Department of Veterans' Affairs Treatment Cycle Initiative Evaluation

FINAL REPORT

QUEENSLAND UNIVERSITY OF TECHNOLOGY (QUT) Kelvin Grove, Queensland

SECTION 1: INTRODUCTION

Acknowledgements

Acknowledgement of Country

The Department of Veterans' Affairs (DVA) acknowledges the Traditional Custodians of Country throughout Australia. We pay our respects to Elders past and present.

We recognise and celebrate Aboriginal and Torres Strait Islander people as the First Peoples of Australia and their continuing spiritual and cultural connection to land, sea and community (DVA, n.d.-a).

In keeping with the spirit of Reconciliation, QUT acknowledge the Turbal, Jagera/Yuggera, Kabi Kabi and Jinbara Peoples as the Traditional Owners of the lands where QUT now stands—and recognise that these have always been places of teaching and learning.

QUT wishes to pay respect to the Elders—past, present and emerging and acknowledge the important role Aboriginal and Torres Strait Islander people continue to play within the QUT community (Anderson, 2020).

Acknowledgement of Service

The Australian Defence Veterans' Covenant serves to recognise and acknowledge the unique nature of military service and the contribution of veterans and their families (DVA, n.d.-b).

Acknowledgement of Contribution

We acknowledge people with a lived experience of allied health treatment cycle arrangements, their families, friends and supporters. We acknowledge all who provided input into this evaluation process, including current and former serving members of the Australian Defence Force and their families, service providers and professional organisations, the DVA Advisory Group and the QUT Expert Reference Group convened for the purposes of this evaluation.

We also acknowledge the input received from Commonwealth agencies, including representatives from the Department of Veterans' Affairs and Primary Health Networks.

Executive Summary

Evaluation context

In 2018, the Australian Government announced a budget measure to improve DVA's dental and allied health arrangements for the veteran community. The reform package included new treatment cycle arrangements for general practitioner (GP) referrals for allied health services, which came into effect on 1 October 2019.

The purpose of the treatment cycle arrangements is to improve the quality of care for DVA clients and strengthen clinical communication between health care providers. Further, the treatment cycle arrangements aim to better target allied health expenditure by ensuring clinically necessary services for DVA clients.

Under the treatment cycle arrangements, referrals from GPs to allied health providers (AHPs) are valid for up to 12 sessions or a year, whichever ends first. DVA clients may have as many treatment cycles as the GP determines clinically required and can continue to see several AHPs at the same time.

This report aims to evaluate the implementation of the treatment cycle arrangements for allied health referrals and assess whether these arrangements contribute to intended policy outcomes for DVA clients and health service providers. The project was guided by the following evaluation questions:

1. How well have the treatment cycle arrangements been implemented?
2. How have stakeholders engaged with the treatment cycle arrangements?
3. What outcomes have been achieved by the treatment cycle arrangements?

The evaluation examined the operational impacts of the treatment cycle arrangements on clients and providers. Additionally, the evaluation measured changes in service usage patterns and health care expenditure. It explored whether the treatment cycle arrangements improved the quality of care for clients and clinical communication between providers.

Evaluation methodology

Three key participant groups were engaged during the evaluation: GPs, AHPs and DVA clients. The evaluation questions were assessed using the following five methodologies:

- a **national survey** of GPs, AHPs and DVA clients to assess the impact and outcomes of the treatment cycle arrangements and the ways in which stakeholders have engaged with the arrangements, open from 24 November 2020 to 12 March 2021
- in-depth **semi-structured qualitative interviews** with a selection of GPs, AHPs and DVA clients to further explore survey themes and findings, held between 7 January and 12 March 2021
- a **stakeholder feedback survey** to engage with key ex-service organisations and professional associations
- a comprehensive **document analysis** of all DVA communications concerning the treatment cycle arrangements to assess the effectiveness of DVA's communication strategy
- quantitative data analysis of **health service usage (health economics)** throughout the implementation of the treatment cycle arrangements.

Key findings: DVA clients

DVA clients: Experience transitioning to the treatment cycle arrangements

- Overall, half of the DVA clients were either satisfied with (34%), or neutral about (17%) their knowledge of the treatment cycle arrangements. In total, more than half of the clients reported being either positively affected (22%) or not affected (37%) by the treatment cycle arrangements.
- A high percentage of DVA clients reported being confident that they understood the referral changes (62%); however, DVA clients' reported satisfaction with the changes was low (49% disagreed that they were satisfied with the changes).
- Half of the DVA clients surveyed reported that the communication of information relating to the treatment cycle arrangements was easy to understand (53%) and relevant to their needs (50%).

- More than half of DVA clients reported that they were prepared for the treatment cycle arrangements (57%).
- DVA clients were more likely to be positive towards the communication of the treatment cycle arrangements if they were 50 years old or younger. Further, clients 50 years or younger were more likely to report that they found the treatment cycle arrangement information easy to understand and that the information was of high quality and relevant to their needs.
- DVA clients aged over 50 years were slightly more likely to report being negatively affected by the treatment cycle arrangements compared to the younger cohort. DVA clients 50 years or younger were more likely to report being positively affected by the treatment cycle arrangements.
- DVA clients located in Queensland were less likely to report that they have been positively affected by the changes compared to NSW, Victoria and other states. Responses based on gender differences were not statistically significant.

DVA clients: Experience with health care coordination

- Overall, 29% of DVA clients reported that the quality of their interactions with their GP had improved, and a similar proportion of DVA clients (31%) reported that the quality of their interactions with their AHP had improved.
- Half of DVA clients (54%) reported that they felt included in the decision-making process to meet their health care needs as a result of the treatment cycle arrangements. Similarly, 42% of DVA clients reported that their GP reviews the reports, discusses the reports, and seeks their opinion.
- A little less than half of DVA clients surveyed (46%) reported feeling informed about communications, decisions and recommendations between their GP and AHPs.

Key findings: Health care professionals (AHPs and GPs)

Health care professional awareness of the treatment cycle arrangements

- AHPs were more likely than GPs to report being aware of the treatment cycle arrangements before October 2019, with 49% of GPs reporting knowledge of the changes compared to 72% of AHPs.

- Less than half of both AHPs (41%) and GPs (39%) reported receiving information from the DVA about the treatment cycle arrangements before October 2019.
- The majority of GPs (87%) reported consulting DVA clients under the treatment cycle arrangements. Interestingly, 28% of GPs reported being informed about the treatment cycle arrangements from their DVA clients rather than other sources.
- Only 13% of AHPs reported being positively impacted by the treatment cycle arrangements, and 54% of AHPs reported being negatively impacted.
- Half of AHPs disagreed that their DVA clients' health care needs are better met by the treatment cycle arrangements. Further, half of AHPs disagreed that their DVA clients have better access to necessary services to meet their health care needs. A little less than half of AHPs disagreed that their DVA clients receive better targeted support based on their health care needs and that they receive better quality health care overall.
- In contrast to AHP attitudes, GPs reported being more positive towards the treatment cycle arrangements. A little more than half of GPs reported that their DVA clients receive better targeted support based on their health care needs, and that they receive better quality health care overall. In total, 58% of GPs reported discussing DVA clients' health care needs with them in more detail before making a referral to treatment cycle arrangements.
- More than half of GPs (55%) reported that their DVA clients have better access to necessary services to meet their health care needs and that the quality of their interactions with their DVA clients has improved.
- More than half of GPs (59%) reported that the number of interactions with their DVA clients has increased, and 60% of GPs reported that they have more opportunities to discuss and review their DVA client's health care needs with them.

GPs: Care coordination between AHPs and GPs

- Reports of care coordination were relatively high, with 61% of GPs reporting that AHPs provide reports relating to DVA clients. In contrast, 78% of AHPs reported they provide reports to their DVA client's GP.

- Both AHPs (76%) and GPs (73%) reported including DVA clients in the decision-making process about their health care.
- Reports of care coordination between AHPs and GPs appeared to be uneven, with GPs feeling more positive about coordinating clients' health care needs compared to AHPs. Of the GPs, 64% reported there are more opportunities to discuss and review their DVA client's health care needs with their AHP, compared to 30% of AHPs reporting the same with GPs.

Key findings: Health economics

Analysis of health service usage data found a substantial reduction in total cost after the treatment cycle arrangements were implemented (Oct 2019 – Sept 2020) compared with the two previous years. This reduction was repeated in mean annual appointments, mean annual spending and the total number of appointments per client. The restrictions imposed due to COVID-19 since March 2020 may have affected the service utilisation of allied health services. When interpreting the trendlines and reductions observed since implementing the treatment cycle arrangements, it is important to consider the effect of COVID-19 since March 2020.

Principal themes

- **Awareness of the new arrangements before implementation:** In the lead up to implementing the treatment cycle arrangements, DVA developed a comprehensive communication strategy. At the time of implementation, less than 50% of GPs reported awareness of the treatment cycle arrangements. By comparison, close to two thirds (72%) of AHPs were aware of the treatment cycle arrangements before October 2019, and knowledge of the treatment cycle arrangements was high among DVA clients, with 62% of clients reporting awareness.
- **Effectiveness of the DVA communication strategy:** The DVA's pre-implementation communication strategy has achieved moderate reach across the three stakeholder groups (GPs, AHPs and DVA clients). The materials were assessed as generally easy to understand and fit for purpose; however, there is some room for improvement in clients' comprehension of the changes. This is not

unusual for new health care treatment programs, and experience with navigating a new program will improve comprehension over time.

- **Usefulness and clarity of the provider notes and clinical resources:** Document analysis indicated that the materials were generally considered easy to understand but more challenging to implement. The analysis also indicated that visual aids and infographics could improve the understandability of the documents. The actionability of the documents could be further improved by providing tangible tools such as checklists to help stakeholder groups take specific actions.
- **Operational impact of the treatment cycle arrangements on GPs and AHPs:** Surveys and interviews conducted with health care practitioners indicated that opinions about the intended outcomes of the treatment cycle arrangements are mixed and that sufficient time may not have passed to adequately assess the impact of treatment cycle arrangements. However, an examination of AHP provider experiences found some small improvements in both the quantity and quality of interactions with GPs in support of their clients' treatment plans, though there remains considerable room for improvement. Both GPs and AHPs reported that the treatment cycle arrangement are more time-consuming, expensive and complex.
- **Impact of the treatment cycle arrangement on DVA Clients:** Within surveys and interviews, DVA clients reported mixed responses to the impact of the treatment cycle arrangements. Almost 75% of clients reported seeing their GP simply to complete paperwork for the additional referrals rather than discuss their care needs. Cost concerns noted by DVA clients included the perceived increased cost to Medicare due to consultation billing for additional or more frequent referrals, although analysis of the health utilisation data indicated that this is not the case. Clients also raised concerns that they did not have better access to health care services under the changes to the treatment cycle arrangements. Seventy per cent of clients reported the treatment cycle arrangements are now more time-consuming, and 44% noted it was more complex. Despite this, 34% of clients reported that they are more engaged in how their health care needs are met, and 40% of clients reported that they discuss and review their health care needs more often and in more detail with their GP.

- **Change in utilisation patterns and DVA health care expenditure:** The results of health utilisation data analysis demonstrated a substantial reduction in total cost after the treatment cycle arrangements were implemented (Oct 2019 – Sep 2020) compared with the two previous years. This reduction was repeated across mean annual appointments, mean annual spending and the total number of appointments per client. It is likely that public health measures put in place to manage COVID-19 since March 2020 may have affected the service utilisation of allied health services.
- **Improved quality of care:** Overall, GPs and AHPs reported improvements in client communication and care coordination. Younger clients (50 years of age or less) were more likely than the older cohort to report that their health care needs were better met under the new arrangements and that they received better quality of care. AHPs expressed concern regarding their DVA clients' health care needs being met by the treatment cycle arrangements, with 52% of AHPs surveyed indicating that they disagreed that their DVA clients' have better access to necessary services to meet their health care needs.
- **Care coordination:** While DVA clients reported increased communication with their GP, they also felt that most of the burden for care coordination rested on themselves rather than their treatment team. All three stakeholder groups reported feeling responsible for the coordination of DVA clients' health care; it is important to note that all groups felt that they have taken on significant responsibility in care coordination due to the treatment cycle arrangements. This indicates that there may be a disconnect between the perceived coordination of care and the practice of DVA client care coordination between the three groups. There is an opportunity for improved clarity about the role of each stakeholder group under the treatment cycle arrangements to minimise duplication and maximise efficiency.
- **Efficacy of the At Risk Client Framework:** The evaluation found that self-reported knowledge of the At Risk Client Framework among GPs is moderate. DVA clients with chronic and severe health conditions expressed dissatisfaction with the 12-session requirement of the treatment cycle arrangements but did not express awareness or utilisation of the At Risk Client Framework, indicating the possibility that there are clients in need of the framework who are not currently accessing it.

Conclusions and next steps

The evaluation has identified multiple instances of good practice and positive outcomes resulting from the implementation of the treatment cycle arrangements. However, the COVID-19 pandemic has undoubtedly affected access and coordination of services. Many strong views have been expressed across each of the participant groups, which indicates the need for ongoing monitoring of treatment cycle stakeholder outcomes, as well as continual improvement in streamlining administrative requirements of the program. Doubt exists among some DVA clients and health care providers about whether the objectives of the treatment cycle arrangements relating to improved coordination and access to services are being met. However, the 12-session structure was generally accepted as being suitable for acute conditions.

In light of the above findings and conclusions, this evaluation has made the following recommendations for the next steps in the ongoing monitoring and implementation of the treatment cycle arrangements.

Communication

- **Improved, better-targeted GP communication:** This report recommends that more emphasis is placed on the DVA improving the GP understanding of and participation in the treatment cycle arrangements. This includes ongoing communication and consultation with GP-specific channels (such as the RACGP and AMA) with emphasis on GP roles within the referral arrangements. This should include specific information regarding the At Risk Client Framework.
- **Communication with AHPs and clients regarding the purpose of the treatment cycle arrangements:** This evaluation recommends more in-depth and ongoing engagement of veteran's groups and AHP associations regarding feedback about the treatment cycle to improve understanding of and engagement with the treatment cycle arrangements. Ongoing opportunities for stakeholder feedback relating to the treatment cycle arrangements and for targeted communications from DVA to stakeholders about the improved quality of care outcomes may help address the sentiment that the treatment cycle arrangements are a cost-saving measure rather than a health care improvement strategy.

- **Tailored communication methods:** Information tailored to the communication mediums most frequently accessed by different age groups is likely to improve uptake, positive perceptions and comprehension of the treatment cycle arrangements. This targeted group segmentation strategy will ensure that information is shared via the platforms most likely to be accessed by the target stakeholder subgroups. There is an opportunity to implement a targeted strategy in the first instance with veterans aged 50 years and older who appear to have experienced reduced exposure to the information offered by the DVA communication plan.
- **Improved written communications:** Actionability of DVA-provided documents relating to the treatment cycle arrangements should be improved by including tangible tools for readers, such as checklists, to ensure that the user takes specific actions to implement and comply with the treatment cycle arrangements.

Quality of care

- **Treatment cycle compliance monitoring:** This evaluation recommends that a structured monitoring program of GP knowledge and compliance be implemented to ensure GP understanding of treatment cycle arrangements. It is essential that compliance monitoring highlights and addresses areas of common noncompliance via mechanisms to improve communication and feedback from stakeholders. Monitoring should also ensure the continuous improvement of operational processes of the treatment cycle arrangements.
- **Review and communication of coordination of care responsibilities:** Pressure and perceived self-coordination of care was a common theme among DVA clients, especially relating to feeling the need to track the number of sessions with their AHP to ensure their referral was current. These psychosocial impacts should guide further communication of the treatment cycle arrangements. Further review and communication of the intended care coordination structure among GPs, AHPs and DVA clients, along with a clearer outline of the responsibilities of care coordination for the treatment cycle arrangements, is recommended to address these concerns. For example, if the intended outcome of the treatment cycle is for AHPs to track the 12-session allowance, this may need to be better communicated to DVA clients and

health care providers. If the 12 sessions are intended to be tracked by DVA clients, a document or diary outline could be published and provided to clients to assist in their health care coordination.

- **End of Cycle report review:** The findings of this evaluation provide an opportunity to revisit and revise the application, efficiency and relevance of End of Cycle reports for AHP and GP implementation and ensure they are fit for the best DVA client health care outcomes. A working group or similar to review the current uses and applicability of End of Cycle reports is recommended to improve the reports for improved veteran quality of care and health provider communication.
- **Access to required treatment:** Data indicated that total daily spending in very remote areas gradually increased after implementing the treatment cycle arrangements. The evaluation notes the opportunity for monitoring this change over time and investigating the impact of the treatment cycle arrangements in remote areas.
- **At Risk Client Framework review:** The evaluation recommends that the At Risk Client Framework is reviewed to ensure the aims of the framework are being met and that DVA clients and GPs are aware and able to apply the framework where applicable. A review of the current number of DVA clients accessing the framework may indicate whether it is currently appropriately accessed. Considering the inclusion of specific AHP types, such as occupational therapists and podiatrists, who deal with long-term conditions and care, may improve the application of the framework and the effectiveness of veteran care.

Economic impacts

- **Analysis of the economic impact of the treatment cycle for stakeholders:** While health economic analysis indicated that the treatment cycle arrangements resulted in overall savings for the DVA per client, it is important to note that this may be at the cost of increased personal expenses for DVA clients and a higher administrative burden for GPs and AHPs. Further rolling analysis of the economic impact of the treatment cycle arrangements on stakeholders should be undertaken to monitor any potential cost shifts to clients.

- **Ongoing financial savings:** This evaluation recommends that DVA further analyse the financial impact of the treatment cycle arrangements to track ongoing trends and patterns. This could be achieved by analysing the next available financial year of data to track ongoing trends and see if estimated savings have remained consistent with the findings of this evaluation.
- **The impact of COVID-19:** The conclusions made by this evaluation regarding the financial savings made as a result of the treatment cycle arrangements should be further tested and consolidated with additional data to account for the impact of COVID-19. While the analysis accounted as much as possible for the impact of the pandemic, further analysis of health usage data will improve our understanding of the impact of COVID-19 on health care access and financial savings concerning the treatment cycle arrangements.
- **Financial remuneration for health care providers:** The administrative burden and cost increases reported by health care providers was an important finding of this evaluation. Addressing the administrative burden on DVA clients and their health care providers through initiatives such as financial remuneration for administrative tasks tied to the treatment cycle arrangements may ensure maximal benefits for all stakeholder groups.

The QUT evaluation team

Table 1.1: QUT evaluation team

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About this document

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Abbreviations

ABS	Australian Bureau of Statistics
ADF	Australian Defence Force
AHP	Allied health provider
AMA	Australian Medical Association
ASGS	Australian Statistical Geography Standard
DVA	Department of Veterans' Affairs
ESO	Ex-service organisations
GEE	Generalized estimating equation
GP	General practitioner
Health providers	Medical (GP) and allied health providers
PEMAT-P Materials	Patient Education Material Assessment tool for Printable
PHN	Primary health networks
QUT	Queensland University of Technology
RACGP	Royal Australian College of General Practitioners
REPOC	Research ethics point of contact
TPI	Totally and permanently incapacitated

Key definitions

For the purposes of this project, the following definitions will be used:

Engagement: number and quality of interactions

Operational impact: measure of change in experience related to time, energy, cost and/or administrative requirements

Quality of care: the quality of service provision to meet health needs

Clinical resources: generic templates provided to GPs and AHPs by DVA (publicly available)

Care coordination: the act of the clinical and administrative oversight of an individual's care across all health practitioners for all health conditions for that individual

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Introduction

Context for this evaluation

In 2018, the Australian Government announced a budget measure to improve the Department of Veterans' Affairs (DVA) dental and allied health arrangements for the veteran community. The reform package included treatment cycle arrangements for general practitioner (GP) referrals for allied health services, which came into effect on 1 October 2019.

On 29 April 2020, DVA released a Request for Quotation (RFQ) to evaluate the treatment cycle arrangements. Queensland University of Technology (QUT) submitted a response to the RFQ that satisfied all criteria established in the statement of requirements and met all conditions set out in the deed of standing offer. In June 2020, QUT was contracted by DVA through an open competitive tender process to undertake an evaluation of the change to the treatment cycle arrangements. QUT then undertook a formative evaluation of the treatment cycle arrangements, which examined the implementation and impact of recent changes to allied health arrangements for DVA clients.

The aim of this project was to evaluate the implementation of the treatment cycle for allied health referrals and assess whether these arrangements contribute to the intended policy outcomes for DVA clients and health service providers. The project was guided by a series of evaluation questions, which are discussed in the evaluation methodology section.

This evaluation investigated the impact of recent changes to allied health arrangements for DVA clients, GPs and Allied Health Providers (AHPs), as well as data from stakeholders within veteran and health care community organisations. The evaluation is specific to the health arrangements affected by the treatment cycle arrangements, specifically chiropractic, clinical or general psychology, diabetes education, dietetics, exercise physiology and physiotherapy, neuropsychology, occupational therapy (including mental health), orthotics, osteopathy, podiatry, social work (including mental health) and speech pathology. Dental, optical and counselling through Open Arms are excluded, as these services are not included under the

treatment cycle arrangements. The evaluation questions that directed data collection are as follows:

Evaluation questions

1. How well have arrangements been implemented?
    a. the usefulness and clarity of provider notes and clinical resources
    b. the operational impact of the treatment cycle on general practitioners and AHPs
    c. the experiences of DVA clients transitioning to the new treatment cycle—this should compare the experience of various demographics and different segments of the treatment population
    d. the effectiveness of DVA's communication strategy in educating stakeholders and ensuring compliance with treatment cycle arrangements.
2. How have stakeholders engaged with the arrangements?
    a. changes in service usage patterns
    b. changes in DVA health expenditure resulting from the treatment cycle.
3. What outcomes have been achieved by the arrangements?
    a. whether the treatment cycle has improved quality of care and increased GP engagement in allied health interventions
    b. whether the goal of improving client care coordination and ensuring access to clinically required treatment has been achieved
    c. the efficacy of the At Risk Client Framework in supporting vulnerable clients with complex care needs.

The evaluation examined the operational impacts of the treatment cycle on clients and providers to answer the evaluation questions. Additionally, the evaluation measured changes in service usage patterns and health care expenditure, and it explored whether the treatment cycle improved the quality of care for clients and clinical communication between providers.

Evaluation methodology

A series of parallel methodologies were undertaken for the evaluation (see Figure 1.1):

- a **national survey** of GPs, AHPs and DVA clients to assess the impact and outcomes of the treatment cycle arrangements and how stakeholders have engaged with the arrangements, open from 24 November 2020 to 12 March 2021
- in-depth **semi-structured qualitative interviews** with a selection of GPs, AHPs and DVA clients to further explore survey themes and findings, held between 7 January and 12 March 2021
- a **stakeholder feedback survey** to engage with key ex-service organisations (ESOs) and professional associations
- a comprehensive **document analysis** of all DVA communications concerning the treatment cycle arrangements to assess the effectiveness of DVA's communication strategy
- quantitative data analysis of **health service usage (health economics)** throughout the implementation of the treatment cycle arrangements.

Detailed results from each of these methodologies are contained in the relevant sections of this report.

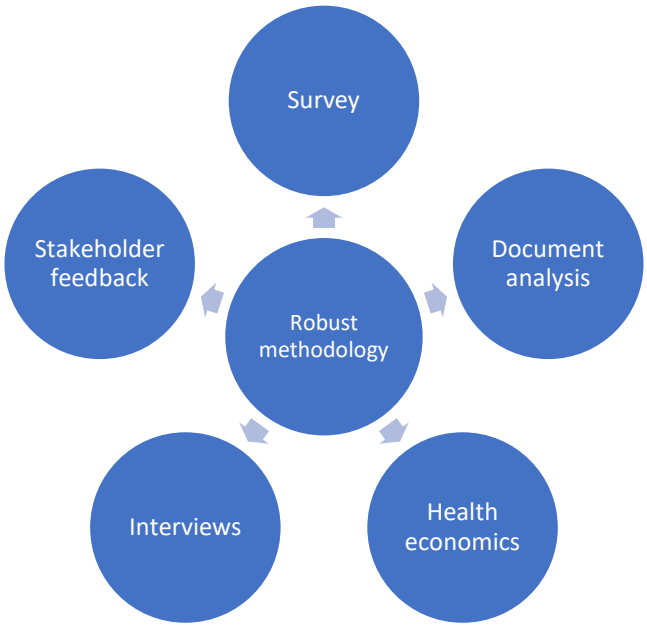


Figure 1.1: Evaluation methodology

Evaluation framework

The evaluation engaged three core informant groups: GPs, AHPs, and DVA clients (see Figure 1.2).

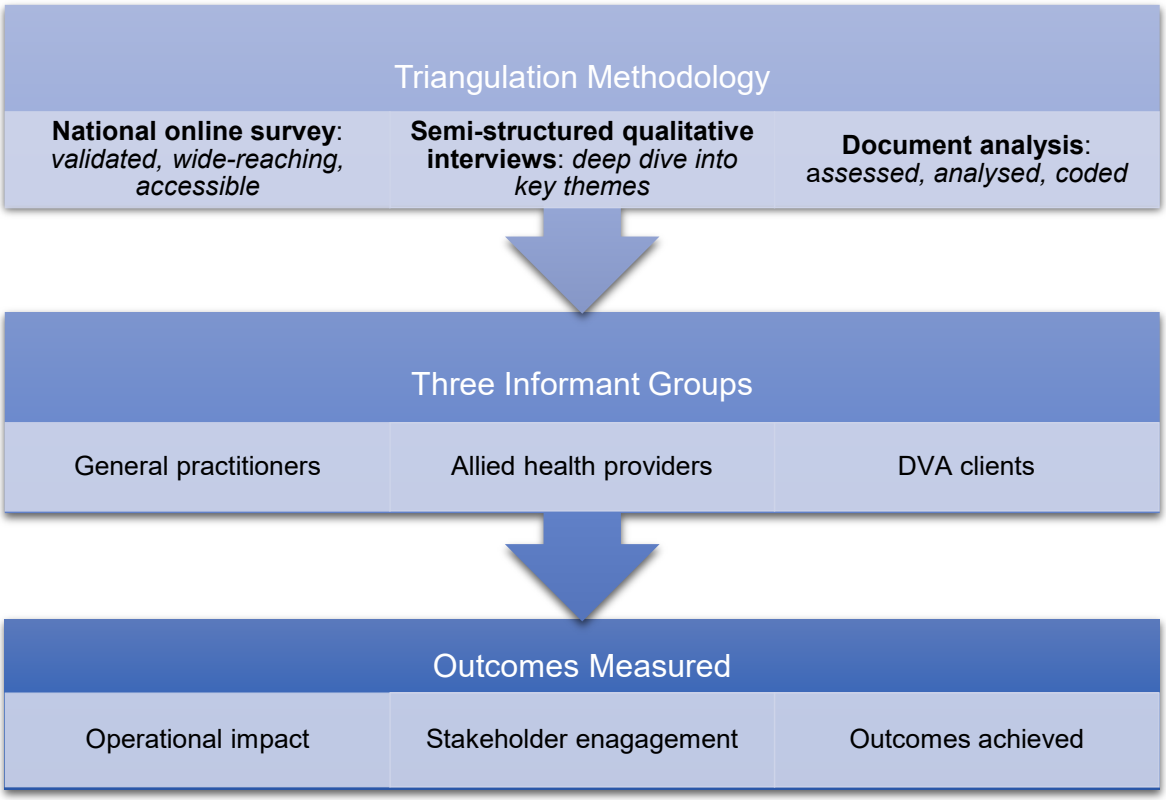


Figure 1.2: Evaluation framework

Ethics

To meet the ethical requirements of the Departments of Defence and Veterans' Affairs Human Research Ethics Committee (DDVA HREC), the team completed and submitted the quality assurance and evaluation activity checklist. All survey questions, participant information sheets, and recruitment materials were submitted as required. The DDVA HREC deemed this project an 'evaluation activity', which, therefore, does not require ethics approval outside the quality assurance and evaluation activity checklist, which is consistent with the National Statement.

As a result of the submission, DDVA HREC confirmed that the guidance 'Ethical Considerations in Quality Assurance and Evaluation Activities, NHMRC 2014' had been applied in preparation for and in conducting of this body of work, with consideration to the individuals who were approached to participate, and this has

been acknowledged by the DDVA HREC. It was confirmed that, as an evaluation activity, no further ethical approval was required.

Complexity of allied health care provision and funding

The complexity of the healthcare system, and the DVA's position as a health care funder, cannot be underestimated. Health resource allocation is fraught with competing aims, where budgets and resource allocation compete with the best clinical outcomes for patients and access to services. The wider Australian health system also battles with similar issues, with rapid urbanisation and continuing inequitable access to health for sections of the population such as Indigenous Australians (Macri, 2016). The changing demographics of the Australian veteran population are an additional issue that adds to the intricacy of DVA funding and health provision. The number of older veterans within the veteran population is declining, and the changing nature of military conflicts has resulted in a population with different treatment needs compared to those in earlier conflicts (Productivity Commission, 2019). As the veteran population changes over time, DVA must balance access, relevance, efficiency and effectiveness in delivering its programs to ensure good quality health outcomes for clients requiring assistance and support.

The US Department of Veterans' Affairs (VA) faced similar issues regarding veterans' access to care and the quality of care delivered. Congress enacted the '*Veterans Access, Choice, and Accountability Act of 2014*' to address access issues by expanding the criteria for veterans to seek care from civilian providers (Farmer et al., 2016). Given that the VA system is very different from DVA, such as VA running their own veteran-specific hospitals for inpatient and outpatient care, the conclusions drawn from the 2014 Act cannot be replicated in an Australian context. However, it is useful to note that government veteran departments are experiencing similar problems across the world.

In the Australian setting, Medicare and the National Disability Insurance Scheme (NDIS) are two funders that deal with the complex nature of allied health provision to a large treatment population. The different ways in which these schemes have approached allied health provision are outlined below. Other national funders of allied health provision, such as My Aged Care, private health insurance, Primary

Health Network programs, and community health services, are too dissimilar to DVA for comparison in this report.

Similar to DVA, NDIS has qualifying criteria for their treatment population: for allied health treatment to be approved under the NDIS, it must be deemed necessary as part of the participant's daily life and result directly from the participant's disability (National Disability Insurance Agency [NDIA], 2021a). Funding is based on an individual needs basis following an independent assessment, in line with the participant's own identified goals (NDIA, 2021a). As of 31 December 2020, the scheme had just under 433,000 active participants with approved plans (NDIA, 2020). As of that date, $28,203 million total committed supports and $9,824 million total payments had been made (note there is a lag between when support is provided and when it is paid) (NDIA, 2020). The NDIS requires allied health practitioners who provide services under their scheme to report on their patient plans to ascertain whether it meets their reasonable and necessary criteria (NDIA, 2021aa). The NDIS provides report writing tips but no forms or templates for reporting.

Medicare provides allied health services to clients following a GP referral (AHPA, n.d.). All Australian residents (inclusive of citizens and permanent visa holders) are eligible to access Medicare (Biggs, 2016). Unlike services provided under DVA and the NDIS, practitioners may choose to set their own fees for service: the 'gap' between the amount Medicare pays for a service and what the practitioner charges is borne by the patient (Biggs, 2016). The Department of Health (2021) report that in 2021 the average patient contribution to cover the 'gap' is $72.75. The number of Medicare-funded visits allowable each year is capped, and that capped number differs between allied health services. The capped number of services also differs based on the chronic health status of patients and other qualifying criteria, such as Indigenous status. Under the Medicare scheme, AHPs need to provide patients' reports to the referring GP following the first and last service (more often if deemed clinically necessary).

Given the complexity of DVA funding with access to 16 different allied health specialties across hundreds of thousands of health care interactions, with tens of thousands of providers, there will inevitably be pressures and challenges in ensuring

the best possible care that meets all needs at the right time in the right way. To some extent, trade-offs may need to be made. An appropriate trade-off may be aiming to promote administrative simplicity and minimising the burden of administrative overheads on health care professionals while ensuring quality of care with robust regulatory structures.

About the veteran community in Australia

As of December 2020, DVA reported their treatment population as 257,211 clients. DVA has estimated that the treatment population will increase to 300,500 by 2023 and 310,900 by 2030 (DVA, 2019a). The inclusion of a veteran identifier question in the 2021 Census may better indicate the number of veterans in the community, but as this will be self-reported data, it will not be conclusive (DVA, 2019a).

The treatment population consists of veterans and dependents who have been issued a Gold or White card entitling them to medical and other treatments at the department's expense under the *Veterans' Entitlements Act 1986*, *Military Rehabilitation and Compensation Act 2004*, *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*, *Australian Participants in British Nuclear Tests and British Commonwealth Occupation Force (Treatment) Act 2006* or *Treatment Benefits (Special Access) Act 2019* (DVA Data and Insights Branch, 2020).

About veterans' health in Australia

Veterans and their families are an important population group for health and welfare monitoring as the unique nature of service in the Australian Defence Force (ADF) promotes protective factors and risk factors that affect health and welfare outcomes (see Table 1.2). While the number of women serving in the ADF continues to increase, women currently account for 18% of all ADF personnel (Roy Morgan, 2020). As such, much of the information and data regarding veteran health are skewed towards males.

Table 1.2: Protective and risk factors for veterans

Protective factors	Risk factors
Maintain physical fitness	Exposure to trauma
Regular health and fitness assessments	Prolonged isolation
Access to health care	Overseas deployments
Access to welfare services	Changes in social support
Stable employment	Frequent relocation
Secure finances	Transitioning from military to civilian lifestyle

About veterans' health care in Australia

Once an ADF member transitions from military to civilian life, health care services are available under the same conditions that apply to other Australians, including Medicare, State and Territory government health arrangements and private sector services. Veterans may also be entitled to support administered or funded by DVA for some health conditions. This support consists of a range of pensions, compensation and income support payments, as well as health and welfare services (including medical, dental, allied health, specialist services, hospitals, pharmaceuticals, rehabilitation, counselling, transport and home care). Dependants such as partners, widow(er)s or children of veterans may also be entitled to certain DVA payments and benefits, depending on their circumstances. DVA funding of health care for entitled veterans is 'demand-driven and uncapped'—this means that the Australian Government increases health care funding if needed (DVA, 2020b).

About the allied health treatment cycle arrangements

On 1 October 2019, referrals from GPs to AHPs changed for DVA clients. Under the treatment cycle arrangements, referrals from GPs to an AHP are valid for up to 12 sessions or a year, whichever ends first. DVA clients may have as many treatment cycles as the GP determines clinically required and can continue to see several AHPs at the same time.

There are 16 recognised allied health service types available through the treatment cycle arrangements:

1. Chiropractic
2. Clinical psychology
3. Diabetes education
4. Dietetics
5. Exercise physiology
6. General psychology
7. Physiotherapy
8. Neuropsychology
9. Occupational therapy
10. Occupational therapy mental health
11. Orthotics
12. Osteopathy
13. Podiatry
14. Social work
15. Social work mental health
16. Speech pathology

At Risk Client Framework

The At Risk Client Framework sits within the allied health treatment cycle arrangements and gives GPs the option to provide a more tailored referral arrangement specific to the veteran's health needs (DVA, 2019b). Options available include allied health referrals that are valid for three, six or twelve months. The GP may also, if eligible, enrol the veteran Coordinated Veterans' Care program, which is for a specific cohort of veterans with severe and complex health needs (DVA, n.d.-c).

The At Risk Client Framework referral does not need approval from DVA; if the clients usual GP determines that a veteran meets the criteria, they can complete the DVA assessment form, and the veteran can access the allied health services needed for the timeframe they have been allocated. The usual end-of-cycle reporting requirements remain.

Totally and Permanently Incapacitated veterans

A veteran who is severely disabled and unable to partake in an otherwise normal working life due to permanent incapacity resulting from their ADF service may be classed as totally and permanently incapacitated (TPI) (Tune, 2019). TPI veterans receive payments, benefits and access to health care in a way that differs from other veterans with accepted claims through DVA.

The allied health treatment cycle does not apply to TPI veterans who are accessing physiotherapy or exercise physiology. TPI veterans must have an annual or indefinite referral to these services from their GP, and the 12-session reporting policy

does not apply (DVA, n.d.-d). TPI veterans must adhere to the allied health treatment cycle arrangements to access all other AHPs.

Purpose of the treatment cycle arrangements

The purpose of the treatment cycle arrangements is to:

1. improve the **quality of care** for DVA clients and **strengthen clinical communication** between health care providers by:
    a. promoting an increase in the opportunities for GPs and AHPs to **provide coordinated care** (increased GP engagement, increase in GP visibility of clinical goals and progress)
    b. fostering **regular communication** between treating professionals at the beginning and end of a treatment cycle (providing a model of care that supports collaboration and communication between treating health professionals and better coordination of care for complex patients)
    c. providing more opportunities to **review clinical goals and outcomes** for the individual veteran
2. provide better, **targeted allied health expenditure** by ensuring clinically necessary services for DVA clients by:
    a. ensuring veterans' access to **clinically required treatment**
    b. increasing the GP's role in assessing the **appropriateness of ongoing treatment** across one or more modalities in conjunction with the AHPs.

Figure 1.3 visually demonstrates the application of the treatment cycle referral arrangements and utilisation of allied health services.

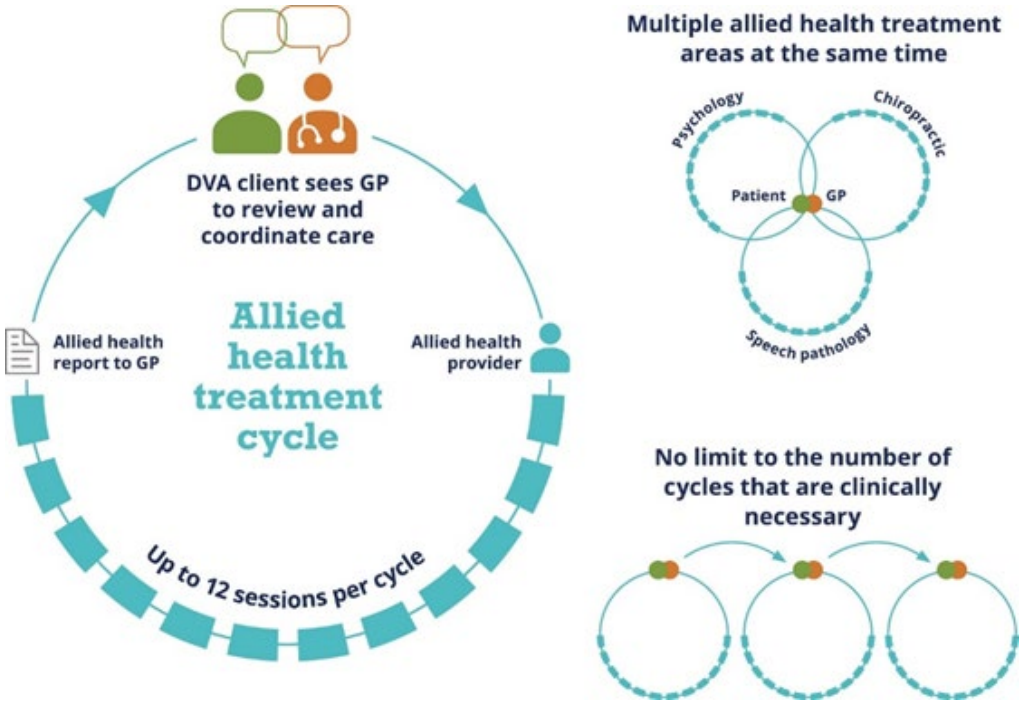


Figure 1.3: DVA infographic to describe the treatment cycle arrangements

Previously, referrals were valid for 12 months or indefinitely for ongoing conditions. The treatment cycle arrangements aim to improve the quality of care for DVA clients by supporting better coordination and communication between GPs, AHPs and clients. The differences between referral arrangements are detailed in Table 1.3.

Table 1.3: Comparison of previous and current referral arrangements

#	Previous referral arrangements	Current referral arrangements
1.	The DVA client talks to the GP about their health needs.	The DVA client talks to the GP about their health needs.
2.	The DVA client receives a referral for an AHP from the GP.	The DVA client receives a referral for an AHP from the GP.
3.	The referral is valid for 12 months or indefinitely for ongoing conditions.	The referral is valid for 12 sessions (one cycle) or 12 months (whichever ends first).
4.	Unlimited sessions are available to meet the DVA clients' health needs.	Unlimited cycles are available to meet the DVA client's health needs.
5.	If the referral was for 12 months, the GP consults the DVA client to decide if another referral is needed for additional treatment (usually another 12 months).	The AHP writes a report on the health outcomes and sends the report to the GP.
6.		The GP reviews the report on the DVA client's health outcomes and consults the DVA client to decide if another referral is needed for additional treatment cycles.

SECTION 2: METHODS

Translating the evaluation methodology

The multiple research methodologies chosen for this evaluation were designed to capture a wide range of experiences from those affected by the treatment cycle arrangements. When collecting qualitative data, it is important to acknowledge that respondents are reporting their experiences of health care provision within their own lived context. The evaluation presents the experiences of all respondents who participated in the project, but acknowledge that these experiences should be contextualised within the larger framework of the Australian health care system, DVA's complex position as a health care funder and the lived experiences of individuals participating in the treatment cycle arrangements.

Any data presented from the surveys or interviews must be considered carefully and not taken as generalisable of all experiences for that cohort. Some respondents took the survey and interviews as an opportunity to air their grievances with the wider DVA system; while valid and important, the responses did not always pertain specifically to the treatment cycle arrangements being evaluated.

Survey methodology

Survey design

An online mixed-methods questionnaire was developed to seek feedback from GPs, AHPs and DVA clients. The 165-item questionnaire was administered via QUT's Key Survey online data collection program.

The survey was designed to capture quantitative and qualitative data to answer the evaluation questions. In addition, several design elements were considered and controlled for, such as willingness to engage, distress, privacy, data storage, complaints and eligibility. These are discussed in more detail below (see Table 2.1).

Table 2.1: Survey design strategy

Issue	Management strategy
Participant willingness to engage	Participation was entirely voluntary; informed consent was obtained; participants were encouraged to self-exclude if necessary (i.e., possible distress). Participants could withdraw at any time by exiting the survey or withdrawing consent during the interview.
Participant distress	Participants were encouraged to contact the following support services if needed: • Open Arms—Veterans & Families Counselling 1800 011 046 • QUT Psychology Clinic 07 3138 0999 • LifeLine 13 11 14 • QUT evaluation team 07 3138 0737 These details were provided before each survey and interview and on the project website.
Privacy, confidentiality and anonymity	Survey responses were anonymous (no identifying information was obtained). Interviews were transcribed and de-identified for reporting and analysis purposes.
Data storage and use	Data were stored on password-protected computers and saved on the secure QUT server, only accessible by the evaluation team. Data are stored and archived for 7 years per QUT research protocols. Data would only be used anonymously in writing the final evaluation report (for DVA internal purposes only). No data would be publicly reported or published by QUT.
Complaints and concerns	Participants were encouraged to contact the evaluation team or the DVA Research Ethics Point of Contact (REPOC) with complaints or concerns.

SECTION 2: SURVEY METHODOLOGY

Participant eligibility

Inclusion criteria for surveys

The inclusion criteria for the survey and interview elements of the evaluation were that participants were over 18 years old and one of the following:

- a DVA client that has accessed at least one treatment cycle for relevant allied health treatment
- a GP that has referred at least one DVA client to an AHP to commence a treatment cycle
- an AHP that has commenced at least one treatment cycle with a DVA client for one of the recognised service types.

Exclusion criteria for surveys

The following exclusion criteria are based on the same exemptions listed on the DVA website (DVA, 2020c). Participants were not eligible to contribute to this evaluation if they only accessed or provided one or more of the following treatment types:

- dental services
- optical services
- hearing services
- counselling services with Open Arms—Veterans & Families Counselling
- therapies that have other treatment limits.

Draft survey validation

Questions were developed to provide data on the impacts of the treatment cycle arrangements, perceptions of quality of care, care coordination, participant attitudes of the treatment cycle processes, provider notes and clinical resources. Questions were drafted and submitted to DVA for review. Upon successful review, the questions were further validated by volunteers from each interest group (one DVA client, GP and AHP).

Online tool used

Key Survey software was used to develop and distribute the survey to DVA clients, GPs and relevant AHPs. The survey flow was designed so that there were three distinct subsets of questions tailored to capture the opinions and experiences of all

three populations. Participants accessed the survey through one link, which directed participants to the relevant questions by selecting whether they were a DVA client, GP or AHP. Data were collected between 24 November 2020 and 12 March 2021.

Question structure

The survey collected quantitative data with some qualitative response options. A range of question types was used, such as Likert scales, multiple-choice selection and qualitative questions. The survey collected general demographic data but did not collect any individually identifiable information to protect participant anonymity. The number and type of questions per participant group is detailed in Table 2.2. A copy of the survey questionnaire can be found in Appendix 1.

Table 2.2: Question type and number of questions per participant group

Type and number of questions	DVA clients	GPs	AHPs
TC awareness and information	11	12	12
Allied health services	1	1	1
COVID-19 impacts	7	6	7
Transition to TC	2	2	2
Impacts and interaction changes	2	2	2
Quality of care	8	8	8
Care coordination (client and GP)	5	5	N/A
Care coordination (client and AHP)	8	N/A	5
Care coordination (GP and AHP)	6	9	9
Care coordination	1	6	6
Other impacts	1	1	1
At Risk Client Framework efficacy	N/A	8	N/A
Total questions	**52**	**60**	**53**

Note: TC: Treatment cycle

Participant recruitment

The evaluation team conducted an online search to identify relevant veteran and health care organisations to approach, which was confirmed when DVA provided the communication strategy they had previously used. The survey was distributed by email to various ESOs, veterans' associations, professional health associations,

primary health networks (PHNs), state hospitals and health services. In addition, the survey was promoted through DVA communication channels (refer to Table 2.3).

The survey was further promoted to veterans and relevant health providers by community organisations and public health services via social media, websites, and online newsletters. In addition, the evaluation team engaged two paid recruitment agencies to specifically target GPs due to low engagement from the GP participant group in the early stages of recruitment. AMPco and PureProfile were engaged in February 2021.

Table 2.3: Recruitment strategy for organisation engagement

Organisation type	Participant type	# Contacted
ESOs and veterans' associations	DVA clients	47
Medical associations and practices	GPs	86
Allied health associations	AHPs	24
State hospital and health services	GPs and AHPs	24
Primary health networks	GPs and AHPs	30
Total		**211**

Participant sample sizes

The following population and sample sizes are representative of all registered practising GPs, specialist practitioners and AHPs in Australia. The relevant population and sample sizes for clients, GPs and AHPs may differ from those reported below as not all DVA clients, GPs and AHPs will be involved in transitioning to and implementing the allied health treatment cycle arrangements.

The following population sizes for GPs and AHPs were obtained from data reported by the Australian Health Practitioner Regulation Agency (Ahpra) and were current as of June 2020 (Australian Diabetes Educators Association, 2019; Australian Orthotic Prosthetic Association, 2012; Chiropractic Board Ahpra, 2020; Dietitians Association of Australia, n.d.; Deloitte, 2016; Medical Board Ahpra, 2020; Occupational Therapy Board Ahpra, 2020; Osteopathy Board Ahpra, 2020; Parliament of Australia, n.d.; Physiotherapy Board Ahpra, 2020; Podiatry Board Ahpra, 2020; Psychology Board Ahpra, 2020). The population size for DVA clients (treatment population) was obtained from the DVA website and was current as of June 2020 (DVA Data and

Insights Branch, 2020). The following sample sizes were calculated using the population size with a confidence interval of 95% and a margin of error of 5% (Qualtrics, n.d.). See Table 2.4 for population size, proposed sample size and actual sample size.

Table 2.4: Population sample sizes

Population type	Population size	Sample size	Actual sample
DVA clients	243,215	384	399
GPs	104,097	382	148
AHPs	154,594	384	441
Total	**501,906**	**1150**	**988**

Expression of interest

The survey was voluntary and anonymous as no personal details were collected as part of the data. At the end of the survey, participants were directed to a separate page with an option to express interest in being contacted for an interview. This will be discussed in more detail in the interview methodology section.

Survey demographics

There was a total of 988 survey responses collected, consisting of 399 DVA clients, 148 GPs and 441 AHPs (see Table 2.5). Total responses were evenly distributed by gender (43% female, 56% male); however, when dividing by gender and participant type, females were less represented in the DVA client (23%) and GP (35%) populations. This reflects the general distribution of gender in these populations, with 27% of DVA clients in 2020 being female (DVA, 2020d) and 45% of GPs practising in Australia being female (Royal Australian College of General Practitioners [RACGP], 2018). Females were more highly represented in the AHP population (65%). Survey data were captured from all Australian states and territories, representing 586 unique postcodes across regional and metropolitan areas (refer to Figure 2.1).

Table 2.5: Participant age and gender

Participant type	Female		Male		Not stated	Total	Age range	Mean
	N =	%	N =	%	N =			
DVA clients	92	23	306	77	1	399	20–97	59
GPs	52	35	96	65	0	148	21–78	44
AHPs	285	65	148	34	8	441	21–68	39
Total	**429**	**43**	**550**	**56**	**9**	**988**		

Note: All percentages are rounded to the closest whole number

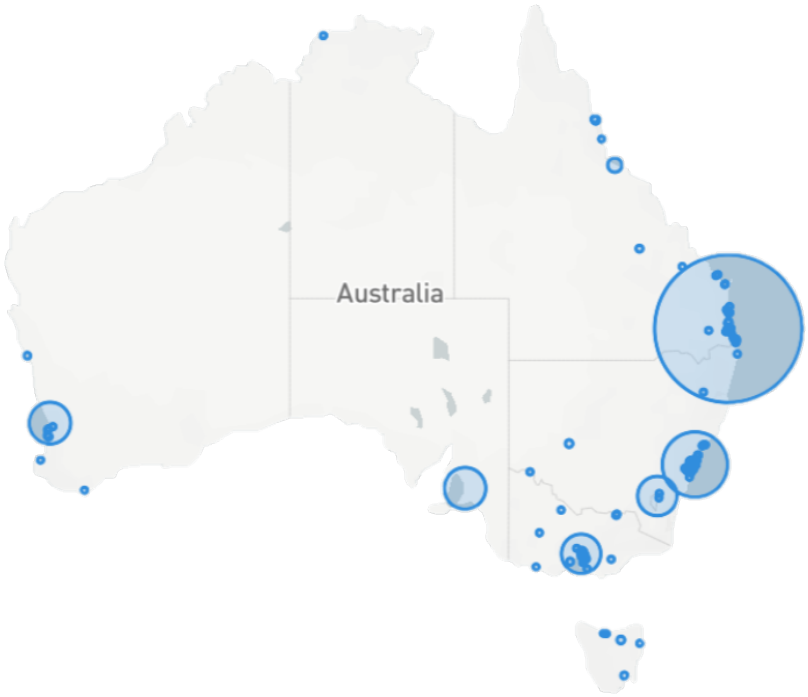


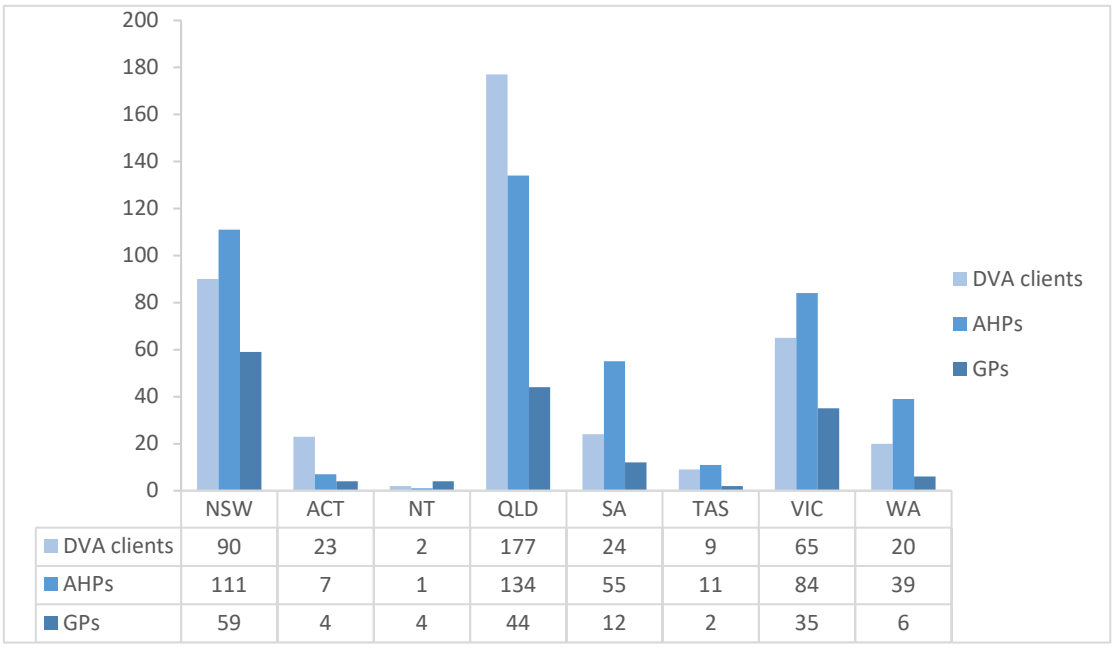
Figure 2.1: Map of survey participant distribution across Australia

The majority of data captured across the participant groups were from Queensland residents (n = 355), with New South Wales (n = 260) and Victoria (n = 184) also representing significant numbers of participants. Veterans were represented across their usual state or territory of residency, as demonstrated in Table 2.6 and Figure 2.2 (DVA Data and Insights Branch, 2020).

Table 2.6: DVA treatment population by state or territory and age

DVA clients by state or territory			DVA clients by age group		
Region	**n =**	**%**	**Age range**	**n =**	**%**
NSW/ACT	79,658	31	< 60	114,981	45
QLD	79,682	31	60–69	33,073	13
SA/NT	24,082	9	70–79	53,790	21
TAS	6,712	3	80–89	24,234	9
VIC	41,129	16	90 >	31,132	12
WA	24,359	10			
Total	**257,211**	**100**	**Total**	**257,211**	**100**

Note: Overseas residents were included in total but not reported. ACT and NT were included within NSW and SA, respectively. Unknown ages were included in the total but not reported separately. All percentages are rounded to the closest whole number.



	NSW	ACT	NT	QLD	SA	TAS	VIC	WA
DVA clients	90	23	2	177	24	9	65	20
AHPs	111	7	1	134	55	11	84	39
GPs	59	4	4	44	12	2	35	6

Figure 2.2: Survey participant numbers by state or territory and group

AHPs were represented across all 16 allied health service types funded by DVA and are detailed in Table 2.7.

Table 2.7: AHPs by service type

Service type	n =	Service type	n =
Chiropractors	20	Orthotists	2
Clinical psychologists	11	Osteopaths	13
Diabetes educators	8	Physiotherapists	86
Dietitians	22	Podiatrists	117
Exercise physiologists	44	Psychologists	14
Neuropsychologists	1	Social workers	9
Occupational therapists	50	Social workers (mental health)	12
Occupational therapists (mental health)	3	Speech pathologists	10

Interview methodology

Interview design

Semi-structured interviews were implemented as a qualitative methodology to complement the quantitative survey data. Semi-structured interviews were chosen to capture rich data that reflect the experiences and opinions of participating medical professionals, service providers and DVA clients. The use of qualitative interviews allowed in-depth exploration of factors and themes that may not otherwise be captured by the survey methodology (DeJonckheere & Vaughn, 2019; Dempsey et al., 2016).

The interview questions were designed to complement the topics of the survey while allowing for deeper exploration of key concepts (see Appendix 3 for the complete list of interview questions). The questions were designed to expressly address the evaluation questions, namely, how well the arrangements were implemented according to DVA clients, GPs and AHPs and how the stakeholders engaged with the treatment cycle arrangements.

The interview questions were written by one research assistant and reviewed and approved by the wider research team prior to validation. The interview processes, including recording software and technology, were tested and validated among research team members before being implemented.

Eligibility

Inclusion criteria for interviews

Inclusion criteria were the same for the survey and interview elements of the evaluation. Participants were required to be over 18 years old and one of the following:

- a DVA client that has accessed at least one treatment cycle for relevant allied health treatment
- a GP that has referred at least one DVA client to an AHP to commence a treatment cycle

- an AHP that has commenced at least one treatment cycle with a DVA client for one of the recognised service types.

Exclusion criteria for interviews

The following exclusion criteria are based on the same exemptions listed on the DVA website (DVA, 2020c). Participants were not eligible to contribute to this evaluation if they only accessed or provided one or more of the following treatment types:

- dental services
- optical services
- hearing services
- counselling services with Open Arms—Veterans & Families Counselling
- therapies that have other treatment limits.

Participant recruitment

Eligible participants for the semi-structured interviews were DVA clients, GPs or AHPs that had met the eligibility requirements for and subsequently completed the online survey. Upon completing the survey, participants were directed to a separate webpage to capture their willingness to be contacted for the interviews. This expression of interest was not linked to their survey responses to ensure anonymity. Participants had to provide valid contact information in their expression of interest. The evaluation team contacted eligible participants to schedule a mutually agreeable time and date for the interview.

A total of 115 participants expressed interest to be interviewed. Fourteen chose to opt out following initial contact, and 50 participants did not respond to initial or follow-up contact. Six participants were denied an interview as their responses were received outside the timeframe for inclusion in the report.

A total of 42 participants were interviewed (see Table 2.8) from all Australian states and territories except Tasmania. See Figure 2.3 for the geographic location of interview participants. Of the 13 AHPs interviewed, there were five occupational therapists, two osteopaths, two exercise physiologists, three podiatrists and one dietician.

Figure 2.3: Interview participant geographic location

Table 2.8: Interview participants

DVA clients	GPs	AHPs	Total
26	3	13	**42**

Evidence indicates that the primary themes identified within a qualitative analysis are frequently uncovered within the first 10 interviews (Guest et al., 2006; Hennink et al., 2017), and this was supported by saturation of themes being reached with DVA client and AHP interview data. Saturation was not reached with GP interview data, and this is addressed within the project limitations.

Interviews (n = 42) were conducted between 7th January and 12th March in 2021, primarily utilising an online web conferencing platform (Zoom). A small number of clients were interviewed via telephone, as was their personal preference. All interviews were audio-recorded. All interviews were conducted by one research associate, who holds tertiary qualifications in psychology and qualitative data collection methods.

Interviews were voluntary and could be discontinued at any time by the participant withdrawing consent. The interviewer gained express consent from the participant immediately before proceeding with the interview. Interviews had no fixed length and

were subject to what the participants shared in terms of the depth of their opinions and experiences. Most interviews ranged between 20 to 40 minutes, with a small number exceeding 60 minutes. While there was a pre-approved list of guiding questions, the interview process was semi-structured in the timing and order of questions asked. Depending on the responses given by participants, the researcher probed further on some topics or excluded some questions based on the relevance to the participant's described experiences.

Data analysis

Interview data were de-identified and professionally transcribed. Data were analysed by three members of the team for initial themes using thematic content analysis (Burnard et al., 2008; Miller & Crabtree, 1999). Thematic analysis was chosen as the most appropriate method as it allowed the team to fully explore the concepts as reflected in the data without the requirement of a theoretical model (Burnard et al., 2008). Data were organised and thematically coded using NVivo v12 software.

After initial themes were identified, a research assistant developed a coding scheme and applied this to all interview data. This coding scheme was used to summarise and categorise all themes present in the interviews and allowed the team to identify overarching themes that were present in the data. These themes were reviewed and second-coded by one of the Chief Investigators (CIs). Once the second coding was complete, themes were analysed and reported, with relevant quotes extracted from the interview data to further support the analysis.

Stakeholder feedback methodology

Survey design

The stakeholder feedback survey was designed to capture the broad opinions of stakeholders that may have been affected by the treatment cycle arrangements. The feedback was qualitative and designed to be provided at an organisational and community level. Data were collected between 24 November 2020 and 12 March 2021.

Structure of questions

The questions were structured to elicit similar information from individual respondents but at an organisational level. The questions were purposefully written to align with the treatment cycle evaluation questions. The survey asked some basic demographic questions and then asked respondents to answer four questions about the treatment cycle arrangements and their organisation's opinions of their implementation (see Appendix 5 for the complete stakeholder feedback form):

1. In your opinion, how well have the treatment cycle arrangements been implemented?
2. In your opinion, how effective has DVA's communication strategy been in educating stakeholders about the treatment cycle arrangements?
3. In your opinion, how have you or your organisation, as DVA stakeholders, engaged with the arrangements?
4. What is your or your organisation's opinion on the outcomes of the treatment cycle arrangements? (Consider the improved quality of care and improved care coordination).

Online tool utilised

Stakeholders were invited to complete the survey via a fillable PDF and submit it via email to the evaluation team. Alternatively, stakeholders could complete the survey online through QUT's Key Survey system.

Recruitment

Stakeholders were identified in the following ways:

- The DVA identified stakeholders as part of the ESO Round Table and other similar activities. DVA directly emailed the sectaries of these forums and requested that they distribute the PDF to their membership.
- DVA organised for their clinical advisors to receive an email with a link to the PDF or online survey.
- The evaluation team compiled a list of ESOs and professional associations (medical and allied health), which were directly emailed by the team inviting participation.
- Evaluation team members and DVA made social media posts on Facebook and LinkedIn. The evaluation team tagged appropriate organisations in an effort to recruit them to participate.

Data analysis

Survey data collected were entirely qualitative. After completing the data collection period, survey data were organised and coded using NVivo v12 software. A coding scheme was used to summarise and categorise all responses to the survey questions. Coding and categorisation were completed by one researcher and subsequently reviewed and second-coded by a second researcher. The results are presented by survey question.

Stakeholder responses were received from every state and territory in Australia, as well as some stakeholder organisations that were national or multi-state/territory.

Stakeholder feedback demographics

There was an almost equal representation of professional associations (i.e., associations that are not Defence or veteran-specific but represent professionals more broadly) and ESOs. The ‘other’ category describes survey responses in which respondents did not state their affiliation, and after examining their responses, are most likely individuals who completed the stakeholder response form. Figure 2.4 shows the geographic distribution of stakeholders, and Figure 2.5 depicts the

breakdown of veteran v. health professional associations. Table 2.9 states the number of responses by organisation type.

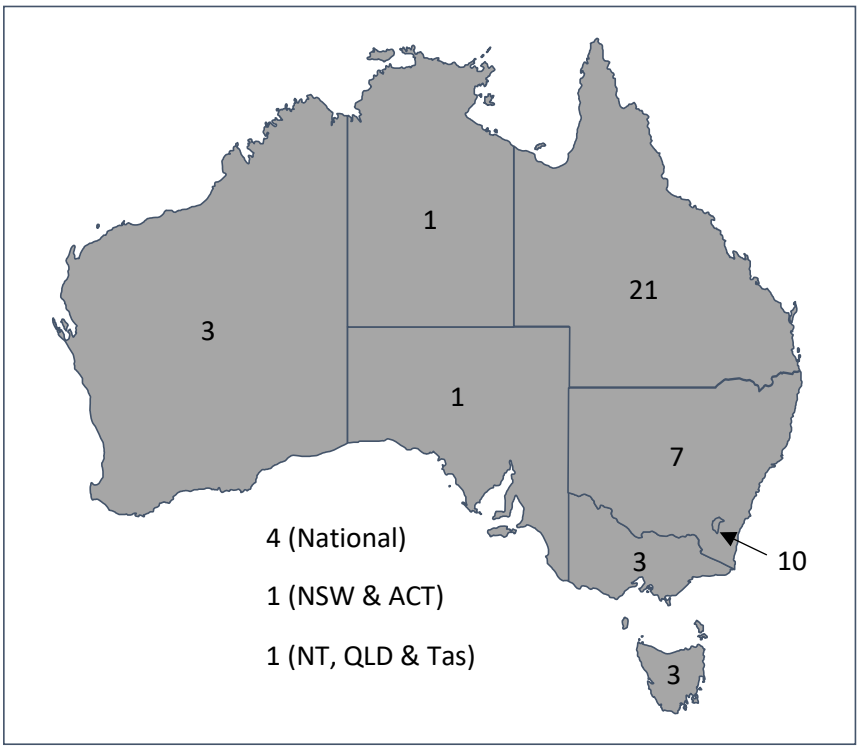


Figure 2.4: Location of stakeholders

Figure 2.5: Stakeholder responses

Table 2.9: Stakeholder organisation types and responses

Organisation type	No. of responses
Ex-service organisation	24
Professional association: AHP	25
Professional association: GP	2
Other	4
Total	**55**

SECTION 2: DOCUMENT ANALYSIS METHODOLOGY

Document analysis methodology

The document analysis was undertaken to address research question 1d, which aimed to evaluate the effectiveness of DVA's communication strategy in educating stakeholders and ensuring compliance with treatment cycle arrangements. The body of DVA communication documents included web content from the DVA website, notes and letters sent to GPs and AHPs, outlines of treatment cycle arrangements, fee schedules, and templates for AHP and GP use. These documents were reviewed and assessed for their congruence with the desired outcomes of the treatment cycle and their clarity for clients, AHPs and GPs.

Design

The research team received 78 documents from DVA to be appraised within the document analysis. These documents included communications between DVA and stakeholders (i.e., clients, GPs, AHPs and associated professional bodies), records of web content and professional notes and fee schedules (see Table 2.10 for a summary of the documents analysed). Data extraction from the documents was conducted using content analysis methodology and involved extraction of the following general information: document title, publisher, intended audience, date and summary. The evaluation questions were used as a guide, and all documents were reviewed and data extracted into a Microsoft Excel spreadsheet.

Table 2.10: Total documents included in the analysis

	Intended audience					
Document type	**GPs**	**AHPs**	**DVA clients**	**GPs and AHPs**	**GPs, AHPs & DVA clients**	**Total # documents**
Web content *(published on DVA website)*	2	15	3	1	2	23
Notes detailing provision of GP and AHP services	1	13*	N/A	0	N/A	14
Letters	2	5	2	0	0	9
Schedule of fees	0	16	N/A	0	0	16
Form templates for AHPs *(End of Cycle report and Patient Care Plan)*	N/A	2	N/A	N/A	N/A	2
General outlines of the treatment cycle arrangements	2	4	2	1	0	9
General notice of changes	0	0	0	0	3	3
Specific outlines for GPs *(TPI and At Risk Client Framework)*	2	N/A	N/A	N/A	N/A	2
Total						**78**

Note: 11 notes were addressed to specific allied health professions: exercise physiologists, physiotherapists, chiropractors, diabetes educators, dieticians, occupational therapists, osteopaths, podiatrists, social workers, speech pathologists and orthotists. One was addressed to mental health care providers as a group and one to AHPs in general.

Measures

Each document was appraised using the Patient Education Material Assessment tool (PEMAT-P) (Shoemaker et al., 2014) and the Health Literacy Checklist for Written Consumer Resources (North Western Melbourne Primary Health Network, 2014).

Both tools were applied to ensure a comprehensive evaluation of the materials (the PEMAT-P and Health Literacy Checklist are included in Appendices 6 and 7).

The PEMAT-P systematically evaluates and compares the **understandability** and **actionability** of patient education materials. The tool consists of 19 items scored as either 0 (disagree), 1 (agree) or N/A (not applicable), with percentages calculated to provide separate scores for each. The higher the score, the more understandable or actionable the material. For example, a document that receives an understandability score of 90% is more understandable than one that receives an understandability score of 60%, and the same for actionability (refer to Table 3.13 for the complete document PEMAT-P scores).

Further, the Health Literacy Checklist for Written Consumer Resources was adapted to the needs of the document analysis to provide a basic guide for ensuring that DVA resources written for stakeholders are clear and easy to understand. The adjusted Health Literacy Checklist was applied to relevant documents to assess content, language and presentation of key messages, with values tallied to provide an overall score out of 13 for comparison (refer to Table 3.13). These tools provided quantitative figures regarding the communication strategy.

Subjectivity control

Further, the documents were appraised against the evaluation questions with relevant content extracted verbatim into an excel spreadsheet to ensure full transparency of the document analysis process. Subjectivity was mitigated in the appraisal, as a second evaluator randomly selected and reviewed 20% of the documents. These were compared to determine any discrepancies between the primary and secondary evaluator and then brought to the evaluation team for further review.

Health economics methodology

Health economics design

To assess changes in service usage patterns and health care expenditure, our expert team with the Australian Centre for Health Service Innovation combined their health economics expertise with big data capabilities to provide robust data analysis and reporting. This part contains the quantitative analysis of the health service usage by DVA clients. The R programming language (version 3.6.0) was used to analyse the data.

The impact of implementing the treatment cycle arrangements for allied health referrals was assessed using the pre- and post-health-service-utilising information provided by the DVA. As the treatment cycle was implemented from 1st October 2019, we determined the pre-health-service stage as any treatment or referral provided before this date. Subsequently, the post-health-service stage was determined as referrals and services provided after 1st October 2019. We hypothesised that the treatment cycle would create less allied health usage from DVA clients and provide cost savings.

The service utilisation by DVA clients before and after the implementation of the treatment cycle in terms of AHP services were compared. AHP services included chiropractic, diabetes education, dietetics, exercise physiology, occupational therapy, orthotics, osteopathy, physiotherapy, podiatry, psychology, social work and speech pathology.

We have provided descriptive information regarding the amount of service utilisation and costs compared between pre– and post–treatment cycle.

SECTION 3: FINDINGS

DVA client findings

DVA client survey results

Key findings for DVA clients are presented here. For a full report of DVA Client survey results, please see Appendix 2.1, Q17–44, and Appendix 2.2.

DVA clients: Information about treatment cycle arrangements

DVA clients' knowledge of the treatment cycle was measured in two parts: first, when clients first became aware of the treatment and where they received information about the treatment cycle (multiple responses were allowed for this question, which is why the total does not add to 100%):

- 62% (n = 250) of clients were aware of the treatment cycle before October 2019.
- 40% (n = 161) of clients received information from DVA about the treatment cycle before October 2019.
- 35% (n = 138) of clients reported that they were informed about the treatment cycle from their GP.

Second, client knowledge of the treatment cycle arrangements was measured by asking clients what they thought of the quality, understandability, actionability and relevance of information. The possible responses were 'agree', 'somewhat agree', 'neither agree nor disagree', 'somewhat disagree' and 'disagree'. Responses were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes.

- 53% (n = 210) of clients thought the information was easy to understand, and 50% (n = 201) of clients thought the information was relevant to their needs.
- 57% (n = 229) of clients reported that they were prepared for the changes, and 62% (n = 245) of clients reported that they understood the changes.
- 72% (n = 287) of clients reported that they were confident with the referral changes; however, only 34% (n = 134) of clients reported they were satisfied with the changes (see Figure 3.1).

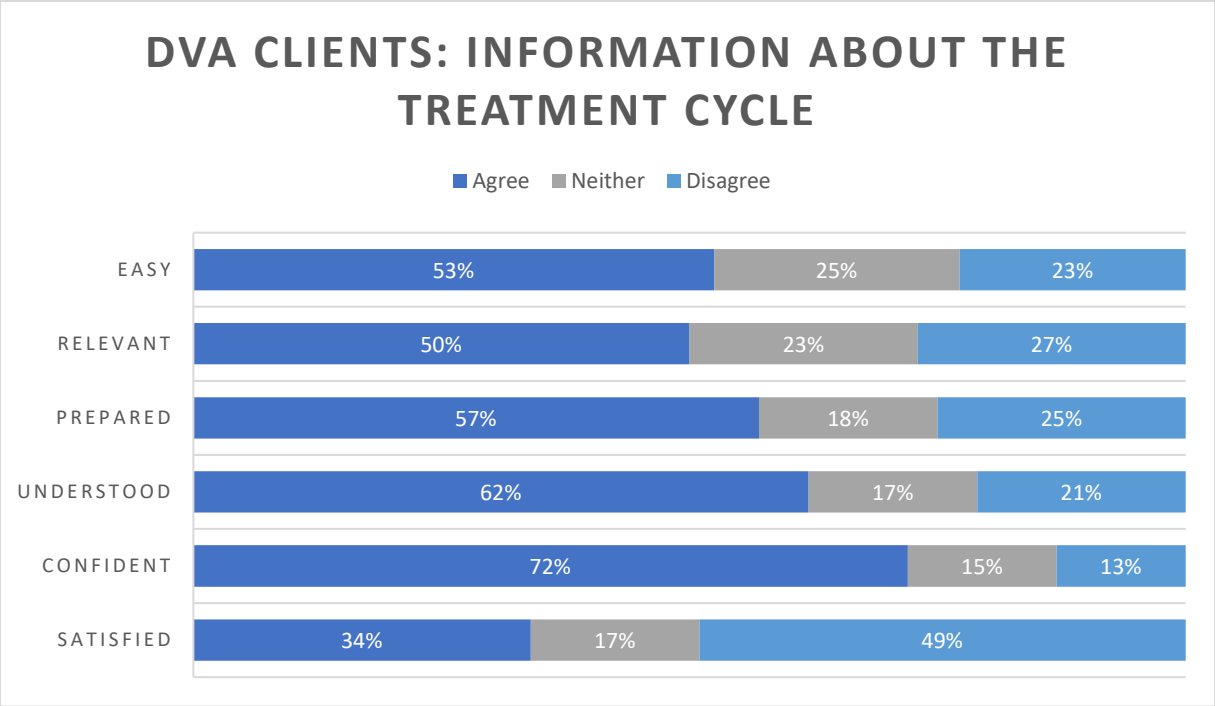


Figure 3.1: Client perspective on treatment cycle information

DVA clients: Client age and communication of the treatment cycle

When analysed by age, DVA clients were more likely to be positive towards the communication of the treatment cycle if they were 50 years old or younger. The analysis revealed that 63% (n = 82) of DVA clients 50 years old or younger found the information easy to understand, compared to 47% (n = 127) of DVA clients aged over 50 years old. DVA clients 50 years or younger were also more likely to find the information relevant to their needs (59%, n = 76) and of high quality (56%, n = 72). Clients over 50 years old were more likely to be unsure of the quality of available information about the treatment cycle, with 43% (n = 117) neither agreeing nor disagreeing that the information was high quality. They were also more likely to disagree that the available information was relevant to their needs when compared to the younger cohort, with 32% (n = 86) of clients older than 50 indicating that they disagreed; this is compared to 17% (n = 22) of clients 50 and younger indicating that they disagreed that the information is relevant to their needs. All noted statistics are significant, with the full reporting available in Table 3.1.

Table 3.1: Communication of the treatment cycle by DVA client age

DVA clients: Available information about the allied health treatment cycle arrangements is:	**Agree N (%)**	**Neither agree nor disagree N (%)**	**Disagree N (%)**	**Sig.**
Easy to understand				
Equal or less than 50 years	82 (63.6)	26 (20.1)	21 (16.3)	< 0.05#
More than 50 years	127 (47.0)	73 (27.0)	70 (25.9)	
Relevant to my needs				
Equal or less than 50 years	76 (58.9)	31 (24.0)	22 (17.0)	< 0.05#
More than 50 years	125 (46.3)	59 (21.8)	86 (31.8)	
High quality				
Equal or less than 50 years	72 (55.8)	36 (27.9)	21 (16.2)	< 0.05#
More than 50 years	87 (32.2)	117 (43.3)	66 (24.4)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

DVA clients: COVID-19 impacts

While COVID-19 was not directly related to implementing the treatment cycle, the impacts of COVID-19 and subsequent restrictions across Australia were experienced by clients. Therefore, clients were asked if and how their GP and AHP services were affected by COVID-19; response options were 'yes' or 'no'. A total of 54% (n = 214) of clients reported impacts to their GP services due to COVID-19, and 53% (n = 212) of clients reported impacts to their AHP services due to COVID-19.

Additionally, clients were asked how their services had changed due to COVID-19. The responses included 'more telehealth', 'less in-person consultation', 'did not access services' or 'no change in services'. In total, 57% (n = 228) of clients reported an increase in telehealth (multiple responses were allowed for this question).

DVA clients: Transitioning to the treatment cycle

Clients were asked when they had transitioned to the treatment cycle arrangements, with responses ranging from October 2019 – October 2020 (time of survey distribution), with two qualifier responses including 'I'm not sure' and 'I haven't transitioned to the treatment cycle'. In total, 48% (n = 192) of clients reported that they transitioned to the treatment cycle in October 2019.

Additionally, to establish allied health service usage baselines, clients were asked when they had received allied health services 'before October 2019 only', 'after

October 2019 only', 'before and after October 2019', or if they had never received allied health services. In total, 78% (n = 310) of clients reported accessing allied health services both before and after the treatment cycle was implemented in October 2019.

DVA clients: Satisfaction with the treatment cycle by location

DVA client satisfaction with the treatment cycle was analysed by client geographic location (see Table 3.2). Differences in DVA client knowledge of the treatment cycle arrangements between states was found to be statistically significant, with clients located outside Queensland, New South Wales and Victoria being less likely to report that they had sufficient knowledge of the changes (49%, n = 41) when compared to these states.

Table 3.2: Satisfaction with the treatment cycle by DVA client state

DVA clients: Since 1 October 2019, think about the first time you visited your GP for an allied health treatment referral.	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
I was prepared for the changes.				
Queensland	102 (58.3)	32 (18.3)	41 (23.4)	NS
New South Wales	50 (58.8)	12 (14.1)	23 (27.1)	
Victoria	35 (54.7)	15 (23.4)	14 (21.9)	
Other	42 (56.0)	12 (16.0)	21 (28.0)	
I understood the changes.				
Queensland	114 (65.1)	26 (14.9)	35 (20.0)	NS
New South Wales	51 (60.0)	18 (21.2)	16 (18.8)	
Victoria	39 (60.9)	12 (18.8)	13 (20.3)	
Other	41 (54.7)	13 (17.3)	21 (28.0)	
I had sufficient knowledge about the changes.				
Queensland	101 (57.7)	37 (21.1)	37 (21.1)	< 0.05#
New South Wales	53 (62.4)	12 (14.1)	20 (23.5)	
Victoria	39 (60.9)	18 (28.1)	7 (10.9)	
Other	37 (49.3)	13 (17.3)	25 (33.3)	
I was confident asking my GP for a referral to a treatment cycle.				
Queensland	129 (73.7)	23 (13.1)	23 (13.1)	NS
New South Wales	68 (80.0)	10 (11.8)	7 (8.2)	
Victoria	43 (67.2)	11 (17.2)	10 (15.6)	
Other	47 (62.7)	18 (24.0)	10 (13.3)	
I was satisfied with the changes.				
Queensland	50 (28.6)	25 (14.3)	100 (57.1)	< 0.05#
New South Wales	39 (45.9)	13 (15.3)	33 (38.8)	
Victoria	29 (45.3)	16 (25.0)	19 (29.7)	
Other	16 (21.3)	16 (21.3)	43 (57.3)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

DVA clients: Impacts of the treatment cycle

Participants were asked 'how have you been impacted by the changes to allied health treatment cycle arrangements? (select one only)'. The choices provided were 'positively impacted', 'negatively impacted' and 'not been impacted'. These data indicate the respondents' perceptions of how the treatment cycle has impacted them. In total, 22% (n = 89) of clients reported being positively impacted, 41% (n = 164) reported being negatively impacted, and 37% (n = 147) reported not being impacted by the treatment cycle (see Figure 3.2). In addition, clients were asked, 'have you

experienced changes in the amount you see your GP? (select one only)'. The response options included 'I see my GP more', 'I see my GP less' and 'I see my GP the same amount'. In total, 54% (n = 214) of clients reported that they see their GP more, 12% (n = 47) reported seeing their GP less, and 34% (n = 138) reported seeing their GP the same amount (see Figure 3.3).

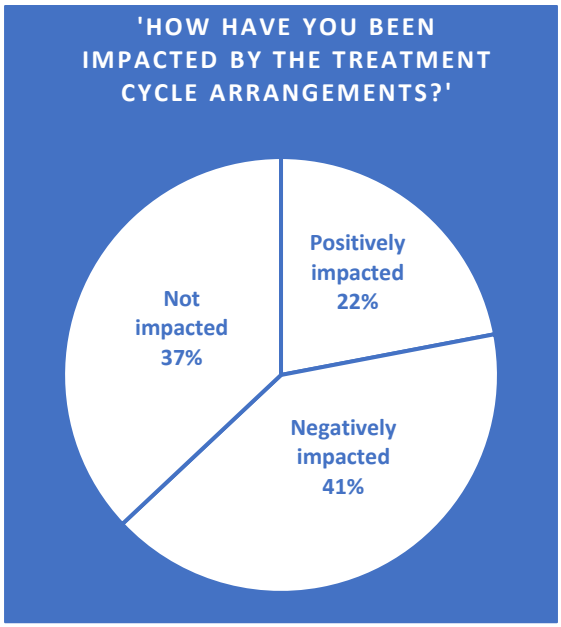


Figure 3.2: Clients' perceived impacts of the treatment cycle arrangements

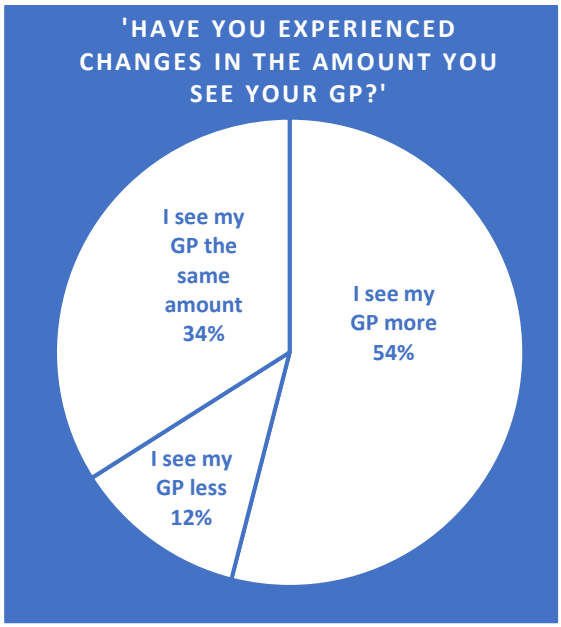


Figure 3.3: Clients' perceived changes to seeing their GP

When analysed by gender, age and state, the impact of the treatment cycle arrangements on DVA clients was mixed. The age and geographic location of DVA clients were significant when considering whether the impact of the treatment cycle is perceived to be positive, negative or not impactful at all. DVA clients aged over 50 years were slightly more likely (46%, n = 123) to report being negatively impacted by the treatment cycle compared to the younger cohort (32%, n = 41). DVA clients 50 years old or younger were more likely to report that they have been positively impacted by the treatment cycle, with 38% (n = 49) indicating positive impacts compared to 15% (n = 40) of the older cohort.

Geographic location within Australia was also found to be statistically significant when considering the perceived impact of the treatment cycle on DVA clients. DVA clients located in Queensland were less likely to report that they have been positively

impacted by the changes (18%, n = 31), compared to NSW (31%, n = 26), Victoria (25%, n = 16) and other states (21%, n = 16). DVA clients in Queensland and other states were more likely to report being negatively impacted, with 47% (n = 83) and 48% (n = 36) reporting this, respectively. Gender did not have a statistically significant influence on the responses. The complete analysis is detailed in Table 3.3.

Table 3.3: Perceived impact of the treatment cycle by DVA client gender, age and state

DVA clients: impacted by the changes to allied health treatment cycle arrangements.	**I have been negatively impacted by the changes N (%)**	**I have not been impacted by the changes N (%)**	**I have been positively impacted by the changes N (%)**	**Sig.**
Gender				
Male	134 (43.8)	109 (35.6)	63 (20.6)	NS
Female	30 (32.6)	37 (40.2)	25 (27.2)	
Age				
Equal or less than 50 years	41 (31.8)	39 (30.2)	49 (38.0)	< 0.05#
More than 50 years	123 (45.6)	107 (39.6)	40 (14.8)	
State				
Queensland	83 (47.4)	61 (34.9)	31 (17.7)	< 0.05#
New South Wales	23 (27.1)	36 (42.4)	26 (30.6)	
Victoria	22 (34.4)	26 (40.6)	16 (25.0)	
Other	36 (48.0)	23 (30.7)	16 (21.3)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

DVA clients: Quality of care

Quality of care was measured by asking clients eight questions related to the quality of care measures, with a response range of ‘agree’, ‘somewhat agree’, ‘neither agree nor disagree’, ‘somewhat disagree’, and ‘disagree’. Responses were consolidated into ‘agree’, ‘neither’ and ‘disagree’ for reporting purposes. In total, 71% (n = 283) of clients reported requiring more referrals to meet their health care needs, and 34% (n = 137) reported that they are more engaged in how their health care needs are met. Further, 40% (n = 157) of clients reported that they discuss and review their health care needs more often and in more detail with their GP, which is similar to the 39% (n = 156) of clients that reported that they discuss and review their health care needs more often and in more detail with their AHP. In total, 29% (n = 117) of clients

reported that their health care needs are better met by the treatment cycle. In addition, 26% (n = 104) of clients reported that they have better access to necessary services to meet their health care needs and that they receive better quality health care overall. Finally, 30% (n = 118) of clients reported they receive better targeted support based on their health care needs (see Figure 3.4).

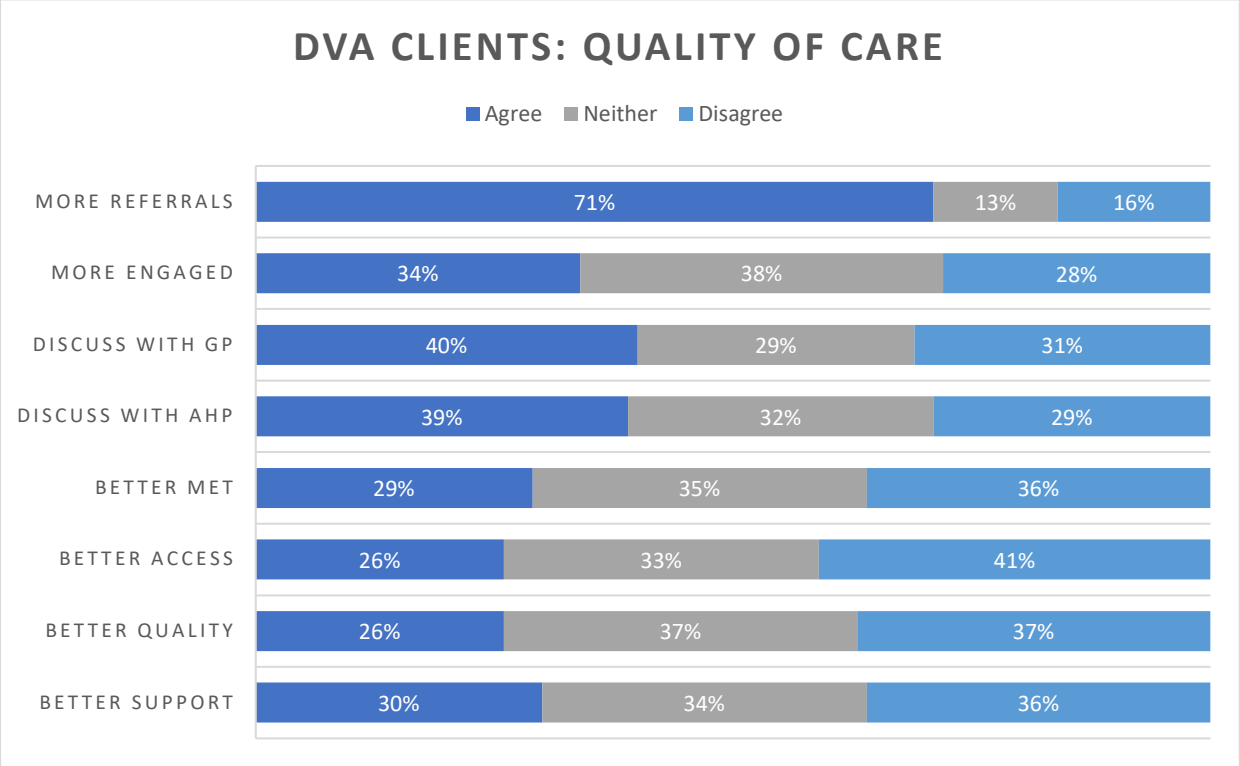


Figure 3.4: Client perspective of quality of care

DVA clients: Quality of care by age

DVA client opinions on the quality of care provided by the treatment cycle were further analysed by client age, as detailed in Table 3.4. DVA clients aged 50 years and younger were more likely to report that they discuss and review their health care needs with their GP more often and in more detail (52%, n = 67) compared to the older cohort (33%, n = 90). Clients aged 50 and younger were also more likely to report that their health care needs are better met (48%, n = 62); they have better access to necessary services (44%, n = 57); they receive better, targeted care (50%, n = 64); and that they receive a better quality of health care overall (46%, n = 59) compared to the older cohort.

Table 3.4: Perceived quality of care by DVA client age

DVA clients: Has your quality of health care changed?	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
I require more referrals from my GP to meet my health care needs.				
Equal or less than 50 years	89 (69.0)	18 (14.0)	22 (17.1)	NS
More than 50 years	194 (71.9)	35 (13.0)	41 (15.2)	
I am more engaged in how my health care needs are met.				
Equal or less than 50 years	55 (42.6)	42 (32.6)	32 (24.8)	NS
More than 50 years	82 (30.4)	110 (40.7)	78 (28.9)	
My GP and I discuss and review my health care needs more often and in more detail.				
Equal or less than 50 years	67 (51.9)	33 (25.6)	29 (22.5)	< 0.05#
More than 50 years	90 (33.3)	84 (31.1)	96 (35.6)	
My AHP and I discuss and review my health care needs more often and in more detail.				
Equal or less than 50 years	60 (46.5)	37 (28.7)	32 (24.8)	NS
More than 50 years	96 (35.6)	90 (33.3)	84 (31.1)	
My health care needs are better met.				
Equal or less than 50 years	62 (48.1)	32 (24.8)	35 (27.1)	< 0.05#
More than 50 years	55 (20.4)	107 (39.6)	108 (40.0)	
I have better access to necessary services for my health care needs.				
Equal or less than 50 years	57 (44.2)	31 (24.0)	41 (31.8)	< 0.05#
More than 50 years	48 (17.8)	101 (37.4)	121 (44.8)	
I receive better quality of health care overall.				
Equal or less than 50 years	59 (45.7)	35 (27.1)	35 (27.1)	< 0.05#
More than 50 years	45 (16.7)	113 (41.9)	112 (41.5)	
I receive better, targeted support based on my health care needs.				
Equal or less than 50 years	64 (49.6)	33 (25.6)	32 (24.8)	< 0.05#
More than 50 years	54 (20.0)	104 (38.5)	112 (41.5)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

DVA clients: Care coordination

Care coordination was measured by asking clients who coordinates their care, with five options provided. These included themselves, their GP, their AHP, their GP and AHP jointly or someone else (other). The results revealed that:

- 56% (n = 223) of clients reported they coordinate their health care needs.
- 25% (n = 98) of clients reported their GP coordinates their health care needs.
- 12% (n = 47) of clients reported their GP and AHP consult each other to jointly coordinate their health care needs.

DVA clients: Care coordination with GP

Clients were asked how their care coordination with their GP has changed since the implementation of the treatment cycle arrangements (see Appendix 2.1, Q37). The results were similar to other questions asked about client, GP and AHP care coordination. Therefore, only questions pertinent to client and GP care coordination are presented below (see Figure 3.5):

- 40% (n = 158) of clients reported that they discuss their health care needs with their GP in more detail before starting a treatment cycle.
- 37% (n = 147) of clients reported that they review their ongoing health care needs with their GP in more detail after finishing a treatment cycle.
- 61% (n = 242) of clients reported that the number of interactions with their GP has increased.
- 29% (n = 115) of clients reported that the quality of their interactions with their GP has improved.
- 36% (n = 145) of clients reported that they have more opportunities to discuss and review their health care needs with their GP.

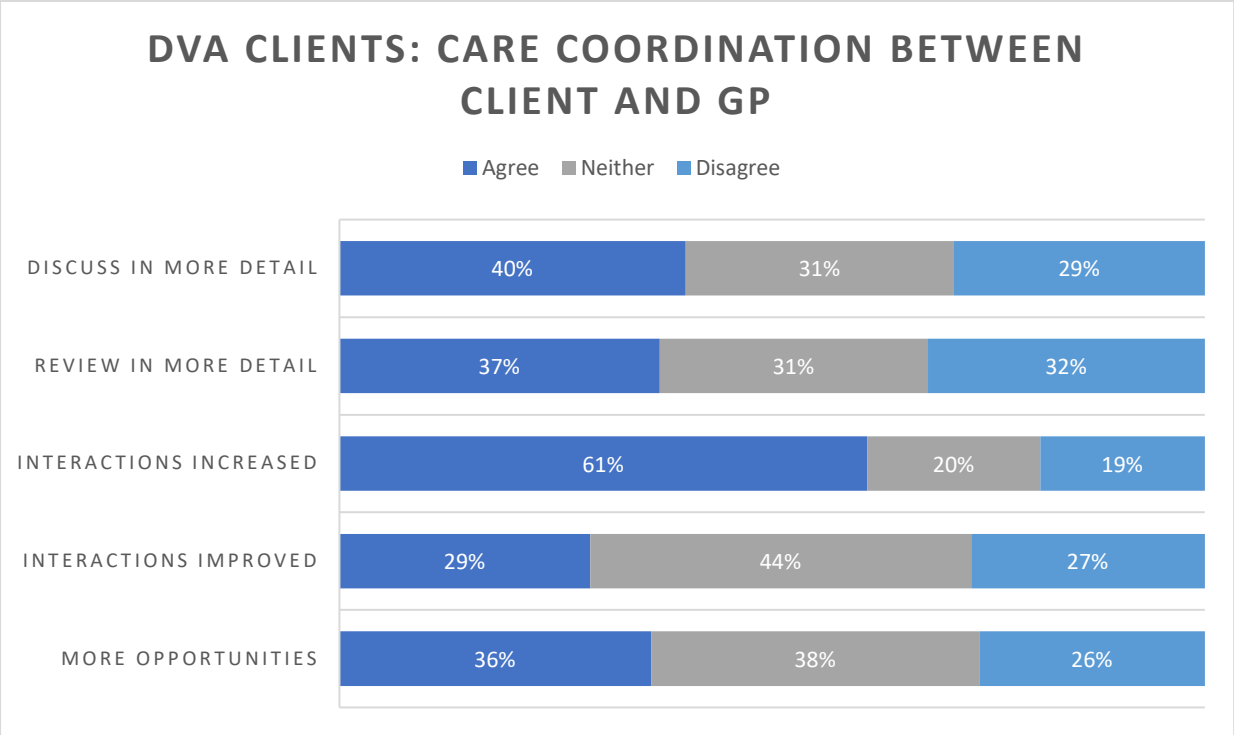


Figure 3.5: Client perspective of care coordination between clients and GPs

DVA clients: Care coordination with AHP

Clients were asked how their care coordination with their AHP has changed since implementing the treatment cycle arrangements. Results were similar to other questions asked about client, GP and AHP care coordination. Therefore, only questions pertinent to the client and AHP care coordination are presented below (see Appendix 2.1, Q39, Figure 3.6 and Figure 3.7):

- 50% (n = 200) of clients reported they develop a Patient Care Plan (PCP) with their AHP before commencing a treatment cycle.
- 51% (n = 203) of clients reported that their PCP details their health care needs.
- 63% (n = 249) of clients reported that their AHPs write notes and assess their health care needs.
- 40% (n = 158) of clients reported that they discuss their health care needs with their AHP in more detail before starting a treatment cycle.
- 42% (n = 165) of clients reported that they review their ongoing health care needs with their AHP in more detail after finishing a treatment cycle.

- 35% (n = 140) of clients reported that the number of interactions with their AHP has increased.
- 31% (n = 125) of clients reported that the quality of their interactions with their AHP has improved.
- 31% (n = 123) of clients reported having more opportunities to discuss and review their health care needs with their AHP.

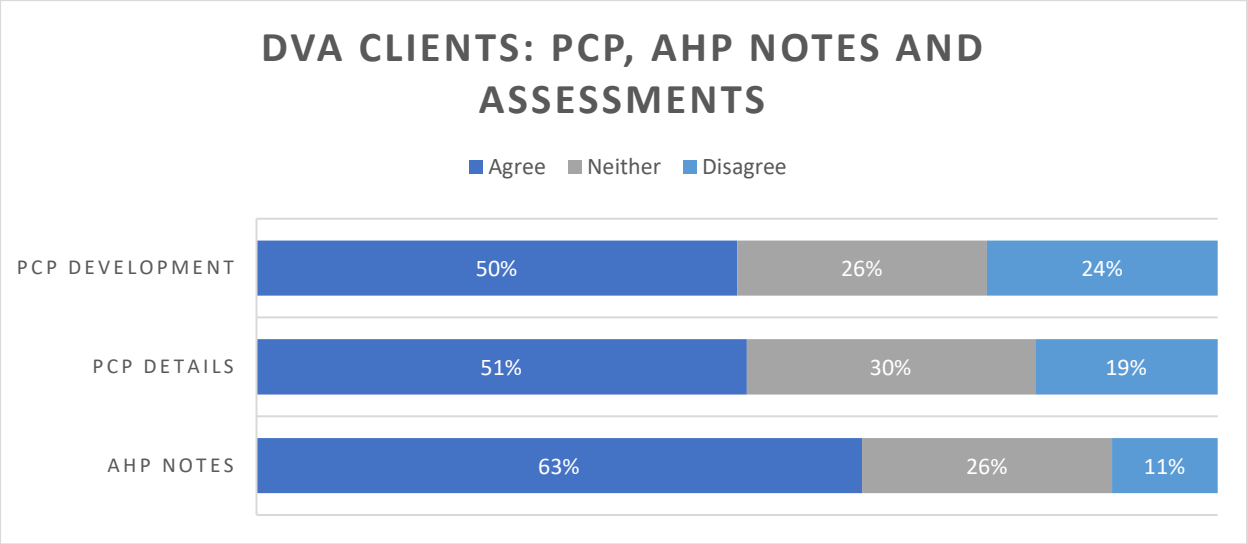


Figure 3.6: Client perspectives of PCP, AHP notes and assessments

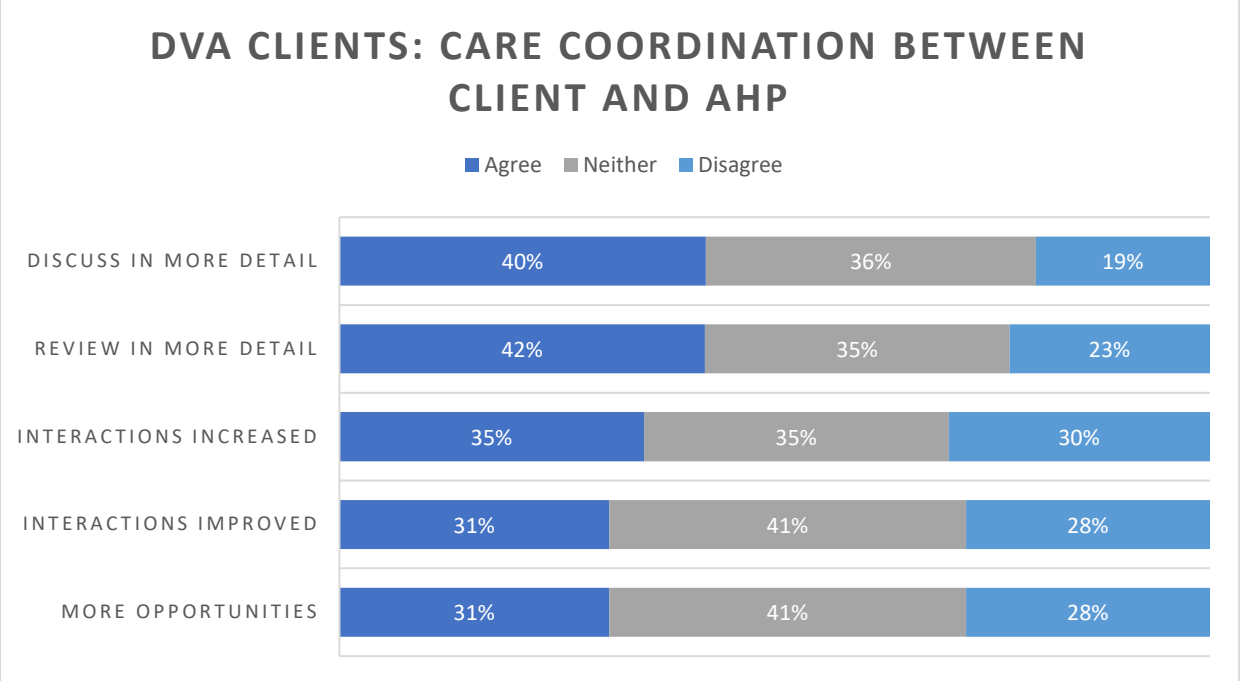


Figure 3.7: Client perspectives of care coordination between clients and AHPs

DVA clients: Care coordination between AHP and GP

Care coordination was measured in three blocks comprised of client and GP, client and AHP, and GP and AHP. Results were similar across the three blocks. The reported results are from the GP and AHP block, and comprehensive results can be viewed in Appendix 2.1. Overall, 52% (n = 206) of clients reported that their AHPs provide reports to their GP, and 42% (n = 169) of clients reported that their GP reviews the reports, discusses the report and seeks their opinion. In total, 50% (n = 200) of clients reported that their GP makes additional referrals based on the report and their opinion. Further, 54% (n = 216) of clients reported feeling included in the decision-making process to meet their health care needs. Finally, 46% (n = 184) of clients felt informed about communications, decisions, and recommendations between their GP and AHPs (see Figure 3.8).

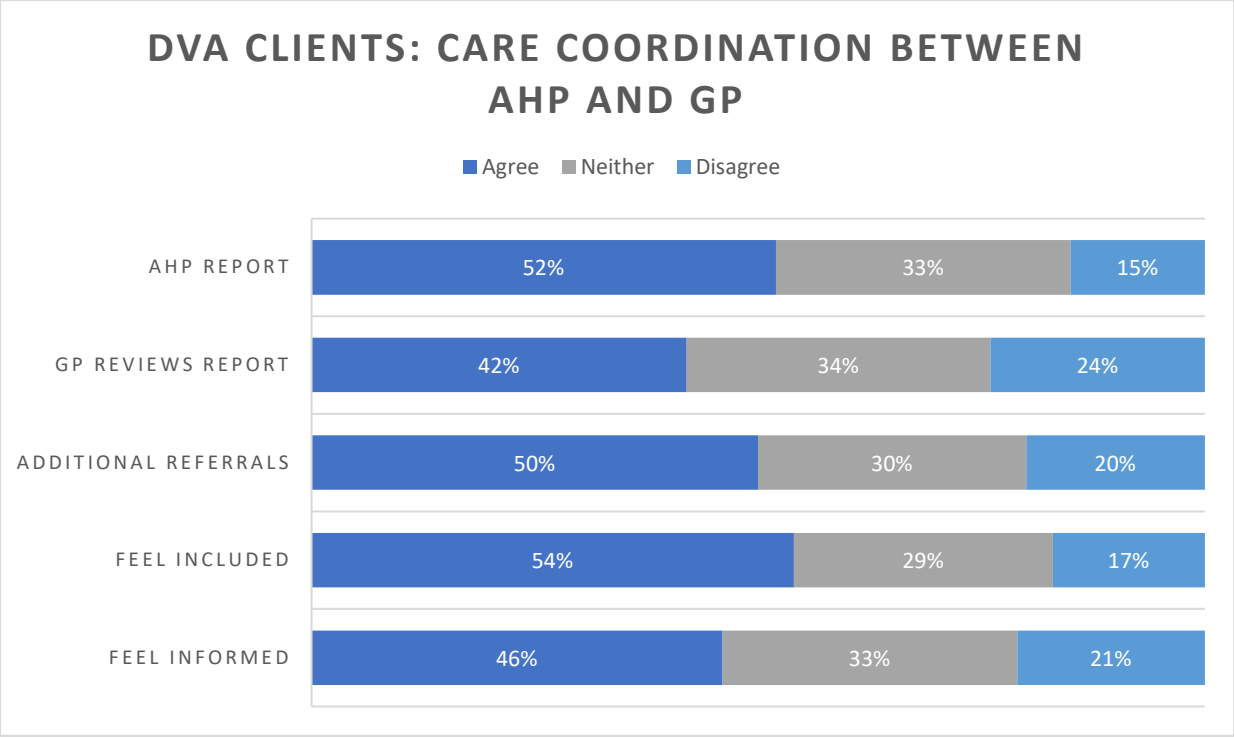


Figure 3.8: Client perspectives of care coordination between AHPs and GPs

DVA clients: Other impacts and themes

Text responses were obtained from DVA clients in the last survey question: 'Compared to before 1 October 2019, I now think that the referral process for treatment cycle arrangements is…'. This question allowed clients to select multiple responses and provide text comments. Note that all text comments quoted in this

report are verbatim from the responses provided: they may or may not be reflective of DVA policy and practice but are an uncensored statement of an individual's experiences and perspectives.

The impacts included 14 options, including more time-consuming or time-efficient; more or less expensive; more complex or simpler and more straightforward; more or less effective; unimproved or improved; worse or improved and better; more or less flexible, responsive, and dynamic; other; and none of the above. The results revealed that:

- 70% (n = 279) of clients reported that the treatment cycle is more time-consuming.
- 35% (n = 140) of clients reported that the treatment cycle is more expensive.
- 44% (n = 176) of clients reported that the treatment cycle is more complex.
- 36% (n = 142) of clients reported that the treatment cycle is less effective.
- 34% (n = 135) of clients reported that the treatment cycle is unimproved and worse as well as less flexible, responsive, and dynamic.

Client and GP engagement

Clients reported feeling inconvenienced by the increased number of GP visits, which were perceived as a waste of time and money. Clients reported feeling like they needed to seek an 'unnecessary' referral, especially those who work full-time or have lifelong conditions. Clients also reported feeling like they were an 'inconvenience' to AHPs and GPs by requiring more appointments. Further, some survey responses described additional GP appointments as provoking stress, anxiety and frustration due to restrictions on appointment times (especially those in rural areas where it is difficult to access GPs) and requiring longer GP appointments (e.g., 30 minutes). Clients also described feeling that GPs are not patient-focused and are unaware of clients' needs. In contrast, some clients reported more communication between their GP and AHP and that their GP is now more aware of their treatment and progress.

'The GP doesn't understand why I need so many referrals for the same thing and constantly wants to terminate treatment'. (DVA client, survey response)

Expenses and costs

Within the qualitative survey responses, DVA clients described increased expenses and costs due to the treatment cycle arrangements. The reasons given for the increased costs were:

- cost of child care or loss of income (taking time off work to attend GP)
- costs associated with time and travel or transport for more GP visits and clinics charging additional costs for appointments
- self-payments covering the cost of treatment when waiting on a new referral

Some respondents also believed the extra costs of GP visits could be better allocated for other veterans to access necessary care/support services.

> *'My rehabilitation needs are long term and as such I believe cases should be assessed individually. I am also unable to access extended appointments for my conditions even if medically necessary, due to the restrictions of cost imposed by DVA, limiting my care I can receive'. (DVA client, survey response)*

Service impacts and outcomes

Within the survey, DVA clients were asked to expand upon the impacts of the treatment cycle arrangements on their health care service and health outcomes. Clients described service impacts and outcomes in the following ways:

- The treatment cycles are too short and described as insufficient to address client health care needs, especially for complex or chronic health conditions.
- There is a loss of treatment time due to paperwork and assessments.
- The treatment cycles are more bureaucratic, with no quality of care added.
- Clients describe not being able to access services due to expired referrals, which negatively affects health conditions.
- Clients describe discontinuing services or experiencing gaps in their treatment due to requiring more referrals and not being able to access the GP in time.
- In contrast, clients also describe the treatment cycle as making goals and changes to care easily identifiable and modifiable.

'Some companies won't take on DVA clients because too much paperwork involved'. (DVA client, survey response)

Psychosocial impacts

DVA clients were asked within the qualitative responses to expand upon their attitudes towards the treatment cycle arrangements. As part of this, clients described a range of psychosocial impacts resulting from the treatment cycle arrangements. Clients described feeling pressure and stress to coordinate their own care by monitoring or tracking their sessions across multiple AHP services. Clients stated that the treatment cycle arrangements have contributed to adverse mental health outcomes such as stress, anxiety and frustration. The treatment cycle arrangements were described as 'additional steps to access care without any perceived benefit' and that it was bureaucratic and time-consuming, involving additional administration and lack of care for veterans.

'The stress in ensuring that I am up to date with referrals constantly is making it less effective'. (DVA client, survey response)

DVA client interview results

Results are presented according to the themes identified within the data. For a full report of interview results, please see Appendix 4.

DVA clients: Availability, quality and clarity of information

Communication of treatment cycle

Within DVA client interviews, participants presented generally negative feedback regarding the availability of information about the treatment cycle arrangements and the timeliness of the communication. Interviewers and participants understood availability as the ease with which the audience can access the required information. If the information needs to be searched for, it has poor availability. If the information is provided in a forum that is easy to access or within expected communication channels, it has good availability. In interviews, clients reported that information

about the treatment cycle arrangements was hard to find or required more investigation by the client. There were multiple reports of clients finding the information from alternative sources rather than directly from DVA sources. Feedback about the quality of information about the treatment cycle arrangements was mixed; interviewees provided some contradictory feedback, but overall, the quality of the information was accepted as good to adequate. Despite this, the reasons for the changes were reported as confusing or lacking logic that could be understood by interviewees.

> *'The information provided was adequate. I can't really say any more than that. I was happy with the information. I was not happy with the fact that it was happening'. (DVA client, 84, ACT)*

DVA client interviewees described that communication of the treatment cycle was often disseminated through veteran-to-veteran communication or veteran advocate or support groups. Three interviewees described that the treatment cycle had affected their ability to experience veteran-to-veteran communication by limiting social contact maintained through exercise groups with physiotherapists or exercise physiologists. Further, some DVA clients expressed frustration at the perceived lack of consultation from DVA about the treatment cycle arrangements.

Perceptions of the treatment cycle arrangements

Throughout the client interviews, there were multiple reports of the treatment cycle arrangements being perceived as confusing, frustrating or clients not understanding the reasons behind the changes. DVA clients and AHPs spoke of the treatment cycle arrangements as a 'cost-saving' measure, often referring to this as their 'understanding' or 'belief' of the true reason for the change. No reference was made to DVA communications specifying this, but rather it was an assumption circulated within the DVA client and health care community.

'I think my understanding, or my belief is that it's a cost driven thing… if DVA is looking to cut back on the, you know, people using services for too long without review, then why not put a time base on it rather than a number of visits? Unless it is just all about cost. That's my question'. (DVA client, 44, NT)

In addition to the belief that the treatment cycle was a cost-saving measure, a common theme across interviewees was that the treatment cycle arrangements were developed in response to individuals (whether DVA clients or AHPs) 'taking advantage' of the previous system. Respondents described being offended by what they perceived as being 'whack[ed] with the same big sledgehammer', referring to being punished for the poor behaviours of others under the previous referral system or arrangements.

DVA clients: COVID-19 impacts

As a result of COVID-19, some DVA client interviewees reported general disruption of access to health care services, with more severe impacts reported from clients in Victoria. Most clients reported minimal impact to their health care services overall, but many clients reported the cancellation of AHP services. Multiple clients reported difficulty in accessing appointments to receive health care from GPs or referrals for the treatment cycle as a result of COVID-19 disruption. Other clients reported reluctance to attend appointments with AHPs or GPs due to concern for their own health or the health of others. There were multiple positive reports from clients, AHPs and GPs regarding the availability of telehealth as an alternative treatment option.

'Getting to access the GP was very difficult, because he was very busy and screening people. In fact, for a little while it was Zoom only and then it was screening people and because I'm complex, he kept saying, I'd prefer you don't come in'. (DVA client, 57, NT)

DVA clients: Clinical notes and administration

Increased burden of administration

A common theme in DVA client interviews was the increased level of administration required as a result of the treatment cycle arrangements. Client interviewees reported needing to spend time and effort recording GP and AHP visits to keep track of the treatment cycles. Many described their perceived need to keep personal diaries, spreadsheets or notebooks to ensure that they had referrals for their health care requirements. This also indicates a certain level of client-coordinated care (DVA clients coordinating their own health care).

> *'Unless I write down in my diary what number treatment I'm having, and I write it in a diary about three weeks before I need a new one, then sometimes you can't even get in to see any doctor just to get them to write a referral'. (DVA client, 56, QLD)*

One DVA client interviewee reported feeling 'embarrassed' that they were causing trouble for AHPs that do not get paid 'as much' to see them as opposed to non-DVA clients.

> *'What we have found—speaking to a couple of veterans, there are less [unclear] DVA providers in Darwin, because they don't get paid as much and we're too—it's too complicated … Because then I'd get all frustrated because I—then I was embarrassed that I was so much trouble to these people who don't get paid as much'. (DVA client, 57, NT)*

Impact of the treatment cycle arrangements on DVA client health outcomes

Multiple DVA client interviewees described experiencing setbacks in treatment or health care due to an inability to access a GP for referral within the cycle. Other DVA client interviewees reported that the treatment cycle affects their mental health due to the increased complexity of service provision and increased requirements to discuss their health care. One GP interviewee expressed disappointment in the

inclusion of psychology in the treatment cycle due to the increased burden of extra GP appointments for vulnerable patients.

'It's probably more to do with maintaining my own mental health. The medical care from DVA, it's all paid for, which I'm not whinging about that at all, but accessing it requires a lot of frustration that sometimes you wonder if it's worth it and in this case, I didn't think it was'. (DVA client, 44, NT)

'So you're also mindful of the psychological impacts of re-hashing these questionnaires all the time because most of them are also people that are trying to get along with life and don't want to be having to re-live all that stuff again'. (AHP, Osteopath, NSW)

'The other thing that disappointed me is that they included psychology in it, because psychology for DVA clients is so important. To have that not limited, but to have that extra burden, that patients have to come in for an extra appointment when psychology is so important. That was very disappointing that they included that'. (GP, QLD)

DVA clients not accessing health care due to treatment cycle arrangements

Multiple DVA client interviewees reported not attending AHP appointments due to the treatment cycle arrangements. Interviewees described the difficulty or inconvenience of attending GP appointments as the reason for cancelling AHP services. This was reported as temporary in some cases and permanent in others.

'If I can't see the doctor within the week or even the fortnight, that means I have to forego my appointments and wait till I get the new referral. That can be a couple of weeks, a month even in between … I've known a few people that just cut it away altogether and they go without rather than having to deal with it. It's not good'. (DVA client, 30, QLD)

'As I said, it just takes more time to coordinate it. When I go in and ask for a referral, the GP goes, yeah, no worries. There's no discussion about it'. (DVA client, 58, QLD)

DVA clients: Care coordination

Client experience: More regular contact with the GP

Some DVA clients noted that they were experiencing more contact with their GP because of the treatment cycle and that this has had a positive impact on their care coordination.

'I believe it's a good thing because what it's actually done, it's put you in much more regular contact with your general practitioner... My opinion of it is it's very positive and very much in the interest of the veteran and the recipient actually'. (DVA client, 81, NSW)

Health care coordination

When asked about the coordination of health care, DVA, GPs and AHPs all felt responsible for the maintenance and ongoing management of DVA clients' care. This may have resulted from a lack of clarification around the question asked, which is addressed in the project limitations.

Health care coordination: DVA clients

DVA client interviewees described their personal responsibility for managing the number of AHP appointments they had left as part of the treatment cycle arrangements and their own coordination of GP appointments for the ongoing provision of care. Two DVA clients mentioned that the GP coordinates their health care through the PCP, though this is in conjunction with their own care management. Some DVA clients described AHPs monitoring the number of appointments they have and informing the client when they needed to receive a new referral. One DVA client reported a change in coordination of care from the GP to himself after the treatment cycle arrangements due to a lack of time from the GP once the arrangements were implemented.

DVA clients: Client experience

DVA clients speaking to local members about the treatment cycle

Two clients felt strongly enough about the treatment cycle to write to their local members about the changes.

> *'As a group, we wrote a letter to the local member, protesting, and the feedback we got from the gentleman that saw it was, thanks for your letter, very interesting, don't call us, we'll call you. Typical politician-type answer'. (DVA client, 72, QLD)*

DVA clients: At Risk Client Framework

Within the interviews, there were mentions of the At Risk Client Framework from DVA clients without prompting from the interviewer. The framework was described by DVA clients as a way to 'get around' the treatment cycle, with one DVA client describing it as a 'loophole'. In general, DVA clients feel it is a positive way to avoid the 12-session limitation. Two DVA clients described that they had brought the framework to the attention of their GP after hearing about it elsewhere.

> *'Yes, that's right. If it was 12 weeks, I'd be grinding my teeth [laughs]. Given this is all private and confidential, that's [At Risk Client Framework] how I'm getting around the 12-week side of things … That form doesn't seem to be easy to find on the DVA website'. (DVA client, 72, QLD)*

GP findings

GP survey results

Key findings for GPs are presented here. For a full report of GP survey results, please see Appendix 2.1, Q17–18, Q45–70.

GP: Information about the treatment cycle

GP knowledge of the treatment cycle was measured in two parts: first by when the GP first became aware of and subsequently by where they received information about the treatment cycle arrangements. The results indicated that:

- 49% (n = 73) of GPs were aware of the treatment cycle arrangements before October 2019.
- 39% (n = 58) of GPs received information directly from DVA about the treatment cycle arrangements before October 2019.
- 28% (n = 41) of GPs reported that they were informed about the treatment cycle arrangements from their DVA clients (multiple responses were allowed for this question).
- 87% (n = 128) of GPs reported they have consulted DVA clients under the treatment cycle arrangements (this was an additional screening question).

GP knowledge of the treatment cycle arrangements was also measured by asking GPs what they thought of the quality, understandability, actionability and relevance of the information provided about the treatment cycle. Responses were provided on a Likert scale that ranged from ‘strongly agree’ to ‘strongly disagree’, which were consolidated into ‘agree’, ‘neither’ and ‘disagree’ for reporting purposes. Overall, 64% (n = 95) of GPs thought the information was easy to understand, and 72% (n = 106) thought it was relevant to their practice. In total, 76% (n = 113) of GPs reported that the information was relevant to their clients’ needs. Further, 58% (n = 85) of GPs reported they were prepared for the changes, and 60% (n = 90) reported that they understood the changes. In addition, 62% (n = 92) of GPs reported feeling confident with the referral changes, and 57% (n = 84) reported that they were satisfied with the changes (see Figure 3.9).

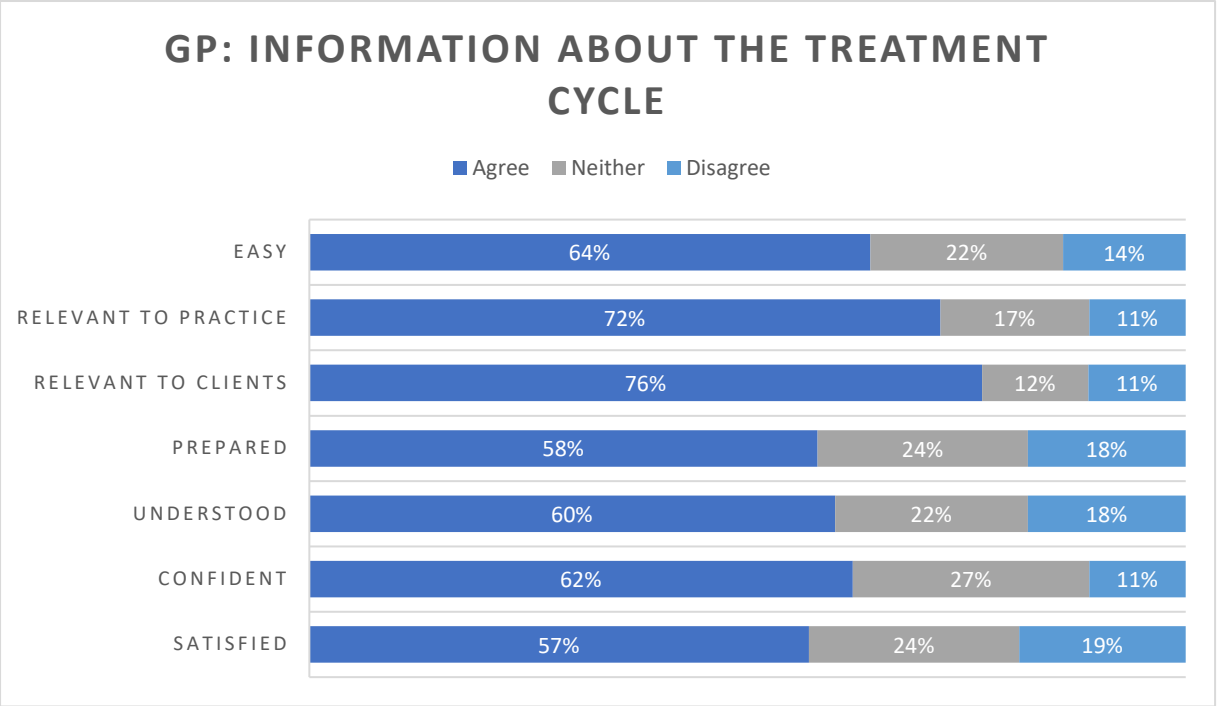


Figure 3.9: GP perspective on treatment cycle information

GP: COVID-19 impacts

GPs were asked if their GP services were impacted by COVID-19; response options were 'yes' or 'no'. In total, 62% (n = 92) of GPs indicated that they experienced impacts to their GP services due to COVID-19. Additionally, GPs were asked how their services had changed due to COVID-19. Responses included 'more telehealth', 'less in-person consultation', 'clients did not access services', 'no change in services', 'none of these' or 'other'. Overall, 62% (n = 91) of GPs reported an increase in telehealth.

GP: Implementing the treatment cycle

GPs were asked when they implemented the treatment cycle arrangements, with responses ranging from October 2019 – October 2020 (time of survey distribution), with two qualifier responses, including 'I'm not sure' and 'I have not implemented the treatment cycle'. Of the GPs, 29% (n = 43) reported implementing the treatment cycle in October 2019.

Additionally, to establish baseline usage of allied health services for DVA clients, GPs were asked when they had referred their DVA clients to allied health services.

Responses included ‘before October 2019 only’, ‘after October 2019 only’, ‘before and after October 2019’, and ‘I have never referred DVA clients for allied health services’. A total of 53% (n = 78) of GPs consulted with DVA clients both before and after the treatment cycle was implemented in October 2019.

GP: Satisfaction with the treatment cycle arrangements by age and location

GP satisfaction with the treatment cycle arrangements was analysed by age and geographic location. It was found that GPs 50 years old and younger were more likely to report that they were satisfied with the changes (63%, n = 72) compared to the older cohort (36%, n = 12). When analysed by geographic location, GPs in Queensland (34%, n = 13) and other states (South Australia, Tasmania, Northern Territory, Western Australia and ACT; 30%, n = 7) were more likely to report that they were not satisfied with the changes when compared to GPs in Victoria and New South Wales. New South Wales GPs were the most positive about the treatment cycle, with 65% (n = 35) reporting satisfaction with the changes. These statistics are shown in full in Table 3.5 and Table 3.6.

Table 3.5: Satisfaction with the treatment cycle by GP age

GPs: Since 1 October 2019, think about the first time you made a referral for a DVA client under the allied health treatment cycle arrangements.	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
I was prepared for the changes.				
Equal or less than 50 years	70 (60.9)	25 (21.7)	20 (17.4)	NS
More than 50 years	15 (45.5)	11 (33.3)	7 (21.2)	
I understood the changes.				
Equal or less than 50 years	73 (63.5)	23 (20.0)	19 (16.5)	NS
More than 50 years	17 (51.5)	9 (27.3)	7 (21.2)	
I had sufficient knowledge about the changes.				
Equal or less than 50 years	79 (68.7)	20 (17.4)	16 (13.9)	NS
More than 50 years	18 (54.5)	8 (24.2)	7 (21.2)	
I was confident referring DVA clients to a treatment cycle.				
Equal or less than 50 years	74 (64.3)	30 (26.1)	11 (9.6)	NS
More than 50 years	18 (54.5)	10 (30.3)	5 (15.2)	
I was satisfied with the changes.				
Equal or less than 50 years	72 (62.6)	23 (20)	20 (17.4)	< 0.05#
More than 50 years	12 (36.4)	12 (36.4)	9 (27.3)	
I have provided allied health services for DVA clients under the treatment cycle arrangements.				
Equal or less than 50 years	64 (55.7)	41 (35.7)	10 (8.7)	NS
More than 50 years	13 (39.4)	13 (39.4)	7 (21.2)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

Table 3.6: Satisfaction with the treatment cycle by GP state

GPs: Since 1 October 2019, think about the first time you made a referral for a DVA client under the allied health treatment cycle arrangements.	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
I was prepared for the changes.				
Queensland	21 (55.3)	5 (13.2)	12 (31.6)	NS
New South Wales	34 (63.0)	15 (27.8)	5 (9.3)	
Victoria	17 (51.5)	10 (30.3)	6 (18.2)	
Other	13 (56.5)	6 (26.1)	4 (17.4)	
I understood the changes.				
Queensland	23 (60.5)	5 (13.2)	10 (26.3)	NS
New South Wales	35 (64.8)	13 (24.1)	6 (11.1)	
Victoria	16 (48.5)	11 (33.3)	6 (18.2)	
Other	16 (69.6)	3 (13)	4 (17.4)	
I had sufficient knowledge about the changes.				
Queensland	24 (63.2)	5 (13.2)	9 (23.7)	NS
New South Wales	38 (70.4)	11 (20.4)	5 (9.3)	
Victoria	18 (54.5)	10 (30.3)	5 (15.2)	
Other	17 (73.9)	2 (8.7)	4 (17.4)	
I was confident referring DVA clients to a treatment cycle.				
Queensland	26 (68.4)	6 (15.8)	6 (15.8)	NS
New South Wales	33 (61.1)	19 (35.2)	2 (3.7)	
Victoria	17 (51.5)	11 (33.3)	5 (15.2)	
Other	16 (69.6)	4 (17.4)	3 (13)	
I was satisfied with the changes.				
Queensland	15 (39.5)	10 (26.3)	13 (34.2)	< 0.05#
New South Wales	35 (64.8)	15 (27.8)	4 (7.4)	
Victoria	19 (57.6)	9 (27.3)	5 (15.2)	
Other	15 (65.2)	1 (4.3)	7 (30.4)	
I have provided allied health services for DVA clients under the treatment cycle arrangements.				
Queensland	16 (42.1)	13 (34.2)	9 (23.7)	NS
New South Wales	33 (61.1)	18 (33.3)	3 (5.6)	
Victoria	16 (48.5)	14 (42.4)	3 (9.1)	
Other	12 (52.2)	9 (39.1)	2 (8.7)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

GP: Impacts of the treatment cycle arrangements

Participants were asked 'how have you been impacted by the changes to allied health treatment cycle arrangements? (select one only)'. The choices provided were 'positively impacted', 'negatively impacted', and 'not been impacted'. These data indicate respondents' perceptions about how the treatment cycle arrangements have affected them. Overall, 45% (n = 67) of GPs were positively affected by the treatment cycle arrangements, 25% (n = 37) of GPs were negatively impacted, and 30%

(n = 45) of GPs were not affected (see Figure 3.10). In addition, GPs were asked, 'have you experienced changes in the amount you see your DVA clients? (select one only)'. The response options included 'I see my DVA clients more', 'I see my DVA clients less', and 'I see my DVA clients the same amount' or 'other'. A total of 46% (n = 68) of GPs reported that they see their DVA clients more, 15% (n = 22) reported seeing their DVA clients less, and 37% (n = 55) reported seeing their DVA clients the same amount. Finally, 2% (n = 3) of GPs selected 'other' (see Figure 3.11).

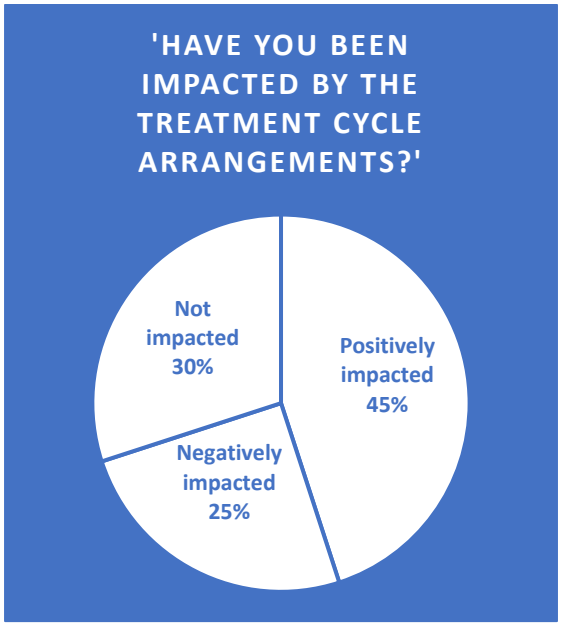


Figure 3.10: GPs' perceived impacts of treatment cycle arrangements

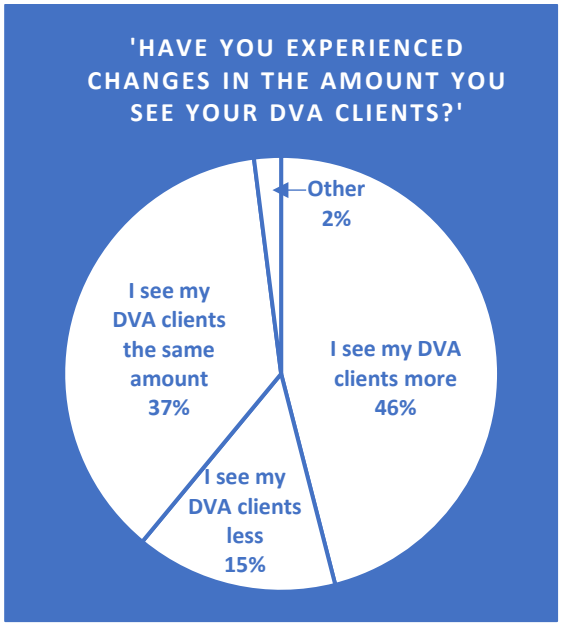


Figure 3.11: GPs' perceived interaction changes with DVA clients

GP: Quality of care

Quality of care was measured by asking GPs eight questions regarding the quality of care factors, with a response range of 'agree', 'somewhat agree', 'neither agree nor disagree', 'somewhat disagree', and 'disagree'. Responses were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes. In total, 55% (n = 82) of GPs reported issuing more referrals to meet their DVA clients' health care needs. A further 51% (n = 75) of GPs reported they contribute more to how their DVA clients' health care needs are met. In addition, 57% (n = 84) of GPs reported they discuss and review their DVA clients' health care needs more often and in more detail with them. In total, 60% (n = 89) of GPs reported they discuss and review their DVA clients' health care needs more often and in more detail with their clients' AHPs.

Overall, 54% (n = 79) of GPs reported that their DVA clients' health care needs are better met by the treatment cycle, and 55% (n = 82) GPs reported that their DVA clients have better access to necessary services to meet their health care needs. Finally, 58% (n = 86) of GPs reported their DVA clients receive better, targeted support based on their health care needs and that they receive better quality health care overall (see Figure 3.12).

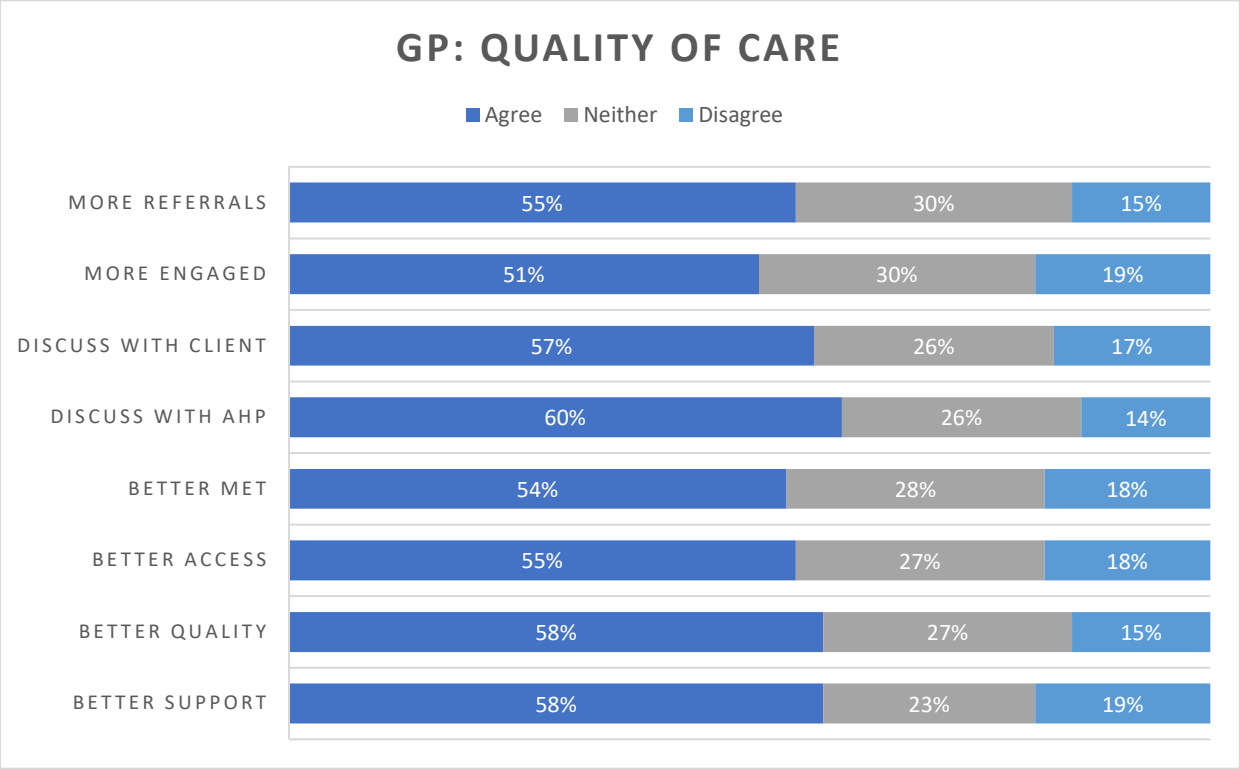


Figure 3.12: GP perspectives on quality of care

GP opinions of the quality of care provided to patients as a result of the treatment cycle were analysed by GP age, with five questions being found statistically significant. GPs aged 50 years or younger were more likely to agree that they provide more referrals for DVA clients to meet their health care needs (61%, n = 70) compared to GPs aged over 50 years, who were more likely to report that they were unsure (52%, n = 17). Similarly, younger GPs were more likely to report that they contribute more to how their DVA clients' health care needs are met (56%, n = 64), compared to the older cohort, who were more likely to be unsure (46%, n = 15). GPs in the 50 years and younger group were also more likely to report that they discuss the needs of their clients with AHPs (66%, n = 76) and that their clients receive better

quality health care overall (66%, n = 76) along with better, targeted health care (65%, n = 75). GPs in the older cohort were more likely to be unsure about each of these measures when compared to the younger group of GPs. These statistics are detailed in Table 3.7.

Table 3.7: Perceived quality of care by GP age

GPs: has your practice of quality health care for DVA clients changed?	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
I make more referrals for my DVA clients to meet their health care needs.				
Equal or less than 50 years	70 (60.9)	28 (24.3)	17 (14.8)	< 0.05#
More than 50 years	12 (36.4)	17 (51.5)	4 (12.1)	
I contribute more to how my DVA clients health care needs are met.				
Equal or less than 50 years	64 (55.7)	29 (25.2)	22 (19.1)	< 0.05#
More than 50 years	11 (33.3)	15 (45.5)	7 (21.2)	
My DVA clients and I discuss and review their health care needs more often and in more detail.				
Equal or less than 50 years	69 (60.0)	25 (21.7)	21 (18.3)	NS
More than 50 years	15 (45.5)	14 (42.4)	4 (12.1)	
My DVA client's AHP and I discuss and review our client's health care needs more often and in more detail.				
Equal or less than 50 years	76 (66.1)	21 (18.3)	18 (15.7)	< 0.05#
More than 50 years	13 (39.4)	17 (51.5)	3 (9.1)	
My DVA clients' health care needs are better met.				
Equal or less than 50 years	67 (58.3)	28 (24.3)	20 (17.4)	NS
More than 50 years	12 (36.4)	14 (42.4)	7 (21.2)	
My DVA clients have better access to necessary services to meet their health care needs.				
Equal or less than 50 years	69 (60.0)	28 (24.3)	18 (15.7)	NS
More than 50 years	13 (39.4)	12 (36.4)	8 (24.2)	
My DVA clients receive better quality of health care overall.				
Equal or less than 50 years	76 (66.1)	25 (21.7)	14 (12.2)	< 0.05#
More than 50 years	10 (30.3)	15 (45.5)	8 (24.2)	
My DVA clients receive better, targeted support based on their health care needs.				
Equal or less than 50 years	75 (65.2)	21 (18.3)	19 (16.5)	< 0.05#
More than 50 years	11 (33.3)	13 (39.4)	9 (27.3)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

GP: Care coordination

Care coordination was measured by asking GPs who coordinates their DVA clients' care, with five options including themselves, their DVA client, their client's AHP, jointly with their client's AHP, someone else, or jointly coordinated with others. Comprehensive results can be viewed in Appendix 2.1, Q65. The results can be summarised as follows (this question was answered on a yes or no basis for each option, hence why the total percentages do not equal 100%):

- 70% (n = 104) of GPs reported that they coordinate their DVA clients' health care.
- 63% (n = 93) of GPs reported that their DVA clients coordinate their health care.
- 57% (n = 85) of GPs reported their DVA client's AHP coordinates their health care.

GP: Care coordination with DVA clients

Care coordination was measured by asking GPs five questions; responses ranged from 'agree' to 'disagree' and were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes (see Figure 3.13). Comprehensive results can be viewed in Appendix 2.1, Q63. The results are as follows:

- 58% (n = 85) of GPs reported that before making a referral to treatment cycles, they discuss their DVA client's health care needs with them in more detail.
- 59% (n = 87) of GPs reported that after finishing a treatment cycle, they review their DVA client's ongoing health care needs with them in more detail.
- 59% (n = 87) of GPs reported that the number of interactions with their DVA clients has increased.
- 55% (n = 81) of GPs reported that the quality of their interactions with their DVA clients has improved.
- 60% (n = 88) of GPs reported that they have more opportunities to discuss and review their DVA client's health care needs with them.

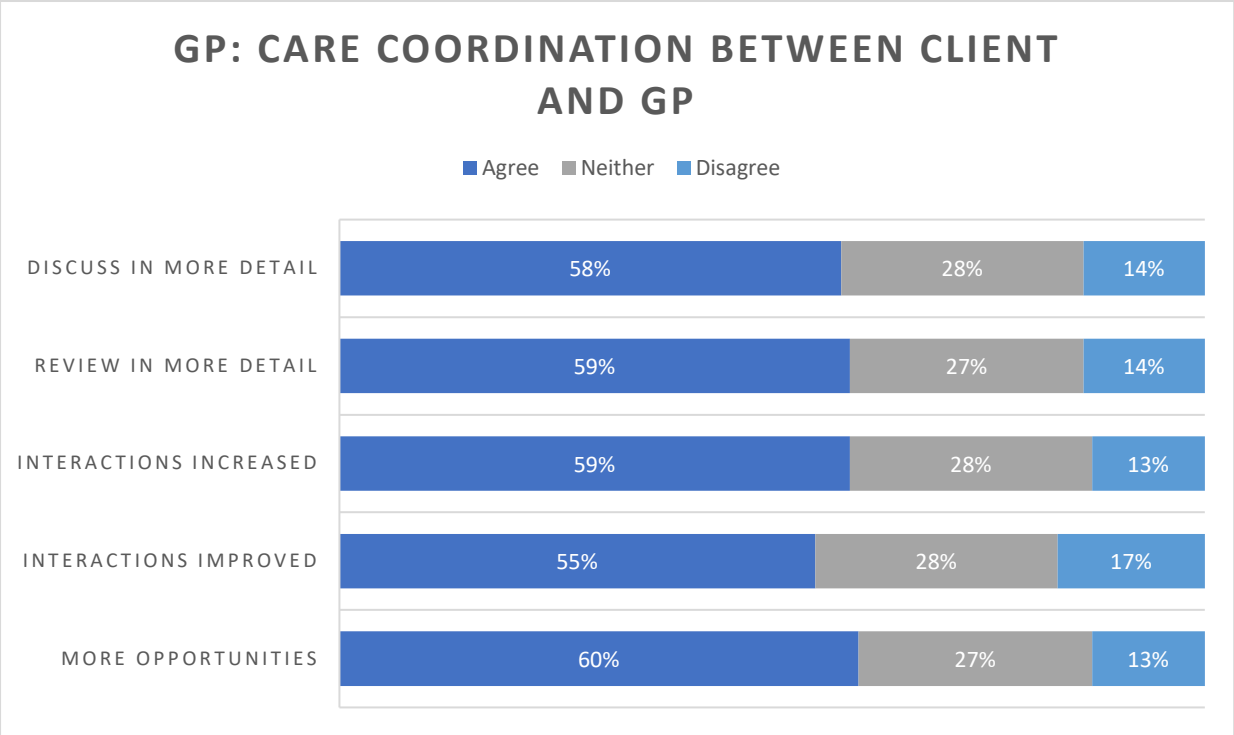


Figure 3.13: GP perspectives on care coordination between clients and GPs

GP: Care coordination between AHPs and GPs

Care coordination was measured by asking GPs nine questions; responses ranged from 'agree' to 'disagree' and were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes. Comprehensive results can be viewed in Appendix 2.1, Q66.

Overall, 61% (n = 91) of GPs reported that their DVA clients' AHPs provide reports. A further 65% (n = 96) of GPs reported that they review and discuss the reports with their clients and seek their opinion. A total of 69% (n = 102) of GPs reported they make additional referrals based on the report, their client's opinion and their own professional judgement. Overall, 73% (n = 108) of GPs reported that they ensure their DVA clients are included in the decision-making process to meet their health care needs. In addition, 68% (n = 101) of GPs reported they ensure their DVA clients are informed about communications, decisions and recommendations between them and their AHPs. Finally, 64% (n = 94) of GPs reported having more opportunities to discuss and review their DVA client's health care needs with their AHP (see Figure 3.14).

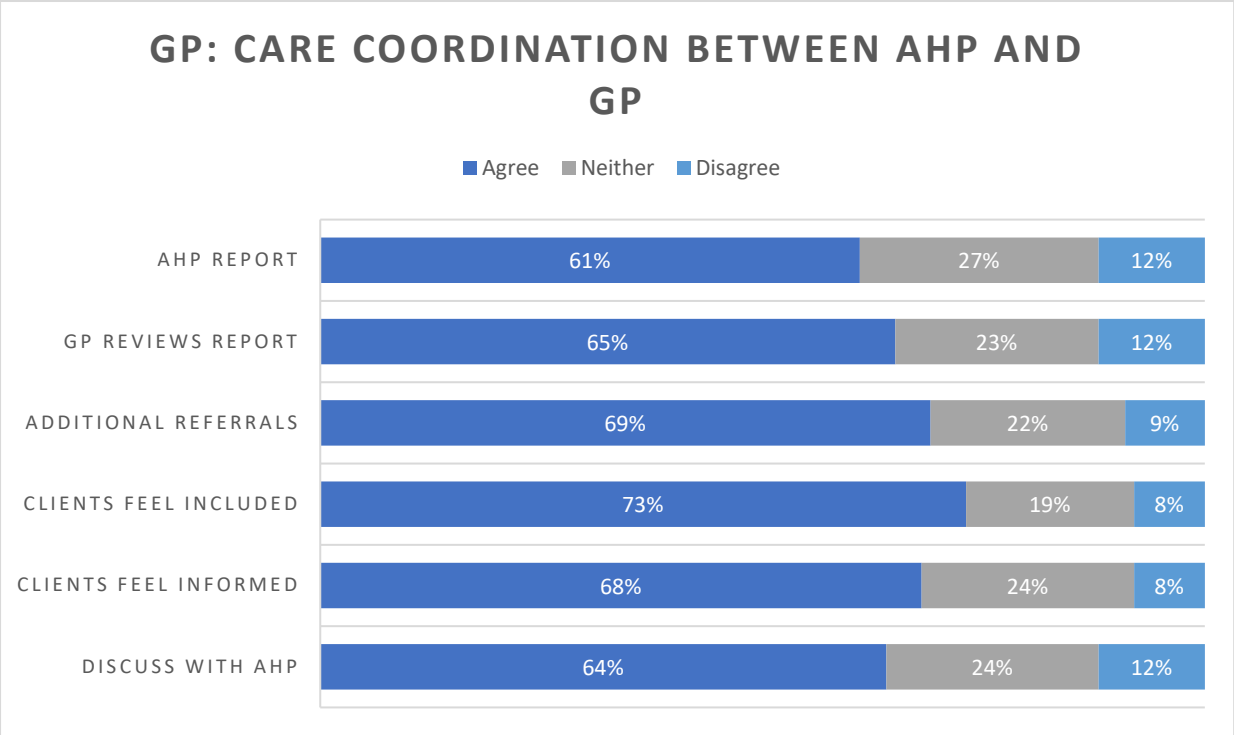


Figure 3.14: GP perspectives on care coordination between AHPs and GPs

GP: At Risk Client Framework efficacy

The efficacy of the At Risk Client Framework was measured by asking GPs eight questions about their opinion of the framework. Responses ranged from 'agree', 'somewhat agree', 'somewhat disagree', and 'disagree'. The responses were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes. In total, 57% (n = 84) of GPs thought they had sufficient knowledge about the framework, and 58% (n = 86) of GPs reported they understood the framework. Further, 63% (n = 94) of GPs reported applying the framework, and 62% (n = 92) were satisfied with the framework criteria. In addition, 54% (n = 80) of GPs agreed that the framework meets complex health care needs, and 60% (n = 89) of GPs believe the framework ensures quality primary coordinated care. Finally, 53% (n = 79) of GPs agreed that few DVA clients require the framework (see Figure 3.15).

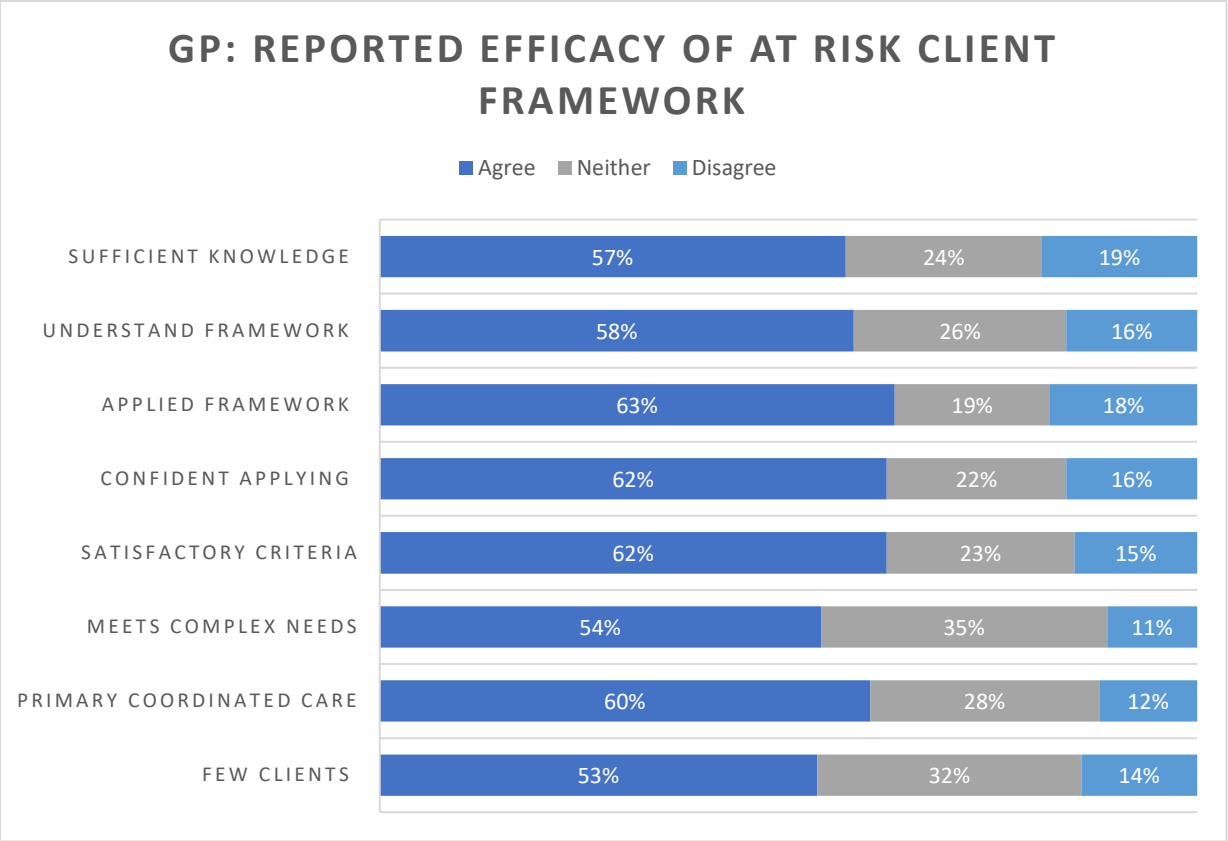


Figure 3.15: Reported efficacy of the At Risk Client Framework

GP opinions on the At Risk Client Framework were analysed by the age and gender of GP survey respondents (see Table 3.8). Both GP age and gender differences were found to be statistically significant in regard to the following statement: 'A very small percentage of DVA clients require tailored referral arrangements under the framework'. GPs 50 years old and younger were more likely to agree with this statement (57%, n = 66) than GPs in the older age group (40%, n = 13). Male GPs were more likely to agree (58%, n = 56) or be unsure regarding the statement (34%, n = 33), compared to female GPs, who were more evenly spread across agree, disagree, and unsure responses.

Table 3.8: Professional opinion of the At Risk Client Framework by GP age and gender

GPs: Professional opinion of the At Risk Client Framework	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
A very small percentage of DVA clients require tailored referral arrangements under the framework.				
Equal or less than 50 years	66 (57.4)	34 (29.6)	15 (13.0)	< 0.05#
More than 50 years	13 (39.4)	14 (42.4)	6 (18.2)	
Male	56 (58.3)	33 (34.4)	7 (7.3)	< 0.05#
Female	23 (44.2)	15 (28.8)	14 (26.9)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

GP: Other impacts and themes

Text responses were obtained from GPs in the last question of the survey, which asked GPs to respond to the following question: 'compared to before 1 October 2019, I now think that the referral process for treatment cycle arrangements is…'. This question allowed GPs to select multiple responses and provide text comments. The impacts included 16 options, including more time-consuming or time-efficient, more or less expensive, more complex or simpler and straightforward, more or less effective, unimproved or improved, more or less flexible, more or less administrative, other and none of the above. For full details, see Appendix 2.1, Q70.

- 49% (n = 73) of GPs reported that the treatment cycle is more time-consuming.
- 29% (n = 44) of GPs reported that the treatment cycle is more expensive.
- 28% (n = 42) of GPs reported that the treatment cycle is more complex.
- 29% (n = 44) of GPs reported that the treatment cycle is more effective.
- 26% (n = 38) of GPs reported the treatment cycle is better and improved.
- 32% (n = 48) of GPs reported the treatment cycle is less administrative.

For the text responses to the above question, the following themes were identified.

GP administrative burden

GP survey respondents reported that client referrals for treatment cycles often do not match, resulting in multiple referrals for multiple conditions.

'One of my patients has twice weekly physio in the home, as well as OT regularly and social work support. None of the DVA cycles match up and I am forever receiving requests from the various agencies to write another referral cycle. It is driving me insane with just this one patient, let alone all the others'. (GP, survey response)

Further, GP survey responses indicated that the treatment cycle involved more appointments and consultations each week just for referrals and paperwork. This resulted in increased consultation times due to the complexity of the referral process. Some GP responses indicated that GPs were required to complete paperwork or referrals unpaid and in their own time. Survey responses also indicated that the forms required are longer, not auto-populated, and cannot be downloaded from the DVA website. GPs reported that referral templates are not user-friendly nor fit for purpose and that the relevant areas are too small and time-consuming.

GP survey respondents also reported issues with receiving End of Cycle reports from AHPs. One respondent explained that, despite increased reporting, they rarely read reports unless it was for an acute issue.

'The increased reporting requirements for AHPs are just bureaucratic red tape. I rarely read them unless it is regarding an acute issue. If a vet[eran] feels they are benefiting, then I will always re-refer them regardless of the report. Putting more paperwork in place doesn't make the system better'. (GP, survey response)

GP opinions of service impacts and outcomes

Some GP survey respondents described the treatment cycle arrangements as not suitable for chronic conditions, especially those with no change in outcomes over time. In contrast, other GP respondents describe the treatment cycle as providing better care. Comments included that the treatment cycle is better for acute care, that more frequent reviews are good, it is more thorough for diabetes care (e.g., podiatry) and that they are seeing DVA clients less.

'For acute care which often turns in to unnecessary chronic care it is good to have limitations'. (GP, survey response)

GP expenses and costs

Survey responses from GPs describe that increased expenses resulting from the treatment cycle arrangements can be attributed to the increased cost to Medicare (consultation billing). Responses also described the unnecessary consultation fees resulting from the treatment cycle arrangements when 12 sessions are insufficient to address clients' health care needs.

'I have to facilitate approx. 20 extra consults per week, charged to Medicare, to facilitate referrals which takes away from my other patients' ability to see me'. (GP, survey response)

GP attitudes towards the treatment cycle arrangements

Overall comments about the treatment cycle arrangements from GPs included that they did not understand the requirements and that they were guessing what to do. Other comments included that they felt that the treatment cycle is bureaucratic, and another respondent explained that they believe that the treatment cycle is worse but provides better feedback from AHPs (especially physiotherapists).

'I still do not fully understand what all the requirements are. DVA have never given me any information—I just have to take my best guess what to do'. (GP survey response)

GP interview results

Results have been presented according to the themes identified within the data. For a full report of interview results, please see Appendix 4.

GP: Perception of treatment cycle communication

There were mixed reports from GP interview participants regarding the communication of the treatment cycle arrangements. Similar to DVA clients, one GP reported that the quality of the information was 'okay' but not clear in communicating the reasons behind the changes and that they would have preferred to be consulted on the changes. One GP interviewee noted that they did not know of the treatment cycle arrangements until completing the survey for this report. There was a recommendation that face-to-face communication, rather than letters or emails, is the most effective way for DVA to communicate information with GPs. Another GP interviewee noted that communication through professional associations was the most common channel of information about the treatment cycle arrangements.

'The first I heard about it was through advocates and patients who told me it was coming. Then I didn't really receive anything until the 11th hour in the sense of it was only either weeks or a month prior to the cycle starting or the requirement starting that I actually heard from DVA and then heard from RACGP'. (GP, QLD)

Communication between GPs and AHPs

Interviews with AHPs revealed the belief that the information presented in the End of Cycle reports will not be read by GPs. Interestingly, this was confirmed by interviews with GPs, who reported that there were too many reports pertaining to DVA clients for them to read them all. Some AHP interviewees described their frustration and difficulties when trying to communicate with GPs and reported that they feel that they are not listened to by GPs.

'We have to send reports to the doctors which are not really showing any major need to communicate so I feel like you're—overcommunicating with the GPs. So, I'm concerned that when I do need to send them emails, they're not going to really pay attention because I'm sending them emails regularly regarding DVAs with no significant information to report'. (AHP, Osteopath, NSW)

'But the other problem about that is that because I have so many DVA clients, I get so many allied health reports, that it's difficult to spend a lot of time in each one, reading them all through and dissecting everything that they say'. (GP, QLD)

GP: Increased burden of administration

An increased administration load was described by GP interviewees. One DVA client interviewee reported an interaction with their GP in which the doctors complained of a higher administration load due to the treatment cycle arrangements. Similar to AHP interviewee reporting, GPs also linked the increased administration to financial issues of DVA remuneration.

'It's just added an administrative burden to my life which I was already busy enough, I didn't really need. So it's just adding an extra layer of complexity to the DVA patient's life, to my life, to receptionists. Of course, every time we need another referral, it's just another administrative step for the receptionist. We don't get paid for those administrative steps, so whether that means they have to scan it and email it to the patient, if you add that extra burden regularly it adds up for their time'. (GP, 39, QLD)

GP: Health care coordination

All GP interviewees reported that they are the sole coordinators of patient health care.

'Yes, that's the whole purpose [of the treatment cycle arrangements], to try and use the GP as the gatekeeper and coordinator, with discussion with the other allied health in respect to the patient'. (GP, VIC)

GP: At Risk Client Framework

None of the GPs interviewed was very familiar with the framework. One had not heard of it at all.

'Yeah, now that you've mentioned it, I didn't know the name of it, but one of my patients had mentioned it or asked about it a while back and I hadn't had a chance to look into it. Again it's just you get so many information emails come through every week and there's only a certain amount of time to read them all and get a handle on what's required of them'. (GP, QLD)

AHP findings

AHP survey results

Key findings for AHPs are presented here. For a full report of AHP survey results, please see Appendix 2.1, Q17–18, Q45–47, Q71–89.

AHP: Information about the treatment cycle arrangements

AHP knowledge about the treatment cycle arrangements was measured in two parts: First, by when AHPs first became aware of the treatment cycle arrangements, and second, where they received information about the treatment cycle. The results are as follows (multiple responses were allowed for this question):

- 72% (n = 316) of AHPs were aware of the treatment cycle arrangements before October 2019.
- 41% (n = 181) of AHPs received information from DVA about the treatment cycle arrangements before October 2019.
- 37% (n = 164) of AHPs reported being informed about the treatment cycle arrangements from their professional association (email/letter).

AHP knowledge of the treatment cycle was further measured by asking AHPs what they thought of the quality, understandability, actionability and relevance of information available about the treatment cycle arrangements. Responses ranged from ‘agree’, ‘somewhat agree’, ‘somewhat disagree’, to ‘disagree’. These categories were consolidated into ‘agree’, ‘neither’ and ‘disagree’ for reporting purposes. Overall, 53% (n = 234) of AHPs thought the information was easy to understand, and 64% (n = 284) of AHPs thought the information was relevant to their practice. A total of 52% (n = 230) of AHPs reported that the information was relevant to their clients’ needs. Further, 57% (n = 254) of AHPs reported they were prepared for the treatment cycle arrangements, and 65% (n = 286) of AHPs reported that they understood the changes. In addition, 64% (n = 283) of AHPs reported they were confident with the referral changes, and 27% (n = 119) AHPs reported satisfaction with the changes (see Figure 3.16).

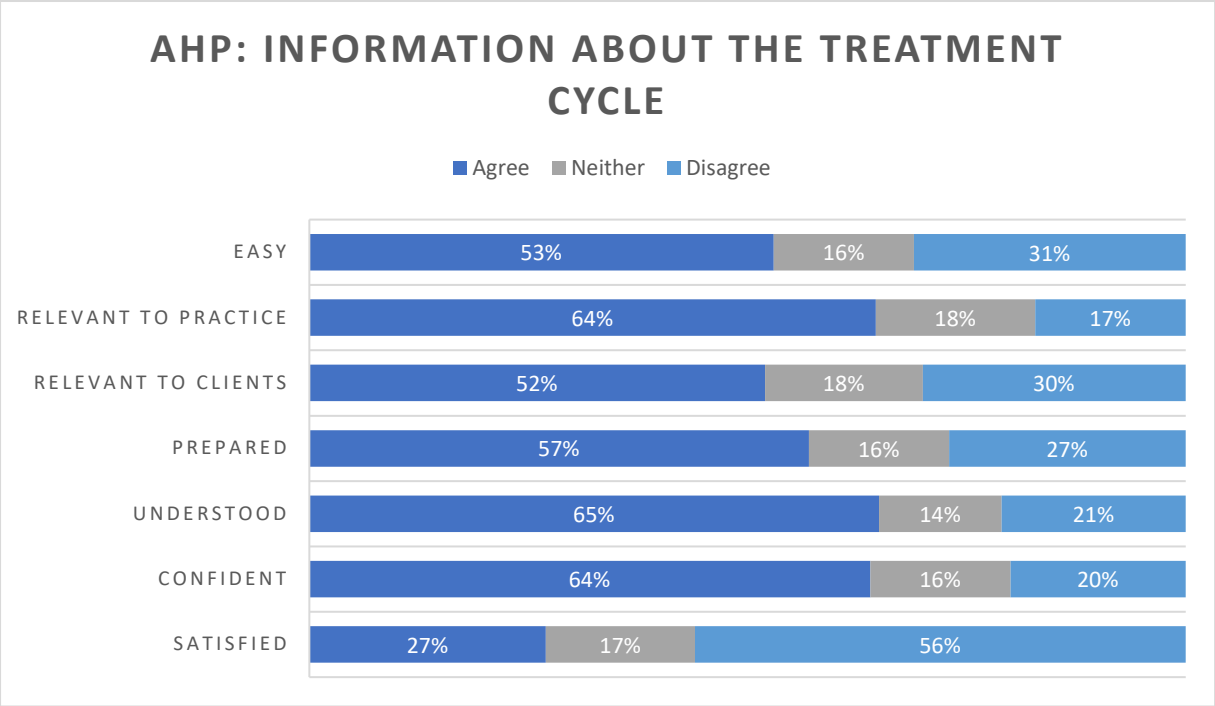


Figure 3.16: AHP perspectives on information about treatment cycle arrangements

AHP: Implementing the treatment cycle arrangements

AHPs were asked when they implemented the treatment cycle with responses ranging from October 2019 – October 2020 (time of survey distribution), with two qualifier responses including 'I'm not sure' and 'I have not implemented the treatment cycle'. In total, 56% (n = 247) of AHPs implemented the treatment cycle in October 2019.

Additionally, to establish DVA clients' baseline usage for allied health services, AHPs were asked when they had treated their DVA clients for allied health services. Responses included 'before October 2019 only', 'after October 2019 only', 'before and after October 2019' and 'I have never treated DVA clients for allied health services'. Overall, 82% (n = 363) of AHPs treated DVA clients both before and after the treatment cycle was implemented in October 2019.

AHP: Impacts of the treatment cycle arrangements

AHP survey respondents were asked, 'how have you been impacted by the changes to allied health treatment cycle arrangements? (select one only)'. The choices provided were 'positively impacted', 'negatively impacted' and 'not been impacted'.

These data indicate the respondents' perceptions about how the treatment cycle has affected them. Overall, 13% (n = 56) of AHPs reported being positively affected, 54% (n = 240) reported being negatively affected, and 33% (n = 145) were not affected by the treatment cycle (see Figure 3.17). In addition, AHPs were asked, 'have you experienced changes in the amount you see your DVA clients?'. The response options included 'I see my DVA clients more', 'I see my DVA clients less', 'I see my DVA clients the same amount' or 'other'. In total, 9% (n = 39) of AHPs reported that they see their DVA clients more, 23% (n = 101) reported seeing their DVA clients less, 63% (n = 276) reported seeing their DVA clients the same amount, and 5% (n = 25) selected 'other' (see Figure 3.18).

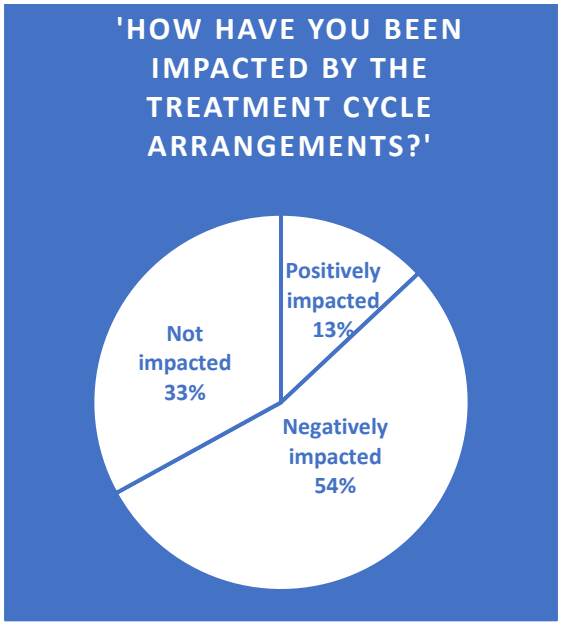


Figure 3.17: AHP perceived impacts of treatment cycle arrangements

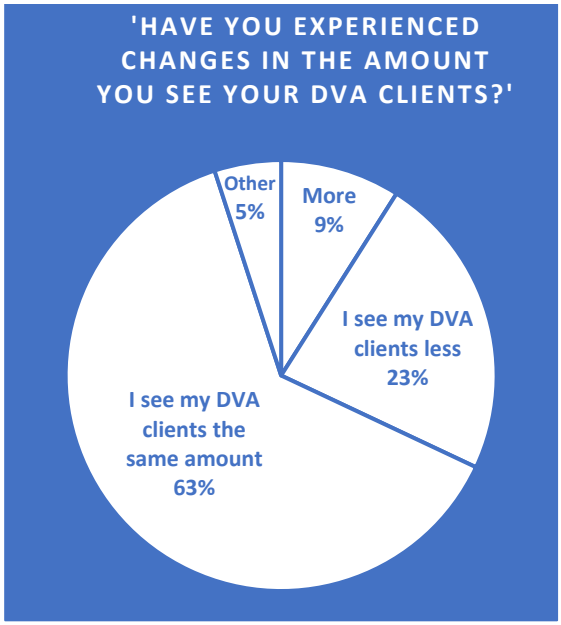


Figure 3.18: AHP perceived changes to interactions with clients

AHP perspectives about the impact of the treatment cycle arrangements were further analysed by AHP gender, age and geographic location. Only AHP state of practice was statistically significant, as detailed in Table 3.9. AHPs practising in New South Wales were slightly more likely to report being positively affected by the treatment cycle arrangements (22%, n = 23) than other states and territories.

Table 3.9: Perceived impact of the treatment cycle arrangements by AHP gender, age and state

AHPs: impacted by the changes to referrals for allied health treatment cycle arrangements	**I have been negatively impacted by the changes N (%)**	**I have not been impacted by the changes N (%)**	**I have been positively impacted by the changes N (%)**	**Sig.**
Gender				
Male	83 (53.5)	48 (31.0)	24 (15.5)	NS
Female	150 (52.6)	96 (33.7)	39 (13.7)	
Prefer not to say	7 (87.5)	1 (12.5)	0 (0.0)	
Age				
Equal or less than 50 years	182 (51.7)	121 (34.4)	49 (13.9)	
More than 50 years	57 (65.5)	23 (26.4)	7 (8.0)	
State				
Queensland	77 (57.9)	47 (35.3)	9 (6.8)	< 0.05#
New South Wales	47 (43.9)	37 (34.6)	23 (21.5)	
Victoria	51 (58.0)	27 (30.7)	10 (11.4)	
Other	65 (57.5)	34 (30.1)	14 (12.4)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

AHP: COVID-19 impacts

AHPs were asked if their health services were affected by COVID-19; response options were ‘yes’ or ‘no’. Overall, 74% (n = 327) of AHPs reported impacts to their allied health services due to COVID-19. Additionally, AHPs were asked how their services had changed due to COVID-19. Responses included ‘more telehealth’, ‘less in-person consultation’, ‘clients did not access services’, ‘no change in services’, ‘none of these’ or ‘other’. In total, 38% (n = 168) of AHPs reported an increase in telehealth, and 51% (n = 224) of AHPs reported fewer in-person consultations.

AHP: Quality of care

Quality of care was measured by asking AHPs eight questions regarding the quality of care measures, with a response range of ‘agree’, ‘’somewhat agree, ‘neither agree’ ‘nor disagree’, ‘somewhat disagree’ and ‘disagree’. Responses were consolidated into ‘agree’, ‘neither’ and ‘disagree’ for reporting purposes. Overall, 21% (n = 94) of AHPs reported receiving more referrals to meet their DVA clients’ health care needs. A further 25% (n = 109) of AHPs reported contributing more to

how their DVA clients' health care needs are met. In addition, 31% (n = 137) of AHPs reported that they discuss and review their DVA clients' health care needs more often and in more detail with them, while 35% (n = 153) reported that they discuss and review their DVA clients' health care needs more often and in more detail with their client's GP. A total of 49% (n = 215) of AHPs disagreed with the statement that their DVA clients' health care needs are better met by the treatment cycle, and 52% (n = 230) of AHPs disagreed that their DVA clients' have better access to necessary services to meet their health care needs. Finally, 46% (n = 201) of AHPs disagreed that their DVA clients receive better, targeted support based on their health care needs and that they receive better quality health care overall (see Figure 3.19).

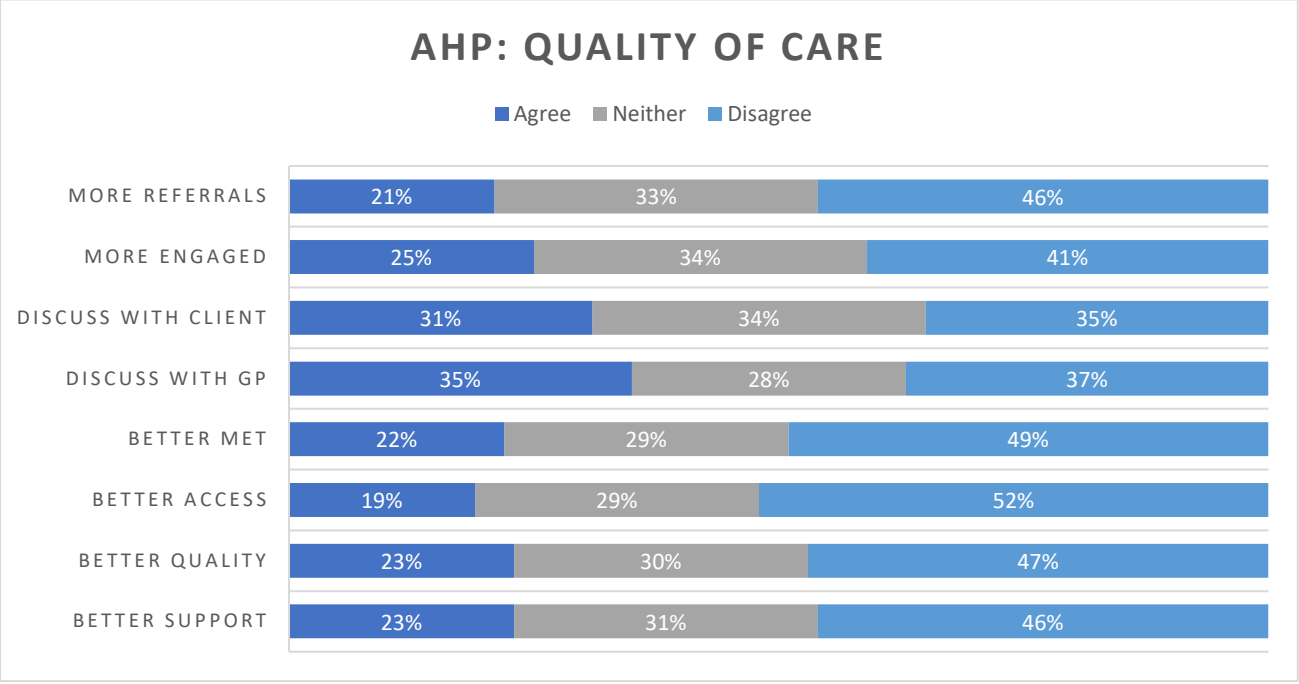


Figure 3.19: AHP perspectives on quality of care

AHP: Quality of care by age

AHP perspectives on the quality of care as a result of the treatment cycle arrangements were analysed by the age of AHP respondents (see Table 3.10). AHPs aged over 50 years were more likely to disagree with the statement 'I discuss and review my DVA client's health care needs with them more often and in more detail' (49%, n = 43) than AHPs aged 50 years old or younger. This younger cohort was more evenly spread across 'agree', 'disagree', and 'neither agree nor disagree' responses. AHPs aged 50 years or younger were also slightly more likely to agree

that they receive and accept more referrals for DVA clients (24%, n = 85) than AHPs aged over 50 years (10%, n = 9).

Table 3.10: Perceived quality of care by AHP age

AHPs: has your practice of quality health care for DVA clients changed?	**Agree** N (%)	**Neither agree nor disagree** N (%)	**Disagree** N (%)	**Sig.**
I receive and accept more referrals for my DVA clients to meet their health care needs.				
Equal or less than 50 years	85 (24.1)	116 (33.0)	151 (42.9)	< 0.05#
More than 50 years	9 (10.3)	28 (32.2)	50 (57.5)	
I contribute more to how my DVA clients' health care needs are met.				
Equal or less than 50 years	91 (25.9)	123 (34.9)	138 (39.2)	NS
More than 50 years	18 (20.7)	27 (31.0)	42 (48.3)	
I discuss and review my DVA clients' health care needs with them more often and in more detail.				
Equal or less than 50 years	116 (33.0)	129 (36.6)	107 (30.4)	< 0.05#
More than 50 years	21 (24.1)	23 (26.4)	43 (49.4)	
I discuss and review my DVA clients' ongoing health care needs with their GPs more often and in more detail.				
Equal or less than 50 years	123 (34.9)	101 (28.7)	128 (36.4)	NS
More than 50 years	30 (34.5)	22 (25.3)	35 (40.2)	

Note: NS = not significant (p > 0.05); # = significant at 0.05 level (p < 0.05).

AHP: Care coordination

Care coordination was measured by asking AHPs who coordinates their DVA clients' care. Survey respondents were provided six options, including themselves, their DVA client, their client's GP, jointly with their client's GP, someone else, or jointly coordinated with others. See Appendix 2.1, Q86 for all responses. The results are compiled as follows (each question required a yes or no answer, hence why the total percentages do not equal 100%):

- 57% (n = 251) of AHPs reported coordinating their DVA clients' health care.
- 62% (n = 271) of AHPs reported that their DVA clients coordinate their health care.

- 79% (n = 347) of AHPs reported that their DVA client's GP coordinates their health care.

AHP: Care coordination with clients

Care coordination was measured by asking AHPs five questions; responses ranged from 'agree' to 'disagree' and were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes (see Figure 3.20). Comprehensive results can be viewed in Appendix 2.1, Q84. The results revealed the following:

- 32% (n = 139) of AHPs reported that before starting treatment cycle arrangements, they discuss their DVA client's health care needs with them in more detail.
- 36% (n = 159) of AHPs reported that after finishing a treatment cycle, they review their DVA client's ongoing health care needs with them in more detail.
- 18% (n = 79) of AHPs reported that the number of interactions with their DVA clients had increased.
- 21% (n = 91) of AHPs reported that the quality of their interactions with their DVA clients had improved.
- 22% (n = 98) of AHPs reported having more opportunities to discuss and review their DVA client's health care needs with them.

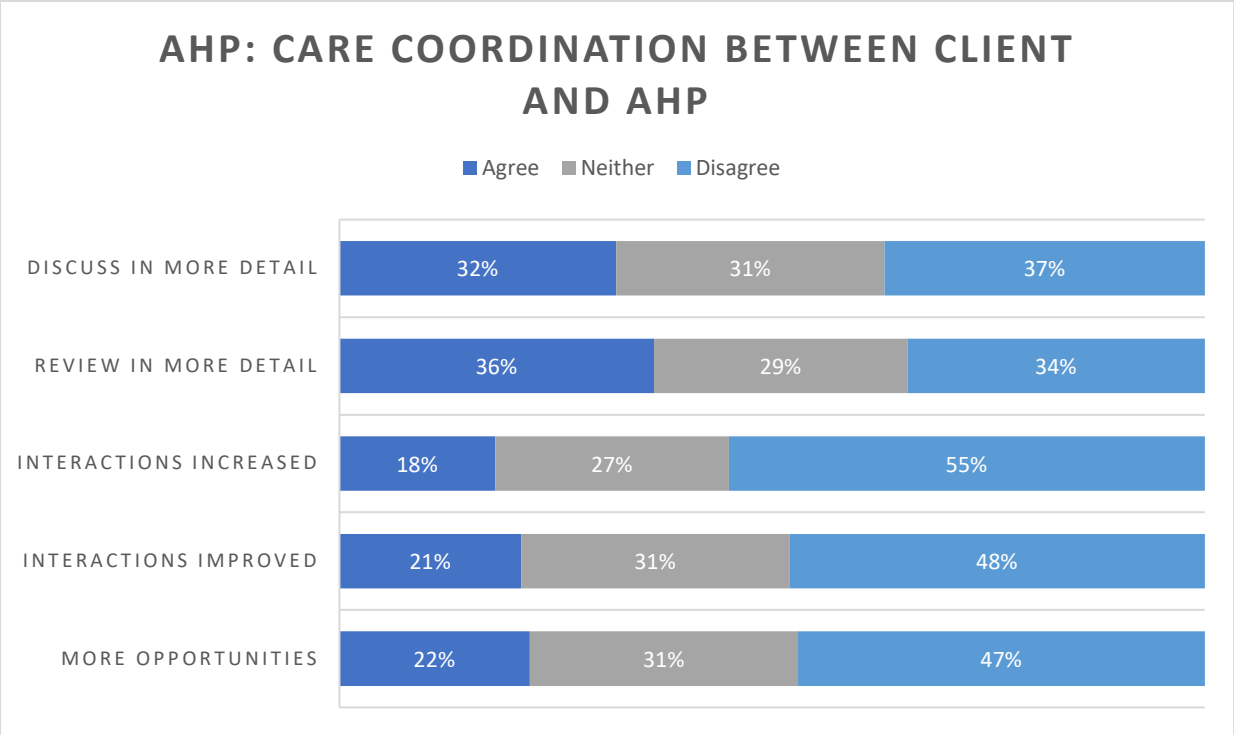


Figure 3.20: AHP perspectives on care coordination between clients and AHPs

AHP: Care coordination between AHPs and GPs

Care coordination was measured by asking AHPs nine questions; responses were consolidated into 'agree', 'neither' and 'disagree' for reporting purposes. Comprehensive results can be viewed in Appendix 2.1, Q17–18, Q45–47, and Q71–89. Overall, 78% (n = 342) of AHPs reported that they provide reports to their DVA client's GP. A further 65% (n = 285) of AHPs reported that they review and discuss the reports with their clients and seek their opinion. A total of 60% (n = 265) of AHPs reported accepting additional referrals based on the report, their client's opinion and the GPs professional judgement. In addition, 76% (n = 336) of AHPs reported ensuring their DVA clients are included in the decision-making process to meet their health care needs, and 75% (n = 331) of AHPs reported ensuring their DVA clients are informed about communications, decisions and recommendations between them and their GP. Finally, 30% (n = 132) of AHPs reported having more opportunities to discuss and review their DVA client's health care needs with their GP (see Figure 3.21).

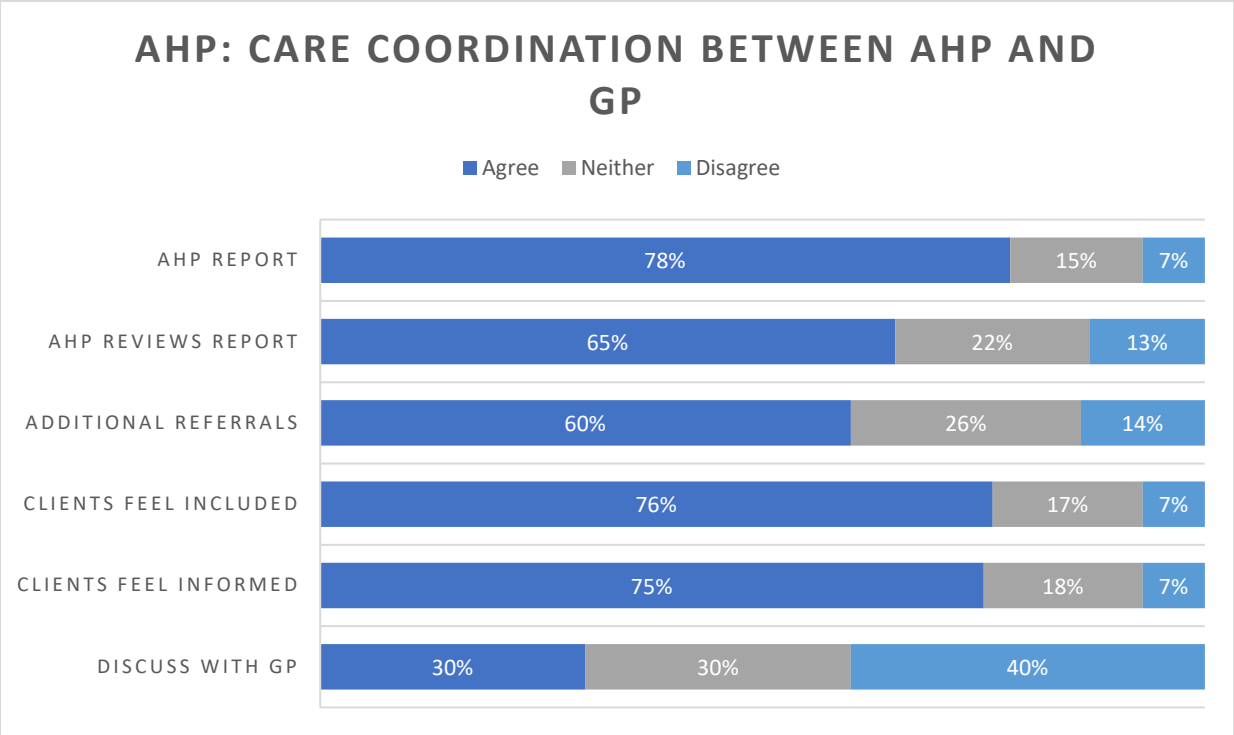


Figure 3.21: AHP perspectives on care coordination between AHPs and GPs

AHP: Other impacts and themes

Themes were obtained from the last question in the survey, which asked AHPs, 'compared to before 1 October 2019, I now think that the referral process for treatment cycle arrangements is…' and allowed AHPs to select multiple responses and provide comments. The impacts included 16 options: more time-consuming or time-efficient; more or less expensive; more complex or simpler and more straightforward; more or less effective; unimproved and worse or improved and better; more or less flexible, responsive and dynamic; more or less administrative; other; and none of the above. The final survey results are as follows:

- 76% (n = 335) of AHPs reported that the treatment cycle arrangements are more time-consuming.
- 41% (n = 180) of AHPs reported that the treatment cycle arrangements are more expensive.
- 56% (n = 246) of AHPs reported that the treatment cycle arrangements are more complex.

- 38% (n = 166) of AHPs reported that the treatment cycle arrangements are less effective.
- 40% (n = 177) of AHPs reported that the treatment cycle arrangements are unimproved and worse.
- 36% (n = 160) of AHPs reported that the treatment cycle arrangements are less flexible, responsive and dynamic.
- 71% (n = 314) of AHPs reported that the treatment cycle arrangements are more administrative.

AHP administrative burden

Similar to the GPs' text responses, AHP survey respondents described the treatment cycle as significantly more time-consuming regarding administration. AHPs described having to constantly monitor referrals and appointments. They also had to schedule completing the End of Cycle report to continue providing care without gaps. AHP respondents reported significantly increased time spent following up requests for additional referrals and that there was more time spent on assessments and paperwork (End of Cycle report) than treatment provision.

> *'This is massive. The HUGE amount of extra documentation is not compensated financially. Also chasing up GP's to get ongoing referrals is a nightmare. It takes forever and we do not get paid for it. It also then means treatment for the veterans is delayed as we cannot see them without an additional referral'. (AHP, survey response, participant's capitalisation for emphasis)*

Reports, frameworks and assessments

AHP survey responses described the report formats as 'smaller' but insufficient for capturing treatment plans and outcomes and that they cannot capture what was actually done with the patient. AHP comments report that the End of Cycle report format is too specific and does not accurately reflect patient treatment and outcomes. Another AHP comment notes that report formats require information that is not relevant to all clients and allied health services. Overall, AHP comments

reflected that additional reporting requirements have resulted from the treatment cycle arrangements with no benefit to clients.

> *'Paperwork not fit for purpose. Not specific to that patient. A letter detailing treatment plans/option and frequencies/health constraints would be more beneficial. I'm sure the GPs don't understand half of that form'. (AHP, survey response)*

AHP service impacts and outcomes

Some AHP text responses reported that the treatment cycle has resulted in more straightforward service. One AHP noted that the treatment cycle was 'more defined, as patients were aware of the treatment plan'. Other AHP comments reported that the arrangements were more effective for establishing timeframes for goals and that the standardisation of care with outcome measures was positive.

> *'More defined and patients aware of the plan'. (AHP, survey response)*
>
> *'[More effective] in terms of implementing a timeframe for goals'. (AHP, survey response)*

In contrast, other AHP text responses described fewer or slower outcomes for patients as a result of the treatment cycle arrangements because of minimal changes within 12 sessions (particularly for chronic conditions). Text comments included that the treatment cycle arrangements negatively impact continuity of care, that there was additional time spent explaining changes to clients and GPs and that there were delays in service provision due to expired referrals.

'Especially if a client is living with a chronic, complex disease and not exempt from the 12-session treatment cycle. MANY DVA clients live with ongoing, complex, chronic disorders, conditions that require ongoing care. Unless there is an acute injury most DVA clients would require more than one 12-session treatment cycle'. (AHP, survey response, participant's capitalisation for emphasis))

AHP expenses and costs

The AHP survey responses reported an overarching theme of increased expenses and costs resulting from the treatment cycle arrangements. The reasons for increased costs were attributed to a wide range of causes; some of these included costs associated with more staff required to follow up on referrals, the End of Cycle report fee ($30) being insufficient to cover the cost of time required to write it, other unpaid administrative costs (e.g., report writing and referral follow-up) and not being paid for initial consultations and assessments. In addition, AHP comments on costs included increased expenses related to software upgrades to accommodate the new templates. Some AHPs noted the treatment cycle arrangements resulting in fewer expenses because clients were forgoing treatment to avoid more GP visits. Further, telehealth options were perceived as a significant improvement for client care and outcomes and were reported as more cost and time-effective.

'Increased admin time to follow up on referrals. Together with low rates offered by DVA, I and my colleagues are likely to cease servicing DVA clients in 2021'. (AHP, survey response)

AHP attitudes towards the treatment cycle

AHP text responses further reported that the treatment cycle arrangements were perceived as not suitable for patients with chronic conditions. In addition, AHPs noted that the treatment cycle arrangements seemed to apply more to physical health than mental health outcomes. AHP comments noted that their perception of the process is more bureaucratic than care-focused. Similar to the GP text

responses, AHP respondents noted that they believed the treatment cycle is not suitable for more complex clients (i.e., those requiring multiple visits to GPs for referrals) and that the 12 sessions provided within the cycle are not sufficient for clients who require more treatment. Further, AHPs noted feeling that there was less autonomy for AHPs and that it seemed like DVA assumed that providers were not assessing and using clinical discernment prior to the treatment cycle arrangements. Overall, some comments reported that the treatment cycle arrangements improved treatment structures and control measures, but with increased paperwork no improvement in quality of care.

'This change is not client-centred at all. It is purely another mechanism to reduce the support to our war veterans and cut costs'. (AHP, survey response)

AHP perception of client impacts

AHP text responses indicate that AHPs' experiences with clients within the treatment cycle arrangements have been complicated. AHPs report experiences indicating that clients do not understand the changes and that the treatment cycle arrangements are perceived as a barrier to treatment and seeing clients. AHPs indicated that they believe clients are worse off under the arrangements and that clients have had negative attitudes towards the treatment cycle, affecting their engagement, treatment and outcomes. AHPs reported that clients were stressed about referrals being valid as opposed to treatment outcomes and were are opting to self-exclude from AHP services.

'The clients most affected have been those with mental health conditions—the treatment cycle has at times created unnecessary stress and anxiety due to poor communication to the clients from DVA, a sense that if they require more than 12 sessions they are doing the wrong thing and that DVA is trying to minimise their access to health services during times of need'. (AHP, survey response)

AHP and GP engagement

The text responses of AHPs within the survey report that AHPs believe that the treatment cycle arrangements are becoming easier with time; however, there are still concerns regarding ongoing care coordination for patients. AHPs reported no improvement in GP and AHP communication and uncertainty around whether GPs read reports. Some AHP text responses describe the belief that GPs simply issue referrals, regardless of whether they are clinically necessary or not. AHPs report that they believe GPs are frustrated at having to constantly issue referrals. Despite this, some AHP comments report that there are more client updates due to the treatment cycle arrangements and that there are opportunities to discuss client needs.

'Unimproved. The GP isn't looking at the ECR at all. They are giving out referrals whenever the client asks whether they are on their 2nd session or 12th session. In a small rural town they [clients] also don't see the same GP each time'. (AHP, survey response)

Other themes

The survey text responses included multiple reports that AHPs are becoming hesitant to take on new DVA clients due to increased paperwork and complexity. AHPs note that taking on DVA clients is less appealing because the remuneration is double for private or NDIS clients. Further, the text responses describe that AHPs are experiencing higher stress levels as clients and GPs do not understand the changes. It is a burden on AHPs to explain these changes, especially for elderly clients who need reminders for referrals.

'Sadly, due to the requirements of the 12-session treatment cycle and time and administration involved in arranging new referrals after 12 sessions and reporting (and only a $30 payment), after almost 10 years of working with DVA clients and their GPs, I hesitate now when asked to see a new DVA client'. (AHP, survey response)

AHP interview results

Results have been presented according to the themes identified within the data. For a full report of interview results, please see Appendix 4.

AHP: Perception of treatment cycle communication

During interviews with AHPs, there were many reports that the information about treatment cycle arrangements was difficult to read, hard to keep up with and too long for their current administration capabilities. Some AHPs described the communication of the treatment cycle arrangements as adequate, but it was difficult for them to communicate the changes to their DVA clients. There were complaints from AHPs that the communication about claiming procedures were inadequate and resulted in non-payment for consults or treatment with DVA clients and other payment issues. Regarding the availability of communications from DVA, most AHPs reported receiving information through professional associations rather than directly from DVA. AHPs generally reported that the communication regarding the treatment cycle arrangements was poor, with only one AHP interviewee describing the information as 'useful'. AHPs generally described communication about the treatment cycle arrangements as inadequate, and as a result, they did not feel prepared for implementing the arrangements. In addition, AHP interviewees reported the belief that the treatment cycle was a cost-saving measure. Another common theme across interviewees' responses was that the treatment cycle arrangements were developed in response to individuals 'taking advantage' of the previous system.

> *'Yeah, so it was a little bit confusing a little bit to get our head around. I felt we still understood it, it wasn't like it was not understandable, but I did feel we got information, the clients didn't. It was very difficult to change the system with the clients, that's probably what we found the hardest'. (AHP, exercise physiology, NSW)*

An AHP interviewee in Victoria noted that the communication of the treatment cycle arrangements was complicated and overshadowed by the ongoing COVID-19 response for AHPs. GPs noted that during the response to COVID-19, they used

telehealth more often and conducted fewer in-person consultations. However, there was feedback from clients and AHPs that GPs needed to see clients in person to issue referrals; otherwise, the referral was not considered valid by DVA and AHPs.

AHPs: Increased burden of administration

In addition to DVA clients' difficulties with administration, AHP interviewees reported a significantly increased administration load, particularly in relation to the implementation timeline of October 2019. Two AHP interviewees reported having to employ further support roles within their businesses to address the increased administrative load. The increased burden of administration was often related to the perceived inadequate financial remuneration from DVA: that it is not enough to cover the cost of increased administration for AHPs treating DVA clients. Within AHP interviews, there were mixed responses to the End of Cycle report from AHPs; some found it to be a positive change, while others found it was too restrictive, did not communicate valuable information, or repeated information that was already being communicated.

> *'What it has done is it's created an enormous amount of administrative burden to make sure all the documentation is in place. Then even when the document is in place and I send it off to the doctor, it's created even more complexity with administration around did we get a referral back'. (AHP Dietician, NSW)*

Further, multiple AHP interviewees reported not wanting to take on DVA clients or continue seeing their current DVA clients due to the administrative and financial burden of the treatment cycle process.

> *'I think a lot of OTs [occupational therapists] chose not to do DVA work anymore because it just doesn't cover costs. I actually used to have three therapists. I've had to let them all go, because what DVA provide doesn't actually cover the cost of them'. (AHP, Occupational Therapist, QLD)*

Service impacts

AHP attitudes to treatment cycle arrangements: Negative impacts on patient care and outcomes

Multiple AHP interviewees described significant impacts to their health care provision and continuity of care due to the treatment cycle arrangements. AHP interviewees reported gaps in continuity of care due to clients not having GP referrals or not being able to contact GPs to provide referrals for patients. AHP interviewees also described impacts on care for patients unable to understand the treatment cycle arrangements due to impaired mental or physical functioning (e.g., 'cognitive deficits or vision impairment or poor hearing' [AHP, Occupational Therapist, NSW]).

> *'I'm not sure that it [the treatment cycle arrangement] improves patient outcomes, put it that way'. (AHP, Osteopath, VIC)*

AHP interviewees also described feeling restricted and unsure about how the treatment cycle affects their provision of care, especially in regard to specific instances of care. For example, an AHP interviewee described how an osteopath might be unsure how to treat back v. shoulder v. other parts of the body. There were also reports of negative impacts on patient care related to the increased administrative burden and remuneration issues for AHPs.

Health care billing and financial burden on GPs and AHPs

AHP interviewees noted that the remuneration received for DVA patients is not sufficient to cover the cost of treating those patients in addition to the administrative requirements. This has resulted in some AHPs reporting that they are unwilling to accept DVA clients for treatment or that the remuneration does not cover longer appointments, affecting the quality of patient care.

'As all referrals now expire, I have to chase the GP up. As we're already poorly paid, I now have more unpaid time chasing up things in order to provide a decent service to the most marginalised of people'. (AHP, Occupational Therapist, QLD)

AHPs: Health care coordination

AHPs reported taking an active role in the health coordination of their patients, with occupational therapists being particularly vocal about their role in health care coordination. Many AHPs indicated that it should be the GPs taking on the role of health care coordination; despite this, AHPs are involved in suggesting referrals, coordinating with families and other forms of patient care. AHPs reported the belief that GPs are time-poor and unable to take on the role of care coordination.

'The care coordination and communication is now far worse because we are now heavily reliant on GP clinics to have their administrative act together in getting referrals out. That is an ongoing struggle'. (AHP, Occupational Therapist, QLD)

At Risk Client Framework

During the interviews, AHPs mentioned the At Risk Client Framework without being prompted by the interviewer. In general, AHPs felt it was a positive way to avoid the 12-session limitation.

'I know they have their complex referral system. I can't remember the wording they use for it but that's still only 12 months. It still doesn't acknowledge chronic conditions. So it's ridiculous and we've had all sorts of variations'. (AHP, Occupational Therapist, QLD)

Stakeholder feedback results

The following section outlines the results from the stakeholder feedback surveys. Findings are presented by question and have been summarised from the qualitative data received within the surveys.

Q1. In your opinion, how well have the treatment cycle arrangements been implemented?

Question 1 asked stakeholders to comment on how well the treatment cycle arrangements had been implemented. Stakeholder responses to this question varied, with positive, negative and neutral responses received. Positive feedback indicated that the respondents believed the treatment cycle arrangements had been implemented well, and others reported that they had experienced a seamless transition.

Other responses were more neutral towards the implementation, noting that the transition to the treatment cycle arrangements has been 'OK', although communication about the changes could have been better. Others reported no change or improvement.

Negative responses were more commonly received from professional associations and primarily noted concerns about the additional administrative workload created by the treatment cycle arrangements. Other responses described issues with specific allied health specialities and that GPs in their professional networks were unaware of the changes to the treatment cycle arrangements. One response reported that the implementation had resulted in an additional burden on veterans for more GP appointments. See Figure 3.22 for a summary of Question 1 responses.

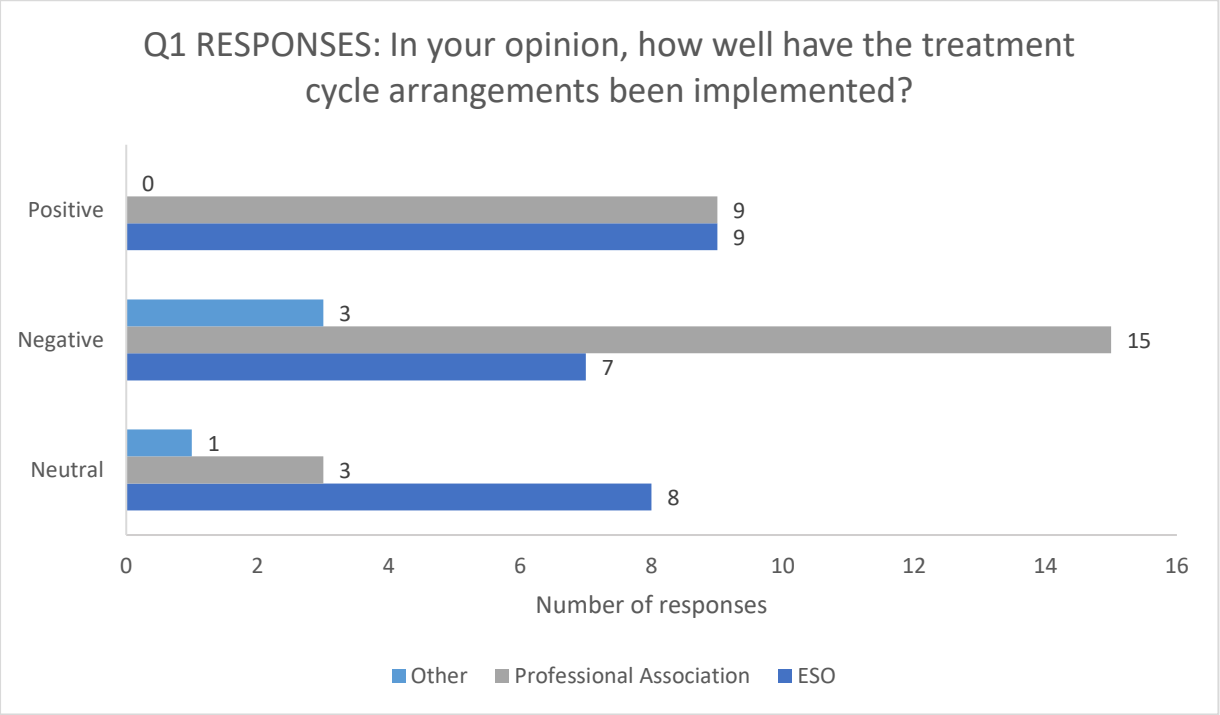


Figure 3.22: Question 1, stakeholder responses

Q2. In your opinion, how effective has DVA's communication strategy been in educating stakeholders about the treatment cycle arrangements?

Question two asked stakeholders to comment on the effectiveness of the communication strategy in educating them about the treatment cycle arrangements. In response to this question, stakeholders reported a variety of different opinions on the communication strategy regarding the treatment cycle arrangements. Positive responses were received from professional associations and ESOs and noted that there was clear communication directly to clinicians and on the DVA website. Respondents described experiencing good engagement from DVA with peak bodies regarding the changes.

In contrast, some stakeholders reported a negative sentiment towards the communication strategy. Negative responses were received from professional associations and ESOs in equal amounts for this question. Responses described poor communication from DVA regarding the changes. One survey respondent reported the belief that there appeared to be different guidelines for different stakeholders.

Other responses from professional associations and ESOs reported more neutral sentiments. One survey respondent described initial communication from DVA as confusing but noted that subsequent communication was much clearer. Another respondent noted that, while they felt that DVA clients were aware of the changes, it seemed that their GPs were not. See Figure 3.23 for a summary of Question 2 responses.

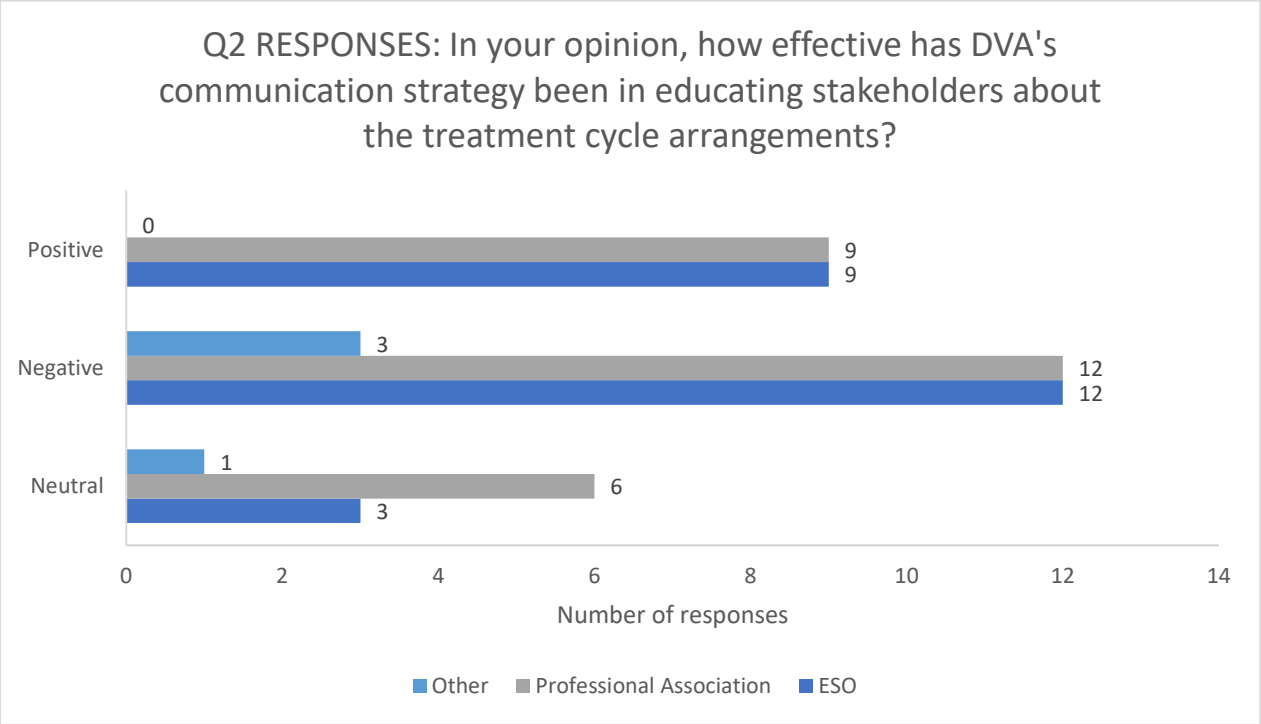


Figure 3.23: Question 2, stakeholder responses

Q3. In your opinion, how have you or your organisation, as DVA stakeholders, engaged with the arrangements?

Question 3 asked stakeholders to report on how their organisation had engaged with the treatment cycle arrangements. Responses to this question were varied, spanning positive, negative and neutral answers. ESO sentiments were evenly distributed, with equal responses received for all three sentimental categories. Professional associations were more likely to report positive responses to this question. Positive responses included participants reporting that they have engaged with the arrangements to the best of their ability and that there had been 'no issues so far'.

Negative responses to this question described respondents feeling like they had no choice in implementing the treatment cycle arrangements, noting that they felt that they had to accept and implement the changes. Further survey responses described more administrative hurdles due to the arrangements, and others noted that the changes are unfair to TPI DVA clients. Other responses claimed that the changes were not clinically necessary.

Other survey respondents noted that they were unsure of the impacts of the treatment cycle arrangements. See Figure 3.24 for the summary of Question 3 responses.

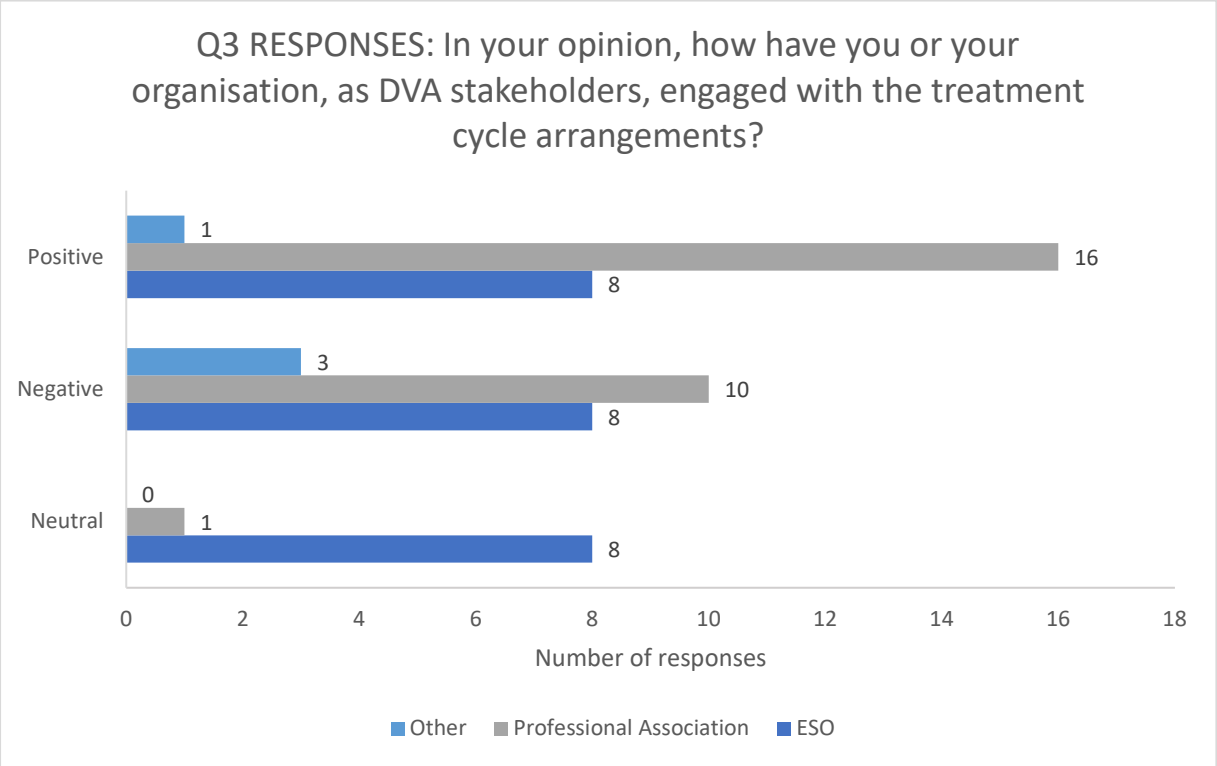


Figure 3.24: Question 3, stakeholder responses

Q4. What is your or your organisation's opinion on the outcomes of the treatment cycle arrangements? (Consider improved quality of care and improved care coordination).

Question 4 asked stakeholders to report on their organisation's opinion of the outcome of the treatment cycle arrangements. Similar to previous questions, sentiments varied, with respondents reporting positive, neutral and negative responses. Professional associations were fairly evenly split between positive and

negative responses, with negative responses being slightly more common. ESOs were more likely to report negative responses, although there were some positive answers received.

Positive responses to question four included descriptions of patient-centred, goal-focused care resulting from the treatment cycle arrangements. One respondent noted that the treatment cycle reports were a good way to track progress. Another response noted that they hope the treatment cycle arrangements will result in a drop in unnecessary care.

Negative responses to this question were also received. One respondent stated that GPs were not conducting case management as expected. Further responses indicated that patients with long-term conditions feel disadvantaged, and others noted that the new system was confusing to them. Other responses were more neutral, noting that it is too early to determine their opinion of the treatment cycle arrangements. For a full summary of Question 4 responses, see Figure 3.25.

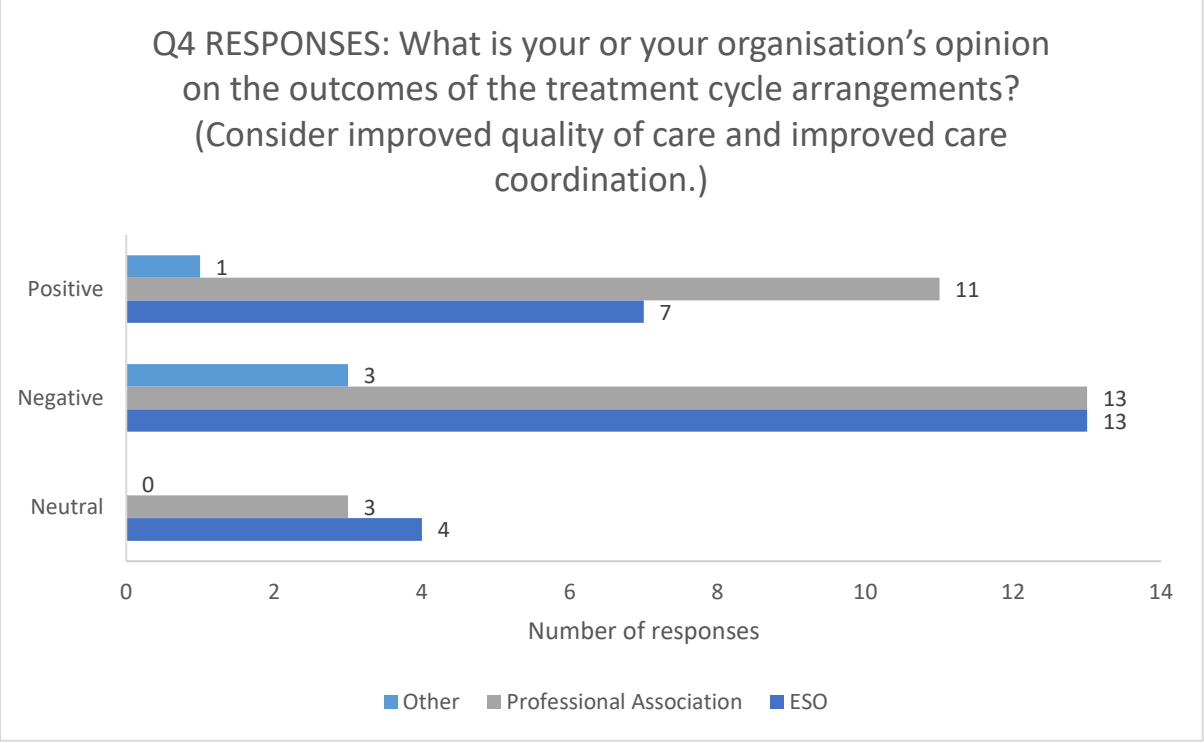


Figure 3.25: Question 4, stakeholder responses

Document analysis results

Overall, materials had higher understandability but lower actionability, with 48 documents scoring very good PEMAT-P understandability ratings (>90% of items met). See Table 3.11 for the statistical measures of PEMAT-P and Table 3.12 for the basic statistical measures of the Health Literacy Checklist. The remaining documents achieved scores between 77% and 89% (n = 30), indicating efforts to ensure the understandability of the content. Measures that advanced the understandability of the documents included the use of everyday language, active voice, informative headers, material breaks and visual cues (e.g., dot points). The use of relevant visual aids with clear captions would have improved the overall understandability score for the documents.

Table 3.11: Basic statistical measures of PEMAT-P

PEMAT-P	N	Mean	Median	SD	Minimum	Maximum
Understandability	78	89.58	91.00	6.83	77.00	100.00
Actionability	78	64.54	60.00	16.67	40.00	100.00

Table 3.12: Basic statistical measures of the Health Literacy Checklist

Health Literacy Checklist	N	Mean	Median	SD	Minimum	Maximum
Checklist score	47	9.83	8.00	1.96	8.00	12.00

The actionability was very good for one document (>90% of items met), with the majority of resources achieving scores between 50 and 89% (n = 60). Further, 22% (n = 17) of documents scored actionability ratings of less than 50%. For the articles returning higher ratings, actionability was promoted by directly addressing the user and breaking down actions into tangible and explicit steps. Actionability for the documents could be improved by providing tangible tools (e.g., a checklist) to help the user take action or by providing visual aids to demonstrate instructions more explicitly.

The overall scores for the Health Literacy Checklist were good and congruent with the higher PEMAT-P understandability ratings of the documents, with all relevant documents tallying a score of eight or over in the PEMAT-P from a total of 13 items (n = 47). Health literacy was encouraged using supportive elements such as short

sentence and paragraph structure; focused content; up-to-date information, including the date of publication within the documents; personalised, consistent and positive language; plain language; active voice; headings and text boxes; and adequate spacing across the documents.

Operational impact of the treatment cycle arrangements

The document analysis intended to address how the operational impact of the change in treatment cycle arrangements on GPs and AHPs was expressed through documented DVA communication. Many documents detailed evidence of the potential operational impact of the treatment cycle arrangements, specifically stating 'more GP involvement in ongoing care' (Document 3), outlining the change in patient care actions for AHPs (Documents 10–15) and stating clear operational changes in letters and web content communications (Documents 39–41, 60, 68–69 and 72–74). All documents that outlined operational impacts were aimed at GP and AHP audiences and outlined the actions required for GPs and AHPs to be compliant with the new treatment cycle arrangements.

Raising awareness of the treatment cycle arrangements among DVA clients, GPs and AHPs

A number of the documents analysed (n = 25) included statements informing the intended audience of the treatment cycle arrangements. Of the documents stating the treatment cycle arrangements, three addressed all three stakeholder groups (DVA clients, GPs and AHPs), five addressed DVA clients, 12 addressed AHPs, and five addressed AHPs.

These results can be compared with the GP surveys, where 64% (n = 95) of GPs stated the information available about the treatment cycle arrangements was 'easy to understand', 66% (n = 97) stated that they had 'sufficient knowledge about the changes' and 60% (n = 90) reported they 'understood the changes'.

DVA client survey results were similar, although a little lower: 53% (n = 210) stated the information available about the treatment cycle arrangements was 'easy to understand', 58% (n = 230) stated that they had 'sufficient knowledge about the changes' and 62% (n = 245) reported they 'understood the changes'.

AHPs were similar in this respect: 53% (n = 234) stated the information available about the treatment cycle arrangements was 'easy to understand', 55% (n = 245) stated that they had 'sufficient knowledge about the changes' and 65% (n = 286) reported they 'understood the changes'.

Perceptions of the changes: A cost-saving measure v. improving quality of care

Thirty documents stated that the aim of the treatment cycle arrangements was to improve the communication between health care professionals quality of care for patients. 'The treatment cycle is designed to improve quality of care for DVA cardholders, with more GP involvement in ongoing care' (Document 3). This is similar to the communication aimed at DVA clients: 'By improving communication and coordination between you, your GP and your allied health providers, the treatment cycle means that everyone can work together to make sure you get the best treatment for your needs' (Documents 8 and 9).

These results can be compared with the interview data, where DVA clients and AHPs spoke of the treatment cycle arrangements as a 'cost-saving' measure': for example, 'I think my understanding or my belief is that it's a cost-driven thing' (DVA client), 'as I understand it, the whole thing was to cut down costs' (DVA client) and 'I felt that it was really about saving some money under the guise of, oh, let's make it much better for the patients … I know they said it was all about patient outcomes, but I suspect it was not' (AHP, VIC).

In comparison, the AHPs' survey responses to the statement, 'quality of interactions between my DVA client's GP and I have improved', were that 24% agree (n = 104) and 43% disagree (n = 192). This was accompanied by a similar response to the statement, 'my DVA client's GP and I have more opportunities to discuss and review their health care needs', with results indicating that 30% agree (n = 132) and 40% disagree (n = 177).

However, GPs responded more favourably to the statement, 'the quality of interactions between my DVA client's AHP and I have improved', with 57% agreeing (n = 84). Further, 64% (n = 94) of GPs agreed that 'my DVA client's AHP and I have more opportunities to discuss and review their health care needs'.

Ensuring stakeholders are aware of the purpose and operational arrangements of the treatment cycle arrangements

Forty-six of the documents analysed stated clear processes of the treatment cycle. Comparatively, the interview data indicated that the quality of the information was accepted as good or adequate (this is supported by PEMAT-P and Health Literacy Checklist scores), albeit the changes themselves were reported as confusing or lacking a logic that could be understood by interview participants. For example, '*the information provided was adequate. I can't really say any more than that. I was happy with the information. I was not happy with the fact that it was happening*' (DVA client).

This was further supported by survey data, with 40% (n = 159) of DVA clients, 67% (n = 98) of GPs, and 36% (n = 161) of AHPs agreeing that the information provided was of high quality but only 34% (n = 134) of DVA clients, 57% (n = 84) of GPs and 27% (n = 119) of AHPs reporting that they were 'satisfied with the changes'. Despite documents outlining the purpose of the treatment cycle, this was not supported by the stated understanding of the treatment cycle arrangements in interview and survey data.

In conclusion, the document analysis provided additional rigour to the evaluation process. Effectively communicating change is crucial to the success of any health program or service. How change is communicated—the language and formatting used through to the distribution and access to information—affects the success of change implementation. Table 3.13 presents the comprehensive document analysis results for this section.

Table 3.13: Document analysis results

	PEMAT-P score (%)		Health Literacy Checklist (X/13)
Document title	**Understandability**	**Actionability**	**Checklist score**
1. Allied health treatment cycle arrangements continue during pandemic	82	60	12
2. Allied health referral changes deferred to 1 October 2019	92	60	12
3. Changes to process for allied health referrals	92	60	12
4. DVA treatment cycle: At Risk Client Framework	100	83	11
5. TPI decision tree	100	83	9
6. End of Cycle report for allied health providers	91	80	N/A
7. DVA treatment cycle: Guide to the treatment cycle for GPs and allied health providers	94	60	10
8. Allied health treatment cycle: TPI clients	100	80	12
9. Allied health treatment cycle: DVA clients	100	80	12
10. Allied health treatment cycle: Physiotherapists and exercise physiologists	100	80	12
11. Allied health treatment cycle: Physiotherapy and exercise physiology practice teams	100	80	12
12. Allied health treatment cycle: Allied health providers	100	80	12
13. Allied health treatment cycle: Allied health practice team	100	80	12
14. Allied health treatment cycle: General practitioners	100	80	12

15. Allied health treatment cycle: General practice teams	100	80	12
16. Patient Care Plan template for allied health providers	100	83	N/A
17. Chiropractors Schedule of Fees	86	83	N/A
18. Clinical psychology Schedule of Fees	86	83	N/A
19. Diabetes educators Schedule of Fees	86	83	N/A
20. Dietitians Schedule of Fees	86	83	N/A
21. Exercise physiology Schedule of Fees	86	83	N/A
22. Neuropsychologists Schedule of Fees	86	83	N/A
23. Occupational therapists (mental health) Schedule of Fees	86	83	N/A
24. Occupational therapists Schedule of Fees	86	83	N/A
25. Orthotists Schedule of Fees	86	83	N/A
26. Osteopaths Schedule of Fees	86	83	N/A
27. Physiotherapists Schedule of Fees	86	83	N/A
28. Podiatrists Schedule of Fees	86	83	N/A
29. Psychologists Schedule of Fees	86	83	N/A
30. Social worker (mental health) Schedule of Fees	86	83	N/A
31. Social worker Schedule of Fees	86	83	N/A
32. Speech pathologists Schedule of Fees	86	83	N/A

33. Letter to Specialist Medical College—RACMA	91	60	12
34. Letter to Australian Podiatry Association	100	100	12
35. APodA deferral letter	92	60	12
36. Marino Podiatry letter	92	67	12
37. Letter A—TPI clients	93	60	12
38. Letter B—DVA clients	93	60	12
39. Letter C—Exercise physiologists and physiotherapists	93	60	12
40. Letter D—AHP	93	60	12
41. Letter E—General practitioners	93	60	12
42. Notes for exercise physiologists	85	40	N/A
43. Notes for mental health care providers	85	40	N/A
44. Notes for allied health providers: General	94	50	N/A
45. Notes for general practitioners	77	40	N/A
46. Notes for physiotherapists	77	40	N/A
47. Notes for chiropractors	77	40	N/A
48. Notes for diabetes educators	77	40	N/A
49. Notes for dietitians	77	40	N/A
50. Notes for occupational therapists	77	40	N/A

51. Notes for osteopaths	77	40	N/A
52. Notes for podiatrists	77	40	N/A
53. Notes for social workers	77	40	N/A
54. Notes for speech pathologists	77	40	N/A
55. Notes for orthotists	77	40	8
56. Web content—Allied health professionals page—1 October publication	91	60	8
57. Web content—Allied health treatment cycle page—1 October publication	92	60	8
58. Web content—Allied health treatment cycle page—3 December update	92	60	8
59. Web content—Dental and allied health fee schedules page—1 October publication	92	40	8
60. Web content—FAQ AHPs	92	60	8
61. FAQ as at 1 October 2019 which mention rehabilitation	91	60	8
62. Web content—FAQs GPs	91	60	8
63. Web content—Improved dental and allied health (for clients) page—1 October publication	92	60	8
64. Web content—Improved dental and allied health (provide) page—1 October publication	92	60	8
65. Web content—Notes for providers page—1 October publication	92	60	8
66. Web content—Treatment cycle—AHP page—1 October publication	93	80	8
67. Web content—Treatment cycle—revised web page for 9 Sept publication	92	60	8

68. Web content—Treatment cycle—AHP FAQs—5 December update	91	60	8
69. Web content—Treatment cycle—AHP FAQs updated 031019	91	60	8
70. Web content—Treatment cycle—Client FAQs—5 December update	91	60	8
71. Web content—Treatment cycle—Clients page—1 October publication	94	80	8
72. Web content—Treatment cycle—GPs FAQ—5 December update	91	60	8
73. Web content—Treatment cycle—GPs FAQ updated 031019	91	60	8
74. Web content—Treatment cycle—GP page—1 October publication	92	60	8
75. Web content—Treatment cycle—Allied health fee schedules page for 9 Sept publication	92	40	8
76. Web content—Treatment cycle—Allied health professionals page for 9 Sept publication	91	60	8
77. Web content—Treatment cycle—notes for providers page for 9 Sept publication	92	40	8
78. Web content—Treatment cycle—published 30 Aug 19	92	40	8

Health economics results

Cost of allied health services

This economic analysis was based on costs acquired on the date of service provision. This descriptive analysis presents total daily spending, mean monthly spending for a client, the average cost of service and total spending, number of appointments, annual spending, mean monthly per-client spending by states and mean monthly per-client spending by remoteness. We hypothesised that the treatment cycle arrangements reduced the costs of service.

Total daily spending

Figure 3.26 shows the daily spending of different allied health services over time. There was a general downward trend in the daily expenditure for osteopathic (G), physiotherapy (H), podiatry (I) and speech pathology (L) services, which continued after the intervention (2019 October). In contrast, an upward trend of the daily expenditure, which continued after the intervention, was observed in the following services: diabetes educators (B), dietetics (C), exercise physiologists (D) and psychology (J). There was a sharp upward trend in the cost of psychology, which increased further after the intervention. The upward trend of expenditure in orthotists (F) then experienced a downward trend after the treatment cycle arrangements were implemented.

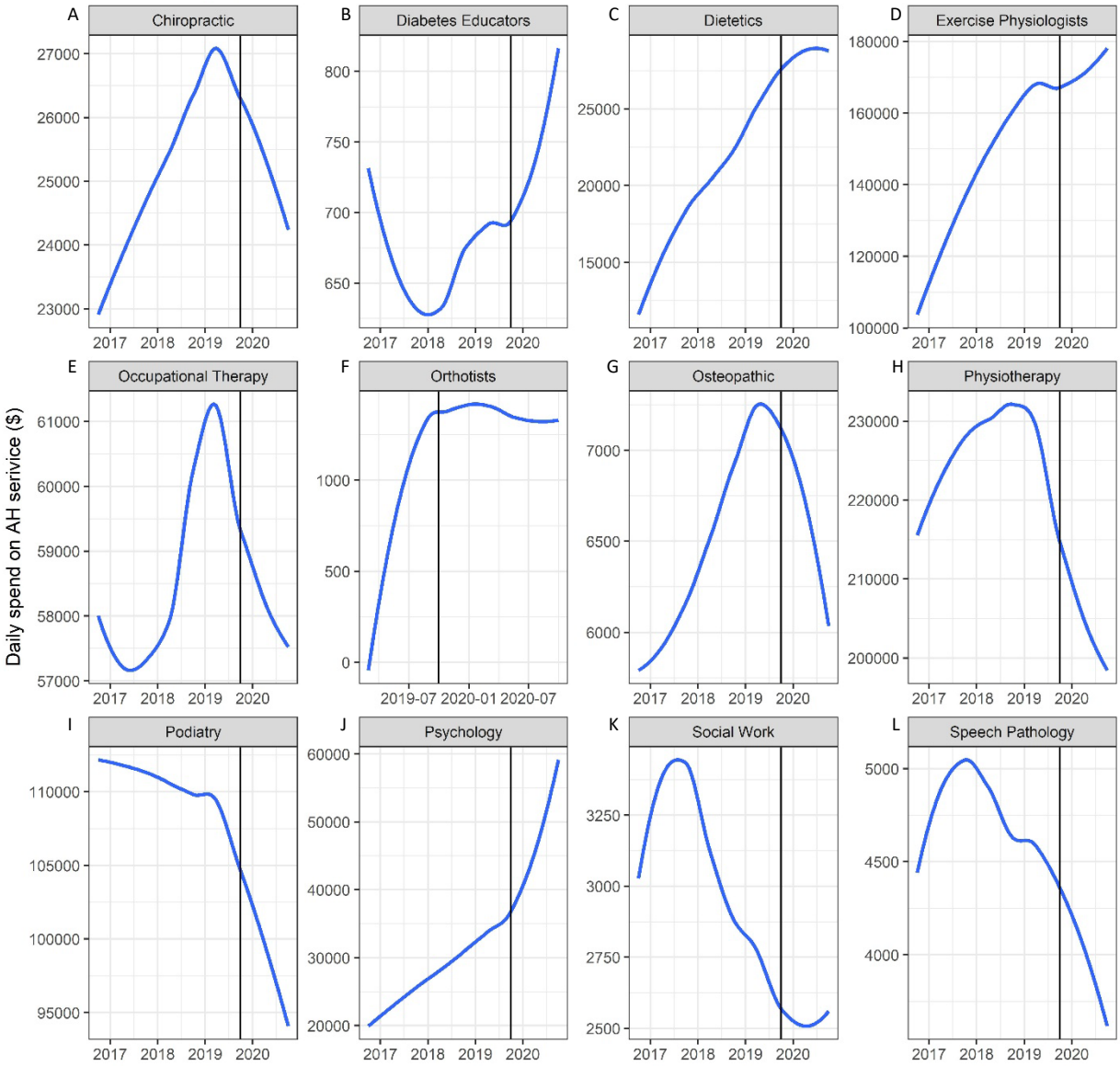


Figure 3.26: Total daily spending for different allied health services. A = Chiropractic; B = Diabetes educators; C = Dietetics; D = Exercise physiologists; E = Occupational therapy; F = Orthotists; G = Osteopathic; H = Physiotherapy; I = Podiatry; J = Psychology; K = Social work; L = Speech pathology. Black vertical lines denote October 2019 (intervention)—the area to the right of the line indicates the post-intervention period. Cost of occupational therapy and social work include mental health services associated those particular services. Podiatry cost does not include costs associated with medical grade footwear. *Data were smoothened (blue line) to detect the trend using local polynomial regression.*

Mean monthly spending for a DVA client

The spending data were aggregated per client per month and summed for each allied health service. Only the clients who received a particular service within a particular month were included, and their average total spend for each month is plotted in Figure 3.27. Monthly average spending by clients who received a particular service gradually increased in chiropractic (A), diabetes educators (B), dietetics (C), osteopathic (G), podiatry (I) and speech pathology (L). However, in social work (K), the per-client (clients who received a particular service) average cost gradually decreased over time. After the implementation of the treatment cycle arrangements, the increasing trend of average monthly spending by clients who received a particular service was reversed to a decreasing trend in occupational therapy (E) while the decreasing trend of exercise physiologists (D), orthotists (F), physiotherapy (H) and psychology (J) was reversed to an increasing trend.

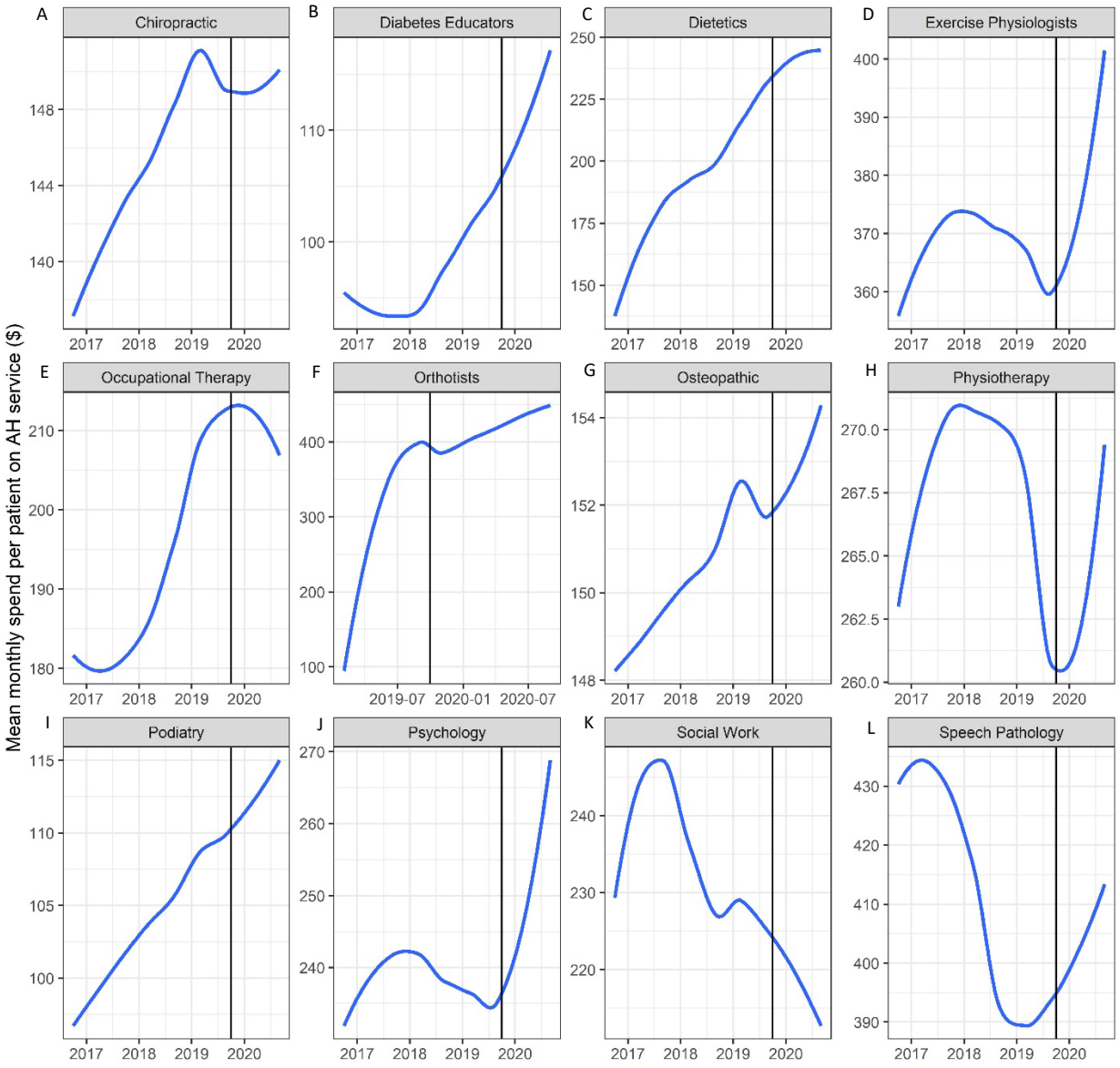


Figure 3.27: Average monthly spending on allied health services by clients receiving that service. A = Chiropractic; B = Diabetes educators; C = Dietetics; D = Exercise physiologists; E = Occupational therapy; F = Orthotists; G = Osteopathic; H = Physiotherapy; I = Podiatry; J = Psychology; K = Social work; L = Speech pathology. Black vertical line denotes October 2019 (intervention)—the area to the right of the line indicates the post-intervention period. Cost of occupational therapy and social work include mental health services associated those particular services. Podiatry cost does not include costs associated with medical grade footwear. Data were smoothened (blue line) to detect the trend using local polynomial regression.

Average cost of service and total spending

Table 3.14 describes the average cost of service per appointment and the total spending on particular allied health services within a 12-month period. The annual total cost ranged from AUD 215 million (October 2016 – September 2017) to AUD 243 million (October 2018 – September 2019). The most expensive service was physiotherapy (approximately 35% of the total cost), followed by exercise physiology (approximately 24% of the total cost). As such, physiotherapy (approximately 35% of the total cost), exercise physiology (approximately 24% of the total cost) and podiatry (approximately 17% of the total cost) accounted for nearly 76% of the total cost. The total expenditure was AUD 10 million less in October 2019 – September 2020, compared to the previous year (October 2018 – September 2019).

Number of appointments and annual spending

An appointment was defined as an individual visit to a particular allied health service. The total number of allied health service appointments in October 2019 – September 2020 was lower than in the two previous years (254,878 fewer than October 2018 – September 2019 and 191,332 fewer than October 2017 – September 2018) (see Table 3.15). The highest number of reductions was noted in physiotherapy, followed by podiatry. Compared to the three previous years, the mean allied health service appointments per patient was lower in October 2019 – September 2020 (132.2 appointments per patient who has accessed services per year). Physiotherapy was the most frequently used service (approximately 23 appointments per patient per year), followed by exercise physiology (approximately five appointments per client per year) and podiatry (approximately two appointments per client per year).

Table 3.14: Average cost of service and total spending on allied health services

Service category	Oct 2016 – Sep 2017			Oct 2017 – Sep 2018			Oct 2018 Oct – Sep 2019			Oct 2019 – Sep 2020 *(post-intervention)*		
	Mean (AUD)	Total (AUD)	%	Mean (AUD)	Total (AUD)	%	Mean (AUD)	Total (AUD)	%	Mean (AUD)	Total (AUD)	%
Chiropractic	64	8,710,491	4.0	64	9,208,158	4.0	65	9,854,022	4.1	66	9,083,755	3.9
Diabetes educators	80	203,555	0.1	79	187,194	0.1	83	219,171	0.1	87	232,879	0.1
Dietetics	116	5,444,179	2.5	117	7,278,333	3.1	122	9,047,563	3.7	123	10,443,800	4.5
Exercise physiologists	65	44,175,554	20.5	66	54,466,865	23.5	67	61,072,803	25.1	70	61,508,649	26.4
Occupational therapy	108	21,147,835	9.8	109	21,189,938	9.1	117	22,167,588	9.1	130	20,890,085	9.0
Orthotists	NA	NA		NA	NA		325	123,440	0.1	375	368,319	0.2
Osteopathic	64	2,120,632	1.0	64	2,315,454	1.0	65	2,561,180	1.1	66	2,398,996	1.0
Physiotherapy	65	81,706,946	37.9	65	83,676,460	36.1	66	83,434,405	34.3	68	73,654,127	31.6
Podiatry	90	40,890,847	19.0	93	40,279,610	17.4	98	39,649,221	16.3	101	36,105,544	15.5
Psychology	127	8,234,425	3.8	128	10,267,685	4.4	128	12,335,713	5.1	125	16,407,460	7.0
Social work	109	1,232,330	0.6	111	1,105,771	0.5	115	968,294	0.4	109	873,354	0.4
Speech pathology	147	1,658,389	0.8	150	1,631,475	0.7	152	1,549,159	0.6	158	1,307,047	0.6
Total	**1,034**	**215,525,183**	**100.0**	**1,046**	**231,606,943**	**100.0**	**1,403**	**242,982,559**	**100.0**	**1,477**	**233,274,015**	**100.0**

Note: Cost of occupational therapy and social work includes mental health services associated with those particular services. Podiatry cost does not include costs associated with medical grade footwear.

Table 3.15: Mean annual number of appointments and mean annual spending per DVA client and total annual appointments according to different allied health services (includes all clients in the population)

Service category	Oct 2016 – Sep 2017			Oct 2017 – Sep 2018			Oct 2018 – Sep 2019			Oct 2019 – Sep 2020 *(post-intervention)*		
	Mean per patient			Mean per patient			Mean per patient			Mean per patient		
	No. appt	Annual $	Total appt	No. appt	Annual $	Total appt	No. appt	Annual $	Total appt	No. appt	Annual $	Total appt
Psychology	9.6	1,220.9	65,552.0	9.6	1,234.8	80,931.0	9.3	1,200.7	96,679.0	9.8	1,237.1	131,494.0
Podiatry	6.2	559.9	454,502.0	6.3	589.1	432,754.0	6.3	616.3	406,925.0	6.0	605.7	359,217.0
Occupational therapy	5.1	547.7	197,501.0	5.3	582.4	195,936.0	5.6	653.6	190,352.0	5.2	676.4	161,849.0
Physiotherapy	23.3	1,528.3	1,259,372.0	23.7	1,555.0	1,286,415.0	23.2	1,549.1	1,262,232.0	20.7	1,423.1	1,084,681.0
Chiropractic	14.9	958.3	137,129.0	15.3	986.9	144,450.0	15.7	1,027.1	152,173.0	14.4	954.2	138,179.0
Exercise physiologists	40.3	2,621.4	687,187.0	40.3	2,657.6	835,730.0	39.5	2,663.4	917,951.0	36.0	2,517.1	889,622.0
Dietetics	5.4	629.0	47,344.0	6.7	781.5	62,530.0	7.4	908.2	74,264.0	8.7	1,079.2	85,439.0
Diabetes educators	2.8	222.8	2,561.0	2.7	214.4	2,374.0	3.0	246.8	2,642.0	3.1	270.5	2,715.0
Speech pathology	8.9	1,311.3	11,288.0	7.5	1,137.4	10,994.0	6.8	1,036.4	10,282.0	6.6	1,045.2	8,343.0
Orthotists	13.8	888.6	33,446.0	13.8	895.5	36,412.0	13.8	904.1	39,683.0	12.5	828.0	36,643.0
Osteopathic	9.3	1,014.7	11,361.0	8.4	937.5	9,963.0	8.7	996.9	8,470.0	7.7	844.7	7,989.0
Social work	9.6	1,220.9	65,552.0	9.6	1,234.8	80,931.0	9.3	1,200.7	96,679.0	9.8	1,237.1	131,494.0
Total	**139.5**	**11,502.8**	**2,907,243.0**	**139.6**	**11,572.2**	**3,098,489.0**	**140.6**	**12,252.0**	**3,161,035.0**	**132.2**	**12,023.9**	**2,907,157.0**

Note: Cost of occupational therapy and social work include mental health services associated with those particular services. Podiatry cost does not include costs associated with medical grade footwear.

Distribution of allied health costs according to states and remoteness

Mean monthly per-client spending by states

In all states, the mean monthly spending per client in the population had fluctuating trends without any relationship to the intervention (see Figure 3.28). The Australian Capital Territory (ACT), New South Wales (NSW), Northern Territory (NT), South Australia (SA) and Victoria (VIC) had the mean monthly spending per patient ranging between $300 to $350, while a higher range ($400 to $450) was noticed in Queensland (QLD) and Western Australia (WA). The lowest mean monthly spending per patient was recorded in Tasmania (TAS).

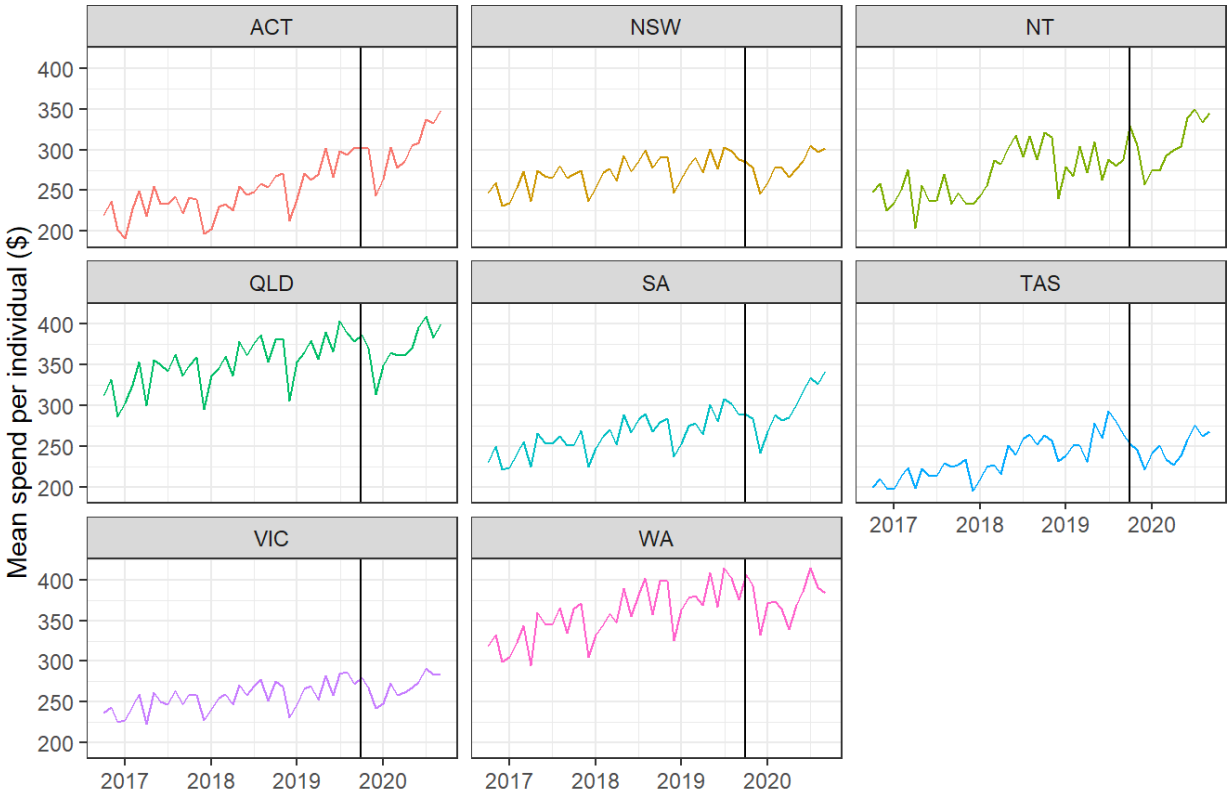


Figure 3.28: Mean monthly spending on allied health services in each state over a 3-year period. Black vertical line denotes October 2019 (intervention)—the area to the right of the line indicates the post-intervention period.

Total daily spending by remoteness

The total daily spending and mean monthly spending per individual on different allied health services according to the remoteness of the service provider location are given in Figures 3.29 and 3.30, respectively. The remoteness of the provider location was classified based on the Remoteness Areas Structure within the Australian Statistical Geography Standard (ASGS), published on the Australian Bureau of Statistics (ABS) website (ABS, 2018). There was an increasing trend of total daily spending in major cities, inner regional and outer regional areas since October 2016, continuing until the first quarter of 2019 (see Figure 3.29). Since then, the trend has reversed, and a decreasing trend continued until September 2020. The total daily spending in very remote areas gradually increased after the treatment cycle arrangements were implemented.

Figure 3.29: Total daily spending on allied health services over a 3-year period in areas of varied remoteness. Black vertical line denotes October 2019 (intervention)—the area to the right of the line indicates the post-intervention period.

Mean monthly spending per client by remoteness

The mean monthly spending per individual in major cities, inner regional and outer regional areas was similar, with the overall average around $325 and no noticeable change noted after the treatment cycle arrangements were implemented (see Figure 3.30). The mean monthly spending per individual in very remote areas showed a wide variation, and the overall average was higher than the other areas.

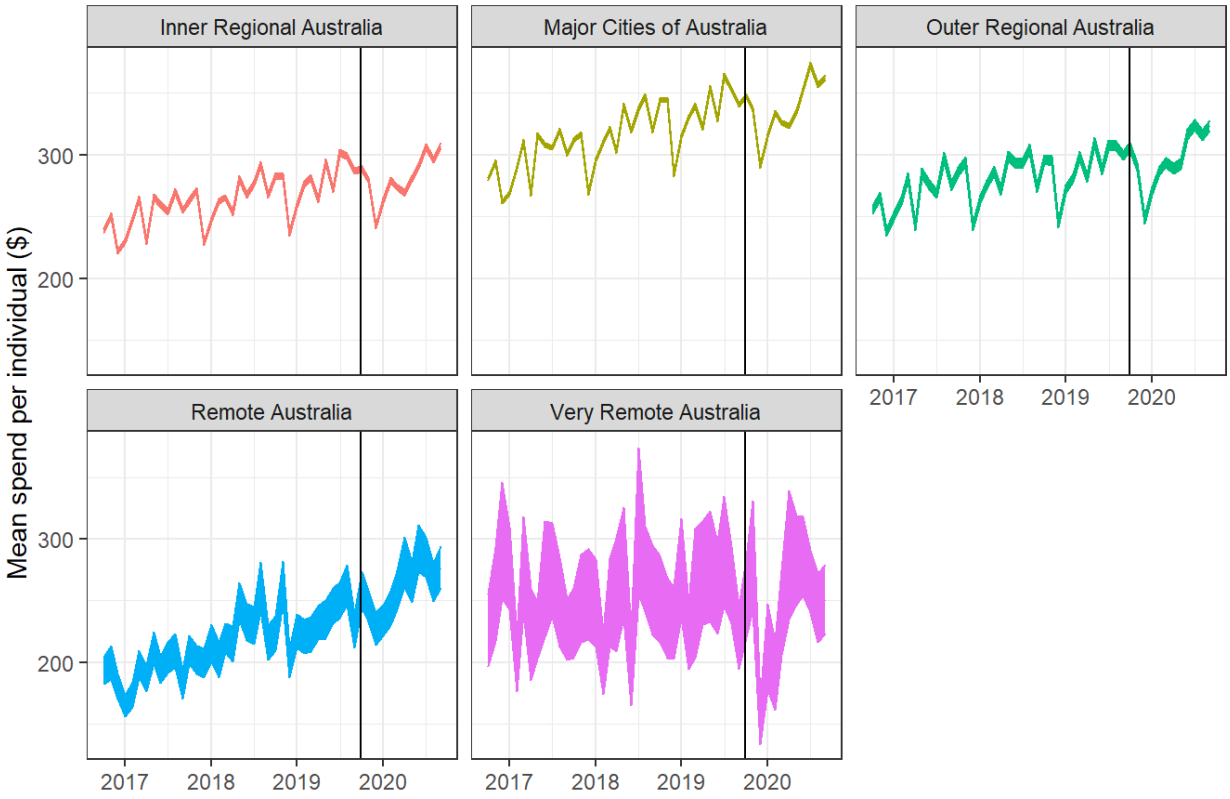


Figure 3.30: Mean monthly spending on allied health services over a 3-year period in areas of varied remoteness. Black vertical line denotes October 2019 (intervention)—the area to the right of the line indicates the post-intervention period.

Multivariable analysis to estimate the reduction in spending associated with the treatment cycle

Generalized estimating equation (GEE) regression was used to evaluate the reduction in spending associated with the treatment cycle arrangements. A detailed description of the methodology is given in Appendix 8.

Our preferred model included five months of data before the treatment cycle arrangements and five months of data afterwards to avoid the period affected by COVID-19.

As indicated in Appendix 8, the estimate for the interaction between allied health services and the treatment cycle arrangements period is –$13.00 (95% CI: [–$14.547, –$11.452]), suggesting that the treatment cycle arrangements were associated with a mean monthly reduction of $13 in spending per client. In this cohort of 94,612 clients, it can be extrapolated that under pre-COVID-19 conditions, this would amount to an annual saving of $14,759,472.

Conclusion

There was a substantial reduction in total cost after the treatment cycle arrangements were implemented (2019 Oct – 2020 Sep) compared with the two previous years. This reduction was repeated in mean annual appointments, mean annual spending and the total number of appointments per client. The lockdowns imposed since March 2020 due to COVID-19 may have affected the service utilisation of allied health services. When interpreting the trendlines observed since implementing the treatment cycle arrangements, it is important to consider the effect of COVID-19 since March 2020. Multivariable analysis indicated that treatment cycle arrangements are cost-saving compared to previous practice.

SECTION 4: LIMITATIONS

Project limitations

Our findings and conclusions are drawn from the materials collected through the course of the evaluation. Given DVA's broad range of services, the complicated nature of health care provision to such a diverse client group, and the impact of COVID-19 on research activities, the evaluation contained some limitations. The evaluation team have used the totality of information collected to identify the common themes, insights and experiences of those who deliver and receive services within the treatment cycle arrangements.

While we have been mindful of the intricacy of veteran health care provision, we acknowledge there may be areas where additional considerations may be required, given the complexities of DVA and veterans' service systems. Some of these additional considerations are outlined below.

Methodological limitations

Representative samples

There is always a risk when relying on self-reported data for research. While a high number of responses for the survey were collected, there is no way of proving or disproving that people were indeed who they claimed to be: that is, a DVA client, an AHP or a GP. The internal consistency of responses indicate that respondents were honest in their self-allocation, but there is no way to prove this.

As the survey was mainly promoted and totally completed online, there is a bias towards responders who have access to and are comfortable accessing information online. This may lead to certain groups being under-represented, such as older veterans, people who have low IT skill levels or literacy, or time-limited AHP or GP populations. There is consistent evidence that the reading level necessary for most health information materials is above the average adult's reading ability (Australian Commission on Safety and Quality in Health Care, 2013). This limitation could be addressed by extending the evaluation research questions in an offline platform.

Further, all methodology responses were from a self-selected sample. Self-selecting samples are inherently biased, as people who have a negative issue with the content of the survey are much more likely to respond than those who do not experience negative issues surrounding the content of the evaluation. This issue can be mitigated through research that is compulsory for all of the relevant research population, but this is outside the scope of this project.

There is likely an element of responder bias in the results, given the relatively small number of interviews and apparent reliance on commentary from Queensland-based occupational therapists, who were over-represented in the AHP respondents.

Low levels of GP engagement may affect the generalisability and reliability of the findings. GPs are a notoriously difficult cohort to engage, and the research team feel that all reasonable options were exhausted in the available timeframe. Further input from GPs would strengthen the report findings.

SECTION 5: DISCUSSION

The treatment needs of the veteran population in Australia are complex and changing. DVA has estimated that the current treatment population consists of 257,211 veterans, and this population will increase to 300,500 by 2023 and 310,900 by 2030 (DVA, 2019a). The demographics of the Australian veteran population are also changing, with the number of older veterans declining and the nature of recent military conflicts resulting in differing treatment needs compared to those in earlier conflicts (Productivity Commission, 2019). Therefore, the needs of older veterans (who are more likely to require independent living assistance, aged care and health services) need to be balanced with the needs of contemporary veterans, who are more likely to require rehabilitation, ongoing wellness care and assistance with transition to work (Productivity Commission, 2019). As the veteran population changes over time, DVA recognises the importance of access, relevance, efficiency and effectiveness in delivering its programs to ensure good quality health outcomes for clients requiring assistance and support. The treatment cycle arrangements were implemented in October 2019 to support improved collaboration between providers and maximise the quality of care for clients of the system by providing a framework for better coordination and communication between GPs, AHPs and clients. Further, the treatment cycle arrangements intended to position DVA clients as the centre of care and the GP as the primary care provider working with other providers to achieve high-quality health care outcomes (DVA, 2019c).

This evaluation was commissioned to determine the outcomes of the first 12 months of this initiative by exploring three key lines of inquiry:

- how well treatment cycle arrangements have been implemented
- the extent to which stakeholders have engaged with the new arrangements
- the client outcomes achieved, specifically, quality of care and GP engagement, care coordination, access to services and the efficacy of the At Risk Client Framework.

SECTION 5: DISCUSSION

As described in the previous chapters, a mixed-method strategy has been applied to engage the experiences and opinions of all key stakeholders in the new arrangements. Both qualitative and quantitative data were collected and analysed to reach the conclusions and recommendations described here. Recommendations will be made throughout this section and then summarised in list format at the end of this report.

How well have the treatment cycle arrangements been implemented?

Awareness of the new arrangements before implementation

Implementing any new service arrangement requires effective communication of program intentions and new processes to both providers and client end-users. In the lead up implementing the treatment cycle arrangements in October 2019, DVA developed a comprehensive series of communications and resources for all relevant stakeholders. These resources were distributed using the department's usual communication channels from May 2018 onwards and included a variety of formats, such as the VetAffairs newspaper, fact sheets on the DVA website, letters and face-to-face meetings.

The 'DVA treatment cycle communications plan' document emphasised the importance of the role of GPs in the establishment and ongoing effectiveness of the treatment cycle arrangements, noting the importance of GPs in care coordination for veterans. The communications plan highlighted the importance of ensuring that GPs and general practice teams are 'aware of the intent and benefits of the treatment cycle, and their role in the new referral arrangements' ('DVA treatment cycle communications plan' document, 2019).

At the time of implementation of the treatment cycle arrangements, less than 50% of the GPs who responded to the survey (49%, n = 73) reported awareness of the treatment cycle arrangements. Of those aware of the program, 39% recalled having received information directly from DVA and 28% from their DVA client group. Despite the emphasis on GP knowledge of the treatment cycle arrangements in the DVA communications plan, GPs reported relatively low awareness of the arrangements

compared to AHPs and DVA clients. GPs reported that professional associations were the most common channel of communication, which is consistent with the DVA communications plan. Despite these moderate awareness rates, 87% (n = 128) of GPs reported they had consulted DVA clients under the treatment cycle arrangements. By comparison, close to two thirds (72%; n = 316) of AHPs were aware of the treatment cycle before October 2019. Of these, 41% (n = 181) of AHPs recalled receiving information directly from DVA about the treatment cycle arrangements before October 2019, and 37% (n = 164) of AHPs reported that they were informed about the treatment cycle arrangements from their professional association. Further emphasis on GP understanding of the treatment cycle arrangements, particularly on communication methods and ongoing consultation with GP roles, will benefit the ongoing treatment cycle outcomes.

Further, the moderate rates of GP treatment cycle arrangements awareness, coupled with high rates of utilisation reported by GPs, may indicate an opportunity for errors to be made in the early stages of treatment cycle implementation. While there is no current evidence of this possibility (and this was not an area addressed by the data collection in this project), structured monitoring of GP knowledge and compliance is advisable. It is essential that monitoring highlights and addresses areas of common noncompliance via mechanisms to improve communication and feedback from stakeholders. It will also be important to ensure continual quality improvement regarding the operational processes of the treatment cycle arrangements.

General awareness of the treatment cycle arrangements was reasonably high among DVA clients, with 62% (n = 250) of clients reporting awareness. Forty per cent (n = 161) of DVA clients reported receipt of this information directly from DVA. A further 35% (n = 138) of clients reported that they were informed about the treatment cycle by their GP. During interviews, clients emphasised the importance of dissemination of new arrangements through veteran-to-veteran communications, such as social media via veteran advocate and support groups. While awareness was moderate to high at the time of the evaluation data collection, clients did report some difficulties accessing the information when the treatment cycle arrangements were implemented in October 2019.

Information was reported to be hard to find or required more investigation by clients. However, overall, slightly more than half of the client respondents reported that the information they did receive was:

- easy to understand (53%; n = 210)
- relevant to their needs (50%; n = 201)
- prepared them for the changes (57%; n = 229)
- helped them to understand the changes (62%; n = 245).

Effectiveness of the DVA communication strategy

The DVA's pre-implementation communication strategy has achieved moderate levels of reach across the three stakeholder groups (DVA clients, GPs and AHPs). The materials have been generally assessed as easy to understand and fit for purpose; however, there is some room for improvement in client comprehension of the changes. This is, of course, not unusual, and experience with navigating a new program will improve comprehension over time. However, ongoing support will be required to support veterans using the treatment cycle arrangements.

At the time of implementation, DVA acknowledged that 'there are some misconceptions about the treatment cycle among providers and clients which need to be addressed' ('DVA treatment cycle communications plan' document, 2019). DVA noted in the communication plan that there was extensive consultation with key stakeholders about the budget measures for the treatment cycle arrangements. A co-design workshop for the treatment cycle arrangements was held in March 2019, facilitated by Macquarie University and attended by multiple allied health and GP associations. This was in addition to internal health policy DVA workshops and working groups, as well as the treatment cycle arrangements being presented to the Ex-Service Organisation Round Table (ESORT) in May 2019.

Despite this comprehensive communication plan at the outset of the treatment cycle arrangements, ongoing communications from DVA have so far appeared to be ad hoc and reactive. An ongoing plan for DVA communications and consultation with key

stakeholder groups (such as the RACGP and Australian Medical Association [AMA] for GPs and ESOs for DVA clients and professional associations) would improve stakeholder understanding of and engagement with the treatment cycle arrangements. Further, while it may be more time- and resource-intensive, more in-depth and ongoing engagement in feedback relating to the treatment cycle arrangements may help address the sentiment that the treatment cycle arrangements are a cost-saving measure rather than a health care improvement strategy. During both survey and interview data collection, participants expressed their relief in being listened to and provided the opportunity to 'have a say' in the treatment cycle arrangements, which may indicate that ongoing opportunities for feedback from stakeholders (in the form of forums, short-form surveys or a DVA feedback email address) would improve stakeholder perception of the treatment cycle arrangements.

Client survey respondents reported hearing about the treatment cycle arrangements via a variety of sources (more than one option could be selected), including:

- 49% from GP sources (advertisements in clinic, the GP themselves, GP website or GP social media)
- 78% from DVA sources
- 27% from ESO sources
- 3% from 'other sources', including veteran-to-veteran communication (e.g., Facebook groups and social contact)
- 19% from AHP sources.

It was interesting to note the role of professional associations and ESOs in improving awareness rates among all three end-user groups. This result reinforces the importance of the department's multichannel approach to end-user engagement and the particular utility of professional and client associations, generally considered 'trusted agents' in ensuring awareness of program change.

The evaluation notes that DVA client respondents aged 50 years of age or less were more were likely to be positive towards communications about treatment cycle arrangements. Sixty-three per cent (n = 82) of this client group found the information

easy to understand compared to 47% (n = 127) of DVA clients aged over 50 years old. This finding highlights an opportunity for stratification of communications as a function of age and needs profile and the importance of trusted agents (such as professional associations) to assist with messaging reach.

The DVA 'Improved Dental and Allied Health Communications Plan' (2018), which we acknowledge outlined the communications strategy for the whole budget measure, not just the treatment cycle arrangements, states that one of the communications principles was to 'make use of existing channels wherever possible'. This strategy may need to be reviewed or supplemented in light of the data reported here concerning the limited reach of messaging about treatment cycle arrangements. In particular, diversification of communication channels, along with age stratification of the treatment cycle arrangement messaging, would improve communication effectiveness.

While the limitations of retrospective recall are acknowledged, there does appear to be room for improvement in strategies to raise awareness and comprehension of new treatment initiatives and associated administrative changes before their implementation. Advertising and information tailored to the communication mediums most frequently accessed by different age groups are likely to improve uptake and comprehension. This target group segmentation strategy ensures that information is shared via the platforms most likely to be accessed by the target subgroups. There is an opportunity to implement targeted strategies in the first instance with veterans aged 50 years and older, who appear to have experienced reduced exposure to the information offered by the DVA communication plan.

Usefulness and clarity of the provider notes and clinical resources

In the 18 months (May 2018 – October 2019) before implementation, DVA developed and distributed a range of information and resources to assist practitioner groups to comprehend and implement the treatment cycle arrangements. These included:

- web content from the DVA website
- notes and letters sent to GPs and AHPs
- outlines of treatment cycle arrangements
- clinical resources
- fee schedules
- templates for AHP and GP use.

The evaluation reviewed 78 documents and communications and assessed their understandability and actionability using PEMAT-P. This analysis indicated that the document contents were generally considered easy to understand but difficult to implement. The analysis also indicated that the use of visual aids and infographics could improve understandability scores. The actionability of the documents could be improved by providing tangible tools such as checklists to help the user take specific actions. The overall scores for the Health Literacy Checklist were good and congruent with the higher PEMAT-P understandability ratings of the documents.

Operational impact of the treatment cycle arrangements on GPs and AHPs

The operational impact of the treatment cycle arrangements on the three stakeholder groups was outlined in the DVA documents assessed as part of the document analysis. The documents prepared and distributed to practitioners detailed the expected operational impact of the treatment cycle arrangements, including more GP involvement in ongoing care, change in patient care actions for AHPs and general operational changes in the way DVA clients and health care providers access the treatment cycles. These documents outlined the actions required of GPs and AHPs to ensure compliance with the new treatment cycle arrangements.

Surveys conducted with health practitioners indicated that opinions about the intended outcomes of the treatment cycle arrangements were mixed and suggested that sufficient time may not have passed to adequately assess its effects. However, an examination of the experience of AHPs found some small improvements in both the quantity and quality of interactions with GPs in support of their clients' treatment plans. Twenty-four per cent (n = 104) of AHPs indicated that the quality of interactions between themselves and their DVA clients' GPs' have improved, and 30% (n = 132) reported that they have more opportunities to discuss and review DVA clients' health care needs with GPs. Despite these improvements, there also remains considerable room for improvement.

Almost half of GP respondents reported the treatment cycle arrangements to be more time-consuming. Further, close to a third of GPs reported that the treatment cycle arrangements were more expensive and complex. Similarly, GPs noted increased time spent each week to complete referrals and paperwork related to the treatment cycle arrangements and that much of this work was completed in their own time, resulting in unpaid work. Within interviews and surveys, providers also indicated concerns about the length and usability of certain forms. Similar sentiments were echoed by the AHPs, with close to 80% reporting that the treatment cycle is now more time-consuming. More than half of AHPs surveyed reported that the treatment cycle arrangements were more complex than previous DVA health care, and more than a third noted it was more expensive, less effective and worse than the previous arrangements.

The most commonly reported operational impacts reported by both GPs and AHP's included:

- the amount of time required for GPs to see their clients
- the time-consuming nature of the treatment cycle arrangements
- the need for greater clarity on the required process from GPs
- the impact on GP clinic capacity due to administrative load, sometimes needing additional staff to manage administration

- concern over management of chronic conditions under the restriction of the treatment cycle arrangements, which may indicate a lack of comprehension of the provisions of the Risk Framework
- some positive impacts on communication and quality of notes from AHPs
- concern over the cost to clients of seeking additional referrals (personally and on the health system).

The findings described above indicate opportunities to streamline the administrative load associated with the treatment cycle arrangements. The evaluation recommends a review of the current administrative burden of the treatment cycle arrangements to ensure that the arrangements are not unnecessarily adding to the administration loads of health care providers. While the treatment cycle arrangements only add limited paperwork to existing administration requirements in the form of End of Cycle reports or the At Risk Client Assessment Form, it is important to recognise that provider perception of an increased administration load was significant. The tension between the slight increase in administration activities intended by the treatment cycle arrangements and the reported impact of actual administration undertaken by health care providers should be investigated, in order to ensure that there is not unintended impacts on the time of health care providers within the treatment cycle arrangements. While we recognise that there are guidelines for clinical communications outside the context of DVA involvement, a working group or forum for feedback from health care providers on the efficacy and efficiency of the current administration needs of the treatment cycle arrangements and subsequent amendments made to the requirements may alleviate the administrative load currently reported by health care providers.

Further, the implementation of End of Cycle reports consistently raised some challenges. In general, while the intended purpose of the reports is understood, AHP and GP respondents both reported concerns regarding:

- the time required to complete reports
- the manual nature of the reports
- restrictive formatting

- perceived duplication of other usual forms of communication
- lack of benefit to clients
- time delays in receiving the reports from AHPs.

Regrettably, GPs noted they rarely had time to read the reports. These findings provide clear opportunities to revisit and revise the application, efficiency and relevance of End of Cycle reports for AHP and GP implementation and ensure they fit the best DVA client health care outcomes.

Despite the perception of an increased administrative load, health care providers also reported improvements in care coordination and communication due to the treatment cycle arrangements. Overall, 64% (n = 94) of GPs reported having more opportunities to discuss and review their DVA clients' health care needs with their AHP, and 30% (n = 132) of AHPs reported increased opportunities to discuss and review clients' health care needs with GPs.

Impact of the treatment cycle arrangements on DVA clients

DVA clients reported mixed responses relating to the impact of the treatment cycle arrangements on their health care. Twenty-two per cent (n = 89) of DVA clients surveyed reported being positively impacted, 41% (n = 164) of clients reported being negatively impacted, and 37% (n = 147) of clients reported not being impacted by the treatment cycle arrangements.

Despite these mixed responses, DVA clients reported consistent concerns about the increased number of GP appointments required under the new arrangements, as well as the quality and purpose of the visit. Many clients (almost 75%) reported seeing their GP to complete paperwork for the additional referrals rather than to discuss their care needs. Cost concerns noted by DVA clients included the perceived increased cost to Medicare due to consultation billing for additional or more frequent referrals; however, analysis of the economic data and client usage data does not indicate this. Health economic analysis indicates overall savings for the DVA per client, although it is important to note that this may be at the cost of increased personal expenses for DVA

clients and a higher administrative burden for GPs and AHPs. Further rolling analysis of the economic impact of the treatment cycle arrangements to stakeholders should be undertaken to monitor any potential cost shifts to clients.

DVA clients reported that they did not have better access to services under the changes to the treatment cycle arrangements. Seventy per cent (70%; n = 279) of clients reported the treatment cycle to be more time-consuming, and 44% (n = 176) noted it was more complex. Close to one third (35%; 140) noted it was more expensive for them, which related to costs associated with additional GP appointments for referrals and administration. The extra expenses included travel, additional child care and taking time off work. Some psychosocial impacts were reported from clients, which should guide further consideration for the future of the treatment cycle arrangements. Pressure and perceived self-coordination of care were common themes, especially relating to the need to track the number of sessions with their AHP to ensure their referral was current.

Despite this, 34% (n = 137) of clients reported that they are more engaged in how their health care needs are met, and 40% (n = 157) reported that they discuss and review their health care needs more often and in more detail with their GP. This was consistent with client perspectives on increased opportunity to discuss and review their health care needs in increased detail (39%; n = 156) with their AHP. Twenty-nine per cent (n = 117) of DVA clients also reported that their health care needs are better met by the treatment cycle arrangements. Slightly over a quarter of clients (26%; n = 104) reported that they have better access to necessary services and that they receive better quality health care overall. Complementing this, 30% (n = 118) of clients reported they receive better, targeted support based on their health care needs.

Overall, administrative burden and cost increases were reported by all respondent groups, with DVA clients noting the challenges of attending additional appointments. DVA clients also noted having to keep track of their referral and health care requirements due to the limitations of the treatment cycle arrangements. These negative impacts need to be balanced with the improvements from the changed treatment cycle arrangements. Addressing the administrative burden on both DVA clients and their

health care providers through initiatives such as financial remuneration for administrative tasks tied to the treatment cycle arrangements may ensure that the treatment cycle arrangements have maximal benefit for all stakeholder groups.

How well have stakeholders engaged with the new arrangements?

Change in utilisation patterns and health care expenditure

More than half of DVA client respondents (54%) reported seeing their GP more frequently, and 71% (n = 283) reported requiring more referrals to meet their health care needs. This is reflected in similar statistics from GPs; 46% (n = 68) of GPs reported that they see their DVA clients more, 15% (n = 22) reported seeing their DVA clients less, and 37% (n = 55) reported seeing their DVA clients the same amount. By comparison, only 9% (n = 39) of AHPs reported that they see their DVA clients more, 23% (n = 101) of AHPs reported seeing their DVA clients less, 63% (n = 276) of AHPs reported seeing their DVA clients the same amount.

Following the implementation of the treatment cycle arrangements, a general downward trend in the daily expenditure for osteopathic, physiotherapy, podiatry and speech pathology services was noted. This trajectory continued after the intervention in October 2019. By contrast, an upward trend of the daily expenditure, which continued after the intervention, was observed in the following services: diabetes educators, dietetics, exercise physiologists and psychology. A sharp upward trend in the cost of psychology was noted, increasing further after the intervention. This could be attributed to related DVA policy initiatives, such as expanding non-liability mental health care for veteran white card holders, although this cannot be confirmed through the current dataset. The upward trend of expenditures in orthotists was not sustained following treatment cycle arrangement implementation. Physiotherapy (approximately 35% of the total cost), exercise physiology (approximately 24% of the total cost) and podiatry (approximately 17% of the total cost) accounted for nearly 76% of the total cost. The total expenditure was AUD 10 million less in October 2019 – September 2020 compared to the previous year (October 2018 – September 2019).

The total number of allied health service appointments in October 2019 – September 2020 was lower than in the two previous years (254,878 fewer than October 2018 – September 2019, and 191,332 fewer than October 2017 – September 2018). The estimate for the interaction between AHP services and the treatment cycle arrangement period is –$13.00 (95% CI: [–$14.547, –$11.452]), suggesting that the treatment cycle arrangements were associated with a mean monthly reduction of $13 in spending per client. In this cohort of 94,612 clients, it can be extrapolated that under pre-COVID conditions, this will amount to an annual saving of $14,759,472.

GEE regression was used to evaluate the reduction in spending associated with the treatment cycle. The results demonstrated a substantial reduction in total cost after the treatment cycle was implemented (2019 Oct – 2020 Sep) compared with the two previous years. This reduction was repeated across mean annual appointments, mean annual spending and the total number of appointments per client. It is likely that public health measures put in place to manage COVID-19 since March 2020 may have affected the service utilisation of allied health services. When interpreting the trendlines observed since implementing the treatment cycle, it is important to consider the effects of COVID-19 since March 2020.

What outcomes have been achieved by the new arrangements?

Improved quality of care

Overall, both GPs and AHPs reported improvements in client communication and care coordination. Younger clients (50 years of age or less) were more likely to report that their health care needs are better met under the new arrangements (48%, n = 62); they have better access to necessary services (44%, n = 57); they receive better, targeted care (50%, n = 64); and they receive a better quality of health care overall (46%, n = 59) compared to the older cohort.

Consistent with feedback from clients, just over half of GPs noted they issued more referrals to their clients since the change to the treatment cycle arrangements, and just over half of GPs agree that their clients' needs are better met. However, AHPs

expressed concern regarding DVA clients' health care needs being met by the treatment cycle arrangements. Of the AHPs, 52% (n = 230) disagreed that their DVA clients' have better access to necessary services to meet their health care needs. Similarly, 46% (n = 201) of AHPs disagreed that their DVA clients receive better, targeted support based on their health care needs and that they receive better quality health care overall. This group reported confusion and stress among clients about the rules and pressures associated with perceived increased self-responsibility for care coordination.

Care coordination

Coordination of care was an interesting finding that emerged from the evaluation data. While DVA clients reported increased communication between themselves and their GP, they also reflected that they felt that most of the burden for care coordination rested on themselves rather than their treatment team. Fifty-six per cent (n = 223) of DVA clients reported that they coordinate their health care needs compared to 25% (n = 98) reporting that their GP coordinates their health care needs and 12% (n = 47%) reporting that their health care needs are jointly coordinated by their GP and AHP. This is at odds with the perspectives of health care practitioners, who reported increased responsibility for care coordination. Seventy per cent (n = 104) of GPs reported that they coordinate their clients' health care needs, and 57% (n = 251) of AHPs reported that they coordinate their clients' health care needs. Despite this, half of the clients surveyed by the evaluation also reported that they had a PCP developed collaboratively with their health care providers. This indicates that there may be a disconnect between the perceived coordination of care and the practice of DVA client care coordination between the three groups.

As a related issue, concern was expressed by DVA clients about the perceived additional pressure of self-coordination of care. This concern was frequently expressed by reports of stress associated with keeping track of the number of sessions with their AHP to ensure their referral was current. DVA clients reported feeling as though they coordinated their own health care, which may be influenced by the apparent increase in

management and tracking of referrals and the number of visits to AHPs. This should be balanced with positive improvements, such as some DVA clients reporting improved communication between their GP and AHP and improved knowledge of treatment options by their GP. Consistent with this, the majority of DVA clients reported more contact and discussion with their GP before starting a treatment cycle and increased regularity of visits to GPs to follow the 12-session structure. Results also indicated that clients perceived benefits regarding the communication between GPs and AHPs; half of the clients indicated that they now had a PCP with their AHP.

An important exception to this improvement was interview and survey data collected from DVA clients, which found that the treatment cycle arrangements negatively impacted their health care coordination and quality of care. Survey responses reported that 36% (n = 143) of DVA clients disagreed that their health care needs are better met by the treatment cycle arrangements, 41% (n = 162) disagreed that they have better access to necessary services to meet their health care needs, and 37% (n = 147) disagreed that they receive better quality health care overall as a result of the treatment cycle arrangements. This was also highlighted within interviews among DVA clients who work full-time or have chronic conditions, with the increased frequency of referrals required being a significant inconvenience. DVA clients also expressed concerns within interviews that they were an 'inconvenience' to AHPs and GPs by requiring more appointments.

All three stakeholder groups reported that they felt they were responsible for the coordination of DVA clients' health care, and it is important to note that all groups feel that they have taken on significant responsibility in care coordination as a result of the treatment cycle arrangements. If the implementation of the treatment cycle arrangements is to remain consistent with the aims of establishing the GP as the primary care provider working with other providers (DVA, 2019c), the burden of care coordination for AHPs and DVA clients may need to be reviewed. Within interviews, AHPs indicated that they were aware that it should be the GPs taking on the role of health care coordination; despite this, they are involved in suggesting referrals, coordinating with families and other forms of patient care. AHPs reported the belief that

GPs are time-poor and unable to take on the role of care coordination. Further review and communication of the intended care coordination structure among GPs, AHPs and DVA clients, along with a clearer outline of the responsibilities of care for the treatment cycle arrangements, is recommended to address these concerns. The opportunity exists for improved clarity about the role of each stakeholder group to minimise duplication and maximise efficiency.

Access to required treatment

Analysis of health usage data demonstrated differences in access to health care treatment as a function of location, as well as a predictable impact on service utilisation due to the impacts of the COVID-19 pandemic. The evaluation identified an increasing trend in total daily spending in major cities and inner and outer regional areas since October 2016, continuing until the first quarter of 2019. Perhaps predictably, this trend reversed during the pandemic, and a decreasing trend in access to treatment continued until September 2020. Interestingly, total daily spending in very remote areas gradually increased after implementing the treatment cycle arrangements. Given known challenges associated with access to services in remote and rural areas, this positive change in access to services may be the result of improved service-related communication and referral to AHP providers by GPs. Monitoring this change over time may help determine whether this is the case.

Efficacy of the At Risk Client Framework

The At Risk Client Framework was developed for a proportion of clients who may require more tailored plans over longer periods (up to 12 months) to achieve the desired quality of care. The DVA communication plan acknowledged that health care providers and DVA clients had expressed concerns that the treatment cycle arrangements would make it difficult for clients with complex health conditions to maintain continuity in their treatment (‘DVA treatment cycle communications plan’ document, 2019). Data collected in this evaluation indicated that these concerns are still present. DVA clients with chronic and severe health conditions expressed dissatisfaction with the 12-session requirement of the treatment cycle arrangements but did not express awareness or

utilisation of the At Risk Client Framework, indicating that some eligible clients may not be accessing it.

The evaluation found that self-reported knowledge of the At Risk Client Framework among GPs is moderate. Less than 60% of GPs thought they had sufficient knowledge about the framework (57%; n = 84) and understood it (58%; n = 86). Despite this, 63% (n = 94) of GPs reported applying the framework, and 62% (n = 92) were satisfied with the framework criteria. Just over half of GP respondents (54%; n = 80) agreed that the framework meets complex health care needs, and 60% (n = 89) believed the framework ensures quality primary coordinated care. Just over half the GP group (53%; n = 79) agreed that few DVA clients require the framework. DVA client interviews indicated that there might be uneven awareness of the framework among clients and GPs, with DVA clients reporting that they had bought the framework to the attention of their GP after hearing about it elsewhere.

The evaluation recommends that the At Risk Client Framework is reviewed to ensure its aims are being met and that DVA clients and GPs are aware of and able to apply the framework where appropriate. A review of the current number of DVA clients accessing the framework may indicate whether it is currently appropriately accessed, although these data were not available for this project. The application of the framework may be improved by more effective communication of the framework to GPs.

Data regarding AHP and DVA client knowledge of the framework were not collected within this project as DVA policy outlines that the framework is only applied by GPs. Despite this, AHPs and DVA clients mentioned the framework during interviews. Interview data collected from occupational therapists and podiatrists highlighted the opportunity for AHPs with ongoing interactions with clients to be able to contribute to discussions of client health conditions, psychosocial factors and functional impairments as a result of the treatment cycle arrangements, and that a dialogue between AHPs and GPs would improve both the quality of care provided to the client and the application of the framework to at-risk clients. Further research regarding AHP knowledge and possible contribution to the application of the At Risk Client Framework is

recommended, as it was outside the scope of this evaluation but is an opportunity for improved patient care outcomes.

SECTIONS 6: CONCLUSIONS AND NEXT STEPS

The evaluation has identified multiple instances of good practice and positive outcomes as a result of the implementation of the treatment cycle arrangements, although the COVID-19 pandemic has undoubtedly had an impact on access and coordination of services. Many strong views have been expressed across each of the participant groups, which indicates the need for ongoing monitoring of stakeholder outcomes and continual improvement in streamlining the administrative requirements of the treatment cycle arrangements. Some DVA clients and health care providers doubted whether the objectives of the treatment cycle arrangements relating to improved coordination and access to services are being met. However, the 12-session structure was generally accepted as being suitable for acute conditions.

Concern was raised by GPs and AHPs about managing clients with chronic conditions. This may indicate a limited understanding of the At Risk Client Framework in the wider practitioner group and requires ongoing monitoring to ensure that clients requiring services under this system are being appropriately identified.

Additionally, further clarity about coordination responsibilities under the treatment cycle arrangements is required but may develop with longer experience of the program and targeted communication about responsibilities for client coordination. Client care coordination requires additional focus and strategies to maximise service efficiency and facilitate desired outcomes. A combination of factors, from the need for increased referrals and additional or new administration, may have overshadowed any potential improvement in care coordination at the time of the evaluation.

Clients who have accessed DVA-funded allied health treatment reported their experience of services was typically very good or excellent from AHPs. Additionally, many clients expressed their gratitude towards DVA for recognising their service, injuries and need for treatment. However, clients have reported that some GPs and AHPs refuse to treat DVA clients due to bureaucracy, administrative requirements, insufficient remuneration and the complexity of DVA client care.

In light of the above findings and conclusions, this evaluation has made the following recommendations for the ongoing monitoring and implementation of the treatment cycle arrangements. These recommendations have been discussed in the previous section but have been summarised here for ease of action. These recommendations are designed to be actionable and to meet the original intentions of the treatment cycle arrangements.

Next steps

Communication

- **Improved, better-targeted GP communication:** This report recommends that more emphasis is placed on the DVA improving the GP understanding of and participation in the treatment cycle arrangements. This includes ongoing communication and consultation with GP-specific channels (such as the RACGP and AMA) with emphasis on GP roles within the referral arrangements. This should include specific information regarding the At Risk Client Framework.
- **Communication with AHPs and clients regarding the purpose of the treatment cycle arrangements:** This evaluation recommends more in-depth and ongoing engagement of veteran's groups and AHP associations regarding feedback about the treatment cycle to improve understanding of and engagement with the treatment cycle arrangements. Ongoing opportunities for stakeholder feedback relating to the treatment cycle arrangements and for targeted communications from DVA to stakeholders about the improved quality of care outcomes may help address the sentiment that the treatment cycle arrangements are a cost-saving measure rather than a health care improvement strategy.
- **Tailored communication methods:** Information tailored to the communication mediums most frequently accessed by different age groups is likely to improve uptake, positive perceptions and comprehension of the treatment cycle arrangements. This targeted group segmentation strategy will ensure that information is shared via the platforms most likely to be accessed by the target

stakeholder subgroups. There is an opportunity to implement a targeted strategy in the first instance with veterans aged 50 years and older who appear to have experienced reduced exposure to the information offered by the DVA communication plan.

- **Improved written communications:** Actionability of DVA-provided documents relating to the treatment cycle arrangements should be improved by including tangible tools for readers, such as checklists, to ensure that the user takes specific actions to implement and comply with the treatment cycle arrangements.

Quality of care

- **Treatment cycle compliance monitoring:** This evaluation recommends that a structured monitoring program of GP knowledge and compliance be implemented to ensure GP understanding of treatment cycle arrangements. It is essential that compliance monitoring highlights and addresses areas of common noncompliance via mechanisms to improve communication and feedback from stakeholders. Monitoring should also ensure the continuous improvement of operational processes of the treatment cycle arrangements.
- **Review and communication of coordination of care responsibilities:** Pressure and perceived self-coordination of care was a common theme among DVA clients, especially relating to feeling the need to track the number of sessions with their AHP to ensure their referral was current. These psychosocial impacts should guide further communication of the treatment cycle arrangements. Further review and communication of the intended care coordination structure among GPs, AHPs and DVA clients, along with a clearer outline of the responsibilities of care coordination for the treatment cycle arrangements, is recommended to address these concerns. For example, if the intended outcome of the treatment cycle is for AHPs to track the 12-session allowance, this may need to be better communicated to DVA clients and health care providers. If the 12 sessions are intended to be tracked by DVA clients, a document or diary outline could be published and provided to clients to assist in their health care coordination.

- **End of Cycle report review:** The findings of this evaluation provide an opportunity to revisit and revise the application, efficiency and relevance of End of Cycle reports for AHP and GP implementation and ensure they are fit for the best DVA client health care outcomes. A working group or similar to review the current uses and applicability of End of Cycle reports is recommended to improve the reports for improved veteran quality of care and health provider communication.
- **Access to required treatment:** Data indicated that total daily spending in very remote areas gradually increased after implementing the treatment cycle arrangements. The evaluation notes the opportunity for monitoring this change over time and investigating the impact of the treatment cycle arrangements in remote areas.
- **At Risk Client Framework review:** The evaluation recommends that the At Risk Client Framework is reviewed to ensure the aims of the framework are being met and that DVA clients and GPs are aware and able to apply the framework where applicable. A review of the current number of DVA clients accessing the framework may indicate whether it is currently appropriately accessed. Considering the inclusion of specific AHP types, such as occupational therapists and podiatrists, who deal with long-term conditions and care, may improve the application of the framework and the effectiveness of veteran care.

Economic impacts

- **Analysis of the economic impact of the treatment cycle for stakeholders:** While health economic analysis indicated that the treatment cycle arrangements resulted in overall savings for the DVA per client, it is important to note that this may be at the cost of increased personal expenses for DVA clients and a higher administrative burden for GPs and AHPs. Further rolling analysis of the economic impact of the treatment cycle arrangements on stakeholders should be undertaken to monitor any potential cost shifts to clients.

- **Ongoing financial savings:** This evaluation recommends that DVA further analyse the financial impact of the treatment cycle arrangements to track ongoing trends and patterns. This could be achieved by analysing the next available financial year of data to track ongoing trends and see if estimated savings have remained consistent with the findings of this evaluation.
- **The impact of COVID-19:** The conclusions made by this evaluation regarding the financial savings made as a result of the treatment cycle arrangements should be further tested and consolidated with additional data to account for the impact of COVID-19. While the analysis accounted as much as possible for the impact of the pandemic, further analysis of health usage data will improve our understanding of the impact of COVID-19 on health care access and financial savings concerning the treatment cycle arrangements.
- **Financial remuneration for health care providers:** The administrative burden and cost increases reported by health care providers was an important finding of this evaluation. Addressing the administrative burden on DVA clients and their health care providers through initiatives such as financial remuneration for administrative tasks tied to the treatment cycle arrangements may ensure maximal benefits for all stakeholder groups.

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Appendix 1: Survey Questions

DVA CLIENT SURVEY QUESTIONS

DVA ALLIED HEALTH TREATMENT CYCLE EVALUATION

In October 2019, the Department of Veterans' Affairs (DVA) implemented treatment cycle arrangements for GP referrals to allied healthcare services.

The treatment cycle arrangements aim to improve quality of healthcare for DVA clients by supporting better coordination and communication between general practitioners (GPs), allied health providers and clients.

The purpose of this evaluation is to review the implementation of treatment cycle arrangements for allied health referrals, and assess whether these arrangements contribute to intended outcomes for DVA clients and health service providers.

Q1 Are you one of the following?

- DVA Client
- General Practitioner (GP)
- Allied Health Provider (AHP)
- None of these

Q2 As a DVA client, have you asked your GP for an allied health referral since 1 October 2019?

- Yes
- No

Q5 DVA CLIENT PARTICIPANT INFORMATION SHEET

Department of Veterans' Affairs – Treatment Cycle Arrangements Evaluation

Brief description of the evaluation

On 1 October 2019, referrals from general practitioners (GPs) to allied health services changed for Department of Veterans' Affairs (DVA) clients. Under the treatment cycle arrangements, referrals from GPs to an allied health provider (AHP) are valid for up to 12 sessions of treatment, or a year, whichever ends first. The treatment cycle arrangements aim to improve quality of care for DVA clients by supporting better coordination and communication between GPs, AHPs and clients.

SECTION 8: APPENDICES – DVA client survey questions

The aim of this evaluation is to investigate the impacts of this change, both positive and negative, on DVA clients and healthcare providers. This evaluation is being completed at the request of the DVA, by Queensland University of Technology (QUT).

You are being invited to take part in this evaluation because you are a DVA client that uses the treatment cycle arrangements for allied health referrals. Your experiences of the treatment cycle arrangements and the impacts on your healthcare services will provide valuable information in this evaluation.

Your part in the evaluation

Your participation in this evaluation is entirely voluntary and there is no obligation to take part. If you do agree to participate, you can withdraw at any time without comment or penalty. Your decision to participate or not will in no way impact upon your current or future relationship with QUT or DVA.

Your participation will involve the following:

- **Completing an online survey to report your opinions and experiences as a user of the DVA treatment cycle arrangements. This will take about 10 minutes to complete.**
- **At the end of the survey you will be invited to express your interest in a follow-up interview. This is completely optional, and at your discretion.**

Inclusion eligibility

To be eligible to participate in this evaluation you confirm that you are:

- **A DVA client that has been referred by your GP to an allied health provider, and commenced at least one treatment cycle for one or more of the service types listed below:**
  - **Chiropractic, clinical or general psychology, diabetes education, dietetics, exercise physiology, physiotherapy, neuropsychology, occupational therapy (including mental health), orthotics, osteopathy, podiatry, social work (including mental health), and speech pathology**

Exclusionary and exempt treatments

You may not be eligible to participate in this evaluation if you only access one or more of the following treatment types:

- **Dental services, optical services, hearing services, counselling services with Open Arms – Veterans & Families Counselling, and therapies that have other treatment limits; or**
- **If you are a DVA client with a Totally and Permanently Incapacitated (TPI) Gold Card, the treatment cycle does not apply for physiotherapy and exercise physiology services. However, if you have used other allied health services, such as occupational therapy, podiatry or psychology under the treatment cycle arrangements, you can participate in this evaluation.**

The above exclusion criteria are based on the same exemptions listed on the DVA website: https://www.dva.gov.au/health-and-treatment/injury-or-health-treatments/health-services/allied-health-treatment-cycle

Withdrawal from the evaluation

If you withdraw from the evaluation, any identifiable information already obtained from you will be destroyed at your request. Any data that has already been de-identified cannot be destroyed, as it is no longer linked to your identity, and so cannot be identified by evaluators for deletion. If you choose not to participate there will be no detriment to your future healthcare.

Risks of participating

There are no expected risks associated with your participation in this evaluation. Although, if you reasonably believe that participation may trigger discomfort and distress, we urge you not to participate. However, if you experience discomfort or distress as a result of your participation please discontinue the survey by closing the browser at any time and feel free to contact the following services for confidential counselling:

- **Open Arms – Veterans and Families Counselling on 1800 011 046 which provides unlimited, free, confidential counselling for veterans and veterans' families**
- **QUT Psychology Clinic on 07 3138 0999 which provides limited free counselling for research participants, when you call the clinic receptionist please indicate that you are a research participant of a QUT project**
- **Lifeline on 13 11 14 for free, confidential crisis counselling**
- **The evaluators can assist you in making this contact if you wish but will only do so with your express permission.**

Privacy and confidentiality

Your answers will be completely confidential and any personal details, which could identify you in any way, will not be passed to DVA. Your answers will not in any way affect any pension, benefits or health services which you are entitled to from DVA or to which you may become entitled in the future.

Please note that any personal data collected will be used for the purpose of this evaluation and no other, without your express permission. All data will be stored on a secure, password protected computer and QUT server only accessible by the evaluation team. All data will be destroyed in seven years, as per QUT research protocols.

Results and findings will be provided to DVA as interim and final evaluation reports. These reports may inform future changes to the treatment cycle arrangements. No personal or identifiable information will be included as part of the reports, or provided to DVA.

The Evaluators

If you have any questions or require further information, please contact one of the evaluation team members below.

- **Ms Louise Baldwin, Chief Investigator, Faculty of Health**
  phone 07 3138 5885 or email l.baldwin@qut.edu.au
- **Dr Kerri-Ann Woodbury, Veterans' Health Expert, Faculty of Health**
  phone 07 3138 0737 or email kerriann.woodbury@qut.edu.au

Complaints or concerns

Should you have any complaints or concerns about the manner in which this evaluation is conducted, please do not hesitate to contact the evaluators as listed above. Or you may prefer to contact the Department of Veterans' Affairs Research Ethics Point of Contact (DVA REPOC) via: ethics.poc@dva.gov.au

Ethics approval

This evaluation has been approved by Department of Veterans' Affairs Research Ethics (Reference No: EVAL-008, Valid to 23/10/2021). QUT ethics has confirmed that this evaluation meets the criteria as an evaluation activity as per the Ethical Considerations in Quality Assurance and Evaluation Activities (National Health and Medical Research Council, [NHMRC] 2014).

Q7 CONSENT

Department of Veterans' Affairs – Treatment Cycle Arrangements Evaluation

I give my consent to participate in the evaluation mentioned above on the following basis:

- **I understand the aims of this evaluation, how it will be conducted and my role in it.**
- **I understand the risks involved as described above.**

I am cooperating in this evaluation on condition that:

- **the information I provide will be kept confidential,**
- **the information will be used only for this evaluation, and**
- **any published reports of this evaluation will preserve my anonymity.**

I understand that:

- **there is no obligation to take part in this evaluation, and**
- **if I choose not to participate there will be no detriment to my entitlements or access to healthcare services.**

Statement of consent:

- **I am over 18 years of age,**
- **I am a DVA client, and**
- **I have read the information sheet and I provide my consent to participate and proceed in the evaluation**

- ○ Agree
- ○ Disagree

Q9 Demographics

What is your age?	
What is your postcode?	

Q10 What is your gender?

- ○ Female
- ○ Male
- ○ Prefer not to say
- ○ I identify my gender as: _____

Q11 In which Australian State or Territory do you receive GP and allied health services?

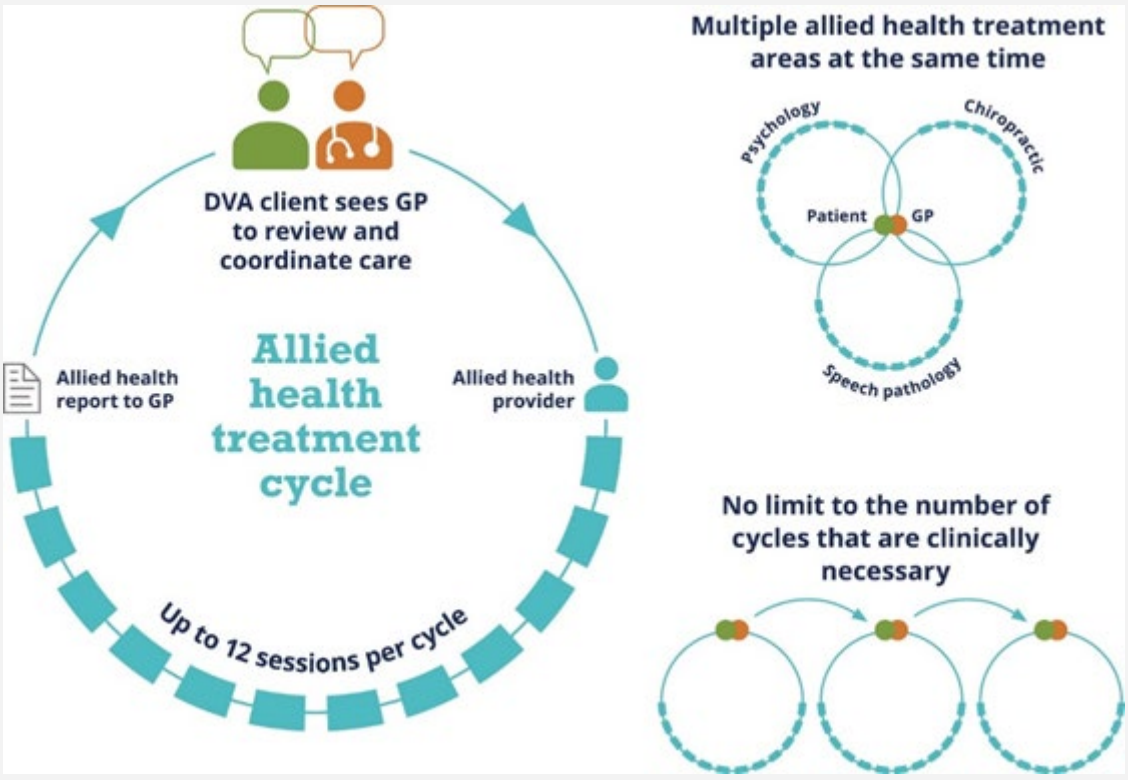
- ☐ ACT
- ☐ NSW
- ☐ NT
- ☐ QLD
- ☐ SA
- ☐ TAS
- ☐ VIC
- ☐ WA

Q14

On 1 October 2019 the Department of Veterans' Affairs (DVA) introduced treatment cycle arrangements for referrals to allied health services. The differences between the referral arrangements are detailed below

#	PREVIOUS REFERRAL ARRANGEMENTS	CURRENT REFERRAL ARRANGEMENT
1.	DVA clients talk to GP about health needs	DVA clients talk to GP about health needs
2.	DVA clients get a referral from GP to an allied health provider (AHP)	DVA clients get a referral from GP to an allied health provider (AHP)
3.	The referral is valid for 12 months or indefinite for ongoing conditions	The referral is valid for 12 sessions (one cycle) or 12 months (whichever ends first)
4.	Unlimited sessions available to meet health needs	Unlimited cycles available to meet health needs
5.	If referral was for 12 months, GP consults DVA clients to decide if another referral is needed for additional treatment (usually another 12 months)	AHP writes a report on health outcomes and sends tl report to GP
6.		GP reviews the report on DVA clients' health outcom and consults DVA clients to decide if another referral needed for additional treatment cycles

Q15



Q16 **More information about the allied health treatment cycle arrangements can be found on the DVA website: https://www.dva.gov.au/health-and-treatment/injury-or-health-treatments/health-services/allied-health-treatment-cycle**

Q17 When did you first become aware of changes to referral arrangements for allied health services? (select one only)

- ○ **Before** 1 October 2019
- ○ **After** 1 October 2019
- ○ I am **not aware** of the changes

Q18 Did you receive information directly from DVA about the allied health treatment cycle arrangements? (select one only)

- ○ Yes - **before** 1 October 2019
- ○ Yes - **after** 1 October 2019
- ○ Unsure
- ○ **No** - I did not receive information directly from DVA

Q19 Where did you receive information about the allied health treatment cycle arrangements? (select all that apply)

- ☐ GP
- ☐ GP clinic (advertisements)
- ☐ GP website
- ☐ GP social media
- ☐ DVA employee / representative
- ☐ DVA letter and leaflet
- ☐ DVA website
- ☐ DVA social media
- ☐ DVA vetaffairs newsletter
- ☐ Professional association website (e.g. RACGP, ESSA, AMA, etc.)
- ☐ Professional association email or letter
- ☐ Professional association social media
- ☐ Google
- ☐ Ex-Service Organisation (ESO) employee / representative
- ☐ ESO website (e.g. RSL QLD, Mates4Mates, etc.)
- ☐ ESO email
- ☐ ESO venue (advertisements)
- ☐ ESO social media
- ☐ AHP employee / representative

- ☐ AHP website
- ☐ AHP email
- ☐ AHP venue (advertisements)
- ☐ AHP social media
- ☐ None of these
- ☐ Other (please specify): _____

Q20 The following questions are about the quality of information and your initial experience with the referral process for allied health treatment cycle arrangements.

Q21 Available information about the allied health treatment cycle arrangements is...

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
Easy to understand					
Relevant to my needs					
High quality					

Q22 Since 1 October 2019, think about the first time you visited your GP for an allied health treatment referral...

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
I was **prepared** for the changes					
I **understood** the changes					
I had **sufficient knowledge** about the changes					
I was **confident** asking my GP for a referral to a treatment cycle					
I was **satisfied** with the changes					

Q23 Since 1 October 2019, has your GP made a referral for you for one or more of the following services? (select all that apply)

RECOGNISED ALLIED HEALTH SERVICES

- ☐ Chiropractic
- ☐ Clinical psychology
- ☐ Diabetes education
- ☐ Dietetics
- ☐ Exercise physiology
- ☐ Neuropsychology
- ☐ Occupational therapy (including mental health)
- ☐ Orthotics
- ☐ Osteopathy
- ☐ Physiotherapy
- ☐ Podiatry
- ☐ Psychology
- ☐ Social work (including mental health)
- ☐ Speech pathology
- ☐ None of these apply to me

Q24 COVID-19 restrictions and lockdown may have impacted your ability to access to your GP and allied health services.

Please indicate your personal experience by responding to the following statements. If you would like to elaborate, please add comments in the boxes provided.

Q25 What impact, if any, has COVID-19 had on your access to healthcare services?

	Yes	No	Comments
My GP services were impacted			
My allied health services were impacted			
I have been able to access my GP services			
I have been able to access my allied health services			
I have chosen to access my GP services			
I have chosen to access my allied health services			

Q26 During COVID-19, what changes, if any, have you experienced with your GP and allied health services? (select all that apply)

- ☐ More telehealth consultation
- ☐ Less in-person consultation
- ☐ I have not accessed GP or allied health services during COVID-19
- ☐ No change in GP or allied health services
- ☐ Other (please specify): _____

Q27 Transitioning to the allied health treatment cycle arrangements: service use

The following questions are about your service use since 1 October 2019.

Q28 When did you first transition to the treatment cycle arrangements? (select one only)

_____ ▼

Q29 Please indicate your allied health service use by selecting one of the following options.

Q30 When have you received allied health treatment services?

- ○ **Before and after** 1 October 2019
- ○ **Before** 1 October 2019 **only**
- ○ **After** 1 October 2019 **only**
- ○ I have **never** received allied health services

Q31 Transitioning to the allied health treatment cycle arrangements: impacts

The following questions are about impacts you may have experienced since 1 October 2019.

Q32 How have you been impacted by the changes to allied health treatment cycle arrangements? (select one only)

- I have been **positively impacted** by the changes
- I have been **negatively impacted** by the changes
- I have **not been impacted** by the changes

Q33 Have you experienced changes in the amount you see your GP? (select one only)

- Yes - I see my GP **more**
- Yes - I see my GP **less**
- No - I see my GP the same amount

Q34 Transitioning to the allied health treatment cycle arrangements: quality of healthcare

The following questions are about your satisfaction with the quality of healthcare you have received since transitioning to the treatment cycle arrangements.

By 'healthcare' we mean health needs, treatment needs, progress, and outcomes

Q35 How, if at all, has your quality of healthcare changed?

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
I require **more referrals** from my GP to meet my healthcare needs					
I am **more engaged** in how my healthcare needs are met					
My GP and I **discuss** and **review** my healthcare needs **more often** and **in more detail**					
My AHP and I **discuss** and **review** my healthcare needs **more often** and **in more detail**					
My healthcare needs are **better met**					
I have **better access** to **necessary services** for my healthcare needs					

I receive **better quality of healthcare overall**	
I receive **better targeted support** based on my healthcare needs	

Q36 Care Coordination between DVA clients and General Practitioners

The following questions are about any changes in how you talk to your General Practitioner (GP) about your healthcare needs and allied health referrals now, compared to before 1 October 2019.

By 'healthcare' we mean health needs, treatment needs, progress, and outcomes

Q37 How, if at all, have your interactions with your GP changed?

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
Before seeking a referral for allied health treatment, my GP and I **discuss** my **healthcare needs** in more detail					
After finishing a treatment cycle, my GP and I **review** my **ongoing healthcare needs** in more detail					
The **number** of interactions with my GP has **increased**					
The **quality** of interactions with my GP has **improved**					
My GP and I have **more opportunities** to discuss and review my **healthcare needs**					

Q38 Care Coordination between DVA clients and Allied Health Providers

The following questions are about any changes in how you talk to your Allied Health Provider (AHP) about healthcare needs now, compared to before 1 October 2019.

By 'healthcare' we mean treatment needs, progress, and outcomes.

By Allied Health Provider, we mean your chiropractor, diabetes educator, dietitian, exercise physiologist, occupational therapist, orthotist, osteopath, physiotherapist, podiatric, clinical psychologist, neuropsychologist, psychologist, social worker or speech pathologist.

Q39 How, if at all, have your interactions with your AHP changed?

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
Before starting a treatment cycle, my AHP and I develop a **Patient Care Plan**					
My **Patient Care Plan** details my **healthcare needs**					
Before starting a treatment cycle, my AHP and I **discuss** my **healthcare needs** in more detail					
After finishing a treatment cycle, my AHP and I **review** my **healthcare needs** in more detail					
My AHP writes notes and assesses my **healthcare needs**					
The **number** of interactions with my AHP has **increased**					
The **quality** of interactions with my AHP has **improved**					
My AHP and I have **more opportunities** to discuss and review my **healthcare needs**					

Q40 Care Coordination between DVA clients, General Practitioners & Allied Health Providers: clinical notes and clinical communication

The following questions are about changes in care coordination between you, your GP and your AHP since 1 October 2019.

By 'healthcare' we mean health needs, treatment needs, progress, and outcomes

Q41 Who coordinates your healthcare needs? (select one only)

- ○ I coordinate my healthcare needs
- ○ My GP coordinates my healthcare needs
- ○ My AHP coordinates my healthcare needs
- ○ My GP and AHP consult each other to jointly coordinate my healthcare needs
- ○ Someone else coordinates my healthcare needs (please specify): _____

Q42 How, if at all, have your interactions between you, your GP and your AHP changed?

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
My AHP provides a report which details my **healthcare needs** and makes recommendations to my GP					
My GP reviews a report from my AHP and **makes recommendations** based on the report					
My GP discusses the report and recommendations with me and **seeks my opinion**					
My GP makes **additional referrals** for treatment cycles based on the report and my opinion					
I feel **included in the decision-making process** to meet my healthcare needs					
I feel **informed about communications, decisions and recommendations** between my GP and AHP					

Q43 You may have been impacted by the changes to the allied health treatment cycle arrangements in the following ways.

Q44 Compared to before 1 October 2019, I now think that the referral process for treatment cycle arrangements is... (select all that apply)

	Yes	Comments
More time-consuming		
More time-efficient		
More expensive (please specify)		
Less expensive (please specify)		
More complex		
Simpler and more straight-forward		
Less effective		
More effective		
Unimproved and worse		
Improved and better		
Less flexible, responsive and dynamic		
More flexible, responsive and dynamic		
Other (please specify)		
None of these apply		

GP SURVEY QUESTIONS

DVA ALLIED HEALTH TREATMENT CYCLE EVALUATION

In October 2019, the Department of Veterans' Affairs (DVA) implemented treatment cycle arrangements for GP referrals to allied healthcare services.

The treatment cycle arrangements aim to improve quality of healthcare for DVA clients by supporting better coordination and communication between general practitioners (GPs), allied health providers and clients.

The purpose of this evaluation is to review the implementation of treatment cycle arrangements for allied health referrals, and assess whether these arrangements contribute to intended outcomes for DVA clients and health service providers.

Q1 Are you one of the following?

- DVA Client
- General Practitioner (GP)
- Allied Health Provider (AHP)
- None of these

Q4 **As an AHP, have you provided allied health services to any DVA client/s since 1 October 2019?**

- Yes
- No

Q6 GP and AHP PARTICIPANT INFORMATION SHEET

Department of Veterans' Affairs – Treatment Cycle Arrangements Evaluation

Brief description of the evaluation

On 1 October 2019, referrals from general practitioners (GPs) to allied health services changed for Department of Veterans' Affairs (DVA) clients. Under the treatment cycle arrangements, referrals from GPs to an allied health provider (AHP) are valid for up to 12 sessions of treatment, or a year, whichever ends first. The treatment cycle arrangements aim to improve quality of care for DVA clients by supporting better coordination and communication between GPs, allied health providers and clients.

The aim of this evaluation is to investigate the impacts of this change, both positive and negative, on DVA clients and healthcare providers. This evaluation is being completed at the request of the DVA, by Queensland University of Technology (QUT).

You are being invited to take part in this evaluation because you are a healthcare provider that uses DVA's treatment cycle arrangements for allied health referrals. Your experiences of the treatment cycle arrangements and the impacts on your provision of services will provide valuable information in this evaluation.

Your part in the evaluation

Your participation in this evaluation is entirely voluntary and there is no obligation to take part. If you do agree to participate, you can withdraw at any time without comment or penalty. Your decision to participate or not will in no way impact upon your current or future relationship with QUT or DVA.

Your participation will involve the following:

- **Completing an online survey to report your opinions and experiences as a user of the DVA treatment cycle arrangements. This will take about 10 minutes to complete.**
- **At the end of the survey you will be invited to express your interest in a follow-up interview. This is completely optional, and at your discretion.**

Inclusion eligibility

To be eligible to participate in this evaluation you confirm that you are one of the following:

- **A GP that has referred at least one DVA client to an allied health service provider to commence a treatment cycle; or**
- **An Allied Health Provider (AHP) that has commenced at least one treatment cycle with a DVA client through the following service types listed below:**
  - **Chiropractic, clinical or general psychology, diabetes education, dietetics, exercise physiology, physiotherapy, neuropsychology, occupational therapy (including mental health), orthotics, osteopathy, podiatry, social work (including mental health), and speech pathology**

Exclusionary and exempt treatments

You may not be eligible to participate in this evaluation if you only provide one or more of the following treatment types:

- **Dental services, optical services, hearing services, counselling services with Open Arms – Veterans & Families Counselling, and therapies that have other treatment limits**

The above exclusion criteria are based on the same exemptions listed on the DVA website: https://www.dva.gov.au/health-and-treatment/injury-or-health-treatments/health-services/allied-health-treatment-cycle

Withdrawal from the evaluation

If you withdraw from the evaluation, any identifiable information already obtained from you will be destroyed at your request. Any data that has already been de-identified cannot be

destroyed, as it is no longer linked to your identity, and so cannot be identified by evaluators for deletion. If you choose not to participate there will be no detriment to your career.

Risks of participating

There are no expected risks associated with your participation in this evaluation. Although, if you reasonably believe that participation may trigger discomfort and distress, we urge you to self-exclude and not participate.

Privacy and confidentiality

Your answers will be completely confidential and any personal details, which could identify you in any way, will not be passed to DVA.

Please note that any personal data collected will be used for the purpose of this evaluation and no other, without your express permission. All data will be stored on a secure, password protected computer and QUT server only accessible by the evaluation team. All data will be destroyed in seven years, as per QUT research protocols.

Results and findings will be provided to DVA as interim and final evaluation reports. These reports may inform future changes to the treatment cycle arrangements. No personal or identifiable information will be included as part of the reports or provided to DVA.

The Evaluators

If you have any questions or require further information, please contact one of the evaluation team members below.

- **Ms Louise Baldwin, Chief Investigator, Faculty of Health**
  phone 07 3138 5885 or email l.baldwin@qut.edu.au
- **Dr Kerri-Ann Woodbury, Veterans' Health Expert, Faculty of Health**
  phone 07 3138 0737 or email kerriann.woodbury@qut.edu.au

Complaints or concerns

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Ethics approval

This evaluation has been approved by Department of Veterans' Affairs Research Ethics (Reference No: EVAL-008, Valid to 23/10/2021). QUT ethics has confirmed that this evaluation meets the criteria as an evaluation activity as per the Ethical Considerations in Quality Assurance and Evaluation Activities (National Health and Medical Research Council, [NHMRC] 2014).

Q8 CONSENT

Department of Veterans' Affairs – Treatment Cycle Arrangements Evaluation

I give my consent to participate in the evaluation mentioned above on the following basis:

- **I understand the aims of this evaluation, how it will be conducted and my role in it.**
- **I understand the risks involved as described above.**

I am cooperating in this evaluation on condition that:

- **the information I provide will be kept confidential,**
- **the information will be used only for this evaluation, and**
- **any published reports of this evaluation will preserve my anonymity.**

I understand that:

- **there is no obligation to take part in this evaluation, and**
- **if I choose not to participate there will be no detriment to my career.**

Statement of consent:

- **I am over 18 years of age,**
- **I am a healthcare provider, and**
- **I have read the information sheet and I provide my consent to participate and proceed in the evaluation**

- ○ Agree
- ○ Disagree

Q9 Demographics

What is your age? _____

What is your postcode? _____

Q10 What is your gender?

- ○ Female
- ○ Male
- ○ Prefer not to say
- ○ I identify my gender as: _____

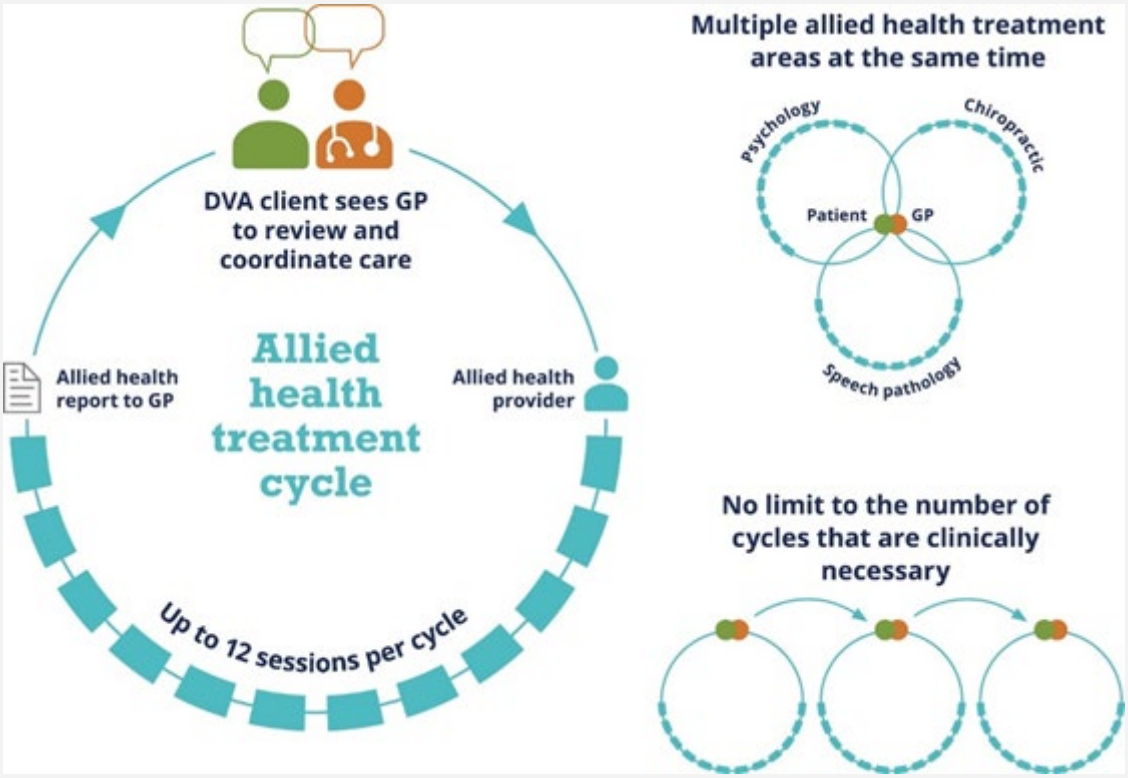
Q12 In which Australian State or Territory do you practice GP or allied health services?

- ☐ ACT
- ☐ NSW
- ☐ NT
- ☐ QLD
- ☐ SA
- ☐ TAS
- ☐ VIC
- ☐ WA

Q14 On 1 October 2019 the Department of Veterans' Affairs (DVA) introduced treatment cycle arrangements for referrals to allied health services. The differences between the referral arrangements are detailed below

#	PREVIOUS REFERRAL ARRANGEMENTS	CURRENT REFERRAL ARRANGEMENT
1.	DVA clients talk to GP about health needs	DVA clients talk to GP about health needs
2.	DVA clients get a referral from GP to an allied health provider (AHP)	DVA clients get a referral from GP to an allied health provider (AHP)
3.	The referral is valid for 12 months or indefinite for ongoing conditions	The referral is valid for 12 sessions (one cycle) or 12 months (whichever ends first)
4.	Unlimited sessions available to meet health needs	Unlimited cycles available to meet health needs
5.	If referral was for 12 months, GP consults DVA clients to decide if another referral is needed for additional treatment (usually another 12 months)	AHP writes a report on health outcomes and sends tl report to GP
6.		GP reviews the report on DVA clients' health outcom and consults DVA clients to decide if another referral needed for additional treatment cycles

Q15



Q16 **More information about the allied health treatment cycle arrangements can be found on the DVA website: https://www.dva.gov.au/health-and-treatment/injury-or-health-treatments/health-services/allied-health-treatment-cycle**

Q17 When did you first become aware of changes to referral arrangements for allied health services? (select one only)

- Before 1 October 2019
- After 1 October 2019
- I am not aware of the changes

Q18 **Did you receive information directly from DVA about the allied health treatment cycle arrangements?** (select one only)

- Yes - before 1 October 2019
- Yes - after 1 October 2019
- Unsure
- No - I did not receive information directly from DVA

Q45 Where did you receive information about the changes to allied health treatment cycle arrangements? (select all that apply)

- ☐ DVA client
- ☐ GP clinic (advertisements)
- ☐ GP website
- ☐ GP social media
- ☐ DVA employee / representative
- ☐ DVA letter and leaflet
- ☐ DVA website
- ☐ DVA social media
- ☐ DVA vetaffairs newsletter
- ☐ Professional association website (e.g. RACGP, AMA, ESSA, OTA, APA, etc.)
- ☐ Professional association email or letter
- ☐ Professional association social media
- ☐ Google
- ☐ Ex-Service Organisation (ESO) employee / representative
- ☐ ESO website (e.g. RSL QLD, Mates4Mates, etc.)
- ☐ ESO email
- ☐ ESO venue (advertisements)
- ☐ ESO social media
- ☐ AHP employee / representative
- ☐ AHP website
- ☐ AHP email
- ☐ AHP venue (advertisements)
- ☐ AHP social media
- ☐ None of these
- ☐ Other (please specify): _____

Q46 The following questions are about the quality of information and your initial experience with the referral process for allied health treatment cycle arrangements.

Q47 Available information about the allied health treatment cycle arrangements is...

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
Easy to understand					
Relevant to my practice					
Relevant to my DVA clients' needs					
High quality					

Q48 Since 1 October 2019, think about the first time you made a referral for a DVA client under the allied health treatment cycle arrangements...

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
I was **prepared** for the changes					
I **understood** the changes					
I had **sufficient knowledge** about the changes					
I was **confident** referring DVA clients to a treatment cycle					
I was **satisfied** with the changes					

Q49 I have consulted a DVA client that needed a referral under the treatment cycle arrangements

- ○ Yes
- ○ No

Q50 Since 1 October 2019, have you referred your DVA clients to one or more of the following services? (select all that apply)

RECOGNISED ALLIED HEALTH SERVICES

- ☐ Chiropractic

- ☐ Clinical psychology
- ☐ Diabetes education
- ☐ Dietetics
- ☐ Exercise physiology
- ☐ Neuropsychology
- ☐ Occupational therapy
- ☐ Occupational therapy (mental health)
- ☐ Orthotics
- ☐ Osteopathy
- ☐ Physiotherapy
- ☐ Podiatry
- ☐ Psychology
- ☐ Social work
- ☐ Social work (mental health)
- ☐ Speech pathology
- ☐ None of these

Q51 COVID-19 restrictions and lockdown may have impacted your service provision.

Please indicate your professional experience by responding to the following questions.

Q52 What impact, if any, has COVID-19 had on your service provision?

	Yes	No	Comments
My GP services were impacted			
My DVA clients have been able to access my GP services			
My DVA clients have chosen to access my GP services			
I have been able to continue to make referrals for DVA clients to treatment cycles			
I have been able to continue to review my DVA clients healthcare needs			

Q53 During COVID-19, what changes, if any, have you experienced with your DVA clients? (select all that apply)

- [ ] More telehealth consultation
- [ ] Less in-person consultation
- [ ] Clients have not sought further consultations, referrals or reviews since COVID-19 restrictions have eased
- [ ] No change in referrals, consultation and review processes
- [ ] None of these apply
- [ ] Other (please specify):

Q54 Implementation of the allied health treatment cycle arrangements

The following questions are about to your professional experience of implementing the allied health treatment cycle arrangements since 1 October 2019.

Q55 When did you first implement the treatment cycle arrangements? (select one only)

Q56 When have you referred DVA clients for allied health treatment services?

- ○ **Before and after** 1 October 2019
- ○ **Before** 1 October 2019 **only**
- ○ **After** 1 October 2019 **only**
- ○ I have never referred DVA clients for allied health treatment services

Q57 Implementation of the allied health treatment cycle arrangements: impacts

The following questions are about impacts you may have experienced since 1 October 2019.

Q58 How have you been impacted by the changes to allied health referrals under the treatment cycle arrangements? (select one only)

- ○ I have been **positively impacted** by the changes
- ○ I have been **negatively impacted** by the changes

- I have **not been impacted** by the changes

Q59 Have you experienced a change in the amount you see your DVA clients?

- **Yes** - I see my DVA clients **more**
- **Yes** - I see my DVA clients **less**
- **No** - I see my DVA clients the **same amount**
- Other (please specify):

Q60 Implementing the allied health treatment cycle arrangements: quality of healthcare

The following questions are about your satisfaction with the quality of healthcare your DVA clients have received since 1 October 2019.

By 'healthcare' we mean health needs, treatment needs, progress, and outcomes

Q61 How, if at all, has your practice of quality healthcare for DVA clients changed?

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
I make **more referrals** for my DVA clients to meet their healthcare needs					
I **contribute more** to how my DVA clients healthcare needs are met					
My DVA clients and I **discuss and review** their health care needs **more often** and **in more detail**					
My DVA client's AHP and I **discuss and review** our client's healthcare needs **more often** and **in more detail**					
My DVA clients healthcare needs are **better met**					

My DVA clients have **better access to necessary services** to meet their healthcare needs	
My DVA clients receive **better quality of healthcare overall**	
My DVA clients receive **better targeted support** based on their healthcare needs	

Q62 Care Coordination between DVA clients and General Practitioners

The following questions are about any changes in how you talk with your DVA clients about healthcare needs, referrals and additional referrals to allied health treatment cycle arrangements now, compared to before 1 October 2019.

By 'healthcare' we mean health needs, treatment needs, progress, and outcomes

Q63 How, if at all, have your interactions with your DVA clients changed?

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
Before making a referral to a treatment cycle, my DVA clients and I **discuss** their **healthcare needs** in more detail					
After finishing a treatment cycle, my DVA clients and I **review** their **ongoing healthcare needs** in more detail					
The **number** of interactions with my DVA clients has **increased**					
The **quality** of interactions with my DVA clients has **improved**					
My DVA clients and I have **more opportunities** to discuss their **healthcare needs**					

Q64 Care Coordination between DVA clients, General Practitioners & Allied Health Providers: clinical notes and clinical communication

The following questions are about changes in care coordination between you, your DVA clients and their AHP since 1 October 2019.

By 'healthcare' we mean health needs, treatment needs, progress, and outcomes

Q65 Who coordinates your DVA client's healthcare needs?

	Yes	No	Comments
I coordinate my DVA client's healthcare needs			
My DVA clients coordinate their healthcare needs			
My DVA client's AHP coordinates their healthcare needs			
I consult my DVA client's AHP to jointly coordinate their healthcare needs			
Someone else coordinates my DVA client's healthcare needs (please specify):			
Other: I jointly coordinate with others for tailored arrangements (please specify):			

Q66 How, if at all, have your interactions between you, your DVA clients and their AHP changed?

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
My DVA client's AHP provides a report which details their **ongoing healthcare needs** and makes recommendations to me					
The AHP clinical notes, report, assessment and recommendations **are clear**					
I **review** and **discuss** the AHP report and recommendations with my DVA clients and I **seek their opinion**					
I ensure my DVA clients are **included in the decision-**					

making process to meet their ongoing healthcare needs	
I ensure my DVA clients are **informed about communications, decisions, and recommendations** between myself and their AHP	
I make **additional referrals** for treatment cycles based on the report, my DVA client's ongoing healthcare needs, their opinion and my professional judgement	
In general, the **number** of interactions between my DVA client's AHP and I have **increased**	
In general, the **quality** of interactions between my DVA client's AHP and I have **improved**	
There are **more opportunities** for my DVA clients' AHP and I to discuss and review their healthcare needs	

Q67 Efficacy of the At Risk Client Framework

The following questions are about the efficacy of the At Risk Client Framework for your DVA clients with complex healthcare needs.

By 'the framework' we mean the At Risk Client Framework

Q68 What is your professional opinion on the At Risk Client Framework?

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
I have **sufficient knowledge** about the framework and tailored referral arrangements					

I **understand** the framework and tailored referral arrangements	
I have applied the framework for DVA clients with complex healthcare needs	
I am **confident** making tailored referral arrangements for DVA clients under the framework	
I am **satisfied** with the criteria of the framework for DVA clients with complex healthcare needs	
The framework **appropriately meets** the needs of DVA clients with **complex healthcare needs**	
The framework ensures that DVA clients with complex healthcare needs receive **quality primary and coordinated care**	
A **very small** percentage of DVA clients require tailored referral arrangements under the framework	

Q69 You may have been impacted by the changes to allied health treatment cycle arrangements in the following ways.

Q70 <u>Compared to before 1 October 2019</u>, now I think that the referral process for treatment cycle arrangements is... (select all that apply)

	Yes	Comments
More time-consuming		
More time-efficient		
More expensive (please specify)		
Less expensive (please specify)		
More complex		

Simpler and more straight-forward
Less effective
More effective
Unimproved and worse
Improved and better
Less flexible, responsive and dynamic
More flexible, responsive and dynamic
More administrative
Less administrative
Other (please specify)
None of these apply to me

AHP SURVEY QUESTIONS

DVA ALLIED HEALTH TREATMENT CYCLE EVALUATION

In October 2019, the Department of Veterans' Affairs (DVA) implemented treatment cycle arrangements for GP referrals to allied healthcare services.

The treatment cycle arrangements aim to improve quality of healthcare for DVA clients by supporting better coordination and communication between general practitioners (GPs), allied health providers and clients.

The purpose of this evaluation is to review the implementation of treatment cycle arrangements for allied health referrals, and assess whether these arrangements contribute to intended outcomes for DVA clients and health service providers.

Q1 Are you one of the following?

- ○ DVA Client
- ○ General Practitioner (GP)
- ○ Allied Health Provider (AHP)
- ○ None of these

Q4 As an AHP, have you provided allied health services to any DVA client/s since 1 October 2019?

- ○ Yes
- ○ No

GP and AHP PARTICIPANT INFORMATION SHEET

Department of Veterans' Affairs – Treatment Cycle Arrangements Evaluation

Brief description of the evaluation

On 1 October 2019, referrals from general practitioners (GPs) to allied health services changed for Department of Veterans' Affairs (DVA) clients. Under the treatment cycle arrangements, referrals from GPs to an allied health provider (AHP) are valid for up to 12 sessions of treatment, or a year, whichever ends first. The treatment cycle arrangements aim to improve quality of care for DVA clients by supporting better coordination and communication between GPs, allied health providers and clients.

The aim of this evaluation is to investigate the impacts of this change, both positive and negative, on DVA clients and healthcare providers. This evaluation is being completed at the request of the DVA, by Queensland University of Technology (QUT).

You are being invited to take part in this evaluation because you are a healthcare provider that uses DVA's treatment cycle arrangements for allied health referrals. Your experiences of the treatment cycle arrangements and the impacts on your provision of services will provide valuable information in this evaluation.

Your part in the evaluation

Your participation in this evaluation is entirely voluntary and there is no obligation to take part. If you do agree to participate, you can withdraw at any time without comment or penalty. Your decision to participate or not will in no way impact upon your current or future relationship with QUT or DVA.

Your participation will involve the following:

- **Completing an online survey to report your opinions and experiences as a user of the DVA treatment cycle arrangements. This will take about 10 minutes to complete.**
- **At the end of the survey you will be invited to express your interest in a follow-up interview. This is completely optional, and at your discretion.**

Inclusion eligibility

To be eligible to participate in this evaluation you confirm that you are one of the following:

- **A GP that has referred at least one DVA client to an allied health service provider to commence a treatment cycle; or**
- **An Allied Health Provider (AHP) that has commenced at least one treatment cycle with a DVA client through the following service types listed below:**
  - **Chiropractic, clinical or general psychology, diabetes education, dietetics, exercise physiology, physiotherapy, neuropsychology, occupational therapy (including mental health), orthotics, osteopathy, podiatry, social work (including mental health), and speech pathology**

Exclusionary and exempt treatments

You may not be eligible to participate in this evaluation if you only provide one or more of the following treatment types:

- **Dental services, optical services, hearing services, counselling services with Open Arms – Veterans & Families Counselling, and therapies that have other treatment limits**

The above exclusion criteria are based on the same exemptions listed on the DVA website: https://www.dva.gov.au/health-and-treatment/injury-or-health-treatments/health-services/allied-health-treatment-cycle

Withdrawal from the evaluation

If you withdraw from the evaluation, any identifiable information already obtained from you will be destroyed at your request. Any data that has already been de-identified cannot be

destroyed, as it is no longer linked to your identity, and so cannot be identified by evaluators for deletion. If you choose not to participate there will be no detriment to your career.

Risks of participating

There are no expected risks associated with your participation in this evaluation. Although, if you reasonably believe that participation may trigger discomfort and distress, we urge you to self-exclude and not participate.

Privacy and confidentiality

Your answers will be completely confidential and any personal details, which could identify you in any way, will not be passed to DVA.

Please note that any personal data collected will be used for the purpose of this evaluation and no other, without your express permission. All data will be stored on a secure, password protected computer and QUT server only accessible by the evaluation team. All data will be destroyed in seven years, as per QUT research protocols.

Results and findings will be provided to DVA as interim and final evaluation reports. These reports may inform future changes to the treatment cycle arrangements. No personal or identifiable information will be included as part of the reports or provided to DVA.

The Evaluators

If you have any questions or require further information, please contact one of the evaluation team members below.

- **Ms Louise Baldwin, Chief Investigator, Faculty of Health**
  phone 07 3138 5885 or email l.baldwin@qut.edu.au
- **Dr Kerri-Ann Woodbury, Veterans' Health Expert, Faculty of Health**
  phone 07 3138 0737 or email kerriann.woodbury@qut.edu.au

Complaints or concerns

Should you have any complaints or concerns about the manner in which this evaluation is conducted, please do not hesitate to contact the evaluators as listed above. Or you may prefer to contact the Department of Veterans' Affairs Research Ethics Point of Contact (DVA REPOC) via: ethics.poc@dva.gov.au

Ethics approval

This evaluation has been approved by Department of Veterans' Affairs Research Ethics (Reference No: EVAL-008, Valid to 23/10/2021). QUT ethics has confirmed that this evaluation meets the criteria as an evaluation activity as per the Ethical Considerations in Quality Assurance and Evaluation Activities (National Health and Medical Research Council, [NHMRC] 2014).

Q8 CONSENT

Department of Veterans' Affairs – Treatment Cycle Arrangements Evaluation

I give my consent to participate in the evaluation mentioned above on the following basis:

- **I understand the aims of this evaluation, how it will be conducted and my role in it.**
- **I understand the risks involved as described above.**

I am cooperating in this evaluation on condition that:

- **the information I provide will be kept confidential,**
- **the information will be used only for this evaluation, and**
- **any published reports of this evaluation will preserve my anonymity.**

I understand that:

- **there is no obligation to take part in this evaluation, and**
- **if I choose not to participate there will be no detriment to my career.**

Statement of consent:

- **I am over 18 years of age,**
- **I am a healthcare provider, and**
- **I have read the information sheet and I provide my consent to participate and proceed in the evaluation**

- ○ Agree
- ○ Disagree

Q9 Demographics

What is your age? _____

What is your postcode? _____

Q10 What is your gender?

- ○ Female
- ○ Male
- ○ Prefer not to say
- ○ I identify my gender as: _____

Q12 In which Australian State or Territory do you practice GP or allied health services?

- ☐ ACT
- ☐ NSW
- ☐ NT
- ☐ QLD
- ☐ SA
- ☐ TAS
- ☐ VIC
- ☐ WA

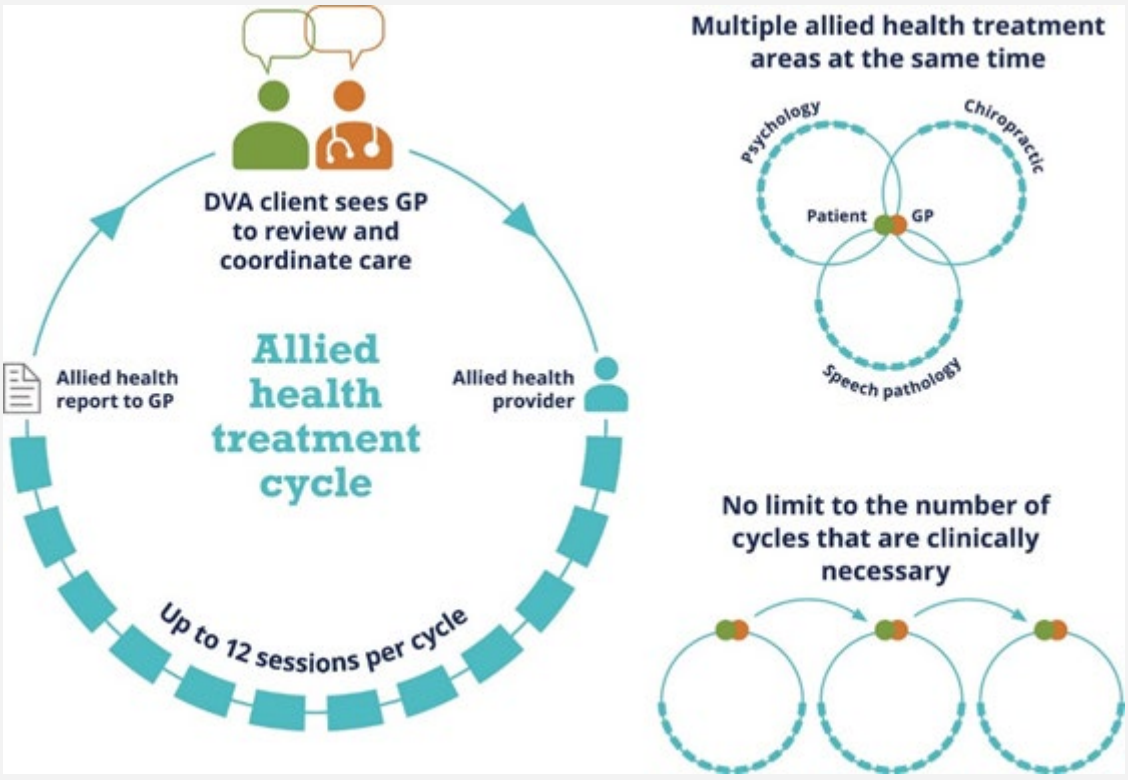
Q13 Please select your Allied Health service type

- ○ Chiropractic
- ○ Clinical Psychology
- ○ Diabetes Education
- ○ Dietetics
- ○ Exercise Physiology
- ○ Neuropsychology
- ○ Occupational Therapy
- ○ Occupational Therapy (mental health)
- ○ Orthotics
- ○ Osteopathy
- ○ Physiotherapy
- ○ Podiatry
- ○ Psychology
- ○ Social Work
- ○ Social Work (mental health)
- ○ Speech Pathology
- ○ None of these apply to me

Q14 On 1 October 2019 the Department of Veterans' Affairs (DVA) introduced treatment cycle arrangements for referrals to allied health services. The differences between the referral arrangements are detailed below

#	PREVIOUS REFERRAL ARRANGEMENTS	CURRENT REFERRAL ARRANGEMENT
1.	DVA clients talk to GP about health needs	DVA clients talk to GP about health needs
2.	DVA clients get a referral from GP to an allied health provider (AHP)	DVA clients get a referral from GP to an allied health provider (AHP)
3.	The referral is valid for 12 months or indefinite for ongoing conditions	The referral is valid for 12 sessions (one cycle) or 12 months (whichever ends first)
4.	Unlimited sessions available to meet health needs	Unlimited cycles available to meet health needs
5.	If referral was for 12 months, GP consults DVA clients to decide if another referral is needed for additional treatment (usually another 12 months)	AHP writes a report on health outcomes and sends tl report to GP
6.		GP reviews the report on DVA clients' health outcom and consults DVA clients to decide if another referral needed for additional treatment cycles

Q15



Q16 **More information about the allied health treatment cycle arrangements can be found on the DVA website: https://www.dva.gov.au/health-and-treatment/injury-or-health-treatments/health-services/allied-health-treatment-cycle**

Q17 When did you first become aware of changes to referral arrangements for allied health services? (select one only)

- ○ **Before** 1 October 2019
- ○ **After** 1 October 2019
- ○ I am **not aware** of the changes

Q18 **Did you receive information directly from DVA about the allied health treatment cycle arrangements?** (select one only)

- ○ Yes - **before** 1 October 2019
- ○ Yes - **after** 1 October 2019
- ○ Unsure
- ○ **No** - I did not receive information directly from DVA

Q45 **Where did you receive information about the changes to allied health treatment cycle arrangements?** (select all that apply)

- ☐ DVA client
- ☐ GP clinic (advertisements)
- ☐ GP website
- ☐ GP social media
- ☐ DVA employee / representative
- ☐ DVA letter and leaflet
- ☐ DVA website
- ☐ DVA social media
- ☐ DVA vetaffairs newsletter
- ☐ Professional association website (e.g. RACGP, AMA, ESSA, OTA, APA, etc.)
- ☐ Professional association email or letter
- ☐ Professional association social media
- ☐ Google
- ☐ Ex-Service Organisation (ESO) employee / representative
- ☐ ESO website (e.g. RSL QLD, Mates4Mates, etc.)
- ☐ ESO email
- ☐ ESO venue (advertisements)
- ☐ ESO social media

- ☐ AHP employee / representative
- ☐ AHP website
- ☐ AHP email
- ☐ AHP venue (advertisements)
- ☐ AHP social media
- ☐ None of these
- ☐ Other (please specify): _____

Q46 The following questions are about the quality of information and your initial experience with the referral process for allied health treatment cycle arrangements.

Q47 Available information about the allied health treatment cycle arrangements is...

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
Easy to understand					
Relevant to my practice					
Relevant to my DVA clients' needs					
High quality					

Q71 Since 1 October 2019, think about the first time you received a referral for a DVA client and provided allied health services under the treatment cycle arrangements...

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
I was **prepared** for the changes					
I **understood** the changes					
I had **sufficient knowledge** about the changes					
I was **confident** receiving a referral from a GP on					

behalf of a DVA client for an allied health treatment cycle			
I was **satisfied** with the changes			
I have **provided allied health services** for DVA clients under the treatment cycle arrangements			

Q72 COVID-19 restrictions and lockdown may have impacted your allied health services.

Please indicate your professional experience by responding to the following questions.

Q73 What impact, if any, has COVID-19 had on your service provision?

	Yes	No	Comments
My allied health services were impacted			
My DVA clients have been able to access my allied health services			
My DVA clients have chosen to access my allied health services			
I have been able to continue to provide allied health treatment cycles to DVA clients			
I have been able to continue to receive referrals for allied health treatment cycles for DVA clients			
I have been able to continue to review my DVA clients healthcare needs			

Q74 During COVID-19, what changes, if any, have you experienced with your DVA clients? (select all that apply)

- [ ] More telehealth consultation
- [ ] Less in-person consultation
- [ ] Clients have not resumed service provision since COVID-19 restrictions have eased
- [ ] No change in referrals, consultation and review processes
- [ ] None of these apply
- [ ] Other (please specify):

Q75 Implementation of the allied health treatment cycle arrangements

The following questions are about your professional experience of implementing the allied health treatment cycle arrangements since 1 October 2019.

Q76 When did you first implement the treatment cycle arrangements? (select one only)

Q77 When have you provided allied health treatment services for DVA clients?

- ○ **Before and after** 1 October 2019
- ○ **Before** 1 October 2019 **only**
- ○ **After** 1 October 2019 **only**
- ○ I have **never** provided allied health treatment services to DVA clients

Q78 Implementation of the allied health treatment cycle arrangements: impacts

The following questions are about impacts you may have experienced since 1 October 2019.

Q79 How have you been impacted by the changes to referrals for allied health treatment cycle arrangements? (select one only)

- ○ I have been **positively impacted** by the changes
- ○ I have been **negatively impacted** by the changes
- ○ I have **not been impacted** by the changes

Q80 Have you experienced a change in the amount you see your DVA clients?

- ○ **Yes** - I see my DVA clients **more**
- ○ **Yes** - I see my DVA clients **less**
- ○ **No** - I see my DVA clients the **same amount**
- ○ Other (please specify): _____

Q81 Implementation of the allied health treatment cycle arrangements: quality of healthcare

The following questions are about your satisfaction with the quality of healthcare your DVA clients have received since 1 October 2019.
By 'healthcare' we mean health needs, treatment needs, progress, and outcomes

Q82 How, if at all, has your practice of quality healthcare for DVA clients changed?

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
I receive and accept **more referrals** for my DVA clients to meet their healthcare needs					
I **contribute more** to how my DVA clients healthcare needs are met					
I **discuss and review** my DVA client's healthcare needs with them **more often** and **in more detail**					
I **discuss and review** my DVA client's ongoing healthcare needs with **their GP more often** and **in more detail**					

My DVA client's healthcare needs are **better met**	
My DVA clients have **better access to necessary services** to meet their healthcare needs	
My DVA clients receive **better quality of healthcare overall**	
My DVA clients receive **better targeted support** based on their healthcare needs	

Q83 Care Coordination between DVA clients and Allied Health Providers

The following questions are about any changes in how you talk with your DVA clients about healthcare needs, referrals and additional referrals to allied health treatment cycles now compared to before 1 October 2019.

By 'healthcare' we mean health needs, treatment needs, progress, and outcomes

Q84 How, if at all, have your interactions with your DVA clients changed?

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
Before starting a treatment cycle, my DVA clients and I **discuss** their **healthcare needs** in more detail					
After finishing a treatment cycle, my DVA clients and I **review** their **ongoing healthcare needs** in more detail					
The **number** of interactions with my DVA clients has **increased**					
The **quality** of interactions with my DVA clients has **improved**					

My DVA clients and I have **more opportunities** to discuss their healthcare needs	

Q85 Care Coordination between DVA clients, General Practitioners & Allied Health Providers: clinical notes and clinical communication

The following questions are about changes in care coordination between you, your DVA clients and their GP since 1 October 2019.

By 'healthcare' we mean health needs, treatment needs, progress, and outcomes

Q86 Who coordinates your DVA client's healthcare needs?

	Yes	No	Comments
I coordinate my DVA client's healthcare needs			
My DVA clients coordinate their healthcare needs			
My DVA client's GP coordinates their healthcare needs			
I consult my DVA client's GP to jointly coordinate their healthcare needs			
Someone else coordinates my DVA client's healthcare needs (please specify):			
Other: I jointly coordinate with others for tailored arrangements (please specify):			

Q87 How, if at all, have your interactions between you, your DVA clients and their GP changed?

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
I provide a report which details my DVA client's **ongoing healthcare needs** and my recommendations to their GP					
My clinical notes, report, assessment and recommendations **are clear**					

I **review** and **discuss** the report and recommendations with my DVA clients and I **seek their opinion**	
I ensure my DVA clients are **included in the decision-making process** to meet their ongoing healthcare needs	
I ensure my DVA clients are **informed about communications, decisions, and recommendations** between myself and their GP	
I accept **additional referrals** for treatment cycles based on the report, my DVA client's ongoing healthcare needs, their opinion and their GP's professional judgement	
In general, the **number** of interactions between my DVA client's GP and I have **increased**	
In general, the **quality** of interactions between my DVA client's GP and I have **improved**	
There are **more opportunities** for my DVA client's GP and I to discuss and review their healthcare needs	

Q88 You may have been impacted by the changes to allied health treatment cycle arrangements in the following ways.

Q89 Compared to before 1 October 2019, now I think that the referral process for treatment cycle arrangements is... (select all that apply)

	Yes	Comments
More time-consuming		
More time-efficient		
More expensive (please specify)		

Less expensive (please specify)
More complex
Simpler and more straight-forward
Less effective
More effective
Unimproved and worse
Improved and better
Less flexible, responsive and dynamic
More flexible, responsive and dynamic
Less administrative
More administrative
Other (please specify)
None of these apply to me

Disclaimer: Your participation is voluntary, and you can discontinue the survey at any point by closing the window. You accept that any data you provide is unable to be identified for deletion.

If you experience distress or discomfort at any point please exit the survey immediately and contact the following services for support:

- **Open Arms – Veterans & Families Counselling on 1800 011 046**
- **QUT clinic on 07 3138 0999**
- **LifeLine on 13 11 14**
- **QUT evaluation team on 07 3138 5885 or 07 3138 0737**

SURVEY SCREEN OUT PAGE (ineligible participants)

Thank you for your time.

Sadly your response makes you ineligible to continue.
Please feel free to close your browser.

Further information is available on the evaluation project website:
www.qut-dva-treatmentcycles-evaluation.com

If you have a Pure Profile account please select the Pure Profile button to login.

DVA ALLIED HEALTH TREATMENT CYCLE EVALUATION

Thank you for completing this survey. Your time and anonymous responses are greatly appreciated.

Further Research: Follow up interviews

If you are interested in being contacted to discuss your opinion and experiences in more detail please follow the link: expression of interest for follow up interview

If you are a GP and you do not wish to be interviewed please click "CLOSE" to be redirected to Pure Profile.

Expression of Interest for DVA treatment cycle evaluation follow up interview

As part of the evaluation of the DVA treatment cycle arrangements, we will be conducting interviews with interested DVA clients, GPs and AHPs who have completed the survey. Please indicate your willingness to be contacted for a follow up interview below.

Your part in the evaluation

Your participation in the interview is entirely voluntary. If you do agree to participate you can withdraw from the interview at any time without penalty. Your decision to participate or not will in no way impact upon your current or future relationship with QUT or DVA.

Your participation will involve the following:

- A recorded interview, via web conferencing or telephone, to explore your opinions and experiences in more depth as a user of the DVA treatment cycle arrangements. There is no set length of time for the interview – it will be an opportunity for you to discuss how the treatment cycle changes have impacted you, both positively and negatively.

Privacy and confidentiality

Your answers will be completely confidential and any personal details, which may identify you in any way, will not be passed to DVA. Your answers will not in any way affect any pension, benefits, or health services which you are entitled to from DVA or to which you may become entitled in the future.

As the interview involves audio recording, please be aware that:

- the audio recording will be destroyed at the end of the project
- the transcribed data will be retained for a period of seven years;
- the audio recording will not be used for any other purpose;
- only the evaluator team will have access to the audio recording; and
- it is possible to participate in the project without being audio recorded.

Please note that any personal data collected will be used for the purpose of this study and no other, without your express permission. Upon request, you will be provided with a copy of your transcript. Interviews will be recorded using web conferencing technology or via telephone/audio.

All data and recordings will be stored on a secure, password protected computer and QUT server only accessible by the evaluation team. Once transcription of the interview is complete, all data is de-identified for results and reporting purposes. All recordings, whether web conferencing or telephone/audio, will be destroyed in seven years, as per QUT research protocols.

I am a:

- ○ DVA Client
- ○ General Practitioner
- ○ Allied Health Provider

Have you completed the online survey?

- Yes
- No

Are you interested in being contacted for a follow up interview?

- Yes
- No

Please provide your contact details and demographic data below

First Name	
Phone Number	
Mobile	
Email Address	
Age	
Gender	
City	
State	

Appendix 2.1: Survey Results

SURVEY RESULTS: DVA CLIENTS

Q17 AWARENESS of TC	DVA clients
Before Oct 2019	62% (n = 250)
After Oct 2019	30% (n = 118)
Not aware	8% (n = 32)

Q18 INFORMATION from DVA	DVA clients
Before Oct 2019	40% (n = 161)
After Oct 2019	16% (n = 63)
No information	20% (n = 80)
Unsure	24% (n = 95)

Q19 Where did you receive information about the treatment cycle?

GP	35% (n = 138)	Professional association website	3% (n = 12)
GP clinic (advertisements)	6% (n = 26)	PA email / letter	2% (n = 7)
GP website	4% (n = 16)	PA social media	1% (n = 5)
GP social media	5% (n = 22)	Google	3% (n = 14)
DVA employee	6% (n = 24)	ESO employee	12% (n = 47)
DVA letter and leaflet	27% (n = 106)	ESO venue (advertisements)	1% (n = 6)
DVA website	14% (n = 57)	ESO website	4% (n = 18)
DVA social media	7% (n = 29)	ESO email	4% (n = 18)
DVA vet affairs newsletter	22% (n = 87)	ESO social media	3% (n = 12)
AHP employee	15% (n = 61)	AHP email	1% (n = 4)
AHP venue (advertisements)	<1% (n = 2)	AHP social media	1% (n = 5)
AHP website	1% (n = 6)	None of these	5% (n = 19)
Other	10% (n = 41)		

- Providers (chiropractor, exercise physiologist, physiotherapist, podiatrist)
- Professionals (allied health colleagues)
- Word of mouth (fellow veterans, war widows, DVA clients)
- Social media (Facebook veterans' groups)
- Bulletins/newsletters (Australian War Widows Bulletin)
- RSL

- DVA (phoned DVA directly and 1 participant was an ex-DVA employee that knew about the treatment cycle)
- Gym
- This survey
- Unsure

Q21 INFORMATION QUALITY	Agree	Neither	Disagree
Easy to understand	53% (n = 210)	25% (n = 99)	23% (n = 91)
Relevant to my needs	50% (n = 201)	23% (n = 90)	27% (n = 108)
High quality	40% (n = 159)	38% (n = 153)	22% (n = 87)

Q22 EDUCATION and COMPLIANCE	Agree	Neither	Disagree
Prepared for the changes	57% (n = 229)	18% (n = 71)	25% (n = 99)
Understood the changes	62% (n = 245)	17% (n = 69)	21% (n = 85)
Sufficient knowledge about the changes	58% (n = 230)	20% (n = 80)	22% (n = 89)
Confident with the referral changes	72% (n = 287)	15% (n = 62)	13% (n = 50)
Satisfied with the changes	34% (n = 134)	17% (n = 70)	49% (n = 195)

Q23 What allied health services have you used?			
Chiropractic	20% (n = 80)	Orthotics	9% (n = 37)
Clinical psychology	18% (n = 72)	Osteopathy	8% (n = 33)
Diabetes education	12% (n = 47)	Physiotherapy	52% (n = 208)
Dietetics	10% (n = 39)	Podiatry	34% (n = 135)
Exercise physiology	57% (n = 227)	Psychology	19% (n = 76)
Neuropsychology	5% (n = 19)	Speech pathology	1% (n = 4)
Occupational therapy (incl mental health)	16% (n = 62)	Social work (incl mental health)	3% (n = 11)
None of these	8% (n = 33)		

Q25 COVID 19 IMPACTS	Yes	No
My GP services were impacted	54% (n = 214)	46% (n = 185)
My allied health services were impacted	53% (n = 212)	47% (n = 187)
I have been able to access my GP services	83% (n = 331)	17% (n = 68)
I have been able to access my allied health services	77% (n = 306)	23% (n = 92)
I have chosen to access my GP services	85% (n = 340)	14% (n = 56)
I have chosen to access my allied health services	82% (n = 325)	18% (n = 71)

Q26 COVID-19 CHANGES	DVA clients
More telehealth	57% (n = 228)

Less in-person consultation	48% (n = 191)
Did not access services	5% (n = 22)
No change in services	28% (n = 111)

Q28 When did you transition to the treatment cycle arrangements?			
October 2019	48% (n = 192)	May 2020	<2% (n = 7)
November 2019	10% (n = 40)	June 2020	<2% (n = 7)
December 2019	4% (n = 18)	July 2020	<2% (n = 7)
January 2020	5% (n = 22)	August 2020	<1% (n = 2)
February 2020	3% (n = 12)	September 2020	<2% (n = 7)
March 2020	3% (n = 14)	October 2020	2% (n = 8)
April 2020	<1% (n = 2)	I have not transitioned	<2% (n = 7)
Unsure	13% (n = 54)		

Q30 When have you received allied health services?	**DVA clients**
Before October 2019 only	8% (n = 31)
After October 2019	13% (n = 54)
Before and after October 2019	78% (n = 310)
I have never received allied health services	1% (n = 4)

Q32 IMPACT OF CHANGES	**DVA clients**
Positively impacted	22% (n = 89)
Negatively impacted	41% (n = 164)
Not impacted	37% (n = 146)

Q33 CHANGE IN INTERACTIONS	**DVA clients**
I see my GP more	54% (n = 214)
I see my GP less	12% (n = 47)
I see my GP the same amount	34% (n = 138)

Q35 QUALITY OF CARE	**Agree**	**Neither**	**Disagree**
I require more referrals from my GP to meet my healthcare needs	71% (n = 283)	13% (n = 53)	16% (n = 63)
I am more engaged in how my healthcare needs are met	34% (n = 137)	38% (n = 152)	28% (n = 110)
My GP and I discuss and review my healthcare needs more often and in more detail	40% (n = 157)	29% (n = 117)	31% (n = 125)
My AHP and I discuss and review my healthcare needs more often and in more detail	39% (n = 156)	32% (n = 127)	29% (n = 116)
My healthcare needs are better met	29% (n = 117)	35% (n = 139)	36% (n = 143)
I have better access to necessary services for my healthcare needs	26% (n = 105)	33% (n = 132)	41% (n = 162)

I receive better quality healthcare overall	26% (n = 104)	37% (n = 148)	37% (n = 147)
I receive better targeted support based on my healthcare needs	30% (n = 118)	34% (n = 137)	36% (n = 144)

Q37 CARE COORDINATION with GP	**Agree**	**Neither**	**Disagree**
Before seeking a referral for allied health treatment, my GP and I discuss my healthcare needs in more detail	40% (n = 158)	31% (n = 125)	29% (n = 116)
After finishing a treatment cycle, my GP and I review my ongoing healthcare needs in more detail	37% (n = 147)	31% (n = 124)	32% (n = 128)
The number of interactions with my GP has increased	61% (n = 242)	20% (n = 83)	19% (n = 74)
The quality of interactions with my GP has improved	29% (n = 115)	44% (n = 175)	27% (n = 109)
My GP and I have more opportunities to discuss and review my healthcare needs	36% (n = 145)	38% (n = 151)	26% (n = 103)

Q39 CARE COORDINATION with AHP	**Agree**	**Neither**	**Disagree**
Before starting a treatment cycle, my AHP and I develop a Patient Care Plan	50% (n = 200)	26% (n = 103)	24% (n = 96)
My Patient Care Plan details my healthcare needs	51% (n = 203)	30% (n = 118)	19% (n = 78)
Before starting a treatment cycle, my AHP and I discuss my healthcare needs in more detail	40% (n = 158)	36% (n = 146)	24% (n = 95)
After finishing a treatment cycle, my AHP and I review my ongoing healthcare needs in more detail	42% (n = 165)	35% (n = 141)	23% (n = 93)
My AHP writes notes and assesses my healthcare needs	63% (n = 249)	26% (n = 105)	11% (n = 45)
The number of interactions with my AHP has increased	35% (n = 140)	35% (n = 141)	30% (118)
The quality of interactions with my AHP has improved	31% (n = 125)	41% (n = 163)	28% (n = 111)
My AHP and I have more opportunities to discuss and review my healthcare needs	31% (n = 123)	41% (n = 164)	28% (n = 112)

Q41 CARE COORDINATION	
I coordinate my healthcare needs	56% (n = 223)
My GP coordinate my healthcare needs	25% (n = 98)
My AHP coordinates my healthcare needs	4% (n = 18)
My GP and AHP consult each other to jointly coordinate my healthcare needs	12% (n = 47)
Someone else coordinates my DVA client's healthcare needs	3% (n = 13)

Q42 CARE COORDINATION with AHP and GP	Agree	Neither	Disagree
My AHP provides a report which details my healthcare needs and makes recommendation to my GP	52% (n = 206)	33% (n = 131)	15% (n = 62)
My GP reviews a report from my AHP and makes recommendations based on the report	42% (n = 169)	39% (n = 157)	19% (n = 73)
My GP discusses the report and recommendations with my and seeks my opinion	42% (n = 168)	34% (n = 134)	24% (n = 97)
My GP makes additional referrals for treatment cycles based on the report and my opinion	50% (n = 200)	30% (n = 122)	20% (n = 78)
I feel included in the decision-making process to meet my healthcare needs	54% (n = 216)	29% (n = 116)	17% (n = 67)
I feel informed about communications, decisions and recommendations between my GP and AHP	46% (n = 184)	33% (n = 133)	21% (n = 83)

Q44 Other Impacts	DVA clients	Q44 Other Impacts	DVA clients
More time consuming	70% (n = 279)	Less effective	36% (n = 142)
More time efficient	11% (n = 46)	More effective	11% (n = 44)
More expensive	35% (n = 140)	Unimproved and worse	34% (n = 135)
Less expensive	6% (n = 26)	Improved and better	10% (n = 42)
More complex	44% (n = 176)	Less flexible, responsive and dynamic	34% (n = 136)
Simpler and more straight forward	12% (n = 48)	More flexible, responsive and dynamic	9% (n = 38)
Other	12% (n = 49)	None of the above	19% (n = 76)

IMPACTS AND THEMES	***EVIDENCE***
Time (consuming vs efficient)	
☒ Inconvenience of increased GP visits (especially those who work full time or have lifelong conditions) ☒ Feeling like an inconvenience to AHPs and GPs ☒ Waste of time seeking unnecessary referrals / increased paperwork ☒ Increased cost due to seeking more referrals ☒ More bureaucratic with no care added ☒ Loss treatment time due to assessment	*"I have to take time off work (I work full time) to visit a GP for no real purpose."* *"as I require exercise physiology twice weekly it is necessary to obtain a referral every 6 weeks and as I see my GP every 3 months on a regular basis this is both time consuming, annoying and I believe unnecessary"* *"Unnecessary visits for an ongoing lifetime condition."* *"most AHPs strive for HART objectives and seek continual improvement, which is understandable for acute cases and their recovery, however counterproductive on many occasions for chronic complex and ongoing cases that need to be carefully managed and "maintained', as opposed to "improved'."* *"AHP doesn't have time to write reports and doesn't get paid. I feel like an inconvenience"* *"Due to the intensive nature of my injuries, I go through a cycle of 12 appointments within 1-2months. I am constantly spending time making and attending GP appointments purely for referrals and ensuring they get distributed to my 5 AHP overloading my rehabilitation time and doing a lot of paperwork."* *"Time to get a referral for Diabetic foot care is a waste. Diabetes is permanent. Podiatrist report is a pointless exercise"* *"Wasting everyone's time making appointments just for a referral"*

☒ Extra GP appointments provoking stress, anxiety and frustration ☒ Time to taken to arrange GP appointments and waiting for appointments	*"Having to visit the GP every 12 weeks for an ongoing problem is time consuming and not practical"* *"More documents. Should be done online."* *"Cost DVA more for veterans to get referrals every 10 weeks"* *"You have created another layer of bureaucracy for medical and AHP that adds no value"* *"More visits to GP and loss of Physiology session due to another assessment"* *"I have to make extra appointments that aggravate my anxiety issues."* *"It drives me mad. I have EP 3 times a week and P 2 times a week, so it means remembering to make GP extra appointments, [it's] very frustrating."* *"Whilst in need for constant physio, ep, hydro and psychology appts [I] was needing new referrals almost less than every 3 months. This meant more appointments stress and physical exertion and wasting of GP and allied health professional time with [paperwork]."* *"Spend a lot more time visiting my GP and arranging appointments and waiting around in waiting rooms"*
☑ Goals and changes to care easily identifiable and modified	"Goals are identified and reported upon and if necessary, changes are made"
Expenses / Costs	
☒ More GP visits / longer GP appointments (30 minutes) – cost to DVA/Medicare ☒ Cost of childcare ☒ Clinics charging additional costs ☒ Costs associated with time and travel/transport associated with more GP visits	*"Every time I see my I require a long appointment which at 30mins is a significant cost to DVA just to print out referrals."* *"Waste of everyone's time and more Dr visits have to be paid for by DVA"* *"This treatment cycle means increased GP consultation for referrals."* *"DVA now paying for more visits to GP"* *"Cost of childcare having to relay and explain stuff to GP and chase reports"* *"local health care (AHP) charge $10:00 per visit over the DVA Fee"* *"Have to pay consultation fee"* *"Cost of attending GP (petrol, wear and tear on car etc)"* *"More transport requirements and parking fees"* *"Travelling to GP more often"*

☒ Cycles are too short (12 sessions) to address needs ☒ Covering cost of treatment when waiting on new referral ☒ Believe the extra costs of GP visits could be better allocated for other veterans ☒ Lost time/treatment due to paperwork/assessments ☒ GPs that aren't patient focused ☒ Taking time off work to attend GP appointments	*"My time and petrol"* *"In time for me and cost to DVA for doctor visits. Prior to this my normal cycle was 3- 4 visits to my GP per year"* *"Costs me time and travel expenses to go back to GP"* *"both for G.P visits and personal e.g. time and fuel cost"* *"Travel not fully reimbursed"* *"More trips to the GP means more kilometres travelled each month which means more kilometres on my car and more expense paying for extra fuel and increased servicing of car due to kilometres adding up quicker"* *"I have to drive about 80 kms round trip to see my GP"* *"Causes too many GP consults. Physio for complex joint replacements etc cannot be handled in 12 sessions. The cycles need the option for longer periods."* *"Either have to stop sessions due to the time delay cycle for new referral or self fund continued sessions in between"* *"Self-payment for additional AHP visits - previously provided by DVA"* *"I now have to pay for my gym membership"* *"it wastes valuable DVA funds that could be used by another Veteran"* *"Definitely as logistics loops are set up, particularly if the cycles are commenced at different dated. Treatment time is spent in assessment - approximately one in ten (1/cycle; 4-5 per year for chronic complex ongoing needs) And, more paperwork, assessments and treatment time is lost in the process - particularly for chronic complex needs"* *"More doctors visits. More time needed for AHP to write reports"* *"Frequency of appointments has now increase and paperwork also increased"* *"Cost of an assessment e.g. one on one with AHP every 6 weeks, cost of GP visit."* *"Too many interactions with my GO that only cares about the fee that she gets from DVA Not about patient care."* *"Time off work to attend extra GP sessions"*
Complexity vs Simplicity	
☒ Complex/chronic needs not adequately met by TC	*"My rehabilitation needs are long term and as such I believe cases should be assessed individually. I am also unable to access extended appointments for my*

☒ Cycles are too short (12 weeks is insufficient) ☒ Taking time off work for referrals ☒ Additional appointments/assessments and GPs not reading reports / GPs not aware of new requirements ☒ Monitoring/tracking appointments/sessions (across multiple AH services) ☒ Contributing to negative mental health (i.e. stress, anxiety, frustration) ☒ Additional steps to access case without any perceived benefit (gaps in service) ☒ Additional administration and lack of care of veterans ☒ Bureaucratic and time consuming	*conditions even if medically necessary, due to the restrictions of cost imposed by DVA, limiting my care I can receive."* *"Too much time wasted on writing updates in such a short period. 12 sessions is insufficient. Needs to be at least 40 to deal with flare ups. Last thing needed is to be chasing a referral when you just need help."* *"I have to take time off work (I work full time) to visit a GP for no real purpose."* *"Needless appointments. Wasted time. Paperwork the GP didn't even read."* *"DVA doesn't bother to educate GPs in the different legislations and how they affect access and acceptance to treatment."* *"Having to arrange more of my time around Drs appointments, Used to see GP 3 times a year now its 12 times a year"* *"Have to keep track of my 12 appointments and book in with my gp more"* *"Having to stay on the ball and manage it all the time"* *"Creates a back and forward mentality as cycles do not overlap when you have multiple providers of care"* *"Need to keep track of my referrals and number of visits aggravates my mental health condition"* *"Having count number of visits to AHP."* *"I need to keep track of how many AHP appointments I've had"* *"Requires more planning"* *"In my case, with multiple AHPs initiated at staggered dated, any one AHP referral may need to ne attended to and renewed, sometime at short notice. This forms a barrier o treatment as i the must phone for an appointment, drive and attend appointment, take a copy of the referral to the AHP. AS I am not in the distribution loop for the report from the AHP to the GP more time is wasted - double GP appointment times have become routine as there is the need to discuss a report I have not seen, need to read and this takes time - some confusion exists where AHPs excluded from the reporting cycle"* *"more complex and a lot more stressful"* *"Way more complex for no real gain in my case - but greater cost to my mental health"*

	"No I used to know when my referrals were due now I have to rely on the AHP's receptionist to remind me" *"The previous system worked well. You have just added more steps, again for no value"* *"there are additional steps such as report writing that are time consuming whereas before consultation between GP and APH could discuss over the phone."* *"Can't go over 12 - until a new letter you miss the appointment - BIG IMPACT"* *"Increased admin for GP and AHP"* *"More administration more GP visits, more time"* *"Too much paperwork. This only keeps somebody employed who doesn't give a shit about Veterans."* *"More visits & paperwork"* *"More red tape - more time consuming"* *"On going assessments for a long-term disability is both time consuming and costly"* *"Takes time up that I don't have"*
Efficacy	
☒ GP being unaware of clients needs / GPs that have never met clients ☒ Discontinued services / treatment gaps due to needing more referrals ☒ Clients paying out of pocket for AH services ☒ Pressure and stress to coordinate care	*"The GP has no idea about my needs. The EP and the Physio do."* *"One AHP uses an online GP for referrals. I've never met them or spoken to them."* *"The GP doesn't understand why I need so many referrals for the same thing and constantly wants to terminate treatment."* *"I have stopped using services because of the need to constantly get new referrals"* *"Gap in treatment is annoying and harmful"* *"Less AHP visits unless self-payment made"* *"More pressure on me to coordinate the report and a new referral"* *"the stress in ensuring that I am up to date with referrals constantly is making it less effective."*
☑ GP is more aware of treatment and progress	*"G.P. is more aware of treatment being undertaken and is in receipt of progress"* *"More communication between GP and Allied Health Provider"* *"Seems better with new considerations"*

☑ More communication between GP and AHP	
Unimproved vs Improved	
☒ TC not suitable for chronic conditions ☒ Not being able to access services due to expired referrals which negatively impacts conditions ☒ Stress due to increased GP appointments ☒ Changes to prescriptions	*"My condition is chronic. It won't be healed. Getting referrals is ridiculous. Nothing has changed."* *"I have missed treatment due to referral not being done. Put me back and made me worse, meaning I saw the psych much more and needed more referrals even quicker!"* *"I have had occasions whereby I have had to delay physiology sessions until I could arrange X-Rays and ultrasounds appointments and consultations with my GP"* *"Because it is a waste of time, and sometimes I miss sessions because I have run out of referrals"* *"The more medical appointments I have the more stressed I get. I would like my life not to be all about medical appointments."* *"Cannot get better medications for sleep Gov seems to think I don't need the higher dose script, bullshit they make decisions about me but they do not know my requirements."* *"The amount of prescriptions has been altered due to Government policy changes and I have to see GP more often some medications have been changed also and now my script are changed this is bullshits"*
Flexibility	
☒ Restrictions on appointment times to meet needs (especially those in rural areas – difficult to access GPs) ☒ AHPs are aware of conditions/needs whereas GPs are not	*"The restrictions on appointment time length does not allow individual flexibility to treat more acute cases, as a blanket approach by DVA restricts extended appointments for ongoing rehabilitation treatment, despite my need."* *"I live in a rural/regional areas where GP clinics are booked 3 weeks in advance with little room for flexibility to rural clients for short notice appointments."* *"time frames for paperwork is less flexible as GP appointments are more difficult to obtain"*

☒ Clients receiving less treatment	*"The AHP, who know my condition, have to ask a GP, who has never met me, about my treatment."* *"The allied health professional is patient aware and doesn't need ongoing review by a non specialist GP"* *"The GP doesn't understand and wants to terminate the cycle much too early to my detriment."* *"Before I received treatment when needed and now I have to space treatments & suffer in pain"*
☑ More flexible for changes	*"With Exercise Physiology, regimes and processes can change, and the current system allows for manoeuvre."*
Other	
☒ Belief that the TC is a revamped version of an older system that doesn't work ☒ Discrepancies between TPI and non-TPI ☒ Improvements in monitoring by GP and AHP ☒ GPs and AHPs refusing DVA clients (due to paperwork)	*"You have reinvented an old system that was proved not to work, well done!"* *"Being EDA should be exempt same as TPI"* *"Don't see what the difference is with an ongoing condition between TPI (12months) and other 12 visits. Still have a condition that needs treatment just might have less number of conditions."* *"Being Gold Card EDA in lieu of TPI necessitates referral visits to GP, TPI get permanent referrals for exercise physiology and"* *"May have improved GP and patient interaction and health management as well as medication monitoring and AHP reporting to GPs"* *"Some companies won't take on DVA clients because too much paperwork involved."*

SURVEY RESULTS: GPS

Q17 AWARENESS of TC	GPs
Before Oct 2019	49% (n = 73)
After Oct 2019	44% (n = 65)
Not aware	7% (n = 10)

Q18 INFORMATION from DVA	GPs
Before Oct 2019	39% (n = 58)
After Oct 2019	37% (n = 55)
No information	13% (n = 19)
Unsure	11% (n = 16)

Q45 Where did you receive information about the treatment cycle? GP

DVA client	28% (n = 41)	Professional association website	17% (n = 25)
GP clinic (advertisements)	27% (n = 40)	PA email / letter	12% (n = 17)
GP website	31% (n = 46)	PA social media	6% (n = 9)
GP social media	21% (n = 31)	Google	9% (n = 13)
DVA employee	14% (n = 21)	ESO employee	7% (n = 11)
DVA letter and leaflet	24% (n = 35)	ESO venue (advertisements)	3% (n = 5)
DVA website	20% (n = 29)	ESO website	7% (n = 11)
DVA social media	14% (n = 21)	ESO email	7% (n = 11)
DVA vetaffairs newsletter	13% (n = 20)	ESO social media	7% (n = 11)
AHP employee	8% (n = 12)	AHP email	5% (n = 8)
AHP venue (advertisements)	3% (n = 4)	AHP social media	3% (n = 4)
AHP website	4% (n = 6)	None of these	6% (n = 9)
Other	5% (n = 8)		

- DVA client
- Unsure (can't recall, too long along and GPs receive too many notices)
- Letter (provided by DVA client)
- Allied health practice manager
- Australian Doctors (AusDoc) magazine
- Allied health providers

Q47 INFORMATION QUALITY	Agree	Neither	Disagree
Easy to understand	64% (n = 95)	22% (n = 32)	14% (n = 21)
Relevant to my practice	72% (n = 106)	17% (n = 25)	11% (n = 17)
Relevant to my DVA clients' needs	76% (n = 113)	12% (n = 18)	11% (n = 17)
High quality	67% (n = 98)	23% (n = 34)	10% (n = 16)

Q48 EDUCATION and COMPLIANCE	Agree	Neither	Disagree
Prepared for the changes	58% (n = 85)	24% (n = 36)	18% (n = 27)
Understood the changes	60% (n = 90)	22% (n = 32)	18% (n = 26)
Sufficient knowledge about the changes	66% (n = 97)	19% (n = 28)	15% (n = 23)
Confident with the referral changes	62% (n = 92)	27% (n = 40)	11% (n = 16)
Satisfied with the changes	57% (n = 84)	24% (n = 35)	19% (n = 29)

Q49 CONSULTATION (screening Q)	Yes	No
I have consulted a DVA client that needed a referral under the treatment cycle arrangements	87% (n = 128)	13% (n = 20)

Q50 What allied health services have you referred clients to?			
Chiropractic	26% (n = 39)	Orthotics	10% (n = 15)
Clinical psychology	23% (n = 34)	Osteopathy	16% (n = 24)
Diabetes education	22% (n = 33)	Physiotherapy	48% (n = 71)
Dietetics	35% (n = 51)	Podiatry	26% (n = 39)
Exercise physiology	37% (n = 54)	Psychology	15% (n = 23)
Neuropsychology	12% (n = 18)	Social work	9% (n = 13)
Occupational therapy	27% (n = 40)	Speech pathology	5% (n = 7)
Occupational therapy (mental health)	13% (n = 20)	Social work (mental health)	6% (n = 9)
None of these	6% (n = 9)		

Q52 COVID 19 IMPACTS	Yes	No
My GP services were impacted	62% (n = 92)	38% (n = 56)
My DVA clients have been able to access my GP services	66% (n = 98)	34% (n = 50)
My DVA clients have chosen to access my GP services	71% (n = 105)	29% (n = 43)
I have been able to continue to make referrals for DVA clients to treatment cycles	70% (n = 103)	30% (n = 44)
I have been able to continue to review my DVA clients healthcare needs	70% (n = 104)	30% (n = 44)

Q53 COVID-19 CHANGES	GPs
More telehealth	62% (n = 91)
Less in-person consultation	45% (n = 67)
Clients have not sough further consultations, referrals or reviews since COVID-19 restrictions have eased	28% (n = 42)
No change in referrals, consultation and review processes	17% (n = 25)
None of these apply	6% (n = 9)
Other	1% (n = 2)

Q55 When did you implement the treatment cycle arrangements?			
October 2019	29% (n = 43)	May 2020	3% (n = 4)
November 2019	18% (n = 26)	June 2020	3% (n = 4)
December 2019	16% (n = 23)	July 2020	1% (n = 2)

January 2020	10% (n = 14)	August 2020	<1% (n = 1)
February 2020	4% (n = 6)	September 2020	3% (n = 4)
March 2020	5% (n = 8)	Unsure	3% (n = 4)
April 2020	4% (n = 6)	I have not implemented the treatment cycle	2% (n = 3)

Q56 When have you referred DVA clients for allied health services?	**GPs**
Before October 2019 only	19% (n = 29)
After October 2019	25% (n = 37)
Before and after October 2019	53% (n = 78)
I have never referred DVA clients for allied health services	3% (n = 4)

Q58 IMPACT OF CHANGES	**GPs**
Positively impacted	45% (n = 67)
Negatively impacted	25% (n = 37)
Not impacted	30% (n = 45)

Q59 CHANGE IN INTERACTIONS	**GPs**
I see my DVA clients more	46% (n = 68)
I see my DVA clients less	15% (n = 22)
I see my DVA clients the same amount	37% (n = 55)
Other:	2% (n = 3)

Q61 QUALITY OF CARE	**Agree**	**Neither**	**Disagree**
I make more referrals for my DVA clients to meet their healthcare needs	55% (n = 82)	30% (n = 45)	15% (n = 21)
I contribute more to how my DVA clients healthcare needs are met	51% (n = 75)	30% (n = 44)	19% (n = 29)
My DVA clients and I discuss and review their healthcare needs more often and in more detail	57% (n = 84)	26% (n = 39)	17% (n = 25)
My DVA client's AHP and I discuss and review our client's healthcare needs more often and in more detail	60% (n = 89)	26% (n = 38)	14% (n = 21)
My DVA clients healthcare needs are better met	54 % (n = 79)	28% (n = 42)	18% (n = 27)
My DVA clients have better access to necessary services to meet their healthcare needs	55% (n = 82)	27% (n = 40)	18% (n = 26)
My DVA clients receive better quality healthcare overall	58% (n = 86)	27% (n = 40)	15% (n = 22)
My DVA clients receive better targeted support based on their healthcare needs	58% (n = 86)	23% (n = 34)	19% (n = 28)

Q63 CARE COORDINATION with clients	Agree	Neither	Disagree
Before making a referral to treatment cycles, my DVA clients and I discuss their healthcare needs in more detail	58% (n = 85)	28% (n = 42)	14% (n = 21)
After finishing a treatment cycle, my DVA clients and I review their ongoing healthcare needs in more detail	59% (n = 87)	27% (n = 40)	14% (n = 21)
The number of interactions with my DVA clients has increased	59% (n = 87)	28% (n = 41)	13% (n = 20)
The quality of interactions with my DVA clients has improved	55% (n = 81)	28% (41)	17% (n = 26)
My DVA clients and I have more opportunities to discuss and review their healthcare needs	60% (n = 88)	27% (40)	13% (n = 20)

Q65 CARE COORDINATION	Yes	No
I coordinate my DVA client's healthcare needs	70% (n = 104)	30% (n = 44)
My DVA clients coordinate their healthcare needs	63% (n = 93)	37% (n = 55)
My DVA client's AHP coordinates their healthcare needs	57% (n = 85)	43% (n = 63)
I consult my DVA clients AHP to jointly coordinate their healthcare needs	58% (n = 86)	42% (n = 62)
Someone else coordinates my DVA client's healthcare needs	36% (n = 53)	62% (n = 95)
Other: I jointly coordinate with others for tailored arrangements	41% (n = 60)	59% (n = 87)

Q66 CARE COORDINATION with client's AHP	Agree	Neither	Disagree
My DVA client's AHP provides a report which details their ongoing healthcare needs and makes recommendations to me	61% (n = 91)	27% (n = 40)	12% (n = 17)
The AHP clinical notes, report, assessment and recommendations are clear	64% (n = 95)	22% (n = 33)	14% (n = 20)
I review and discuss the AHP report and recommendations with my DVA clients and I seek their opinion	65% (n = 96)	23% (n = 34)	12% (n = 18)
I ensure my DVA clients are included in the decision-making process to meet their ongoing healthcare needs	73% (n = 108)	19% (n = 28)	8% (n = 12)

I ensure my DVA clients are informed about communications, decisions and recommendations between myself and their AHP	68% (n = 101)	24% (n = 35)	8% (n = 12)
I make additional referrals for treatment cycles based on the report, my DVA client's ongoing healthcare needs, their opinion and my professional judgement	69% (n = 102)	22% (n = 33)	9% (n = 13)
The number of interactions between my DVA client's AHP and I have increased	60% (n = 89)	25% (n = 37)	14% (n = 21)
The quality of interactions between my DVA client's AHP and I have improved	57% (n = 84)	29% (n = 43)	14% (n = 21)
My DVA client's AHP and I have more opportunities to discuss and review their healthcare needs	64% (n = 94)	24% (n = 36)	12% (n = 18)

Q68 FRAMEWORK EFFICACY	**Agree**	**Neither**	**Disagree**
Sufficient knowledge about the framework	57% (n = 84)	24% (n = 36)	19% (n = 28)
Understand the framework	58% (n = 86)	26% (n = 39)	16% (n = 23)
Applied the framework	63% (n = 94)	19% (n = 28)	18% (n = 26)
Confident applying the framework	62% (n = 93)	22% (n = 32)	16% (n = 23)
Satisfied with the framework criteria	62% (n = 92)	23% (n = 34)	15% (n = 22)
Meets complex healthcare needs	54% (n = 80)	35% (n = 52)	11% (n = 16)
Ensures quality primary coordinated care	60% (n = 89)	28% (n = 42)	12% (n = 17)
Few clients require the framework	53% (n = 79)	32% (n = 48)	14% (n = 21)

Q70 Other Impacts	GPs	Q70 Other Impacts	GPs
More time consuming	49% (n = 73)	Less effective	20% (n = 30)
More time efficient	33% (n = 49)	More effective	29% (n = 44)
More expensive	29% (n = 44)	Unimproved and worse	21% (n = 31)
Less expensive	19% (n = 28)	Improved and better	26% (n = 38)
More complex	28% (n = 42)	Less flexible, responsive and dynamic	18% (n = 27)
Simpler and more straight forward	26% (n = 39)	More flexible, responsive and dynamic	19% (n = 28)
More administrative	12% (n = 18)	Less administrative	32% (n = 48)
Other	9% (n = 13)		

IMPACTS AND THEMES	***EVIDENCE***
Time (consuming vs efficient)	
☒ Cycles don't match up (multiple referrals for multiple conditions and clients) ☒ More consultations each week just for referrals ☒ TC not suitable for chronic conditions (with no change in outcomes) even with annual referrals as opposed to indefinite/ongoing referrals	*"One of my patients has twice weekly physio in the home, as well as OT regularly and social work support. None of the DVA cycles match up and I am forever receiving requests from the various agencies to write another referral cycle. It is driving me insane with just this one patient, let alone all the others."* *"I have to facilitate approx. 20 extra consults per week, charged to Medicare, to facilitate referrals which takes away from my other patients' ability to see me."* *"New referrals form only"* *"For chronic disease e.g. diabetes and podiatry it is a waste of time doing it so often"* *"Making referrals annually for chronic stable conditions is a far better use of everyone's time"* *"Need to make more cycle referrals"*
Expenses / Costs	
☒ More appointments/consultations for referrals / paperwork	*"I will not do this paperwork in my non existent spare time, so I get the patient in to discuss whether they still need care, go through the report from the AHP with them, and write the new referral. Either in person or telehealth. That is a lot of DVA*

☒ Increased consultation times due to complexity of process ☒ Completing paperwork/referrals in own time (unpaid) ☒ Increased cost to medicare (consultation billing) ☒ Unnecessary consultation fees when 12 sessions is insufficient to address health needs ☑ Provides better care ☑ For acute care it is good to have limitations ☑ Seeing DVA clients less	*appointments for this paperwork, where in the past I could once a year write a referral, indicate the frequency , and then see the patients as appropriate for them , NOT for the paperwork"* *"Increased consultation time required due to increased complexity of process"* *"More consults with myself in order to facilitate referrals, more cost to Medicare; some AHP's using online GP's to provide referrals"* *"I am completing referrals in my own time or needing to fit in T/H appointments for my patients out of hours"* *"Stable patients who I previously saw every 6-12 months are now coming in every 3 months simply for me to tick some boxes on a form"* *"Medicare gets the bill for the extra sessions with the GP"* *"Some unnecessary consultation fees when clearly 12 visits is not sufficient"* *"Due to more GP consultations"* *"More consultation costs with GPs"* *"It ends up costing more trying to help the newer parents by needing up to date tech"* *"More visits"* *"Provides better care"* *"For acute care which often turns in to unnecessary chronic care it is good to have limitations"* *"I tend to see DVA clients less"*
Complexity vs Simplicity	
☒ Former is longer and not auto-populated ☒ Still do not understand the requirements of the TC – guessing what to do ☒ Issues with getting EOC reports from AHPs	*"Form is longer and especially since the template that at least auto-populated the patient details has disappeared from your software and not been able to replace so we download a 3PAGE DOCUMENT to fill out by hand every time"* *"I still do not fully understand what all the requirements are. DVA have never given me any information -- I just have to take my best guess what to do."* *"Have trouble in getting reports back from AHPs - have to chase them up for reports"*
Efficacy	

☑ More thorough for diabetes care (e.g. podiatry) ☑ More frequent reviews are good	"E.g. diabetic foot care is done thoroughly and all diabetics" "Requiring a review after 12 sessions is good"
Unimproved vs Improved	
☒ Increased reporting but rarely read reports unless for an acute issue ☒ Bureaucratic ☒ Will always re-refer if clients believe that they are benefiting from treatment (not due to AHP report)	*"The increased reporting requirements for AHPs are just bureaucratic red tape. I rarely read them unless it is regarding an acute issue. If a Vet feels they are benefiting, then I will always re-refer them regardless of the report. Putting more paperwork in place doesn't make the system better"*
☑ Believes that the TC is worse but provides better feedback from AHPs (especially physiotherapists)	*"can't tell you the amount of worse I find it as a GP. But am getting better feedback from physiotherapists in particular"*
Administrative burden	
☒ Significantly more administrative ☒ No downloadable forms from DVA ☒ Referral templates are not user-friendly and fit for purpose (too small and time consuming) ☒ Following up AHP reports	*"Huge increase in amount of paperwork for both AHP's and GP's"* *"DVA do not have any downloadable Allied health referral forms anymore--MAJOR time waste. Big hassle. I have to photocopy old templates and modify them"* *"Referral templates area small and time consuming."* *"Have to chase up reports"*

SURVEY RESULTS: AHPS

Q17 AWARENESS of TC	AHPs
Before Oct 2019	72% (n = 316)
After Oct 2019	23% (n = 103)
Not aware	5% (n = 23)

Q18 INFORMATION from DVA	AHPs
Before Oct 2019	41% (n = 181)
After Oct 2019	14% (n = 61)
No information	27% (n = 120)
Unsure	18% (n = 79)

Q45 Where did you receive information about the treatment cycle? AHP

DVA client	16% (n = 71)	Professional association website	30% (n = 133)
GP clinic (advertisements)	4% (n = 16)	PA email / letter	37% (n = 164)
GP website	4% (n = 19)	PA social media	13% (n = 56)
GP social media	1% (n = 7)	Google	5% (n = 24)
DVA employee	2% (n = 11)	ESO employee	<1% (n = 4)
DVA letter and leaflet	29% (n = 126)	ESO venue (advertisements)	<1% (n = 2)
DVA website	22% (n = 95)	ESO website	<1% (n = 3)
DVA social media	4% (n = 19)	ESO email	<1% (n = 3)
DVA vetaffairs newsletter	3% (n = 14)	ESO social media	<1% (n = 4)
AHP employee	6% (n = 27)	AHP email	7% (n = 30)
AHP venue (advertisements)	<1% (n = 3)	AHP social media	<5% (n = 21)
AHP website	6% (n = 26)	None of these	3% (n = 15)
Other	9% (n = 41)	• Manager / boss • Other professionals or colleagues (OTs) • Workplace (but not aware when working in hospital setting) • Other companies • Word of mouth • DVA clients / veterans • Letter from DVA • Special interest group • Unsure / can't recall	

- Social media (podiatry facebook group)
- GP
- Practice manager
- Professional associations: ACAUD, APod
- ADEA newsletter
- Professional conference

Q47 INFORMATION QUALITY	Agree	Neither	Disagree
Easy to understand	53% (n = 234)	16% (n = 71)	31% (n = 136)
Relevant to my practice	64% (n = 284)	18% (n = 80)	17% (n = 77)
Relevant to my DVA clients' needs	52% (n = 230)	18% (n = 79)	30% (n = 132)
High quality	36% (n = 161)	33% (n = 143)	31% (n = 137)

Q71 EDUCATION and COMPLIANCE	Agree	Neither	Disagree
Prepared for the changes	57% (n = 254)	16% (n = 69)	27% (n = 118)
Understood the changes	65% (n = 286)	14% (n = 63)	21% (n = 92)
Sufficient knowledge about the changes	55% (n = 245)	18% (n = 79)	27% (n = 117)
Confident with the referral changes	64% (n = 283)	16% (n = 69)	20% (n = 89)
Satisfied with the changes	27% (n = 119)	17% (n = 74)	56% (n = 248)

Q73 COVID 19 IMPACTS	Yes	No
My allied health services were impacted	74% (n = 327)	26% (n = 113)
My DVA clients have been able to access my allied health services	86% (n = 378)	14% (n = 62)
My DVA clients have chosen to access my allied health services	89% (n = 391)	11% (n = 49)
I have been able to continue to provide allied health treatment cycles to DVA clients	88% (n = 386)	12% (n = 54)
I have been able to continue to receive referrals for allied health treatment cycles for DVA clients healthcare needs	91% (n = 399)	9% (n = 41)
I have been able to continue to review my DVA clients healthcare needs	89% (n = 394)	11% (n = 46)

Q74 COVID-19 CHANGES	AHPs
More telehealth consultation	38% (n = 168)
Less in-person consultation	51% (n = 224)

Clients have not resumed service provision since COVID-19 restrictions have eased	21% (n = 91)
No change in referrals, consultation and review processes	27% (n = 120)
None of these apply	6% (n = 28)
Other	11% (n = 49)

Q76 When did you implement the treatment cycle arrangements?			
October 2019	56% (n = 247)	May 2020	<1% (n = 4)
November 2019	13% (n = 59)	June 2020	1% (n = 6)
December 2019	4% (n = 18)	July 2020	<1% (n = 4)
January 2020	6% (n = 27)	August 2020	<1% (n = 3)
February 2020	2% (n = 10)	September 2020	<1% (n = 2)
March 2020	<2% (n = 7)	October 2020	2% (n = 9)
April 2020	<2% (n = 8)	Unsure	6% (n = 27)
		I have not implemented the treatment cycle	2% (n = 10)

Q77 When have you referred DVA clients for allied health services?	**AHPs**
Before October 2019 only	4% (n = 17)
After October 2019	12% (n = 54)
Before and after October 2019	82% (n = 363)
I have never provided allied health services for DVA clients	<2% (n = 7)

Q79 IMPACT OF CHANGES	**AHPs**
Positively impacted	13% (n = 56)
Negatively impacted	54% (n = 240)
Not impacted	33% (n = 145)

Q80 CHANGE IN INTERACTIONS	**AHPs**
I see my DVA clients more	9% (n = 39)
I see my DVA clients less	23% (n = 101)
I see my DVA clients the same amount	63% (n = 276)
Other:	5% (n = 25)

Q82 QUALITY OF CARE	**Agree**	**Neither**	**Disagree**
I receive and accept more referrals for my DVA clients to meet their healthcare needs	21% (n = 94)	33% (n = 145)	46% (n = 202)
I contribute more to how my DVA clients healthcare needs are met	25% (n = 109)	34% (n = 150)	41% (n = 182)

My DVA clients and I discuss and review their healthcare needs more often and in more detail	31% (n = 137)	34.5% (n = 152)	34.5% (n = 152)
My DVA client's GP and I discuss and review our client's ongoing healthcare needs more often and in more detail	35% (n = 153)	28% (n = 123)	37% (n = 165)
My DVA clients healthcare needs are better met	22% (n = 99)	29% (n = 127)	49% (n = 215)
My DVA clients have better access to necessary services to meet their healthcare needs	19% (n = 85)	29% (n = 126)	52% (n = 230)
My DVA clients receive better quality healthcare overall	23% (n = 102)	30% (n = 130)	47% (n = 209)
My DVA clients receive better targeted support based on their healthcare needs	23% (n = 103)	31% (n = 137)	46% (n = 201)

Q84 CARE COORDINATION with clients	**Agree**	**Neither**	**Disagree**
Before starting a treatment cycle, my DVA clients and I discuss their healthcare needs in more detail	32% (n = 139)	31% (n = 138)	37% (n = 164)
After finishing a treatment cycle, my DVA clients and I review their ongoing healthcare needs in more detail	36% (n = 159)	29% (n = 130)	34% (n = 152)
The number of interactions with my DVA clients has increased	18% (n = 79)	27% (n = 119)	55% (n = 243)
The quality of interactions with my DVA clients has improved	21% (n = 91)	31% (n = 138)	48% (n = 212)
My DVA clients and I have more opportunities to discuss and review their healthcare needs	22% (n = 98)	31% (n = 136)	47% (n = 207)

Q86 CARE COORDINATION	**Yes**	**No**
I coordinate my DVA client's healthcare needs	57% (n = 251)	43% (n = 190)
My DVA clients coordinate their healthcare needs	62% (n = 271)	38% (n = 169)
My DVA client's GP coordinates their healthcare needs	79% (n = 347)	21% (n = 93)

I consult my DVA clients GP to jointly coordinate their healthcare needs	60% (n = 266)	40% (n = 175)
Someone else coordinates my DVA client's healthcare needs	19% (n = 82)	81% (n = 358)
Other: I jointly coordinate with others for tailored arrangements	30% (n = 133)	70% (n = 307)

Q87 CARE COORDINATION with client's GP	**Agree**	**Neither**	**Disagree**
I provide a report which details my DVA client's ongoing healthcare needs and make recommendations to their GP	78% (n = 342)	15% (n = 66)	7% (n = 33)
My clinical notes, report, assessment and recommendations are clear	76% (n = 334)	17% (n = 76)	7% (n = 31)
I review and discuss the report and recommendations with my DVA clients and I seek their opinion	65% (n = 285)	22% (n = 98)	13% (n = 58)
I ensure my DVA clients are included in the decision-making process to meet their ongoing healthcare needs	76% (n = 336)	17% (n = 76)	7% (n = 29)
I ensure my DVA clients are informed about communications, decisions and recommendations between myself and their GP	75% (n = 331)	18% (n = 78)	7% (n = 32)
I accept additional referrals for treatment cycles based on the report, my DVA client's ongoing healthcare needs, their opinion and their GP's professional judgement	60% (n = 265)	26% (n = 116)	14% (n = 60)
The number of interactions between my DVA client's GP and I have increased	43% (n = 191)	26% (n = 116)	31% (n = 134)
The quality of interactions between my DVA client's GP and I have improved	24% (n = 104)	33% (n = 145)	43% (n = 192)
My DVA client's GP and I have more opportunities to discuss and review their healthcare needs	30% (n = 132)	30% (n = 132)	40% (n = 177)

Q89 Other Impacts	AHPs	Q89 Other Impacts	AHPs
More time consuming	76% (n = 335)	Unimproved and worse	40% (n = 177)
More time efficient	10% (n = 45)	Improved and better	11% (n = 50)
More expensive	41% (n = 180)	Less flexible, responsive and dynamic	36% (n = 160)
Less expensive	4% (n = 17)	More flexible, responsive and dynamic	10% (n = 43)
More complex	56% (n = 246)	Less administrative	5% (n = 23)
Simpler and more straight forward	10% (n = 46)	More administrative	71% (n = 314)
Less effective	38% (n = 166)	Other	9% (n = 41)
More effective	14% (n = 60)		

IMPACTS AND THEMES	***EVIDENCE***
Time (consuming vs efficient)	
☒ Administratively time-consuming ☒ Time spent following up requests for additional referrals in order to continue providing care ☒ Constantly monitoring referrals ☒ More time spent on assessments and paperwork (EOC report) than treatment provision ☒ Time taken to find relevant tools to measure outcomes (especially difficult for podiatry nail care)	*"EOC reports take away vital time from the patient. I must keep checking if referrals are up to date"* *"The amount of admin required of us has at least DOUBLED. It is a HUGE waste of time"* *"Monitoring the number of sessions remaining, preparing the report, chasing the GP, explaining the system to clients, explaining to the clients that I would like to visit them, but need to have a new referral first - reassuring the clients."* *"In addition to report writing, a session per cycle is spent reassessing outcomes instead of progressively assessing and re-evaluating organically and as clinically indicated rather than time indicated, throughout the year."* *"GPs are frustrated at the additional volume of correspondence and extra time to maintain an active referral for those who require ongoing support."* *"Spending a whole session conducting re-assessment, when most times the conditions are chronic and so will not see significant changes in 12 weeks. Time spent writing report, which is usually unchanged so not necessary. Disruptive to treatment when patient must wait for available appointment to renew referral."* *"This is massive. The HUGE amount of extras documentation is not compensated financially. Also chasing up GP's to get ongoing referrals is a nightmare. It takes for*

☒ Additional time spent explaining changes to clients and GPs ☒ Delays in service provision due to expired referrals ☒ Reports are insufficient at capturing treatment plans and outcomes ☒ Lack of framework/outcome measures (time spent researching measures and frameworks) ☒ Reports are insufficient at capturing treatment plans and outcomes ☒ Lack of framework/outcome measures	*ever and we do not get paid for it. It also then means Tx for the veterans is delayed as we cannot see them without an additional referral"* *"Discussing goals, and for some of them, finding a tool that allows for accurate measurement of improvement is difficulty (i.e. if they are attending for ongoing general skin and nail care)"* *"Paperwork not fit for purpose. Not specific to that patient. A letter detailing treatment plans/option and frequencies/health constraints would be more beneficial. I'm sure the GPs don't understand half of that form"* *"I have always written comprehensive reports to the GP but these new reports need to include USELESS information which is repeated over and over"* *"The lack of framework surrounding what constitutes a outcome measure and how to measure success mean we spend a significant portion of time with questionnaire to ensure compliance"* *"Consumes additional clinician time, takes time away from clients program to complete objective/subjective measures needed for reports"*
☑ Reports are smaller ☑ The TC is more time efficient and innovative	*"Reports are smaller."* *"It is more time efficient now"* *"Innovative"*
Expenses / Costs	
☒ Administrative costs (more staff) to follow up referrals ☒ EOC report fee ($30) is insufficient to cover cost of time to write it (in additional to issues with claiming report with/without an initial consultation at the start of cycle for ongoing client care)	*"Time to record visits, send and receive communication, follow up problems"* *"It takes more time therefore it is more expensive"* *"Pt pays additional fees to GP"* *"Increased cost to the health system for more regular appointments with GP's. Clients often not happy that they need appointments for another referral."* *"I have to spend more time on writing reports that I am not compensated for."* *"Use more appointment allocations to fill in start & end of cycle reports"* *"Greater burden on reception staff"* *"Increase reception hours chasing referrals"* *"More time involved for very little, if any improvement in patient welfare."*

☒ Clients required to see GPs more often (cost of GP visit) ☒ Unpaid administrative costs (e.g. report writing and referral follow up) ☒ Less billable client time / loss of income due to treatment delays (outstanding referrals) ☒ Not being paid for initial consultations/assessments ☒ Low DVA fees compared to NDIS or private clients / fees charged at the same rate for home or clinic visits ☒ Costs related to software upgrades/changes in order to accommodate the new templates ☒ Less expensive as clients forgoing treatment to avoid more GP visits ☑ Telehealth options	*"I have had to employ more admin to cope with the constant chasing of GPs to complete new cycle referrals"* *"Cost of admin support to chase referrals, send and manage letters, monitor approvals."* *"Time taken to do a report is not equivalent to the DVA charge rate of $33"* *"Insufficient fee for time and effort taken to complete ph94 reports"* *"Increased Admin time to follow-up on referrals. Together with low rates offered by DVA, I and my colleagues are likely to cease servicing DVA clients in 2021."* *"Time dedicated to writing reports is time that I cannot be seeing clients and generating income"* *"When losing appointments due to lack of new referrals frequently"* *"Although we can now claim and be paid for the end of cycle report F990; it's the time spent at the BEGINNING of the treatment cycle preparing and conducting the "Evidenced-based assessment" that takes up valuable clinic time that is not remunerated."* *"I do a detailed assessment at the beginning of a cycle and this does not get paid unless I only get the patient in for an assessment and discussion not general treatment as well."* *"Home visit fees match clinic fees when home visits cost us more to deliver than a clinical service. The scheduled fee for home visits needs to increase to at least match what NDIS recognise as a reasonable charge per hour."* *"Will not load onto medical object, there is no template that can be used without the help notes. We spent hours trying to format it"* *"Client reducing supervision to avoid more GP sessions (reduced level of care)"* *"More telehealth"*
Complexity vs Simplicity	
☒ AHPs report that clients and GPs do not understand the changes and it is a burden on them (especially elderly clients that need reminders for referrals)	*"Changes are causing clients to be confused about the process. Has made it more challenging for clients who have difficulty accessing the community / to their GP clinic too. Some individuals have been able to rely on telehealth at the moment to request referrals but if telehealth stops then these clients may not have a way to easily request new referrals. These are often the clients who need follow-up more regularly and use of our services."* *"Clients find it especially confusing, especially elderly"*

☒ AHPs perceived that information about the TC was "wrong initially" and difficult to clarify ☒ Monitoring referrals vs appointments and scheduling when to complete the EOC report in order to continue providing care without gaps ☒ Additional reporting requirements with no benefit to clients ☒ Reports require information that isn't relevant to all clients/allied health services ☒ Ambiguity of TC in regards to changes in conditions and goals during cycles / intervention flexibility does not fit TC ☒ Researching and selecting an evidence-based assessment when there are none or very few that are relevant	*"Older clients often need several reminders to get the new referral, we then cannot see them/address their needs without this referral meaning their needs are left unmet while we wait for the referral"* *"Some of these patients have complex needs, and having to stop treatment whilst waiting for new referrals is detrimental to their health"* *"Trying to research so much a d some information was wrong initially"* *"Our DVA patients do not understand these changes and it is a burden on them and their GP"* *"Often there is a delay between reporting after the 12th session and receiving a referral for a new cycle when it is necessary, this can be a numbest of weeks with some GPs despite communicating the need for haste, and this causes big disruptions and regression in clients who have then missed out on physio during that time."* *"Working out when to reassess to allow enough time for report to be completed and sent, then for the client to make a GP appointment, the GP to send a new referral often exact same as it was before"* *"Extra end of cycle reports as well as the usual letters to GPs makes the process more complex"* *"More steps to complete the process, for no additional benefits."* *"The form requires huge amounts of additional information that is often not relevant for my clients"* *"It's cumbersome to patients, GP's and the AHP's. Are cycles different for different conditions? What if conditions change during treatment? What happens if goals change during the cycle? What happens to cycles that are not completed within 12 months and haven't exceeded 2 visits? How are GP's actually encouraged to communicate with the AHP's through this initiative?"* *"To coordinate treatment cycle and plan appropriate intervention. This change is not client-centred at all. It is purely another mechanism to reduce the support to our war veterans and cut costs."* *"Every treatment cycle to be separately collated instead of continuing. Broad ongoing goals such as maintaining home safety and independence with interventions tailored to suit changing circumstances over time does not fit with treatment cycle arrangements."*

☑ Simpler and more straight forward	*"investigating and choosing the options for evidenced-based assessment - there are NONE applicable to podiatry for general, ongoing podiatry care - the AusTOMs PT for podiatry outcome measures does NOT have a high degree of valid research for inter/intra-assessor reliability !!!! This has met with mixed acceptance and usage within our high standards clinic"* *"The billing codes on how to claim the final report is not explained completely"* *"More defined and patients aware of the plan."*
Efficacy	
☒ Fewer/slower outcomes for clients due to treatment cycle (12 sessions) ☒ Negatively impacts continuity of care ☒ TC perceived as a "*barrier to seeing clients*" ☒ Minimal changes in outcomes within 12 sessions ☒ Clients are more stressed about their referrals and self-excluding from services ☒ No improvement in GP communication / uncertainty around GPs reading reports ☒ TC not suitable for chronic conditions ☒ More paperwork and less treatment time	*"I achieved more for my clients in less visits prior to the treatment cycles"* *"Limits to 12 sessions, inefficient continuum of care as needing to wait for a new referral before proceeding"* *"If a client doesn't have a new referral (over 12appointments) there is a pause in treatment until this is completed and this results in slower treatment, reduced outcomes and overall more appointments due to the delay in getting referrals from GPs."* *"Less of a wholistic assessment approach, due to report allowing space for two assessment measures."* *"Minimal change in 12 visits with most DVA clients in the community so minimal reporting of changes outcome measures"* *"It is more time consuming and stressful for the client as they are constantly worrying about where they are in the cycle and getting a new referral"* *"I have clients who report they see some HPs less now. E.g. podiatry visits - clients report they see them less often at the podiatrist direction."* *"Clients will choose to cease allied health intervention instead of go to the GP for a new referral so often. Many of my clients have given up exercise physiology as this referral can be used in as little as 4 weeks."* *"GP's have not increased their level of engagement with client or HP. No response to ongoing referral requests on end of cycle reports - unsure whether they are read. I receive more referral information if the client has requested something specific from GP e.g. personal response system or mobility aid etc."*

☑ More effective	*"As stated before this works for passive treatment to fix an injury eg. physio. However, does not help as much with chronic conditions that need a lot more time and effort. Muscle takes 12 weeks minimum to build and needs to be worked more often (lot of clients are not suitable to exercise at home)"* *"Especially if a client is living with a chronic, complex disease and not exempt from the 12 session treatment cycle. MANY DVA clients live with ongoing, complex, chronic disorders, conditions that require ongoing care. Unless there is an acute injury most DVA clients would require more than one 12 session treatment cycle."* *"Less effective due to extra admin time + inability for some clients to get GP referrals intake to be seen. Did not improve communication with GP's."* *"More paperwork equals less treatment time available* *"In terms of implementing a timeframe for goals"*
Unimproved vs Improved	
☒ GPs not reading reports and simply issuing referrals ☒ Clients self-excluding from treatment to avoid GP visits ☒ Clients unable to access treatment due to referral delays ☒ No improvement in GP / AHP communication / more bureaucratic ☒ Clients negative attitude towards TC requirements instead of focusing on treatment	*"Unimproved. The GP isn't looking at the ECR at all. They are giving out referrals whenever the client asks whether they are on their 2nd session or 12th session. In a small rural town they [clients] also don't see the same GP each time."* *"Client's reduced sessions based on not wanting to see GP so often. Client's struggling to get appointments with GPs for new referrals before treatment cycle is up. Re-assessments too frequently cutting into treatment times. Reduced participation in group based exercise."* *"We would regularly communicate with GPs on DVA clients' progress, goals, treatment plans prior to the changes. The hold up is with GPs sending new referrals for additional cycles. Patients then suffer. Sometimes waiting weeks with no treatment until we get the referral. My DVA clients are mostly frail and deteriorate quickly, putting them at increased risk of hospitalisation, falls etc if they miss treatment."* *"Slow return referrals from GPs, lack of understanding by Doctors about increased referrals, more labour for the client with the GP, having to stagger visits to wait for a new referral affects quality of care and long term outcomes as clients get lower volume of care."*

☑ Standardisation with outcome measures ☑ More client updates and opportunity to discuss client needs	*"Increased burden on DVA clients. Sometimes they don't want to be bothered with the services the GP and I find clinically relevant because it is too much effort going to the GP each time to get a new referral"* *"This change does not achieve the desired result of improving communication between the AHP and the GP. It just results in more frequent lower quality correspondence that doesn't enhance client outcomes"* *"In actual fact GP's have not altered their carte blanche attitude and processes for writing referrals. They do not take time to acknowledge, interact or provide feedback on the end of treatment cycle reports. So as AHP we are spending more time, getting no more money while the GP's get paid (even if it's the practice nurse who is writing the referrals and doing their assessments!)"* *"the treatment cycle added additional red tape, not quality of care"* *"Negative client attitudes about the frequency of reassessment and increased GP visits instead of focusing on their treatment"* *"Accountability with the use of outcome measures"* *"more update on client's needs and progress for any referral or correspondence if required"* *"More chance to discuss what's good the for the DVA client"*
Flexibility	
☒ TC is not suitable for more complex clients (i.e. multiple visits to GP for referrals) ☒ Clients are worse off ☒ Client stress about referral being valid ☒ The cycle is not enough time and limits clients who require more treatment ☒ The EOC report is too specific and does accurately	*"12 session model does not suit everyone, particularly complex, long term or those completing an exposure intervention twice-weekly. Lots of trips to GP is bothersome for client and inefficient. For less complex it works fine"* *"Limits the number of sessions of clients who really need more input (e.g. the frail, carers requiring support, cognitively impaired, frequent faller, frequent hospital admissions or mental health conditions)"* *"Our clients are WORSE OFF because of this system"* *"restrictive and disruptive to treatment, client rapport, consistency"* *"A lot less flexible as the client is constantly worried about where they are in their cycle and getting a doctor's appointment"* *"The report is very specific and doesn't let me explain to the GP what I actually did"* *"GPs are getting sick of having to issue new referrals all the time"*

reflect treatment and outcomes ☒ GPs are frustrated at having to constantly issue referrals ☒ TC is bulky, slow, complicated and expensive for AHPs ☒ Improved structure and control measures but increased paperwork with no improvement in quality of care ☒ Less autonomy for AHPs ☒ TC seems to apply more to physical health rather than mental health ☑ More oversight and responsiveness	*"It's not flexible, responsive or dynamic. The new process is bulky, slow, complicated and expensive for AHPs"* *"Improved structure with direct process and quality control measures. However, increased time for practitioners to complete without any increase in quality of care."* *"Less independence as a primary specialist means less flexibility in patient care. And more paperwork to justify therapy before sending a patient back to their GP for another unnecessary referral."* *"Seem to be a physical health based model rather than considering mental health elements."* *"For the cases of where there had been overservicing ."*
Administrative burden	
☒ Significant increase in administrative requirements ☒ PCP, EOC report, following up for referrals ☒ Tracking timeframes instead of treatment outcomes ☒ Assessment of clients ☒ Issues claiming EOC reports and having to conduct initial	*"I now dedicate an additional 6 hours a week to completing the additional admin required."* *"It is more work for admin. More costly for AHP practices. And not beneficial to the veterans' health and does not improve outcomes."* *"Paperwork equals administration and HINDERS patient treatment"* *"There is definitely more admin involved for both the podiatrist and the support staff. Letters have to be typed and posted to the DVA clients advising that their referrals are about to expire. This costs us time and money."* *"practice managers needing to follow up for new referrals from GP's; checking the number of visits within the referral period; setting up software triggers and reminders to ensure the visit counts are recorded and remain accurate"*

assessments for ongoing clients ☒ AHP hesitant to take on new DVA clients due to increased paperwork	*"implementation of systems to track time frames and number of visits instead of treatment outcomes"* *"a real problem to track referral expiry vs treatment number"* *"Sadly, due to the requirements of the 12 session treatment cycle and time and administration involved in arranging new referrals after 12 sessions and reporting (and only a $30 payment), after almost 10 years of working with DVA clients and their GP's, I hesitate now when asked to see a new DVA client."* *"There have been issues about claiming end of cycle reports"* *"Initial consultation item number should not be mandatory for an ongoing client treatment in order to charge end of cycle report some 12 months later."* *"Requesting more new referrals from elderly clients is confusing for them and can be a very long process. It was so much better when we could have ongoing referrals and I always sent GP reports with any findings or changes anyway. GPs are sending the wrong referrals or taking weeks to send them with follow up required also adding to my admin. Makes DVA referrals very unappealing to receive."* *"More chasing patient or GP for referral. Patients forget and then we have to postpone treatment. Seriously considering refusing any new DVA referrals."* *"Makes treating DVA very unattractive. Payment already low without excessive paper and forms."* *"More paperwork for no improvement in patient care."* *"To many reports in a short period of time required that go unread"*
Other	
☒ Usability of the EOC report (cannot sign electronically) ☒ No longer willing to treat DVA clients ☒ Suggest that DVA audits high service use providers and clients ☒ Waste of tax payer money (additional GP appointments)	*"The End of Cycle Report cannot be signed with a Surface Pen (or other), it has to be printed & this wastes time and paper."* *"Won't be taking on DVA patients anymore. Too much work and remuneration no longer worth it. it wasn't before but was happy to provide this service... now too much work"* *"UNAPPEALING for many health professionals. I work in a rural area and was told by another AHP recently that they are not seeing DVA clients when they can see Homecare Package clients or NDIS clients and be pain double and more from the government for the same service provided to a DVA client. Sadly I am seeing DVA clients missing out of services and I wonder if this is due to the referral and*

☒ Ambiguity if TC applies to aids assessments ☒ Stress on clients and clients not understanding how to access more than 12 sessions	*payment system in place. One good thing in the new treatment arrangements now that DVA recognises a written report from an allied health professional when previously there was no recognition of reporting or expectations for this when there should have been. No health professional should be providing ongoing treatments and have no accountability, revising or reporting of their services. Unless a DVA client has an acute condition or for e.g. requires a mobility assessment or other type of assessment, I believe that the majority of DVA client require ongoing care (this has been my experience) and hence ongoing referrals throughout the year. This is very time-consuming for both the AHP and GP."* *"I understand reasoning behind changes as some AHP milk the DVA system; maybe better auditing of AHP's that 'double dip' regularly appointment codes would be more effective in reducing the increased costings DVA has encountered."* *"An utter waste of tax payers money, paying for additional unnecessary GP appointments."* *"Although I have been using the CP's and CP reviews, I still don't know if the treatment cycle applies to Aids Assessment/prescription visits or only to treatments."* *"The clients most affected have been those with mental health conditions- the treatment cycle has at times created unnecessary stress and anxiety due to poor communication to the clients from DVA, a sense that if they require more than 12 sessions they are doing the wrong thing and that DVA is trying to minimise their access to health services during times of need."*
☑ Easier with time but still issues with ongoing care coordination	*"It is becoming easier with time, it does force communication with GP, which with older 'Indefinite referrals' could be an issue. If there was a need to communicate with a GP, I would anyway. The question is, does it really translate to better outcomes for patients?"* *"I think that the changes are a good idea and should work to improve co-ordination of care, but I'm not sure if they are doing so in practice in my clinic"*

Appendix 2.2: Survey Results Analysis

Table 1: Communication of the treatment cycle by respondent category and gender

Question	Agree N (%)	Neither agree nor disagree N (%)	Disagree N (%)	Sig
DVA clients: Available information about the allied health treatment cycle arrangements is				
Easy to understand				
Male	156 (50.9)	76 (24.8)	74 (24.1)	NS
Female	53 (57.6)	23 (25)	16 (17.3)	
Relevant to my needs				
Male	148 (48.3)	71 (23.2)	87 (28.4)	NS
Female	52 (56.5)	19 (20.6)	21 (22.8)	
High quality				
Male	116 (37.9)	122 (39.8)	68 (22.22)	NS
Female	42 (45.6)	31 (33.6)	19 (20.6)	
GPs: Available information about the allied health treatment cycle arrangements is				
Easy to understand				
Male	64 (66.6)	20 (20.8)	12 (12.5)	NS
Female	31 (59.6)	12 (23.1)	9 (17.3)	
Relevant to my practice				
Male	72 (75)	15 (15.625)	9 (9.375)	NS
Female	34 (65.3)	10 (19.2)	8 (15.3)	
Relevant to my DVA clients' needs				
Male	71 (73.9)	11 (11.4)	14 (14.5)	NS
Female	42 (80.7)	7 (13.4)	3 (5.7)	
High quality				
Male	66 (68.75)	17 (17.7)	13 (13.5)	NS
Female	32 (61.5)	17 (32.6)	3 (5.7)	
AHPs: Available information about the allied health treatment cycle arrangements is				
Easy to understand				
Male	71 (47.9)	30 (20.3)	47 (31.8)	NS
Female	158 (55.4)	40 (14.0)	87 (30.5)	
Prefer not to say	5 (62.5)	1 (12.5)	2 (25)	
Relevant to my practice				
Male	95 (64.2)	29 (19.6)	24 (16.2)	NS
Female	183 (64.2)	51 (17.9)	51 (17.9)	
Prefer not to say	6 (75.0)	0 (0.0)	2 (25.0)	
Relevant to my DVA clients' needs				
Male	70 (47.3)	32 (21.6)	46 (31.1)	NS
Female	156 (54.7)	47 (16.5)	82 (28.8)	
Prefer not to say	4 (50.0)	0 (0.0)	4 (50.0)	
High quality				
Male	51 (34.4)	48 (32.4)	49 (33.1)	NS
Female	107 (37.5)	95 (33.3)	83 (29.1)	
Prefer not to say	3 (37.5)	0 (0.0)	5 (62.5)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Table 2: Communication of the treatment cycle by respondent category and age

Question	Agree N (%)	Neither agree nor disagree N (%)	Disagree N (%)	Sig
DVA clients : Available information about the allied health treatment cycle arrangements is				
Easy to understand				
Equal or less than 50 years	82 (63.6)	26 (20.1)	21 (16.3)	<0.05#
More than 50 years	127 (47.0)	73 (27.0)	70 (25.9)	
Relevant to my needs				
Equal or less than 50 years	76 (58.9)	31 (24.0)	22 (17.0)	<0.05#
More than 50 years	125 (46.3)	59 (21.8)	86 (31.8)	
High quality				
Equal or less than 50 years	72 (55.8)	36 (27.9)	21 (16.2)	<0.05#
More than 50 years	87 (32.2)	117 (43.3)	66 (24.4)	
GPs : Available information about the allied health treatment cycle arrangements is				
Easy to understand				
Equal or less than 50 years	78 (67.8)	24 (20.8)	13 (11.3)	NS
More than 50 years	17 (51.5)	8 (24.2)	8 (24.2)	
Relevant to my practice				
Equal or less than 50 years	83 (72.1)	20 (17.4)	12 (10.4)	NS
More than 50 years	23 (69.7)	5 (15.1)	5 (15.1)	
Relevant to my DVA clients' needs				
Equal or less than 50 years	90 (78.3)	15 (13.0)	10 (8.7)	NS
More than 50 years	23 (69.7)	3 (9.1)	7 (21.2)	
High quality				
Equal or less than 50 years	82 (71.3)	24 (20.9)	9 (7.8)	NS
More than 50 years	16 (48.5)	10 (30.3)	7 (21.2)	
AHPs : Available information about the allied health treatment cycle arrangements is				
Easy to understand				
Equal or less than 50 years	192 (54.5)	55 (15.625)	105 (29.8)	NS
More than 50 years	41 (47.1)	16 (18.4)	30 (34.5)	
Relevant to my practice				
Equal or less than 50 years	235 (66.7)	60 (17.0)	57 (16.2)	NS
More than 50 years	48 (55.2)	20 (23.0)	19 (21.8)	
Relevant to my DVA clients' needs				
Equal or less than 50 years	187 (53.125)	67 (19.0)	98 (27.8)	NS
More than 50 years	43 (49.4)	12 (13.8)	32 (36.8)	
High quality				
Equal or less than 50 years	134 (38.1)	114 (32.4)	104 (29.5)	NS
More than 50 years	27 (31.0)	29 (33.3)	31 (35.6)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Table 3: Communication of the treatment cycle by respondent category and state

Question	Agree N (%)	Neither agree nor disagree N (%)	Disagree N (%)	Sig
DVA clients : Available information about the allied health treatment cycle arrangements is				
Easy to understand				
Queensland	97 (55.4)	35 (20.0)	43 (24.6)	NS
New South Wales	47 (55.3)	21 (24.7)	17 (20.0)	
Victoria	32 (50.0)	22 (34.4)	10 (15.6)	
Other	33 (44.0)	21 (28.0)	21 (28.0)	
Relevant to my needs				
Queensland	87 (49.7)	34 (19.4)	54 (30.8)	NS
New South Wales	48 (56.5)	20 (23.5)	17 (20.0)	
Victoria	36 (56.2)	16 (25.0)	12 (18.7)	
Other	30 (40.0)	20 (26.7)	25 (33.3)	
High quality				
Queensland	67 (38.3)	62 (35.4)	46 (26.3)	NS
New South Wales	42 (49.4)	24 (28.2)	19 (22.3)	
Victoria	30 (46.9)	28 (43.7)	6 (9.4)	
Other	20 (26.7)	39 (52.0)	16 (21.3)	
GPs : Available information about the allied health treatment cycle arrangements is				
Easy to understand				
Queensland	22 (57.9)	10 (26.3)	6 (15.8)	NS
New South Wales	37 (68.5)	12 (22.2)	5 (9.2)	
Victoria	23 (69.7)	5 (15.1)	5 (15.1)	
Other	13 (56.5)	5 (21.7)	5 (21.7)	
Relevant to my practice				
Queensland	28 (73.7)	1 (2.6)	9 (23.7)	NS
New South Wales	41 (75.9)	9 (16.7)	4 (7.4)	
Victoria	24 (72.7)	5 (15.1)	4 (12.1)	
Other	13 (56.5)	10 (43.5)	0 (0.0)	
Relevant to my DVA clients' needs				
Queensland	26 (68.4)	5 (13.1)	7 (18.4)	NS
New South Wales	43 (79.6)	4 (7.4)	7 (12.9)	
Victoria	26 (78.8)	5 (15.1)	2 (6.1)	
Other	18 (78.3)	4 (17.4)	1 (4.3)	
High quality				
Queensland	21 (55.3)	8 (21.0)	9 (23.7)	NS
New South Wales	36 (66.7)	16 (29.6)	2 (3.7)	
Victoria	23 (69.7)	7 (21.2)	3 (9.1)	
Other	18 (78.3)	3 (13.0)	2 (8.7)	
AHPs : Available information about the allied health treatment cycle arrangements is				
Easy to understand				
Queensland	71 (53.4)	24 (18.0)	38 (28.6)	NS
New South Wales	52 (48.6)	20 (18.7)	35 (32.7)	
Victoria	41 (46.6)	12 (13.6)	35 (39.8)	
Other	70 (61.9)	15 (13.3)	28 (24.8)	
Relevant to my practice				

Queensland	84 (63.1)	30 (22.5)	19 (14.2)	NS
New South Wales	65 (60.7)	20 (18.6)	22 (20.5)	
Victoria	55 (62.5)	16 (18.1)	17 (19.3)	
Other	80 (70.7)	14 (12.3)	19 (16.8)	
Relevant to my DVA clients' needs				
Queensland	65 (48.8)	26 (19.5)	42 (31.5)	NS
New South Wales	56 (52.3)	20 (18.6)	31 (28.9)	
Victoria	46 (52.2)	12 (13.6)	30 (34.0)	
Other	63 (55.7)	21 (18.5)	29 (25.6)	
High quality				
Queensland	44 (33.0)	43 (32.3)	46 (34.5)	NS
New South Wales	43 (40.1)	30 (28.0)	34 (31.7)	
Victoria	30 (34.0)	26 (29.5)	32 (36.3)	
Other	44 (38.9)	44 (38.9)	25 (22.1)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Table 4: Satisfaction with the treatment cycle by respondent category and gender

Question	**Agree** **N (%)**	**Neither agree nor disagree** **N (%)**	**Disagree** **N (%)**	**Sig**
DVA clients : Since 1 October 2019, think about the first time you visited your GP for an allied health treatment referral				
I was prepared for the changes				
Male	172 (56.2)	53 (17.3)	81 (26.5)	NS
Female	57 (62)	17 (18.5)	18 (19.6)	
Prefer not to say	0 (0)	1 (100)	0 (0)	
I understood the changes				
Male	178 (58.2)	59 (19.3)	69 (22.5)	NS
Female	66 (71.7)	10 (10.9)	16 (17.4)	
Prefer not to say	1 (100)	0 (0)	0 (0)	
I had sufficient knowledge about the changes				
Male	174 (56.9)	62 (20.3)	70 (22.9)	NS
Female	55 (59.8)	18 (19.6)	19 (20.7)	
Prefer not to say	1 (100)	0 (0)	0 (0)	
I was confident asking my GP for a referral to a treatment cycle				
Male	224 (73.2)	45 (14.7)	37 (12.1)	NS
Female	62 (67.4)	17 (18.5)	13 (14.1)	
Prefer not to say	1 (100)	0 (0)	0 (0)	
I was satisfied with the changes				
Male	99 (32.4)	50 (16.3)	157 (51.3)	NS
Female	34 (37)	20 (21.7)	38 (41.3)	
Prefer not to say	1 (100)	0 (0)	0 (0)	
GPs : Since 1 October 2019, think about the first time you made a referral for a DVA client under the allied health treatment cycle arrangements				
I was prepared for the changes				

Male	54 (56.3)	27 (28.1)	15 (15.6)	NS
Female	31 (59.6)	9 (17.3)	12 (23.1)	
I understood the changes				
Male	55 (57.3)	24 (25)	17 (17.7)	NS
Female	35 (67.3)	8 (15.4)	9 (17.3)	
I had sufficient knowledge about the changes				
Male	60 (62.5)	21 (21.9)	15 (15.6)	NS
Female	37 (71.2)	7 (13.5)	8 (15.4)	
I was confident referring DVA clients to a treatment cycle				
Male	60 (62.5)	23 (24)	13 (13.5)	NS
Female	32 (61.5)	17 (32.7)	3 (5.8)	
I was satisfied with the changes				
Male	58 (60.4)	23 (24)	15 (15.6)	NS
Female	26 (50)	12 (23.1)	14 (26.9)	
I have provided allied health services for DVA clients under the treatment cycle arrangements				
Male	53 (55.2)	30 (31.3)	13 (13.5)	NS
Female	24 (46.2)	24 (46.2)	4 (7.7)	
AHPs : Since 1 October 2019, think about the first time you made a referral for a DVA client under the allied health treatment cycle arrangements				
I was prepared for the changes				
Male	87 (58.8)	22 (14.9)	39 (26.4)	NS
Female	162(56.8)	46 (16.1)	77 (27)	
Prefer not to say	5 (62.5)	1 (12.5)	2 (25)	
I understood the changes				
Male	93 (62.8)	25 (16.9)	30 (20.3)	NS
Female	187 (65.6)	38 (13.3)	60 (21.1)	
Prefer not to say	6 (75)	0 (0)	2 (25)	
I had sufficient knowledge about the changes				
Male	79 (53.4)	34 (23)	35 (23.6)	NS
Female	163 (57.2)	44 (15.4)	78 (27.4)	
Prefer not to say	3 (37.5)	1 (12.5)	4 (50)	
I was confident receiving a referral from a GP on behalf of a DVA client for an allied health treatment cycle				
Male	90 (60.8)	29 (19.6)	29 (19.6)	NS
Female	189 (66.3)	37 (13)	59 (20.7)	
Prefer not to say	4 (50)	3 (37.5)	1 (12.5)	
I was satisfied with the changes				
Male	41 (27.7)	28 (18.9)	79 (53.4)	NS
Female	78 (27.4)	45 (15.8)	162 (56.8)	
Prefer not to say	0 (0)	1 (12.5)	7 (87.5)	
I have provided allied health services for DVA clients under the treatment cycle arrangements				
Male	133 (89.9)	11 (7.4)	4 (2.7)	NS
Female	253 (88.8)	19 (6.7)	13 (4.6)	
Prefer not to say	7 (87.5)	0 (0)	1 (12.5)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Table 5: Satisfaction with the treatment cycle by respondent category and age

Question	Agree N (%)	Neither agree nor disagree N (%)	Disagree N (%)	Sig
DVA clients : Since 1 October 2019, think about the first time you visited your GP for an allied health treatment referral				
I was prepared for the changes				
Equal or less than 50 years	82 (63.6)	20 (15.5)	27 (20.9)	NS
More than 50 years	147 (54.4)	51 (18.9)	72 (26.7)	
I understood the changes				
Equal or less than 50 years	82 (63.6)	23 (17.8)	24 (18.6)	NS
More than 50 years	163 (60.4)	46 (17)	61 (22.6)	
I had sufficient knowledge about the changes				
Equal or less than 50 years	80 (62)	25 (19.4)	24 (18.6)	NS
More than 50 years	150 (55.6)	55 (20.4)	65 (24.1)	
I was confident asking my GP for a referral to a treatment cycle				
Equal or less than 50 years	93 (72.1)	21 (16.3)	15 (11.6)	NS
More than 50 years	194 (71.9)	41 (15.2)	35 (13)	
I was satisfied with the changes				
Equal or less than 50 years	67 (51.9)	27 (20.9)	35 (27.1)	NS
More than 50 years	67 (24.8)	43 (15.9)	160 (59.3)	
GPs : Since 1 October 2019, think about the first time you made a referral for a DVA client under the allied health treatment cycle arrangements				
I was prepared for the changes				
Equal or less than 50 years	70 (60.9)	25 (21.7)	20 (17.4)	NS
More than 50 years	15 (45.5)	11 (33.3)	7 (21.2)	
I understood the changes				
Equal or less than 50 years	73 (63.5)	23 (20)	19 (16.5)	NS
More than 50 years	17 (51.5)	9 (27.3)	7 (21.2)	
I had sufficient knowledge about the changes				
Equal or less than 50 years	79 (68.7)	20 (17.4)	16 (13.9)	NS
More than 50 years	18 (54.5)	8 (24.2)	7 (21.2)	
I was confident referring DVA clients to a treatment cycle				
Equal or less than 50 years	74 (64.3)	30 (26.1)	11 (9.6)	NS
More than 50 years	18 (54.5)	10 (30.3)	5 (15.2)	
I was satisfied with the changes				
Equal or less than 50 years	72 (62.6)	23 (20)	20 (17.4)	<0.05#
More than 50 years	12 (36.4)	12 (36.4)	9 (27.3)	
I have provided allied health services for DVA clients under the treatment cycle arrangements				
Equal or less than 50 years	64 (55.7)	41 (35.7)	10 (8.7)	NS
More than 50 years	13 (39.4)	13 (39.4)	7 (21.2)	
AHPs : Since 1 October 2019, think about the first time you made a referral for a DVA				

client under the allied health treatment cycle arrangements				
I was prepared for the changes				
Equal or less than 50 years	202 (57.4)	59 (16.8)	91 (25.9)	NS
More than 50 years	51 (58.6)	10 (11.5)	26 (29.9)	
I understood the changes				
Equal or less than 50 years	230 (65.3)	53 (15.1)	69 (19.6)	NS
More than 50 years	55 (63.2)	9 (10.3)	23 (26.4)	
I had sufficient knowledge about the changes				
Equal or less than 50 years	196 (55.7)	67 (19)	89 (25.3)	NS
More than 50 years	49 (56.3)	12 (13.8)	26 (29.9)	
I was confident receiving a referral from a GP on behalf of a DVA client for an allied health treatment cycle				
Equal or less than 50 years	225 (63.9)	56 (15.9)	71 (20.2)	NS
More than 50 years	58 (66.7)	11 (12.6)	18 (20.7)	
I was satisfied with the changes				
Equal or less than 50 years	99 (28.1)	62 (17.6)	191 (54.3)	NS
More than 50 years	20 (23)	12 (13.8)	55 (63.2)	
I have provided allied health services for DVA clients under the treatment cycle arrangements				
Equal or less than 50 years	314 (89.2)	25 (7.1)	13 (3.7)	NS
More than 50 years	77 (88.5)	5 (5.7)	5 (5.7)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Table 6: Satisfaction with the treatment cycle by respondent category and state

Question	**Agree** **N (%)**	**Neither agree nor disagree** **N (%)**	**Disagree** **N (%)**	**Sig**
DVA clients : Since 1 October 2019, think about the first time you visited your GP for an allied health treatment referral				
I was prepared for the changes				
Queensland	102 (58.3)	32 (18.3)	41 (23.4)	NS
New South Wales	50 (58.8)	12 (14.1)	23 (27.1)	
Victoria	35 (54.7)	15 (23.4)	14 (21.9)	
Other	42 (56)	12 (16)	21 (28)	
I understood the changes				
Queensland	114 (65.1)	26 (14.9)	35 (20)	NS
New South Wales	51 (60)	18 (21.2)	16 (18.8)	
Victoria	39 (60.9)	12 (18.8)	13 (20.3)	
Other	41 (54.7)	13 (17.3)	21 (28)	
I had sufficient knowledge about the changes				
Queensland	101 (57.7)	37 (21.1)	37 (21.1)	<0.05#
New South Wales	53 (62.4)	12 (14.1)	20 (23.5)	
Victoria	39 (60.9)	18 (28.1)	7 (10.9)	
Other	37 (49.3)	13 (17.3)	25 (33.3)	
I was confident asking my GP for a referral to a treatment cycle				
Queensland	129 (73.7)	23 (13.1)	23 (13.1)	NS
New South Wales	68 (80)	10 (11.8)	7 (8.2)	

Victoria	43 (67.2)	11 (17.2)	10 (15.6)	
Other	47 (62.7)	18 (24)	10 (13.3)	
I was satisfied with the changes				
Queensland	50 (28.6)	25 (14.3)	100 (57.1)	<0.05#
New South Wales	39 (45.9)	13 (15.3)	33 (38.8)	
Victoria	29 (45.3)	16 (25)	19 (29.7)	
Other	16 (21.3)	16 (21.3)	43 (57.3)	
GPs : Since 1 October 2019, think about the first time you made a referral for a DVA client under the allied health treatment cycle arrangements				
I was prepared for the changes				
Queensland	21 (55.3)	5 (13.2)	12 (31.6)	NS
New South Wales	34 (63)	15 (27.8)	5 (9.3)	
Victoria	17 (51.5)	10 (30.3)	6 (18.2)	
Other	13 (56.5)	6 (26.1)	4 (17.4)	
I understood the changes				
Queensland	23 (60.5)	5 (13.2)	10 (26.3)	NS
New South Wales	35 (64.8)	13 (24.1)	6 (11.1)	
Victoria	16 (48.5)	11 (33.3)	6 (18.2)	
Other	16 (69.6)	3 (13)	4 (17.4)	
I had sufficient knowledge about the changes				
Queensland	24 (63.2)	5 (13.2)	9 (23.7)	NS
New South Wales	38 (70.4)	11 (20.4)	5 (9.3)	
Victoria	18 (54.5)	10 (30.3)	5 (15.2)	
Other	17 (73.9)	2 (8.7)	4 (17.4)	
I was confident referring DVA clients to a treatment cycle				
Queensland	26 (68.4)	6 (15.8)	6 (15.8)	NS
New South Wales	33 (61.1)	19 (35.2)	2 (3.7)	
Victoria	17 (51.5)	11 (33.3)	5 (15.2)	
Other	16 (69.6)	4 (17.4)	3 (13)	
I was satisfied with the changes				
Queensland	15 (39.5)	10 (26.3)	13 (34.2)	<0.05#
New South Wales	35 (64.8)	15 (27.8)	4 (7.4)	
Victoria	19 (57.6)	9 (27.3)	5 (15.2)	
Other	15 (65.2)	1 (4.3)	7 (30.4)	
I have provided allied health services for DVA clients under the treatment cycle arrangements				
Queensland	16 (42.1)	13 (34.2)	9 (23.7)	NS
New South Wales	33 (61.1)	18 (33.3)	3 (5.6)	
Victoria	16 (48.5)	14 (42.4)	3 (9.1)	
Other	12 (52.2)	9 (39.1)	2 (8.7)	
AHPs : Since 1 October 2019, think about the first time you made a referral for a DVA client under the allied health treatment cycle arrangements				
I was prepared for the changes				
Queensland	76 (57.1)	25 (18.8)	32 (24.1)	NS
New South Wales	59 (55.1)	16 (15)	32 (29.9)	
Victoria	50 (56.8)	11 (12.5)	27 (30.7)	

Other	69 (61.1)	17 (15)	27 (23.9)	
I understood the changes				
Queensland	83 (62.4)	30 (22.6)	20 (15)	<0.05#
New South Wales	68 (63.6)	14 (13.1)	25 (23.4)	
Victoria	56 (63.6)	10 (11.4)	22 (25)	
Other	79 (69.9)	9 (8)	25 (22.1)	
I had sufficient knowledge about the changes				
Queensland	73 (54.9)	29 (21.8)	31 (23.3)	NS
New South Wales	61 (57)	18 (16.8)	28 (26.2)	
Victoria	46 (52.3)	15 (17)	27 (30.7)	
Other	65 (57.5)	17 (15)	31 (27.4)	
I was confident receiving a referral from a GP on behalf of a DVA client for an allied health treatment cycle				
Queensland	84 (63.2)	23 (17.3)	26 (19.5)	NS
New South Wales	68 (63.6)	18 (16.8)	21 (19.6)	
Victoria	54 (61.4)	9 (10.2)	25 (28.4)	
Other	77 (68.1)	19 (16.8)	17 (15)	
I was satisfied with the changes				
Queensland	27 (20.3)	27 (20.3)	79 (59.4)	NS
New South Wales	41 (38.3)	15 (14)	51 (47.7)	
Victoria	25 (28.4)	13 (14.8)	50 (56.8)	
Other	26 (23)	19 (16.8)	68 (60.2)	
I have provided allied health services for DVA clients under the treatment cycle arrangements				
Queensland	123 (92.5)	10 (7.5)	0 (0)	<0.05#
New South Wales	89 (83.2)	11 (10.3)	7 (6.5)	
Victoria	77 (87.5)	3 (3.4)	8 (9.1)	
Other	104 (92)	6 (5.3)	3 (2.7)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Table 7: Impact with the treatment cycle by respondent category, gender, age and state

Question	**I have been negatively impacted by the changes N (%)**	**I have not been impacted by the changes N (%)**	**I have been positively impacted by the changes N (%)**	**Sig**
DVA clients : Impacted by the changes to allied health treatment cycle arrangements				
Gender				
Male	134 (43.8)	109 (35.6)	63 (20.6)	NS
Female	30 (32.6)	37 (40.2)	25 (27.2)	
Prefer not to say	0 (0)	0 (0)	1 (100)	
Age				
Equal or less than 50 years	41 (31.8)	39 (30.2)	49 (38)	<0.05#
More than 50 years	123 (45.6)	107 (39.6)	40 (14.8)	
State				
Queensland	83 (47.4)	61 (34.9)	31 (17.7)	<0.05#
New South Wales	23 (27.1)	36 (42.4)	26 (30.6)	
Victoria	22 (34.4)	26 (40.6)	16 (25)	
Other	36 (48)	23 (30.7)	16 (21.3)	

GPs : Impacted by the changes to allied health referrals under the treatment cycle arrangements				
Gender				
Male	27 (28.1)	32 (33.3)	37 (38.5)	NS
Female	10 (19.2)	12 (23.1)	30 (57.7)	
Age				
Equal or less than 50 years	27 (23.5)	32 (27.8)	56 (48.7)	
More than 50 years	10 (30.3)	12 (36.4)	11 (33.3)	
State				
Queensland	11 (28.9)	13 (34.2)	14 (36.8)	NS
New South Wales	11 (20.4)	13 (24.1)	30 (55.6)	
Victoria	8 (24.2)	11 (33.3)	14 (42.4)	
Other	7 (30.4)	7 (30.4)	9 (39.1)	
AHPs : Impacted by the changes to referrals for allied health treatment cycle arrangements				
Gender				
Male	83 (53.5)	48 (31)	24 (15.5)	NS
Female	150 (52.6)	96 (33.7)	39 (13.7)	
Prefer not to say	7 (87.5)	1 (12.5)	0 (0)	
Age				
Equal or less than 50 years	182 (51.7)	121 (34.4)	49 (13.9)	
More than 50 years	57 (65.5)	23 (26.4)	7 (8)	
State				
Queensland	77 (57.9)	47 (35.3)	9 (6.8)	<0.05#
New South Wales	47 (43.9)	37 (34.6)	23 (21.5)	
Victoria	51 (58)	27 (30.7)	10 (11.4)	
Other	65 (57.5)	34 (30.1)	14 (12.4)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Table 8: Quality of care with the treatment cycle by respondent category and gender

Question	**Agree** **N (%)**	**Neither agree nor disagree** **N (%)**	**Disagree** **N (%)**	**Sig**
DVA clients : Has your quality of healthcare changed?				
I require more referrals from my GP to meet my healthcare needs				
Male	220 (71.9)	41 (13.4)	45 (14.7)	NS
Female	63 (68.5)	11 (12)	18 (19.6)	
Prefer not to say	0 (0)	1 (100)	0 (0)	
I am more engaged in how my healthcare needs are met				
Male	102 (33.3)	113 (36.9)	91 (29.7)	NS
Female	35 (38)	38 (41.3)	19 (20.7)	
Prefer not to say	0 (0)	1 (100)	0 (0)	
My GP and I discuss and review my healthcare needs more often and in more detail				
Male	112 (36.6)	95 (31)	99 (32.4)	NS
Female	45 (48.9)	21 (22.8)	26 (28.3)	
Prefer not to say	0 (0)	1 (100)	0 (0)	

My AHP and I discuss and review my healthcare needs more often and in more detail				
Male	119 (38.9)	95 (31)	92 (30.1)	NS
Female	37 (40.2)	31 (33.7)	24 (26.1)	
Prefer not to say	0 (0)	1 (100)	0 (0)	
My healthcare needs are better met				
Male	89 (29.1)	105 (34.3)	112 (36.6)	NS
Female	28 (30.4)	33 (35.9)	31 (33.7)	
Prefer not to say	0 (0)	1 (100)	0 (0)	
I have better access to necessary services for my healthcare needs				
Male	79 (25.8)	96 (31.4)	131 (42.8)	NS
Female	26 (28.3)	35 (38)	31 (33.7)	
Prefer not to say	0 (0)	1 (100)	0 (0)	
I receive better quality of healthcare overall				
Male	79 (25.8)	112 (36.6)	115 (37.6)	NS
Female	25 (27.2)	35 (38)	32 (34.8)	
Prefer not to say	0 (0)	1 (100)	0 (0)	
I receive better targeted support based on my healthcare needs				
Male	83 (27.1)	105 (34.3)	118 (38.6)	NS
Female	35 (38)	31 (33.7)	26 (28.3)	
Prefer not to say	0 (0)	1 (100)	0 (0)	
GPs : has your practice of quality healthcare for DVA clients changed?				
I make more referrals for my DVA clients to meet their healthcare needs				
Male	55 (57.3)	30 (31.3)	11 (11.5)	NS
Female	27 (51.9)	15 (28.8)	10 (19.2)	
I contribute more to how my DVA clients healthcare needs are met				
Male	50 (52.1)	29 (30.2)	17 (17.7)	NS
Female	25 (48.1)	15 (28.8)	12 (23.1)	
My DVA clients and I discuss and review their health care needs more often and in more detail				
Male	53 (55.2)	27 (28.1)	16 (16.7)	NS
Female	31 (59.6)	12 (23.1)	9 (17.3)	
My DVA client's AHP and I discuss and review our client's healthcare needs more often and in more detail				
Male	61 (63.5)	25 (26)	10 (10.4)	NS
Female	28 (53.8)	13 (25)	11 (21.2)	
My DVA clients healthcare needs are better met				
Male	49 (51)	30 (31.3)	17 (17.7)	NS
Female	30 (57.7)	12 (23.1)	10 (19.2)	
My DVA clients have better access to necessary services to meet their healthcare needs				

Male	52 (54.2)	28 (29.2)	16 (16.7)	NS
Female	30 (57.7)	12 (23.1)	10 (19.2)	
My DVA clients receive better quality of healthcare overall				
Male	56 (58.3)	27 (28.1)	13 (13.5)	NS
Female	30 (57.7)	13 (25)	9 (17.3)	
My DVA clients receive better targeted support based on their healthcare needs				
Male	55 (57.3)	23 (24)	18 (18.8)	NS
Female	31 (59.6)	11 (21.2)	10 (19.2)	
AHPs: has your practice of quality healthcare for DVA clients changed?				
I receive and accept more referrals for my DVA clients to meet their healthcare needs				
Male	35 (23.6)	45 (30.4)	68 (45.9)	NS
Female	58 (20.4)	98 (34.4)	129 (45.3)	
Prefer not to say	1 (12.5)	2 (25)	5 (62.5)	
I contribute more to how my DVA clients healthcare needs are met				
Male	39 (26.4)	48 (32.4)	61 (41.2)	NS
Female	70 (24.6)	101 (35.4)	114 (40)	
Prefer not to say	0 (0)	1 (12.5)	7 (87.5)	
I discuss and review my DVA client's healthcare needs with them more often and in more detail				
Male	53 (35.8)	45 (30.4)	50 (33.8)	NS
Female	84 (29.5)	102 (35.8)	99 (34.7)	
Prefer not to say	0 (0)	5 (62.5)	3 (37.5)	
I discuss and review my DVA client's ongoing healthcare needs with their GP more often and in more detail				
Male	57 (38.5)	36 (24.3)	55 (37.2)	NS
Female	96 (33.7)	84 (29.5)	105 (36.8)	
Prefer not to say	0 (0)	3 (37.5)	5 (62.5)	
My DVA client's healthcare needs are better met				
Male	36 (24.3)	42 (28.4)	70 (47.3)	NS
Female	63 (22.1)	84 (29.5)	138 (48.4)	
Prefer not to say	0 (0)	1 (12.5)	7 (87.5)	
My DVA clients have better access to necessary services to meet their healthcare needs				
Male	30 (20.3)	47 (31.8)	71 (48)	NS
Female	55 (19.3)	78 (27.4)	152 (53.3)	
Prefer not to say	0 (0)	1 (12.5)	7 (87.5)	
My DVA clients receive better quality of healthcare overall				
Male	36 (24.3)	44 (29.7)	68 (45.9)	NS
Female	66 (23.2)	85 (29.8)	134 (47)	
Prefer not to say	0 (0)	1 (12.5)	7 (87.5)	

My DVA clients receive better targeted support based on their healthcare needs				
Male	35 (23.6)	52 (35.1)	61 (41.2)	NS
Female	68 (23.9)	82 (28.8)	135 (47.4)	
Prefer not to say	0 (0)	3 (37.5)	5 (62.5)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Table 9: Quality of care with the treatment cycle by respondent category and age

Question	**Agree** **N (%)**	**Neither agree nor disagree** **N (%)**	**Disagree** **N (%)**	**Sig**
DVA clients : Has your quality of healthcare changed?				
I require more referrals from my GP to meet my healthcare needs				
Equal or less than 50 years	89 (69)	18 (14)	22 (17.1)	NS
More than 50 years	194 (71.9)	35 (13)	41 (15.2)	
I am more engaged in how my healthcare needs are met				
Equal or less than 50 years	55 (42.6)	42 (32.6)	32 (24.8)	NS
More than 50 years	82 (30.4)	110 (40.7)	78 (28.9)	
My GP and I discuss and review my healthcare needs more often and in more detail				
Equal or less than 50 years	67 (51.9)	33 (25.6)	29 (22.5)	<0.05#
More than 50 years	90 (33.3)	84 (31.1)	96 (35.6)	
My AHP and I discuss and review my healthcare needs more often and in more detail				
Equal or less than 50 years	60 (46.5)	37 (28.7)	32 (24.8)	NS
More than 50 years	96 (35.6)	90 (33.3)	84 (31.1)	
My healthcare needs are better met				
Equal or less than 50 years	62 (48.1)	32 (24.8)	35 (27.1)	<0.05#
More than 50 years	55 (20.4)	107 (39.6)	108 (40)	
I have better access to necessary services for my healthcare needs				
Equal or less than 50 years	57 (44.2)	31 (24)	41 (31.8)	<0.05#
More than 50 years	48 (17.8)	101 (37.4)	121 (44.8)	
I receive better quality of healthcare overall				
Equal or less than 50 years	59 (45.7)	35 (27.1)	35 (27.1)	<0.05#
More than 50 years	45 (16.7)	113 (41.9)	112 (41.5)	
I receive better targeted support based on my healthcare needs				
Equal or less than 50 years	64 (49.6)	33 (25.6)	32 (24.8)	<0.05#
More than 50 years	54 (20)	104 (38.5)	112 (41.5)	
GPs : has your practice of quality healthcare for DVA clients changed?				
I make more referrals for my DVA clients to meet their healthcare needs				

Equal or less than 50 years	70 (60.9)	28 (24.3)	17 (14.8)	<0.05#
More than 50 years	12 (36.4)	17 (51.5)	4 (12.1)	
I contribute more to how my DVA clients healthcare needs are met				
Equal or less than 50 years	64 (55.7)	29 (25.2)	22 (19.1)	<0.05#
More than 50 years	11 (33.3)	15 (45.5)	7 (21.2)	
My DVA clients and I discuss and review their health care needs more often and in more detail				
Equal or less than 50 years	69 (60.0)	25 (21.7)	21 (18.3)	NS
More than 50 years	15 (45.5)	14 (42.4)	4 (12.1)	
My DVA client's AHP and I discuss and review our client's healthcare needs more often and in more detail				
Equal or less than 50 years	76 (66.1)	21 (18.3)	18 (15.7)	<0.05#
More than 50 years	13 (39.4)	17 (51.5)	3 (9.1)	
My DVA clients healthcare needs are better met				
Equal or less than 50 years	67 (58.3)	28 (24.3)	20 (17.4)	NS
More than 50 years	12 (36.4)	14 (42.4)	7 (21.2)	
My DVA clients have better access to necessary services to meet their healthcare needs				
Equal or less than 50 years	69 (60)	28 (24.3)	18 (15.7)	NS
More than 50 years	13 (39.4)	12 (36.4)	8 (24.2)	
My DVA clients receive better quality of healthcare overall				
Equal or less than 50 years	76 (66.1)	25 (21.7)	14 (12.2)	<0.05#
More than 50 years	10 (30.3)	15 (45.5)	8 (24.2)	
My DVA clients receive better targeted support based on their healthcare needs				
Equal or less than 50 years	75 (65.2)	21 (18.3)	19 (16.5)	<0.05#
More than 50 years	11 (33.3)	13 (39.4)	9 (27.3)	
AHPs: has your practice of quality healthcare for DVA clients changed?				
I receive and accept more referrals for my DVA clients to meet their healthcare needs				
Equal or less than 50 years	85 (24.1)	116 (33)	151 (42.9)	0.05#
More than 50 years	9 (10.3)	28 (32.2)	50 (57.5)	
I contribute more to how my DVA clients healthcare needs are met				
Equal or less than 50 years	91 (25.9)	123 (34.9)	138 (39.2)	NS
More than 50 years	18 (20.7)	27 (31)	42 (48.3)	
I discuss and review my DVA client's healthcare needs with them more often and in more detail				
Equal or less than 50 years	116 (33)	129 (36.6)	107 (30.4)	0.05#
More than 50 years	21 (24.1)	23 (26.4)	43 (49.4)	
I discuss and review my DVA client's ongoing healthcare needs with their GP more often and in more detail				
Equal or less than 50 years	123 (34.9)	101 (28.7)	128 (36.4)	NS

More than 50 years	30 (34.5)	22 (25.3)	35 (40.2)	
My DVA client's healthcare needs are better met				
Equal or less than 50 years	85 (24.1)	103 (29.3)	164 (46.6)	NS
More than 50 years	14 (16.1)	24 (27.6)	49 (56.3)	
My DVA clients have better access to necessary services to meet their healthcare needs				
Equal or less than 50 years	75 (21.3)	103 (29.3)	174 (49.4)	NS
More than 50 years	10 (11.5)	23 (26.4)	54 (62.1)	
My DVA clients receive better quality of healthcare overall				
Equal or less than 50 years	89 (25.3)	105 (29.8)	158 (44.9)	NS
More than 50 years	13 (14.9)	25 (28.7)	49 (56.3)	
My DVA clients receive better targeted support based on their healthcare needs				
Equal or less than 50 years	89 (25.3)	111 (31.5)	152 (43.2)	NS
More than 50 years	14 (16.1)	26 (29.9)	47 (54)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Table 10: Quality of care with the treatment cycle by respondent category and state

Question	**Agree** **N (%)**	**Neither agree nor disagree** **N (%)**	**Disagree** **N (%)**	**Sig**
DVA clients : Has your quality of healthcare changed?				
I require more referrals from my GP to meet my healthcare needs				
Queensland	136 (77.7)	20 (11.4)	19 (10.9)	NS
New South Wales	53 (62.4)	12 (14.1)	20 (23.5)	
Victoria	39 (60.9)	13 (20.3)	12 (18.8)	
Other	55 (73.3)	8 (10.7)	12 (16)	
I am more engaged in how my healthcare needs are met				
Queensland	63 (36)	64 (36.6)	48 (27.4)	NS
New South Wales	31 (36.5)	32 (37.6)	22 (25.9)	
Victoria	25 (39.1)	27 (42.2)	12 (18.8)	
Other	18 (24)	29 (38.7)	28 (37.3)	
My GP and I discuss and review my healthcare needs more often and in more detail				
Queensland	65 (37.1)	49 (28)	61 (34.9)	<0.05#
New South Wales	44 (51.8)	16 (18.8)	25 (29.4)	
Victoria	27 (42.2)	24 (37.5)	13 (20.3)	
Other	21 (28)	28 (37.3)	26 (34.7)	
My AHP and I discuss and review my healthcare needs more often and in more detail				
Queensland	62 (35.4)	52 (29.7)	61 (34.9)	<0.05#
New South Wales	41 (48.2)	27 (31.8)	17 (20)	
Victoria	31 (48.4)	26 (40.6)	7 (10.9)	

Other	22 (29.3)	22 (29.3)	31 (41.3)	
My healthcare needs are better met				
Queensland	46 (26.3)	59 (33.7)	70 (40)	<0.05#
New South Wales	32 (37.6)	30 (35.3)	23 (27.1)	
Victoria	25 (39.1)	22 (34.4)	17 (26.6)	
Other	14 (18.7)	28 (37.3)	33 (44)	
I have better access to necessary services for my healthcare needs				
Queensland	41 (23.4)	56 (32)	78 (44.6)	NS
New South Wales	31 (36.5)	27 (31.8)	27 (31.8)	
Victoria	20 (31.3)	24 (37.5)	20 (31.3)	
Other	13 (17.3)	25 (33.3)	37 (49.3)	
I receive better quality of healthcare overall				
Queensland	41 (23.4)	59 (33.7)	75 (42.9)	<0.05#
New South Wales	30 (35.3)	31 (36.5)	24 (28.2)	
Victoria	21 (32.8)	27 (42.2)	16 (25)	
Other	12 (16)	31 (41.3)	32 (42.7)	
I receive better targeted support based on my healthcare needs				
Queensland	49 (28)	52 (29.7)	74 (42.3)	<0.05#
New South Wales	29 (34.1)	30 (35.3)	26 (30.6)	
Victoria	25 (39.1)	27 (42.2)	12 (18.8)	
Other	15 (20)	28 (37.3)	32 (42.7)	
GPs : has your practice of quality healthcare for DVA clients changed?				
I make more referrals for my DVA clients to meet their healthcare needs				
Queensland	17 (44.7)	12 (31.6)	9 (23.7)	NS
New South Wales	33 (61.1)	15 (27.8)	6 (11.1)	
Victoria	18 (54.5)	11 (33.3)	4 (12.1)	
Other	14 (60.9)	7 (30.4)	2 (8.7)	
I contribute more to how my DVA clients healthcare needs are met				
Queensland	17 (44.7)	8 (21.1)	13 (34.2)	NS
New South Wales	33 (61.1)	16 (29.6)	5 (9.3)	
Victoria	14 (42.4)	13 (39.4)	6 (18.2)	
Other	11 (47.8)	7 (30.4)	5 (21.7)	
My DVA clients and I discuss and review their health care needs more often and in more detail				
Queensland	16 (42.1)	13 (34.2)	9 (23.7)	NS
New South Wales	38 (70.4)	11 (20.4)	5 (9.3)	
Victoria	18 (54.5)	9 (27.3)	6 (18.2)	
Other	12 (52.2)	6 (26.1)	5 (21.7)	
My DVA client's AHP and I discuss and review our client's healthcare needs more often and in more detail				
Queensland	18 (47.4)	11 (28.9)	9 (23.7)	NS
New South Wales	39 (72.2)	11 (20.4)	4 (7.4)	
Victoria	18 (54.5)	10 (30.3)	5 (15.2)	
Other	14 (60.9)	6 (26.1)	3 (13)	
My DVA clients healthcare needs are better met				
Queensland	15 (39.5)	12 (31.6)	11 (28.9)	NS
New South Wales	36 (66.7)	14 (25.9)	4 (7.4)	

Victoria	16 (48.5)	10 (30.3)	7 (21.2)	
Other	12 (52.2)	6 (26.1)	5 (21.7)	
My DVA clients have better access to necessary services to meet their healthcare needs				
Queensland	16 (42.1)	10 (26.3)	12 (31.6)	<0.05#
New South Wales	35 (64.8)	15 (27.8)	4 (7.4)	
Victoria	16 (48.5)	12 (36.4)	5 (15.2)	
Other	15 (65.2)	3 (13)	5 (21.7)	
My DVA clients receive better quality of healthcare overall				
Queensland	15 (39.5)	11 (28.9)	12 (31.6)	<0.05#
New South Wales	39 (72.2)	13 (24.1)	2 (3.7)	
Victoria	18 (54.5)	11 (33.3)	4 (12.1)	
Other	14 (60.9)	5 (21.7)	4 (17.4)	
My DVA clients receive better targeted support based on their healthcare needs				
Queensland	18 (47.4)	7 (18.4)	13 (34.2)	NS
New South Wales	36 (66.7)	13 (24.1)	5 (9.3)	
Victoria	18 (54.5)	10 (30.3)	5 (15.2)	
Other	14 (60.9)	4 (17.4)	5 (21.7)	
AHPs: has your practice of quality healthcare for DVA clients changed?				
I receive and accept more referrals for my DVA clients to meet their healthcare needs				
Queensland	25 (18.8)	53 (39.8)	55 (41.4)	NS
New South Wales	26 (24.3)	34 (31.8)	47 (43.9)	
Victoria	17 (19.3)	26 (29.5)	45 (51.1)	
Other	26 (23)	32 (28.3)	55 (48.7)	
I contribute more to how my DVA clients healthcare needs are met				
Queensland	23 (17.3)	51 (38.3)	59 (44.4)	NS
New South Wales	30 (28)	42 (39.3)	35 (32.7)	
Victoria	25 (28.4)	24 (27.3)	39 (44.3)	
Other	31 (27.4)	33 (29.2)	49 (43.4)	
I discuss and review my DVA client's healthcare needs with them more often and in more detail				
Queensland	34 (25.6)	50 (37.6)	49 (36.8)	NS
New South Wales	38 (35.5)	38 (35.5)	31 (29)	
Victoria	22 (25)	28 (31.8)	38 (43.2)	
Other	43 (38.1)	36 (31.9)	34 (30.1)	
I discuss and review my DVA client's ongoing healthcare needs with their GP more often and in more detail				
Queensland	40 (30.1)	32 (24.1)	61 (45.9)	NS
New South Wales	44 (41.1)	33 (30.8)	30 (28)	
Victoria	26 (29.5)	24 (27.3)	38 (43.2)	
Other	43 (38.1)	34 (30.1)	36 (31.9)	
My DVA client's healthcare needs are better met				
Queensland	19 (14.3)	41 (30.8)	73 (54.9)	<0.05#
New South Wales	34 (31.8)	28 (26.2)	45 (42.1)	
Victoria	16 (18.2)	28 (31.8)	44 (50)	
Other	30 (26.5)	30 (26.5)	53 (46.9)	

My DVA clients have better access to necessary services to meet their healthcare needs				
Queensland	17 (12.8)	37 (27.8)	79 (59.4)	NS
New South Wales	29 (27.1)	33 (30.8)	45 (42.1)	
Victoria	15 (17)	26 (29.5)	47 (53.4)	
Other	24 (21.2)	30 (26.5)	59 (52.2)	
My DVA clients receive better quality of healthcare overall				
Queensland	19 (14.3)	40 (30.1)	74 (55.6)	<0.05#
New South Wales	36 (33.6)	31 (29)	40 (37.4)	
Victoria	18 (20.5)	27 (30.7)	43 (48.9)	
Other	29 (25.7)	32 (28.3)	52 (46)	
My DVA clients receive better targeted support based on their healthcare needs				
Queensland	21 (15.8)	40 (30.1)	72 (54.1)	NS
New South Wales	35 (32.7)	32 (29.9)	40 (37.4)	
Victoria	20 (22.7)	30 (34.1)	38 (43.2)	
Other	27 (23.9)	35 (31)	51 (45.1)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Table 11: Professional opinion on the At Risk Client Framework by respondent category and gender

Question	**Agree** **N (%)**	**Neither agree nor disagree** **N (%)**	**Disagree** **N (%)**	**Sig**
GPs : Professional opinion on the At Risk Client Framework				
I have sufficient knowledge about the framework and tailored referral arrangements				
Male	58 (60.4)	25 (26)	13 (13.5)	NS
Female	26 (50)	11 (21.2)	15 (28.8)	
I understand the framework and tailored referral arrangements				
Male	61 (63.5)	23 (24)	12 (12.5)	NS
Female	25 (48.1)	16 (30.8)	11 (21.2)	
I have applied the framework for DVA clients with complex healthcare needs				
Male	62 (64.6)	21 (21.9)	13 (13.5)	NS
Female	32 (61.5)	7 (13.5)	13 (25)	
I am confident making tailored referral arrangements for DVA clients under the framework				
Male	63 (65.6)	20 (20.8)	13 (13.5)	NS
Female	30 (57.7)	12 (23.1)	10 (19.2)	
I am satisfied with the criteria of the framework for DVA clients with complex healthcare needs				
Male	58 (60.4)	24 (25)	14 (14.6)	NS
Female	34 (65.4)	10 (19.2)	8 (15.4)	
The framework appropriately meets the needs of DVA clients with complex healthcare needs				
Male	52 (54.2)	30 (31.3)	14 (14.6)	NS
Female	28 (53.8)	22 (42.3)	2 (3.8)	

The framework ensures that DVA clients with complex healthcare needs receive quality primary and coordinated care				
Male	55 (57.3)	30 (31.3)	11 (11.5)	NS
Female	34 (65.4)	12 (23.1)	6 (11.5)	
A very small percentage of DVA clients require tailored referral arrangements under the framework				
Male	56 (58.3)	33 (34.4)	7 (7.3)	<0.05#
Female	23 (44.2)	15 (28.8)	14 (26.9)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Table 12: Professional opinion on the At Risk Client Framework by respondent category and age

Question	**Agree** **N (%)**	**Neither agree nor disagree** **N (%)**	**Disagree** **N (%)**	**Sig**
GPs : Professional opinion on the At Risk Client Framework				
I have sufficient knowledge about the framework and tailored referral arrangements				
Equal or less than 50 years	67 (58.3)	27 (23.5)	21 (18.3)	NS
More than 50 years	17 (51.5)	9 (27.3)	7 (21.2)	
I understand the framework and tailored referral arrangements				
Equal or less than 50 years	68 (59.1)	31 (27)	16 (13.9)	NS
More than 50 years	18 (54.5)	8 (24.2)	7 (21.2)	
I have applied the framework for DVA clients with complex healthcare needs				
Equal or less than 50 years	74 (64.3)	22 (19.1)	19 (16.5)	NS
More than 50 years	20 (60.6)	6 (18.2)	7 (21.2)	
I am confident making tailored referral arrangements for DVA clients under the framework				
Equal or less than 50 years	75 (65.2)	23 (20)	17 (14.8)	NS
More than 50 years	18 (54.5)	9 (27.3)	6 (18.2)	
I am satisfied with the criteria of the framework for DVA clients with complex healthcare needs				
Equal or less than 50 years	76 (66.1)	24 (20.9)	15 (13)	NS
More than 50 years	16 (48.5)	10 (30.3)	7 (21.2)	
The framework appropriately meets the needs of DVA clients with complex healthcare needs				
Equal or less than 50 years	64 (55.7)	39 (33.9)	12 (10.4)	NS
More than 50 years	16 (48.5)	13 (39.4)	4 (12.1)	
The framework ensures that DVA clients with complex healthcare needs receive quality primary and coordinated care				
Equal or less than 50 years	74 (64.3)	28 (24.3)	13 (11.3)	NS
More than 50 years	15 (45.5)	14 (42.4)	4 (12.1)	
A very small percentage of DVA clients require tailored referral arrangements under the framework				
Equal or less than 50 years	66 (57.4)	34 (29.6)	15 (13)	<0.05#
More than 50 years	13 (39.4)	14 (42.4)	6 (18.2)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Table 13: Professional opinion on the At Risk Client Framework by respondent category and state

Question	Agree N (%)	Neither agree nor disagree N (%)	Disagree N (%)	Sig
GPs : Professional opinion on the At Risk Client Framework				
I have sufficient knowledge about the framework and tailored referral arrangements				
Queensland	21 (55.3)	8 (21.1)	9 (23.7)	<0.05#
New South Wales	37 (68.5)	9 (16.7)	8 (14.8)	
Victoria	17 (51.5)	13 (39.4)	3 (9.1)	
Other	9 (39.1)	6 (26.1)	8 (34.8)	
I understand the framework and tailored referral arrangements				
Queensland	22 (57.9)	10 (26.3)	6 (15.8)	NS
New South Wales	37 (68.5)	10 (18.5)	7 (13)	
Victoria	17 (51.5)	13 (39.4)	3 (9.1)	
Other	10 (43.5)	6 (26.1)	7 (30.4)	
I have applied the framework for DVA clients with complex healthcare needs				
Queensland	24 (63.2)	6 (15.8)	8 (21.1)	NS
New South Wales	38 (70.4)	9 (16.7)	7 (13)	
Victoria	18 (54.5)	11 (33.3)	4 (12.1)	
Other	14 (60.9)	2 (8.7)	7 (30.4)	
I am confident making tailored referral arrangements for DVA clients under the framework				
Queensland	25 (65.8)	7 (18.4)	6 (15.8)	NS
New South Wales	38 (70.4)	9 (16.7)	7 (13)	
Victoria	18 (54.5)	11 (33.3)	4 (12.1)	
Other	12 (52.2)	5 (21.7)	6 (26.1)	
I am satisfied with the criteria of the framework for DVA clients with complex healthcare needs				
Queensland	21 (55.3)	9 (23.7)	8 (21.1)	NS
New South Wales	37 (68.5)	10 (18.5)	7 (13)	
Victoria	19 (57.6)	10 (30.3)	4 (12.1)	
Other	15 (65.2)	5 (21.7)	3 (13)	
The framework appropriately meets the needs of DVA clients with complex healthcare needs				
Queensland	18 (47.4)	13 (34.2)	7 (18.4)	NS
New South Wales	35 (64.8)	15 (27.8)	4 (7.4)	
Victoria	13 (39.4)	17 (51.5)	3 (9.1)	
Other	14 (60.9)	7 (30.4)	2 (8.7)	
The framework ensures that DVA clients with complex healthcare needs receive quality primary and coordinated care				
Queensland	20 (52.6)	11 (28.9)	7 (18.4)	NS
New South Wales	39 (72.2)	9 (16.7)	6 (11.1)	
Victoria	16 (48.5)	15 (45.5)	2 (6.1)	
Other	14 (60.9)	7 (30.4)	2 (8.7)	
A very small percentage of DVA clients require tailored referral arrangements under the framework				
Queensland	18 (47.4)	12 (31.6)	8 (21.1)	NS
New South Wales	32 (59.3)	14 (25.9)	8 (14.8)	

Victoria	17 (51.5)	12 (36.4)	4 (12.1)	
Other	12 (52.2)	10 (43.5)	1 (4.3)	

NS – Not significant (p>0.05), # - Significant at 0.05 level (p<0.05)

Appendix 3: Interview Questions

Semi-structured interview questions: 'DVA Treatment Cycle Evaluation interviews, 2021'

DVA CLIENTS QUESTIONS

Demographics and Confirmatory Questions

1. Are you a DVA client?
2. Please state your age.
3. Please indicate your gender.
4. Please specify your state of residency.
5. Have you accessed the allied health treatment cycle arrangements?
6. When did you first transition to the arrangements?
7. What allied health services have you used?
8. Have you completed the online survey?

COVID-19

1. Please tell me if and how you were impacted by COVID-19, including your ability to access your usual GP and allied health services.

Available Information and Implementation

1. What do you think of the quality of available information about the treatment cycle arrangements?
2. How well you think the arrangements have been implemented?

Engagement and Service Use: Impacts and Outcomes

1. Please tell me about your allied health service use history (e.g. how long have you been using services and what types of services)
2. Please tell me if and how transitioning to the treatment cycle arrangements has impacted your services
3. Please tell me how you have engaged with the arrangements
4. Please tell me about what, if any, outcomes you have achieved through the arrangements

Transitioning: Quality of Healthcare

1. Please tell me about your initial opinion of the treatment cycle arrangements
2. Please tell me if and how transitioning to the treatment cycle arrangements has impacted the quality of healthcare you receive

3. Please tell me if and how transitioning to the treatment cycle arrangements has impacted the way and amount you interact with your GP
4. Please tell me if and how transitioning to the treatment cycle arrangements has impacted the way and amount you interact with your AHP
5. Please tell me if and how transitioning to the treatment cycle arrangements has impacted your healthcare goals and outcomes

Care Coordination: Clinical Notes and Clinical Communication

1. Who coordinates your healthcare?
2. Please tell me if and how the treatment cycle arrangements has impacted the coordination of your healthcare
3. Please tell me if and how transitioning to the treatment cycle arrangements has impacted the way and amount you, your GP and your AHP interact
4. Please tell me if and how transitioning to the treatment cycle arrangements has impacted the way and amount your GP and your AHP interact
5. Please tell me about any reports or Patient Care Plans you have read or developed with your GP and AHP

Other experiences

1. Please tell me about your overall opinion of the allied health treatment cycle arrangements
2. If you have any other comments, opinions or experiences that have we have not already covered please feel to share those now (is there anything else you would like to add?)

GP QUESTIONS

Demographics and Confirmatory Questions:

1. Are you a GP?
2. Please state your age
3. Please indicate your gender
4. Please specify your state of practice
5. Have you implemented the allied health treatment cycle arrangements?
6. When did you first implement the arrangements?
7. Have you made referrals for DVA clients under the arrangements?
8. Have you completed the online survey?

COVID-19

1. Please tell me if and how you were impacted by COVID-19, including your ability to consult your DVA clients and review their healthcare needs

Available Information and Implementation

2. Please tell me what you think of the quality of available information about the treatment cycle arrangements
3. Please tell me how well you think the arrangements have been implemented

Engagement and Service Provision: Impacts and Outcomes

1. Please tell me about your health service provision history (e.g. how long have you been practicing, what types of services and how many DVA clients you have provided services to)
2. Please tell me if and how implementing the treatment cycle arrangements has impacted your service provision (including administrative and financial impacts)
3. Please tell me how you have engaged with the arrangements
4. Please tell me about any outcomes you have achieved through the arrangements

Implementing: Quality of Healthcare

1. Please tell me about your initial opinion of the treatment cycle arrangements
2. Please tell me if and how implementing the treatment cycle arrangements has impacted the quality of healthcare your DVA clients receive
3. Please tell me if and how implementing the treatment cycle arrangements has impacted the way and amount you interact with your DVA clients
4. Please tell me if and how implementing the treatment cycle arrangements has impacted your DVA clients' healthcare goals and outcomes

Care Coordination: Clinical Notes and Clinical Communication

1. Who coordinates your DVA clients' healthcare?
2. Please tell me if and how the treatment cycle arrangements has impacted the coordination of your DVA clients' healthcare
3. Please tell me if and how implementing the treatment cycle arrangements has impacted the way and amount you, your DVA clients and their AHP interact
4. Please tell me if and how implementing the treatment cycle arrangements has impacted the way and amount you and DVA clients' AHP interact

5. Please tell me about any reports or Patient Care Plans you have read or developed with your DVA client and their AHP

At-Risk Client Framework

1. Are you familiar with the At-Risk Client Framework?
2. Please tell me about your opinion on the At-Risk Client Framework (including efficacy and applicability for clients with complex healthcare needs)

Other experiences

1. Please tell me about your overall opinion of the allied health treatment cycle arrangements
2. If you have any other comments, opinions or experiences that have we have not already covered please feel to share those now (is there anything else you would like to add?)

AHP QUESTIONS

Demographics and Confirmatory Questions

1. Are you an AHP?
2. Please state your age
3. Please indicate your gender
4. Please specify your state of practice
5. Have you implemented the allied health treatment cycle arrangements?
6. When did you first implement the arrangements?
7. Have you provided allied health services for DVA clients under the arrangements?
8. Have you completed the online survey?

COVID-19

1. Please tell me if and how you were impacted by COVID-19, including your ability to provide allied health services to your DVA clients.

Available Information and Implementation

1. Please tell me what you think of the quality of available information about the treatment cycle arrangements.
2. Please tell me how well you think the arrangements have been implemented.

Engagement and Service Provision: Impacts and Outcomes

1. Please tell me about your health service provision history (e.g. how long have you been practicing, what types of services and how many DVA clients you have provided services to)
2. Please tell me if and how implementing the treatment cycle arrangements has impacted your service provision (including administrative and financial impacts)
3. Please tell me how you have engaged with the arrangements
4. Please tell me about any outcomes you have achieved through the arrangements

Implementing: Quality of Healthcare

1. Please tell me about your initial opinion of the treatment cycle arrangements
2. Please tell me if and how implementing the treatment cycle arrangements has impacted the quality of healthcare your DVA clients receive
3. Please tell me if and how implementing the treatment cycle arrangements has impacted the way and amount you interact with your DVA clients
4. Please tell me if and how implementing the treatment cycle arrangements has impacted your DVA clients' healthcare goals and outcomes

Care Coordination: Clinical Notes and Clinical Communication

1. Who coordinates your DVA clients' healthcare?
2. Please tell me if and how the treatment cycle arrangements has impacted the coordination of your DVA clients' healthcare
3. Please tell me if and how implementing the treatment cycle arrangements has impacted the way and amount you, your DVA clients and their GP interact
4. Please tell me if and how implementing the treatment cycle arrangements has impacted the way and amount you and DVA clients' GP interact
5. Please tell me about any reports or Patient Care Plans you have developed with your DVA client and/or their GP

Other experiences

1. Please tell me about your overall opinion of the allied health treatment cycle arrangements
2. If you have any other comments, opinions or experiences that have we have not already covered please feel to share those now (is there anything else you would like to add?)

Appendix 4: Interview Results

INFORMATION AVAILABILITY AND QUALITY/CLARITY

Communication of TC changes:

DVA Clients:

- Generally negative feedback regarding the availability of information about the TC changes, as well as the timeliness of the communication
- Information was reported to be hard to find or required more investigation by the client. There were multiple reports of clients finding the information from alternate sources, rather than directly from the DVA (issues with availability)

"To me, there wasn't enough given as to the total aims and so forth of the program - of change in the program." (DVA client, 71, NSW)

"It's like most things that I've experienced with the branches of government. The information is there but you have to find it yourself. They don't send you a link on - this will take you to the page you need. It's, just look on the website, it'll be there. Where? You spend an hour digging." (DVA client, 30, QLD)

"I was told about it by the providers. I was told I had to go get fresh referrals for physio and exercise physiology and I queried why and they said that's just the new system now. So I don't think it was communicated at all that well." (DVA client, 44, NT)

"I think I got it - DVA didn't identify me and tell me. What happened was we found out through the allied health professional that they're changing to this 12 cycle arrangement, rather than the 12 months that we'd been used to." (DVA client, 75, QLD)

"Yes it took me a little by surprise, as it did the podiatrist. It sort of seemed to creep up on people and we really didn't have a good understanding of it at the time and in a way I suppose the DVA were a little bit slow in getting that information out but once it came out, yes indeed, we did understand it and there was really no problem… When it arrived, I understood it and I was satisfied with it." (DVA client, 78, WA)

"Yes, I did. I received quite a few emails and publications - paperwork just relating to what we could still do, how it was going to be approached if we still needed it all. So, yep, I got it both through the mail and emails." (DVA client, 74, VIC)

- Feedback about the quality of information about the TC changes: some contradictory feedback, but overall, the quality of the information was accepted as good/adequate, albeit the changes themselves were reported as confusing, or lacking a logic that could be understood by interview participants.

Positive feedback (quality)	Negative feedback (quality)
"The information provided was adequate. I can't really say any more than that. I was happy with the information. I was not happy with the fact that it was happening." (DVA client, 84, ACT)	*"The information given - I don't think the aims of it were stated categorically. I think they were just alluded to… I really don't think they advertised it enough as to what they were going to do and how they were going to achieve what the results might be, what sort of contribution they needed from the actual members themselves, the DVA clients. That wasn't fully stated, in my mind." (DVA client, 71, NSW)*
"To be honest I love it, I think it's good, because I've gone and read it and I'm teaching myself to be a better informed person… So, and I edit a little newsletter which I put around for local ex-servicemen and I often put in there little bits about the health services that are available through DVA. I don't get any response, but it doesn't matter, I put it in there anyway. *Facilitator: So you thought the information, was it easy to understand?* *Interviewee: Yes, yeah." (DVA client, 74, QLD)*	*"I don't know. Anything like that, you've got to aim it at the lowest common denominator. Same as if you're teaching; you've got to teach to the slowest learner in the class. Now, as I said, vets are quite a range from wherever, across the spectrum, so it probably could have been a bit more basic in explaining the reasons behind it. I'm still not really sure of the actual logic behind it. They're introducing it and this is what you have to do, and we all said, oh well, bugger me, and that was it." (DVA client, 70, QLD)*
"When it arrived, I understood it and I was satisfied with it. I thought it was fairly standard government sort of writing and it explained things. Maybe that's not the way people would do it in private industry, but I understood that	

that's how you would do it in a big organisation where you're looking at issues of governance. So yeah." (DVA client, 78, WA)	*"I think we got an email from them saying that they were looking at changing it. I didn't really understand what it all meant… I don't know that so much it was confusing, but I didn't really think at the time that it was going to impact me. I didn't really think of it along those lines. I do remember them saying - sending us, I think it was an email, or a letter it might have been, I don't remember now, that they were changing or were going to change the system of referrals." (DVA client, 73, WA)*
I was fully informed, so there's no question that I knew what was involved. I may not have agreed with it, but I had to comply with it because, for me to continue with the program, I had to abide by it, yes… The quality was good. The relevance was there. I have no qualms that I was well informed." DVA client, 74, SA)	
"Yes, it was both helpful and informative so that I had - I could really know where I stood. As I said, I was suffering a little bit psychologically, and that was a big help." (DVA client, 74, VIC)	*"I found it very confusing and very much drawn out. I think it could have been condensed and a lot easier to understand. When I went to - I spoke to the doctor about it and she said all it's going to do is make more work for them and the reports." (DVA client, 74, QLD)*
"Well the quality was all right. We were all shocked at the information, but there was – I guess there was a level of confusion initially because nobody really knew why this was being introduced when we had a system that for me and my husband, it was working." (DVA client, 63, SA)	*"I'm not sure how DVA communicates with people at all. In fact, I'm more confused about the system than ever. The problem is, even the person who's acting as my case manager has trouble getting answers out of DVA because each time you start getting an answer or somebody takes an interest in it, then they rotate chairs. Then you start getting different answers. So, you can't even rely on the information that you've been given because it could change*
"It was fine. I understood what they were saying, unfortunately [laughs]... I have no issues with any of the information that they give, they're very thorough about everything." (DVA client, 73, QLD)	

	every time you talk to someone." (DVA client, 47, QLD)

- Communication of the TC was often disseminated through veteran-to-veteran communication, or veteran advocate/support groups.
- TC impacted on veteran-to-veteran communication, through limiting social contact maintained through exercise groups with physios or EPs

"I had to go looking, actually, and we talked about it over coffees, because we have a group of vets who get together every Saturday morning, and we talked about it over coffee" (DVA client, 71, NSW)

"So, as soon as I found out, I sent it to a couple of my veteran mates who are in Darwin - because we don't have a centre that we can go to, we don't use the same GP; sent it to them so that they were able to get on to it." (DVA client, 57, NT)

- DVA clients expressed frustration at the perceived lack of consultation from the DVA about the TC changes

"It was a little frustrating, especially not having a say - you're going to do this, this is how you're going to do it. It was like, ah, okay now, I see how it is." (DVA client, 30, QLD)

"At the time I was extremely annoyed with it, because at no stage had we as clients been contacted to ask our views or anything like that. When I read the report, they said we'd been to service organisations, et cetera, like that, but at no stage, even though I was a member of the RSL and still am a member of the RSL, was I contacted by the RSL or any other service organisation regarding this change to the treatment cycles, et cetera, like that going through… But if you want to start doing anything with us, ask us how you can assist or something like that, for God's sake, just ask. Just talk to us. That's all you've got to do." (DVA client, 70, QLD)

"So they didn't really - DVA didn't really consult in terms of what do you think of this? It was more, this is what we're doing, what's your feedback? And nothing changed. So there was no real - there wasn't a consultation process unless it happened at the national level, which I wasn't on at that point and it may have done. But I suspect even if it was, there wasn't a lot of listening going on." (AHP OT, QLD)

- Some DVA clients reported that their health provider did not know about the changes:

"The information was lacking on the GP aspect and from my hydrotherapy provider. They did not know about it at all whatsoever." (DVA client, 78, NSW)

"It was very confusing for the GPs. Then when I kept showing them the little flyer that came from DVA - because as a TPI, I was one of the first ones that received the flyer from DVA, because there were exemptions for TPIs, so that was important that they assimilated that information." (DVA client, 56, QLD)

"Not well. Not at all well. It was - from the beginning it was indefinite - it wasn't clear as to exactly what dates it was going to start and the service providers really weren't sure about what they had to do and what was involved. My GP, he knew nothing about it. Even when I went back for my first - to get the first referral from - or the second referral to go back, he said why?" (DVA client, 78, QLD)

"My advocate said to me, I think you're going to be in a world of hurt, [with] this is coming in. So, he got on to the website and showed me. I got him to print it and I gave it to my physio, who hadn't seen it; I gave it to my GP, who hadn't seen it; I gave it to my clinical psychologist and my psychiatrist, who hadn't seen it." (DVA client, 57, NT)

TC changes are confusing, frustrating:

- Multiple reports of the TC changes being "confusing", frustrating or clients not understanding the reasons behind the changes.

"There was confusion about that. There was confusion at the GP clinic in the beginning about what was happening, and a lot of the times I was telling them about what they should be doing rather than them knowing. It was just - it was a bit of a shambles." (DVA client, 70, QLD)

"I think there was confusion… in both the medical profession and in the providers, in that - why are we doing this and what does it all mean? … I think there was an element of confusion and an element of - there wasn't resistance because they had to do it, but they couldn't understand the true meaning of why it was being done" (DVA client, 74, SA)

"The 12 weeks seems to be a bit confusing" (DVA client, 72, QLD)

"No, it wasn't good. Because it didn't - it wasn't explained very well. It was difficult for me to understand what exactly we had to do." (DVA client, 78, QLD)

Perceived as a "cost saving measure" for the DVA

- DVA clients and AHPs spoke of the TC changes as a "cost-saving" measure, often referring to this as their "understanding" or "belief" of the true reason for the change. No reference was made to DVA communications about this, but rather an assumption that was circulated within the DVA client and healthcare community.

"I think it was okay, we got enough information to explain why it was being done. I didn't - I necessarily - I was a little bit cynical in that I thought it was actually to save money rather than to improve the quality of conversation between you and your health providers, your various health providers." (DVA client, 74, QLD)

"I think my understanding or my belief is that it's a cost driven thing… I don't see - if DVA is looking to cut back on the, you know, people using services for too long without review, then why not put a time base on it rather than a number of visits? Unless it is just all about cost. That's my question." (DVA client, 44, NT)

"As I understand it, the whole thing was to cut down costs. If you go three times a week, your 12 services are used in a month, which means you then have to go to your doctor to get [a referral]." (DVA client, 78, NSW)

"Look, my summary of it is that it may have had some impact on the number of sessions that bill - providers are billing and therefore saving DVA some money, which his obviously the real reason… I know they're trying to save money, that's fine, but I think what they really need to do is look at the professions who are the ones spending most of the money and target them and leave the rest of us alone [laughs]. That would be my take on it." (AHP OT 45 QLD)

"I must admit, my impression - which was your question, I think - was that I wasn't very happy about it. I felt that it was really about saving some money under the guise of, oh, let's make it much better for the patients... I know they said it was all about patient outcomes, but I suspect it was not. I suspect it was about money and keeping an eye on what was going on" (AHP Osteo, VIC)

"I don't know what their idea was, I have no idea. Save money I suppose but I think eventually, in the long run, as the doctor said, it was costing them more money if half

of us – well, most of us of the war widows were fronting up every six weeks to get a new referral." (DVA client, 76, QLD)

Impressions of TC changes in response to 'rorting' the system:

- In addition to the belief that the TC changes were a cost-saving measure, a common theme across interviewees was the TC changes being in response to individuals (whether DVA clients or AHPs) taking advantage of the previous system. Respondents described offense at being "whack[ed] with the same big sledgehammer", referring to being punished for the poor behaviours of others under the previous referral system/arrangements.

"DVA patients - I've never experienced any sense from those patients that they are either being over-serviced or wanting to be seen when they don't need to be... But it doesn't feel, to me, like a system that people are likely to be wholesale rorting or not doing the right thing for their patients. It's quite a privilege to see these patients and I think there's that." (AHP Osteo, VIC)

"If there was a problem, address it with the people who were rorting it, not with the - …We just don't need that as a once-off or a 12-week cycle; we need it for the rest of our lives. So this, I think they just didn't think it through. That's just my opinion. I think they targeted the wrong people. The only people making money out of it, instead of the exercise physiologists, are the GPs." (DVA client, 76, QLD)

"It's extremely time-consuming, and I think it's - I can see the benefit of it, because obviously some people probably milk the system and sort of have no review of it" (DVA client, 34, QLD)

"I think ultimately this document reeked of, we don't trust you to do what you've been doing for the last 30 years as a professional. If they don't trust the new graduates that are coming out deal with that process. But don't whack all of us with the same big sledgehammer… I can't imagine too many OTs abusing it. If they were, those OTs needed to be audited and educated. You don't just punish a whole population of occupational therapists because you've got a handful doing the wrong thing." (AHP OT 53 QLD)

"I think a lot of people are overdoing it [AHP services] and just keeping going and going and going… So I fully agree with reducing it down and doing it on the five and

then the GP can ascertain whether it's required again. So I like the idea of it being reduced down to the current one." (DVA client, 74, VIC)

"I guess my understanding of why they've done it is because there were unscrupulous allied health out there, which I absolutely acknowledge, because I have actually reported some allied health companies for doing unscrupulous things." (GP, 39, QLD)

"This is where in one sense, having the 12 treatment cycle will vet some of those people that are what I call rorting and playing the system, because they want free gym membership." (DVA client, 56, QLD)

AHPs:

- AHP reports of the quality of TC information being difficult to read, hard to stay current with, and too long for their current admin capabilities.
- Some AHPs described the communication of the TC changes as being adequate, but that it was difficult for them to communicate the changes to their DVA clients.
- There were some complaints from AHPs that the communication of claiming procedures were inadequate and resulted in non-payment for consults or treatment with DVA clients.

"Because it was slow, it was clunky… it's written in legalese and it reads like a contract." (AHP Osteo, VIC)

"The legal term is plain language, I think, and I don't think DVA write like that. So there's all of these 1.2 and 2.2a and all of this sort of stuff and then you've forgotten what the acronyms are and you can't - I'm not silly and I've done this for a long time. It's really dull and it's really dry and it's actually really hard to retain. I know it's important and I know they're all about making sure that we understand what our requirements are and all of that." (AHP Osteo, VIC)

"But I don't think they make that easy, is the short answer to your question. I think it's difficult to read and I don't think it's presented as clearly and plainly as it could be… It's not straight forward, so I think that could be better." (AHP Osteo, VIC)

"it was a bit confusing. We called a few different times and got different answers. We'd been told that referrals before October 1 would be valid for the previous 12 months. As we got closer, we found out that was not true, so all our clients had just

gone and got a new referral and it was just - I don't know. I think we got a little bit of different information or mixed information, especially around the July plan date." (AHP EP, 48, QLD)

"So when the information finally came the information was in a really useful format. The little booklet is fantastic. It's only small. I read it on a train or a plane, I can't remember where. But the information was useful." (AHP OT, 53, QLD)

"I can't quite remember what form that was in, whether it was directly from DVA or whether it was via the OT association. I can't remember, but I do remember getting a handout that had the little cycle diagram with the 12 things. I remember seeing that, and it was fairly easy for me to understand that, because we were already working with care plans, Medicare care plans, so knowing there'd be a limit - we understood that. That was fine." (AHP OT, NSW)

"Yeah, so it was a little bit confusing a little bit to get our head around. I felt we still understood it, it wasn't like it was not understandable, but I did feel we got information, the clients didn't. It was very difficult to change the system with the clients, that's probably what we found the hardest." (AHP EP, NSW)

"It was okay. It was still very confusing. No one told us about - yeah, it wasn't thorough. We were 12 months into it before we were told - and this is not from DVA, this is on a forum, that we had to charge - had to have a different code for the first consult to the remaining 11 and that we could actually get a report at the end of the 12. No one told us that." (AHP Osteo, NSW)

"I think what the information provided did a few things which were of benefit. One is it standardised things, so DVA have always asked a dietitian to put a care plan together for a patient and they listed in that what should be in a care plan. That's on the DVA website. But my guess is it wouldn't have been standardised across the country, so I think the template for the care plan is useful because it standardises things." (AHP Dietician, NSW)

"We had to do some sort of scaling or rating or something, I can't remember what they called it, for the treatment, and they didn't provide us with that at all. There was no pro forma as to this is the sort of thing we mean, so I had to ask around and the Podiatry - I think the Podiatry Association then put out something. Everyone was just sort of fossicking around, saying what sort of scale - what are we doing? What does this mean?" (AHP Pod, VIC)

"It's difficult to judge [the quality of information]. There was a fairly large booklet that came through, it was like a 10-page booklet, something like that. There were things missing in that because even when I went back to look at it, I couldn't quite work out where it was saying we needed to claim the initial consultation to be able to trigger the payment at the end. So, it actually took us that 12-month cycle to realise, actually it was by August the following year that we realised we hadn't claimed all the initial consults." (AHP Pod, QLD)

- The availability of TC communications from the DVA: most AHPs reported receiving information through professional associations, rather than directly from the DVA
- AHPs generally reported that the communication regarding the TC was poor, with only one AHP interviewee describing the information as "useful". AHPs generally described the communication of TC changes as poor, and as a result they did not feel prepared for implementation of the arrangements.

"I think that the information was there about it. Well, I certainly had access to it. So, I found that quite useful." (AHP OT, 48, QLD)

"Yes, but that was very poorly managed because the implementation date was set. No information came. No information came. We were faced with - those of us who had staff - you can't just be told one day and two weeks later implement it. There's a lead-up to that. Things need to be - processes and systems need to be developed. So we found ourselves chasing DVA. That is extremely problematic because there is no one in DVA responsible for occupational therapy administrative issues. So it astounds me that in an organisation that large there is no one there whose job is to advocate for occupational therapists." (AHP OT, 53, QLD)

"There's no newsletters come out anymore. It's very, very poor communication." (AHP OT, 53, QLD)

"So I think it's very hard for people to understand how bad it is communicating with DVA because I have not met another system that underdeveloped in this current era, especially an Australian government one… There is no system to communicate about changes in the direct processes and equipment and things relative to OTs, just nothing at all." (AHP OT, 53, QLD)

"I received information from ESSA, our governing body and that was before when it was supposed to be implemented on 1 July, before it was delayed. So we actually

prepped all our clients before them and then – but I didn't receive anything from DVA until more close to the October date." (AHP EP, NSW)

"I read everything that I thought I needed to read and then I didn't read anything about an OM10 versus an OM11, which meant that then we missed out on our treatment - we missed out on hundreds of dollars of payments for reports. Because it - there's just - it's so verbose. There's so much information and then you've got to go looking for it." (AHP Osteo, NSW)

"Minimal [information]. I think I had to go and look it up. There was some sort of inkling that they were changing the thing, yeah. It's a long time ago now." (AHP Pod, VIC)

"I mean, Veterans' Affairs are notoriously not communicative about anything. You have to do all the research yourself. They don't even send you information to say, please note, the fees have gone up... They don't send you - they don't communicate with you as a provider much at all." (AHP Pod, VIC)

"did we hear from Department of Veteran Affairs? We don't think so, we have not ever received notifications from them on anything really for many years. A long time ago, you might be able to work out I've been doing it for a while, we did use to receive things in paper form, sometime back when there were changes but not with this. It was I think 100 per cent through our association we got information." (AHP Pod, QLD)

GPs:

- One GP interviewee noted that they did not know of the TC until completing the survey for this report.
- Recommendation for DVA to communicate with GPs through face-to-face methods.
- Similarly to DVA clients, one GP reported that the quality of the information was "okay", but not clear in communicating the reasons behind the changes, and would have preferred consultation.
- Communication through professional associations most common

"Interviewee: I can't recall seeing any information about the treatment cycle, so hard to comment on quality.

Facilitator: Yeah. So how did you find out about it?

Interviewee: When I got the survey" (GP, 48, SA)

"I think we did, probably from the AMA. I'm not sure with the college, or other - possibly the Primary Health Network. But I remember the AMA one coming out… I thought that was sufficient, it was okay, good quality." (GP, 63, VIC)

"The first I heard about it was through advocates and patients who told me it was coming. Then I didn't really receive anything until the 11th hour in the sense of it was only either weeks or a month prior to the cycle starting or the requirement starting that I actually heard from DVA and then heard from RACGP" (GP, 39, QLD)

"I think the quality was okay, it's a pretty simple explanation. I guess probably for my mind I would have preferred more background as to why they made the changes. Certainly I would have preferred a period of consultation time, like what you're doing now, prior to it being put in to ask key stakeholders what they thought of that. As usual, most of the time when they do things like that, they would have said we did consult with all the key bodies." (GP, 39, QLD)

Communication between GPs and AHPs:

- Belief from AHPs that the information that they are writing in the End of Cycle reports will not be read by GPs.
- This was confirmed by GPs who said that there were too many reports from DVA clients for them to read them all.

"We have to send reports to the doctors which are not really showing any major need to communicate so I feel like you're - overcommunicating with the GPs. So, I'm concerned that when I do need to send them emails, they're not going to really pay attention because I'm sending them emails regularly regarding DVAs with no significant information to report." (AHP Osteo, NSW)

"But the other problem about that is that because I have so many DVA clients, I get so many allied health reports, that it's difficult to spend a lot of time in each one, reading them all through and dissecting everything that they say." (GP, QLD)

"I personally can't just send an end-of-cycle report, I've got to send a cover letter that goes with that to say attached you'll find the end-of-cycle report, here is the key findings from it. Because I can tell you, if you give a doctor that documentation it's unlikely the doctor will read it, it's too much information." (AHP Dietician, NSW)

"The care co-ordination and communication is now far worse because we are now heavily reliant on GP clinics to have their administrative act together in getting referrals out. That is an ongoing struggle." (AHP OT QLD)

"The thing we struggled the most with this is actually the difference with what GPs are told to what we're told and then what the client gets told. Unfortunately they don't align all the time. So that's kind of what we're struggling with still even now." (AHP EP, NSW)

- Some AHPs described their frustration and difficulties when trying to communicate with GPs, and reported that they feel that they are not listened to by GPs.

"I make it very clear - further OT intervention is needed. Please send a new OT referral - with big stars. I often circle it. No referral comes. What does that tell me? They don't read them. So I then have to chase up a new referral anyway through phone calls or emails." (AHP OT, QLD)

"We just chase harder if we need another referral. We just keep chasing. The assistant sometimes will call twice a day the GP for weeks, and then finally they get the cranks enough that they will send it through" (AHP OT, NSW)

COVID-19 IMPACTS

Impact of COVID:

DVA Clients:

- Clients reported general disruption of access to healthcare services, with more severe impacts reported from clients in Victoria. Most clients reported minimal impact to their healthcare services overall, but many clients reported cancellation of AHP services.
- Multiple clients reported difficulty in accessing appointments to receive healthcare from GPs, or to receive referrals for the TC.
- Some clients reported reluctance to attend appointments with AHPs or GPS due to concern for their own health, or the health of others.
- Positive reports from clients, AHPs and GPs about the availability of Telehealth as an alternative treatment option

"It's hard to say, because I think COVID interrupted everything, and things changed. For instance, if we want to get a visit to the GP, we've got to book at least a month to

six weeks in advance at the moment. Yeah. So we virtually go in today, we'll book for six weeks in time sort of thing, not knowing what's going to be happening at that stage and so forth." (DVA client, 71, NSW)

"It was a bit more of a drag having to go through all the extra hoops, but the physio that I was seeing had a lot of elderly clients, so it was a bit of - I didn't want to bring something in by chance, so it was definitely, I should hold off a little bit more." (DVA client, 30, QLD)

"I think there was one stage last year when the physiotherapist was closed. The clinic was closed. I couldn't access that service through Telehealth. But DVA wouldn't cover that through the physio at the time. I went for I think probably two months without any physiotherapy… It just meant that I had to be a bit more careful and manage the pain myself." (DVA client, 78, QLD)

"getting to access the GP was very difficult, because he was very busy and screening people. In fact, for a little while it was Zoom only and then it was screening people and because I'm complex, he kept saying, I'd prefer you don't come in" (DVA client, 57, NT)

AHPs:

- AHP in Victoria noted that the communication of the TC was complicated and overshadowed by the ongoing Covid-19 response for AHPs.

"Yes, there was a period of time where we were only allowed to see emergency clients and so D04 clients, almost by definition, would probably not fit into that. They're more chronic conditions, so I didn't see anybody through that middle of the year… people tended to stay home even if they were able to come for treatment. Because we were open. We didn't see many of the older population, families tended to make them stay home or they stayed home. So we're rebuilding this year, I guess." (AHP Osteo, Vic)

"We were working, not knowing if we had to shut down. People were cancelling right, left and centre. There were financial issues, there was negotiation with landlords, it was horrendous. So DVA really wasn't top of mind, to be honest… Yeah, so it impacted us a lot and that's made that flow of information - probably it just got sucked up in a whole lot of other stuff as well." (AHP Osteo, Vic)

"Once we clarified that OT were deemed essential services - it took a while. That's understandable. There was a lot happening. But it took a while to determine whether or not we were considered essential services and therefore allowed to visit people. So yes, definitely impacted." (AHP OT, 53, QLD)

GPs:

"I guess it makes it more difficult to do face-to-face consultations. That's probably the primary thing. Patients, in general, including DVA patients, are less likely to have preventative health care done, especially during the periods where they've had high anxiety about community spread." (GP, 48, SA)

"Well, we certainly used Telehealth a lot more. People were reluctant to come in. So, people would come late for their presentations for things like skin lesions, or procedures, or some of their chronic disease management. Some of the others I probably did more home visits, some of the more frail ones who are more homebound… Yeah, quite a few changes." (GP, 63, VIC)

CLINICAL NOTES (REPORTS and PATIENT CARE PLANS)

Patient Care Plans and Reports:

AHPs:

- Connected strongly to the themes of GP and AHP communication, as well as the increased burden of administration.
- Mixed responses to the end of cycle report from AHPs – some found it a positive change, while others found them too restrictive, not communicating valuable information, or repeating information that was already being communicated.

"We were doing the reports anyway. In fact, we were doing better reports than their template. Their template's terrible. Oh, it's appalling. Whoever wrote that is clearly never worked in health… So the end of cycle report template means that our reports are worse. We don't have the scope to write what we'd normally write. The - they ask for outcome measures which we would have included in our report anyway but because it's such a focus of their form, we have to have them in there, which is fine but the GPs don't read it." (AHP OT 45, QLD)

"I do write a better report now with just a little bit more information So, before I would've written just what I'd done. Whereas, now, I do write the client's got - it was always about what they needed, but now - it probably is written back a little bit better. Whether they read it or not I don't know." (AHP OT 48, QLD)

"The whole thing is really arduous and now you have to write ridiculous reports every 12 sessions which they've really not got significant enough change for you to be reporting back that often… basically it means that we waste valuable treatment time filling out outcome measures. We have to send reports to the doctors which are not really showing any major need to communicate so I feel like you're - overcommunicating with the GPs. So I'm concerned that when I do need to send them emails, they're not going to really pay attention because I'm sending them emails regularly regarding DVAs with no significant information to report." (AHP Osteo, NSW)

"I think the end of cycle report does encourage people to say, well, where are we? Where are we going? What do you want to keep achieving? So I think there's benefit in the documentation and from what I understand, and I would hope this wasn't in my practice but certainly from what I understand, the purpose was people were seeing DVA clients for long periods of time and not communicating with the doctor." (AHP Dietician, 55, NSW)

Increased Burden of Administration:

DVA Clients:

- DVA clients report needing to spend time and effort recording GP and AHP visits to keep track of the treatment cycle, with many describing diaries, spreadsheets, or notebooks to ensure that they have referrals for their healthcare requirements.
- Indicates a certain level of client coordinated care (DVA clients coordinating their own healthcare)

"unless I write down in my diary what number treatment I'm having, and I write it in a diary about three weeks before I need a new one, then sometimes you can't even get in to see any doctor just to get them to write a referral." (DVA client, 56, QLD)

"It means I've got to do more work, I've got to keep more records, I keep a spreadsheet of what I'm doing… I keep a diary, I use the computer for that, I keep spreadsheets, I record all my treatment and so does the doctor now" (DVA client, 74, QLD)

"It just means that I have to be a bit more careful about and keep track of how many times I'm going to the physio and how many services I've used in a particular space of time" (DVA client, 78, QLD)

"Every - you've actually got to not only log how many times you've seen the physio, you have to log which injury you've seen them for and it's just turned into a nightmare… I'm sitting with my GP with a notebook going, let's just count - let's just list all of my providers, my medical people; we'll send them a referral and I'll tick as I go to see them" (DVA client, 57, NT)

"I put marks on my calendar, count the days down, and then a week beforehand I make an appointment, because you just can't ring up and say, I want to see the doctor today, or even tomorrow." (DVA client, 73, QLD)

"But then I've also got this admin side of it that I've got to manage. So I'm always sort of trying to, yeah, balance everything. If I only had one or two it'd be okay, but yeah, I've got sort of five/six providers that I'm always sort of doing all my own paperwork for and chasing up" (DVA client, 34, QLD)

AHPs:

- Increased admin load reported by AHPs, particularly in relation to the implementation timeline in October, 2019. AHP interviewees reported having to employ further support roles to address the increased administrative load.
- Burden of administration is often tied in to the financial renumeration from DVA, that it is not enough to cover the cost of increased administration for AHPs treating DVA clients.

"In October 2020, all 600 [patients] rolled over and we had to scramble to try and get all those referrals updated by that date. So enormous, enormous, enormous admin load.

The thing is that we are big enough to have some admin support. For a sole provider, I had no idea how they would manage that… In fact, we had to bring forward the hiring of a new admin person just to get through that October phase." (AHP, OT, QLD)

"So it just has not done anything good. It's made everything harder from an admin point of view and from the clinician's point of view" (ibid, QLD)

"Well for us I wasn't particularly happy with it. I think it just adds a layer of administration to a small practice that doesn't have a lot of admin support. That was difficult. There's so much reading." (AHP, Osteo, VIC)

"Care planning - patient care plans, they take time. So the whole first visit and sometimes the second visit are occupied doing paperwork to meet the requirements of the treatment cycles but adding nothing to their OT intervention." (AHP OT QLD)

"I would say that we've had a huge increase in the amount of administrative time and effort that is put into firstly chasing the GPs for a new referral, because we're often finding that the GPs don't have an understanding and so they just resend the same referral thinking that we've lost the form or something." (AHP OT NSW)

"What it has done is it's created an enormous amount of administrative burden to make sure all the documentation is in place. Then even when the document is in place and I send it off to the doctor, it's created even more complexity with administration around did we get a referral back" (AHP Dietician, NSW)

"Now, personally I like veterans and the veterans I see are nice people and I like seeing them, so I want them to keep having access to care and I like seeing them and I think we do a good job. But the amount of work that's required, my wife is our

practice manager, has said to me, are you sure you want to keep seeing some of these people because it's just so much work on us." (AHP Dietician, NSW)

"Well, administratively, there has been, obviously, an increase in work, for which we are not compensated" (AHP Pod, VIC)

- Multiple AHPs report not wanting to take on DVA clients, due to the administrative and financial burden of the TC process.

"I think that they are going to have less practitioners willing to provide them with treatment because it's getting harder and harder and as I said, it's really just moral obligations that we feel obliged to keep providing the care… yeah, it's getting harder to do that when you're taking more of a financial loss and taking on more to be able to do that without, I think, the good support to back that up.

… it's getting harder and harder and we're a small practice who are really overloaded and fully booked. So I can see why other practices would just say look, I'm sorry, I can treat somebody else for an extra $30 per session, I'm not taking on any more DVAs. I know other practices that do that for that reason. So - and that's not fair to the vets." (AHP Osteo, NSW)

"But I know that the physios were very close to saying, we can't do this for DVA clients. They're considering not taking new DVA clients… Because my husband's a veteran and he was going to a physio for ages and they just stopped taking DVA clients… he was months without treatment and I kept saying to him, you're not going to have a choice. Then we go, you know what, this is not okay" (DVA client, 57, NT)

"I think a lot of OTs chose not to do DVA work anymore because it just doesn't cover costs. I actually used to have three therapists. I've had to let them all go, because what DVA provide doesn't actually cover the cost of them." (AHP OT, 28, QLD)

"DVA patients often do need longer because they take ages to get dressed and undressed because they're old. All of that sort of stuff that - private practice can refuse to see third party payers but we can't with DVA. So I'll take them but when that extra - what looked like extra admin, extra paperwork came on I must admit I kind of went, really?" (AHP Osteo, VIC)

"Yeah. I was talking to her – I saw the podiatrist this morning, for example. She said that several of her fellows in other businesses had seriously considered or some had stopped taking DVA patients as a result." (DVA client, 84, ACT)

GPs:

- *An increased administration load was described by GP interviewees as well. DVA clients reported interactions with their GPs in which the doctors complained of a higher administration load as a result of the TC changes.*
- *Similarly to AHP reporting, GPs also linked the increased administration to financial issues of DVA renumeration*

"It's just added an administrative burden to my life which I was already busy enough, I didn't really need. So it's just adding an extra layer of complexity to the DVA patient's life, to my life, to receptionists. Of course, every time we need another referral, it's just another administrative step for the receptionist. We don't get paid for those administrative steps, so whether that means they have to scan it and email it to the patient, if you add that extra burden regularly it adds up for their time." (GP, 39, QLD)

"We don't get paid for those administrative steps, so whether that means they have to scan it and email it to the patient, if you add that extra burden regularly it adds up for their time." (GP QLD)

"it's more administrative work." (GP, 63, VIC)

"When I went to - I spoke to the doctor about it and she said all it's going to do is make more work for them and the reports. She didn't mind that too much because they get paid to do the reports, but the thing was it is still time consuming." (DVA client, 74, QLD)

SERVICE IMPACTS

AHP Attitudes to TC changes:

Negative impact on patient care/outcomes:

- Many AHPs described significant impacts to their healthcare provision and continuity of care as a result of the TC.
- AHPs have reported gaps in continuity of care as a result of not having GP referrals, or not being able to contact GPs to provide referrals for patients. AHPs have also described an impact on patient care for patients unable to understand the TC changes due to impaired mental or physical functioning (e.g. "significant lower limb oedema" (AHP OT, 45, QLD) or "cognitive deficits or vision impairment or poor hearing" (AHP OT, 43, NSW))

- AHPs have also described feeling restricted and unsure about how the TC impact on their provision of care (especially in regards to specific instances of care: e.g. Osteo unsure of how to treat back vs. shoulder vs other parts of the body)
- Negative impacts on patient care related to increased administrative burden and renumeration issues for AHPs

"I just think it's an unnecessary - I'm not sure that it improves patient outcomes, put it that way." (AHP Osteo, VIC)

"If you're creating a treatment plan around 12 sessions rather than creating a treatment plan around a patient, I don't think that's ideal either… coming back to that 12 months of indefinite visits referral is probably better from that point of view" (AHP Osteo, VIC)

"But it just felt like it really wasn't about the outcome for the patient. I just don't see how by limiting their access is likely to make things better for them, if you know what I mean?" (AHP Osteo, VIC)

"I think that the referral usually had a specific area on it or a problem but there was sort of a - because it was less rigid, you'd sort of treat them for that and whatever else they came with. But this time I'm a bit like, I don't think I'm supposed to be doing anything to your low back. So, again, that affects outcomes as well. Because that could be what I need to do, is to sort that low back out before the top part of his back will be better. I just feel restricted with it and I feel like there are lots of rules with it and I feel like I might be doing it wrong, put it that way, and that's not really how you treat a patient." (AHP Osteo, VIC)

"It's just an administrative nightmare. Didn't exist prior to that because I had an indefinite referral. So the continuity of care is far worse due to the abolishing of indefinite referrals for OTs, far worse continuity of care." (AHP OT, 53, QLD)

"Previously, indefinite referral, continuity of care was perfect. I'd go the next day, sort it out, get it fixed, get her a loan one. Can't do it. So I think for the vulnerable people we've actually made their lives worse." (AHP OT, 53, QLD)

"So for 100 per cent of my clients I need a new referral 12 monthly or 12 visits. So the care and co-ordination is far worse under the treatment cycles process." (AHP OT, 53, QLD)

"It has definitely not made it any better [laughs] and I know that's what they thought they were doing, is trying to improve things for the patients. It's just worse." (AHP OT, 45, QLD)

"Yeah, so yeah, we haven't changed the way we operate in terms of the quality of care but yeah, it's certainly made it harder and there have been gaps. There's been more than one occasion where we've had to say to people, you can't get there [for treatment]. You have to get onto your GP. Go and talk to your GP. Make an appointment. Hassle them because we've been hassling for months and it's still not working." (AHP OT, 45, QLD)

"I can only speak from an exercise physiology perspective and to me, yes, because it discourages them from coming a bit more often, just because of the cycle. But I can – look, to be honest, I can see that this cycle works really well for someone who's had an injury and then needs like an acute lot of treatment sessions, probably mor with like a physio or a chiropractor or that kind of health provider. I just don't see this as functional for people with chronic conditions and people that need a lot more for it." (AHP EP, NSW)

"I think the treatment cycle gets in the way of providing them adequate care because you've got to fill out all of this extra paperwork that takes time away from treating them." (AHP Osteo NSW)

"I hope they make the changes because I think it will be detrimental to the care of the veterans if they don't because I'm sure there will be other places that just end up getting frustrated and just can't take that hit financially from doing it. I mean if we've got five and six [DVA clients] on our books, that's significant - that adds up. That adds up with the loss to the practice." (AHP Osteo NSW)

Healthcare Billing/Financial burden on GPs and AHPs:

- AHPs note that the renumeration received for DVA patients are not sufficient to cover the cost of treating those patients, in addition to the administrative requirements. This has resulted in some AHPs reporting that they are unwilling to take on DVA clients for treatment, or that the renumeration does not cover longer appointments, and this is impacting on the quality of patient care.

- One DVA client reported feeling "embarrassed" that they were causing trouble to AHPs that don't get paid as much to see them

"DVA seems to be happy to pay a fee that requires us either to pay staff illegally or to run at a business loss. DVA does not pay us for office time, paperwork time, reviewing emails, calling patients. Anything not done with the client is done in my own free time, basically on everyone's weekend" (AHP OT, QLD)

"For the payment that you get for that, which is nominal really, it just makes it less appealing than it might have been. As I say, I would never deter DVA patients, I really like them actually. As a patient group I like seeing them. But I certainly wouldn't be going out of my way to make my practice a more DVA heavy practice." (AHP Osteo, VIC)

"But it's not that I don't like seeing DVA patients and I feel really pleased that we can offer that services, it's great. But it's costly and it's costly to us, really. If you see one of those and it takes you 45 minutes instead of seeing two patients who are paying the full amount for half an hour, that's okay but you couldn't do it all day." (AHP Osteo, VIC)

"So I attach all that documentation. For that I get paid $30.45. Now a report for an NDIS client that I see, they pay $183 for it… For a consultation with a DVA client I get paid $66. So the amount of work that is required for the end-of-cycle report is disproportional to the value that they're providing for the report. I can earn six times as much writing a report for an NDIS client as I can for a DVA client. So where is the incentive to treat DVA clients?" (AHP Dietician, NSW)

"As all referrals now expire I have to chase the GP up. As we're already poorly paid I now have more unpaid time chasing up things in order to provide a decent service to the most marginalised of people." (AHP OT QLD)

"As OTs, we're paid to be reasonable. We have to limit the time at the consults. I mean a reasonable time. I mean, 45 or so minutes. I don't think that's the best way to treat complex clients. It can also be very disrespectful for veterans who are suffering psychologically from their service. We often need to stay longer for veterans to feel safe and comfortable and listened to prior to us starting to do things, in their safe place, in their home. So, we need to take - veterans are becoming more complex, I've found, with a lot of the younger veterans. So, sessions can be significantly longer just to provide good care." (AHP OT, 43, QLD)

"it's not worth the effort to treat DVAs. The only reason we do is because we feel like they've given a lot and we should help them out… we're in a small practice who are very, very busy. If you're having a look at - with treatment cycles coming up every 12 appointments and if you could pop in a private patient who's going to pay you the full amount and not need a report over a DVA who is going to need - who you're going to charge less for the same amount of time and you're going to have to be writing ridiculous amounts of letters, you're going to find that some of them are going to be bumped from appointments because we're not getting compensated enough for the amount of paperwork that's to be done. " (AHP Osteo NSW)

"What we have found - speaking to a couple of veterans, there are less [unclear] DVA providers in Darwin, because they don't get paid as much and we're too - it's too complicated… Because then I'd get all frustrated because I - then I was embarrassed that I was so much trouble to these people who don't get paid as much." (DVA client, 57, NT)

- Multiple AHPs report confusion and frustration with the billing process for DVA clients. AHPs expressed that they were not informed of different billing codes for DVA clients, and communication with the DVA about billing issues is inadequate.

"It was still very confusing. No one told us about - yeah, it wasn't thorough. We were 12 months into it before we were told - and this is not from DVA, this is on a forum, that we had to charge - had to have a different code for the first consult to the remaining 11 and that we could actually get a report at the end of the 12. No one told us that." (AHP Osteo, NSW)

"Then even when we've gone back to re-claim on some of the cycles where we weren't aware that we had to claim it as an OM10, we've been knocked back on re-submissions. I would suggest there's - we've still got a few hundred dollars outstanding in reports from over 12 months ago that weren't - haven't been handled well and then you have to sit online and wait on the phone for over an hour for somebody to speak to you. It's terrible." (AHP Osteo, NSW)

"It's another burden, yep because they're not clear when they knock you back why. There's just some random code with no explanation why and then you'll have to sit on the phone for two hours to find out why. Well two hours of our time, we could do other things. So the whole point with DVA is it's become quite unbearable and we're

only doing it because we respect our veterans and we want to keep providing them the service." (AHP Osteo, NSW)

"Nobody told us that was how it was going to work. We had to find that out for ourselves and I don't know if you've ever tried to have a conversation on the phone with either Medicare Billing or DVA Billing? But you - not only do you wait a long time to talk to someone but then you get a different answer depending on which staff member you talk to on which day." (AHP OT, 45, QLD)

Negative impact of TC to client healthcare goals or outcomes:

Client unable to see a GP within the TC timeframe:

- DVA clients describe experiencing setbacks in treatment or healthcare due to being unable to access a GP for referral within the cycle.

"If I can't see the doctor within the week or even the fortnight, that means I have to forego my appointments and wait till I get the new referral. That can be a couple of weeks, a month even in between. Then you're pretty much starting back from scratch and you keep having to reset just because you need that little bit of paper on a particular day and if you can't get it, it's, sorry, we can't do anything." (DVA client, 30, QLD)

"[The treatment cycle] could impact to the point where I stop having physio and finish up in hospital because of this stupid regulation." (DVA client, 84, ACT)

"No. I generally - when the 12 sessions are up I don't sort of rush up and see the, or rush over and see the GP. I might just pay for a [couple] myself." (DVA client, 74, QLD)

"I think some cases it has because we're forced to wait for new referrals more so than we ever have before and ironically enough, it's for the ones who've got the longstanding difficult chronic conditions. So they're the ones who can least afford a gap, generally, in service." (AHP OT, QLD)

Impact on DVA client mental health:

- Multiple DVA clients have reported the TC impacting on their mental health, due to increased complexity of service provision and increased requirements to discuss their healthcare.

- One GP interviewee expressed disappointment in the inclusion of psychology in the TC, due to the increased burden of extra GP appointments.

"I've almost given up. It's too hard. I'm just going to go without and suck it up. But it's good for me to do it, and I'm here for my kids rather than for me. I'd rather be able to play with them and just push through." (DVA client, 30, QLD)

"It's probably more to do with maintaining my own mental health. The medical care from DVA, it's all paid for, which I'm not whinging about that at all, but accessing it requires a lot of frustration that sometimes you wonder if it's worth it and in this case, I didn't think it was" (DVA client, 44, NT)

"I said, I've just - I can't keep going out of my way to come in and see the GP, who's running late, and sitting in a room with people that are sick and then being late for an appointment that actually I should have gone to. I was just like - so I started to deteriorate… It impacted my health, my mental health, sure. But my goals, no" (DVA client, 57, NT)

"So you're also mindful of the psychological impacts of re-hashing these questionnaires all the time because most of them are also people that are trying to get along with life and don't want to be having to re-live all that stuff again." (AHP Osteo, NSW)

"The other thing that disappointed me is that they included psychology in it, because psychology for DVA clients is so important. To have that not limited, but to have that extra burden, that patients have to come in for an extra appointment when psychology is so important. That was very disappointing that they included that." (GP, QLD)

"So, then each time - so, because I'm seeing the psychologist every week, that means I need to go back every 10 weeks to get another referral which in itself creates an anxiety loop. So, I'm in this - the system itself is actually creating a bigger rut than anything else." (DVA client, 47, QLD)

DVA clients not accessing healthcare due to TC changes:

- Multiple DVA clients report not attending AHP appointments due to the TC changes. Interviewees describe difficulty or inconvenience attending GP

appointments as the reason for cancelling AHP services. This has been reported as temporary in some cases, and permanent in others.

"If I can't see the doctor within the week or even the fortnight, that means I have to forego my appointments and wait till I get the new referral. That can be a couple of weeks, a month even in between." (DVA client, 30, QLD)

"I've known a few people that just cut it away altogether and they go without rather than having to deal with it. It's not good." (DVA client, 30, QLD)

"The continually having to go back and get referrals has put me off actually accessing the healthcare so it sort of - it has impaired with my willingness to make the effort to go there and get the services needed… in the end it was easier to just take some anti-inflammatories and crack on than do the stuffing around really" (DVA client, 44, NT)

"Well, like I said, I stopped going because of the amount of annoyance and time required to continually go back to the GP." (DVA client, 44, NT)

"Yeah. We had a few clients who did their own protest against it and cut themselves from two sessions to one because they didn't want to return to the doctor every six weeks." (AHP EP QLD)

"It did at first because I was having one physio treatment a week and you can see the exercise physiologist once a week. That meant that I used up the services in six weeks. That meant going back to the GP, getting a new referral. I just didn't think that it was [unclear] for that. I stopped the exercise physiologist. I just go to physio now" (DVA client, 76, QLD)

"They [other DVA clients] get really quite frustrated with this change. I know for a fact that some of them now have - did stop going to physio and they needed it. I have encouraged them to go back and do it. But because of this, it just became too much of a bother for them and they stopped it. They stopped going." (DVA client, 78, QLD)

"I appreciate that, and obviously if they decided that we have to go every 12 - after 12 visits for a new referral, well, obviously I'm not going to start screaming and shouting, but I have a feeling, because I've spoken to a couple of other vets who are in the same situation as me, and they get to the - they're getting the feeling that oh, it's not worth going to the doctor every 12 visits to get a new referral, and they're

dropping out of getting their treatment, and I think that's detrimental. I think that's really detrimental to the system and to the veterans." (DVA client, 73, WA)

"If I give up this program because it's becoming so administrative, my health will deteriorate, and I'll become a burden on the system. I'm going to be 75 years old, and I think I'm in pretty good shape because I'm doing something to help my health so I'm not a burden on the medical system." (DVA client, 74, SA)

"I started to not go to my physio and I started to not do the hydro, in fact, I cancelled the hydro. That's when we made the decision, we won't go and see the EP, the exercise physiologist; I just wasn't coping." (DVA client, 57, NT)

"The other aspect with this that has caused problem is we have lost a number of DVA clients, because what these DVA clients have interpreted by this whole process is that Veterans' Affairs only want them to do a certain number of visits and they can't go back again... Now, those patients potentially are going to have a negative impact on their health. I can't tell you that at the moment because I haven't seen some of those people again, but that's another consequence." (AHP Dietician, NSW)

CARE COORDINATION

Client Experience with GP:

More regular contact with the GP:

- Some DVA clients noted that more contact with their GP as a result of the TC changes has had a positive impact on their care coordination.

"I believe it's a good thing because what it's actually done, it's put you in much more regular contact with your general practitioner... My opinion of it is it's very positive and very much in the interest of the veteran and the recipient actually." (DVA client, 81, NSW)

"The doctor, he does talk to me. We don't just walk in; he writes the referral and walk out. We sit down and chat about it, yeah." (DVA client, 70, QLD)

- Multiple other DVA clients describe the GP appointments that they attend as only for referral writing, and that there is no communication of health goals between themselves and the GP.

"From what I remember reading, the reason they wanted you to go back is so that there was a communication between the physio and the GP. There really isn't though, because the physio doesn't write a letter. You go to the doctor - hey, I need

a new referral. They go, yeah, sweet, type, type, type, print, here you go… The GP visits are 5, 10 minutes long, and most of it's just scripts, referrals, done, out. There's no real sit-down - unless I bring up - hey, doc, this is going on, or I think this is wrong; can we try and look into it? There's no - it's the same old, same old every month." (DVA client, 30, QLD)

"Yeah. DVA also seem to have a rose-coloured glasses view of GPs in terms of how willing they are to engage with all their processes and paperwork, because I had a GP actually almost yelling based on his annoyance about the paperwork that the DVA are asking for." (DVA client, 44, NT)

"No, not really. It's like a shopping trip. I go in there and I say I need a referral to the eye doctor, I need a referral for the physio, you know. It is like a shopping trip." (DVA client, 78, WA)

"It was meant so that it would go back to the GP after a 12-week cycle and then he would decide whether that – what you were having and that kind of treatment was useful or not useful. It just didn't seem to fit the bill, because the GPs just give another referral." (DVA client, 76, QLD)

Coordination of Healthcare:

- When asked about the coordination of healthcare, each interviewee group generally described that they themselves are responsible for the maintenance and ongoing management of DVA client care.

DVA clients:

- DVA clients described their responsibility for managing the number of AHP appointments left as part of the TC, and their own coordination of GP appointments for the ongoing provision of care. Some DVA clients mentioned the patient care plan from the GP as a factor in coordination of their healthcare, though this is in conjunction with their own management of care.
- Many DVA clients described AHPs as monitoring the number of appointments that they have and informing the client when they needed to receive a new referral.
- One DVA client reported a change in coordination of care, from the GP prior to the TC to himself after, due to lack of time once the TC was implemented (DVA client, 57, NT).

"As I said, it just takes more time to coordinate it. When I go in and ask for a referral, the GP goes, yeah, no worries. There's no discussion about it." (DVA client, 58, QLD)

"the GP has now got a health plan and he's got all that stuff written in there and he knows exactly what I'm up to… I keep spreadsheets, I record all my treatment and so does the doctor now." (DVA client, 74, QLD)

"It got to the last week and she said oh [Client Name], you will need a referral next week. Obviously, the physio hadn't realised that she had to go - she was supposed to write a report. Get that done and then I was to get to the GP, get that done and get a referral before the time ran out." (DVA client, 78, QLD)

"There's no way my GP can cope with [monitoring my healthcare] - I monitor myself… Before the treatment cycle, my GP managed my healthcare, because it was quality, we had the time. Once the treatment cycle kicked in, it was like it was all over to me; it was too difficult, it was too much." (DVA client, 57, NT)

AHPs:

- AHPs report taking an active role in the health coordination of their patients (OTs in particular).
- Many AHPs describe an awareness that it should be the GPs taking on the role of healthcare coordination, but despite this they are involved in suggesting referrals, coordinating with families, and other forms of patient care. AHPs report the belief that GPs are time-poor, and not able to take on the role of care coordination.

"In terms of the case management of services and family and other treatment options, it's allied health [that coordinates care]. Every time. Every single time. It'll be broadly the OT or the social worker. Occasionally you get a proactive physio that does it but generally, it's OT or social work or a community nurse sometimes... It's not like the GPs have suddenly stepped up." (AHP OT, 45, QLD)

"So the patient is doing it [coordinating care]. In other cases, the patient had no idea that there'd been a change even, so then no one was coordinating that, so I had to try and explain it. A bit of a mixture, but I actually think that allied health practitioners are probably in a better position, time wise, to be helping people navigate that." (AHP Osteo, VIC)

"The care co-ordination and communication is now far worse because we are now heavily reliant on GP clinics to have their administrative act together in getting referrals out. That is an ongoing struggle." (AHP OT, 53, QLD)

"That's the problem with the process. It assumes all GPs care about paperwork, the DVA processes. The GP wants to treat the person medically. They want to just get the patient in, work out what - they're not into all of this administration. That's a major flaw in the system. The GP is the wrong person to be as the care co-ordinator. It needs to be an optional thing for clients or a shared process that home visitors and the GP can share information. But they've got to feed the information to the OTs and physios on the ground so that we can prompt the GP, please do this." (AHP OT, 53, QLD)

"Our first port of call is always the GP, because as DVA tells us, they're the ones that are the care coordinators and the case manager of the client. I think in practice that doesn't happen all that often. Often it is an OT that starts to drive things, because we're in the home a lot more so we can see what's going on. Also as part of our assessment we'll generally talk with family, so we get a picture of what's happening socially and where the supports are and where they're not" (AHP OT, 43, NSW)

"Well I would say if you had to say probably medicolegally the GPs are the ones who are coordinating those things but I would say that we do take on a role in trying to refer them to other services and other bits and pieces because you know, being an allied health practitioner that spends quite a bit of time, like we have got 45-minute consultations, we are often ones that might be referring... I think in a lot of cases, the GPs are so busy and they can only do so much in the consults with filling out all the other paperwork and so on… Yep, I think the GPs do the best they can but I think they're not case managed well" (AHP Osteo, NSW)

GPs:

- GPs report that they are the sole coordinators of patient healthcare.

"Facilitator: Who coordinates your DVA clients' health care?
Interviewee: I do. I'm the GP.
Facilitator: Yep [laughs].
Interviewee: Who else would do it? No one." (GP, 48, SA)

"Yes, that's the whole purpose [of the TC], to try and use the GP as the gate keeper and coordinator, with discussion with the other allied health in respect to the patient." (GP, 63, VIC)

Client Experience:

Clients speaking to local members about TC:

- Two clients felt strongly enough about the TC to write to their local members about the changes.

"I did approach my federal member but I'm afraid he was extremely rude and I did eventual email in again and state the fact that I thought he was very, very rude because his comment came back was, oh I was only doing it because it was free - I'm meaning exercise physiologist. I was only doing that twice a week because it was free and why did I think, as a war widow, I was entitled to more than the average old age pensioner because an old age pensioner couldn't have the same facilities. So I was really, really annoyed and it did impact. My doctor, he understood, but I just felt that it was just unnecessary. Unnecessary." (DVA client, 76, QLD)

"As a group, we wrote a letter to the local member, protesting, and the feedback we got from the gentleman that saw it was, thanks for your letter, very interesting, don't call us, we'll call you. Typical politician-type answer." (DVA client, 72, QLD)

At Risk Client Framework:

- Some mention of the At-Risk Framework from AHPs and DVA clients, without prompting from the interviewer. The Framework is described as a way to 'get around' the current TC, with one DVA client describing it as a "loophole". In general, AHPs and DVA clients feel it is a positive way to avoid the 12-session process.
- Two DVA clients bought the At-Risk Client Framework to the attention of their GP, after hearing about it elsewhere.
- None of the GPs interviewed were very familiar with the At Risk Client Framework. One had not heard of it at all.

"I know they have their complex referral system. I can't remember the wording they use for it but that's still only 12 months. It still doesn't acknowledge chronic

conditions. So it's ridiculous and we've had all sorts of variations." (AHP OT, 45, QLD)

"Yes, that's right. If it was 12 weeks, I'd be grinding my teeth [laughs]. Given this is all private and confidential, that's [At Risk Framework] how I'm getting around the 12 week side of things… That form doesn't seem to be easy to find on the DVA website." (DVA client, 72, QLD)

"I spoke to somebody in DVA, and they told me that I could download a form and it would allow for your GP to fill it out, and even if you didn't have a TPI card, which I don't… So, it was a bit of a loophole around their system, but I took advantage of their loophole because I didn't want to be going to the doctor every five weeks… So, I got this form signed by my doctor, and all I had to do was advise DVA, send them a copy of the form. They didn't have to approve it or anything, but it was automatically that I could go for 12 months' referrals" (DVA client, 73, WA)

"Just recently the GP agreed that he could apply for the 12 months referral again so that's now been accepted by Veteran Affairs that, instead of having to go every six weeks for the exercise physiologist, I now only have to go once every 12 months… I had to find out the number of the form for him because he wasn't sure but I know now. He doesn't know anything about it." (DVA client, 76, QLD)

"I know you can get some sort of exemption. We've had a client who tried so hard to get it and he ended up coming in with a big written-up referral that says, this client is exempt from the 12-session process for three months. I don't know. He wasn't one of mine. Yeah, so some sort of exemption that's easy to understand for those high-needs condition people." (AHP EP, QLD)

"Facilitator: Have you – are you aware of the at-risk client framework?
Interviewee: Yeah, to some extent. Again, it's nothing earth-shaking in there. It's all common-sense stuff, so there's really no significant difference in that sense." (GP, 48, SA)

"[After Facilitator explains the At Risk Client Framework] …I mean, most of them, if they have a dozen treatments, they can always get an assessment and get some more treatment. So, I haven't - I wasn't aware of that [the Framework] and I'm not sure why it hasn't been passed on, so that's probably not relevant." (GP, 63, VIC)

"Yeah, now that you've mentioned it, I didn't know the name of it, but one of my patients had mentioned it or asked about it a while back and I hadn't had a chance to

look into it. Again it's just you get so many information emails come through every week and there's only a certain amount of time to read them all and get a handle on what's required of them." (GP, 39, QLD)

Appendix 5: Stakeholder Engagement Form

Stakeholder Engagement Form

Brief description of the evaluation

On 1 October 2019, referrals from general practitioners (GPs) to allied health services changed for DVA clients. Under the treatment cycle arrangements, referrals from GPs to an allied health provider (AHP) are valid for up to 12 sessions of treatment, or a year, whichever ends first. This 'treatment cycle' aims to improve the quality of healthcare for DVA clients.

The aim of this evaluation is to investigate the impacts of this change, both positive and negative, on DVA clients and health professionals. This evaluation is being completed at the request of the DVA, by Queensland University of Technology (QUT).

You are being invited to take part in this evaluation because you are a DVA clinical advisor or an identified organisation that supports veterans, medical practitioners and/or allied health practitioners who have transitioned to DVA's treatment cycle arrangements. Your opinions of the treatment cycle change and its impacts on the healthcare outcomes will provide valuable information in this evaluation.

Q1 Where is your organisation located? (please select all that apply)

- ☐ ACT
- ☐ NT
- ☐ NSW
- ☐ QLD
- ☐ SA
- ☐ TAS
- ☐ VIC
- ☐ WA

Q2 Which stakeholder group does your organisation/association represent? (please select one only)

	Yes	Organisation Name:
Ex-Service Organisation	☐	
Veterans' Association	☐	
Professional Association - Medical / General Practitioners	☐	
Professional Association - Allied Health Practitioners	☐	
DVA Clinical Advisors	☐	
Other	☐	

Q3 **In your opinion, how well have the treatment cycle changes been implemented?**

Q4 **In your opinion, how effective has DVA's communication strategy been in educating stakeholders about the treatment cycle changes?**

Q5 **In your opinion, how have you or your organisation, as DVA stakeholders, engaged with the arrangements?**

Q6 **What is your, or your organisations, opinion on the outcomes of the treatment cycle changes?** (consider improved quality of care and improved care coordination)

Appendix 6: PEMAT-P tool template

Title of Material:

Name of Reviewer: Review Date:

Read the PEMAT User's Guide (available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/pemat/) before rating materials.

UNDERSTANDABILITY

Item #	Item	Response Options	Rating
Topic: **Content**			
1	The material makes its purpose completely evident.	Disagree=0, Agree=1	
2	The material does not include information or content that distracts from its purpose.	Disagree=0, Agree=1	
Topic: **Word Choice & Style**			
3	The material uses common, everyday language.	Disagree=0, Agree=1	
4	Medical terms are used only to familiarize audience with the terms. When used, medical terms are defined.	Disagree=0, Agree=1	
5	The material uses the active voice.	Disagree=0, Agree=1	
Topic: **Use of Numbers**			
6	Numbers appearing in the material are clear and easy to understand.	Disagree=0, Agree=1, No numbers=N/A	
7	The material does not expect the user to perform calculations.	Disagree=0, Agree=1	
Topic: **Organization**			
8	The material breaks or "chunks" information into short sections.	Disagree=0, Agree=1, Very short material*=N/A	
9	The material's sections have informative headers.	Disagree=0, Agree=1, Very short material*=N/A	
10	The material presents information in a logical sequence.	Disagree=0, Agree=1	
11	The material provides a summary.	Disagree=0, Agree=1, Very short material*=N/A	
Topic: **Layout & Design**			
12	The material uses visual cues (e.g., arrows, boxes, bullets, bold, larger font, highlighting) to draw attention to key points.	Disagree=0, Agree=1 Video=N/A	

* A very short print material is defined as a material with two or fewer paragraphs and no more than 1 page in length.

ACTIONABILITY

Item #	Item	Response Options	Rating
20	The material clearly identifies at least one action the user can take.	Disagree=0, Agree=1	
21	The material addresses the user directly when describing actions.	Disagree=0, Agree=1	
22	The material breaks down any action into manageable, explicit steps.	Disagree=0, Agree=1	
23	The material provides a tangible tool (e.g., menu planners, checklists) whenever it could help the user take action.	Disagree=0, Agree=1	
24	The material provides simple instructions or examples of how to perform calculations.	Disagree=0, Agree=1, No calculations=NA	
25	The material explains how to use the charts, graphs, tables, or diagrams to take actions.	Disagree=0, Agree=1, No charts, graphs, tables, or diagrams=N/A	
26	The material uses visual aids whenever they could make it easier to act on the instructions.	Disagree=0, Agree=1	

***Total Points*:** _____

***Total Possible Points*:** _____

Actionability Score (%): _____

(*Total Points* / *Total Possible Points*) × 100

Item #	Item	Response Options	Rating
Topic: **Use of Visual Aids**			
15	The material uses visual aids whenever they could make content more easily understood (e.g., illustration of healthy portion size).	Disagree=0, Agree=1	
16	The material's visual aids reinforce rather than distract from the content.	Disagree=0, Agree=1, No visual aids=N/A	
17	The material's visual aids have clear titles or captions.	Disagree=0, Agree=1, No visual aids=N/A	
18	The material uses illustrations and photographs that are clear and uncluttered.	Disagree=0, Agree=1, No visual aids=N/A	
19	The material uses simple tables with short and clear row and column headings.	Disagree=0, Agree=1, No tables=N/A	

***Total Points*:** _____

***Total Possible Points*:** _____

Understandability Score (%): _____

(*Total Points* / *Total Possible Points*) × 100

Appendix 7: Health Literacy Checklist template

Health Literacy Checklist for Written Consumer Resources

This tool provides a basic guide for ensuring resources written for consumers are clear and easy to understand. Additional guidance can be found in the resources listed over the page.

Preparation	
	Audience, objectives and outcomes are defined prior to writing resource. *[Tip: Consider involving representatives of your target audience early in the development process.]*
Content	
	Sentences are short. *[Tip: Aim to limit sentences to 8-10 words.]*
	Paragraphs are short. *[Tip: Aim to limit paragraphs to 3-5 sentences.]*
	Content is focused on 2-3 key messages. *[Tip: Delete any unnecessary content that could detract from the key messages.]*
	Information is up-to-date. *[Tip: Include the date of publication.]*
Language	
	Language is personalised to the reader. *[Tip: Use "you" rather than "the patient/consumer".]*
	Resource is free of medical jargon. *[Tip: Replace medical jargon with simple English wherever possible. See Centers for Disease Control and Prevention's Plain Language Thesaurus. Create a glossary of medical terms, if necessary]*
	Language is consistent. *[Tip: Use the same words for ideas and procedures.]*
	Language is positive. *[Tip: Say "eat less cheese" rather than "don't eat lots of cheese".]*
	The active voice is used. *[Tip: Use sentences where the subject acts – subject + verb + object. For example, "Joan (subject) is eating (verb) the sandwich (object)" rather than "the sandwich is being eaten by Joan".]*
Presentation	
	Text is broken into sections. *[Tip: Use headings and text boxes to chunk information.]*
	Font is simple and consistent. *[Tip: Use a 12-point font at minimum. Consider a larger font for older audiences.]*
	Spacing is adequate between individual sentences and sections. *[Tip: Aim for 40-50% white space.]*
	Diagrams and illustrations provide useful information and are adequate size. *[Tip: Include captions or labels.]*

Readability	
	The resource is written to a reading grade level of 7 or less *[Tip: Online tools such as https://readability-score.com provide results for Average Grade Level, which combines results from multiple readability tests.]*
Review	
	A colleague has reviewed this resource using the checklist and provided feedback.
	The resource has been tested with a sample of consumers representing the intended audience.

Appendix 8: Multivariable analysis to estimate the reduction in spending associated with the treatment cycle

Generalized estimating equation (GEE) regression was used to evaluate the reduction in spending associated with the treatment cycle. GEE was used as it accounts for multiple observations from each person in the data. Our preferred model included 5-months (month, year) of data before the treatment cycle period to 5-months post (month, year) to avoid the COVID affected period. Client spending was aggregated separately for each month based on whether that spending was on allied health services which received the intervention or not. Allied health services which were not subject to the treatment cycle included dental, orthoptists, optical, and miscellaneous services; all other spending was aggregated in the treatment cycle group. The model included a covariate to represent the grouping of allied health services, a covariate to indicate whether the month being aggregated was before or after the treatment cycle period, as well as the interactions. The estimate of the interaction term represented the added spending on allied health services which were subject to the treatment cycle compared to those which were not in the period after the treatment cycle was implemented. For controlling purposes, level of remoteness, client age, gender, and state were also included in the model. The data used in the model excluded clients who did not use services during the relevant period. Therefore, the estimates should not be interpreted as representative of the population of veterans but just of veterans who are receiving allied health services.

In addition to the 5-months pre post model (5 months pre-October 2019 and 5 months post October 2019), we performed sensitivity analyses by fitting a 3-months pre-post model and two 12-months pre post models: one with an added covariate for COVID-19 (representing whether or not the data were from before or after March 2020) and one without. The preferred model was the 5-month pre-post as the influence of COVID-19 cannot be properly controlled as its effects differ between allied health services and irregular restriction periods in different states.

As indicated in Table 3.16, the estimate for the interaction between allied health service and the treatment cycle period is -$13.00 (95% CI: [-14.547, -11.452]), suggesting that the treatment cycle was associated with a mean monthly reduction of $13 in spending per client. In this cohort of 94,612 clients, it can be extrapolated that under pre-COVID conditions, this will amount to an annual saving of $14,759,472.

Table 3.16: GEE analysis of monthly allied health service spending before and after the treatment cycle.

Coefficients	Estimate	95% Confidence Interval
(Intercept)	10.279	4.7 to 15.9
Male gender	22.9959	21.3 to 24.7
Client age	0.2509	0.2 to 0.3
Receiving allied health intervention	91.4905	89.7 to 93.3
Intervention period	-0.5023	-1.7 to 0.7
Remoteness (Inner Regional Australia)	-14.7399	-16.6 to -12.9
Remoteness (Outer Regional Australia)	-28.863	-31.1 to -26.6
Remoteness (Remote Australia)	-49.7567	-55.5 to -44
Remoteness (Very Remote Australia)	-62.139	-74.5 to -49.8
State (NSW)	14.9043	10.5 to 19.3
State (NT)	1.3738	-8.1 to 10.9
State (QLD)	55.4697	51.0 to 60.0
State (SA)	22.7267	17.8 to 27.7
State (TAS)	14.5668	8.8 to 20.4
State (VIC)	8.6971	4.2 to 13.2
State (WA)	49.3216	44.4 to 54.3
Interaction between the intervention and intervention period	-12.9994	-14.5 to -11.5