Department of Veterans' Affairs

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Health Policy Section
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Executive Summary

In June 2023, the Department of Veterans' Affairs (DVA) commissioned Abt Associates to independently evaluate the Coordinated Veterans' Care Program (CVC Program).

The CVC Program

When established in May 2011, the CVC Program was originally accessible only to eligible Gold Card holders (GCHs). Following expansion in July 2021, CVC became accessible to White Card holders (WCHs) with chronic DVA accepted mental health conditions (eligible WCHs). While initially considering the reduction of hospital admissions an appropriate outcome measure, a more contemporary approach is to focus on participant health and wellbeing outcomes as a more appropriate measure of effectiveness. This occurs through improved management of chronic conditions, promotion of health literacy, provision of self-management support, and coordinated care from the eligible client's usual General Practitioner (GP).

The CVC Program involves a care team consisting of the CVC participant, their carer (if applicable), the GP, and the care coordinator (who can be the treating GP but is most often either a practice nurse [Registered or Enrolled Nurse], Aboriginal and Torres Strait Islander Primary Health Worker, or Community Nurse [CN] from a DVA-approved provider). Specialists and allied health professionals may also join the team as required.

CVC Program implementation, as described in the Notes for CVC Providers, involves a comprehensive health assessment by the GP, the development of a personalised care plan with the GP, and regular follow-up appointments to review and update the plan. Care coordinators play a crucial role in coordinating care, managing administrative tasks, and ensuring effective communication among healthcare providers.

As of 2022, the CVC Program had 21,193 participants, with active engagement from 5,322 providers. DVA's Transport and CVC Programs section oversees program administration, with Medicare processing CVC claims on a 90-day billing cycle. DVA maintains a Program communication strategy to educate stakeholders and promote program compliance through regularly updating DVA website information, development of detailed guidance documents, and stakeholder liaison. As part of the communication strategy, feedback mechanisms and targeted awareness campaigns are intended to facilitate participation by Program care team members. The intent is to demonstrate the Program's positive impact to care team members and external stakeholders, who may then promote the positive Program impact further by encouraging participation with both their peers and eligible patients. This multi-faceted approach seeks to ensure that stakeholders are informed and engaged and are therefore able to contribute to the Program's sustainability.

Evaluation of the CVC Program

DVA's purpose in commissioning this evaluation was two-fold. First, to undertake a programmatic evaluation of the CVC Program across selected evaluation criteria; and second, based on the programmatic evaluation and other available evidence, to identify options to potentially redesign the Program in the context of the contemporary health system (including future directions) and relevant policy, as they relate to the veteran cohort. The three key evaluation questions were:

1. *To what extent has the CVC Program been implemented in line with its intended design?*
2. *To what extent has the CVC Program achieved its intended outcomes?*
3. *How could the CVC Program potentially be redesigned to better meet the needs of current and future DVA clients?*

Evaluation methods and data sources

A comprehensive, mixed methods approach was used to conduct the evaluation including:

- An environmental scan and literature review examined care coordination for veterans in the other Five Eyes countries and contrasted this with Australia's approach. This extensive review (see Section 2.2.1), encompassing academic and grey literature, informed the evaluation's design and provided contextual background that further informed opportunities for CVC Program reform (see Section 5.1).
- Quantitative methods, including program data and cost-efficiency analysis, assessed CVC participant characteristics and program implementation with a view to complement, rather than duplicate routine analytics available through the CVC Program dashboards (see Section 2.2).
- A range of stakeholder consultation processes were undertaken to further inform and enrich the evaluation (Section 2.2.2). This included consultation with and/or written submissions from DVA, other government agencies, health profession peak bodies/associations, ex-service organisations (ESOs), and case studies with general practices. The case studies included consultation with CVC participants, GPs, Practice Nurses and Practice Managers. Additionally, results of the independently facilitated 2023 CVC Participant Survey [1] were incorporated into the evaluation findings.

Key Evaluation Findings

The CVC Program is being managed by DVA in accordance with its intended design and is highly valued by program participants and other key program stakeholders. The scope of the Program and the policy and health system context for its implementation have shifted markedly since program commencement – pressing for adjustment to the Program design and the way in which it is implemented. The evaluation provides a set of recommendations for how the Program can more effectively meet the needs of current and future DVA clients and further demonstrate this effectiveness.

Implementation: To what extent has the CVC Program been implemented in line with its intended design?

The CVC Program has largely been implemented in line with its intended design. Administered and maintained by DVA since its inception, the Program has seen stable participation across the period 2016–2022, reaching 21,193 participants across Australia in 2022. Initially designed for GCHs, the Program was expanded in 2021 to include WCHs with a chronic DVA-accepted mental health condition. While this expansion has been positively received, WCH enrolment remains low due to the complexity of eligibility criteria and the CVC claiming process, and low level of stakeholder awareness. Additionally, there are associated concerns about payment claims, and challenges in marketing the Program to eligible individuals, as most benefits and promotional materials target GCHs.

The establishment of care teams and facilitation of improved care for participants aligns with the CVC Program design. The challenge remains that the capacity to facilitate personalised care for all participants is constrained by a lack of provider expertise, which inhibits the implementation of coordinated care. Most GPs and nurses only perform basic coordination tasks, such as sending written referrals and using practice software notes, with limited case conferencing, multidisciplinary discussions, or other substantive processes of coordinated 'patient-centred' care. To enhance care coordination, DVA could consider providing training for GPs and practice nurses on CVC best practice.

Fundamental to the CVC Program design is long-term participation which supports achieving ongoing improved health outcomes. The Program's results for service utilisation and continuity of participants are mixed. In their first year of enrolment, around half of CVC participants accessed five or six services; however, 19% received two or fewer services. Additionally, 26% of participants disengaged in their first year, and it is estimated that only one-third of exits were due to a participant entering residential care or passing away. There is a suggestion there may be significant instances of non-compliance, whereby some organisations, who are not the usual GPs of relevant participants, are directly marketing their services to

veterans through inducements, and enrolling them in the CVC Program. This involves the provider claiming for both an initial consult and billing (UP01), and for ongoing claiming every 90 days thereafter. DVA are currently investigating this area of non-compliance. Other notable trends in participation for further consideration include the decreasing average age of participants (from 78 years in 2016 to 65 years in 2022), and the increasing proportion of male participants (from 54% in 2016 to 73% in 2022).

The CVC Program's strengths centre on its ability to tailor support to the health care needs of eligible persons, and the specific individuals participating in the Program. Positive feedback was received about the implementation of the CVC Program by practices or GPs that have a military association, and some participants highlighted they felt GPs and practice staff who understood or had lived-military experience provided empathetic, trauma-informed care.

Accessing CVC through their usual GP, veterans feel better understood, trusted, and respected, reducing the need for repetitive storytelling. There is opportunity for an enhanced service in relation to veteran-centric care. DVA could consider: (i) providing and/or supporting (including incentivising) a range of activities (e.g. information, training, education policy, liaison roles) that equip the practice team to deliver more veteran-centric care, and (ii) develop a mechanism that provides formal recognition for practices that have demonstrated that they provide veteran-friendly services to a defined standard.

While establishing GCH eligibility was considered straightforward, a number of challenges to determining WCH eligibility were identified. GP feedback indicated broader uncertainty about WCH entitlements that are wider than the CVC Program. This limited understanding/awareness of Program criteria and business rules for WCHs has led to some reluctance for GPs to enrol eligible WCHs. Feedback noted that providers were hesitant to enrol WCH participants due to the risk of their claim for payment being rejected due to client ineligibility. Specific communication to GPs in relation to WCH eligibility for the Program is warranted.

More general challenges for CVC Program uptake by veterans include low awareness of the Program by entitled persons and insufficient promotion of the Program in the context of transitioning ADF members. For GPs, challenges include low awareness of the Program, inadequate funding support for smaller practices that do not benefit from economies of scale, and perceived significant administrative burden and communication challenges with DVA.

While DVA is already implementing many communication strategies, stakeholders would particularly value improvements in feedback mechanisms for rejected billings and timely communication targeting Nurses and Practice Managers prior to implementation. There would be benefit in using the GP Advisory Group (GPAG) to discuss this issue.

Outcomes: To what extent has the CVC Program achieved its intended outcomes?

Regular communication and follow-up with participants and personalised care from health care professionals underpins very high levels of satisfaction with the Program by CVC participants. As a result of their participation in the Program, participants reported feeling more empowered to manage their health, well supported by their care teams, and confident in their navigation of the health system (Section 4.2).

There has been no identifiable significant impact of the CVC Program on its original intent, reduction of unplanned hospital admissions (Section 4.1). There were no statistically significant differences in use of hospital services by Program participants, as measured by the number of hospital episodes, length of stay, or costs. This finding is consistent with the earlier Program analyses and is not unique within the Australian healthcare context. For example, a robust analysis in NSW showed that after enrolment in a chronic disease management program, significant increases in service utilisation were observed for a range of hospital services [2]. Hospital utilisation is determined by many factors beyond the control of primary care providers, and as such, does not provide a useful policy rationale or outcome measure for care coordination programs such as the CVC Program. Consistent with DVA's decreasing emphasis on

Program cost-savings, improvements such as more robust outcome measures on treatment compliance and outcomes, integrating with other chronic disease management services, and enhancing data integration could be considered.

Program Reform Opportunities: How could the CVC Program potentially be redesigned to better meet the needs of current and future DVA clients?

Any potential redesign of the CVC Program needs to be informed by evidence and lessons learnt from the Program to date, as well as the quickly evolving Australian health system. Recent health policy developments, in particular, the new voluntary patient registration model (MyMedicare), the Australian Primary Health Care 10 Year Plan,[3] the Strengthening Medicare Taskforce Report,[4] and the Medicare Benefits Schedule Review Taskforce,[5-7] are expected to transform the primary care landscape in Australia. In this context, and that of a changing veteran cohort and the evidence for best practice chronic disease management, five areas for program improvement and/or are proposed.

1. Adopting Alternative Funding Models (Sections 5.2 and 5.4): The Productivity Commission Report recommended that the CVC Program adopt a risk-based payer model, in which providers are paid a fee per client based on their risk profile and become responsible for delivering all services required by the client during the year [8]. Similar capitation and bundled payments systems in the UK and the US incentivise early prevention and intervention multidisciplinary teams delivering care integrated across providers and system levels, and efficiency improvements in health outcomes. However, these risk-based, value-added funding mechanisms require transformational practice changes for success, including adopting models of care tailored for multidisciplinary team-based services, altering the composition and roles of practice staff, and supporting digital and business infrastructure. Noting upcoming changes to primary care funding aimed at incentivising continuity of care and service quality, it is recommended that substantial changes to the Program funding mechanism should be considered once more information about new practice incentives and the broader primary care funding landscape matures.

2. Expanding CVC Program Eligibility (Section 5.3): Various stakeholders have identified veteran cohorts currently ineligible for enrolment who would benefit from the Program. Consideration should be given to expanding eligibility, subject to resource availability, with priority given to groups most likely to benefit from early intervention and prevention associated with patient-centred care programs, as well as cohorts with relatively less access to health services. In order of priority, it is recommended that consideration be given to the following groups: medically discharged ADF members, an expanded group of WCHs that includes people with chronic DVA-accepted physical conditions and those with a mental health diagnosis, and GCHs in residential aged care and/or that have a terminal diagnosis.

3. Outcome Measures (Section 5.5): The CVC Program is not well positioned to demonstrate the achievements of outcomes. It is recommended the stated outcomes and associated measures are revised to reflect the reasonably anticipated outcomes of the Program that can drive quality and improvement in a timely way, and that have readily available data. Potential outcome areas and specific measures to consider include Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs), chronic disease markers, and measures of holistic well-being such as improved social support networks, community engagement, enhanced coping mechanisms, and better quality of life.

4. Enhancing Digital Interoperability (Section 5.5): Efficient data utilisation and integration are crucial for optimising healthcare delivery and minimising administrative burden, particularly for time-constrained GPs. By leveraging existing data collections and linking these with mainstream systems, such as electronic health records and patient management platforms, healthcare providers can streamline data collection processes and access comprehensive patient outcome data. However, achieving this relies heavily on the interoperability of systems used by general practices and hospitals, as well as the establishment of appropriate data governance and privacy measures, which were highlighted as significant challenges by peak health providers.

5. Implementing a Stepped-Model of Care Coordination (Section 5.6): It is recommended that reforms to the CVC Program be considered as part of a broader approach to patient-centred and coordinated care for veterans. This broader approach could include: a structured approach to healthcare delivery where the level of care coordination provided to veterans is matched to their individual needs, tailored care plans developed for each individual with specific budgets, and coordination across DVA program, for example, the Wellbeing and Support Program.

Summary of Findings and Proposed Improvements and Reforms

Proposed short-term improvements to the CVC Program are tabulated below, along with key evaluation findings.

Key Evaluation Findings	Short-term Improvement
CVC Program Trends (Section 3.1)	
• Consistent levels of participation from 2016–2022. • Significant drop-out rates in the first year of enrolment. • Average participant age is decreasing. • Proportion of male participants is increasing. • There is overlap between the CVC Program and other chronic disease management services.	• Investigate underlying causes of early drop-out rates and address these through appropriate interventions. • Introduction of additional program controls to prevent and/or mitigate the impact of organisation's enrolling eligible persons in the CVC Program and not providing continuity of care. • The decreasing age of CVC participants is a factor that requires consideration as part of Program improvement and/or reform in the future. • Reinforce communication of WCH eligibility • Provide clarity for GPs about whether concurrent use of GPMP/TCA with the CVC Program is acceptable.
Appropriateness of eligibility criteria (Section 3.2)	
• Stakeholders supported the current GCH eligibility criteria, but determining WCH eligibility was challenging. • Low uptake of WCHs since expansion of eligibility in 2021.	• Improve clarity and awareness of WCH eligibility criteria.
Strengths and enablers (Section 3.3)	
• CVC participants valued frequent contact, care coordination, and services tailored to veterans' needs. • Veteran-centric care is highly valued. • Communication strategy is mixed, there is low awareness of the CVC Program and the associated Social Assistance Program.	• Develop a proactive communication strategy and national awareness campaigns targeting GPs, allied health providers, and eligible veterans (particularly WCHs) to promote the CVC Program and associated Social Assistance Program. • Provide and/or support (including incentivise) a range of activities (e.g. information, training, education policy, liaison roles) that equip the practice team to deliver more veteran-centric care. • Investigate the development of a formal mechanism to recognise veteran-centric providers identifiable by veterans and their families.

Key Evaluation Findings	Short-term Improvement
Program challenges and barriers (Section 3.4)	
• Barriers included concerns with use of the CVC Program as intended, administrative burden, lack of awareness, and challenges in identifying eligible veterans. • Low awareness and use of the Notes for CVC Program Providers; need for better integration of clinical care coordination forms with GP software. • Metropolitan practices without dedicated practice nurse coordinators found the funding inadequate, and high administrative burdens were reported.	• Simplify administrative processes, improve communication about necessary forms and rejected billings, and increase awareness campaigns (for GPs and eligible veterans). • Improve support for transitioning ADF members through use of Veteran Support Officers and Transitioning Case Managers. • Simplify and streamline the Notes for CVC Providers and improve interoperability of other forms necessary for clinical care coordination with GP practice software. • Review funding adequacy and consider billing options to reduce administrative burdens through better tools and support. • Further consideration and potential development of guidance on care coordination within the CVC Program and other chronic disease management services. • Review and update the communications strategy to ensure it meets current needs.

Recommendations for long term improvement and or reform of the DVA primary care arrangements.

Long-term Improvements/Reform
• Expanding Eligibility (Section 5.3): Expanding eligibility to include additional groups: transitioning ADF members, WCHs with chronic conditions, and GCHs in residential aged care or with terminal diagnoses. • Emphasising Patient-Reported Outcomes (Section 5.5): Shifting the focus to patient-reported outcomes and experiences (PROMs and PREMs), rather than hospital cost savings could better reflect the CVC Program's value to participants. • Enhancing Digital Interoperability (Section 5.5): Enhancing digital interoperability and data integration would offer an opportunity to streamline care delivery and reduce administrative burdens. • Implementing a Stepped-Model of Care Coordination (Section 5.6): Implementation of a stepped-model of care coordination tailored to individual needs would improve personalised care and overall CVC Program effectiveness.

Conclusion

The evaluation of the CVC Program confirms its positive impact on participants' health and satisfaction. Key strengths include improved healthcare education and trust among veterans. However, challenges such as administrative burdens, funding inadequacies, and limited efficiency gains persist. Short-term improvements should reduce administrative tasks, enhance GP software interoperability, and improve provider communication and education. Long-term strategies should focus on integrated care starting from the transition to civilian life, supported by sustainable funding. Ongoing assessment and adaptation are essential to maintain the program's effectiveness and relevance, ensuring better healthcare for the veteran community. Opportunities for reform in DVA primary health care arrangements should be considered to enhance service delivery.

1. Introduction

Abt Associates were engaged in June 2023 to undertake an evaluation of the Coordinated Veterans' Care Program (CVC Program). This document presents the final report of the evaluation.

1.1 Background

The CVC Program is a flagship DVA program that commenced on 1 May 2011. Originally as a cost-saving budget measure only for eligible Gold Card holders (GCHs), it was expanded to include White Card holders (WCHs) with a chronic DVA-accepted mental health condition from 1 July 2021. The Program aims to improve overall health and wellbeing and reduce unplanned hospitalisations of CVC participants by improving the management of chronic conditions and promoting health literacy, self-management, and best practice coordination of care through a person-centred approach.

1.2 CVC Program Context

The model of care for the CVC Program is based on a care team, which includes the CVC participant, their carer (if applicable), the GP and the care coordinator (who can be the treating GP), but is most often either a practice nurse (Registered or Enrolled Nurse), Aboriginal and Torres Strait Islander Primary Health Worker, or Community Nurse.[1] Care teams may include relevant specialists and allied health practitioners, depending on the care required. The care team works together to develop and regularly review an agreed comprehensive care plan and provide ongoing care coordination within the general practice setting.

1.2.1 Current eligibility criteria

The Notes for CVC Program Providers outline the following participant eligibility criteria:

- a current GCH or WCH with a chronic DVA-accepted mental health condition
- living in the community (i.e. not in a residential aged care facility (RACF))
- not likely to be terminal within 12 months (not terminal on CVC enrolment)
- diagnosed with one or more chronic conditions
- at risk of unplanned hospitalisation
- having complex care needs
- able to give their informed consent to participate in the CVC Program.

An eligibility tool and other tools and resources are available in the CVC Toolbox (available at https://cvctoolbox.dva.gov.au/Eligibility) for GPs to use to support their care coordination.

1.2.2 CVC Program implementation

The CVC Program is designed to enhance care coordination for veterans with chronic conditions and complex care needs. Program implementation guidelines are documented in the Notes for CVC Program Providers. General practitioners and care coordinators play a central role in its implementation.

The process begins with a comprehensive health assessment conducted by a GP, who then collaborates with the CVC participant to develop a personalised care plan. This plan outlines specific health goals, management strategies, and necessary interventions. During the health assessment, the entitled person is informed about the CVC Program, its benefits, and what participation entails. They are then asked to

[1] From a DVA approved Community Nursing (CN) provider.

provide their informed consent to participate in the Program and to have their health information shared among their healthcare providers for the purpose of care coordination.

GPs and/or care coordinators perform regular follow-up appointments, typically every three months, to review and update the care plan. Monthly reviews, often conducted by the care coordinator by telephone, involve monitoring the participant's progress, addressing any emerging health issues, and providing necessary support and education. This includes discussing medication management, lifestyle modifications, and preventive measures.

Care coordinators also play a crucial role in coordinating care among various healthcare providers, ensuring that all aspects of the CVC participant's health are managed cohesively. They handle much of the administrative workload, such as updating and maintaining the care plan, organising referrals, and facilitating case conferences when required.

The program emphasises proactive management, continuous monitoring, and effective communication among the healthcare team. GPs and the care coordinator (where different personnel) work closely to ensure that CVC participants receive timely, comprehensive, and coordinated care, aiming to improve their overall health outcomes and quality of life and reduce unplanned hospitalisation.

1.2.3 CVC participants and providers

Evaluation program data analytics show stable CVC Program participation, peaking at 21,193 CVC participants in 2022 and a low of 19,275 in 2019. Due to data limitations for the evaluation outlined in Section 2.3.1, provider analysis was not conducted. However, the CVC Program Quarterly Report for April to June 2023 noted 5,322 active providers, including GPs and CN providers, with a median of two CVC participants per GP. Nine GPs had over 100 participants, with the highest being 395.

1.2.4 CVC Program administration and funding

The DVA Transport and CVC (TCVC) Programs section (formerly Nursing and Program Operations) oversees the CVC Program administration. The role of the TCVC Program team is to manage the Program, which includes responsibility for veteran and provider education; issuing the CVC Provider Notes; communication materials, such as brochures and DVA website information; managing client and provider enquiries and complaints; review and analysis of CVC data; and identifying program improvements.

The CVC Program is funded by the Australian Government as a medical service through DVA's portfolio budget. CVC claims are processed by Medicare (Figure 1.1). Providers submit an initial claim through Medicare for the assessment and enrolment of CVC participants and claim at the end of the 90-day care period for the review and coordination services provided during the period. Claims must be lodged after the care period is complete.

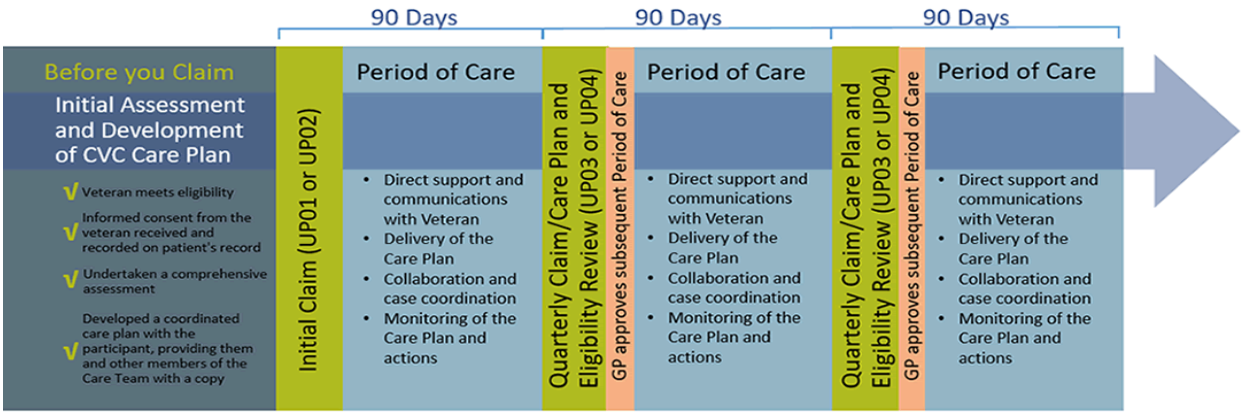

Figure 1.1: Flowchart of CVC Claiming Process for Providers (Source: https://cvctoolbox.dva.gov.au/Claim-Calculator last visited 12 June 2024).

1.3 Evaluation of the CVC Program

DVA's purpose in commissioning this evaluation was two-fold. Firstly, to undertake a programmatic evaluation of the CVC program across selected evaluation criteria; and secondly, based on the programmatic evaluation and other available evidence, identify options to potentially redesign the CVC program in the context of the contemporary health system (including future directions) and relevant policy, as it relates to the veteran cohort.

1.3.1 A programmatic evaluation

To understand the benefits of the CVC Program, including its clinical outcomes and impact on wellbeing across appropriateness, effectiveness, and cost-effectiveness domains, this component builds on previous assessments. These assessments include a cost analysis undertake in the 2019 Bupa cost-shifting analysis[9], and the 2019 Nous review of post-hospital coordination programs [10]. Through examining the past performance of the Program, the programmatic evaluation addresses the first two key evaluation questions (KEQs):

KEQ1: To what extent has the CVC Program been implemented in line with its intended design?

KEQ2: To what extent has the CVC Program achieved its intended outcomes?

1.3.2 A policy focussed review

This review was undertaken to identify potential options to redesign the CVC Program (a forward-looking strategy), particularly with respect to a changing primary care policy and funding landscape and veteran cohort, particularly given the Program's initial design occurred prior to 2011. This component addresses the third KEQ:

KEQ 3: How could the CVC Program potentially be redesigned to better meet the needs of current and future DVA clients?

2. Evaluation approach and methodology

The following approach and methods were used to inform the evaluation of the CVC program including both the programmatic and policy components and the discussion of a forward-looking strategy. A more detailed description of the evaluation approach and methodology is provided in Appendix A.

2.1 Overview

A comprehensive, mixed methods approach was used to conduct the evaluation providing a thorough understanding of the CVC Program's effectiveness and opportunities for improvement and more substantial reform. Methods included a literature review, consultation with a range of key stakeholders, and data analysis focused on participant details, hospital use, and cost savings.

2.1.1 Evaluation design

Activities undertaken to inform the design of this evaluation included:

- a review of the international literature with a focus on the structure/system for and delivery of care coordination and management of chronic diseases for veterans in the Five Eyes countries
- examination of the key policy developments in the Australian primary care sector
- a review of previous CVC Program evaluations and those with relevance to the CVC Program (including the existing, endorsed program logic)
- interviews with key informants
- discussion of and review of available data elements
- weekly discussions on program strategic and implementation considerations with the Project Management Team (PMT) and a co-design workshop to provide DVA the opportunity to discuss the evaluation framework.

2.2 Qualitative Methods

This section provides an overview of the qualitative methods used in the evaluation.

2.2.1 Environmental scan/Literature review

A review of the literature was undertaken with an emphasis on care coordination for veterans in Canada, New Zealand, the UK and the US (Five Eyes) to contrast this with the approach used in Australia for both veterans and the broader population (provided to DVA as an Annex to the evaluation design).

The results of the environmental scan informed the evaluation design and provided background and context to the key findings. Specifically, a lessons-learned rather than a theoretical approach has been used in this report to summarise the main findings of the environmental scan and inform the forward-looking strategy for the CVC Program.

Academic literature (predominantly studies since 2015) and grey literature, including government reports and websites, were extensively searched to ensure the most up-to-date information on care coordination services for veterans was included. Sixty-eight studies, reports and documents were scanned/reviewed. A further 46 documents relating to broader issues of financing and care coordination/integration were also reviewed. Finally, over 64 Australian studies and reports of relevance in Australia, including key policy documents, as well as reports examining a wide range of issues including the challenges of strengthening primary care and reducing hospital costs were identified and scanned/reviewed.

2.2.2 Stakeholder consultations

A broad range of stakeholders were consulted through various processes, including telephone/video interviews, written submissions, and case studies. Those consulted included:

DVA AND OTHER AREAS OF GOVERNMENT

Telephone/MS Teams consultations were undertaken with DVA and other government agencies with respect to the existing CVC Program and/or a forward-looking strategy for the Program in the context of the Australian primary care landscape. This included:

- 11 business areas/sections of DVA
- Department of Health and Aged Care – MyMedicare
- the Australian Digital Health Agency.

EX-SERVICE ORGANISATIONS

Enabling ESOs the opportunity to inform the evaluation, a consultation paper that included key evaluation questions was developed in collaboration with the PMT and distributed to participating ESOs through the National Consultation Framework Secretariat. A written response was provided directly to the evaluators on behalf of their members. Responses were received from:

- Australian War Widows Inc.
- Totally and Permanently Incapacitated (TPI) Federation of Australia.

CASE STUDIES WITH GENERAL PRACTICES

The evaluation was designed to consult with general practices across a range of typologies (to the extent this was feasible given the voluntary nature of the evaluation), examining the effects of location, size and ownership. Targeting general practices to participate also necessitated identifying those practices that had engaged WCHs in the program, particularly given the limited uptake by this cohort.

While the aim was to speak to each of the key personnel (GP, care coordinator, administration officer and CVC participant) from the practice involved in the CVC Program, not always the case that all participated (particularly CVC participants). Table 2.1 and Table 2.2 summarise the consultations conducted with general practices and their participants (see Appendix A for more details).

Table 2.1: Summary of case study sites and general practice CVC participants consulted as part of the evaluation.

ID	Jurisdiction	Geography	GP	PN	Admin/Billing/ Manager	Total
1	ACT	Metro	1	1	1	**3**
2	QLD	Metro	4	5	3	**12**
3	QLD	Inner Regional	1	0	1	**2**
4	SA	Inner Regional	1	5	2	**8**
5	SA	Metro	3	1	5	**9**
6	SA	Outer Regional	2	1	1	**4**
7	NSW	Metro	2	0	0	**2**
8	NSW	Inner Regional	1	1	2	**4**
9	VIC	Inner Regional	1	1	0	**2**
TOTAL	**5**		**16**	**15**	**15**	**46**

Table 2.2: Summary of the characteristics of CVC participants interviewed as part of the evaluation.

	GCH		Total GCH	WCH	Total WCH	Total Veteran Card holders
State/territory	**Dependent**	**Veteran**		**Veteran**		
ACT				**1**	**1**	**1**
Metro				1	1	1
QLD		**4**	**4**	**1**	**1**	**5**
Metro		4	4	1	1	5
SA	**3**	**9**	**12**	**2**	**2**	**14**
Inner Regional		3	3			3
Metro		1	1	2	2	3
Outer regional	3	5	8			8
TOTAL	**3**	**13**	**16**	**4**	**4**	**20**

GENERAL PRACTICE, NURSING AND ALLIED HEALTH COLLEGES/ASSOCIATIONS/PROFESSIONAL BODIES CONSULTED

A broad range of general practice, nursing, and allied health colleges/associations/professional bodies were consulted, either directly by the evaluators, or through a written submission process facilitated via the DVA Health Providers' Partnership Forum (HPPF) Secretariat.

Those consulted and/or who provided a submission included:

- DVA GP Advisory Group (GPAG)
- Royal Australian College of General Practitioners (RACGP)
- Australian College of Rural and Remote Medicine
- Australian Primary Health Care Nurses Association
- Dietitians Australia
- Occupational Therapy Australia
- Exercise & Sports Science Australia
- Australian, New Zealand & Asian Creative Arts Therapist Association
- Australian Association of Psychologists Incorporated
- Australian Physiotherapy Association
- Australian Association of Practice Management
- Primary Health Networks (Country to Coast QLD)

2.3 Quantitative Methods

The following section provides a more detailed summary of the quantitative methods used in the evaluation.

2.3.1 Program data analysis

The key variables of interest for this evaluation related to CVC participant characteristics and their use of the CVC Program and hospital services. The data analytics examined program implementation and cost-efficiency, including impact on hospital savings, with a primary focus on GCHs. Since WCHs represented less than 5% of participants in a given year, it was agreed that a separate analysis for them was not warranted. Additionally, current datasets offered limited opportunities for useful quantitative assessments to inform a forward-looking strategy for this cohort.

Since some standard metadata were not routinely available (e.g. data report specifications), accessing the specifics of the variables and datasets required was not possible. Accordingly, an iterative process with multiple cross-checks and discussions with the DVA Data & Insights (D&I) Team was undertaken.

Analysis was undertaken against 28 datasets, including, but not limited to: chronic condition, hospital episodes, service items, RACF, and geographical location. Challenges in relation to detailed information from private hospitals prevented the use of emergency department data for eligible GCHs to build an indicator of unplanned hospital admissions (and associated costs).

To refine the dataset and create a final version with complete information on unique Veteran Card holders and their chronic conditions, a cross-validation process was undertaken that involved several steps, including examining whether the classification of individuals as CVC Program participants or eligible persons aligned with records of CVC Program treatment in the primary care dataset.

Following comprehensive validation, the final sample of unique individuals in the chronic condition dataset was 116,013. Among non-CVC participants, the final sample was 71,654; all in this group were alive as of September 2023. For Veteran Card holders with at least one CVC Program treatment record in 2016–2023, the final sample was 44,359, with approximately 68% still alive as of November 2023.

Standard data and health economics analytics methods were used, including descriptive statistics and multivariate regression analysis to examine program data and estimate metrics of program implementation and outcomes.

In some instances, the year of enrolment was chosen as the time variable for the analysis, and in others, the fiscal year in which the service was delivered was used. This approach allowed consideration of different time perspectives, providing a comprehensive understanding of the dynamics and patterns within the data.

2.3.2 Cost-efficiency analysis

A cost-efficiency analysis was conducted alongside program data analytics to identify areas for optimising resource use within the CVC Program. This analysis examined service delivery patterns, associated expenditures, participant characteristics, and the availability of other chronic condition management programs like GP Management Plans (GPMP) and Team Care Arrangements (TCA). This comprehensive approach provided actionable insights for potential improvements.

To assess the CVC Program's impact on hospital expenditure, regression analysis was used, comparing entitled persons using GPMP/TCA services who never used the Program as a control group. All costs are reported in constant Fiscal Year 2021 dollars to account for inflation, using health price indexes from the Australian Institute of Health and Welfare (AIHW).[11] For primary services costs, the AIHW's Medicare medical services fee index was applied, and 2022 expenditures were adjusted using the Consumer Price Index (CPI).

2.4 Limitations

The evaluation of the CVC Program faced two key limitations:

- **Data availability**. A time lag in the final recording of data resulted in selection of more limited time frames for analysing data sets. This is described in detail in the relevant sections.
- **Small sample size**. For Practices and CVC participants, the voluntary nature of participating in the evaluation and delays to recruitment (participants), resulted in a smaller and less geographic representation than aimed for. Whilst this may lead to some caution in interpreting findings, it is important to note that responses within and between these two main stakeholder groups were consistent. Additionally, CVC participant feedback was consistent with the themes identified in the 2023 Participant Survey.[1] GP feedback was consistent with issues raised by GPAG members and other key stakeholders.

3. Program Implementation Findings

Chapter 3 describes the evaluation findings as they relate to **KEQ1: To what extent has the CVC Program been implemented in line with its intended design?**

The chapter addresses the four key areas of: (i) Trends in CVC Program uptake and attrition and Integration with other chronic disease management programs, (ii) Appropriateness of the eligibility criteria, (iii) Strengths and enablers and (iv) Program challenges and barriers.

3.1 CVC Program Trends

The effectiveness of chronic disease management services is tied to sustained engagement over extended periods of time [12, 13]. Consistent engagement allows healthcare professionals to monitor and adjust care plans according to the dynamic nature of a patient's condition, fostering a patient-centred approach to their management. Furthermore, the establishment of an ongoing relationship between healthcare providers and patients facilitates the development of trust, encouraging individuals to actively participate in their care and adhere to recommended interventions [12-15]. Therefore, the longevity of service utilisation is intrinsic to achieving sustained improvements in health outcomes and the associated cost savings from reduced hospital utilisation. This issue was underscored by previous CVC Program evaluations, whose findings showed that many years of enrolment were required for the Program to achieve the expected cost savings.

A wealth of indicators focused on CVC Program uptake trends are routinely monitored by DVA. In particular, the Quarterly CVC Program Reports examine socio-demographic characteristics of CVC participants, enrolment status by type of Veteran Card, use of services, and expenditure. Additionally, the program dashboards offer supplementary indicators, enabling management to access the most recent metrics continuously and effortlessly.

The following section details CVC participant characteristics and changes in program uptake over time, using data from Quarterly Reports and program analytics. Stakeholder feedback and academic literature are included to contextualise the trends.

3.1.1 Program uptake

Considering the constraints imposed by the current data landscape and leveraging the insights available from program dashboards, the following section presents an overview of CVC Program uptake trends. This overview serves as a contextual foundation for the remaining data analytics presented in this report.

Table 3.1 illustrates key demographic characteristics of CVC participants for the fiscal years 2016–2022, with the key findings being:

- A stable trend in the number of CVC participants, with a peak of 21,193 in 2022 and a low of 19,275 in 2019. While these numbers are approximately 15% lower than those routinely reported in the program dashboards, this discrepancy is likely attributed to the calculation method used for the evaluation, which only includes participants that received a service during that fiscal year and did not extend to those who received services in the three months prior.
- A discernible trend in the mean age of CVC participants decreasing, from 81 years in 2016 to 74 years in 2022, reflecting a similar trend in the overall veteran population.
- The proportion of male CVC participants is increasing – from 52% in 2016 to 67% in 2022.
- The percentage of CVC participants residing in major city/regional areas has remained stable – ranging from 90% in 2016 to 87% in 2022.

Table 3.1: CVC participants and demographic characteristics by fiscal year (2016–2022).

Fiscal year	CVC participants(N)	Current age (mean)	Male (%)	% Major city/regional area
2016	20,276	81	52%	90%
2017	19,627	81	53%	89%
2018	19,372	80	55%	89%
2019	19,275	79	58%	88%
2020	19,470	78	60%	88%
2021	19,319	76	64%	86%
2022	21,193	74	67%	87%

Table 3.2 illustrates the count of new CVC participants for each fiscal year, average age at enrolment, and sex:

- Despite fluctuations in enrolment trends since 2016, analysis of the data suggests that program uptake remained relatively unaffected by the COVID-19 pandemic, with consistent intake numbers from fiscal years 2019 through 2021.
- Notably, there was a significant surge in the number of new CVC participants for the last fiscal year (2022), marking an increase of 66% over the previous year. The upward trend in CVC Program participation continued, with 2,577 eligible Veteran Card holders joining in the first four months of the 2023 fiscal year. However, qualitative findings (see Section 0) suggest that some new enrolees may not be 'genuine participants', with DVA currently analysing this trend.
- In line with age and sex trends for each service year and the overall CVC participant population, when looking at newly enrolled participants:
  - There is a substantial trend of decreasing age, with average age being 78 years in 2016, down to 65 years in 2022.
  - The proportion of males increased from 54% in 2016 to 73% in 2022, this is supported by the 2023 CVC Participant Survey [1].
  - These trends were further investigated employing regression analysis, with both trends found to be statistically significant and seeming to persist in the first four months of 2023.

Table 3.2: New CVC participants and demographic characteristics by fiscal year (2016–2022).

Fiscal year	New CVC participants (N)	Age at enrolment (mean)*	Male (%) **
2016	3,454	78	54%
2017	2,948	77	56%
2018	3,102	76	58%
2019	3,181	74	63%
2020	3,177	72	66%
2021	3,021	66	70%
2022	5,030	65	73%

*Decreasing time trend significant at the 1% level ** Increasing time trend significant at the 1% level

The following section discusses the implications of broader systemic challenges of identifying the target cohort and its general effect on CVC Program uptake and of other DVA services.

SYSTEMIC CHALLENGES IDENTIFYING VETERANS AND THEIR FAMILIES

To assess eligibility (and thus uptake) for the CVC Program, GPs must be aware of their patients' potential eligibility for DVA entitlements. However, this status is not always known to service providers due to veterans and/or their eligible family members being reluctant to disclose it, often due to feelings of shame related to their mental health and well-being. Discussions with general practices in relation to eligibility criteria revealed challenges in identifying patients who may be eligible for DVA entitlements. The key findings were:

- Self-Employed GPs admitted they often did not know whether new patients were veterans or family members of ADF personnel unless patients self-identified or requested to pay with a Veteran Card.
- Larger Corporate Practices commonly understood their patient characteristics, including Veteran Card holder status, using GP practice software (e.g., Best Practice™, MedicalDirector™), and regular segment analysis.
- Veteran-Centric Practices had comprehensive intake systems that included asking new patients whether they or their family had ever served in the Australian Defence Force (ADF). This indirect question was found to be less confronting for those reluctant reveal their status. This approach is also recommended by organisations like AIHW and the Australian Bureau of Statistics (ABS) and used by other non-veteran-specific service providers such as mental health and homelessness services.
- Non-Veteran-Centric Practices acknowledged that the veteran and family population was small and often difficult to determine unless they self-identified.

The degree of veteran focus, practice size, business model, and familiarity with the CVC Program were factors in a practices' awareness of their patients' veteran status. While this issue is not specific to the CVC Program, awareness-raising efforts by the DVA should include promoting initiatives and approaches for mainstream services to identify patients who may have DVA entitlements. Additionally, appropriate referral points for support and information, including DVA and peer support networks, should be included with the patient's consent.

3.1.2 High attrition and service delivery patterns

To contextualise the qualitative findings on implementation of the CVC Program, data pertaining to key service patterns within the broader landscape of chronic disease management services were examined.

Table 3.3 presents a detailed analysis of CVC participants who received only one or two services during their first year of enrolment in the 2016–2020 period, noting five to six would be expected. Analysis was restricted to an end point of 2020 to take potential delays in recording of services into consideration.

- Over the full period analysed, the proportion of new CVC participants receiving only one service averaged 12%, with a range from 10% in 2018 to 17% in 2020.
- The higher percentage observed in 2020 could potentially be an effect of the pandemic. Future monitoring of service usage should examine whether these elevated levels of attrition persist in subsequent years and investigate their underlying cause.
- A further 7% of CVC participants received only two services in their first year of enrolment, indicating that 19% of participants receive two or less services in their first year of enrolment.

These high rates of non-adherence to the expected quarterly services, (a) poses financial challenges for practices (examined below), and (b) will have a significant impact on the overall effectiveness of the CVC Program through limited attendance.

Table 3.3: CVC participants receiving 1 or 2 services only in year one of enrolment by fiscal year (2016–2020).

Service received in Year 1 of CVC enrolment	2016	2017	2018	2019	2020	Total
Total new CVC participants	3,454	2,948	3,102	3,181	3,177	15,862
# receiving one service only	364	361	323	372	526	1,946
% of total CVC participants	11%	12%	10%	12%	17%	12%
# receiving two service only	249	217	218	209	254	1,147
% of total CVC participants	7%	7%	7%	7%	8%	7%
Proportion receiving two or less services	18%	19%	17%	19%	25%	19%

Further analysis of low service usage found that a significant number of CVC participants only stayed in the program for one year or less between 2016 and 2020. In line with the above findings, 26% of participants disengaged within their first year, with the highest rate of disengagement occurring in 2020, as seen in Table 3.4.

Table 3.4: CVC participants enrolled for 1 year or less by enrolment fiscal year.

Number of CVC participants enrolled for 1 year or less	2016	2017	2018	2019	2020	Total
Total new CVC participants	3,454	2,948	3,102	3,181	3,177	15,862
# disengaged in first year of enrolment	853	787	776	774	939	4,129
% of new CVC participants	25%	27%	25%	24%	30%	26%

To investigate whether factors beyond CVC participants' control influenced their decision to leave the CVC Program in the first year of enrolment, the proportion of participants who entered RACF or passed away during their initial year was examined by fiscal year of enrolment (see Table 3.5).

Table 3.5: CVC participants enrolled for 1 year or less by enrolment fiscal year – % that entered RACF or died (low and high scenarios).

Fiscal year of enrolment	2016	2017	2018	2019	2020	Total
Estimate of the # (range) of CVC participants exiting the program due to entering a RACF or passing away	285 – 325	233 - 258	197-203	162- 193	171 - 201	1048 - 1188
% of CVC participants exiting in year 1	33-39%	30-33%	24-26%	21-25%	18-21%	25-29%

In terms of RACF, a substantial number of CVC participants exiting the program in the first year of enrolment recorded multiple aged care entries. For some, the episodes appeared consecutive. It is possible that some of these entries represent multiple occurrences of respite in RACF, which does not preclude participants from remaining enrolled in the CVC Program and are thus recorded as such.

In Table 3.5, a range of estimates based on different criteria for including a CVC participant as having entered RACF are provided. In the lower scenario estimate, an admission of at least six months is included. In the higher scenario, participants with at least one admission without any time parameters is included.

- The first row provides the estimated range (using the low and high scenarios) of the number of CVC participants within each fiscal year who exited the CVC Program due to entering RACF or passing away. The second row shows the percentage range of participants who left the Program in the first year due to these reasons. This is estimated as a proportion of the total participants that exited the program in year 1.

- In the fiscal year 2016, 853 CVC participants exited the CVC Program in year 1 (as shown in Table 3.4). Of these, 33% to 39% of exited due to entering residential care or passing away. On average, in the 2016–2020 period, between 25% to 29% of participants that remained in the Program for one year or less left due to factors beyond their control, such as passing away or entering RACF.
- Accordingly, on average, in the 2016–2020 period, between 71–75% did not continue in the CVC Program after 12 months for other reasons.
- Notably, a decreasing trend was found in the proportion of participants leaving the CVC Program due to factors such as death or entering RACF in both the lower and higher scenarios. Taking the high scenario estimate, it decreased from 39% in 2016 to 26% in 2018 before further declining to 21% in 2020.
- The robustness of this trend was further scrutinised by considering only CVC participants who passed away during their first year of enrolment, since this information is less subject to data recording issues for RACF. The results indicate a similar decreasing trend of participants exiting the CVC Program in their first year of enrolment due to death – from 21% in 2016 to 13% in 2020.

The evidence reviewed here suggests a changing pattern in the reasons for CVC Program exits that likely aligns with a relatively younger cohort of CVC participants. Since attrition rates in year one remain high (as shown in Table 3.4), notwithstanding the decline in the proportion of individuals exiting due to factors beyond their control, it is important to continue monitoring these trends.

OTHER SERVICE PATTERNS FOR SERVICES DELIVERED IN THE FIRST YEAR OF ENROLMENT

Table 3.6 shows new CVC participants have five and six claims annually during 2016–2021. Of note, a relatively high proportion of clients (approximately 29% in their first year of enrolment) have six claims. After cross-validation with the TCVC team, six claims were concluded to be within the business rules.

Table 3.6: Number of CVC participants receiving 5 or 6 CVC Program services in year one of enrolment by fiscal year (2016-2021).

# of CVC participants enrolled for 1 year or less	2016	2017	2018	2019	2020	2021	Total
Total new CVC Program enrolments	3,454	2,948	3,102	3,181	3,177	3021	18,883
# received five services	**1,050**	**1,005**	**878**	**954**	**867**	**769**	**5,523**
% of all new CVC Program enrolments	30%	34%	28%	30%	27%	25%	29%
# received six services or more	**1,028**	**763**	**953**	**1,023**	**881**	**865**	**5,513**
% of all new CVC Program enrolments	30%	26%	31%	32%	28%	29%	29%

COST-EFFICIENCY IMPLICATIONS OF HIGH DROP-OUT RATES IN THE FIRST YEAR OF ENROLMENT

Building on the insights derived from analysis of CVC Program attrition in the first year of enrolment, the cost-efficiency implications are more pronounced.

- The 4,129 CVC participants that left the CVC Program during their first year of enrolment incurred a total cost to DVA of approximately $5 million. With approximately half of the exiting participants having received two or less services, the benefits of that expenditure with respect to individual and program outcomes in a chronic disease management program context would have been negligible.
- Furthermore, for the 2016–2018 cohort, which represent CVC participants who could have stayed in the CVC Program four years or longer, a further 19 to 20% remained enrolled three years or less, a period insufficient for a key program objective of anticipated cost savings arising from reduced hospitalisations to materialise.

Note that the cost-efficiency implications of these service enrolment patterns apply in all circumstances; that is, including instances where exiting the CVC Program was beyond the control of CVC participants, such as entering RACF or passing away. Moreover, the data suggests high attrition rates continue, even as the proportion of CVC participants entering residential care or passing in year one declines.

LIMITED VOLUNTARY CVC PROGRAM DROP-OUTS

The following section discusses the qualitative findings that supports the notion of voluntary CVC Program drop-out being limited. Only current CVC participants and not those who had exited the Program were interviewed for the evaluation; this would have required an additional layer of ethical clearance requiring additional time that was unavailable. Accordingly, GPs were asked for their experience with participant drop-out and perspectives as to the high drop-out rates observed in the data (see Table 3.4).

Interviewed GPs indicated that to their knowledge, neither Veteran Card holder cohort dropped out voluntarily. The consistent feedback provided was:

- GCHs exited the program mainly for two non-voluntary reasons: entering RACF (per the Program rules) or death, both analysed above.
- Occasionally, GCHs dropped out if they travelled and needed a new regular GP who may not be a current CVC Program provider or have an interest in doing so. However, it was indicated that some GPs were maintaining them in the Program using telehealth, while the CVC patient supplemented their healthcare with a local non-regular GP for non-urgent purposes (coughs/colds). However, a few GPs interviewed indicated that they did not use 'shared care' for this purpose and would exit a participant if they travelled for an extended period.
- A few GPs and CVC participants indicated that access to certain medications that may not be prescribed by their regular treating doctor, or easy to access in certain states (such as cannabinoid oil), may have been the reason for changing GPs (and by extension, dropping out of the CVC Program if the new GP did not use the Program).
- There was a view that some WCHs found the frequency of communication associated with the CVC Program overwhelming, and consequently dropped out, otherwise the reasons outlined above applied to them as well (travel and access to certain treatments).

Many GPs theorised that the recent high drop-out rate was more likely to be reflective of what they considered to be 'non-genuine' CVC Program enrolments by some 'organisations' that were enrolling new patients not in line with the Program's intent, further discussed in the next section. Some GPs indicated there would be benefit in a DVA exit survey to determine the reason for Program drop-out in the future.

RECRUITING PARTICIPANTS IN LINE WITH THE CVC PROGRAM INTENT

Internal stakeholders, health provider peaks and many GPs held a strong view that there were organisations operating in 'veteran compensation and health' that were not using the CVC Program as intended. They were reported to be predominantly accessing newly transitioned patients, enrolling them in the Program via a telehealth consult and billing for the initial consult (UP01) unbeknownst to their regular GP. Allegedly, this included enticements of free medication, including cannabinoid oil. It was reported that continuity in the Program with the enrolling GP did not occur in line with the intent of the Program, potentially a cause of the increasing year one attrition discussed above.

When the regular GP subsequently enrolled an eligible participant in the CVC Program, they would not be aware that this had already occurred until after the 90-day billing cycle had elapsed. Accordingly, they would have a high degree of frustration upon receiving a rejected UP01 claim for significant administration and treatment they had already provided to develop the comprehensive care plan.

It has been suggested that this may be partially mitigated through re-introducing a requirement that GPs obtain written consent from an eligible participant to be enrolled in the CVC Program. Further, that the

business rules be amended to require that this written consent be submitted to DVA with the UP01 claim and a copy be provided to the CVC participant. This requirement may:

- create some reluctance amongst those with no intent to continue offering the CVC Program to enrol an eligible participant; and
- through having the consent, possibly reinforce to the CVC participant their enrolment (many forget the name or specifics of the programs they are on), thereby increasing the chance they will alert their regular GP to the fact they are already enrolled – saving GPs the additional efforts associated with enrolment without payment.

Both GPs and CVC participants voiced the importance of treatment and provider choice; however, also acknowledged that when a provider was offering to pay for all medications and aids (such as orthotics, hearing aids etc), in exchange for signing up to a Program over the phone, that it would seem attractive to participants who did not understand the consequences for themselves (no intent of ongoing care) and their 'regular GP'. One GP noted that patients seemed to assume that they would continue to be the CVC participant's regular doctor and continue to provide CVC treatments/reviews while another provider supplied the patient with their medication and billed for the treatment/reviews. The patient was very distressed that shared care was not an option for them.

Separate to the issues discussed above; however, in the same vein, some CVC participants expressed concerns about ensuring the CVC Program was not just a checkbox exercise by GPs. They emphasised the importance of maintaining integrity within the Program and ensuring that Program resources are used effectively and efficiently to support genuine healthcare needs.

From the data analysis demonstrating high and increasing attrition in year one of CVC Program enrolment and related stakeholder feedback, the DVA should consider a more in-depth investigation of this trend to assess the underlying cause(s) and address them accordingly. This could include:

- Implementing a dashboard indicator to measure drop-out rates, particularly in the first year of CVC Program enrolment. As data architecture improves, this indicator could be disaggregated by major causes such as entering RACF, death, and other factors.
- Conducting a detailed analysis of available internal datasets to identify patterns and trends related to specific GPs or individual characteristics associated with both the drop-out and/or limited service episodes in year one of enrolment.
- Surveying and interviewing veterans who in recent years exited the program in the first year of enrolment to gather qualitative data and insights.

3.1.3 Integration with other chronic disease management services

During evaluation design discussions, the evaluators were requested to examine the extent to which the CVC Program was delivered alongside chronic disease management services, more specifically GP Management Plans (GPMP) and Team Care Arrangements (TCA).

Table 3.7 presents an analysis of the intersection between CVC participants and those concurrently receiving the GPMP/TCA services and the associated costs. The data showed:

- consistent utilisation patterns across fiscal years, with a substantial proportion of CVC participants also receiving chronic disease management services, in the range of 62% (2021) to 67% (2019)
- CVC participants receive a similar average number of services from each of the chronic disease management initiatives every year from GPs, though slightly higher for the CVC Program
- total service costs for CVC participants amounted to $216 million over the 2016–2022 period, with an additional $34 million spent on GPMP/TCA services for the same participants.

Further analysis showed that when looking beyond concurrent fiscal year services, a higher percentage (approximately 90%) of CVC participants during the 2016–2022 period also received chronic condition management services at some point in time. This has important implications for evaluating the impact of the CVC Program, since a large proportion of participants have received and benefited from the delivery of both service types. It should be noted from a program cost-efficiency perspective, that those additional resources may be justified if patients receiving both services have more complex needs. GPs tend to enrol patients in the Program with more conditions, higher severity of illnesses or a history of more intensive healthcare utilisation.

Table 3.7: Treatments and costs for CVC participants who received concurrent chronic condition management services (2016–2022).

Fiscal year	CVC participants			CVC participants also receiving GPMP/TCA			
	# of CVC participants	Program Treatments (mean)	Annual Cost	# of CVC Participants	As % of Total	Treatments (mean)	Annual Cost
2016	20,276	3.4	$32,721,190	13,375	66%	3.2	$5,248,609
2017	19,627	3.4	$31,423,730	13,025	66%	3.2	$5,087,422
2018	19,372	3.4	$30,851,189	12,972	67%	3.2	$4,934,982
2019	19,275	3.4	$30,678,822	12,934	67%	3.2	$5,002,752
2020	19,470	3.4	$30,252,739	12,895	66%	3.2	$4,842,811
2021	19,319	3.3	$29,439,722	11,957	62%	3.2	$4,382,089
2022	21,193	3.0	$30,322,669	13,371	63%	3	$4,871,000
Total	138,352		$215,690,060	90,529			$34,369,666

TIMING OF SERVICES AND CVC PARTICIPANT 'SELECTION'

To further explore these findings, the analysis focussed on the intermediate years, specifically 2018–2020, enabling an assessment of CVC Program treatment utilisation for CVC participants both prior to and after their enrolment in the Program.

Table 3.8 provides a breakdown of the number of new CVC participants for each fiscal year, categorised by enrolment in GPMP and TCA services between 2016 and 2023. The data underscores a notable trend of a substantial proportion of new participants (ranging from 88% to 90%) also receiving GPMP/TCA services during the study period. For those who received GPMP/TCA services, the timing of their first recorded engagement was explored – whether it occurred before, concurrently with, or after their enrolment in the CVC Program. The analysis showed:

- the majority of CVC participants received their first GPMP/TCA services in the years preceding their CVC Program enrolment, showing an upward trend from 46% in 2018 to 55% in 2020
- a significant portion of CVC participants received their first services in the same year as their CVC enrolment. However, in alignment with the above trend, this percentage decreased from 42% in 2018 to 36% in 2020
- a smaller percentage received their first GPMP/TCA services after their first CVC year of enrolment, a trend of decline from 12% in 2018 to 6% in 2020.

The reviewed evidence suggests a growing trend among providers to leverage the CVC Program for patients engaged in GPMP/TCA, aligning with the earlier observation of a substantial increase in new Program enrolments in recent fiscal years.

Table 3.8: New CVC participants – timing of GPMP/TCA services (2018–2020).

	2018	2019	2020
New CVC participants (N=)	3,102	3,181	3,177
Received GPMP/TCA treatments in 2016-2023?			
No	297 10%	337 11%	397 12%
Yes	2,805 90%	2,844 89%	2,780 88%
If yes, when received their first GPMP/TCA treatment?			
• **In the years prior to their CVC Program enrolment**	1,303 46%	1,465 52%	1,526 55%
• **In their CVC Program year of enrolment**	1,169 42%	1,057 37%	1,009 36%
• **After their CVC Program year of enrolment**	333 12%	322 11%	156 6%

Given this trend of an increasing proportion of CVC participants having already been enrolled in GPMP/TCA, the evaluation examined the extent to which providers channelled more complex patients into the CVC Program. While not having access to the health condition of patients prior to their enrolment in the Program, the chronic conditions dataset held by DVA provided invaluable information to fill this gap for a sub-sample of individuals.

The dataset identified the chronic conditions of CVC participants, as well as those of other GCHs currently alive and not in RACF. These conditions were measured in the second semester of 2023 based on past usage of health care services, including hospital services and primary care. Since there was a significant delay of up to 18 months for some of the treatments/services used for these measurements, it was assumed that they captured the health status prior to 2022 and was not heavily contaminated by their use of services since July 2022. On this assumption, the chronic conditions dataset was used to assess the extent to which providers direct their patients with more complex needs (as measured by the number of chronic conditions identified) towards receiving dual services (GPMP/TCA and the CVC Program).

As shown in Table 3.9, the total sample represents GCHs that enrolled in GPMP/TCA as a new GCH in 2022 (4,200), which included those that received GPMP/TCA services exclusively (3,195) and those concurrently enrolled in the CVC Program that year (1,005).

- Within this sample, logistic regression was applied to estimate the probability of these GCHs receiving dual services. To ensure the robustness of findings, alternative samples were explored, such as including those engaged with GPMP/TCA in the previous years. Notably, the results remained consistent across these alternative specifications.
- The key focus was the number of chronic conditions per GCH. A positive and significant result showed that providers tended to refer more complex patients to the CVC Program. The basic model considered age and sex, while alternative models also included remoteness classification. This additional factor was not significant, and the results remained consistent.

Basic descriptive statistics (mean and standard deviation) are described in Table 3.9 for the total sample and the two cohorts, while Table 3.10 shows the results of the regression analysis. The descriptive statistics in Table 3.9 suggest GCHs with dual services are younger, have a slightly higher average number of chronic conditions, and are more likely to be male than those exclusively receiving GPMP/TCA services. The logistic regression results shown in Table 3.10 show that:

- An additional chronic condition increased the odds of joining the CVC Program by approximately 7.6 %, with the effect being statistically significant. That is, there was a positive association between the number of chronic conditions and Program enrolment, which supported that providers were enrolling more complex patients in the Program.
- Of note, an additional year of age decreased the odds of joining the program by 2.8% and the effect was statistically significant. This appears to align with earlier findings of an increasingly younger profile of CVC participants.
- Being male increased the odds of a CVC Program enrolment, which aligns with earlier results; however, the effect was not statistically significant.

For chronic disease management, prioritising relatively younger cohorts with more complex health needs may be beneficial. Younger individuals may have a longer time horizon for potential health benefits, making this type of intervention more impactful.

Table 3.9: Descriptive statistics – GCH with GPMP/TCA only vs. GCHs also receiving Program treatment (2022).

	Eligible GCH with GPMP/TCA only*		Eligible GCH also joined CVC Program*		Total*	
Sample Size	3,195	76.1%	1,005	23.9%	4,200	100%
Variables	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
# of chronic conditions	1.99	(1.24)	2.01	(1.21)	1.99	(1.23)
Age	72.1	(14.35)	64.9	(18.01)	70.4	(15.63)
Male	0.60	(0.49)	0.71	(0.454)	0.624	(0.484)
*Mean & (Standard Deviation)						

Table 3.10: Logistic regression results - Probability of a new GPMP/TCA GCH also receiving CVC Program treatment (2022).

Probability of a GPMP/TCA GCH enrolling in the CVC Program in 2022	
Variables	**Odds Ratio**
Number of chronic conditions	1.076**
Age	0.972*
Male	1.211

* Significant at the one percent (1%) level ** significant at the five percent (5%) level

INFORMAL INTEGRATION OF OTHER CHRONIC DISEASE MANAGEMENT COMPLEMENTARY BILLING CODES

In support of the quantitative findings, many interviewed GPs reported using the CVC Program with chronic disease management items (particularly GPMP and TCA) for very complex patients. Some GPs were confused about whether this practice was allowed under CVC business rules due to the perceived overlap in purpose. Several GPs noted that GCHs were entitled to significant health treatment through the Program, which sometimes led to 'over-servicing'. Team Care Arrangements were less commonly used due to challenges with allied health providers accepting DVA funding, creating billing issues and disincentives. Gap payments were also a barrier for lower socio-economic patients.

The GPMP item was seen as particularly useful for billing and coordinating necessary health services within the CVC Program. Most GPs understood the different purposes of these items. Combining these items ensured regular monitoring of complex patients and provided a billing safety net for issues with CVC Program billing.

Some GPs indicated that the proposed merging of GPMP and TCA items would be beneficial under the upcoming MyMedicare reforms, although many were unsure how these changes would impact or benefit them.

3.1.4 Summary of CVC Program trends

The number of CVC participants remained stable through the period 2016 to 2022. There was a significant increased uptake in 2022 that would partially relate to expansion of the program eligibility criteria in 2021, to include WCH with a chronic DVA-accepted mental health condition. However, feedback from GPs was that some of the recent new enrolees may not be 'genuine participants' and there is a suggestion that contrary to the CVC Program design intent, some organisations (that are not usual GPs of relevant participants) are directly marketing their services to veterans and enrolling them in the CVC Program for the limited purpose of an initial consult and billing (UP01). This assertion is potentially supported by program data analysis of variable service access and relatively high attrition rates in in year one of enrolment. While around half of CVC participants accessed five or six services, 19% received two or fewer services in their first year. Additionally, 26% of participants disengaged in their first year, and it is estimated that only one-third of exits were due to a CVC participant entering residential care or passing away. The vulnerability of the program to this capture behaviour is heightened by limited awareness of the CVC Program and the status of patients as veterans by usual GPs (self-employed GPs in particular).

Separately, there is a very high proportion of CVC participants that are concurrently enrolled in other chronic disease management services. Whilst most GPs understood the purpose of the CVC Program, as well as other primary care chronic disease arrangements such as GPMP and TCA, and how they can best be used together, there was some confusion on what was allowable and sensible to avoid overservicing and increased complexity for patients and service providers.

The decreasing age of CVC Participants is a factor that needs consideration as part of Program improvement and/or reform in the future, with the average age being 78 years in 2016 and falling to 65 years in 2022. Additionally, the proportion of males increased from 54% in 2016 to 73% in 2022.

3.2 Appropriateness of the Eligibility Criteria

This section describes the appropriateness of and the ease of determining CVC Program eligibility.

3.2.1 Appropriate eligibility criteria

The current GCH eligibility criteria was widely supported as appropriate by stakeholders, particularly GPs, as targeting the appropriate cohort to meet the aims of the program. All case study participants agreed that the current GCH eligibility criteria was appropriate to reduce unplanned hospitalisations. They noted that regular monitoring of these patients theoretically allowed for early intervention to prevent hospitalisations and also noted the recommendations. Additionally, the Productivity Commission report [8] indicated that earlier enrolment into care coordination programs was a more efficient use of funding. A number of CVC Program participants indicated that regular monitoring of their vital signs kept them accountable and may have prevented complications. However, many GPs also indicated that hospitalisations were very likely for this cohort regardless of their care due to their age, and sometimes it was the best place for them.

The flexibility allowing GPs to use their professional judgment in selecting suitable participants, especially those with complex chronic conditions, was seen as a key advantage. However, some expressed concerns about the risks of non-compliance if audited, questioning whether their assessments of complexity would be sufficient. This compliance concern arose from audits related to non-DVA funded programs.

While establishing GCH eligibility was considered straightforward, a number of challenges to determining WCH eligibility were identified and are discussed in Section 3.4.1.

The benefits of expanding the CVC Program eligibility criteria to include other cohorts was explored with stakeholders and through the literature review. This raised a range of opportunities that would require a relatively major reform of the program and thus is discussed in more detail in Section 5.3.

3.2.2 Summary of the appropriateness of CVC Program eligibility criteria

Stakeholders, especially GPs, generally supported the current eligibility criteria for GCH and there were no concerns of note in establishing that eligibility. Determining WCH eligibility posed challenges for some GPs. Stakeholder feedback and evidence from the literature supports consideration of expanding the CVC Program eligibility criteria to other cohorts who would benefit from a program of care coordination.

3.3 Program Strengths and Enablers

The following section describes CVC Program strengths and enablers identified through stakeholder consultation and the academic literature. These strengths include ease of determining GCH eligibility, the benefits of veteran-centric healthcare, tools and resources for implementation, participant education and information, and high participant satisfaction. Where stakeholder feedback is nuanced by location or general practice business model, it is identified as such.

3.3.1 Gold Card holder eligibility

The evaluation finding was that there are no concerns of note in establishing the GCH eligibility to participate in the CVC Program. Stakeholders attributed this to:

- The CVC Program was originally designed for GCHs in 2011 with limited to no 'chronic condition' limitations; thus, their eligibility has had the time (and openness) to be well established.
- Generally, GCHs are an older cohort, and as such, are highly likely to have at least one chronic condition with multiple comorbidities, a degree of complexity and as such at risk of an unplanned hospitalisation – the large group of older GCHs are almost eligible for the program by default.

However, feedback from some practices, in particular, those that are veteran-centric, was that with the changing veteran demographic, the GCH cohort presenting to them was increasingly younger. Accordingly, the previously safe assumption for the vast majority of GCHs that older age equals chronic condition and co-morbidities, and thus, eligibility for the CVC Program no longer stood. These veteran-centric practices (that appear to be attracting younger GCHs than practices for mainstream patients) tended to have a more targeted intake system, knew their patients DVA card holder status, had a greater understanding of their entitlements, and a greater willingness to complete DVA claims paperwork.

3.3.2 Advantage of veteran-centric healthcare

Case study consultation revealed health professionals providing the CVC Program tended to have lived military experience or an understanding and/or personal interest in veteran health and wellbeing. Veteran centric practices with high concentrations of staff with lived military experience tended to be located close to Veterans and Families' Hubs and current military bases, coinciding with the location of high concentrations of newly transitioned veterans [16]. Data are not available to describe how many GPs/providers that provide the Program are veterans themselves.

Research in relation to veteran-specific barriers for accessing services, including care coordination, demonstrates a key factor being a lack of trust in providers' understanding of the veteran's experience [17]. Interviewed CVC Program participants supported that the primary drivers for their sustained enrolment are GPs who are personally motivated and have military backgrounds. GPs and practice staff who understand or have lived-military experience can provide more empathetic, trauma-informed care. Veterans feel better understood, trusted, and respected, reducing the need for repetitive storytelling.

IMPROVING ACCESS TO AN APPROPRIATE HEALTH WORKFORCE

Stakeholders expressed that identifying the location of veteran-centric healthcare providers was crucial; however, it was difficult for entitled persons to identify and/or access these providers if they did not live close to a hub or military base. The high mobility of the veteran cohort often complicated continuous healthcare access and raises challenges of how to ensure access to an appropriate health workforce for all entitled persons, notwithstanding the general workforce access challenges in regional areas.

It is unrealistic to expect that all eligible persons are treated by a GP who is a veteran, and in accordance with the importance of individual choice in provider, not all entitled persons want to be treated by a provider who is affiliated with the military.

Given the improbability of having GPs with military backgrounds available in all regions of Australia providing the CVC Program, it is essential to consider how to achieve veteran-centric care more widely. A strategy could involve enhancing the capabilities of mainstream providers to better understand veterans' experiences, thereby equipping them to manage veterans' needs more effectively.

While accepting that some GPs will not have an interest or consider it overly important to be more veteran-centric, the following strategies could be considered and will likely require CVC Program support and possibly incentivisation (as discussed further below):

- Information provided to all GPs who provide the CVC Program as part of the communication strategy (e.g. how to create a welcoming environment that fosters trust and confidence among veteran patients).
- Education and training of the healthcare team in military culture and the unique needs of veterans and their families. This could include promoting online training modules and encouraging participation in programs that improve the understanding of DVA processes. It is understood that this was previously available through PHNs.
- Developing veteran-specific policies and procedures.
- Incorporating a Veteran Liaison role within practices to help the team navigate DVA administrative processes and coordinate care more effectively, echoing the successful elements of the UK's Veteran-Friendly Practices accreditation.

Some form of incentive is likely to be key to the success of mainstream practices undertaking the more substantive activities that will enable them to be more veteran-centric. This could include:

- exploring opportunities for continuing professional development points (CPD) to be attached to any training programs offered
- payment for completion of substantive activities
- the payment (incentive or a higher rate of UP) attached to a form of recognition that the practice is veteran centric.

A RECOGNISED VETERAN-CENTRIC PRACTICE

A strategy supported by stakeholders and the wider literature involves developing a mechanism that increases the visibility of veteran-centric GPs and practices, that is, it is formally recognised and can be branded as such.

The benefit to veterans and their families is that they are provided with information that allows them to make more informed choices about their healthcare providers. Additionally, they have greater assurances that their interactions with this practice team and the support they obtain will cater to their unique needs, ultimately improving their health outcomes.

The mechanism for recognising a GP or a practice as being veteran-centric would require much greater examination and consideration. It could be relatively simple, with limited criterion being established that if met would facilitate them being recognised as such with an identifier on the National Health Services Directory. Of course, practices could subsequently highlight this recognition in their branding and promotion.

A more extensive mechanism for recognition would be through a more expansive accreditation system such as the 'Veteran Friendly Accreditation scheme' established in the UK. Such a scheme could be broader than the CVC Program and recognise and incentivise businesses, healthcare providers, and educational institutions that demonstrate a commitment to veteran-friendly practices [18].

It should be noted that in the UK, the success of the Veteran Friendly Accreditation scheme, adopted by approximately half of all practices, has been highlighted by a recent survey finding that 63% of veterans would be more inclined to seek help if they knew their GP practice was accredited, which has prompted renewed efforts to encourage more practices to join the scheme [18].

In relation to the CVC Program specifically, an 'extreme' approach would be to make accreditation a condition of eligibility to deliver the Program, albeit this would need to be a long-term strategy. Alternatively, accreditation could be voluntary, with practices motivated to take up accreditation to receive an incentive payment.

Designing and implementing an accreditation system in Australia would require specific consideration and would not be a case of simply 'installing' the UK system. The health and veteran compensation systems in Australia and the UK differ significantly. The structural differences imply that any accreditation scheme in Australia must align with both public and private healthcare providers, potentially complicating implementation compared to the UK's more centralised system.

Additionally, DVA administers various benefits, including pensions, healthcare, and rehabilitation services. Veterans UK, a part of the UK Ministry of Defence, operates compensation schemes such as the War Pension Scheme (WPS) and the Armed Forces Compensation Scheme (AFCS). The UK system's bifurcation based on the date of injury or illness contrasts with Australia's more integrated approach [19]. Thus, the policy framework for a veteran-friendly accreditation scheme in Australia must accommodate a broader range of services and providers, ensuring compatibility with existing DVA programs.

Introducing a veteran-friendly accreditation scheme in Australia involves several policy challenges, including navigating existing regulatory frameworks, securing government support, and ensuring alignment with current DVA policies to avoid duplication. Effective stakeholder engagement is essential, requiring trust-building within the veteran community and clear value propositions for businesses. Substantial initial funding would be required for development, marketing, and administration, with a focus on long-term sustainability through continuous funding. Raising awareness among the veteran community, businesses, and the public is vital, along with providing incentives for participation. Establishing clear, fair accreditation standards and robust quality control mechanisms is crucial for credibility. Addressing cultural and social barriers, ensuring compliance with privacy and anti-discrimination laws, and developing reliable methods for measuring the scheme's impact are necessary for successful implementation and continuous improvement.

To achieve enhanced access to veteran-centric care across the CVC Program, the DVA should consider:

- How they could provide and/or support (including incentivise) a range of activities (e.g. information, training, education policy, liaison roles) that equip the practice team to deliver more veteran-centric care.
- A mechanism that provides formal recognition for practices that have demonstrated to a defined standard that they provide veteran-friendly services.

3.3.3 Tools and resources to support implementation

A range of tools and resources are available for providers on the DVA website.[2] The one resource that received consistently positive feedback from stakeholders was the DVA Claims calculator. One practice manager stated:

> *"…without it, it would be impossible to keep track of when it was time for billing."*

However, different practice models used a variety of in-house tools that varied in sophistication to monitor the 90-day billing cycle (such as spreadsheets and calendar reminders). Similarly, ensuring CVC Program compliance varied depending on the practice typology, and included:

- larger corporate practices with hundreds of CVC participants used more automated scheduling tools, and with economies of scale assigning dedicated days for CVC Program review calls by the care coordinator
- smaller, regional general practices more often utilised a spreadsheet – but still blocked out dedicated care coordinator time for CVC participant reviews
- for self-employed GPs that only coordinated a handful of CVC participants, this was completed ad hoc by the care coordinator, if there was one available, or completed themselves.

USE OF TAILORED COMPREHENSIVE CARE PLANS

Consistent with the intended program design, all GPs indicated that they were using a tailored care plan. Those integrating their GPMP reported that the goals were often similar, but the CVC Program structure meant that the patient was more involved in the goal setting. Although GPs indicated that care plan templates were provided by DVA, not one GP interviewed indicated that they were using them, instead they used the care coordination templates found in their existing practice software.

While a range of CVC Program forms are available for GPs to use, there is no mandate for their use. However, it seemed apparent to the evaluators from the GPs interviewed that their perceptions were that they must be used or are highly recommended. With this understanding and a concern for ensuring compliance, GPs provided the following feedback:

- Many GPs indicated that the formats of the templates in the CVC Toolbox did not integrate with the software that they regularly used (i.e. did not auto populate) and this was an immense barrier as the time taken to fill out each section manually for each CVC participant was considerable.
- Most GPs indicated that they modified the templates available to them through their practice software 'in house' and there may be benefit from DVA contracting out this role to establish a plan with inter-operability. There was a common view that there would be benefit in providing the DVA care plan in a format that was user friendly and would increase its uptake.
- The DVA referral form was the only template that some GPs indicated was the least cumbersome to modify to integrate into their software and some did not modify it at all.

Most interviewed CVC participants did not mention a 'comprehensive care plan,' but many indicated that they did have "*regular discussions about their healthcare and their goals and how they were tracking*" and the program looked very "*structured for the GP but informal for the [CVC participant]*". Most participants supported that their care plan was discussed thoroughly every three months with their GP and the monthly phone calls ensured that logistics such as referrals were organised prior to their next GP appointment. Their increased health literacy empowered them to make decisions about their own healthcare.

[2] At the time of report writing (April–May 2024) the Notes for CVC Program Providers were under review by the TCVC team in response to stakeholder feedback about their length and complexity.

The 2023 CVC Participant Survey supported the finding above and found that approximately 67% of respondents actively participated in preparing or reviewing their care plan. Additionally, 83% reported having a care team beyond their GP and care coordinator. Most respondents (85%) maintained regular contact with GPs or the care coordinator, with face-to-face consultations being most common [1].

However, one participant indicated (noting this was not wide-spread feedback) that this did not seem to be the case, as their GP seemed to be using the CVC Program solely to complete DVA claims. The CVC participant expressed:

> *"[It] makes [me] feel sick when [I] need a doctor's appointment…. [I want] to have blood tests and pain medication alternatives…. [but it has] opened up conversation with [a] psychiatrist who is very busy, and I can only see once every 6 months …... [I] need to see a GP to see [about] more scripts and referrals – but [I] have issue getting scripts filled – time seems to be taken up with DVA claims…. [there is] no goal setting, no health checks. – [I] want prostate, blood tests, testosterone tests…"*

One general practice (confirmed by their interviewed CVC participants) was using a physical 'Blue Book' system that summarised their care plan and what treatments they were currently on that they could take with them to referrals/hospital. The participants at the practice liked having the book with them, as it meant not having to re-tell their story to different health providers and that they had responsibility and accountability for their own health information. Stakeholders and GPs supported that many participants did not trust digital health records and had the right to options.

The DVA should consider a communique to GPs to reiterate that the forms and templates provided in the toolbox are not mandatory.

In the longer term, there could be an advantage in establishing forms, templates and a care plan that have inter-operability with practice software, noting this may be challenging with multiple systems in place. This opportunity could first be raised with the GPAG.

3.3.4 Participant education and information

The thematic analysis of the 20 CVC participant interviews regarding information and education received during the CVC Program by their treating doctor or care coordinator confirmed the following:

- CVC participants received education on managing various health conditions, including blood pressure, cholesterol, pain management, and medication use, to help them understand and manage their health effectively.
- Educational resources such as brochures, emails, and websites were provided covering health conditions, treatment options, wellness, and support services, offering diverse learning opportunities.
- Consultations with healthcare professionals, including GPs and practice nurses, provided personalised education and information about the CVC Program, treatment plans, and ongoing support.
- CVC participants were connected with external resources and support services, like Open Arms – Veterans & Families Counselling and dietitian services, addressing specific needs such as mental health and nutrition.
- The proactive health management approach of the CVC Program, including a comprehensive onboarding process (45–60 minutes), empowered participants to take control of their health and make informed decisions.
- A physical 'Blue Book' was valued for its portability, ensuring continuity of care and access to treatments while traveling, though only one practice used it for recording health information.
- Some CVC participants explored alternative treatments like cannabinoid oils, reflecting a willingness to find effective health management approaches, but faced access restrictions in certain jurisdictions.

Overall, CVC participants interviewed highlighted several strengths of the CVC Program including the importance of comprehensive health education, diverse educational resources, personalised support from healthcare professionals, and connections to external support services. Additionally, adopting a proactive approach to health management, ensuring information accessibility, and exploring alternative treatment options were seen as key benefits. These elements demonstrate that the program is being implemented as intended and contribute to its overall effectiveness and participant satisfaction.

3.3.5 Participants are satisfied with the CVC Program

Overall CVC participants, those interviewed or 2023 CVC Participant Survey respondents [1], were generally very satisfied and valued the CVC Program for themselves and other veterans.

CVC participants interviewed highlighted common themes about their experiences with care teams and collaboration within the CVC Program and these themes were supported by the 2023 CVC Participant Survey results. The survey showed strong agreement with GPs referring patients to other healthcare providers and those providers sharing progress updates with the GPs [1]. However, there was lower agreement regarding care coordinator assistance in making appointments and communication with other providers on the patient's behalf. Through the qualitative interviews, CVC participants:

- valued frequent contact with their care teams, particularly through monthly phone calls or in-person appointments, which facilitated ongoing health monitoring and support.
- expressed satisfaction with communication and coordination within their care teams, appreciating check-in calls from nurses and efficient referrals to allied health professionals and specialists.
- benefited from receiving care at veteran-centric medical practices, which offered tailored support and access to veteran-specific services and advocacy.
- Appreciated the accessibility of services, including GPs, allied health professionals, and specialists, and this was particularly the case in regional areas with limited healthcare options.
- noted that initial concerns, such as staff turnover or communication issues, were generally resolved over time, leading to improved experiences with the CVC Program.

A GCH CVC participant said they felt:

"Prioritised. When [I have] bad days – [I] can ring up [my] doctor if [I] need to talk … and get prioritised straight away. Other doctors will also see you…. [I] don't have to repeat [my] medical history…." The same participant also noted that they: *"Got asked a lot of questions initially – [and] wouldn't want to go through that again with a new practice…."*

3.3.6 Summary of CVC Program strengths and enablers

The strengths of the CVC Program centre on its ability to tailor support to the health care needs of eligible persons, and the specific individuals participating. This is best demonstrated where the program is implemented through veteran-centric practices or GPs that have a military association. As supported in the relevant literature, these practices are better positioned to understand and build trust with veteran patients and readily understand and address veteran-specific barriers to accessing health services and broader health needs. It is recommended that these types of practices be made more visible to veterans (including potentially through the CVC Program and its requirements), although ready access to GPs of this kind will not be feasible in all regions of Australia. More generally, regular communication and follow-up with participants and personalised care from health care professionals underpinned very high levels of satisfaction with the CVC Program by its participants. Additionally, adopting a proactive approach to health management, ensuring information accessibility, and exploring alternative treatment options were seen as key benefits.

CVC Program tools, including the comprehensive care plans, are fundamental to the program design intent and hold further potential to support tailored care for entitled persons and the specific program participants. Currently however, there appears to be very limited use of the comprehensive care plans and other program tools, other than for administrative purposes such as DVA claims. The primary reasons for limited use of the tools by GPs was the lack of integration with the routine systems of their practices and confusion if they were mandatory for program compliance.

3.4 Program Challenges and Barriers

The following section identifies key program challenges and barriers, primarily derived from stakeholder consultation feedback. These challenges relate to WCH eligibility, low program awareness, care coordination difficulties, funding issues, insufficient promotion, and support for medically discharged ADF members, high administrative burden, and communication challenges.

3.4.1 White Card holder eligibility

The available evidence on the impact of models of care related to coordination and interdisciplinary management suggests that programs with clearly targeted interventions for a well-defined cohort of clients are more likely to improve outcome [20-22]. This seems to be in contrast with the current design of the CVC Program, which has a broad eligibility criteria, providing GPs with flexibility when enrolling eligible persons in the program. However, current evidence may reflect the challenges of measuring outcomes for broader cohorts of clients, which may be under-represented in the current literature.

The following findings reflect themes from the qualitative consultation with a focus on the challenges of determining WCH eligibility. Where findings are nuanced by location or general practice business model, they have been identified as such.

GENERAL WHITE CARD HOLDER CHALLENGES

Many issues highlighted by WCHs and GPs that treated this cohort were broader than the CVC Program and included issues with access to a health workforce, and confusion about their entitlements in general. This evaluation did not attempt to review the entitlements of WCHs, but acknowledge that at the time of report writing (April–May 2024) public consultation was being conducted by DVA regarding harmonisation of Australia's veterans' compensation system in response to Recommendation 1 of the Royal Commission's Interim Report [23].

The evaluation finding in relation to establishing WCHs' eligibility to participate in the CVC Program is that this was more difficult than for eligible GCHs. Notably:

- Key informants and members of the PMT revealed that there were barriers for GPs to easily establish whether a patient had a chronic DVA-accepted mental health condition and was therefore eligible for the CVC Program.
- Problems with diagnosis coding for accepted conditions prevented the evaluation team from identifying eligible CVC participants from the available data set. This was exacerbated by broader issues related to WCH eligibility for DVA funding for treatment in general.

GP RELUCTANCE TO ENROL WHITE CARD HOLDERS INTO THE CVC PROGRAM

GPs were reluctant to enrol WCHs for three main reasons; (i) poor understanding/awareness of WCH eligibility criteria and CVC Program business rules, (ii) Program claiming for GPs was considered too financially risky for some GPs and (iii) the Program was difficult to promote as the benefits and promotional material targeted GCHs.

A common theme from interviewed GPs included a lack of understanding of WCH eligibility. Specifically, how to determine whether a mental health condition was accepted by DVA (further described below). This was also reflected in a response from a peak health provider that indicated a *"…veteran patient of*

any age who affected by a mental health condition" (omitting 'DVA-accepted') were eligible for the CVC Program. This omission was particularly evident from GPs that did not work in veteran-centric practices who had a lower familiarity with DVA administrative processes in general, and the assumption that all mental health issues are caused by their service.

GPs who were veterans and owned veteran-centric practices maintained that even though they were experienced in working with DVA for compensation claims, the risk of not being paid for their treatment and the lack of communication about rejected claims was a deterrent. It simply was not "*good business sense*", especially given the high administration load required for CVC Program compliance (see Section 3.4.6). Some of these very experienced GPs/practice managers remained unclear as to why some patients were continually rejected, even if they seemed to meet the Program business rules (see Section 3.4.7).

Another common reason for not using the CVC Program for WCHs was the "*difficultly to sell*" to eligible persons, as it was not clear how it was benefiting them. A number of GPs and practice nurses indicated that the current Program promotional material available through the DVA website targeted the (generally) older GCH, whereas WCHs were much younger and could not relate. There was a sense that the Program was operating two different programs and would benefit from a name change and re-branding as it related to WCHs and supporting the management of mental health.

MENTAL HEALTH DIAGNOSIS AND ACCESS TO TREATMENT

Further to the issues above, most interviewed GPs indicated that the main barrier to determining WCH eligibility was criterion of having a chronic DVA-accepted mental health condition. Many GPs indicated that they had newly transitioned patients whose DVA claims were still being processed, making them ineligible for the CVC Program when they were most at risk and could benefit the most from the Program structure. Some acknowledged that this cohort was eligible for Provisional Access to Medical Treatment (PAMT),[24] but many were not aware of this entitlement. This concern for those awaiting a determination was echoed by a peak health provider. They advocated for a mental health diagnosis being the criterion for eligibility criteria, rather than it being accepted as caused by their military service, especially given the priority of the Royal Commission into Defence and Veteran Suicide. Although many GPs acknowledged that these patients were eligible for some treatments under non-liability health care (NLCH),[25] and Commonwealth funded GP mental health care plans (GP MHCP), a degree of frustration was expressed that the significant administration required to satisfy DVA claims paperwork was not being compensated and negatively influencing CVC Program uptake. No GPs reported utilising other incentive schemes to support these patients, such as the Veterans' Access Payment (VAP) [26].

One peak body suggested that expanding the eligibility to WCHs with a complex mental health diagnosis could mean that some of this claims administration time could be supported by practice nurses who are "*highly skilled, are excellent health promoters and patient advocates and build cumulative trust and long-lasting relationships with patients*". A dedicated practice nurse funding item for this purpose was suggested. Notwithstanding, a number of GPs who treated WCHs also noted that they were undertaking the majority of the care coordination for these patients, with very minimal administration support from any practice nurses except to ensure appointments and scripts were current.

These initial findings support the lower-than-expected uptake of WCHs since the expansion of CVC Program eligibility in 2021 to include WCHs with a chronic DVA-accepted mental health condition.

In summary, establishing GCH eligibility was not considered difficult because the population characteristics of the current cohort meant that they were generally eligible due to age and likely chronic conditions. However, determining eligibility for WCHs, especially regarding establishing if their mental health condition was DVA-accepted, posed challenges. Many GPs hesitate to enrol WCHs due to financial risks and unclear benefits.

Section 5.3 provides further discussion related to the policy ramifications of the current eligibility criteria for both GCHs and WCHs and considerations for how they may be expanded.

3.4.2 Low CVC Program awareness

GPs and entitled but not enrolled persons have low awareness of the CVC Program, including specific supports such as the CVC Social Assistance Program.

LOW AWARENESS OF THE CVC PROGRAM AMONG GENERAL PRACTITIONERS

Stakeholder consultation revealed that many GPs were unaware of the CVC Program. Some GPs came to know of the CVC program through colleagues, while others discovered the Program by chance, such as when researching billing codes. This lack of awareness appears widespread, as confirmed by feedback from health and allied health provider organisations, as well as ESOs and CVC participants.

Increasing the number of GPs who know about and offer the CVC Program, especially in areas where it is less available, could improve access for veterans. Mapping veteran populations against practices offering the Program could help the DVA focus on raising awareness where it is needed most. This would also reduce the reliance on a limited number of providers and enhance options for veterans seeking care.

LOW AWARENESS OF THE CVC PROGRAM BY ENTITLED PERSONS

Despite reminders, 29% of CVC participants surveyed in 2023 were unaware of having a CVC Program care plan [1]. This suggested many participants do not know about the Program or its benefits. Better promotion through veteran networks and ESOs was proposed by stakeholders, who also indicated that many veterans were not aware of their entitlements, particularly contemporary veterans who have recently transitioned out of service. This lack of awareness means they are less likely to ask for the Program, although some veterans may be overusing services compared to others who could benefit but are not eligible. For example, GCHs often use physiotherapy sessions for general wellness, while WCHs are more sparingly prescribed these sessions specifically for treatment. Allied health providers also indicated that they had a role in promotion of the Program to their entitled patients to increase awareness.

CVC PARTICIPANTS WERE NOT RECEIVING SOCIAL ASSISTANCE

A 12-week CVC Social Assistance program is available to CVC participants at risk of becoming socially isolated and/or at risk of unplanned hospitalisation because of social isolation.[27] The CVC Social Assistance Program had very low uptake, with fewer than 10 participants in the last five years. This low uptake seems primarily due to a lack of awareness among both GPs and participants. Many GPs and nurses interviewed were unaware of the Social Assistance Program, and therefore did not offer it to their patients. Some interviewed participants reported that they were not offered support for participating in social activities or groups through the CVC Program and either did not remember if it was offered by their GP or indicated that they did not receive such support.

Instead, GPs and nurses indicated that their CVC participants were using other social supports, such as sporting clubs, RSLs, and social media groups, which were more commonly used by contemporary veterans. Some general practices even explored alternative programs like community gardens and art therapy, though funding for these was a challenge. Many interviewed participants expressed a preference for their own social activities or felt they did not need additional support due to their existing networks. However, some suggested that more organised community engagement activities could improve the social aspect of the CVC Program and enhance their overall wellbeing.

INCREASE UPTAKE OF ELIGIBLE VETERAN CARD HOLDERS WITH A FOCUS ON WHITE CARD HOLDERS

Notwithstanding the recent trend in increasing CVC Program uptake, less than 1,000 WCHs accessed the Program, and they were treated by a small number of specialised GPs. Although some stakeholders commented on the DVA fees-structure for overall health services in general, the general sentiment was that Program fees provided a financial incentive for general practices to participate in the program and that low uptake was probably related to lack of awareness and implementation challenges.

Stakeholders indicated that there would be benefit from improved communication from the DVA to improve participant uptake with the following to be considered:

- re-branding the CVC Program for relevance to the contemporary veteran cohort, combined with
- a national awareness campaign with a focus on any eligibility changes and the benefits of the Program for eligible veterans. The target audience should include providers, allied health, and eligible but not enrolled persons through channels relevant to entitled persons.
- promote the CVC Program Social Assistance Program to providers.

3.4.3 Insufficient promotion and support for transitioning ADF

A number of GPs and external stakeholders, and Royal Commission submissions expressed concern at the level of support received by medically discharged transitioning Australian Defence Force (ADF) members with serious mental health conditions. Suggestions made for better promoting the availability of the CVC Program to this cohort included through:

- Veteran Support Officers on base
- Transitioning Case Managers
- DVA Triage and Connect – that currently accepts external GP and veteran self-referrals.

The limitation of DVA being unable to promote specific treatments or services to their clients is a barrier to promoting the CVC Program, as not all GPs offer the Program. Some stakeholders highlighted the recent research coming from the Royal Commission into Defence and Veteran Suicide, indicating that military service could be a risk factor for suicide [28]. The advantage of this research finding is that it is an opportunity to promote the Program that can manage mental wellbeing and empower new entitled Veteran Card holders who could enquire about it to their GP.

Stakeholders suggested expanding eligibility criteria for WCHs to address equity concerns and noted a service gap for transitioning ADF members (discussed in Section 5.2). The DVA should consider:

- promoting the CVC Program to this cohort through utilising Veteran Support Officers, Transitioning Case Managers and leveraging DVA Triage and Connect; and
- investigating a mechanism to identify 'veteran-friendly' providers, as discussed in Section 3.3.2.

3.4.4 Care coordination challenges

The following challenges related to care coordination were identified by stakeholders.

LACK OF KNOWLEDGE OF CARE COORDINATION MODELS

Many GPs lack training and understanding of care coordination and best practices due to gaps in their curriculum. When asked about care coordination models, many GPs could not identify any and assumed they understood care coordination based on the CVC Program guidelines, which are not frequently reviewed. Most GPs and nurses only perform basic coordination tasks, such as sending written referrals and using practice software notes, with limited case conferencing or multidisciplinary discussions.

Stakeholders suggested that the care coordination program aim should be reframed to be more ‘patient-centred’. Key findings included:

- GPs are often not the best at care coordination due to time constraints for case conferencing.
- GPs could refer complex mental health patients to social workers but often do not.

- Coordination of care is mostly done through practice software notes, with care coordinators following up on referrals if available.

GP CARE COORDINATION OF ELIGIBLE WHITE CARD HOLDERS

Interviews with GPs managing WCHs showed that GPs commonly undertook the majority of care coordination, even where a practice nurse care coordinator was available. These CVC participants were typically complex and had strong bonds with their GPs, resulting in frequent contact, sometimes multiple times a day. This intensive involvement was often seen in ex-military GPs or highly veteran-centric practices.

Nurses played a larger role in coordinating chronic disease management for GCHs and less complex WCH patients. However, concerns were raised about practice nurses' lack of mental health experience or training and the potential impact on their mental health and wellbeing. Stakeholders suggested that DVA should provide training, such as Mental Health First Aid, to better equip nurses for these roles.

ALLIED HEALTH BARRIERS IMPACTING CARE COORDINATION SERVICES

Although allied health professionals cannot undertake care coordination under current CVC Program rules, GPs and allied health peaks identified barriers impacting patient care, including:

- exercise physiology and physiotherapy services, beneficial for mental health conditions, cannot be used together due to treatment cycle barriers
- some allied health professionals do not accept DVA funding, preventing GPs from billing the item. The proposed merging of GPMP and TCA under MyMedicare may address this issue
- two-tier rebates for clinical and non-clinical psychologists limit access and equity in treatment
- a lack of time and funding for case conferencing hinders effective care coordination.

Some allied health professionals suggested they could perform care coordination within their scope of practice, especially in large corporate practices.[29] However, most GPs and peak bodies preferred the role remain with practice nurses. There was no support for administrative staff without a clinical background to perform this function. For mental health patients, a social worker or psychologist could potentially undertake the coordinator role.

The DVA could consider the following targeted workforce development opportunities to enhance care for veterans and support mainstream chronic disease management:

- training for GPs and practice nurses in best practice care coordination; and
- Mental Health First aid training for care coordinators with large numbers of WCHs.

3.4.5 CVC Program funding challenges

General practice location and business model influenced the attitude of GPs around the adequacy of renumeration:

- In regional areas, funding was considered adequate as long as there were economies of scale (sufficient nursing support) and an appropriately skilled workforce that understood veterans' needs.
- CVC Program funding was considered sufficient in metropolitan locations for veteran-centric practices if there was a dedicated care coordinator and many DVA clients. Funding was considered sufficient for 'concierge service' and to purchase support staff such as practice nurses and social workers if there were enough regular CVC participants. It enabled no extra appointments to be billed for scripts/referrals for participants – these administration tasks were absorbed by Program payments.

- Funding was considered inadequate in metropolitan locations to compensate GPs without the assistance of a practice nurse care coordinator where only treating a handful of eligible Veteran Card holders. This was particularly true of self-employed GPs where the administrative activity (follow up appointments, etc) was too great to cover the cost of a GP conducting the role. The following feedback was also provided:
  - This model is insufficient to pay for a practice nurse on site if a general practice is small or with low numbers of veterans, especially as the billing cycle is paid in arrears.[3]
  - RACGP noted that even though the GP fee under the CVC Program is 115% of the normal Medicare Benefits Schedule (MBS) item rebate for the equivalent service, they are unable to charge DVA clients a gap fee. The increased rate is insufficient to compensate the shortfall associated with poor indexation and the increasing reliance on many general practices to move to mixed-billing to support their business needs.[30]
- Some internal stakeholders suggest aligning CVC payments to the date of service, while external stakeholders were concerned about unclear payment processes.

Regardless of case study location or practice type, many GPs were using some CVC Program time to also fill out/follow up DVA claims paperwork, this was considered an incentive to use the Program as a means of getting some compensation for this time if their care coordination aligned with other DVA claims processes. One case was reported by a CVC participant that their doctor was exclusively using Program time for DVA claims, which was not the purpose of the Program, albeit this was not raised by any other participants interviewed.

Proposed considerations regarding reform of the funding mechanism for the CVC Program are discussed in Section 5.2. Whilst noting the recommendation in that section that changes to the funding arrangements should be considered once more information about new practice incentives and the broader primary care funding landscape becomes available, options that the DVA could consider mitigating against the funding challenges described above include:

- Enhancing support for regional practices with sufficient nursing and skilled workforce and increasing funding for metropolitan practices without dedicated care coordinators, especially those with few veteran patients.
- Addressing billing cycles paid in arrears for small practices and improving the indexation of GP fees to match rising costs would support mixed-billing practices.

3.4.6 High administration burden

Practice nurse care coordinators and practice managers reported a significant administrative burden for CVC Program compliance, often viewed as a 'concierge' service. Common feedback included:

- Most case studies indicated that the program forms/templates were customised in-house to integrate with practice software, as the DVA templates for general referrals, Client At Risk and care planning were not user-friendly and did not auto-populate.[4]
- Monthly reviews were time-consuming, involving multiple calls and informal interactions, especially with WCH participants and their GPs, occurring at all hours.
- In addition to the three-monthly in-person consultations and monthly phone calls, CVC participants often had direct access to GPs via private phone and email for healthcare queries.
- Referrals or regular prescriptions were approved without separate billed consultations.

[3] NB using DVA contracted practice nurses is available, but none of the case study sites or GPs interviewed used them.
[4] Stakeholders acknowledged that these were not CVC specific forms, nor were they mandated; however, they were necessary for clinical care coordination and/or access to service/treatment to be coordinated.

- CVC participant consultations were typically longer than usual, sometimes lasting up to an hour.
- Many of these providers were highly passionate about veteran health and wellbeing and seemed to go above and beyond the Program requirements.

Different locations and general practice business models had varying opinions on CVC Program remuneration for Program administration. Metropolitan general practices, both large corporate and self-employed GPs, felt that the fees, though higher than the equivalent MBS rate, were still insufficient to cover the significant administrative burden associated with caring for this vulnerable cohort (see Section 3.4.4). The high administrative load was particularly challenging for practices with fewer CVC participants and part-time care coordinator. One practice nurse coordinator noted, "*administration took time from providing healthcare*".

VARYING USE OF PROGRAM TOOLS BY GPS

Regarding the strengths and weaknesses of the Notes for CVC Program Providers, most GPs interviewed had not reviewed them recently, which is understandable given their long-standing participation in the program. Only one regional practice, new to the Program, had conducted a recent review due to concerns about audit compliance. Key Program documentation and tool findings include:

- Most GPs and care coordinators were unsure where to find the Notes for CVC Program Providers on the DVA website, with some admitting they had never reviewed them and were operating on a general understanding of the program and principles of care coordination.
- A few experienced GPs noted that while the Notes for CVC Program Providers and GP Guide had improved over time and the DVA CVC Toolbox offered Program resources, they lacked time to review extensive documents. They suggested streamlining resources to create more accessible, concise materials for time-pressed GPs, such as a one-page project summary summarising the business rules.

The following improvements were suggested by stakeholders to streamline administrative processes and incentivise general practice to use the CVC program. The DVA should consider:

- simplifying Notes for CVC Program Providers/GP Guide;[5] and
- improving interoperability of forms/templates necessary for clinical care coordination with common general practice software.

3.4.7 Communication challenges

Many stakeholders indicated that an overhaul of the DVA communication strategy to be more proactive with general practice (and not reliant on care coordinator email/newsletter) rather than reactive regarding CVC Program changes, would be welcomed. However, many stakeholders did not provide explicit suggestions on how it could be improved.

CVC PROGRAM COMMUNICATION STRATEGY

The current CVC Program communication strategy is multifaceted to educate stakeholders and ensure CVC Program compliance. This strategy includes information sessions and training workshops for GPs and practice nurses, supported by detailed guidance documents such as the Notes for CVC Program Providers. Regular updates through newsletters, bulletins, email campaigns, and the program's website promote continuous information dissemination. Clinical resources and patient education materials further aid healthcare providers and CVC participants in understanding and benefiting from the Program.

[5] NB at the time of report writing, DVA noted that this is currently in progress.

Feedback mechanisms, including CVC Participant Surveys and interviews, gather input and drive continuous improvement. Targeted awareness campaigns highlighted the CVC Program's expansion. These campaigns used case studies and success stories to illustrate the Program's positive impact, encouraging participation and compliance. This approach ensures stakeholders are informed and engaged, contributing to the Program's overall sustainability.

STAKEHOLDER FEEDBACK AND OPPORTUNITIES TO IMPROVE COMMUNICATION

A number of practice managers expressed frustration about the lack of specific communication and feedback and an easy way to communicate with DVA regarding rejected billings and any changes to CVC Program business rules that affected payments.

Internal DVA feedback indicated that in most cases, rejected billings were due to an inappropriate 'date of service' entered and billing before the 90 days had elapsed. However, a number of interviewees suggested that for experienced practices who had submitted claims for many years and understood the billing cycle rules, this was unlikely. Regardless, the perspectives of those interviewed was that getting a response to issues by calling DVA was considered a 'frustrating' process that ultimately had no resolution and resulted in significant unbilled work when it involved many patients. Other feedback included:

- GPs acknowledged that their inbox was often full and promotion to nurses/practice managers was probably a better communication target (especially if it involved changed administration).
- There was varying support of promotion through PHNs from stakeholders due to mixed relationships between general practices and their associated PHNs across Australia.
- Participants suggested that ESOs should be more of a target to promote the program to entitled persons – including that of the Social Assistance Program, but social media/Apps may be more appropriate for contemporary veterans.

Notwithstanding that much of the feedback about communication improvements was directed at DVA, some CVC participants noted that communication with some practices would also improve CVC Program implementation and the experience for participants. Some participants (associated with a particular general practice) reported difficulties in communication or access to services, such as challenges in reaching receptionists or delays in getting appointments due to high demand for popular GPs; however, most participants provided positive interview feedback regarding communication between the care team.

While the DVA is already implementing many communication strategies, stakeholders would particularly value improvements in feedback mechanisms for rejected billings and timely communication targeting nurses and practice managers before implementation. There would be benefit in using the GPAG to discuss this issue.

The DVA should consider investigating or optimising the following strategies:

- Review and update the communications strategy to ensure it meets current needs.
- Digital marketing and website optimisation: Enhance targeted social media, email newsletters, online ads, mobile accessibility, and search engine optimisation of CVC Program information and feedback on DVA website.
- Educational webinars: Conduct regular webinars for GPs and include program information in medical education.
- Community engagement and outreach: Partner with ESOs, Open Arms – Veterans' & Families Counselling, and participate in community events to increase awareness amongst entitled persons.
- Referral incentives: Implement incentives for referrals by GPs and participants.

3.4.8 Summary of CVC Program challenges and barriers

Whereas the strengths of the CVC Program focus on its ability to provide tailored care to veterans that is personalised to the specific individual, the challenges constrain the ability of the Program to achieve this for all participants. In particular, the program does not appear to work as well for WCHs. General practitioners were reluctant to enrol WCHs for three main reasons; (i) poor understanding/awareness of WCH eligibility criteria and CVC Program business rules, (ii) CVC Program claiming for GPs was considered too financially risky for some GPs and (iii) CVC Program was difficult to promote as the benefits and promotional material targeted GCHs. Further, the ability of the Program to facilitate personalised care for all participants appears to be constrained by lack of expertise and/or implementation of coordinated care. Most GPs and nurses only perform basic coordination tasks, such as sending written referrals and using practice software notes, with limited case conferencing, multidisciplinary discussions, or other substantive processes of integrated 'patient centred' care. Care coordination is further constrained in relation to allied health due to various access barriers.

More general challenges for program uptake by veterans include low awareness of the CVC Program by entitled persons and insufficient promotion of the CVC program in the context of transitioning ADF members. Challenges for uptake by GPs include low awareness of the CVC program among GPs, inadequate funding support for non-veteran-centric practices that do not benefit from economies of scale, and significant administrative burdens and communication challenges with DVA.

3.5 Implementation summary and proposed improvements

The following table provides a summary of the key evaluation findings and potential program improvements to enhance CVC Program implementation for the DVA's consideration.

Key Evaluation Findings	Short-term Improvement
CVC Program Trends (Section 3.1)	
• Consistent levels of participation from 2016–2022. • Significant drop-out rates in the first year of enrolment. • Average participant age is decreasing. • Proportion of male participants male is increasing. • There is overlap between the CVC Program and other chronic disease management services.	• Investigate underlying causes of early drop-out rates and address these through appropriate interventions. • Introduction of additional program controls to prevent and/or mitigate the impact of organisation's enrolling eligible persons in the CVC Program and not providing continuity of care. • The decreasing age of CVC participants is a factor that requires consideration as part of Program improvement and/or reform in the future. • Reinforce communication of WCH eligibility • Provide clarity for GPs about whether concurrent use of GPMP/TCA with the CVC Program is acceptable.
Appropriateness of eligibility criteria (Section 3.2)	
• Stakeholders supported the current GCH eligibility criteria, but determining WCH eligibility was challenging. • Low uptake of WCHs since expansion of eligibility in 2021.	• Improve clarity and awareness of WCH eligibility criteria.

Key Evaluation Findings	Short-term Improvement
Strengths and enablers (Section 3.3)	
• CVC participants valued frequent contact, care coordination, and services tailored to veterans' needs. • Veteran-centric care is highly valued. • Communication strategy is mixed, there is low awareness of the CVC Program and the associated Social Assistance Program.	• Develop a proactive communication strategy and national awareness campaigns targeting GPs, allied health providers, and eligible veterans (particularly WCHs) to promote the CVC Program and associated Social Assistance Program. • Provide and/or support (including incentivise) a range of activities (e.g. information, training, education policy, liaison roles) that equip the practice team to deliver more veteran-centric care. • Investigate the development of a formal mechanism to recognise veteran-centric providers identifiable by veterans and their families.
Program challenges and barriers (Section 3.4)	
• Barriers included concerns with use of the CVC Program as intended, administrative burden, lack of awareness, and challenges in identifying eligible veterans. • Low awareness and use of the Notes for CVC Program Providers; need for better integration of clinical care coordination forms with GP software. • Metropolitan practices without dedicated practice nurse coordinators found the funding inadequate, and high administrative burdens were reported.	• Simplify administrative processes, improve communication about necessary forms and rejected billings, and increase awareness campaigns (for GPs and eligible veterans). • Improve support for transitioning ADF members through use of Veteran Support Officers and Transitioning Case Managers. • Simplify and streamline the Notes for CVC Providers and improve interoperability of other forms necessary for clinical care coordination with GP practice software. • Review funding adequacy and consider billing options to reduce administrative burdens through better tools and support. • Further consideration and potential development of guidance on care coordination within the CVC Program and other chronic disease management services. • Review and update the communications strategy to ensure it meets current needs.

4. Program Outcomes Findings

Chapter 4 describes the evaluation findings concerning **KEQ2: To what extent has the CVC Program achieved its intended outcomes?** It includes a discussion on the impact of the CVC Program on accessing health services and cost savings as the key goal of the CVC program, as well as a summary of findings in relation to patient-centredness of care and participant views.

It should be noted that while the CVC Program was initially designed as a cost-saving measure in 2011 and hence a significant focus on hospital savings as an outcome measure, it has shifted to focus on participant health and wellbeing outcomes as a more appropriate measure of effectiveness.

4.1 Hospital Service Impacts

The following section examines the impact of the CVC Program on hospitals, drawing primarily from program and cost data, as well as academic literature. This analysis focuses on the Program's effects on hospital services and cost savings, particularly in relation to hospital efficiency savings, which is a key goal of the Program.

4.1.1 Hospital services and cost savings

Despite widespread agreement on the importance of care coordination and integration, some expected outcomes, such as efficiency gains and reductions in hospital services due to improved care coordination, remain elusive [31]. This was a finding of the earlier Bupa Cost shifting analysis [9], which demonstrated a moderate impact of the CVC Program on hospitalisations and cost savings. The more in-depth analysis showed that this was mostly due to enrolment periods being shorter than the necessary long periods required to attain anticipated savings.

These findings are not unique within the Australian healthcare context. For example, a robust analysis in NSW showed that after enrolment in a Chronic Disease Management Program, significant increases in service utilisation were observed for a range of hospital services [2]. These increases were partly explained by the Program's success in identifying the unmet needs in the target population.[2] Similarly, an evaluation of a care coordination model for older vulnerable people in the Central Coast Local Health District also noted increased hospital services usage [12].

As presented in the early literature review (provided as an annex to the evaluation design), these findings are understandable, as many factors beyond the control of primary care providers are at play, ranging from lifestyle choices to the funding system and associated incentives for hospitals.[32]-[33]

In this context, the evaluators, and many stakeholders, acknowledge that hospital services and the associated cost savings are not ideal metrics for assessing the impact of a primary care program like the CVC Program. However, since this was one of the intended objectives of the Program, the available data have been examined to determine the impact of the Program on hospital costs, as follows:

- The substantial overlap between the CVC Program and GPMP/TCA services makes it challenging to isolate the impact of the Program. To address this, GCHs receiving both services were compared to a control group receiving only GPMP/TCA services. By establishing GPMP/TCA as the base treatment, the specific contributions of the Program were identified.
- Previous evaluations and literature indicate that sustained engagement with chronic disease management programs is necessary to achieve cost savings. Therefore, the sample included GCHs who remained in treatment for at least three consecutive years and were actively enrolled the year prior to the outcome measurement.
- The number of identified chronic conditions was used as a proxy for health complexity, a key determinant of hospital costs. Analysis was restricted to GCHs alive in 2023, as data were only available for them.

- To control for health status, past hospital service usage was used to measure the number of chronic conditions. The analysis focused on hospital costs for 2021, the most recent fiscal year with complete data to reduce confounding risk.
- The model included controls for age, sex, and residence (living in major cities or inner regional areas) to account for demographic factors affecting hospital costs.

Table 4.1 presents the descriptive statistics, mean and standard deviation (in parentheses) for the sample. The dependent variable was hospital expenditure in 2021. The table also includes the number of hospital episodes per individual and the hospital length of stay (days).

The main variable of interest was a binary one indicating whether the eligible GCH received GPMP/TCA exclusively (control group) or both GPMP/TCA and CVC Program services (intervention group). Controls were included for number of chronic conditions, age, sex, and residence (major city/inner regional area).

Table 4.1: Descriptive statistics – hospital episode costs 2021 (GCH with only GPMP/TCA services vs. those also receiving CVC Program treatment).

	GCH with GPMP/TCA only (control)		GCH also receiving CVC Program (intervention)		Total	
Sample size	10,467	65%	5,470	34.8	15,746	100%
Variables	Mean	SD	Mean	SD	Mean	SD
Number of hospital episodes	1.43	(5.4)	1.54	(4.8)	1.47	(5.2)
Number of hospital days	4.44	(13.3)	4.46	(12.3)	4.46	(12.9)
Hospital costs ($)	6,638	(16,435)	6,947	(16,036)	6,745	(16,297)
Number of chronic conditions*	2.53	(1.4)	2.63	(1.2)	2.56	(1.3)
Male*	62%	(0.49)	64%	(0.48)	63%	(0.49)
Age*	77.9	(10.3)	75.8	(12.7)	77.2	(11.2)
GCHs living in major city/inner regional area	88%	(0.3)	88%	(0.3)	88%	(0.3)
*Differences are statistically significant						

As shown in Table 4.1, when compared against GCH receiving GPMP/TCA services only, there were no statistically significant differences in terms of use of hospital services as measured by the number of hospital episodes, length of stay and costs.

In line with earlier findings (Section 3.1.2), GCH receiving both GPMP/TCA and the CVC Program were younger, had a higher number of chronic conditions and had a larger proportion of males with the observed differences being statistically significant. There were no statistically significant differences in the proportion of GCH living in major city/inner regional areas.

The use of hospital services was investigated through regression analysis, summarised in Table 4.2 and with a focus on hospital expenditure (2021). Based on these results and noting the earlier caveats, the analysis showed that:

- Enrolment in the CVC Program was not associated with hospital expenditure when compared against GCH that received GPMP/TCA services only. Although the coefficient on the key variable of interest was positive (in line with the descriptive statistics associated with hospital episodes), it was not statistically significant.
- Of note, each additional chronic condition increases hospital expenditure by $1,555 and the effect was statistically significant.

- The coefficient on eligible GCH age was also statistically significant at conventional levels, though relatively modest (a $31 increase in hospital expenditure for each additional year of age).
- The male coefficient was negative, while the coefficient on residential area was positive, but neither was statistically significant after controlling for other covariates.

Table 4.2: Key regression results for hospital episode costs in 2021.

OLS regression results (hospital episode costs, 2021)	
Variable	**Coefficient**
Eligible Veteran GCHs with dual service	216
Number of chronic conditions	1,555*
Age	30.7**
Male	-175.5
Eligible Veteran GCHs living in major city/inner regional area	371.6

*Statistically significant at 1% level. ** Statistically significant at 5% level

After interrogating the results against the following alternative specifications, they remained robust:

- alternative years for measuring outcomes, within the constraints of the available data
- different specifications for the sample, including removing the constraint of GCH being active in 2020 or only including eligible GCH that enrolled after 2017
- alternative model specifications, including Poisson regression to account for the large number of zeroes in the outcome variable and results remained robust.

The results, which remained robust even with a sample including only GCHs with at least three years of sustained engagement, suggest that the CVC Program has a limited impact on hospital savings. This aligns with previous evaluations of the program. However, due to data limitations, these findings should be considered as indicative only.

4.1.2 Revisiting hospital efficiency savings as a goal of the CVC Program

In the context of recent literature, the results are understandable. The primary focus of the CVC Program is on care coordination for eligible Veteran Card holders with existing complex needs, rather than on preventing these individuals from reaching a stage where their need for care coordination and hospital services is greater.

Additionally, access to primary care is only one determinant of hospital costs [34]. Although primary care programs like the CVC Program can play a pivotal role in advancing preventive care, managing chronic conditions, and enhancing overall population health, their direct impact on hospital costs may also be constrained by the intricacies of the health financing system. As noted by the recent Australian Health Care Homes Trial, achieving outcomes such as reduced hospital services cannot rely solely on the primary care system and funding architecture; it also requires engagement and incentives for other providers and stakeholders across the health system [35].

Primary care programs like the CVC Program do not operate in isolation. The current activity-based funding system, which reimburses hospitals based on the volume and complexity of services provided, creates financial incentives that often prioritise acute and specialised care over preventive and care coordination services. A recent review of value-based care emphasised that an activity-based funding system oriented towards episodic care sits at odds with the growing share of patients with chronic conditions who require continuous, rather than episodic, engagement with health services.[32]

Since there are limited leverage points for the CVC Program to influence hospital costs for the target population (elderly chronic patients with high and complex needs), it is unrealistic to set such a goal for the Program, especially within the current health funding architecture. This point was stressed by GPs, who highlighted the challenges of reducing hospitalisations for the cohort of older GCHs, while noting the importance of engaging the population at younger ages (i.e. around 50) to realise the many benefits of early intervention and prevention.

The case studies also identified additional practical considerations that make hospital savings an inappropriate outcome for the program, as there are important methodological challenges to measure and attribute such outcome. GPs noted issues such as the choice of hospital metric to capture 'unplanned' or 'preventable' hospitalisations, the limitations of available data and confounding factors such as access to other primary care and community services.

While hospital savings is a less-than-ideal CVC Program outcome measure, this does not negate the DVA exploring other potential efficiency savings, such as those related to the delivery of Program treatment and integration with other chronic disease management services.

4.2 Patient-centred Outcomes and Experiences

Patient-centred care aims to provide healthcare services in a way that is respectful of and responsive to individual patient preferences, needs, and values. This approach is expected to lead to higher quality care and better outcomes for patients [36]. By involving patients as active participants in their own care, patient-centred care can improve communication and build a stronger provider-patient relationship built on trust. This may encourage patients to share more information, ask questions, and actively participate in developing treatment plans. Patient-centred care is also expected to increase patient satisfaction, adherence to recommended treatments, and self-management of chronic conditions.

The following section includes a sample of quotes from CVC participants about how the CVC Program impacted their general wellbeing and aided in managing symptoms caught early, followed by participants' perspectives on communication, empowerment, and program satisfaction.

4.2.1 CVC participant perspectives on patient-centred outcomes

Table 4.3 illustrates some of the interviewed CVC participants' perspectives on their experience of the CVC Program and its benefits, with common themes including hospital avoidance, mental health crisis de-escalation, the benefits of a regular doctor, and peace of mind.

Table 4.3: Quotes from CVC participants on their program experience.

Theme	CVC participant quote
Hospital avoidance	"Discussion of gut health resulted [prompted investigation and resulted] in gall bladder removal."
Mental health de-escalation/hospital avoidance	"… [I don't] think [I'd] be here without access to [my GP]."
Trust and rapport	"…if you go in about something else, they know you well enough to not think you're a hypochondriac."
Peace of mind	"…It's essential because it's keeping me focused – and I don't need to worry about the medical stuff and I don't need to worry about the DVA… [it] takes the pressure off, including having to think about when I need to take medication etc; my chemist works closely with the GP/nurse too…"

In addition to, and supporting the findings above, the 2023 CVC Participant Survey reported the highest benefits of participating in the CVC Program were being connected to relevant medical, health, and community services (56%) and receiving assistance with healthcare coordination (53%). However, only 12% reported an impact on social connection, and 23% reported a reduction in unplanned hospital stays [1].

The following sections present evidence from interviewed CVC participants supported by CVC Participant Survey results, demonstrating effective communication and trust with the program. Most participants expressed satisfaction and highly valued the program [1].

4.2.2 Effective communication and trust

CVC participants reported effective communication between healthcare providers and participants fostered trust and confidence in the care received. Participants highlighted the following regarding their communication with care teams:

- Relief at not having to explain their story to different doctors as there was a shared understanding of military culture – this was highlighted in particular by CVC participants of veteran-centric general practices as a major benefit.
- They felt supported by their care teams, who demonstrated a thorough understanding of their medical history and needs, and who communicated well outside of regular appointments to ensure a streamlined program experience.
- They appreciated the continuity of care provided by having the same nurse or doctor regularly and many contrasted this with their experience in the ADF that meant they did not see a regular doctor and they often waited months for appointments.
- CVC participants emphasised the importance of coordination and continuity of care within the program. They appreciated the cohesive approach, where information shared with one provider was communicated to others, improving care coordination and continuity. This streamlined approach reduced the need to repeat their medical history and ensured a holistic understanding of their healthcare needs.

4.2.3 CVC participants felt empowered by the CVC Program

CVC participants revealed the impact of information and education on their healthcare and communication with GPs or care providers. These themes were consistent across various general practice locations and business models and aligned with the CVC Participant Survey results [1]:

- CVC participants felt more confident discussing their health concerns and treatment plans due to improved knowledge and understanding of their conditions, medications, and treatments. This enhanced health literacy empowered them to actively participate in healthcare decisions and advocate for themselves.
- CVC participants reported better communication with their GPs or care providers, feeling more comfortable discussing difficult topics, asking questions, and having open, honest conversations. This improved communication fostered stronger trust between participants and healthcare providers.
- CVC participants felt empowered to take control of their health and set improvement goals. They expressed a desire for more proactive health checks and goal-setting discussions within the CVC Program, contributing to their overall sense of empowerment and well-being.
- Some CVC participants explored alternative treatments, such as cannabinoid oils, meditation, yoga, breathing practices, and art therapy. They discussed these options with healthcare providers and shared experiences with other veterans, indicating a willingness to consider holistic health approaches.

4.2.4 Most CVC participants are satisfied with and value the CVC Program

The 2023 CVC Participant Survey and CVC participant interviews across practice locations supported overall satisfaction was high for both GPs and nurse coordinators, with GPs receiving higher scores. Participants expressed the highest satisfaction with health condition management and understanding their healthcare needs. Although satisfaction with overall health and wellbeing was slightly lower, the CVC Program's contribution remained positive [1]. Key findings from participant interviews included:

- CVC participants felt comfortable and trusted the CVC Program, enabling open communication with healthcare providers without feeling judged.
- Regular check-ups, appointment and medication reminders, and monthly check-ins helped CVC participants stay on top of their healthcare needs and encouraged active health management.
- CVC participants reported better health and wellbeing due to early diagnosis, regular check-ups with familiar doctors, and effective care coordination.
- The CVC Program's personalised approach, including regular check-ups with the same doctor and streamlined processes, reduced stress, and ensured timely care.
- Some CVC participants emphasised the need for better understanding of veterans' experiences and advocated for veteran-specific healthcare hubs.

Overall, the 2023 CVC Participant Survey [1] broadly supported the evaluation qualitative findings that the highest benefits of the CVC Program are connecting participants to relevant medical, health, and community services and assisting with healthcare coordination. Effective communication and trust, rooted in a shared understanding of military culture and support from knowledgeable care teams, are key to the CVC Program's success for CVC participants. While only 12% of survey respondents reported improved social connection and 23% noted fewer unplanned hospital stays, the Program enhances participants' confidence, knowledge, and proactive health management [1]. These factors contributed to improved health outcomes, overall wellbeing, and high Program satisfaction.

4.2.5 Outcomes summary

Evaluation findings regarding the extent to which the CVC Program has achieved its intended outcomes indicate that the program has improved the quality of care and patient centredness of care for participants. Its impact on hospital cost savings remains limited, however, it is noted that DVA no longer consider this the primary intent of the CVC Program. Participants valued the personalised and proactive management approach, which included regular check-ups, medication reminders, and effective care coordination. This fostered a supportive environment of comfort and trust, empowering participants to actively manage their health. While direct financial sustainability and value for money in terms of hospital cost reductions were less clear, the overall health improvements and participant satisfaction suggest the Program provides value. To further enhance the Program's effectiveness consistent with DVA's decreasing emphasis on Program cost-savings, improvements such as more robust outcome measures on treatment compliance and outcomes, integrating with other chronic disease management services, and enhancing data integration could be considered.

4.3 Outcomes Summary and Proposed Improvements

The following table provides a summary of the key evaluation findings and potential program improvements to enhance CVC Program outcomes for the DVAs' consideration.

Key Evaluation Findings	Program Improvements
Hospital Service Impacts (Section 4.1)1)	
• The CVC Program has contributed to improvements in quality of care and health outcomes (per section 4.2) but has a limited impact on hospital costs. • While the direct impact on hospital cost savings is unclear, overall health improvements suggest value for money.	• Explore other potential efficiency savings, such as those related to the delivery of CVC Program treatment and integration with other chronic disease management services.
Patient-centred outcomes and experiences (Section 4.2))	
• Outcomes are influenced by factors such as age, sex/gender, risk profile, and practice size. • Improved care coordination and access to necessary treatments through regular check-ups and consistent communication. The proactive approach of the CVC Program helps participants stay on top of their healthcare needs, ensuring nothing falls through the cracks. • The program fosters a supportive environment where participants feel comfortable and trust their healthcare providers. • The CVC Program empowers participants to actively participate in their healthcare decisions and advocate for themselves. • Personalised care including regular check-ups with the same doctor and streamlined processes, reduces stress, and ensures timely care.	• Enhance data integration and leverage existing data systems to reduce administrative burden (Section 5.6).

5. Program Reform Opportunities

Chapter 5 addresses **KEQ3: How could the CVC Program potentially be redesigned to better meet the needs of current and future DVA clients?**

This chapter explores major reforms that could enhance DVA primary care arrangements, informed by stakeholder consultations, approaches to veteran care coordination in other Five Eyes countries, experiences within Australia's primary care landscape, and considerations for a younger veteran cohort.

Section 5.1 provides key lessons learned from other Five Eyes countries through a rapid literature review, focusing on best practices for delivering and funding care coordination for veterans. These findings are detailed in an annex to the evaluation design.

Sections 5.2–5.6 outline considerations for a forward-looking strategy for DVA primary care arrangements. The primary emphasis is on how the Program can leverage upcoming policy developments in Australia's primary care sector to improve outcomes for a new cohort of younger veterans. These considerations are exploratory, as details about MyMedicare and other funding reforms were still emerging at the time of writing (April–May 2024). Additionally, the forthcoming report from the Royal Commission into Defence and Veteran Suicide, due in September 2024, is expected to contain recommendations that will impact the design of the CVC Program.

Data sources for this chapter include stakeholder feedback, reviewed literature, and CVC Program data analytics. A summary of key reform considerations concludes the chapter.

5.1 Key Lessons in Veteran Care Coordination across Five Eyes Countries

This section first provides the experiences in other Five Eyes countries, and subsequently, a brief overview of ongoing developments in the Australian primary care landscape that are directly relevant to care coordination programs like the CVC Program, particularly the introduction of MyMedicare.

5.1.1 New Zealand and Canada – Veteran specific care coordination only for complex cases

The limited publicly available information on New Zealand and Canada suggests most health services and their coordinated delivery are funded and delivered through the mainstream health system. A veteran-specific care coordination system exists only for those individuals with complex needs.

In New Zealand, Veterans Affairs covers only service-related injuries or illnesses. When the required treatment exceeds 'usual' care, approval for a treatment plan is required. This plan seemingly functions as both a coordinating and cost-containing mechanism. Recent consultations on broader service coordination indicate ongoing efforts to improve care delivery, recognising the need for more integrated and comprehensive approaches, particularly for veterans with complex needs [37-41].

In Canada, veterans with disabilities or requiring long-term care qualify for additional benefits beyond those offered by mainstream health services and receive a health card. Care coordination services, primarily listed under health benefits, focus on case management for veterans in transition or who were released from service years ago, but are still in need of complex care [42-45].

5.1.2 USA – Team-based approach supported by transformational general practice change and funding

In the United States, the Veteran's Health Administration (VHA) has implemented the Patient Aligned Care Teams (PACT) model, the largest Patient-Centred Medical Home 'demonstration' in the country. The model is funded through a complex blended formula that includes risk-adjusted per capita allocations [46-54]. PACT is recognised as a transformative approach to healthcare delivery, emphasising patient-centred care and coordination across the entire healthcare system, aligning with the primary objectives of coordinated care programs like CVC and broader initiatives such as the Health Care Homes trial in Australia.[35]

The PACT model consists of interdisciplinary 'teamlets' that provide ongoing care to enrolled patients within their designated healthcare home. These teamlets typically include:

- GPs or Primary Care Physicians: responsible for overall patient care management, diagnosis, and treatment planning.
- Nurses: who play a vital role in patient education, care coordination, and follow-up.
- Medical Assistants: who assist with administrative tasks, patient intake, and basic medical procedures.
- Clerks: who provide administrative support, schedule appointments, and manage patient records[12, 31, 54-58].

This teamlet composition addresses the wide range of tasks required for delivering integrated care, from health professionals developing and implementing treatment plans, to more mundane, but critical care coordination tasks, such as facilitating timely appointments and referrals and maintaining accurate patient records, undertaken by clerks.

Despite the advantages of teamlets, which optimise the use of highly qualified and scarce professionals such as GPs and nurses, their implementation requires transformational changes in practice operations and funding. A recent report highlighted that significant changes to how Australia funds GPs—potentially involving a mix of fee-for-service and flexible per capita budgets based on need—are necessary to support team care and enable GPs to spend more time on complex clients.[59] Since this seems to be the direction towards which the new MyMedicare scheme is moving (Section 5.1.4), the evaluators recognise the large potential of leveraging MyMedicare to provide improved care coordination to veterans.

5.1.3 The UK – Care coordination outside the NHS only for veterans with complex needs and starting prior to military service discharge

Similar to the USA model, integrated care is at the core of how health services are delivered to the UK population, including veterans.[60-62] Healthcare for veterans is seamlessly integrated within the National Health Service (NHS) Clinical Commissioning and Integration Systems, which prioritise coordination and integration of care services.

According to the 2019 Integrated Personal Commissioning for Veterans (IPC4V)[63], care coordination for veterans with broad health and social care needs is managed and funded through mainstream services - the NHS. Veterans with complex and enduring health care needs are enrolled into the IPC4V program.

The framework emphasises that planning for delivering care and support to veterans should begin before they are discharged from military service. Thus, prior to discharge, veterans' care coordination needs are identified and matched to the appropriate services and providers, whether through the NHS or the IPC4. [63].

In addition to healthcare, the IPC4V commissioning package includes coordination of services related to accommodation, domestic assistance, transport, carers, finance, family support, social life, and work/education. This comprehensive approach recognises that veterans may require support in various aspects of their lives beyond medical care.[63]

Once a referral to the program is made, a multi-disciplinary, multi-agency steering group oversees the case. The program is implemented through Veterans Welfare Managers, who serve as local area coordinators. These managers support veterans in developing personalised plans, connecting them to community resources, including veteran organisations, and facilitating referrals to health and/or social care services. Funding is provided through personal budgets allocated to individuals based on their personalised care plans.[63]

5.1.4 Australian key primary care developments and care coordination

Recent policy developments, in particular, the new voluntary patient registration model (MyMedicare), the Australian Primary Health Care 10 Year Plan,[3] the Strengthening Medicare Taskforce Report,[4] and the Medicare Benefits Schedule Review Taskforce,[5-7] are expected to transform the primary care landscape in Australia.

Of specific relevance to the CVC Program is MyMedicare, a new voluntary patient registration model aimed at providing a platform for funding reform to incentivise quality of care and improved outcomes for at-risk population groups such as those with complex and chronic conditions who frequently attend hospitals.[64] This scheme aims to formalise the relationship between patients, their, general practice, and primary care teams.

MyMedicare benefits include longer MBS funded telehealth consultations, triple bulk billing incentives for longer MBS telehealth consultations for priority populations, including pensioners and more regular GP visits and better care planning for people living in a residential aged care home. Additional benefits for practices registered with MyMedicare in 2024–2025 include:

- improved access to information about their regular clients
- new blended funding payments for clients living in the community who are frequent users of hospital services
- financial incentives to deliver the new aged care services, including regular health assessments, care plans and regular GP visits
- the linking of patients' registrations to chronic disease management items. This linkage will ensure that for registered patients, only their regular GP (i.e. their registered practice) is able to provide chronic disease management items, as expected with models of care for chronic conditions.

In late April 2024, a large number of practices across the country had registered with MyMedicare and continuing efforts by the Australian Government to achieve full coverage are underway.

At the time of writing this report, details about the frequent hospital users' scheme were still emerging. However, brief discussions with the Department of Health and Aged Care (DOHAC) indicated that the scheme would be piloted with five to nine PHNs and associated general practices in the coming year. Each PHN is likely to have flexibility in how the CVC Program is implemented and assessed, with the pilot informing national rollout.

Additionally, in the coming months, a review of the Practice Incentives Program (PIP) is expected to outline changes to the model, including how incentives are paid.

These potential changes reflect some recommendations from a recent evaluation of the Better Access to Psychiatrists, Psychologists, and General Practitioners through the MBS initiative (Better Access) to promote more care [65]. Details are still to emerge regarding the extent to which items such as GP

Mental Health Plans will be linked to a patient's registration with a specific practice under MyMedicare in the near future.

The requirement under MyMedicare that chronic disease management items only be provided by the practice with which they are registered could be extended to the CVC Program. This would contribute to ensuring the client's regular GP delivers CVC Program services/treatments, and thus, improve outcomes for clients. This measure could also prevent the enrolment of eligible CVC participants solely for financial gain, without having a regular and established relationship with them.

Currently, DVA only has access to information about individual GPs providing services. By implementing this measure, data could also be obtained at the practice level, which would enhance CVC Program performance monitoring. This would include tracking indicators such as the rate of practice clients discontinuing participation.

5.2 Funding Mechanisms

The Productivity Commission Report recommended that the CVC Program adopt a risk-based payer model, in which providers are paid a fee per client based on their risk profile and become responsible for delivering all services required by the client during the year.[8] Similar capitation and bundled payments systems in the UK and the US incentivise early prevention and intervention multidisciplinary teams delivering care integrated across providers and system levels, and efficiency improvements in health outcomes.

At the core of these types of funding mechanisms is a capitation payment adjusted by risk factors, so that the higher the risks and health needs of an individual, the higher the per capita payment the provider receives.

Providers assume the financial risks and rewards of delivering care within the allocated per capita funding, with financial incentives linked to achieving specific outcomes.

Funding agencies play a crucial role in ensuring the actuarial soundness of the allocated funding, supporting system requirements such as data exchange platforms, monitoring outcomes, and using data to drive quality improvements.

However, these risk-based, value-added funding mechanisms require transformational practice changes for success, as highlighted by the recent Health Care Homes trial. These changes include adopting models of care tailored for multidisciplinary team-based services, altering the composition and roles of practice staff, and supporting digital and business infrastructure.[35, 66-68]

This type of transformational change at general practice level requires scale; thus, there are important challenges for the Department to use funding reform to transform the way services are delivered by general practices when veterans and their families represent a minority of practices income and clients.

With the veteran population representing a minority of general practice clients, it is understandable that the qualitative findings revealed higher costs for practices where operating procedures deviated from their usual business models.

In this context, it is likely that relatively high financial incentives are required for practices to adopt risk-based payer funding to deliver the CVC Program and offset those higher costs. This would potentially erode any of the expected efficiency savings that can be theoretically expected. Without these incentives, there is the risk of many practices discontinuing the Program.

Upcoming changes to primary care funding aim to incentivise continuity of care and service quality. Evaluators suggest that substantial changes to the CVC funding mechanism, such as adopting risk-based funding, should be considered once more information about new practice incentives and the broader primary care funding landscape becomes available.

Discussions with the DOHAC also indicated that future approaches to primary care funding may be more aligned with how CVC Program services are currently funded, with payments provided at the end of the service cycle and additional incentives tied to specific outcomes. While the review of primary care incentives is ongoing and implementation of any mainstream funding reform would be a decision for Government, adopting a whole-of-Government approach could address concerns with the current funding mechanism, which lacks linkages to outcomes.

Notwithstanding the way chronic disease management services and CVC Program treatments/services are concurrently delivered, it seems advisable to consider the advantages of formally integrating the delivery and funding of both, bringing current payments in line with Medicare systems. However, the mechanism to do so should consider the new practice funding mechanisms, the details of which are yet to be released. It is advisable to reserve changes to CVC provider funding until more information is available about broader primary care financing reform.

Importantly, a strategic redesign of DVA primary care arrangements in line with best-practice models, such as the UK's IPC4V, should be considered. This would involve various care coordination models tailored to the levels of entitled persons' needs. While some care coordination could be delivered and funded through general practice, other models for complex clients may require different providers supported by new financing models.

5.3 Changes to CVC Program Eligibility

Various stakeholders have identified veteran cohorts currently ineligible for enrolment who would benefit from the CVC Program. This section is organised within the context of resource allocation and budgetary constraints, incorporating stakeholder perspectives and available research evidence. Prioritisation has considered groups most likely to benefit from early intervention and prevention associated with patient-centred care programs, as well as cohorts with less generous access to health services. This is not a value-based judgement on who is more deserving of the Program. This is particularly important, because this evaluation adds to previous evidence of limited to no hospital savings derived from the Program, as described in Section 4.1.1.

This section discusses considerations for first prioritising CVC Program eligibility expansion for transitioning ADF members and WCHs. As a second priority, the expansion considers eligible GCHs in RACF and those with a terminal diagnosis.

5.3.1 Consider prioritising eligibility to medically discharged ADF members

Australian Defence Force members transitioning to civilian life are at risk of poorer mental and physical health outcomes. Recent research from the Royal Commission into Defence and Veteran Suicide indicates that military service may actually be a risk factor for suicide, rather than a protective factor.[28, 69] Accordingly, these individuals may significantly benefit from preventive care and early intervention services, which can prevent the escalation of health issues in the long term.[70, 71]

Care coordination models that emphasise integrated care across providers are well positioned to address the challenges veterans face when navigating from a highly structured military healthcare system to a more complex, unstructured, and unfamiliar mainstream system [17]. Stakeholders and evidence from other jurisdictions support patient-centred and care coordination programs, such as the CVC Program, especially when provided in the early stages of the transitioning process. These programs can offer a stable start, improve integration into civilian life and enhance long-term stability and productivity.

The benefits of early intervention are a key factor behind the UK model, where veterans' care coordination needs are identified prior to discharge from military service [63]. This approach also

underpins the Canadian emphasis on care coordination for recently discharged or transitioning individuals.

Further to the evaluation findings in Section 3.4.3, a number of GPs, external stakeholders, and submissions to the Royal Commission expressed concern about the low level of support for medically discharged transitioning members with serious mental health conditions.

Some stakeholders noted that DVAs limitations on promoting specific treatments or services is a barrier, as not all GPs offered the CVC Program. Promoting the Program and encouraging newly entitled veteran card holders to enquire about it with their GPs could mitigate this issue. The advantage of this approach is to promote the Program and empower newly entitled persons to enquire about it to their GP.

Notwithstanding legal issues related to the treatment principles and eligibility criteria for Veteran Cards in general, and with the caveat of the upcoming Royal Commission report, there is a compelling case for DVA to consider prioritising CVC Program eligibility for transitioning ADF members. Section 5.6 presents a stepped care model approach similar to that used in the UK. This model identifies the need for care coordination during the transition process and customises services and funding to the identified needs of the veteran.

5.3.2 Consider expanding eligibility to existing White Card holders with chronic DVA-accepted physical conditions and those with a mental health diagnosis

The case study interviews highlighted the potential efficacy of a 'care coordination' program aimed at reducing hospitalisations through early intervention and regular monitoring of chronic diseases. GPs emphasised the value of engaging with the population earlier, starting at age 50. This approach, also supported by health provider peak bodies, aims to slow the progression of chronic disease, reduce mortality, and alleviate patient complexity. These efforts can ultimately lead to long-term healthcare system savings and improved patient outcomes.

Lowering the age threshold to the 50+ age group aligns with evidence indicating that disease is a leading cause of death in this demographic, particularly among former and current male veterans [30] [72] [73] [74] [75]. Additionally, this age group faces heightened risks of diabetes and chronic obstructive pulmonary disease, which are targeted health conditions for the Program. This approach also aligns with the changing demographic of an increasingly younger veteran population.

Consistent with many of the case study and GP interviews, and peak body written submissions a number of considerations for expanding the current eligibility for WCHs were suggested, including:

- WCHs aged 50+ with a chronic health condition that is not a mental health condition
- functional pain disorders
- musculoskeletal disorders commonly associated with service
- diabetes (as recommended by the diabetes review [KPMG report to DVA]).

Regarding WCHs with non-accepted conditions, stakeholders noted that it seemed incongruous to fund treatment for non-accepted mental health conditions, but not for the integrated and person-centred care benefits targeted by the CVC Program, which are essential to quality mental health care delivery.

WCHs, a cohort with more restricted access to benefits, may be considered as the next priority group for extending CVC Program eligibility under budget constraints. Specific groups, as suggested by stakeholders and supported by research that would benefit from accessing the CVC Program, include:

1. WCHs over the age of 50 with a complex chronic physical or mental health condition accepted by DVA, similar to the current eligibility for GCHs.
2. WCHs with a mental health diagnosis (not DVA-accepted) already eligible for NLHC and PAMT (see Section 3.4.1)

5.3.3 Consider expansion of Gold Card holder eligibility to residential aged care and terminal diagnosis

Under a process of prioritisation, extending coverage to GCHs would then be considered. Specifically, some internal stakeholders suggested extending CVC Program coverage to GCH in residential aged care and under palliative care.

The following themes reflect the perspectives of health provider peaks, internal DVA, and external government stakeholders in relation to CVC Program eligibility ceasing on entering RACF, and/or having a terminal diagnosis:

- peak health providers noted that there was an upcoming expansion of GP accreditation to include aged care facilities, which should encourage GPs to work more with RACF in the future
- plans to extend MyMedicare to aged care from August 2024
- there was feedback that on entering RACF, CVC participants thought that their entitlements for service had been 'taken away'
- a view that an existing terminal diagnosis should not deem an otherwise eligible GCH from the CVC Program as palliation may take many years and encourage participants to stay at home longer – noting that if a CVC participant was in the Program prior to a terminal diagnosis, that it did not exit them from the Program immediately.

Since ongoing MyMedicare developments are targeting residential aged care residents, including eligible persons, a key consideration would be the extent to which the upcoming MyMedicare reforms would effectively address this gap.

Regarding palliative care for those outside residential aged care, an additional consideration beyond prioritisation and available funding relates to the extent to which additional support would be required for GPs to effectively operate in this role. Unlike chronic disease prevention and management, which are already established as a routine part of general practice, additional supports may be required to empower GPs to provide advance care planning and other care coordination activities related to palliative care.[76, 77]

5.4 Care Team Composition

Integrated care involves the seamless coordination of healthcare services across different providers and settings to ensure patients receive comprehensive and continuous care tailored to their individual needs. This approach prioritises person-centred care, empowering patients to actively participate in their own health management through self-management strategies and decision-making processes.[78] Qualitative interviews found that elements of person-centred care, such as personalised care plans and goals, were salient in the models of care across practices in the case studies. However, as discussed earlier, there is variability in the extent to which practices engaged in pro-actively coordinating the care delivered by

other providers, which is critical to ensure a continuum of care for clients and improved outcomes (see Section 3.4.4).

Notwithstanding the name of the program, the current model of care behind the CVC Program places insufficient emphasis on the role of general practice in facilitating and coordinating care delivered by other providers. This issue points to systemic limitations that need to be addressed in the context of ongoing primary care reforms, as discussed below.

Best-practice models for integrated, veteran-centric care that is coordinated and continuous—rather than fragmented—involves a wide range of clinical and administrative tasks. These tasks include making appointments for referral services, warm handovers to avoid clients having to repeatedly tell their story, pro-active information sharing between providers, and routine follow-up with clients and providers.

Given the spectrum of tasks involved in person-centred and coordinated care, it is understandable that the US teamlets model involves much more than a GP and practice nurse. It operates in a supportive environment that facilitates regular communication, information exchange, and collaboration with other providers.

In this context and supported by Section 3.4.4, the evaluators acknowledge that:

- Important system constraints, including privacy issues, digital platforms interoperability, and organisational culture will have an impact on the extent to which general practices are able to coordinate care with other providers, including allied health professionals and hospitals.
- For less complex clients, the use of practice nurses to undertake many of the administrative tasks required to routinely communicate and exchange information with other providers may not provide good value for money nor be in scope, especially related to the care coordination needs of highly complex mental health patients. Case study interviews also suggested that CVC Program funding has been insufficient to fund the ongoing employment of supporting administrative workers or to employ more practice nurses for care coordination purposes, except in circumstances where general practices were veteran-centric (see Section 3.4.5).

Noting that a wider teamlet is ideal for delivering programs like the CVC, implementing such transformational change requires a 'whole practice' approach. Qualitative findings emphasise the high costs for practices to deviate from their 'Medicare business as usual' processes. The extent to which upcoming changes to MyMedicare and funding reform will incentivise practices to employ expanded teamlets for delivering integrated care—emphasising both patient-centred care and care coordination, as seen in other countries—remains unknown. In this context, it would be advisable for the Department to wait for further developments in the primary care space before making any changes to the composition of the team delivering CVC. Specific changes to team composition would need to be considered, along with financing incentives.

Stakeholders particularly noted the issue of care coordination of musculoskeletal conditions, common among ex-serving members. Both physiotherapists and exercise physiologists indicated they should be allowed to undertake care coordination for these CVC participants (see Section 3.4.4).

A recent review commissioned by DVA considered extending the CVC Program to include allied health professionals in the care coordination role.[79] The report noted the key challenge of very few practices currently employing an allied health professional. However, providing this option may incentivise practices to hire allied health professionals for care coordination. It should also be noted that the current option exists for the engagement of a DVA-contracted CN to provide the care coordinator role (with a separate UP0 billing code). Arguably, a similar sort of external contracted agency could be implemented should another provider be used in care coordination for the CVC Program.

Several critical issues require further consideration before including allied health professionals in a care coordination role for the CVC Program:

- An important aspect of the CVC Program is person-centred care, including nurses' routine monitoring of clients, advice relating to medication, and the management of complex psycho-social issues for some clients. Some of these tasks may be outside the remit of allied health practitioners; thus, given their current scope of practice, they may not be a suitable substitute for nurses.
- If the intention behind including an allied health professional is to incentivise general practices to engage a multi-disciplinary team (GP, nurse and allied health professional) to facilitate the delivery of person-centred care and coordination of services, consideration should be given to other aspects of the model, including funding reform (discussed above) and outcome monitoring.
- Without funding changes, providing practices with the flexibility to substitute a practice nurse with an allied health professional may lead to some practices enrolling less-complex clients that do not need the routine monitoring of a practice nurse. These practices would be receiving the same funding as practices enrolling more complex clients that receive the services of practice nurses. Without monitoring the risk profile of clients enrolled in the CVC Program and their outcomes, it will be difficult for the Department to assess the extent to which providing the same level of funding for practices delivering different models of care is warranted.

In summary, while integrating allied health professionals into the CVC Program's care coordination role has potential benefits, it requires careful consideration of scope of practice, multidisciplinary team integration, and funding mechanisms to ensure the Program continues to deliver high-quality, person-centred care.

5.5 Outcome Measures

The findings in Section 4.2 described how the CVC Program has contributed to continuous and trusting relationships between clients and their healthcare teams, client education, knowledge, and self-management. These outcomes were assessed against relevant issues identified in the literature.[80-83] For example, studies have shown that patient-centred care models that enhance client education and knowledge empower clients to self-manage their conditions. Such models ensure clients understand their needs, are aware of available options, and are actively engaged in the decision-making process.

While hospital cost savings have been considered an outcome of the CVC Program, it may be necessary to reassess this focus. Attributing hospital cost savings directly to a primary care program like the CVC, which serves a large proportion of elderly clients, presents significant challenges (Section 4.1.2).

The upcoming frequent hospital users' pilot by PHNs under DOHAC's guidance may offer valuable insights. This pilot, which targets frequent hospital users specifically, could potentially provide a more realistic approach to achieving hospital cost savings compared to the current CVC design that broadly focuses on clients at risk of hospitalisation.

In recent years, health systems worldwide have increasingly adopted patient-centred approaches, which is at the core of the CVC model of care. The literature underscores the importance of a patient-centred approach in improving client experience and system efficiency through enhanced client empowerment, satisfaction, and increased system responsiveness [80, 84-87]. Consultations with health provider peaks indicated strong support for Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs). These measures are well-documented to support clinician decision-making and shared care planning, and are considered good indicators of overall patient outcomes, particularly for conditions where health and wellbeing levels are more significant than mortality risk. Despite the availability and routine use of metrics for PROMs and PREMs in patient-centred care, they are not routinely collected as part of the CVC Program.

The following considerations regarding CVC Program outcomes were primarily derived from qualitative consultations undertaken for this evaluation. However, they must be examined in the context of upcoming primary care reforms to ensure routine Program outcomes and reporting mechanisms align closely with mainstream systems and incur minimal transaction costs for practices.

5.5.1 Chronic disease markers as a measure of CVC Program effectiveness

Although many case study interviews did not discuss chronic disease markers as a measure of CVC Program success (acknowledging it as a care coordination program and the limitations of health information collection by DVA), some stakeholders indicated that linking chronic disease markers with GPMP or the Program (which were being informally integrated by many general practitioners as described in Section 3.1.2) could enhance their effectiveness in managing chronic conditions and improve patient outcomes especially as this data was already being routinely collected.

There was acknowledgement of many challenges to overcome relating to legislative barriers and privacy concerns in addition to the resistance of further data collection from general practices.

Table 5.1 provides an overview of potential markers for consideration within the constraints of data collection.

Table 5.1: Chronic disease markers to indicate CVC Program effectiveness.

Chronic disease marker	Rationale for inclusion into CVC Program outcomes
Blood pressure	Regular monitoring of blood pressure levels is integral to CVC programs, allowing care coordinators to ensure that patients receive appropriate medication management, lifestyle counselling, and follow-up appointments to control hypertension and reduce the risk of cardiovascular events
Blood glucose levels and HbA1c levels	Chronic disease management programs often focus on optimising diabetes management by monitoring blood glucose levels and HbA1c levels. Care coordinators work with patients to develop personalised care plans, including medication adherence, dietary recommendations, and regular blood glucose monitoring to achieve glycaemic control and prevent diabetes-related complications.
Cholesterol levels	The CVC Program could incorporate lipid management strategies to address dyslipidaemia and reduce cardiovascular risk. Care coordinators collaborate with patients to implement lifestyle modifications and medication regimens aimed at improving lipid profiles and reducing the risk of atherosclerotic cardiovascular disease.
Body Mass Index (BMI)	Care coordinators could assist patients in managing weight through nutrition counselling, physical activity recommendations, and referrals to weight management programs or specialists. Monitoring BMI trends allows for early intervention to prevent obesity-related comorbidities and promote overall health.
Lung function tests:	Pulmonary rehabilitation and smoking cessation interventions for patients with COPD or other respiratory conditions could be coordinated through the CVC Program. Care coordinators could monitor lung function test results to assess disease progression, optimise medication management, and coordinate referrals to pulmonary specialists or rehabilitation services.
Kidney function tests	Kidney health could be improved by monitoring kidney function tests and implementing strategies to slow the progression of chronic kidney disease. Care coordinators could collaborate with nephrologists and dietitians to optimise medication management, blood pressure control, and dietary interventions to preserve kidney function and prevent complications.
Mental health screenings and mental health assessment tools	The importance of addressing mental health needs alongside physical health concerns was also highlighted – in addition to the interplay of both physical and mental health in general. Care coordinators could utilise mental health screenings to identify patients at risk of depression or

Chronic disease marker	Rationale for inclusion into CVC Program outcomes
	anxiety and coordinate referrals to behavioural health specialists for counselling, therapy, or medication management. Validated assessment tools such as the Patient Health Questionnaire (PHQ-9) for depression, the Generalised Anxiety Disorder 7-item (GAD-7) scale for anxiety, or the PTSD Checklist for DSM-5 (PCL-5) for post-traumatic stress disorder could be used to measure changes in symptom severity over time.

Some stakeholders suggested that by integrating these chronic disease markers into care coordination programs, healthcare teams could proactively manage chronic conditions by way of determining a change in health condition over time, improve patient engagement and adherence to treatment plans, and ultimately, enhance overall health outcomes for patients.

5.5.2 PREM/PROM as outcome measures

Most stakeholders supported the involvement of patients in the evaluation of health policies as part of a patient-centred approach to health and health policy and more specifically, the health peaks consulted were supportive of the use of PROMs and PREMs to achieve this goal. PREMs proposed for consideration included patients:

- feeling that they understand their condition/s and how they are being treated
- understanding who they should see about specific health concerns
- knowing how to access support if their health conditions worsen
- identifying supports outside of the health setting
- not feeling stressed or confused about managing appointments, tests and treatment as part of their care plan.

When assessing the appropriateness of these measures for GCHs and WCHs, stakeholders emphasised the differing eligibility requirements and the need for customised outcome measures for both cohorts. WCHs who can only access the CVC Program for mental health conditions, often require access to non-health supports for day-to-day living needs and to help maintain social and emotional wellbeing being. Accordingly, PROMs tailored to mental health and wellbeing, such as the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) and the WHO-5 Wellbeing Index were suggested by a peak health body to capture subjective experiences of mental health and life satisfaction.

5.5.3 Support for more holistic approach to wellbeing

In aligning with the holistic approach advocated by stakeholders, in particular, as they related to the WCH CVC Program cohort, the Program outcomes could be aligned with the DVA Wellbeing Model and the upcoming dual ADF/DVA Mental Health and Wellbeing Strategy. These encompass various dimensions of wellbeing, including physical, psychological, social, and financial aspects. This framework could guide the Program's efforts towards addressing not only immediate healthcare needs, but also the broader factors influencing overall health and quality of life for the WCH cohort [88].

Holistic indicators to gauge CVC Program effectiveness for WCH suggested by stakeholders included:

- metrics such as improved social support networks
- increased community engagement
- enhanced coping mechanisms
- better quality of life measures.

The evaluators were also informed of a collaborative effort between the DVA and the ADF to identify and track wellbeing measures, underscoring the DVA's commitment to comprehensive evaluation and continuous improvement. By integrating such initiatives, the CVC Program aims could be enhanced with an emphasis on the promotion of wellbeing and resilience among the target population; thus, achieving more meaningful and sustainable outcomes.

5.5.4 Data collection for new CVC Program outcomes leveraging mainstream systems

The examination of new CVC Program outcomes must be conducted with careful consideration of routine data collection practices within general practices and the broader healthcare system. This assessment should consider the implementation of new outcomes and performance metrics expected in the upcoming years as part of primary care reforms. It was universally recognised that seamless data integration enables the longitudinal tracking of patient outcomes, which facilitates proactive interventions, and the development of personalised care plans tailored to individual needs.

Efficient data utilisation and integration are crucial for optimising healthcare delivery and minimising administrative burden, particularly for time-constrained GPs. This sentiment was echoed in case study interviews and supported by feedback from external government interviews. By leveraging existing data collections and linking these with mainstream systems, such as electronic health records and patient management platforms, healthcare providers can streamline data collection processes and access comprehensive patient outcome data. However, this relies heavily on the interoperability of systems used by general practices and hospitals, as well as the establishment of appropriate data governance and privacy measures, which were highlighted as significant challenges by peak health providers.

5.6 A New System of Integrated Care

A longer-term reform of the CVC Program, this section proposes an overarching framework for a new system of integrated care that delivers both patient-centred and coordinated care to veterans.

During the transition phase, assessments should be undertaken to clearly identify veterans' care coordination needs as they transition to civilian life. This could involve assessing veterans' physical and mental health needs, as well as identifying any social or logistical challenges they may face.

5.6.1 Adopt a stepped model of care coordination

A stepped model of care would provide a structured approach to healthcare delivery where the level of care coordination provided to veterans is matched to their individual needs. The level of needs and the intensity of support of each veteran would be assessed during the transition process.

- At the lowest step of the model, veterans with relatively straightforward needs may require minimal care coordination, which could be managed within the primary healthcare system.

- As the complexity of their need increases, veterans may step up to higher levels of care coordination, involving specialised services, multidisciplinary teams, and closer collaboration between healthcare providers and support agencies.

This stepped approach would ensure that veterans receive the right level of support at the right time, optimising their health outcomes and enhancing their overall well-being. It would also allow for a more efficient allocation of resources, with additional resources being directed to those veterans who require the most intensive support, while still providing appropriate care to those with less complex needs.

5.6.2 Different needs, different care coordination agents

In a system where care coordination is tailored to veterans' needs, the provider responsible for coordinating care differs between less complex and complex clients. For veterans with less complex needs, general practice often serves as the central hub for managing their care coordination. GPs are well-positioned to oversee the healthcare needs of veterans with relatively straightforward requirements, such as routine check-ups, minor illnesses, and basic mental health support. This could be facilitated through existing mainstream services such as chronic disease management items.

Conversely, veterans with more complex healthcare needs may surpass the expertise or capacity of GPs to effectively manage their care coordination. In such cases, a multidisciplinary team approach involving specialists, allied health professionals, and case managers may be required.

These complex clients may have multiple chronic conditions, complex mental health issues, or significant social support needs that necessitate a more comprehensive and coordinated approach to their care. Specialist providers, such as mental health professionals, rehabilitation specialists, and social workers, may take the lead in coordinating care for these clients. This could involve coordinating care delivered by GPs, working collaboratively to address their diverse needs, and ensuring continuity of care across different healthcare and social settings.

In delivering holistic care coordination for veterans with more complex needs, these services could be provided in-house by dedicated case managers within DVA (such as CCS) or commissioned to external agencies specialising in care coordination and support services. In both cases, their tasks include care planning, coordination of appointments; and assisting veterans in accessing benefits and supports offered by DVA and other agencies.

For example, a number of stakeholders have highlighted the potential benefits of promoting and formalising the integration of the CVC Program with existing case management programs and services offered by DVA. This integration would necessitate further resources but could greatly enhance the support available to veterans, as outlined below.

COORDINATED CLIENT SUPPORT (CCS) CASE MANAGERS ALREADY AVAILABLE TO ELIGIBLE VETERANS WITH COMPLEX NEEDS

These veterans are referred to CCS via DVA Triage and Connect from a referral from DVA support staff, Open Arms – Veterans & Families Counselling and the ADF. The CCS then contacts the individual in need to discuss their circumstances and needs – some that may involve clinical care coordination. It was noted that veterans can self-refer to DVA Triage and Connect. External parties such as representatives from ESOs, doctors and other government agencies can also refer; however, there seems to be minimal GP awareness of the role of Triage and Connect (including linking veterans with advocates) from the case study consultations. The CCS program rules are very clear that CCS does not provide a crisis management service, clinical case management services or counselling, undertake any processing role, or investigate or determine a client's entitlements/claims, nor does participation provide prioritisation of claims, or claims advocacy.

For example, the 12-month Wellbeing and Support Program (WASP) aims to connect newly transitioned veterans to local services in their community, with the purpose of adjustment to life after service. This service was considered a 'step down', particularly if CVC participants with complex mental health conditions were stabilised, as a way of introducing them to local community supports that they could continue to access.

However, DVA's inability to recommend specific treatments and services due to the separation between health and claims business areas as it relates to data sharing/privacy is a barrier. Some stakeholders noted that while case management alone is not a comprehensive solution, the DVA requires a specific product to offer veterans and their families who require complex psychosocial supports. Common feedback from all stakeholders emphasised the necessity for a simplified pathway to determine veterans' entitlements and for health providers to ensure the best support for the veteran cohort.

Moreover, it is important to acknowledge that the insights and recommendations from the forthcoming Royal Commission Report are expected to significantly influence any strategic considerations for delivering integrated care to younger veterans with complex needs.

5.6.3 Tailored care plans are developed for each client

Given the emphasis on care coordination and patient-centred care in this model, individualised plans that identify client needs and match them with evidence-based treatment options should be developed for each client. These plans are used to monitor progress and should include baseline treatment outcomes, as well as the entitled person's personal goals to assess whether progress has been achieved.

To avoid fragmentation, these plans need to be holistic, encompassing a range of services from social support to physical health services. This comprehensive approach is particularly critical for clients with complex needs and will also facilitate their ability to navigate the available healthcare and social support systems.[81]

5.6.4 Personal budgets linked to tailored care plans for complex clients

For veterans with complex needs, care plans should be developed to outline the services, treatments, and support required to achieve their health and well-being goals. These care plans should be assessed and approved to establish the necessary budget for covering both health and social services. Regular monitoring and review of the care plan and budget allocation would be conducted to ensure that the veteran's needs continue to be met effectively. Adjustments to the care plan and budget may be made based on changes in the veteran's health status, goals, or circumstances. This ongoing review process helps optimise resource use and ensures that the veteran receives the most appropriate and beneficial support over time.

5.7 Summary of CVC Program Reform Opportunities

This chapter addressed how the CVC Program could potentially be redesigned to better meet the needs of current and future DVA clients. The evaluation explored major reforms informed by stakeholder consultations, international practices in veteran care coordination, and changes in Australia's primary care landscape. Key findings indicated that adopting alternative funding models, such as risk-adjusted per capita funding and team-based care approaches, could better meet the needs of DVA clients. Expanding eligibility to include transitioning ADF members, existing WCHs with chronic conditions, and those in residential aged care or with terminal diagnoses could enhance early intervention and long-term health outcomes. Additional supports for providers, such as integrating care coordination roles for allied health professionals and adopting a teamlet approach could improve multidisciplinary care. Emphasising digital interoperability and streamlined data integration could reduce administrative burdens and improve care coordination.

The key improvement for the CVC Program is enhancing data integration to streamline healthcare delivery and reduce administrative burdens. This involves leveraging existing data systems, ensuring interoperability, and adopting a patient-centred approach to care coordination and outcome measurement. Shifting focus from hospital cost savings to patient-reported outcomes and experiences can better capture the Program's impact on health and wellbeing. These proposed reforms aim to make the Program more responsive to the needs of current and future DVA clients, ensuring better health outcomes and more efficient use of resources.

6. Conclusion

The evaluation of the CVC Program has provided valuable insights into its implementation, outcomes, and potential avenues for redesign to better meet the needs of current and future DVA clients. Operating within a complex environment marked by impending policy changes and ongoing reforms, the Program's efficacy and adaptability are critical for ensuring continued support and care for veterans and their families. At the time of report writing, upcoming policy changes affecting the management of mainstream chronic disease under the remit of the DOHAC, in addition to changes to the veteran support system underpinned by the current Royal Commission into Defence and Veteran Suicide, were ongoing.

In evaluating the extent to which the CVC Program aligns with its intended design, several key themes emerged. While the expansion of eligibility criteria to include WCHs has facilitated broader access, challenges persist in determining eligibility and promoting CVC Program awareness among both GPs and entitled Veteran Card holders. The CVC Program model of care exhibits both strengths, such as improved education about healthcare for participants, and challenges, including administrative burdens and funding inadequacies.

Assessing the CVC Program's achievement of its intended outcomes revealed a mixed picture. While improvements in care coordination have fostered trust and proactive management among participants, the anticipated efficiency gains and reductions in hospital services remain elusive. The Program's impact on hospitalisations and cost savings has been limited, with enrolment periods falling short of the necessary duration to realise significant benefits. Nevertheless, the Program's focus on personalised and streamlined care has contributed to improved health outcomes and overall satisfaction among veterans and their families.

Exploring potential redesign strategies highlights opportunities for enhancing the CVC Program's effectiveness amidst evolving health policy and funding landscapes. Drawing lessons from Veteran care coordination models in the Five-Eyes countries, as well as upcoming DOHAC reforms and PHN trials, suggests avenues for expanding eligibility, addressing uptake challenges, and streamlining implementation processes to reduce transaction costs for practices stemming from procedural issues and insufficient integration with mainstream systems. Short-term Program improvement considerations include streamlining administration for providers, improving interoperability with GP software, improving communication with providers, and providing education for providers. Longer-term strategic considerations encompass a holistic approach to integrated care, beginning at transition and tailored to individual client needs, with funding mechanisms aligned to support sustainable Program delivery.

In conclusion, this evaluation underscores the importance of ongoing evaluation and adaptation in ensuring the continued relevance and effectiveness of the CVC Program in meeting the healthcare needs of DVA clients. By addressing implementation challenges, enhancing outcomes, and embracing strategic redesign, the Program can better serve its beneficiaries within an ever-evolving healthcare landscape.

Appendix A: Detailed Evaluation Methodology

As illustrated below (Figure 6.1), the evaluation draws on mixed methods, combining various analytical approaches and data sources to answer the proposed evaluation questions. An environmental scan/literature review was undertaken that informed the evaluation design and that is used here to contextualise findings and provide an evidence-base for recommendations.

The quantitative component is mostly focused on analytics of program data, including a cost-efficiency analysis of various aspects of the program. A cost-efficiency rather than other economic approaches was used to provide practical guidance on programmatic areas where current resources could be more efficiently spent. Additionally, this also allowed extension of the analytics to examine the cost-savings in terms of hospital expenditure, which was an intended objective of the program.

The illustrated qualitative approach in Figure 6.1 is described more technically in the following sections.

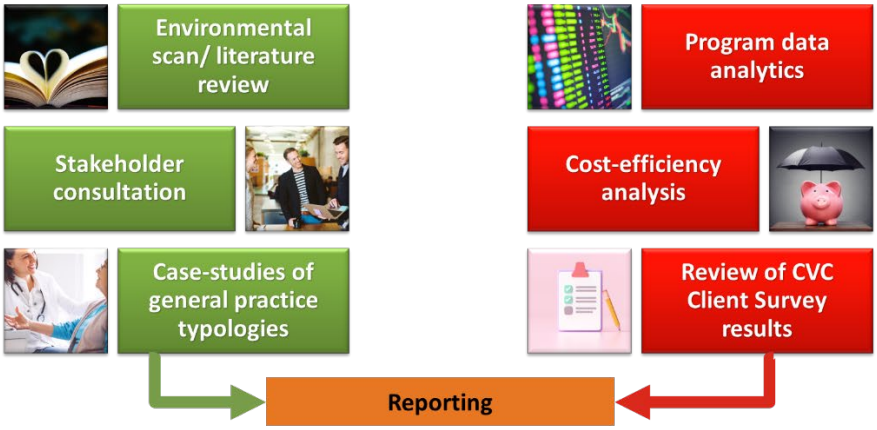

Figure 6.1: Illustrative summary of the mixed methods evaluation.

Environmental Scan /Literature Review

With a view to inform the evaluation framework, a review of the literature was conducted with emphasis on care coordination for veterans in Canada, New Zealand, the United Kingdom and the United States. This was provided as an annex to the evaluation framework and is available from DVA.

Although the academic literature was included, particularly in relation to broader models of care for delivering integrated and patient-centred care, the grey literature, including government reports and websites, were extensively searched to ensure that current and most up-to-date information on care coordination services for veterans was included.

With a few exceptions, only academic studies since 2015 were included. Special care was taken to ensure that the most recent information was available for the grey literature on veterans in the Five Eyes countries. For example, although the 2019 commissioning framework for veterans in England [63] include extensive references to the comprehensive model for personalised care prevalent at the time, this information was triangulated against the most recent developments and the newly revised personalised care operating model supported by personal health and integrated personal budgets was used to draw relevant lessons for the CVC Program [60].

In addition to country specific terms and veterans and defence personnel, search terms included care coordination, health/care integration, patient-centred care, integrated care, chronic disease management, stepped care, funding reform primary health care, case management, personalised care, value-based health care, patient aligned care teams, patient segmentation, and predictive risk modelling. Once key articles or reports were identified, references were examined to further identify relevant additional studies.

In total, 63 studies, reports and documents concerning health services and more specifically care coordination for veterans in Five Eyes countries were scanned/reviewed, in addition to 44 related to broader issues of financing and care coordination/integration. We also identified over 60 Australian studies and reports of relevance in Australia. As noted in the Annexed Power Point Presentation, they include key policy documents, as well as reports examining a wide range of issues including the challenges of strengthening primary care and reducing hospital costs in the country [32, 59, 89-96]

The results of the environmental scan were used to inform the evaluation design and to provide background and context to the evaluation key findings. Specifically, for this report, a lessons-learned rather than a theoretical approach to summarise the main findings of the environmental scan and inform the forward-looking strategy for the CVC Program. This allowed the integration of the literature review findings with the recent primary care developments in Australia. The aim was to present actionable recommendations that leveraged the ongoing system and funding reforms in the country for an improved CVC Program delivering outcomes to patients, providers and taxpayers.

Quantitative Methods

Data analytics examined CVC Program implementation and cost-efficiency, including the impact on hospital savings, with a primary focus on GCH. Since WCH represented less than 5% of CVC participants in a given year, a separate analysis for them was not warranted. Additionally, current datasets offered limited opportunities for useful quantitative assessments to inform a forward-looking strategy for this cohort. White Card holders could be accessing numerous treatments through their Medicare cards, which creates strong biases for data analytics based on their usage of DVA-funded services, which were the only datasets available for the evaluation. This was further complicated by the fact that a large number of accepted condition records had no recorded International Classification of Diseases (ICD) codes (approximate 30%), so this dataset could not be used to identify their need of services.

In this section the datasets available for this evaluation are described, followed by an overview of the main methodological approach used.

Available datasets and the process for assembling the final data for the evaluation

The key variables of interest for this evaluation related to program services, Veteran card holder characteristics and their use of hospital services. Since some standard metadata, such as data report specifications was not routinely available or accessible to allow the identification of variable specifics and datasets needed for this evaluation. An iterative process with multiple cross-checks and discussions with the Data & Insights (D&I) team was undertaken as described below.

The first set of datasets

Twenty-eight datasets were received from the D&I team on 21 August 2023. They included files with variables describing characteristics of Veteran Card holders (i.e. age or sex/gender) and services (i.e. date of hospital admission and separation), as well as files with variables describing the codes (i.e., the remoteness classification of addresses across the country). In total they contained 364 variables, with some of them corresponding to Surrogate Keys that were used to link the various datasets. The smallest dataset had 711 observations and the largest 23,880,692. They covered use of the CVC Program and hospital services since January 2016 to the last date available when the data was extracted.

After receiving the datasets, STATA was used to examine each dataset. In the absence of standard metadata, the variables were mapped under each dataset to identify their content and establish any potential linkages.

To establish potential linkages, the unique identifier was located under each dataset and examined variable names to identify potential matches. The matching and assessment process was subsequently undertaken. If observations in the files describing characteristics of Veteran Card holders or treatments could be matched with the corresponding variables in the metadata files, they were flagged, and confirmation from the D&I team was sought to ensure the correct understanding of the Surrogate Keys. When no matching was possible, alternative variables were sought and when none was found, the D&I team was consulted.

A preliminary review of some Veteran Card holder and treatment datasets with a view to assert the validity of assumptions about what each dataset measures was also undertaken. For example, for Veteran Card holder data, the number of unique Veteran Card holders under key datasets was examined and reviewed if the ballpark estimate of Veteran Card holders was in line with publicly available data. Disparities in those estimates was discussed with DVA and that data was available only for a sub-sample of Veteran Card holders, that is, those with either a recorded hospital episode or a CVC Program treatment item.

Since this data did not include information on any control group, new datasets with a new sample of Veteran Card holders was requested. During these early discussions, the then Nursing Programs and Operations team (now TCVC) suggested the sample should include entitled persons as identified through DVA internal modelling of chronic conditions, based on previous service use data. The TCVC team also requested that we examined potential overlaps with other chronic condition management programs.

As a result, data on a new sample of Veteran Card holders was requested that included those with chronic conditions and/or accessing chronic condition management services including GP Management Plans (GPMP) and Team Care Arrangements (TCA).

In the interim, discussions with DVA staff were held about available hospital data, which indicated there were delays of up to 18 months in the recording of hospital services. They also noted challenges with some detailed information from private hospitals, which prevented the use of emergency department data for eligible GCH to build an indicator of unplanned hospital admissions (and associated costs).

Assembling datasets for a new sample of Veteran Card holders

A second collection of datasets was received on 17 November 2023, which included a new sample of Veteran Card holder data, covering those identified as having a chronic disease based on previous service usage and DVA-accepted conditions as well as those accessing selected primary care services, such as GPMP and TCA.

In the subsequent weeks, the D&I team was consulted to validate linkages between the new datasets. This led to a new suite of datasets with valid linkages on 30 November2023. Additional data on Veteran Card holders living in residential care, which restricts access to Program treatment services, was provided on 22 December 2023[d]. The list of all datasets received to date is shown in Table 6.1.

Table 6.1: Datasets (including codes) received from the D&I team.

Dataset Name	Description
cvc_inlist	Data – Chronic conditions (CVC participants)
cvc_not_enrolled	Data – Chronic conditions (persons)
abt_agedcare	Data – Residential Aged Care
query_for_client_dim.dta	Data – Veteran Card holder demographics
query_for_client_dim2.dta	Data - Veteran Card holder (other)
query_for_client_disability_elig.dta	Data - Veteran Card holder disability
query_for_client_reside_addr_eli.dta	Data - Veteran Card holder address

Dataset Name	Description
query_for_crd_type.dta	Data - Veteran Card
query_for_emergency_dept_patient.dta	Data - Emergency Department Presentations
query_for_hospital_episode_dim.dta	Data - Hospital Episodes
query_for_hospital_episode_fact.dta	Data - Hospital Episodes
query_for_integrated_client_fact.dta	Data - Veteran Card holder, Cards, Episodes, CVC Program
query_for_service_item_dim.dta	Codes - Service Items
service_item_dim.dta	Codes - Service items
remoteness.dta	Codes - Geographical location
ed_misc_detail_dim.dta	Codes - Emergency Department Presentations
hosp_episd_admission_care_dim.dta	Codes - Hospital Episodes
hosp_episd_admission_dim.dta	Codes - Hospital Episodes
hosp_episd_previous_key_map.dta	Codes - Hospital Episodes
hosp_episd_separation_dim.dta	Codes - Hospital Episodes
ic_outpatient_clinic_typ_dim.dta	Codes - Outpatient services
ic_udg_dim.dta	Codes - Emergency Department Presentations
ic_urg_dim.dta	Codes - Emergency Department Presentations
icd_diagnosis_detail_dim.dta	Codes - Diagnosis (ICD)
icd_diagnosis_detail_sq_brdg.dta	Codes -Diagnosis
icd_morphology_detail_dim.dta	Codes - Morphology
icd_morphology_detail_sq_brdg.dta	Codes - Morphology
icd_procedure_detail_dim.dta	Codes - Procedures
icd_procedure_detail_sq_brdg.dta	Codes - Procedures
drg_dim.dta	Codes - Diagnostic Related Groups

A thorough validation of available datasets was undertaken and, whenever possible, findings were cross-checked with the D&I and TCVC teams. Specifically for CVC Program related services, estimated indicator (i.e. number of active CVC participants) were validated against those available through routine program dashboards, which were provided for the evaluation. For other datasets, a rigorous, but pragmatic approach was undertaken.

As shown in the findings section, whenever possible, the robustness of results under alternative scenarios based on a different interpretation of individual variables was assessed. For example, the RACF dataset contained a mix of very short and long stays, and the former did not necessarily preclude access to CVC Program treatment.

After inspecting the data, multiple aged care admissions were registered consecutively for some CVC participants, suggesting that they could potentially be treated as a single admission for the purposes of establishing length of stay. However, for other CVC participants, these multiple entries were short and spaced over time, which seemed to align with respite care, and did not preclude the use of CVC Program treatment.

Estimates were provided under two scenarios, using different criteria to assess whether a record of RACF reflects an admission to aged care that preludes the CVC participant from accessing CVC Program treatment/services.

For other datasets, such as the ones identifying GCH with chronic conditions, the datasets were triangulated against other sources of information to assess the validity of the sample. If this process showed that a GCH was incorrectly identified as a CVC participant, they were reclassified.

Variables were only excluded from this analysis that showed a large proportion of records (well above the accepted rule of thumb of 10%) with invalid or missing information that could not be rapidly addressed. This was the case for example, for data on DVA-accepted conditions, which we found had missing information on primary ICD codes for approximately 30% of records. Along similar lines, out of 857,755 Emergency Department records, 156,942 (18%) had incomplete ICD codes.

To illustrate this process of data cleansing and cross-validation, the example of the chronic conditions' dataset is described below. Similar processes were followed with the various datasets provided to ensure valid samples with valid linkages.

Data validation processes – The example of the chronic conditions datasets

The D&I team leveraged available data on service usage and DVA-accepted conditions to identify Veteran Card holders with likely current diagnoses. The dataset encompassed six major categories of chronic conditions: cardiovascular disease, diabetes, chronic kidney disease, chronic lung disease, cancer, and mental health, and so offers invaluable information about entitled persons, as it is the only source of information on the health status of DVA clients available to the Department.

A dataset for CVC participants encompassing 56,196 unique individuals and another dataset for other entitled persons identified with a chronic condition and not receiving Program treatment encompassing 87,557 records was received.

To refine the dataset and create a final version with complete information on unique Veteran Card holders and their chronic conditions, a cross-validation process was undertaken that involved several steps, including examining if the classification of individuals as CVC Program participants or eligible persons aligned with records of CVC Program treatment in the primary care dataset. Specifically, validation that all CVC participants had at least one recorded CVC Program service during the study period was undertaken and that no individual in the entitled persons group had a recorded CVC Program service.

Validation that all CVC Program participants in the dataset had at least one recorded chronic condition (physical or mental) and that the final combined dataset did not have redundant observations, that is, CVC Program participants with the same unique identification but with multiple records was also undertaken. As a result of this process and bearing in mind that specific numbers vary according to the order of each step:

- Over 7,500 Veteran Card holders identified as CVC Program participants had no recorded Program treatment. Evaluators were unable to ascertain whether these individuals never received a Program treatment or if they belonged to the group of individuals that received all their Program treatment prior to 2016. On these grounds, they were excluded from the analysis.
- Approximately 7,800 Veteran Card holders that were initially categorised as eligible persons in the chronic condition dataset were found to have a Program treatment recorded in the primary care dataset. These individuals were reclassified as CVC participants.
- Between 9,000 to 10,000 redundant observations were removed from the combined dataset and an additional 8,000 individuals who had no recorded chronic conditions (mental or physical), which were also excluded.

The final sample of unique individuals in the chronic condition dataset, stands at 116,013, representing 81% of the initial 143,753 records provided. Among non-CVC participants, the final sample is 71,654, representing an 18% reduction from the original dataset records. All individuals in this group were alive as of September 2023. For Veteran Card holders with at least one Program treatment record in 2016-2023, the final sample is 44,359, with approximately 68% still alive as of November 2023.

Program data analytics

Standard data and health economics analytics methods were used, including, descriptive statistics and multivariate regression analysis to examine program data and estimate metrics of program implementation and outcomes.

In some instances, the year of enrolment as the time variable for the analysis was chosen, and in others the fiscal year in which the service was delivered was used. This approach allowed consideration of different time perspectives, providing a comprehensive understanding of the dynamics and patterns within the data. STATA 18.0 MP Parallel Edition was used for all analyses.

Whenever feasible, the robustness of results were examined by subjecting them to alternative metrics, sample choices, and regression model specifications. For example, the standard Ordinary Least Squares regression alongside Poisson models was conducted, specifically designed to accommodate the substantial number of zeros in the data. Both analyses were also undertaken for alternative samples of Veteran Card holders. This approach allowed the thorough assessment of the robustness of findings regarding the impact of the CVC Program on hospital expenditure.

To provide an understanding of the methodological decisions, the specifics of the methodology are contained in the relevant findings' sections. The complexities surrounding the delivery of the CVC Program treatment/service, along with the intricacies and limitations of the available datasets compelled the discussion of these issues in the context of the actual implementation of the Program. For example, the rationale for the choice of sample to evaluate the extent to which eligible Veteran Card holders enrolled in the CVC Program are likely to show higher levels of need or complexity needs assessment in the context of the CVC Program and earlier findings.

By integrating these methodological discussions into the relevant sections, we offer the reader a more nuanced view of the data available for monitoring and evaluating the CVC Program, while also highlighting the strengths and limitations of analytics based on current datasets.

Cost-Efficiency Analysis

A cost-efficiency analysis was conducted alongside program data analytics to delve into distinct programmatic areas where resource use can be the optimised. A focus on examining service delivery patterns and analysing associated expenditure, while considering other aspects such as the characteristics of CVC participants and the availability of other chronic condition management programs, such as GPMP and TCA. This holistic view of the CVC Program provides actionable information, highlighting concrete areas for potential improvements to the program.

Since efficiency gains associated with hospital expenditure reductions are an intended outcome of the CVC Program, we have also used regression analysis to estimate the impact of the CVC Program on hospital expenditure, leveraging the available data and service implementation patterns. Specifically, entitled persons using GPMP/TCA services who have never used the CVC Program were used as a control group and leverage the chronic conditions dataset, to control for the level of needs and complexity of eligible Veteran Card holders.

All costs are reported in constant dollars (Fiscal Year 2021). The use of constant prices removes the inflation effect, so estimates indicate what the equivalent or expenditure would have been had 2021 prices applied in all years. Hospital costs have been adjusted based on the health price indexes for government final consumption expenditure on hospitals and nursing homes as estimated by the

Australian Institute of Health and Welfare (AIHW). For the cost of primary services (the CVC Program and GPMP/TCA), we use the health price index for Medicare medical services fees charged also estimated by the AIHW [97]. For expenditure recorded in 2022, we have extrapolated the expected AIHW price index using information on the Consumer Price Index (CPI).

Review of CVC Participant Survey results

Although, strictly speaking the 2023 CVC Participant Survey [1] does not represent a methodological approach used in the evaluation, it has been used as they are a data source to answer some of the evaluation questions.

Results of the 2021 CVC Participant Survey Report were provided to Abt on 12 July 2023, and the Final Report of the 2023 Participant Survey [1] was provided on 9 April 2024. These survey results were reviewed and used to address the relevant agreed evaluation questions, after triangulation against other sources of data, particularly interviews and focus group discussions with CVC Program participants undertaken in the context of the case studies.

It should be noted that integration of these results have been used with caution for the following reasons:

- many respondents were unsure or unaware that they were on the CVC Program (approximately 1/3)
- there was no reference to other healthcare services that they could have been receiving (particularly relevant as many GPs in consultation were using GPMP and the CVC Program concurrently)
- only current participants were invited.

Qualitative Methods

A range of qualitative consultation processes was used including telephone/video interviews with a broad range of stakeholders, interviews with a sample of general practices and interviews/consults through case studies that would include CVC Program participants. Each of these are discussed in more detail below.

Engagement and consultation with key stakeholders

A key aspect of this evaluation was a broad and comprehensive consultation process. A Stakeholder Engagement Plan that detailed the Who, Why, How and When of the consultation process and included the differentiated consultation tool for each stakeholder group was developed and informed by key informant interviews and discussions with the PMT. Consistent with this Plan, in addition to internal DVA stakeholders, a range of government stakeholders external to DVA were engaged through a combination of snowballing to discuss the broader context of how the CVC Program fits amongst upcoming reforms and how the CVC Program intersects with other areas of government, particularly to explore:

- the upcoming MyMedicare reforms (Department of Health and Aged Care)
- the utility of MyHealth Records for CVC Program management and population outcome measures (Australian Digital Health Agency)

See below for the full consultation list.

Case studies

A case study is a qualitative research or evaluation strategy used to explore and analyse a particular complex phenomenon in-depth. Undertaking a case study involves delving into specific and well-defined ‘cases’ to unpack the context; examine a broad range of issues, data and variables from various perspectives and generate insights into ‘how’ interventions/programs work and ‘why’. [98].

For the purposes of capturing the breath of experiences across different types of practices and to allow for an in-depth exploration of the various issues affecting the delivery of the program, a multiple embedded case study design was implemented, that is:

- multiple cases: CVC Program delivery by various typologies of General Practices (the units of analysis)
- with sub-units embedded within each 'case'
- These sub-units are: practices within each typology; practice staff including GPs, practice nurses, practice managers and other relevant staff such as receptionists; other health providers involved in delivering care for the veteran and individual CVC participant.

This case study design, explained in more detail below, allowed the evaluators to uncover for each typology how the different pieces of the program fit together, that is, the experience of practice staff, the business model/case for the practice itself, the experience of other health professionals involved, and last, but not the least, the experience of CVC participants themselves.

General practice typologies as the unit of analysis

The unit of analysis for a case study can be an individual, an organisation, or a particular program. For this evaluation, we propose the unit of analysis to be the whole of CVC Program delivery in the context of a particular typology of general practice (illustrated in Figure 6.2).

Discussions with the PMT, the DVA GPAG and the Chief Health Office (CHO) suggested it was important to capture the various typologies of general practice, including those engaged and not engaged with the CVC Program for GCHs and WCHs.

Figure 6.2: Illustrated case study approach to ensure all aspects of the CVC program are considered.

This is echoed by the recent Health Care Homes Trial evaluation, which examined different barriers and enablers of implementation by different types of practices [35]. Although the Health Care Homes trial represents a very different model of care to the CVC Program, their examination of the effects of location, size, and ownership helps to illustrate the type of barriers that can be found, how they may vary by practice typology, and how the various typologies may overlap. This in turn can inform the refinement of the typologies of General Practices to be used as the 'units' of the case studies.

- Practice location: Logistics, challenges to recruit staff and availability of services in general are particular challenges affecting program uptake outside metropolitan areas. However, due to their challenges, rural practices tended to be more holistic, and team oriented in their approach which could provide an incentive to engage with the CVC Program.

- Practice size: Larger practices are less affected by staff turnover and have more resources to implement and deliver new programs. However, one of the potential barriers is having more established processes, which are harder to change and also reduced flexibility to make decisions such as encouraging GPs to engage in a new program.

- Ownership: There is a correlation between practice ownership and size with large practices usually being corporately owned.

Four basic typologies were used as units of analysis to capture the breath of experiences across practices in Australia. They were based on practice location (by ASGS classification) and to allow comparisons of like with like, two separate typologies were included for metropolitan based on ownership (veteran-centric vs. non-veteran centric), which will also cover practice size.

- Inner regional
- outer regional
- metropolitan – veteran centric
- metropolitan - non-veteran centric.

Sampling practices within each typology

The evaluation aimed to include between 2 to 4 practices per case study/typology to capture views from practices engaged and not engaged with Gold Card and White Card holders. As noted in the quantitative findings, community nurses represent less than 1% of CVC services, so the focus is on care coordination undertaken by a practice nurse within the practice. Due to project management delays and challenges with case study recruitment the evaluation was unable to sample a practice that used DVA-contracted community nurses for Care Coordination.

To sample practices within each typology, a purposeful sampling strategy was used to ensure the engagement with practices and capture the nuanced nature of delivering primary care across the country. The evaluation aimed at including practices in Queensland, which is home to the largest proportion of the DVA treatment population [99], and at least two other states.

An initial snowballing approach was intended utilising both the DVA GPAG, and members of the CHO to identify 10 practices that fit in the proposed typology (i.e., 2 per typology), and also include general practices that did and did not participate in the CVC Program. This approach was relatively unsuccessful due to project management delays pushing consultation closer to Christmas when many practice staff were on leave and also delays with internal DVA ethical processes to enable consultation with CVC participants. Consequently, a number of recruitment avenues to encourage general practice engagement and recruitment were employed including:

- a number of unsuccessful recruitment surveys through health/peak bodies (one case study site was recruited in this way)
- cold-calling known general practices that used the CVC Program from a list provided by DVA that detailed practice name, state, and categorised how many CVC participants were recorded by category (to determine practice size). A small number of practices were excluded by DVA from the list.

A practice incentive payment was ultimately offered to general practices of $500 for case study participation to interview multiple staff (see next section) and $100 to individual GPs.

Between 12 to 16 practices were estimated to be needed before saturation occurred. For these purposes, after data for a new practice within a specific typology was collected, it was examined and coded to assert if the repetition of themes or patterns became apparent, as an indicator that the richness of the data adequately represented the diversity of experiences within each typology. Saturation was considered adequate at thirteen practices from five jurisdictions.

General practice staff interviews

Key informants interviewed agreed that it was important to capture various perspectives within each practice and that includes not only the General Practitioner and the Practice Nurse, but also the practice manager and even receptionists as relevant.

Practice managers, administration and billing staff provided insights into 'the ease of doing business' aspects of the CVC Program, such as issues with processing claims, integration with software practice, the costs of training staff to participate in the program and overall incentives and costs of participating in the CVC Program.

It was assumed initially that for a practice to be considered a case study site that there would be representation from all relevant staff described above, however due to challenges with recruitment, a case study site was considered one where there was participation from at least one GP and one Nurse Coordinator.

General practices that participated in the evaluation received an incentive payment of $500.

Participating eligible Veteran Card holder interviews and ESOs

On 19 and 20 March 2024, consistent with the agreed DVA-approved ethical process, 11 general practices were encouraged to invite their currently enrolled CVC Program participants to an evaluation interview. On 8 April 2024, two weeks before the consultation period endpoint, general practices that were currently unrepresented by interview bookings were reminded with one email and/or telephone call. It is unknown how many CVC Program participants were invited to participate or if all medical practices contacted their participants. Abt scheduled interviews directly with consenting CVC Program participants following this process.

Table 2.2 summarises their Veteran Card holder status, state/territory and ASGS region that they received their healthcare coordinated through the CVC Program.

Through the NCF Secretariat, ESOs were invited to submit a written response to a paper developed with DVA on the behalf of their members. They were allowed six weeks to input into the evaluation.

Sample representation and bias

Project management and delays in agreement of the recruitment process and advising CVC Program participants about the evaluation by general practices resulted in a non-representative CVC Program sample and potential bias in responses. It should be noted an:

- over representation of veteran-centric general practice experience in the Queensland metropolitan respondents (n = 5) with a heavy reliance on DVA funding and a younger veteran demographic are not representative of most general practice business models operating across Australia
- minimal representation of the inner regional CVC participant experience (n = 3, from the same general practice in South Australia)
- over-representation of outer regional perspectives (n = 8, from two general practices in the Riverland in South Australia).

To minimise the effect of this practice-level bias, thematically analysis focused on ASGS region regardless of state/territory was used to explore the nuances of CVC Program implementation across Australia. Despite the limitations above, there was broad thematic consistency with the feedback obtained through the 2023 CVC Participant Survey [1].

CVC Program participant respondents did not receive evaluation participation incentives.

Other practitioners

Other practitioners (such as allied health) delivering wrap-around care to CVC participants were also identified through interviews with practice staff or CVC participants themselves and were included in the case study analysis as relevant. This allowed the examination of care coordination with other primary care providers, but also to explore issues related to White Card holders who are not engaged with the CVC Program.

Health and allied health provider peaks/professional bodies were also engaged through the DVA HPPF Secretariat to gather the input of their members for the evaluation. Individual online (MS Teams or equivalent) interviews, small focus groups or written submissions captured the input of CVC Program practicing health professionals outside the case study catchments to strengthen the case study approach.

Case study data collection and analysis

Noting the busyness of health professionals in general, Abt offered a number of flexible options relating to timing (including after hours) and focus groups in lieu of individual face to face/telephone/MS Teams modes to maximise evaluation participation that resulted in:

- forty-six general practice staff (case study interviews)
- nine extra individual interviews were conducted with health professionals
- seven health/allied health professional bodies were represented through individual/focus group or written submission.

Abt consultants also interviewed 20 CVC participants by telephone between 25 March - 17 April 2024, that were representatives from five general practices. Telephone (n=19) and video (n=1) interviews ranged from 20 to 45 minutes in length. Due to challenging timeframes and logistics, face to face interviews were only offered to CVC Program participants residing in Brisbane and the Gold Coast, QLD, and this may have impacted evaluation participation. Sixteen eligible GCHs (13 veterans and three dependents) and four eligible WCHs consented to discuss their CVC Program participation from three Australian states/territories (Australian Capital Territory, South Australia and Queensland).

Ex-service organisations were invited to submit a written response on behalf of their members. Two responses were received.

In line with best practice for case studies [98], the contextual and literature reviews extensively informed the evaluation questions, which were organised along relevant themes identified in the literature. Various conceptual frameworks for patient-centred care and care coordination have been used to outline relevant themes that guide the data analysis.

During the analytical stages, patterns in the data were examined and various explanations that emerged from the analysis were explored. Since the views of multiple stakeholders across various case studies were sought, they were triangulated and any rival explanations of a particular phenomenon, such as the expected impact of the program or barriers for program uptake were explicitly addressed.

The evaluation team critically examined the data considering other available evidence and as required, refined questions as the fieldwork progressed to continue unpacking the information and provide nuanced interpretations of findings.

Reporting

The themes and key findings from the quantitative and qualitative analysis were thematically analysed in an integrated way and reported against the key evaluation questions. This included triangulation (cross-verified) of all data to validate the overall evaluation findings and examine the robustness and consistency of results.

Specifically, the initial consultations that took place during the development of the evaluation framework were used to inform the quantitative approach, including the issues examined through data analytics, such as the potential overlap between the CVC Program and other chronic disease management services. Subsequently, discussion occurred with respect to the preliminary quantitative findings with key stakeholders to validate and further unpack the results presented.

Following the completion of the quantitative analysis, iterative refinement of the qualitative instruments occurred, to further validate and explore the implications of the data analytics, ensuring a comprehensive and nuanced understanding of different aspects of the CVC Program. After cross-validating and triangulating results, they were reviewed at a key findings workshop prior to submission of the draft report.

Stakeholders Consulted

Key informant interview participants

Key informant interviews to inform the design of the evaluation framework were conducted between 1 August – 25 August 2023.

DVA Business Area represented and number of participants consulted	Date interviewed
Nursing Programs and Operations, Program Delivery Division (1)	01 August 2023
Veterans' Home Care & Transport Programs I Client Programs, Program Delivery Division (2)	02 August 2023
CHO Division and GP (2)	07 August 2023
DVA General Practitioner Advisory Group (10 members)	25 August 2023

Evaluation co-design workshop participants

Three Abt evaluators facilitated a two hour, MS Teams meeting on 13 September 2023:

DVA Business Area	Number of representatives consulted
Nursing Programs and Operations Section	2
Data & Insights Branch	2
Veterans Home Care and Transport Programs Section	2
Program Governance and Evaluation Section	3
Health Policy Section	3
TOTAL	**12**

Evaluation interviews – Internal and external government stakeholders

More than 30 individual internal and external government stakeholders participate in the evaluation through individual interview, focus group or written response to questions in the agreed Evaluation Framework.

External government	Number of representatives consulted	Date consulted
Australian Digital Health Agency (ADHA)	4	19 April 2024
Department of Health and Aged Care (DOHAC)	3	26 April 2024
Primary Health Network (PHN)	1	27 February 2024
TOTAL	**8**	

DVA Business Area	Number of representatives consulted	Date consulted
Quality and Safety and Mental Health Programs | Mental and Social Health Programs Branch	3	4 October 2023
Data and Insights Branch, Chief Financial Officer Division	8	11 October 2023
Rehabilitation Policy	2	25 March 2024
Rehabilitation and Household Services	1	25 March 2024
Transition Policy	1	20 March 2024
Clinical Policy	1	20 March 2024
Aged & Community Care Taskforce	1	2 April 2024
Residential Aged Care Section	1	2 April 2024
Disability and Wellbeing Section	2	2 April 2024
Program Delivery Division	3	3 April 2024
DVA Triage and Connect	2	9 April 2024
TOTAL	**25**	

Evaluation interviews – health and allied health peaks

Health and allied health peak bodies inputted into the evaluation through the DVA HPPF Secretariat by written response or individual/focus group interview. Because of their representative nature, DVA GPAG and CHO key informant interviews were considered amongst these responses but have been listed separately due to not having been engaged through the same mechanism.

Health Provider Partnership Forum	Number of representatives consulted	Date consulted/ written submission received
Royal Australian College of General Practitioners	3	Written submission 3 April 2024 Focus group on 11 April 2024
Dietitians Australia	1	27 March 2024
Occupational Therapy Australia	1	Written submission 3 April 2024
Exercise & Sports Science Australia	2	18 March 2024
Australian Physiotherapy Association	2	8 April 2024
Australian Association of Psychologists Incorporated (AAPi)	1	Written submission 3 April 2024
TOTAL	**10**	

One extra written submission was received from the Australian, New Zealand and Asian Creative Arts Therapists Association (ANZACATA) on 10 April 2024.

General practice consultations

Interviews with individual members of the DVA GPAG, have been included as they were involved in promotion and/or evaluation recruitment through dissemination of recruitment surveys to their networks and individual interviews, yet also provided valuable CVC Program insights in their own right.

GPAG participants were not offered a financial incentive to participate in the evaluation unless participating as a case study.

Individual GPAG consultations	Number of representatives consulted	Date consulted
GPAG member (represented Australian Association of Practice Management)	1	First contact 10 October 2023 (multiple engagements)
GPAG member (non-CVC Program user, represented Australian College of Rural & Remote Medicine)	1	24 October 2023
GPAG member (represented Australian Primary Healthcare Nurses Association)	1	10 October 2023 (multiple engagements)
TOTAL	**3**	

Nine individuals participated in the evaluation. Individual GPs were compensated $100 for their participation via telephone/MS Teams and lasted approximately 1 hour.

Individual consultations	Profession represented (location) consulted	Date consulted
Individual GP (non-CVC Program user)	• GP (SA)	29 January 2024
Individual GP (CVC Program user)	• GP (QLD)	6 February 2024
Individual GP (CVC Program user)	• GP (SA)	15 February 2024
Individual GP (CVC Program user)	• GP (SA)	13 March 2024
Individual allied health (CVC Program user)	• Psychologist (WA)	15 March 2024
Individual allied health (CVC Program user)	• Psychologist (QLD)	Written response 2 April 2024
Individual GP (CVC Program user)	• GP (SA)	5 April 2024
Individual practice nurse (CVC Program user)	• Practice Nurse (NSW)	21 March 2024
Open Arms – project with Renmark Medical Centre	• Community Engagement Coordinator at Open Arms SA	26 February 2024

Forty-six individual participants were consulted as part of the evaluation case study consultation from 13 practices across five jurisdictions. Participants role in CVC Program has been referred to in main body of report where relevant.

These practices were compensated $500 for their evaluation participation of up to two hours' time by telephone/MS Teams. Some practices split this time up over two sessions to accommodate differing participant availability.

Case study sites	ASGS code	Number of representatives consulted	Date consulted
GO2 Health, Brisbane, QLD	Metro	6	29 February 2024
Limestone, Brisbane, QLD	Metro	2	4 March 2024 5 March 2024
Innovative Medicine, Gold Coast, QLD	Metro	4	29 February 2024 1 March 2024
Renmark Medical Centre, Renmark, SA	Outer regional	2	13 February 2024 20 February 2024
Berri Medical Centre, Berri SA	Outer regional	2	21 February 2024
St Agnes Surgery, Ridgehaven, SA	Metro	7	21 February 2024
Windsor Village Medical Centre, Paradise, SA	Metro	2	21 February 2024
Goolwa Medical Centre, Goolwa, SA	Inner regional	8	15 March 2024
Holt Medical Centre, ACT	Metro	3	18 March 2024
The Surgery at Jerra, NSW	Metro	2	5 April 2024
Ashfield Country Practice, QLD	Inner regional	2	27 March 2024
Beach Street Medical Practice, Woolgoolga, NSW	Inner regional	4	18 March 2024 27 March 2024
Bellarine Medical Group, Drysdale, VIC	Inner regional	2	4 March 2024
TOTAL		**46**	

Ex Service Organisation written submissions

The following ESOs provided written submissions to the evaluation.

Organisation	Written response received
Australian War Widows Inc	8 May 2024
TPI Federation of Australia	28 May 2024

Project Management Team (PMT)

The PMT met fortnightly over the period of the evaluation except over the significant consultation/analysis and report writing period in April – May 2024 when meetings were monthly/as required. The team did experience some turnover over the evaluation due to a DVA restructure and evaluation needs over time. The following participants were present at more than three meetings.

Organisation/DVA Business Area represented	Number of participants
Abt Associates	3
DVA Health Policy Section	5
Nursing Programs and Operations/Transport and CVC Programs	3
Data & Insights Branch	2
Program Governance & Evaluation	2

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