Australian Government
Department of Veterans' Affairs

Procedural Guideline
Rehabilitation Plan Development

In this Section:

1. Overview

Procedural Guidelines outline DVA's requirements and supporting guidance for Rehabilitation Providers (providers) and their Rehabilitation Consultants (consultants) working with DVA clients. Consultants are expected to follow this guideline in developing Rehabilitation Plans for DVA clients. Providers are responsible for ensuring DVA requirements are followed by their consultants.

The development of a Rehabilitation Plan (plan) commences after an Initial Rehabilitation Assessment (assessment) has been completed. It is founded upon the recommendations in the assessment form and will reference this as required. The aim of a plan is to provide:

- an outcome-oriented plan that addresses the identified rehabilitation requirements of the client and their rehabilitation goals
- an itemised list of recommended activities aligned with rehabilitation goals specific to the client's needs, and
- detailed costs of the activities and the proposed timeframes for these to commence and be completed.

2. Rehabilitation Plan requirements

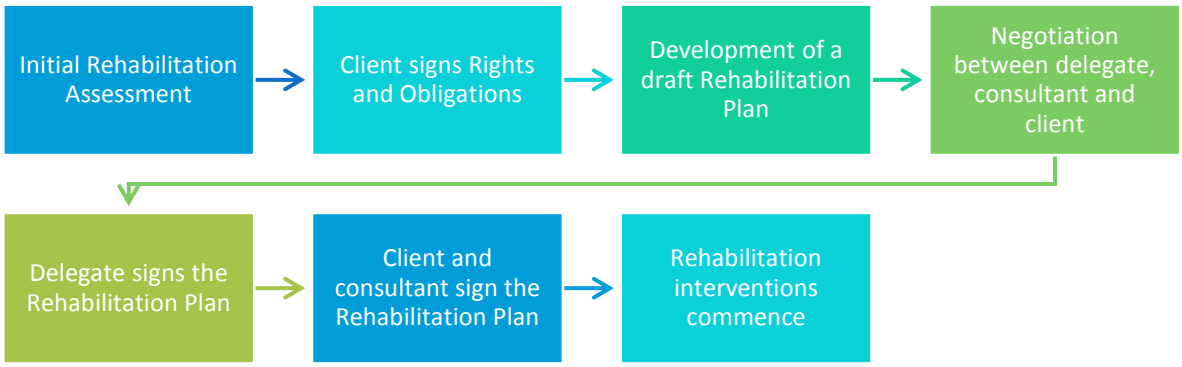
Table 1: Rehabilitation Plan requirements

Topic	Requirement
Rehabilitation Plan	The plan must: • be completed using the D1347 Rehabilitation Plan form • address all sections on the form template, and provide sufficiently detailed information for the Rehabilitation Delegate (the delegate) to make an informed decision • NOT be signed by the client or the provider, until the delegate has reviewed and signed the draft plan • be informed by medical evidence from the client's medical practitioners and other health professionals • link directly to the findings of the initial rehabilitation assessment • specify rehabilitation goals and activities that are Specific, Measurable, Achievable, Realistic within a given Timeframe (SMART) • align itemised activities with specific rehabilitation goals • for each activity, provide realistic timeframes for commencing and completing the activity, itemised costs, and the rationale • detail the outcome for each goal, using the GAS scale method, • be uploaded using the Provider Upload Portal.

Topic	Requirement
Client Welfare	DVA must be advised immediately where the provider and/or consultant becomes aware the client has urgent needs or is at risk.
Timeframes	The plan must be submitted within 15 business days of the referral being issued. Where the plan cannot be submitted within 15 business days due to client circumstances or factors outside of the consultant's control (such as inability of client to obtain reports from the client's treating general practitioner in rural and remote areas), the consultant seek an extension from the delegate via email and provide a justification for the delay.

3. Rehabilitation Plan development process

Figure 1: Rehabilitation plan development overview



Plan development commences after the assessment has been completed. The plan is submitted to the delegate in draft, together with the assessment and other supporting documents. The plan must NOT be signed by the client or the provider before the delegate has been provided with a draft copy and given their agreement to the plan by signing the plan. This is to ensure that the client's expectations in regard to their plan and associated activities are managed appropriately.

3.1. Whole of person rehabilitation approach

DVA's whole-of-person approach to rehabilitation must always be used to guide decision making. The consultant must ensure that a client's plan is tailored to their current needs and circumstances and appropriate services are identified to maximise rehabilitation via the most direct route. A client may work towards a combination of vocational, medical management and/or psychosocial goals concurrently, or may initially focus on achieving specific types of goals (i.e. medical management and/or psychosocial) before moving onto others. This will be determined by what is most appropriate for each client given their individual circumstances and needs.

3.2. Types of Rehabilitation Plans

Plans fall into two categories: return to work plans, and non-return to work plans. Return to work plans will have a vocational element to them, whereas non-return to work plans focus solely on non-vocational rehabilitation (i.e. psychosocial goals and activities including medical management).

Where it is reasonable to expect that the client will be able to commence vocational rehabilitation activities to work towards a return to work goal within the next 12 months, then a return to work plan should be prepared. Where it is unlikely that the client will be able to commence vocational rehabilitation activities within 12 months then a non-return to work plan should be prepared.

Figure 2: Return to work versus non-return to work Rehabilitation Plans

Return to work plan

- May have an initial focus on non-vocational activities (e.g. six months) but must include a vocational goal.
- Medical clearance for work is not needed but there should be a reasonable prospect of medical clearance to work within 12 months.
- Client is expected to be ready to participate in some vocational activities within the next 12 months
- Client is motivated to work towards vocational goals

Non-Return to Work plan

- Only includes non-vocational goals and activities.
- Client is not expected to be able to participate in vocational activities for at least 12 months.
- Client is not motivated to work towards vocational goals, or their participation in vocational goals and activities may harm their rehabilitation.
- Client is not expected to be medically cleared for work within 12 months

Even if a return to work plan is proposed for the client, vocational rehabilitation must not be the first, or the only, priority. The plan must be tailored to the client's current needs, whilst considering the longer term goals of the client. In some cases, this may mean that a client is placed on a return to work plan but there is initially a focus on psychosocial goals (including medical management) until they are ready to participate in vocational rehabilitation activities

In cases where a client does not have capacity for vocational activities at the start of the plan a vocational goal might be: 'Review capacity for vocational activities in 6 months.' or 'Maintain regular discussion around capacity for vocational activities and clients vocational options for 6 months.'

Further guidance on vocational and non-vocational rehabilitation is covered in the Vocational Rehabilitation Provider Procedural Guideline and the Non-Vocational Rehabilitation Provider Procedural Guideline. *Note, the Non-Vocational Rehabilitation guidelines are expected to be released in April 2020.*

3.3. Client engagement and communication

A client will be motivated to participate in their plan when they have been actively engaged in planning rehabilitation goals and activities. Therefore, the development of a plan and the goals and activities within it must be a collaborative process that involves the client at every step in the process. This will help ensure that the right activities and services are provided to the client at the right time and enable cost effective service delivery that avoids unnecessary duplication. Where appropriate, the client's general practitioner (GP), treating specialists, allied health professionals, family/significant others and employers/work colleagues should also be involved. This may assist in aligning expectations of all key parties and ensure that medical clearance is obtained.

Good communication is key to managing expectations and ensuring the client has a strong understanding of realistic activities and goals that may be included in their plan. It is essential that the client has made a significant contribution to developing the activities and goals of their plan, to ensure that the client is engaged with their rehabilitation, motivated to achieve their identified goals, understands their role and responsibilities in meeting their goals and comfortable when signing their approved plan.

When developing a plan, the consultant must clearly explain the roles and responsibilities of the client, the delegate and the consultant in the rehabilitation process. This helps to ensure that the integrity of the relationship between all parties is maintained.

3.3.1. Expectations Management

Throughout the assessment and plan development process, consultants are expected to proactively manage client's expectations as to potential interventions and services that may be offered as part of their rehabilitation. It is important that the client is aware that plan goals and activities are subject to negotiation and agreement with the delegate. Consultants should proactively manage client's expectations as to what interventions meet DVA's reasonableness criteria and ensure that interventions meet the requirements of the Vocational Rehabilitation Procedural Guideline and Non-Vocational Procedural Guideline as relevant. *Note, the Non-Vocational guidelines are expected to be released in April 2020.* This includes ensuring the activities reflect the client's circumstances and are cost effective.

3.4. Rehabilitation Plan form

The D1347 Rehabilitation Plan form must be used to document the client's plan. In line with the template, the plan must include:

- the program of activities with clearly defined SMART goals
- expected short-term and longer-term objectives and clearly written GAS outcome scale
- a start date and an anticipated end date for the plan
- clearly defined timeframes for goals and activities, and
- itemised costs for each recommended activity listed on the plan.

If the plan is not completed to a satisfactory standard, the delegate will return the plan to the consultant for revision.

3.4.1. Rehabilitation Plan duration

As a general rule, to assist with the effective management of plans, a client's first plan with DVA should initially run for a period of six months. After six months, where it is envisaged that more time is needed to implement a plan, a plan amendment or new plan may be proposed that includes longer timeframe depending on the circumstances of the client. Typically, subsequent plans would go for six to twelve months. Regardless of plan duration, there needs to be periodic progress reporting during the duration of a plan at three month intervals or as otherwise agreed with the delegate.

If a client is undertaking study and needs minimal support based on the first six months, further plans may be developed for a longer period with minimal contact from the consultant. Note that for longer spanning plans, plan management costs are expected to be lower than the costs for management of more intensive plans, to reflect the reduced work effort by consultants.

When submitting draft plans to the delegate that are outside of the standard timeframes (six months initially and then six to twelve months thereafter), the consultants should include the rationale for why they have specified a particular plan duration.

DVA does not impose generic timeframes for goals, as goals need to be tailored to the client's individual circumstances. Consultants should work with the client to ensure that timeframes are appropriate for each goal, and can realistically be achieved be the client. Goal end dates must not exceed the duration of the plan.

3.4.2. Procedure for signing a Rehabilitation Plan

Once the plan has been developed in close consultation with the client, a draft plan must be submitted to the delegate for approval PRIOR TO the client or consultant signing the plan. The client must not be given a copy of the draft plan until it has been reviewed and approved by the delegate. This is to ensure that the delegate has the opportunity to review the plan for appropriateness, cost-effectiveness and sustainability, and propose any revisions if necessary. The development of a plan involves negotiation and close engagement between the consultant, the delegate and the client to come up with a plan that is satisfactory to all parties.

Note: For high risk or complex clients, it may be beneficial to hold a case conference prior to the plan being signed, so that all parties including the client's general practitioner, allied health professionals and family/significant others are aware of the proposed activities and rehabilitation goals and are 'on the same page'.

Once a suitable plan has been negotiated between all parties, the delegate signs the plan first, prior to the plan going back to the client and consultant for signature. The fully signed plan must be returned to the DVA delegate by the consultant within 3 business days of the client signing the delegate approved plan. The signature of each party (delegate, consultant and client) confirms they have contributed to the plan and agreed to the goals and activities included in the plan. The plan start date, and the date the approval for the funding detailed in the plan, is the date the fully signed plan is uploaded to the PUP.

A copy of the signed plan, without the costings page, is provided to the client by the delegate with the plan approval letter so that the client has a record of their plan. Consultants must return the

scanned, signed plan to the delegate with the costing page separate. This is because the plan is provided electronically to the client and the delegate has no way of removing the costing page from the pdf document.

3.4.3. Client refusal to sign their Rehabilitation Plan

A client is not considered to be non-compliant with their rehabilitation program merely because they have refused to sign their plan. If this situation arises, it is important that there is a discussion between the consultant and the client to resolve any concerns that the client has about the focus of the plan or any of the activities detailed within the plan. If the situation cannot be resolved, the delegate must be notified via phone or email so they can assist the consultant and client come to a satisfactory solution.

Where a client still refuses to sign the plan, the reason should be documented by the consultant and recorded on the plan and the plan submitted to the delegate. Work should continue between the consultant, delegate and client to achieve agreement and implement the plan.

3.5. Provider Upload Page

It is mandatory that providers upload the plan via the Provider Upload Page (PUP). In the event that the PUP is offline, the consultant should wait several hours and try accessing the portal again. Where upload is still not possible, the consultant should contact the delegate before submitting the documentation via email.

For further information about using the PUP, please consult the PUP user guide and frequently asked questions available through the PUP home page.

4. Timeframes for completing the plan

The draft plan must be provided to the delegate within 15 business days. There may be situations where the plan cannot be completed in this timeframe, including:

- delays in performing the assessment because:
    - it is not in the client's best interests to commence or complete the assessment, such as where there are concerns over the client's wellbeing
    - the consultant is unable to make contact with the client
    - the consultant is unable to organise a suitable time to meet with the client to complete the assessment, or
- the client is unable to obtain reports from their treating medical practitioner in rural and remote areas.

In these situations, the consultant should notify the delegate via email and provide a justification for the delay. This information should also be captured by the provider so that it can be included in the six monthly Quality Report to DVA. Where medical reports could not be obtained within 15 business days, the consultant should still submit the draft plan together with the assessment to the delegate within the 15 business day timeframe. Once medical reports have been obtained the consultant should either:

- confirm with the delegate via email or phone if the assessment and draft plan are consistent with the medical reports and no changes are required to the assessment and plan, or
- submit a revised assessment and/or draft plan to the delegate if medical reports warrant changes or additions to the assessment and/or plan.

5. Developing meaningful goals and outcome scales

Consultants must utilise the following information when developing goals and outcome scales for a DVA client. Examples of goals and outcome scales can be found at Appendix 1 of this PPG.

5.1. Life Satisfaction indicator

The Life Satisfaction Indicator (LSI) is a DVA questionnaire to obtain information about how the client is feeling about a range of areas of their life. It is relevant to the rehabilitation goal setting process as it provides information from the client that is valuable for developing goals under the rehabilitation program. It is obtained by the client completing the D9230 Life Satisfaction Indicators form.

DVA expects that where a client indicates a poor level of satisfaction in a specific area of the questionnaire that the consultant would initiate a discussion with the client about whether a goal should be formulated to improve the clients satisfaction in that area of their life. The LSI must also be used to identify other areas where the client requires support outside of the rehabilitation program.

The LSI questionnaire must be completed by the client at the initial assessment stage, 3 monthly once the plan has started, and again at plan closure. The consultant cannot complete the LSI on the client's behalf.

The LSI results are also used as a measure for assessing how clients rate their own life satisfaction before, during and after rehabilitation. Completing the LSI at the outset of rehabilitation provides a baseline for which client's life satisfaction improvements or deterioration can be measured. This can be considered when reviewing the effectiveness of a client's rehabilitation.

5.2. Goal setting

Goals are what the client wants to achieve, or the desired outcome that they are working towards. The goal must be something that helps the client return to, or as close to, the same physical, psychological, social and vocational status and functioning that they were prior to their injury/illness. They must be developed in close consultation with the client to ensure they reflect both the client's needs and their capability. The consultant needs to ensure all clients goals are specific and detailed. This ensures the goals will:

- be engaging and motivating for the client and provide a point of focus.
- assist in developing a clear plan of action (activities) to achieve the specific outcome of the goal.
- allow for better measurement of progress towards, and achievement of the goal.

As part of goal setting, the consultant must clearly set out the purpose and role of the DVA rehabilitation program so that clear expectations are established with the client regarding what goals DVA can and cannot assist with.

The consultant must work collaboratively with the client to develop goals that follow the SMART goal model (refer Figure 3 below). SMART goals are specific, measurable, attainable, relevant and time-based.

Figure 3: SMART model for goal setting

A well written goal must:

- not be an activity. It must focus on behaviours and/or participation in activities to achieve a change in functioning and/or behaviour.
- have only one outcome it is aiming to achieve. This means a single goal should not be trying to achieve change to various aspects of the client's functioning or life. For example, a goal should not be aiming to both reduce substance abuse and increase physical activity. These should be separate goals.
- include an outcome that can be objectively measured. For example, where a goal is to 'successfully engage' in something, or 'improve overall fitness', or 'adopt a healthy lifestyle' it is hard to objectively assess progress towards the successful completion of the outcome, and when or if the goal is achieved.
- be supported by a medical certificate stating the client has the capacity, or will have the capacity, to achieve the goal.
- achieve an identified need of the client and reflect the purpose of the DVA Rehabilitation program.
- Have a specific timeframe tailored to the goal. For example, setting a time frame for a broad goal such as 'Participating in job seeking assistance' is harder than if the goal is more specific, such as 'Participating in updating resume'.
- Use positive, supportive language.

As SMART goals need to be specific and time based this means that the overarching, or end, goal of the client may need to be broken down into smaller goals that represent specific sub-goals, or stages, that the client will need to achieve to attain the end goal.

Examples of well written SMART goals are as follows:

- Participate fully in treatment plan issued by physiotherapist to improve functioning of right knee condition.
- Meet with family and/or friends twice weekly outside of the home for 6 months.
- Identify medically suitable vocational options within 3 months.
- Complete Cert IV in training within 12 months.
- Participate in swimming and/or yoga 3 times a week.
- Achieve self-management of treatment for back condition within 6 months.
- Participate in resume writing training within 2 months.

Multiple activities may be included under each goal to help the person to reach their goal. For example, the goal of 'Identify medically suitable vocational options' could have the activities of:

- 'review with client their existing skills and training to identify vocational options',
- 'attend vocational assessment', and
- 'case conference with treating doctor to ensure client capacity for identified vocational options'.

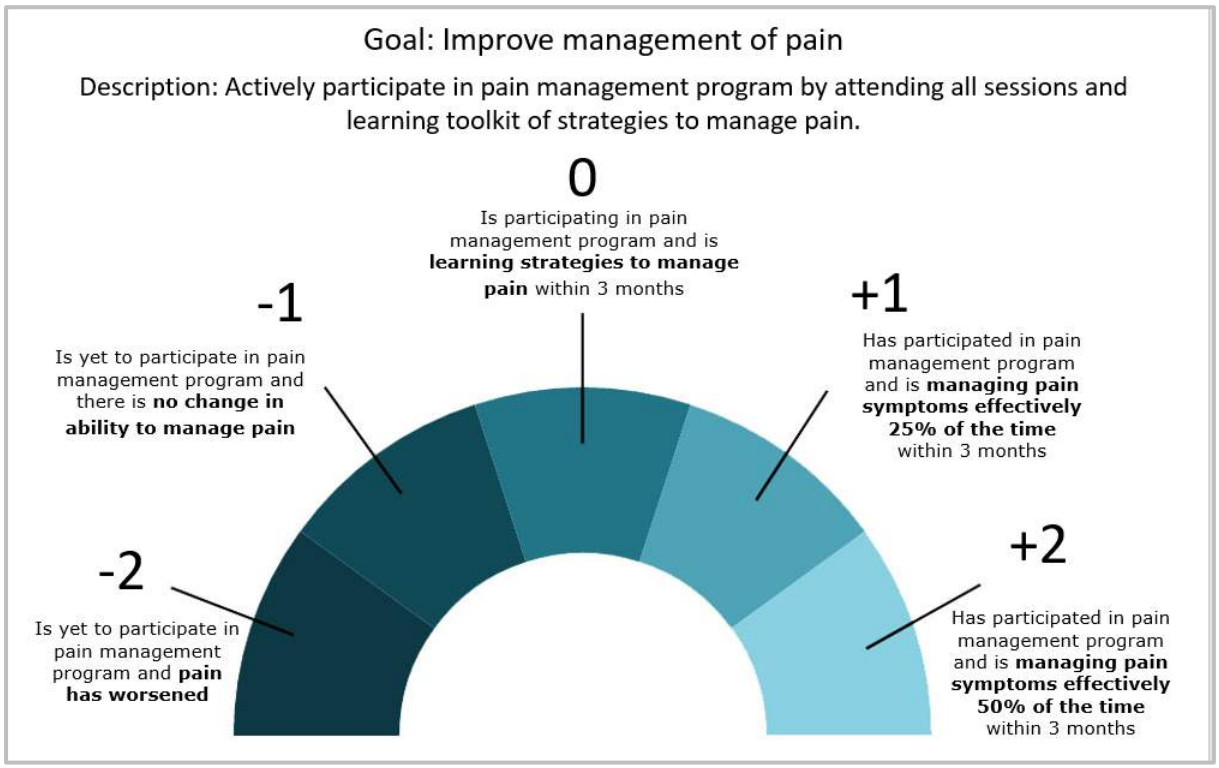
5.3. Goal Attainment Scaling

The consultant must use Goal Attainment Scaling (GAS) to develop personalized outcome scales for each of the client's goals. It is the provider's responsibility to ensure the consultant is proficient in the use of Goal Attainment Scales (GAS).

As an overview, GAS uses a scale to describe both expected and other possible outcomes for each of the client's goals. Each possible outcome is given a measure of -2 to +2, where:

- -2 is the least favourable outcome and means that very little progress has been made towards the goal.
- -1 is an outcome that was less than what was expected and means the goal has not been met, but some progress was made towards the goal.
- 0 is the expected outcome of the goal. This means what the client aims to achieve after completing the associated activities under their plan.
- +1 means the expected outcome has been exceeded. This means the client has made additional progress beyond the expected outcome of the goal.
- +2 means the expected outcome has been significantly exceeded. This means the client has achieved the best possible outcome for the goal.

Figure 4: Example GAS rating for expected goal outcomes



The GAS must be created in collaboration with the client, and contain specific, personalized outcomes that reflect the goal, and the clients need.

The use of GAS:

- Maximises client involvement in goal setting by engaging the client in discussion on the possible outcomes of the goal.
- Ensures the consultant and the client have the same understanding and expectations of the client's rehabilitation goals as it clearly articulates the outcome of the goal.
- Ensures the goal is well written to reflect the client's desired outcome, by allowing the consultant to check that the outcomes on the scale mirror the aim of the goal.
- Provides a documented reference point to facilitate discussion on progress towards the various levels of outcome throughout the life of the plan.
- Provides a point of focus for the client to engage in the progress they are making towards their goal as it clearly sets out the various degrees to which they can achieve their goal.

The consultant must explain the purpose and benefits of the GAS process to the client so that they can understand why it is being used. It is important that the client understands that it is an important and valuable tool for them and not a data gathering exercise.

5.3.1. Developing the GAS

As the GAS is personalised to each client it means that an expected outcome for two different clients with similar goals may be quite different. This is because each client will have different health and other situations that affect their expected outcome. For example, a client with lower functioning may have +2 outcome that is the same as a zero outcome for a client with higher functioning.

The expected outcome for a client should not be what they can currently achieve. It should be the outcome the client and consultant agree the client should be able to achieve after the completion of the associated activities. It should balance being realistic and attainable, whilst also being challenging and motivating, without being daunting.

With regards to expected outcomes, it is also important to note that where a client is at risk of a reduction in functioning that maintaining current functioning is an appropriate expected outcome.

The outcomes on the GAS scale must be things that are within the client's control, such as changes in behaviour or level of participation/effort in activities. They should not include outcomes related to the client's level of symptoms as the client may not be able to improve their symptoms regardless of how well they participate in the identified activities.

Other factors to note when creating the GAS:

- Use positive, supportive language, particularly in relation to the -1 and -2 outcomes
- Where possible, use wording that relates to imbedding sustainable, positive behaviours for the client.
- Use the same methodology when writing each scale to ensure consistency, and in turn credibility, of the GAS process.
- Ensure each point on the outcome scale is specific so that it is easy to identify a measurable difference between each point on the scale.
- Ensure objective measurement criteria is used so it is clear which outcome 'level' has been achieved.
- Ensure only one outcome is stated in each point on the outcome scale, rather than multiple outcomes. For example, 'Client completes approved gym program 3 times per week and achieves an improvement in fitness' is measuring two things. Attendance and participation, and fitness. These would be more effectively and accurately measured as two goals and associated outcomes.
- Ensure the medical certification for the client indicates that they have capacity, or will have capacity, to achieve the proposed outcomes.

5.3.2. Scoring the outcome of the GAS

Selecting the appropriate 'score', or outcome', from the GAS scale should be straightforward where the scale is well written. The scoring must be done in consultation with the client. When discussing the outcome with the client please discuss the steps the client can take to continue progressing towards, or maintaining, the best possible outcome.

The consultant must score the goal, and record the score, at the time that the goal is completed, not at the plan closure. This ensures accurate, meaningful recollection of the outcome achieved. Additionally, please provide details in the progress and/or closure report of why the score was selected including any additional relevant specifics about the achievement/completion of the goal.

A goal or plan amendment impacts on the way that the goal/s should be 'scored'. This is to ensure that we do not inaccurately give the impression through the score that an outcome was achieved, as

in that the goal was completed, when it in fact was not completed. Please follow the below guidelines when scoring goals at the time of goal amendment or plan variation:

- Where a goal is amended prior to the original goal being actioned a GAS score of N/A should be provided for the goal. The new, amended goal will need a new, or at least amended, GAS scale.
- Where a plan variation occurs and hence the goals are being closed on the existing plan, each goal must be scored based on its status at the time the plan is closed:
    - Goals that have been completed – they should be scored
    - Goals that have terminated prematurely, not fully completed – mark as N/A
    - Goals that have not been actioned or commenced – mark as N/A

If the consultant is unsure as to whether the goal should be deemed completed, they should consider if the client had a fair chance to participate in the activities under the goal. If the client had time and opportunity to participate in the activities but did not engage then this goal would be considered completed at the time of goal or plan change even where it is not achieved.

6. Reasonableness of costs to deliver the Rehabilitation Plan

The consultant must itemise all costs for the recommended services and activities listed on the plan by completing Attachment A of the plan form.

Consultants are required to ensure that rehabilitation costs are efficient and effective. This includes undertaking due diligence to ensure that activities specified in a plan represent value for money and documenting the justification in Attachment A of the plan form. The Framework for 'Reasonableness' should be referenced when determining the cost effectiveness of particular interventions.

6.1. Consultant travel costs

Consultants must use all reasonable attempts to minimise travel costs. Where possible and appropriate for the client's circumstances, consultants are encouraged to utilise telehealth arrangements, including teleconference and videoconference. The exception to this is the initial Rehabilitation Assessment, where an in-person meeting would generally be preferable except in situations where the client is very remote of there are safety concerns associated with meeting in person.

Travel costs need to be itemised and justified in the plan, with delegate approval prior to any travel occurring. The following factors should be considered when determining whether consultant travel is appropriate:

- the type of service being delivered
- the location of the appointment
- the timing of the appointment to minimise the need for overnight travel,
- where a consultant's journey starts and finishes, and
- the stage of the rehabilitation plan.

6.1.1. Allowable travel claims

Consultants are able to claim their travel time under certain circumstances when delivering the following services. These include:

- face-to-face meetings with clients, including but not limited to Initial Rehabilitation Assessments Vocational Assessments, Work Environment Assessments and Ergonomic Assessments
- work site visits to work trial host employers, and
- case conferences with the treating doctor or specialist. This is only to be used in exceptional circumstances, when case conferencing via teleconference or videoconference is not suitable.

6.1.2. Limitations on travel claims

Limitations to claiming consultant travel time:

- When developing the plan, the consultant will need to consider the individual client's needs when quoting travel costs. The need for travel will vary depending on the complexity of the case, the client's preferences and needs, and the stage of the rehabilitation plan. At initial assessment and plan development meeting in person is important to gain rapport. During plan management and implementation occasional phone calls and videoconferencing can be considered as viable alternatives to in person meetings, where these delivery modes are agreed to by and appropriate for the client. The frequency of face-to-face meetings and other alternatives should be discussed with, and agreed by, the client as the plan is being drafted. All anticipated travel costs over the life of the plan should be included in the plan (or plan amendment) if required.
- The geographic location of the client will have an impact on the associated travel costs in developing a plan. For clients residing in rural and remote locations as described by the Modified Monash Model zones 4-7, as far as practicable, a provider with an office nearby the client's location will be allocated the case. Travel in these circumstances will be undertaken by vehicle and billed at an hourly rate, unless other arrangements are negotiated with the delegate.
- In rare situations, for example, for clients who live in remote locations, or have specific requirements, a consultant may be required to travel distances that cannot be reasonably serviced by vehicle travel. In such circumstances the consultant may be required to travel by commercial airlines to attend a face-to-face meeting with the client. Air travel must only be undertaken where other communication tools, such as teleconferencing and videoconferencing, are ineffective. Air travel proposals must be forwarded to the delegate for approval and itemised in the draft plan. No air travel is to take place without delegate approval. Reimbursement for costs associated with air travel and overnight accommodation will be in accordance with the Australian Government Domestic Travel Policy (Resource Management Guide No. 404).

6.1.3. Ways to increase efficiency of travel costs

Consultants should consider flexible ways of working to reduce consultant travel time. To increase efficiency, consultants may wish to consider:

- meeting with the client at the provider premises, if appropriate
- scheduling back-to-back appointments for numerous clients in the same geographical locality and splitting travel time over the number of clients they visit, and/or
- helping clients to coordinate the timing of periodic appointments for medical and other services (particularly in remote and regional areas).

7. Completion of additional assessments (including vocational assessments)

Detailed specific assessments such as a Vocational Assessment, Functional Capacity Evaluation, Ergonomic Assessment and Work Environment Assessment should only be undertaken following the approval of the delegate. It is a requirement that additional assessments are specified in the draft plan, or a subsequent plan amendment, and submitted for approval by the delegate before they are undertaken. The client should be at an appropriate point in their rehabilitation before undertaking additional assessments. For some clients, this may be after they have progressed past a period of focus on medical management and/or psychosocial rehabilitation interventions, or when they have received clearance for participation in vocational activities.

For additional information and requirements on completing vocational assessments, providers should consult the Vocational Rehabilitation and Vocational Assessment Procedural Guidelines. These guidelines includes information on Functional Capacity Assessments, Ergonomic Assessments and Work Environment Assessments.

8. Invoicing for rehabilitation plan development

Instructions for invoicing DVA for the costs associated with performing the assessment and plan development are included in the Initial Rehabilitation Assessment Procedural Guideline. Please refer to this guideline for further information.

9. Appendix 1. Examples of Rehabilitation Goals, Goal Attainment Scales and Activities

Goal 1: To identify employment options in-line with medical and vocational capability within 4 months			
To be achieved within (indicate timeframe)**: 4 Months**			
Category (Psychosocial, Medical Management, Vocational)**: Vocational**			
Describe <u>all</u> of the following Outcomes - **Most unfavourable outcome (-2): Nil consideration of transferrable skills, vocational interests and labour market. Nil options identified within 4 months.** **Less than expected outcome (-1): Skills and qualifications considered, nil medically and vocationally suitable job options identified within 4 months** **Expected outcome (0): Medically and vocationally suitable job options identified within 4 months.** **More than expected outcome (+1): Medically and vocationally suitable job options identified and applications for employment completed within 4 months.** **Most favourable outcome (+2): Medically and vocationally suitable job options identified and employment obtained within 4 months.**			
Activities to achieve goal:	**Parties involved:**	**Start date:**	**End date:**
Obtain information on client's capacity for employment/vocational rehabilitation based on their conditions.	Client Medical practitioner Provider	1 April 2020	14 April 2020
Discuss with client vocational skills and qualifications and identify jobs the client can perform.	Client Provider	14 April 2020	30 April 2020
If unclear what job options are suitable based on client's conditions, skills and qualifications, obtain vocational assessment.	Client 3rd party undertaking vocational assessment	If required	

Case conference with GP to obtain updated medical opinion on identified jobs or vocational assessment recommendations.	Medical Practitioner Provider	1 June 2020	15 June 2020
Discuss with client outcome of medical case conference, and (where required) vocational assessment and identify job options.	Client Provider	15 June 2020	30 June 2020
Importance of goal for client: ☐ **A little** ☐ **Moderately** ☐ **Very**			
Challenge in achieving goal: ☐ **A little** ☐ **Moderately** ☐ **Very**			

Goal 2: Client is self-managing her attendance at all appointments relating to the treatment of her psychological conditions			
To be achieved within (indicate timeframe)**: Three months**			
Category (Psychosocial, Medical Management, Vocational)**: Medical Management**			
Describe <u>all</u> of the following Outcomes - **Most unfavourable outcome (-2): Ms Bobs is not attending appointments with treating medical practitioners for review and treatment of her psychological conditions** **Less than expected outcome (-1): Ms Bobs is not regularly attending appointments with treating medical practitioners for review and treatment of her psychological conditions.** **Expected outcome (0): Ms Bobs is attending regular reviews with her treating medical practitioners for review and treatment of her psychological conditions.** **More than expected outcome (+1): Ms Bobs is self managing her psychological conditions and attending less frequent scheduled reviews with her treating doctor due to her management of her condition.** **Most favourable outcome (+2): Ms Bobs is self managing her psychological conditions and symptoms and is independent in recognising when re-engagement with her treating medical practitioners is required.**			
Activities to achieve goal:	**Parties involved:**	**Start date:**	**End date:**
Provider to obtain consent from client to liaise with treating health professionals as required	Provider Client	1 April 2020	14 April 2020
Provider to ensure that they have a copy of the client's treatment plan/s, and if not obtain this information.	Provider Client Treating health professionals	14 April 2020	30 April 2020

Discuss with client their attendance at medical appointments	Client Provider	30 April 2020	30 June 2020
Provider to liaise with treating health professionals regarding treatment plan/s, appointment attendance, and amendments to the treatment plan as required.	Provider Treating health professionals	14 April 2020	30 June 2020
Importance of goal for client: ☐ **A little** ☐ **Moderately** ☐ **Very**			
Challenge in achieving goal: ☐ **A little** ☐ **Moderately** ☐ **Very**			

Goal 3: Client attending all appointments with treating health professionals, and undertaking at home exercises, related to the treatment of her knee conditions

To be achieved within (indicate timeframe)**: Three months**

Category (Psychosocial, Medical Management, Vocational)**: Medical Management**

Describe <u>all</u> of the following Outcomes -

Most unfavourable outcome (-2): Ms Smith is not routinely attending all appointments with all treating parties related to the treatment of her knee conditions.

Less than expected outcome (-1): Ms Smith is attending all appointments with all treating parties related to the treatment of her knee conditions but does not undertake any recommended at home therapies

Expected outcome (0): Ms Smith is attending all appointments with all treating parties related to the treatment of her knee conditions but does not consistently undertake all recommended at home therapies

More than expected outcome (+1): Ms Smith is attending all appointments with all treating parties related to the treatment of her knee conditions and undertakes all recommended at home therapies within 2 months

Most favourable outcome (+2): Ms Smith is attending all appointments with all treating parties related to the treatment of her knee conditions and undertakes all recommended at home therapies within 1 month

Activities to achieve goal:	**Parties involved:**	**Start date:**	**End date:**
Provider to obtain consent from client to liaise with treating health professionals as required	Provider Client	1 April 2020	14 April 2020
Provider to ensure that they have a copy of the client's treatment plan/s, and if not obtain this information.	Provider Client Treating health professionals	14 April 2020	30 April 2020
Discuss with client their attendance at medical appointments	Client Provider	30 April 2020	30 June 2020
Provider to liaise with treating health professionals regarding treatment plan/s, appointment attendance, and amendments to the treatment plan as required.	Provider Treating health professionals	14 April 2020	30 June 2020

Provider to support client to obtain medical aids and/or supports required for at home exercise. This includes liaising with treating health professionals to confirm appropriate aids/supports.	Provider Client Treating health professionals	30 April 2020	14 May 2020
Appropriate assessments have been done by associated DVA services to support client's completion of at home exercise, where required	Provider Client DVA/DVA providers	30 April 2020	14 May 2020
Importance of goal for client: ☐ **A little** ☐ **Moderately** ☐ **Very**			
Challenge in achieving goal: ☐ **A little** ☐ **Moderately** ☐ **Very**			

Goal 4: Client maintains participation in swimming and/or yoga 3 times a week
To be achieved within (indicate timeframe)**: 3 months**
Category (Psychosocial, Medical Management, Vocational)**: Psychosocial**
Describe <u>all</u> of the following Outcomes - **Most unfavourable outcome (-2): Mr Jones is participating in swimming and/or yoga once a week within 3 months** **Less than expected outcome (-1): Mr Jones is participating in swimming and/or yoga 2 times a week within 3 months** **Expected outcome (0): Mr Jones is participating in swimming and/or yoga 3 times a week within 3 months** **More than expected outcome (+1): Mr Jones is participating in swimming and/or yoga 3 times a week within 2 months** **Most favourable outcome (+2): Mr Jones is participating in swimming and/or yoga 3 times a week within 1 month**

Activities to achieve goal:	**Parties involved:**	**Start date:**	**End date:**
Obtain medical clearance for client to participate in yoga and swimming	Client Medical practitioner Provider	1 April 2020	14 April 2020
Client to identify a yoga studio easily accessible to them and attend regular classes that are appropriate for their capacity.	Client Third party	14 April 2020	30 June 2020
Client to identify a swimming pool/club easily accessible to them and attend regularly based on their capacity.	Client Third party	14 April 2020	30 June 2020

Provider to monitor, through discussion with the client, the clients participation in regular yoga classes and swimming.	Client Provider	14 April 2020	30 June 2020
Importance of goal for client: ☐ **A little** ☐ **Moderately** ☐ **Very**			
Challenge in achieving goal: ☐ **A little** ☐ **Moderately** ☐ **Very**			

Goal 5: Client achieves and maintains regular contact with family and/or friends over the next 3 months			
To be achieved within (indicate timeframe)**: 3 months**			
Category (Psychosocial, Medical Management, Vocational)**: Psychosocial**			
Describe <u>all</u> of the following Outcomes - **Most unfavourable outcome (-2): Mr Toms has contact with family and/or friends once a week within 2 months** **Less than expected outcome (-1): Mr Toms has contact with family and/or friends 2 times a week within 2 months** **Expected outcome (0): Mr Toms has face to face contact with family and/or friends once a week within 3 months** **More than expected outcome (+1): Mr Toms has face to face contact with family and/or friends once a week within 2 months** **Most favourable outcome (+2): Mr Toms has face to face contact with family and/or friends 2 times a week within 2 months**			
Activities to achieve goal:	**Parties involved:**	**Start date:**	**End date:**
Obtain medical capacity information from treating health professional for client to engage regularly in social settings	Provider Medical practitioner Provider	1 April 2020	14 April 2020
Discuss with client their plan for how (where, when, how) they will engage with friends and family regularly.	Client Provider	1 April 2020	30 June 2020
Regularly discuss with client their contact with family and friends and identify, as required, if additional support is required to support the goal.	Client Provider	1 April 2020	30 June 2020
Importance of goal for client: ☐ **A little** ☐ **Moderately** ☐ **Very**			
Challenge in achieving goal: ☐ **A little** ☐ **Moderately** ☐ **Very**			