

    a) multiple comorbidities that complicate treatment

    b) unstable condition with a high risk of acute exacerbation

    c) the condition is contributed to by frailty, age and/or social isolation factors

    d) limitations in self-management and monitoring

32. These complex needs require a treatment regimen that involves one or more of the following complexities of ongoing care:

    a) multiple care providers

    b) complex medication regime

    c) frequent monitoring and review

d) support with self-management and monitoring.

33. The GP assesses a person's eligibility for the CVC Program and decides whether the person is suitable to be enrolled as a participant.

34. If any of the following apply to a potential participant, they are considered ineligible for the CVC Program:

    a) currently residing in a residential aged care facility

    b) a participant in the Department of Health (DOH) Transition Care Program, diagnosed with a condition that, in the GP's opinion, is likely to be terminal within 12 months.

    (NOTE: this applies only for initial program enrolment, not where the diagnosis occurs after enrolment in the CVC Program.)

35. If a GP is unsure of an entitled person's eligibility, a CVC toolbox is available through the DVA website which may assist in checking the eligibility of potential participants.

4. Gain informed consent

36. During the process of checking eligibility, the GP explains to the participant what it means to be enrolled in the CVC Program. The GP must gain informed consent from the participant, explaining this includes sharing the person's medical information, data and comprehensive Care Plan with the nominated Care team members. Consent is in addition to the standard consents for a Gold Card holder or White Card holder with a mental health condition. Suggested wording for obtaining consent is at **Attachment A** of the Notes.

37. The sharing of relevant medical information amongst the Care team allows for collaborative care planning and a holistic understanding of the participant's health needs and goals. Information privacy principles must be observed by all Care team members.

38. Participants must also consent to information being provided by DVA to contracted third parties from time to time for the purpose of providing DVA with data analytics, monitoring, evaluation and reporting for the CVC Program. This includes information on participation numbers, demographics, program utilisation and measuring outcomes and program performance.

39. If the entitled person is unable to provide informed consent, a person who is legally authorised to give substitute consent to treatment under relevant State / Territory law (e.g. The Public Trustee, Guardian, a holder of an appropriate Special Power of Attorney, etc.) may consent on their behalf.

40. If the person does not provide consent, the GP cannot enrol them in the CVC Program.

5. Individual Assessment

41. Once a participant has been identified and they have consented to participate in the CVC Program, time is made with the GP and Coordinator to commence an individual assessment. The assessment process will form the basis of the Care Plan.

42. There are no specific assessment tools or tests to be completed for this step. Any assessment must take into account the individual needs of the participant including health needs, personal preferences and level of engagement at the outset of the program. Assessment is intended to be undertaken as required, with an ongoing review process built into the delivery of the program.

6. Comprehensive Care Plan

43. The development of an individual comprehensive Care Plan (Care Plan), in consultation with the participant and based on their own goals, preferences, priorities and intentions is a key element of the CVC Program.

44. The Care Plan should include goals, interventions and self-management aspects, the role of the Care team members, and plans for the regular monitoring and review of the Care Plan.

45. The development of the Care Plan must be collaborative with the GP, participant and Coordinator, and where appropriate, other members of the Care team.

46. Care Plans should include, at a minimum:

    a) a description of all chronic and other health conditions

    b) for each condition - current care guide, targets, red flags, background information, current management and most recent results

    c) a medication list including dose frequency and known adherence

    d) a list of allergies and adverse reactions

    e) self-management goals and strategies

    f) any family and/or carer contact details

    g) other treatment providers and their contact details

    h) referrals

    i) devices being used.

47. General Practices use a variety of Care Plan templates and tools. As long as Care Plans are tailored to each individual participant and are treated as live and evolving documents, always based on participant needs, there is no specified template to be used for the comprehensive Care Plan. An example template is

available on the DVA website as an optional resource.

48. A copy of the signed Care Plan must be given to the participant.

7. Recording Enrolment

49. A patient is considered enrolled in the CVC program when the above steps have been completed. There is no specific enrolment form and no information is provided to DVA by the GP.

50. At this time the enrolment, including the patient's consent, must be noted on their patient file and the signed Care Plan shared with the participant and all broader Care team members.

8. Claiming

51. There are four claim codes associated with the delivery of the CVC Program to be used by GP practices:

    a) UP01 – Initial Assessment and Program Enrolment with a practice nurse

    b) UP02 – Initial Assessment and Program Enrolment without a practice nurse

    c) UP03 – Completion of 90 day Period of Care – Review of Care Plan and Eligibility with a practice nurse

    d) UP04 – Completion of 90 day Period of Care – Review of Care Plan and Eligibility without a practice nurse

    Claims are processed directly through Medicare. See clauses under **Financial responsibilities** for information about billing procedures

52. There are two additional claim codes to be used by DVA contracted Community Nursing providers where the they are the Coordinator:

    a) UP05 – CVC Initial Care Coordination

    b) UP06 – CVC Subsequent Care Coordination.

53. An Initial payment (UP01 or UP02) can only be claimed once in the life of a patient.

54. Quarterly care payments (UP03 / UP04) are claimed on a 90-day (quarterly) basis for the period of ongoing clinical care. These claims are paid retrospectively. A claim calculator to determine the claim dates and date of service to use for each claim period is available on the DVA website.

9. Provide Ongoing Care

55. The GP and Coordinator work with participants and the other members of the care team on an ongoing basis to monitor and review the participant's care. The Care Plan is to be implemented during the period of care and the Coordinator is

to ensure effective and regular communication occurs with the participant and other members of the Care team.

The GP is to provide regular feedback and guidance to the Coordinator.

56. It is expected that once a person is enrolled in the CVC Program, they will remain an enrolled participant as an ongoing means of managing their chronic condition/s for as long as they remain eligible and benefit from continued enrolment in the Program.

57. There should be regular contact between the Coordinator and participant, with the involvement of the GP and other Care team members as required. Regular contact can be in the practice setting or as appropriate for the participant (e.g. by telephone or home visit).

58. The Coordinator carries out coordination activities regularly including:

    a) at least monthly contact with the participant to ensure adherence to the Care Plan

    b) health coaching and motivational guidance

    c) detecting and addressing emerging issues promptly.

59. Where a practice nurse is fulfilling the role of Coordinator, and the participant lives within a reasonable distance and time from the practice, it is recommended at least one home visit is undertaken by the practice nurse within the first month of entering the CVC Program. If no initial in-home assessment was conducted, and at least one home visit per year.

60. The Coordinator provides a copy of the Care Plan to all Care team members and to the participant, when it is first developed and after each update, and monitors the actions of all care providers (for example prescriptions, tests, referrals and recommendations) through feedback from the participant, the carer, consultation reports and communication with other Care team members.

61. The Coordinator regularly updates the Care Plan as necessary and ensures that:

    a) regular feedback is provided to the GP on the participant’s condition and progress against the goals

    b) where applicable, the participant’s carer is involved in the care coordination process and informed of the participant’s progress and any changes to the Care Plan

    c) a review or renewal of the Care Plan is conducted with the participant and GP, and other relevant Care team members, before the expiry of all quarterly periods of care.

10. Review of the comprehensive Care Plan and Subsequent periods of care

62. The GP must review participation in the CVC Program at least every 90 days (quarterly), prior to the commencement of the next period of care, to determine if the participant remains eligible and the CVC Program is still an appropriate model of care for the participant. This includes deciding whether the person's continued participation would meet the aims of the program i.e. reduce unplanned hospitalisation, improve their wellbeing, avoid duplication of services, and/or provide cost-effective treatment.

63. Participants may remain in the program until one or more of the following occur:

    a) they enter residential aged care (other than for respite)

    b) the GP determines the program is no longer suitable for their needs

    c) the participant decides to no longer participate in the program.

64. As part of the review of participation every 90 days (quarterly), the Care Plan must be reviewed and updated to ensure it remains current. Participants are actively involved in the review of their Care Plan and updated versions are to be provided to the participant and members of the Care team. The Care Plan must be renewed at least every 12 months.

65. Where the GP decides that the person should continue in the program, the GP then approves and documents the approval of the subsequent 90 day (quarterly) period of care.

66. Where the approval is made before an existing quarterly period of care expires, the subsequent period of care commences on the day after the current period expires. Where a quarterly period has already expired, the subsequent period of care commences on the day the decision is made to approve the subsequent period of care.

67. Where the GP decides not to approve a subsequent period of care, the GP must perform all of the following:

    a) notify the participant

    b) notify (including by telephone) any relevant DVA contracted Community Nursing providers, if the participant is a DVA contracted Community Nursing provider is the Coordinator

    c) notify (including by telephone) the VHC Assessment Agency, if the participant is receiving CVC Social Assistance.

Social Assistance

68. Social Assistance for CVC participants is the provision of short term assistance to encourage longer term socialisation outcomes, for example assistance with participating in community activities or courses.

69. Assistance will be short term (up to 12 weeks) intensive services focused 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. These benefits include re-entry into community life, expanding the type and frequency of social contact and encouraging the veteran to proactively engage with communities of interest.

70. The focus is on short term intervention rather than ongoing assistance and aims to promote social health and independence rather than dependency.

71. At the point of enrolment in the CVC Program or any time thereafter, the GP may determine that a participant could benefit from a Veterans' Home Care (VHC) assessment for Social Assistance. The GP provides a written referral to a VHC Assessment Agency. The contact details are at the end of these notes.

72. The criteria for a referral for a VHC assessment are that the GP has determined that the CVC participant:

    a) has a limited or inadequate social support network and could reasonably be at risk of hospitalisation because of that social situation

    b) is at risk of being hospitalised for a chronic condition which may be significantly reduced if the person receives social assistance.

73. Information on VHC regions is available on the DVA website.

74. The GP and/or Coordinator follows up on the referral with the participant and monitors the assistance supplied and the effect on the participant's social isolation.

Planned and unplanned admissions to hospital

75. On learning of a participant's unplanned admission to hospital, the GP or Coordinator will contact the hospital, advise the treating health professional and/or discharge planner that the participant is in the CVC Program and has a Care Plan, and request to be advised of the discharge date, receive a copy of the discharge papers and wherever possible, to be involved in the discharge planning process.

76. Within two days following discharge from hospital, the GP or Coordinator contacts the participant to arrange for either or both of the following:

    a) an appointment with the GP either in the surgery or at home, to review the participant's condition and possibly review the Care Plan

    b) where the Coordinator is a DVA contracted Community Nursing provider a home visit to review the participant's condition and make a recommendation to the GP on the need for a review of the Care Plan.

77. Where appropriate, the GP or Coordinator should liaise with the hospital during a planned admission including during the discharge planning process, and follow up with the participant on discharge.

78. The GP and Coordinator must ensure that the participant is provided with maximum opportunity to continue in the CVC Program as an ongoing means of managing their chronic condition/s.

Transfer of provider

79. A change of GP may occur in a number of circumstances, including when a participant chooses to change GP or the current GP moves location or retires. See clause **GP Claims for Initial Assessment and Program Enrolment Payment** for information on claiming following a transfer to a new GP.

80. A change from practice nurse to a DVA contracted Community Nursing provider may occur when one or other of the following occur:

    a) the participant and/or the GP decide that a DVA contracted Community Nursing provider is better placed to coordinate the care. In this case, the GP should make all attempts to complete the current three month period of practice nurse coordinated care before making the change. This will ensure a seamless transition to the DVA contracted Community Nursing provider who can begin coordinating care straight away and can claim after the first 28 day period has been completed. The GP will be required to provide a referral to the DVA contracted Community Nursing provider

    b) the GP no longer has access to a practice nurse to undertake the Coordinator role in the CVC Program

    c) the participant changes GP and the GP does not have a practice nurse or the practice nurse cannot provide the coordination service.

81. A change from DVA contracted Community Nursing provider to practice nurse may occur where one of the following occur:

    a) the participant and/or the GP decides that a practice nurse is better placed to coordinate the care, or the GP previously did not have a practice nurse. In this case, the GP should attempt to align the transition with the next 90 day (quarterly) care period

    b) the participant changes GP and the participant and/or the GP decides that the care will be coordinated by the GP's practice nurse, or the previous GP did not have a practice nurse.

82. The new GP with a practice nurse may choose to commence coordination of the Care Plan immediately but they will not be entitled to claim for the UP03 – Completion of 90 day Period of Care payment until the current 90 day (quarterly) care period expires.

Service Expectations for treating Coordinated Veterans' Care Program participants

83. A GP under the CVC Program is required to provide services based on the following:

a) GPs are to recognise DVA’s mission, vision and values and undertake, when dealing with entitled persons, to do so with respect, courtesy and understanding in accordance with DVA’s Service Charter (available on the DVA website: www.dva.gov.au).

DVA management requirements

Eligibility to provide DVA funded treatment

84. DVA statutory registration allows GPs who are eligible to claim for treatment services under the Medicare Scheme to be eligible to provide treatment services to entitled persons under DVA's statutory provisions without having to enter into a contract with DVA. These provisions for statutory registration are covered by the relevant sections of the *Treatment Principles*. To apply for a Medicare provider number or amend details please contact Medicare (see the contact list at the back of these Notes for details).

85. To be eligible to provide treatment to entitled persons under the DVA health care scheme, the GP must be a registered provider with Medicare at the time the service is provided and a Medicare benefit must be claimable for the service.

86. In addition, one of the following conditions must be met to provide DVA funded treatment:

    a) if the GP is practising in a State or Territory that has legislation requiring the registration of the occupation, the GP must be registered under that legislation

    b) if the GP is practising in a State or Territory that does not have legislation concerning registration (occupational licensing legislation), the GP must, at a minimum, possess qualifications that would permit registration in another State or Territory (if another State or Territory has relevant occupational licensing legislation).

87. GPs must meet the professional and ethical standards, including continuing education requirements, set by their professional regulatory and/or representative body.

Insurance & indemnity

88. State or Territory laws or provider registration bodies may require, as a condition of registration, GPs carry a certain level of insurance and indemnity. This may vary across provider type and jurisdiction. For GPs covered under DVA's statutory registration scheme (i.e. registered with Medicare), DVA does not stipulate insurance requirements or level of coverage but expects providers to hold adequate levels of insurance.

89. DVA requires that providers shall at all times indemnify and hold harmless the Commonwealth, the Repatriation Commission and the Military Rehabilitation and Consultation Commission (MRCC) (collectively referred to as the Commissions), their officers, employees and agents (in this paragraph referred to as 'those indemnified') from and against any loss (including legal costs and expenses on a solicitor/own client basis), or liability, incurred or suffered by any of those indemnified arising from any claim, suit, demand, action, or proceeding by any person against any of those indemnified where such loss or

liability was caused by any wilful, unlawful or negligent act or omission by yourself, your officers, employees or agents in connection with DVA's statutory registration scheme or in the course of, or incidental to, performing the health services.

Privacy

90. GPs must ensure ongoing compliance with the *Privacy Act 1988* (Cth) (Privacy Act) and Australian Privacy Principles (APPs) with regard to the collection, storage, security, use and disclosure of their patient's personal information. GPs should have regard to the Australian Privacy Principle Guidelines and Guide to Health Privacy as published by the Office of the Australian Information Commissioner (OAIC).

91. GPs should also have regard to any obligations or guidance material provided by relevant health authorities, such as the Australian Health Practitioner Regulation Agency (AHPRA) in respect to the collection, storage, security, use and disclosure of their patient's personal information.

Record keeping requirements and provision of information

92. The GP must create and maintain adequate and appropriate records relating to all administrative and clinical aspects of the provision of treatment to an entitled person under the CVC Program, including treatment provided by a practice nurse or Aboriginal and/or Torres Strait Islander Primary Health Worker. Records should be maintained of any consent required under the *Treatment Principles* or the Notes.

93. The Care Plan must be updated in a timely manner in relation to health care services provided on a specific date of service.

94. Records are to be retained by a GP for the period, if any, required by any legislation that regulates the keeping of medical records in the State or Territory in which the GP provides treatment under the CVC Program. Such records are to be securely stored and must be available to DVA on request.

95. GPs will comply with any reasonable request from DVA to supply information in relation to any entitled person in the CVC Program. In relation to complaints, the GP must cooperate fully with DVA in investigating the matter, and must provide sufficient information to enable a response to the complaint within seven days of receiving any information request from DVA. Where appropriate, DVA may liaise with the relevant regulatory and industry bodies regarding the performance issues.

96. GPs must ensure entitled persons understand that it is a **condition of participation in the CVC Program** that they consent to his or her personal (treatment) information being provided to DVA, Medicare, hospital personnel, other health care providers providing services, **and by DVA to third parties contracted for the purpose of providing DVA with data analytics, monitoring, evaluation and reporting for the CVC Program which may include surveys**.

Electronic Communication

97. For the purpose of the Notes, and unless the contrary intention appears, DVA and a GP may communicate about any matter by electronic transmission e.g. secure email, facsimile message.

98. Electronic communication is appropriate for making a request or to provide a notice or document.

Advertising

99. The provisions of the *Health Practitioner Regulation National Law Act 2009* must be adhered to by all DVA providers. In addition, GPs must not refer to DVA or the CVC Program or its participants in any promotional material unless they observe the following all of these conditions:

    a) permission must be sought in writing from DVA to include reference to DVA or the CVC Program or its participants in advertisements or promotions. The request for permission must include the proposed wording of the advertisement or promotional material and any image(s) that will be used

    b) the Australian Government logo must not be used in advertisements

    c) the advertisement or promotional material must not imply endorsement as DVA's preferred GP, or that the GP is an employee or agent of DVA. The advertisement may only advise that the GP treats participants under the CVC Program

    d) no false or misleading information is to be included in the advertisement or promotional material

    e) advertisements or promotional material referring to DVA will not be permitted if legislation or occupational standards prohibit advertising by the GP

    f) no inducements or other offers are to be made to CVC Program participants or their families.

100. If the advertisement or promotional material is only brought to DVA's attention after publication, the GP will be contacted and advised of these guidelines. If the advertisement or promotional material does not conform to these guidelines it can no longer be used and must be removed from the public space.

101. If a GP has been informed of these guidelines and breaches them, DVA can take appropriate and necessary action which could include action under the *Competition and Consumer Act 2010*.

Use of locums, students and/or assistants

102. DVA will accept financial responsibility for the services of a locum if the locum GP is eligible to provide services under statutory registration and is willing to

treat entitled persons under the CVC Program.

103. DVA will not accept financial responsibility for CVC Program health care services provided fully or in part to an entitled person by a fieldwork student or an assistant. An assistant or student undertaking practical experience can only provide treatment under direct supervision of the GP subject to seeking the appropriate consent from the program participant. The supervising GP must be present at all times during the DVA funded consultation.

Independent Monitoring and Evaluation

104. DVA may contract third parties to provide services such as:

   a) undertaking ongoing data analysis and reporting, including surveys, to support program monitoring and evaluation of program outcomes. Monitoring of program outcomes is an important element of the program

   b) promoting the program and providing supplementary support materials for GPs and participants in the program.

DVA Monitoring

105. DVA has systems in place to monitor the servicing and claiming patterns of GPs. DVA uses this information, in addition to best practice guidelines from professional regulatory and/or representative bodies, to establish internal benchmarks for the future delivery of services and to identify possible instances of overpayment resulting from administrative error, inappropriate servicing, non-compliance or fraud.

106. DVA may conduct audits of GPs. The audits will examine whether a GP is complying with the *Treatment Principles*, Notes and DVA's administrative arrangements.

107. The key objectives of the audit process are to achieve all of the following:

   a) ensure compliance with DVA's management requirements

   b) provide an opportunity for DVA to educate GPs about their responsibilities when treating entitled persons

   c) monitor the quality of treatment being provided

   d) monitor the achievement of health care outcomes for entitled persons

   e) minimise the risk of overpayment as a result of administrative error, inappropriate servicing and non-compliance

   f) address cases of individual non-compliance.

108. The compliance audits may be conducted via telephone or at the GP practice, or at a DVA office at DVA's discretion. The GP will be given reasonable advance written notification of the audit. DVA has the right to seek feedback on

service performance from CVC Program participants through various confidential means including random surveys.

Continuous Improvement

109. DVA's vision is to achieve excellence in service delivery.

110. Changes in the CVC Program due to improvements and the application of new efficiencies should be expected and GPs will need to accommodate those developments as they affect the provider's relationship with DVA.

111. Accordingly GPs must be flexible in their dealings with DVA and receptive to improvements in the CVC Program and be prepared to alter their business practices in order to ensure the business relationship with DVA works effectively.

112. DVA undertakes to consult with relevant Commonwealth and State/Territory regulators and professional bodies where a change to the CVC Program would affect GPs and to give reasonable notice to providers before a change is implemented, with a period of 21 days to be used as a guide as to what may be reasonable notice.

Inappropriate claiming

113. In addition to any levels of servicing imposed by a relevant Commonwealth and State/Territory regulator and/or professional body, the Commissions reserve the right to broadly determine the level and type of servicing for entitled persons for which they will accept financial responsibility.

114. Should it appear a GP is supplying inappropriate levels or types of health care services, or has been submitting incorrect claims, DVA may contact the GP by telephone or in writing to discuss and clarify the Department's concerns. DVA may additionally advise the relevant State/Territory regulator.

115. A reasonable period of time (not exceeding 14 days) will be given to the GP to achieve one or both of these actions:

    a) demonstrate the health care services supplied were appropriate to meet the entitled person's treatment needs

    b) implement an agreed remedial action plan with DVA.

Right of the Australian Government to recover money

116. Without limiting the Australian Government's rights under any provision of the Notes, the *Treatment Principles*, any other legislation or under the Common Law, any payment or debt owed by the GP to the Australian Government under the Notes may be recovered by the Australian Government. The Australian Government can recover the amount of payment from any claim or from any other monies payable to the GP for any debt owed.

117. Recovery of monies paid to health care providers by DVA can also be pursued

via the civil recovery process through the Australian Government Solicitor.

GST and ABNs

118. It is the GP's responsibility to notify Medicare of all changes to GST registration status. Medicare must have current information to ensure correct GST processing of claims for payment. Failure to notify Medicare could result in failure to comply with GST law.

119. DVA requires GPs treating entitled persons to enter into a Recipient Created Tax Invoice (RCTI) Agreement with DVA if they are registered for GST, and will be providing services to DVA.

120. The RCTI Agreement permits Medicare to automatically add GST to claimed taxable items. It also allows Medicare to issue the GP with an RCTI to comply with GST law.

121. If a GP does not complete the RCTI Agreement with DVA, Medicare will reject claims for payment. The RCTI Agreement is available on the DVA website.

122. All GPs who receive payments under DVA's health care scheme are required to have an Australian Business Number (ABN). Having an ABN does not automatically mean a business is registered for GST.

Financial matters

Financial responsibilities

123. Under the CVC Program, the Commissions accept financial responsibility for the provision of services to entitled persons (incur a liability) and DVA meets that liability by paying for those services.

124. The services must be delivered in accordance with the *Treatment Principles* and these Notes.

125. Medicare processes GP claims for payment. Medicare operates a computerised claims processing system to pay GPs who treat entitled persons. Payment can be delayed or rejected if GPs submit claims that contain incomplete, inaccurate or illegible information.

126. Fee Schedules for medical services are available on the DVA website.

127. Subject to Government policy, DVA indexes the fees for most health care providers annually.

Billing Procedures

128. DVA's method of invoicing is by electronic means. For treatment under the CVC Program, GPs should utilise the same claims procedures they would for any other treatment claim.

129. Claims for payment should be forwarded to Medicare as soon as practicable after the admission of a participant to the CVC Program or the end of a period of care. A claim submitted more than two years after the date of service will not be paid unless there are special circumstances e.g. hardship would be caused to the GP if the claim is not met.

GP assesses a person for eligibility

130. When a GP assesses a person for eligibility, the assessment consultation can be billed as a separate consultation to the CVC Program items which are in addition to all existing Repatriation Medical Fee Schedule (RMFS) items.

GP Claims for Initial Assessment and Program Enrolment Payment

131. Payment to GPs for treatment under the CVC Program is based on the RMFS contained in the DVA document 'The Department of Veterans' Affairs Fee Schedules for medical services. Fees for the CVC Program are also listed on the CVC page of the DVA website, see link at the end of the notes.

132. Having enrolled the patient in the CVC Program, the GP then claims the Initial Assessment and Program Enrolment Payment which is higher for a GP with a practice nurse (including an Aboriginal and Torres Strait Islander Primary Health Worker) who will be conducting the care coordination than for a GP who does not have a practice nurse conducting the care coordination.

133. The Initial Assessment and Program Enrolment Payment is made only once per participant in the life of the program. Where the participant changes GP or ceases to be a participant and later re-enters the program, the initial Assessment and Program Enrolment Payment will not be applicable.

134. In making a claim for an Initial Assessment and Program Enrolment Payment, the GP is affirming that all of the requirements in the Notes for enrolling a patient in the CVC Program have been observed.

GP Claims for completion of 90 day period of care – review of Care Plan and eligibility payment

135. At the expiry of a 90 day (quarterly) period of care, the GP submits a claim for payment.

136. The date of service for the period of care is the first day of the quarterly period e.g. if the period of care runs from 7 May to 6 August, the date of service is 7 May but the claim cannot be made until after 6 August.

137. Where the participant changes GP after entering the program, the new GP can only claim for a quarterly care period that commenced after the expiry of the previous GP's quarterly care period whether or not the new GP knew of the existence of a previous period of care.

Effect on claims for other items on the Repatriation Medical Fee Schedule

138. A claim for any fee items in the CVC Program range does not affect a claim for any other items on the RMFS that the participant is eligible to receive, including the Chronic Disease Management items.

DVA contracted Community Nursing provider payments

139. A GP using a DVA contracted Community Nursing provider should be aware of all of the following payment methods and rules for DVA Community Nursing providers so that payments to the providers are not delayed by the actions of the GP:

    a) the GP must have submitted the claim for the Initial Assessment and Program Enrolment Payment and the claim must have been accepted, before a DVA contracted CN provider claim for a CVC item will be accepted and paid

    b) payment to a DVA contracted Community Nursing provider is made via their existing 28 day claim period

    c) a 90 day (quarterly) period of care must be current on at least one day of the DVA contracted Community Nursing provider 28 day claim period

    d) the initial care coordination payment covers the first 28 day period of care coordination commencing after the date the participant was admitted to the CVC Program by the GP

e) acceptance of the Initial Assessment and Program Enrolment Payment claim will enter the participant on the system and will dictate the eligibility for all other payments. It is important that the GP lodges the Initial Assessment and Program Enrolment Payment claim promptly.

Effect of death on periods of care

140. Where a participant death occurs part way through a period of care both these entitlements are true:

    a) the GP is entitled to claim the full amount of the GP 90 day (quarterly) payment, whether that is with or without a practice nurse

    b) the DVA contracted CN provider is entitled to the full amount for the 28 day period in which the death occurred.

Non-payment of claims and resubmitting claims

141. If a claim is received by Medicare and there is an error with the claim, it will be rejected by Medicare and will need to be resubmitted. Payment will not be processed until a new claim is submitted. Any queries about rejected claims should be directed to Medicare in the first instance, contact details are listed below.

142. Should queries about claims need to be directed to DVA following contact with Medicare, an email can be sent to cvcprogram@dva.gov.au

DVA Contact List

General enquiries from GPs and entitled persons

143. GPs can contact DVA for advice using the following contact methods:

Phone	1800 550 457
Email	cvcprogram@dva.gov.au
Postal address	CVC Program
	GPO Box 9998
	Brisbane QLD 4001
CVC Website	CVC Program
CVC Toolbox	CVC Toolbox

144. Entitled persons can contact DVA for general information on the following:

General enquiries	1800 838 372 (1800 VETERAN)
Email	GeneralEnquiries@dva.gov.au

Other DVA health programs and providers

145. Information about DVA's Community Nursing Program is available at:

Community Nursing Website	Community Nursing
Phone	1800 550 457
Email	nursing@dva.gov.au

146. The Panel of DVA contracted Community Nursing providers is available at:

https://www.dva.gov.au/providers/health-programs-and-services-dva-clients/community-nursing/panel-community-nursing

147. Information about DVA's VHC Program is available at:

VHC Website	VHC Program
Phone:	1800 550 457

Queries about claims for payments

148. Telephone queries about payments should be directed to Medicare:

Phone	1300 550 017

149. Written queries and completed claims for payment should be sent to:

Medicare

GPO Box 964

ADELAIDE SA 5001

150. Information about online claiming:

Phone	1800 700 199
Email	ebusiness@servicesaustralia.gov.au

Reporting fraud

151. To report allegations of fraud or report suspected fraud to the Department's Business Compliance Section:

Phone	03 9284 6402
Email	fraudallegation@dva.gov.au

DVA Information

152. A range of information is available for GPs and entitled persons on the DVA website.

Information about the CVC Program for entitled persons is available at Health and Treatment and for providers at Information for providers

Appendix A – Suggested Wording for Obtaining Consent for enrolment in the CVC Program

The following form of words is recommended to obtain informed consent from the person before admitting them to the CVC Program:

> *As part of participating in the CVC Program is the sharing of your relevant medical information with your health care providers to ensure effective collaboration across your Care team. This can include your specialists, pharmacists, allied health providers, community nurse, hospitals, discharge planners and nominated carers. The sharing of relevant medical information allows a common understanding of your condition and treatments and allows everyone to operate as a team to improve your health. Sharing your Care Plan will enable the Care team to work together to assist you in achieving your health goals.*
>
> *In addition,* the information provided to DVA may, from time to time, be shared with third parties for the purpose of providing DVA with data analytics, monitoring, evaluation and reporting for the CVC Program. This includes information on participation numbers, demographics, program utilisation and measuring outcomes and program performance. *DVA may need to access 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 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 medical information and data as I have outlined?* (A yes/no answer will be expected and a record made of the response).