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Australian Government

Department of Veterans' Affairs

Discussion Paper

Preventable Admissions and Improved Community Care Program

Strengthening Primary and
Community Care for
Australia's Veterans Most at
Risk

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Primary Care Policy Group

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1. Overview

- 1.1. The Preventable Admissions program aims to improve the health outcomes of veterans and war widows with chronic conditions who are most at risk of illness. Improving the health outcomes will reduce the need for preventable hospitalisations and improve the quality of life for veterans and war widows.
- 1.2. The program will target veterans and war widows with one or more of five chronic conditions, namely congestive heart failure, coronary artery disease, pneumonia, chronic obstructive pulmonary disease and diabetes. These 5 conditions produce a high number of hospital admissions and readmissions amongst our veterans. Studies have shown that these conditions are better treated by proactive co-ordinated primary care resulting in improved health and reduced need for hospitalisation.
- 1.3. The strategies underpinning the program are:
 - a) To analyse veterans' health data held by the Department of Veterans' Affairs (DVA) to identify the target group and advise potential participants and their Local Medical Officers (LMOs) of the program;
 - b) To pay LMOs to admit eligible veterans to the program and then provide comprehensive care, including care planning and monitoring, to that veteran in quarterly periods;
 - c) To pay LMOs for co-ordination of the care plan provided by their practice nurse;
 - d) To pay DVA contracted community nurse providers for co-ordination of the GP Management Plan (GPMP) where the LMO has provided a referral and a practice nurse is not undertaking this role;
 - e) To provide training and resources to LMOs, practice nurses and community nurses in best practice chronic disease management and team based care; and
 - f) To provide additional resources to address the impact of social isolation on health outcomes including, for those most affected by social isolation, access to social support services via an expansion of the existing Veteran's Home Care (VHC) program.

2. Entry to the Program

- 2.1. DVA's unique health care data will be analysed to identify possible participants for the program. Current health service usage, such as recent hospitalisation with diagnosis of one or more of the 5 conditions, will identify those veterans who potentially fit the program criteria. When a possible participant is identified, both the veteran or war widow and the LMO will be

notified in writing and receive information on the program. The veteran or war widow may decide to make an appointment for an assessment with their LMO or the LMO may contact the veteran or war widow and invite them to attend for an assessment.

- 2.2. There are a number of other ways that a veteran or war widow can be identified for possible entry to the program including:
 - a) LMO identifies the veteran or war widow as a result of reviewing the veteran's history or during a consultation;
 - b) A veteran or war widow presents to the LMO and requests an eligibility assessment;
 - c) On recommendation to the LMO via hospital discharge of the veteran; or
 - d) On recommendation to the LMO from other providers e.g. community nurse, allied health, specialist etc.
- 2.3. Admission to the program can only be through an assessment for eligibility by the LMO. Participation in the program is voluntary and the veteran or war widow must provide their consent before being admitted to the program.

3. Eligibility

- 3.1. The program targets our most at risk veterans and aims to have 17,000 veterans participating in the program by the 4th year.
- 3.2. To be eligible a veteran must satisfy all of the following criteria:
 - 3.2.1. Must be a veteran, war widow or war widower, or dependant with a DVA Gold Card.
 - 3.2.2. Must be living in the Australian community and not:
 - a) a resident of a residential aged care facility at the time of entry into the program. Eligibility for the program ceases once a person enters a residential aged care facility; or
 - b) a hospital in-patient at the time of entry into the program or the commencement of a period of care.
 - 3.2.3. Must be diagnosed by the LMO as having one or more of the following chronic conditions:
 - a) congestive heart failure;
 - b) coronary artery disease;
 - c) pneumonia;
 - d) chronic obstructive pulmonary disease;
 - e) diabetes; or

- f) another chronic condition or conditions that in the opinion of the LMO:
 - i. has resulted in the person being frequently admitted to a hospital; or
 - ii. could result in the person being frequently admitted to a hospital.
- 3.2.4. Must be assessed by the LMO as being at risk of hospitalisation, defined as meaning that in the opinion of the LMO:
- a) the person has been frequently admitted to a hospital and is at risk of rehospitalisation; or
 - b) the person is at risk of frequent hospitalisation as a consequence of the chronic condition.
- 3.2.5. Must be assessed by the LMO as having complex care needs, defined as the individual having one or more of the following:
- a) multiple co-morbidities that complicate the treatment regime;
 - b) unstable condition with high risk of acute exacerbation;
 - c) contribution of frailty, age and/or social isolation factors;
 - d) limitations in self management and monitoring; or
- requiring a treatment regime that involves some or all of the following complexities of ongoing care:
- a) multiple care providers;
 - b) complex medication regime;
 - c) frequent monitoring and review; or
 - d) support with self management and self monitoring.
- 3.2.6. At the time of initial assessment for eligibility for the program, the person must be assessed by the LMO as not suffering from a condition that in the reasonable opinion of the LMO is likely to be terminal in the next 12 months. A diagnosis of terminal illness after entry to the program, will not affect ongoing eligibility.
- 3.2.7. Must not be a participant, in any of the following Department of Health and Ageing programs:
- a) Coordinated Care for Patients with Diabetes commencing July 2012 ;
 - b) Extended Aged Care at Home (EACH) Program;
 - c) Community Aged Care Package (CACP) Program; or
 - d) Transition Care.

4. Payments Overview

- 4.1. The Preventable Admissions program makes payments to LMOs and DVA-contracted community nursing providers for the provision of services to participants in the Preventable Admissions program. Preventable Admissions items are in addition to existing Repatriation Medical Fee Schedule (RMFS) items.
- 4.2. LMOs are paid :
- a) a one-off incentive payment for admitting a person to the program; and
 - b) quarterly in arrears payments for the provision of care leadership and where applicable, care co-ordination.
- 4.3. DVA-contracted community nursing providers are paid (within the existing retrospective 28 day claim periods):
- a) a one off initial payment is made for the first 28 day claim period in which the community nurse first commences the co-ordination of care under the Preventable Admissions program; and
 - b) all subsequent 28 day claims are paid at the regular rate.
- 4.4. A Summary of Item Descriptors is at Attachment A.

5. Payments to LMOs

5.1. Overview

- 5.1.1. LMOs are paid a one-off incentive payment for admitting a person to the program, followed by quarterly payments in arrears for care leadership. Where an LMO uses a practice nurse (PN) to co-ordinate the care, the payments to the LMO are higher than for an LMO who does not use a practice nurse.

Table 1 – Preventable Admissions Payments to LMOs

	Incentive admission payment	All quarters in arrears	Total year 1	Total years 2 onwards (each year)
LMO with PN co-ordinator	\$400	\$417.50	\$2070	\$1670
LMO without PN	\$250	\$187.50	\$1000	\$750

5.2. Payments are in addition to existing MBS items

5.2.1. The Preventable Admissions program aims to improve the integration and co-ordination of care of the target cohort. There are a number of existing RMFS items relevant to care planning and co-ordination including:

- a) Surgery consultations, home visits and hospital consultations;
- b) Health assessments;
- c) Chronic Disease Management (CDM) items provide payments for preparation and review of a GP Management Plan (GPMP), co-ordinating the development and review of Team Care Arrangements (TCA) and organising and co-ordinating a Community Case Conference; and
- d) Home Medication Management Review.

5.2.2. The availability of these items has led to an increase in care planning activity. The Preventable Admissions program builds on the existing care planning items and other fee for service items to implement comprehensive and co-ordinated periods of care. LMOs are providing ongoing clinical leadership and management of these periods of care. The periods of care are divided into 3 month periods to encourage continuity balanced against portability. That is, the period of time is not so long that it locks a participant in to the one provider, and not so short that it discourages renewal of the care period.

5.2.3. The LMO is still entitled to claim for existing RMFS items including the items listed above.

5.2.4. The LMO is also still entitled to claim for item 10997 – services provided by a practice nurse for a person who has a GPMP, TCA or Multi Disciplinary Care Plan.

5.2.5. The new Preventable Admissions program payments are for the provision of ongoing clinical leadership and management of the comprehensive and co-ordinated care periods. The payment amounts reflect an expectation of the comprehensiveness of the care provided and the time that LMOs will devote to providing the ongoing oversight of care, as well as recognition of the non face to face time spent in providing care leadership.

5.3. LMO admits a participant and quarterly care period commences

5.3.1. The LMO assesses a person's eligibility for the program and decides whether to admit the veteran as a participant. The person must consent to participating in the program. Consent includes consent to the GPMP being given to other care providers for that person. Where the person consents to being a participant, the LMO prepares a GPMP (or reviews an existing GPMP) and discusses the GPMP with the participant so that

they understand the goals, interventions and self-management aspects of the plan. The methods of monitoring and evaluating the plan should also be explained as well as the need for regular monitoring and formal reviews.

- 5.3.2. The LMO records the participant consent on the GPMP and then provides the participant a copy of the GPMP. It is important that the participant takes a copy of the care plan, particularly in respect of the self managed aspects of the plan.
- 5.3.3. The participant is then admitted to the program and the first quarterly period of care commences on the date of admission.
- 5.3.4. For the purposes of RMFS claims, the date of service for the quarterly period is the first day of the period. The claim cannot however be made until the quarterly period expires.

5.4. LMO claims for Initial Incentive payment

- 5.4.1. Having admitted the person to the program, the LMO then claims the LMO Initial Incentive item number which pays \$400 if the LMO has a practice nurse who will be conducting the care co-ordination, or \$250 where the LMO does not have a practice nurse who will be conducting the care co-ordination.
- 5.4.2. The guidelines for LMOs will spell out the expectations of the LMO and practice nurse involvement at the point of the person being admitted, to justify the higher payment.
- 5.4.3. Where the LMO does not have a practice nurse and refers to a DVA-contracted community nursing provider for a community nurse to conduct the care co-ordination, the LMO is required to claim the Initial Incentive Payment promptly. This is to ensure that the DVA-contracted community nursing provider is able to successfully claim payment under the Preventable Admissions program at the end of their 28 day claim period/s.
- 5.4.4. The Initial Incentive Payment is made only once per participant in the life of the Preventable Admissions program. Where the participant changes LMO or ceases to be a participant and later re-enters the program, the incentive payment will not be applicable.

5.5. Practice Nurse Co-ordination

- 5.5.1. Where a practice nurse provides the co-ordination, the payment for the co-ordination services is built into the LMO with Practice Nurse Payment.

5.6. Quarterly Payment

- 5.6.1. At the expiry of the quarterly period of care, the LMO submits a claim

for payment. Payments will be:

- a) \$417.50 where the LMO has used a Practice Nurse to co-ordinate the care; or
- b) \$187.50 where the LMO has not used a Practice Nurse to co-ordinate the care.

5.7. Commencing a new quarterly period of care

- 5.7.1. The expiry of a quarterly period of care and submission of a claim for payment provides a prompt to the LMO to review the participant's records, recent medical history and progress against the care plan.
- 5.7.2. Where the LMO considers it necessary, the GPMP should be formally reviewed or a new GPMP prepared. The frequency of review and renewal of the GPMP is up to the LMO but must be within the RMFS guidelines for these items.
- 5.7.3. The current RMFS guidelines for the review of a GPMP are that the item is claimable quarterly, except where there has been significant change in the patient's clinical condition or care circumstance that requires the earlier review of a GPMP. RMFS recommended frequency of review of a GPMP is once every 6 months.
- 5.7.4. The guidelines for preparation of a new GPMP allows the item to be claimed annually except where there has been significant change in the patient's clinical condition or care circumstance that requires the earlier preparation of new GPMP. RMFS recommended frequency of preparation of a new GPMP is once every 2 years.

Table 2 -Frequency of RMFS claims for GPMP

	New GPMP	Review GPMP
Minimum - Earlier where significant change in condition or circumstance	12 months	3 months
Recommended	2 years	6 months

- 5.7.5. Having been assessed as eligible for the Preventable Admissions program, the very nature of the complexity and acuteness of the participant's condition may warrant the review and renewal at the minimum or earlier timeframes.
- 5.7.6. In rolling over to a new quarterly period of care, the LMO will take into account whether the participant continues to satisfy the eligibility criteria.

5.7.7. The previous quarterly period of care must have expired before a new quarterly period of care can commence.

5.7.8. At the expiry of the quarterly period of care, the LMO submits a claim for payment as in 5.6 above.

6. Payments to DVA-contracted community nursing providers

6.1. Community Nursing - Initial Care Payment

6.1.1. Where the care co-ordination is provided by a DVA-contracted community nursing provider, payment is made via the existing 28 day claim period structure. The Initial Care Payment is \$170.00 and covers the first 28 day period in which care co-ordination commences. The initial 28 day period commences on the day that co-ordination of care commences.

6.1.2. Where the participant is already being serviced by a DVA-contracted community nursing provider, the 28 day period for the initial claim to be made is the 28 day period in which the co-ordination of care under the Preventable Admissions program first commenced.

6.1.3. The LMO must have submitted the claim for the LMO Initial Incentive Payment and the claim must have been accepted. Acceptance of the LMO Initial Incentive claim will enter the participant on the claiming system and will dictate the eligibility for all other payments.

6.1.4. The payment is made to the DVA-contracted community nursing provider, not the community nurse.

6.1.5. For the purposes of Community Nursing Fee Schedule claims, the date of service for the 28 day period is the first day of the period. The claim cannot however be made until the 28 day period expires.

6.1.6. Restrictions on payment:

- a) The initial payment is made only once per participant in the life of the Preventable Admissions Treatment Program.
- b) Where the participant changes DVA-contracted community nursing provider, or ceases to be a participant and later re-enters the program, the incentive payment will not be applicable.
- c) Where an LMO-with Practice Nurse Initial Incentive Payment has been made in respect of the participant, the DVA-contracted community nursing provider – Initial Care Payment will not be paid i.e. there is only one initial payment for nursing services, whether provided by practice nurse or community nurse. In this case, the DVA-contracted community nursing provider can only claim the Subsequent Care payments.

6.2. Community Nursing – Subsequent Care Payment

6.2.1. Following the claim for the Initial Care Payment, all subsequent 28 day billing periods are paid at the rate of \$85.00 per period.

6.2.2. Restrictions on payment:

- a) A quarterly period of care must be current on at least one day of the 28 day claim period;
- b) Where a quarterly period of care expires during a 28 day claim period, the payment for that period will be made but subsequent payments will not be made until a new quarterly period commences; and
- c) Where there is a change in DVA-contracted community nursing provider, the first 28 day claim period in which a Subsequent Care claim can be made must commence on a date after the expiry of the 28 day claim period paid to the previous DVA-contracted community nursing provider.

6.3. Relationship between claims for Care Co-ordination and claims for services under the DVA Community Nursing Program Classification System and Schedule of Item Numbers and Fees

6.3.1. Care co-ordination payments cover activities over and above the item numbers that DVA-contracted community nursing providers can claim under the Clinical Care Schedule, Personal Care Schedule and Other Schedule in the Community Nursing Classification System, including but not restricted to: phone calls to the participant, phone calls to other providers and the LMO and written advice to the LMO.

7. Role of the LMO

7.1. The LMO will prepare a comprehensive GPMP which will include diagnosis, clinical treatment plan and goals, interventions, roles and responsibilities for providing interventions, self management goals and support, overall outcomes and monitoring and evaluation. DVA will not be stipulating a format or template for the GPMP but will provide minimum standards for the GPMP.

7.2. The LMO will discuss the GPMP with the veteran so that they understand the goals, interventions and self-management aspects of the plan. The methods of monitoring and evaluating the plan should also be explained to the participant as well as the need for regular monitoring and formal reviews.

7.3. The LMO will discuss the care co-ordination arrangements with the veteran i.e. whether co-ordination will be provided by the nominated practice nurse or a community nurse through a DVA-contracted community nurse provider.

7.4. At this stage the LMO establishes whether the veteran is an existing client of

- a DVA-contracted community nursing provider to avoid potential duplication of community nursing services.
- 7.5. The LMO then provides the veteran a copy of the GPMP. It is important that the veteran takes a copy of the GPMP, particularly in respect of the self managed aspects of the plan.
- 7.6. The quarterly care period then commences and the veteran then becomes a participant in the Preventable Admissions program.
- 7.7. The LMO may also be requested to participate in monitoring and evaluation activities of the Preventable Admissions program. For example, the LMO may be required to respond to DVA generated surveys or provide data for evaluation.

8. Role of the Care Co-ordinator

- 8.1. Care co-ordination is provided by either a practice nurse or a DVA-contracted community nursing provider. Preferably, a Registered Nurse (RN) will provide the care co-ordination. Where a practice only has an Enrolled Nurse (EN), the EN may co-ordinate the care but the LMO is expected to play a closer supervisory role in ensuring all clinical aspects of the care are co-ordinated.
- 8.2. A care co-ordinator has primary responsibility for co-ordinating the participant's ongoing care needs and self-management support as set out in the care plan. The care co-ordinator works with the veteran and the service providers nominated in the care plan to ensure the services are provided, the care plan is carried out and that the care plan relates to the participant's current condition. The care co-ordinator is responsible for providing the LMO with information on treatments and maintaining an integrated and up to date patient record. Where a participant's condition changes, the care co-ordinator is responsible for feeding back to the LMO for possible changes to the care plan.
- 8.3. Co-ordination activities include, but are not limited to:**
- a) Receiving and reading the GPMP and Supplementary Notes;
 - b) Discussing and clarifying any elements of the GPMP and Supplementary Notes with the LMO;
 - c) Initial meeting/contact with the participant to discuss care co-ordination activities;
 - d) Carrying out care co-ordination activities such as making appointments with other care providers, providing an appointment reminder service, medication review, self management advice and monitoring with the participant– whether by home visit or telephone;
 - e) Monitoring veteran's physical and mental condition;

- f) Liaising with emergency departments and/or hospital discharge;
- g) Assessing and addressing ongoing social isolation issues;
- h) Providing advice to the LMO on the veteran's need for social; support services through the Veterans' Home Care (VHC) program;
- i) Maintaining a comprehensive clinical record;
- j) Providing feedback to LMO; and
- k) Providing alerts to the LMO where changes occur in the veteran's condition.

8.4. Initial Arrangements - Practice Nurse

- 8.4.1. Where the practice nurse will be co-ordinating the care plan, the LMO will prepare supplementary notes, where necessary, for the practice nurse, and discuss the care plan and supplementary notes with the practice nurse. There may also be the opportunity for the practice nurse to be involved in developing the care plan. The practice nurse will then arrange to meet or contact the participant to begin the care co-ordination.
- 8.4.2. Generally, the practice nurse co-ordinator will be one individual although it is recognised that on occasions the co-ordination may be shared across the nurses within the practice.

8.5. Initial Arrangements - Community Nurse

- 8.5.1. Where a community nurse will be co-ordinating the GPMP, the LMO will refer the participant to the DVA-contracted community nursing provider. If a DVA-contracted community nursing provider is not already involved in providing care to the participant, a referral will have to be made for a DVA-contracted community nursing provider to be able to claim the Community Nursing Fee Schedule item. If the participant is already receiving community nursing under the community nursing program the LMO would make a request to the DVA contracted community nursing provider to provide care co ordination under the Preventable Admissions program. The LMO, or the LMO's staff, will contact a DVA-contracted community nursing provider to arrange for a copy of the care plan and any supplementary notes to be sent to the provider, with a referral.
- 8.5.2. A DVA-contracted community nursing provider will arrange for a community nurse to contact the participant and arrange the 1st face to face visit to discuss the GPMP and care co-ordination outcomes with the participant.
- 8.5.3. Before commencing the care co-ordination role the LMO and community nurse may arrange for an initial discussion of the GPMP.

8.6. Supplementary Notes for care co-ordinator

- 8.6.1. The preparation of supplementary notes is encouraged but not mandatory. As participants will be encouraged to take a copy of the GPMP, supplementary notes might cover matters that the LMO thinks inappropriate to state on the GPMP.
- 8.6.2. The Supplementary Notes for the practice nurse or community nurse might also include:
 - a) instructions on the clinical records to be maintained;
 - b) instructions on how the LMO is to be kept informed of the co-ordination activities and the veteran's condition; and
 - c) the circumstances in which the LMO is to be alerted to a change in the participants condition/deviation from the care plan.
- 8.6.3. Where the LMO does not prepare Supplementary Notes, the above items may be inserted on the GPMP.

8.7. Working with the care co-ordinator

- 8.7.1. The care co-ordinator and the LMO will liaise in accordance with the LMO's advice in the GPMP or the Supplementary Notes.
- 8.7.2. The care co-ordinator will alert the LMO to changes in the participant's condition or deviation from the GPMP. The LMO will examine the participant's file and decide on follow up action whether that might be arranging for the participants to have a consultation with the LMO or another provider, or arranging for a phone call to the participant from the LMO or the care co-ordinator etc.
- 8.7.3. The GPMP needs to be up to date. Where the participant's condition changes, the GPMP should be reviewed.

9. Record Keeping & Retention Requirements

- 9.1. The LMO will keep comprehensive clinical records as per the Medical Records Act in each State and Territory.
- 9.2. The DVA-contracted community nursing provider will keep records as per existing requirements.

10. Co-ordination Requirement

10.1. Co-ordination of a participants care, according to the GPMP, is a mandatory requirement of the program. A key expectation of the program is that a practice nurse or community nurse will co-ordinate the veteran's care. However, DVA recognises that in certain circumstances this may not be possible or may not be the best outcome. Examples of those circumstances are:

- a) The LMO has no practice nurse and is unable to secure an appropriate DVA-contracted community nursing provider, so the LMO provides the care co-ordination themselves. In this case the LMO is still only entitled to the LMO without Practice Nurse Payments; and
- b) The care co-ordination may be provided by a state funded nursing or community service.

10.2. In making a claim for a quarterly payment, the LMO is affirming that care co-ordination has taken place. The guidelines for LMOs will provide more detail on this.

11. Effect of Hospitalisation on Care Periods

11.1. Where a participant is hospitalised part way through a care period the following rules apply:

- a) A quarterly claim for LMO clinical leadership and care co-ordination is still payable where the participant was not hospitalised at the start of the claim period; and
- b) Where a quarterly care period expires whilst a participant is in hospital, a new quarterly period of LMO clinical leadership and care co-ordination cannot commence until the participant is discharged from hospital.

12. Effect of Death

12.1. Where a participant dies part way through a care period:

- a) the LMO is entitled to claim the full amount of the LMO quarterly payment, whether that is with or without a Practice Nurse; and
- b) the DVA-contracted community nursing provider is entitled to the full amount for the 28 day period in which the death occurred.

13. Effect of Admission to a Residential Aged Care Facility

- 13.1. The Preventable Admissions program is not available for residents of a Residential Aged Care Facility (RACF). Where a participant becomes a resident of an RACF part way through a quarterly period of care, the LMO is entitled to full payment for that quarter but cannot commence a new quarterly period of care unless the participant returns to live in the community and meets all the other eligibility criteria.
- 13.2. A participant who enters a RACF for temporary respite is not considered to be a resident of a RACF.

14. Engagement with Other Health Professionals

- 14.1. The Preventable Admissions program recognises and encourages the role of the multi disciplinary team in providing comprehensive care and it is expected that existing opportunities for involving pharmacists and medication reviews, specialists, allied health practitioners, emergency department personnel and hospital discharge planning will be maintained and strengthened.

15. Relationship with Better Discharge Planning

- 15.1. The Better Discharge Planning program involves DVA making a payment to a private hospital to assist the patient in the first two weeks post discharge to ensure an effective transfer of care. Assistance may include accessing services, medication review, arranging community nursing services, arranging follow-up medical appointments and monitoring patient well being.
- 15.2. DVA will provide guidance on the respective roles played by the discharge planner and care co-ordinator under the Preventable Admissions program.

16. Role of the Carer

- 16.1. The carer will be encouraged to be involved in the care planning and co-ordination process. Where a carer has medical power of attorney, enduring power of attorney or enduring guardianship, as recognised by the laws of the relevant State or Territory, the carer may provide the necessary consents for the veteran to be admitted to the program and receive services.

17. Self Management and the Role of the Participant, Carer and Family

- 17.1. A key feature of the care model is the involvement of the participant and encouragement of self management. An understanding of the health goals, interventions and aspects of self-management will empower and improve

the confidence of the participant in managing their condition.

17.2. A broad definition of self-management involves individuals working in partnership with their families/carers and health professionals so that they can:

- a) know their condition and various treatment options;
- b) negotiate a care plan and review/monitor the plan;
- c) engage in activities that promote and protect health;
- d) monitor and manage the symptoms and signs of the condition;
- e) manage the impact of the condition on physical functioning, emotional and interpersonal relationships; and
- f) have confidence in their ability to use support services.

17.3. The care model also encourages the involvement of carers and family where possible to provide additional support. With the consent of the participant, a copy of the GPMP may be provided to the carer and family.

18. Education, Training and Resource Support

18.1. A significant component of the Preventable Admissions program is the provision of education, training and resource support to the people delivering the care and co-ordination. Training will cover a range of topics such as:

- a) Care planning;
- b) Self management support and counselling;
- c) Re-organising a general practice to provide care co-ordination; and
- d) Identification of social isolation issues.

19. Rules for transfer of provider

19.1. Rules will cover transfers between LMOs, and between practice nurses and DVA-contracted community nursing providers. The rules will allow changes to providers but will prevent multiple claims from different providers in the one claim period.

19.2. LMO to LMO

19.2.1. Where the participant changes LMO after entering the program, the new LMO:

- a) Cannot claim the Initial Incentive Payment; and
- b) Can only claim for a quarterly care leadership period that commenced after the expiry of the previous LMOs quarterly care period, whether or not the new LMO knew of the existence of a previous period of care.

19.3. From practice nurse to a DVA-contracted community nursing provider

19.3.1. A change from practice nurse to DVA-contracted community nursing provider may occur where:

- a) The veteran and/or the LMO decide that a community nurse is better placed to co-ordinate the care. In this case, the LMO should make all attempts to complete the current quarterly period of practice nurse co-ordinated care before making the change. This will ensure seamless transition to the DVA-contracted community nursing provider who can begin co-ordinating care straight away and can claim after the first 28 day period has been completed. The LMO will be required to provide a referral to the DVA-contracted community nursing provider
- b) The veteran changes LMO and the LMO doesn't have a practice nurse or the practice nurse cannot provide the care co-ordination service.

19.3.2. The new DVA-contracted community nursing provider is unable to make a claim for the first 28 day care co-ordination period until a new quarterly period of care is in place.

19.4. From DVA-contracted community nursing provider to practice nurse

19.4.1. A change from DVA-contracted community nursing provider to practice nurse may occur where:

- a) The participant and/or the LMO decide that a practice nurse is better placed to co-ordinate the care, or the LMO previously did not have a practice nurse; or
- b) The participant changes LMO and the veteran and/or the LMO decided that the care will be co-ordinated by the LMOs practice nurse, or the previous LMO did not have a practice nurse.

19.4.2. In both cases, the LMO should advise the DVA-contracted community nursing provider that the referral for the Preventable Admissions program is withdrawn. In considering this action the LMO should take into consideration whether the veteran is receiving community nursing services under the Community Nursing Program as these community nursing services would be ongoing thus creating a potential for duplication of some service provision.

19.4.3. The LMO or new LMO may choose to commence the practice nurse co-ordination straight away but will not be entitled to claim for the LMO with Practice Nurse Payment until the next quarterly care period expires.

19.5. From one DVA-contracted community nursing provider to another

19.5.1. Where a veteran changes DVA-contracted community nursing provider, the new provider cannot commence a 28 day claim period of co-ordinated care until the existing 28 day claim period of co-ordinated care from the previous provider has expired. The LMO will be required to provide a referral to the new DVA-contracted community nursing provider.

20. Social isolation

20.1. DVA recognises the increasing prevalence of social isolation amongst veterans and war widow/widowers and the impact of social isolation on health outcomes. Strategies to address this issue are:

- a) Training will be offered to general practitioners and nurses to better understand the effects of social isolation on health outcomes and the identification of social isolation issues in patients;
- b) Source and make better use of available resources to address social isolation issues;
- c) Better use and understanding of the role and involvement of family, carers and the community in chronic disease management; and
- d) New social support services available through Veterans' Home Care.

21. Veterans' Home Care Social Support Services

21.1. The Veterans' Home Care (VHC) Program will expand its services to include a social support service type for selected participants in the program with higher care needs.

21.2. The VHC program helps Australia's veterans and war widows with low care needs to remain in their own homes. Four service types are currently available:

- a) Domestic assistance, which provides assistance with tasks such as household cleaning, dishwashing, clothes washing and ironing, shopping for the veteran and bill paying;
- b) Personal care, which provides assistance with daily self-care tasks such as eating, bathing, toileting, dressing, grooming, getting in and out of bed and moving about the house;
- c) Respite care, which provides temporary relief to the eligible person's carer (or to the eligible person if they are the carer); and
- d) Safety-related home and garden maintenance, which assists in keeping the home safe and habitable by minimising environmental health and safety hazards.

- 21.3. DVA contracts with 16 VHC Assessment Agencies across Australia to assess, approve and coordinate VHC services for eligible veterans. Assessments are conducted primarily by phone (with capacity to conduct in-home assessments where warranted) using a standardised validated assessment tool. DVA separately contracts with over 170 VHC service providers across Australia to deliver VHC services.
- 21.4. Under the Preventable Admissions program a new type of VHC service will be available for social support. The aim is to assist in reducing preventable hospital admissions by targeting those most at risk of admission or readmission to hospital due in part to the lack of social support available.

21.5. Eligibility

- 21.5.1. Only veterans and war widow/widowers eligible for the Preventable Admissions program, who also have higher level care needs for home support services, will be eligible for the new social support service type through the VHC program.
- 21.5.2. The LMO will determine which participants will benefit from social support services, with the VHC Assessment Agency being responsible for putting those services in place. VHC Assessment Agencies already have communication channels in place with LMOs as part of their assessment and coordination role for VHC services, and should be aware of other services the participant is already receiving beyond VHC (for example Home and Community Care program services).
- 21.5.3. Where the LMO identifies social isolation issues and determines eligibility for the new social support services, the LMO will provide a referral to the contracted VHC Assessment Agency. The Assessment Agency will then determine the type and duration of the services and allocate to a contracted VHC Service Provider in the veteran's locality so that services can be delivered.
- 21.5.4. Whilst up to 17,000 veterans and war widows are expected to participate in the wider Preventable Admissions program over 4 years, around 3,750 (per annum), or 1 in 5 program participants, will receive the VHC social support services.
- 21.5.5. The LMO will be provided with definitions, criteria and guidelines to assist in determining whether a veteran participating in the Preventable Admissions program is eligible for VHC social support services. This determination would include consideration of the following:
- a) current care relationships;
 - b) social contact, including amount of contact with family, friends and neighbours;
 - c) recent extended feelings of sadness, depression or nervousness;
 - d) recent extended feelings of isolation and loneliness;

- e) satisfaction with level of social activity, participation and social involvement;
- f) barriers preventing social activities and social involvement; and
- g) ability to receive help if needed or wanted (e.g. are sick and have to stay in bed, need someone to talk to, need help with daily chores or need help taking care of themselves).

21.6. Service selection

21.6.1. A schedule of available services under the social support service type will be provided to LMOs. Types of services will primarily include keeping a person company in the home or facilitating participation in community activities (i.e. clubs with outside social supports). In some circumstances, accompanied outings for activities such as shopping, bill paying, banking, non-medical appointments or meal preparation in the home may be provided on a limited basis.

21.7. Service delivery

21.7.1. When the LMO has determined that a participant in the Preventable Admissions program will benefit from social support services, the LMO will make a referral to the VHC Assessment Agency by fax or other communication means. A standard referral template will be developed for this purpose.

21.7.2. The VHC Assessment Agency will allocate a contracted VHC service provider to deliver the services. This will be done through the creation of a VHC Service Plan as with current VHC services.

21.8. Review

21.8.1. As a part of the LMOs regular review process, the VHC Assessment Agency will provide the LMO with a standard report of the social support services that will be delivered.

21.9. Payment

21.9.1. Contracted VHC service providers will be paid an hourly rate for the social support services that they deliver in the same way that they are paid for other VHC services. Contracted VHC assessment agencies already receive an annual fee for undertaking assessment and co-ordination services for each eligible participant.

21.10. System

21.10.1. The VHC system will record:

- a) the allocation of the contracted VHC service provider for social support services;
- b) the VHC Service Plan issued to the contracted VHC service provider and the service details (referred to as the VHC Care Plan) for the participant for the social support services; and
- c) the claims for payment for the delivering of the social support services by the contracted VHC service.

22. Relationship with E-Health

22.1. The Personally Controlled Electronic Health Record (PCEHR) System will provide all Australians who choose to participate, with the ability to more actively participate in their health care with their health care providers. Key features of the system are:

22.1.1. Australians will be able to check their key health history online through the introduction of personally controlled electronic health records.

22.1.2. The foundation of the PCEHR will be a summary view and may contain the following data elements:

- a) basic demographic information;
- b) an event summary;
- c) current medications;
- d) allergies; and
- e) alerts.

22.1.3. Additional health information will also be available through the PCEHR over time, including:

- a) pathology test results;
- b) diagnostic images;
- c) discharge summaries;
- d) referrals; and
- e) specialists letters.

22.2. The System will be available for registration from 2012 – 2013 and will contribute to the efficiency and effectiveness of the Preventable Admissions program by:

22.2.1. Allowing program participants to be actively involved in managing

their health information by having easy access to their medical history;

22.2.2. With the participant's authorisation, doctors, nurses, paramedics, pharmacists and other health professionals will be able to access their relevant history;

22.2.3. Improved ability for multi-disciplinary team to effectively share patient information such as test results, medical records and reasons for referrals either by paper or electronically; and

22.2.4. Improved availability of health information across care settings will reduce avoidable adverse drug events and preventable hospital admissions.

23. Information Flows, Reporting, Monitoring and Evaluation

23.1. DVA will monitor the service delivery performance of the program and report on a regular basis.

23.2. Information provided through reporting and monitoring functions will feed back into communication messages, training and education material and policy review. Alerts to DVA may also result in DVA conducted audits of selected service providers.

23.3. A qualified consultant will develop an evaluation framework and undertake an ongoing independent evaluation of the program savings. Monitoring of program savings is an important element of the program and this activity will commence early to establish effective baseline measures, and support monitoring of program outcomes, including reductions in hospital admissions and costs.

24. ATTACHMENT A - Preventable Admissions Payment Items

24.1. New Service Items

24.1.1. Payments for new items will be processed by Medicare Australia under the RMFS or Community Nursing Fee Schedule. These six items are required for the new services provided by LMOs, practice nurses and DVA-contracted community nursing providers associated with this initiative. The following table provides a description and some business rules for each new item:

	Item Name	Item Description	Business Rules
1.	LMO Initial Incentive Payment – -Preventable Admissions Program With Practice Nurse Co- ordinator \$400	The payment is for admitting a person to the Preventable Admissions program and having done all things necessary for the admission.	<ul style="list-style-type: none"> • This item will only be paid once per eligible veteran regardless of a change in LMO provider or in practice nurse arrangements. • Where a person ceases to be a participant and later re-enters the program, the incentive payment will not be applicable. • This item will be claimed on admission of a participant to the Preventable Admissions program.
2.	Without Practice Nurse Co- ordinator \$250		

<p>3.</p> <p>4.</p>	<p>LMO Quarterly Payment – Preventable Admissions Program</p> <p>With Practice Nurse Co-ordinator \$417.50</p> <p>Without Practice Nurse Co-ordinator \$187.50</p>	<p>This item enables an LMO to claim a fee for the ongoing clinical care leadership of a veteran in the Preventable Admissions program in quarterly periods of care. This item covers a period of care as opposed to existing MBS items that are for individual face-to-face visits.</p>	<ul style="list-style-type: none"> • Only one of these items in any quarterly period and only 4 items in any 12 month period. • The previous quarterly period of care must have expired before the commencement of the new quarterly period. • A claim will be rejected for a care period commencing after a participant's date of death.
<p>5.</p>	<p>DVA-contracted community nursing provider Initial Care Coordination – Preventable Admissions Program \$170</p>	<p>DVA-contracted community nursing provider periods of care are provided in 28 day claim periods.</p> <p>This item enables a DVA-contracted community nursing provider to claim for the initial care coordination provided over the initial 28 day period of co-ordinated care for a participant in the Preventable Admissions program.</p> <p>The initial 28 day claim period commences on the day that co-ordination of care commences.</p> <p>Where the veteran is already receiving services from a DVA-contracted community nursing provider, the 28 day period for the initial claim to be made is the 28 day period in which the co-ordination of care under the Preventable Admissions program first commenced.</p>	<ul style="list-style-type: none"> • This item will only be claimed by a DVA-contracted community nursing provider. • This item will only be paid once for each eligible veteran. • This item can only be claimed following a claim for the LMO Incentive Payment item. • An LMO-with Practice Nurse Quarterly item cannot be claimed as well as this item. • Where an LMO with Practice Nurse Initial Incentive Payment has been made in respect of the participant, the Community Nurse Provider – Initial Care Co-ordination Payment will not be paid i.e. Only one initial payment for nursing services will be paid, whether provided by practice nurse or community nurse. • Where the participant changes DVA-contracted community nursing provider, or ceases to be a participant and later re-enters the program, the incentive payment will not be applicable. • A claim will be rejected for a 28 day period that commences after a veteran's date of death.

6.	Community Nursing Subsequent Care Coordination – Preventable Admissions Program \$85	This item enables a DVA-contracted community nursing provider to claim, on a 28 day claim period basis, for subsequent care coordination activities.	<ul style="list-style-type: none"> • This item will only be claimed by a DVA-contracted community nursing provider. • An LMO-with Practice Nurse Quarterly Payment item for the same period of time cannot be claimed as well as this item. • An LMO Initial Incentive Payment must have been claimed, thereby entering the veteran in the program. • A quarterly period of care must be current for all or part of the 28 day claim period. • Where a quarterly period of care expires during a 28 day claim period, the payment for that period will be made but subsequent payments will not be made until a new quarterly period of care commences. • Where there is a change in DVA-contracted community nursing provider, the first 28 day claim period in which a Subsequent Care Co-ordination Claim can be made must commence on a date after the expiry of the 28 day claim period paid to the previous DVA-contracted community nursing provider. • A claim will be rejected for a 28 day period that commences after a participant's date of death.
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