DISCHARGE PLANNING RESOURCE GUIDE

Planning a sustainable discharge from hospital
ABOUT THE RESOURCE GUIDE

The Department of Veterans’ Affairs (DVA) is committed to facilitating the seamless transfer of Entitled Persons to their homes and communities, following a hospital stay. Effective discharge planning optimises positive post-hospital physical and mental health outcomes for patients and can increase their independence.

The DVA Discharge Planning Resource Guide is designed to provide discharge planners, Veteran Liaison Officers (VLOs) and other health professionals with information regarding DVA services, and best practice principles for achieving sustainable discharge. The Guide provides information about:

- Eligibility
- DVA administered health and support programs
- Commonwealth initiatives
- Sustainable discharge program information
- Other resources to assist with discharge
- Discharge planning flow chart.

The DVA website contains fact sheets on discharge planning and contact details for related funded services.

The DVA Discharge Planning Resource Guide is available online on the hospitals and Day Procedure Centres webpage Hospitals and Day Procedure Centres | Department of Veterans’ Affairs
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<td>ACAS</td>
<td>Aged Care Assessment Service</td>
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<td>ACATs</td>
<td>Aged Care Assessment Teams</td>
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<tr>
<td>ACD</td>
<td>Advance Care Directive, also known as a “Living Will”</td>
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<tr>
<td>ACHA</td>
<td>Assistance with Care and Housing for the Aged program</td>
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<td>ADF</td>
<td>Australian Defence Force</td>
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<td>APPs</td>
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<td>ASIST</td>
<td>Applied Suicide Intervention Skills Training</td>
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<td>BDP</td>
<td>Better Discharge Planning program</td>
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<td>CCP</td>
<td>Comprehensive Care Plan</td>
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<td>DCD</td>
<td>Consumer Directed Care</td>
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<td>CHSP</td>
<td>Commonwealth Home Support Program Services</td>
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<td>Co-payment</td>
<td>Patient contribution charge</td>
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<td>CPAP</td>
<td>Continuous positive airways pressure therapy machines</td>
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<tr>
<td>CTVS</td>
<td>Country Taxi Voucher Scheme</td>
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<tr>
<td>CVC</td>
<td>Coordinated Veterans’ Care Program</td>
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<tr>
<td>Cwth</td>
<td>Commonwealth</td>
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<td>DAA</td>
<td>Dose Administration Aid</td>
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<td>DTC</td>
<td>Day Therapy Centres program</td>
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<td>EoL</td>
<td>End of Life Care</td>
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<td>ESTHR</td>
<td>Emergency Short-Term Home Relief</td>
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<td>GPs</td>
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<td>HACC</td>
<td>Commonwealth Home and Community Care (HACC) program</td>
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<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<td>MFS</td>
<td>Mobility and Functional Support</td>
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<td>MMR</td>
<td>Medication Management Reviews</td>
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<td>NRCP</td>
<td>National Respite for Carers Program</td>
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<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<td>PRS</td>
<td>Personal Response Systems</td>
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<td>PTSD</td>
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<td>RAP Schedule</td>
<td>National Schedule of Equipment</td>
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<td>RAS</td>
<td>My Aged Care Regional Assessment Service</td>
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<tr>
<td>RCF</td>
<td>Residential Care Facility</td>
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<tr>
<td>RPBBS</td>
<td>Repatriation Pharmaceutical Benefits Scheme</td>
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<tr>
<td>RTS</td>
<td>Repatriation Transport Scheme</td>
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<tr>
<td>VAPAC</td>
<td>Veterans’ Affairs Pharmaceutical Approvals Centre</td>
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<td>Veterans’ MATES</td>
<td>Veterans’ Medicines Advice and Therapeutics Education Services</td>
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<tr>
<td>VHC</td>
<td>Veterans’ Home Care</td>
</tr>
<tr>
<td>VLOs</td>
<td>Veteran Liaison Officers</td>
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<tr>
<td>VVCS</td>
<td>Veterans and Veterans’ Families Counselling Service</td>
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1. IDENTIFYING ENTITLED PERSONS

1.1. Definition of an Entitled Person

An ‘Entitled Person’ is a person who has elected to be treated under DVA arrangements and
a) Has been issued with:

- A Gold Card (all conditions);
- A White Card (specific conditions);
- An Orange Card (pharmaceuticals only); or
- A written authorisation by DVA on behalf of the Military Rehabilitation and Compensation Commission; or

b) Is a Vietnam Veteran or his/her dependant who is not otherwise eligible for treatment, and who is certified by a medical practitioner as requiring urgent hospital treatment of an injury or disease, where the treatment is provided in a former Repatriation Hospital.

1.2. Determining eligibility for treatment

Entitled Persons may include:

- Veterans;
- Members of the ADF;
- Members of Peacekeeping Forces;
- War widows and widowers;
- Australian mariners;
- Children and dependants of veterans; and
- Persons from overseas who are entitled to treatment under an arrangement with another country (Commonwealth or Other Allied Veterans).

Before admitting an Entitled Person for treatment, confirm their eligibility for the requested treatment and seek financial authorisation if:

- there is any doubt about their eligibility;
- the admission is related to surgical/medical procedures not listed on the Medicare Benefits Schedule (MBS);
- admission is related to prostheses not listed on the Department of Health Prostheses List; and/or
- admission is related to specific treatments nominated in writing by DVA from time to time, such as cosmetic surgery.

To check eligibility phone DVA’s Provider Line on 1300 550 457
Regional callers 1800 550 457
1.3. **DVA entitlement cards**

There are 3 categories of DVA health cards - Gold, White and Orange

1.3.1. **Gold Card for all conditions.**

A Gold Card entitles the holder to DVA funding for services for all clinically necessary health care needs, and all health conditions, whether or not they are related to war service.

Refer to [Factsheet HSV59 Eligibility for DVA Health Card – For all Conditions (Gold)](https://example.com/hsv59) and [HSV60 Using the DVA Health Card - All Conditions (Gold)](https://example.com/hsv60).

1.3.2. **White Card for specific conditions**

A White Card entitles the holder to care and treatment for:

- accepted injuries or conditions that are service related;
- non-liability health care treatment\(^1\), whether service related or not, for the following conditions:
  - malignant cancer;
  - pulmonary tuberculosis;
  - post-traumatic stress disorder;
  - anxiety disorder;
  - depressive disorder;
  - substance use disorder; and/or
  - alcohol use disorder.


\(^1\) DVA funding for treatment is subject to a confirmed medical diagnosis and application for approval to DVA.
1.3.3. Orange Card for pharmaceuticals only

The possession of a DVA Health Card (Orange) does not entitle a person to admission to a hospital. The Orange Card enables the holder to access pharmaceuticals only, under the Repatriation Pharmaceutical Benefits Scheme (RPBS). It cannot be used for any other treatment entitlements such as medical or allied health.

Refer DVA Factsheet HSV69 “Repatriation Pharmaceutical Benefits Card (Orange)”.

1.3.4. Other Health Cards

DVA may issue eligible DVA beneficiaries with the Commonwealth Seniors Health Card (Green), however this card does not entitle holders to DVA treatment.

1.3.5. Letter of authorisation

An Entitled Person may be issued with a letter of authorisation from DVA specifying his or her eligibility for treatment.

1.4. Spouses and dependants of living Entitled Persons

Spouses and dependants of a living Entitled Person are generally ineligible for treatment under DVA arrangements, unless they are eligible because of their own ADF service and, as a result, have their own DVA Health Card.

Only the person named on the card or letter is covered. Family members and carers of eligible members must hold their own entitlement card to receive DVA benefits.

1.5. Spouses and dependants of deceased Entitled Persons

The spouse and eligible dependants of a deceased Entitled Person, whose death is accepted by the Repatriation Commission as war-related, are eligible for treatment under DVA arrangements. They will be issued with their own DVA health card.

1.6. Commonwealth & other allied veterans

DVA acts as an agent for certain countries whose Entitled Persons reside in Australia. These countries include United Kingdom, New Zealand, Canada and South Africa.

Note: Not all countries have the same treatment entitlements.

A DVA White Card will be issued for any disability accepted as war related by the country the person enlisted with, providing eligibility criteria for that country is met.

See DVA Factsheet HSV62, “Commonwealth and Other Allied Veterans”.
1.7. Confidentiality

Confidentiality of Entitled Persons’ details must be strictly maintained in accordance with the provisions outlined in the *Privacy Act, 1988* (Cwth) and the Australian Privacy Principles (APPs). These are available at: [http://www.oaic.gov.au](http://www.oaic.gov.au).

1.8. Feedback (complaints, compliments or suggestions)

Feedback in the form of complaints, compliments and suggestions, is one of the most effective ways to help DVA improve services. Anyone can provide feedback.

For more information about how to provide feedback, visit the DVA website. Refer [DVA Factsheet DVA21 “Feedback”](#).
2. SUSTAINABLE DISCHARGE PRACTICE

2.1. Discharge planning: an overview

Good discharge planning is designed to facilitate the safe, efficient and effective transition of an Entitled Person from hospital to the community.

Good discharge planning focuses on the continuity of care for the Entitled Person and supports their short and long term health. Good discharge planning identifies potential issues for DVA clients navigating independently in the community after a hospital stay, to:

- decrease post discharge complications and unplanned hospital readmissions;
- support appropriate provision of community health and support services;
- increase satisfaction.

Planning for discharge involves complex and often cyclical processes that:

- consider the Entitled Person’s needs in the context of their usual living environment;
- identify the key people who may provide input into discharge planning;
- assist the Entitled Person to self-manage and to improve knowledge of their physical and mental health;
- target appropriate and available local community services and supports;
- develop and implement achievable discharge plans; and
- evaluate a discharge plan’s progress and outcome.

Hospitals have contractual responsibilities regarding discharge planning which are specified in the relevant DVA Hospital Services Agreement. For further information see: DVA Factsheet HIP40 "Hospital Admission and Discharge".

2.2. Discharge planning principles

The DVA Discharge Planning Resource Guide presents eight principles which reflect quality standards recognised by quality accreditation groups in the healthcare industry:

1. Appropriate and timely discharge planning should be an integral part of every hospital admission;
2. Discharge planning is the responsibility of all involved health care providers. A specific person is designated and identified as being responsible for ensuring that all aspects of discharge planning have been addressed by the time of discharge;
3. A multi-disciplinary approach is most appropriate to the development and implementation of discharge plans. To achieve best practice discharge planning, the multidisciplinary teams should work collaboratively and in a planned, integrated manner;
4. A documented discharge plan should commence before, or on admission to hospital. The plan should be subject to ongoing assessment throughout the hospital stay to take account of changes in the health of patients and carers, and should demonstrate that effective consultation has involved the patient, carer(s) and/or relatives;
5. The Entitled Person should be consulted and informed at all stages during the discharge planning process;
6. At all stages of the hospital stay, information and education should be provided on all required aspects of care after leaving hospital;
7. Discharge from hospital should be timely and, where necessary, linked to appropriate and available local health and community based services; and
8. Ongoing communication and coordination between hospitals and community based services is essential to ensure, safe, effective and efficient discharge from hospital to the community.

2.3. Who can assist with discharge planning

Planning for discharge requires a multidisciplinary approach and can involve a number of health professionals. Where appropriate, these may include:

<table>
<thead>
<tr>
<th>Clinicians</th>
<th>Medical specialists</th>
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<tr>
<td>Community nursing services</td>
<td>Nurse unit managers (NUM)</td>
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<tr>
<td>Discharge planners</td>
<td>Occupational therapists</td>
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<tr>
<td>General Practitioner liaison nurses</td>
<td>Other allied health practitioners</td>
</tr>
<tr>
<td>Hospital and community pharmacists</td>
<td>Physiotherapists</td>
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<tr>
<td>Medical practitioners (general and hospital)</td>
<td>Rural liaison nurses</td>
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2.4. Practicalities of planning for discharge

The Entitled Person: When making discharge arrangements, consider the needs of the Entitled Person within the context of their usual environment. Consider too the Entitled Person’s specific knowledge about their physical, mental and social needs, and their ability to manage in the community.

Enable the Entitled Person to organise aspects of their return to community living by:
- improving their knowledge of their health problems;
- assisting them to self-manage (e.g. medications, diet, exercise etc.); and
- providing them with knowledge to self-organise community services and equipment.

The hospital should identify if the Entitled Person has a carer or requires the assistance of a carer prior to discharge.

The carer: When the Entitled Person is too ill to be included in discharge planning discussions, involve their carer as the primary representative. It is important to establish early (prior to or on admission) who the carer is and identify the role(s) they are prepared to undertake.

Clearly outline care expectations, especially as these relate to time commitments, mental and/or physical demands, level of skill required and confidence to deliver care. Discuss suitable and available support network options and access arrangements, such as respite care for when the carer needs a break.

The Entitled Person’s doctor: To obtain an accurate picture of the Entitled Person in their environment, involve the treating doctor in planning admission and discharge. Using the “Chronic Disease Management” items in the MBS schedule\(^2\), the doctor can be more involved in care coordination prior to and post admission. This is integral when the Entitled Person has complex

\(^2\) The Chronic Disease Management items allow the treating doctor to have more involvement in care coordination by supporting them to conduct extended consultations including those involving other medical and allied health care providers, review management and ensure the needs of Entitled Persons, their carers and their dependants are recognised and addressed.
health needs, if their carer is ill, or if a dependant of the Entitled Person is involved. Under these items, doctors can be reimbursed for contributing to, or organising, discharge care conferences and care plans for people with chronic conditions\(^3\) and multidisciplinary care needs.

### 2.5. Disclosure of information

It may be necessary to disclose an Entitled Person’s medical details to other health professionals involved in providing care. It is important that the Entitled Person and their carer are informed and understand that this may happen.

More information can be found in the provisions of the Privacy Act 1988, including the Privacy Amendment (Private Sector) Act 2000 and Privacy Amendment Act 2004.

### 2.6. Pre-admission or admission

Where possible, when a hospital admission is elective, commence discharge planning pre-admission. This is particularly important when it is known that the Entitled Person cares for someone else as this allows for arrangements to be put in place.

Early discharge planning is important when the admission has been unplanned, such as in an emergency. In this case the Entitled Person and their carer’s physical and emotional capacity to be involved in planning for discharge may be reduced and it may take several days to provide answers to questions which ideally should have been asked before admission.

Assess the suitability of the Entitled Person for admission by developing pre-admission screening protocols. These protocols will also help to ensure that the hospital can provide the required treatment during the entire episode of care.

Provide written information to the Entitled Person and their carer regarding what they might expect during the impending hospital stay, surgery, recovery and rehabilitation. This will allow them to consider aspects of planning for discharge in their own time.

The treating doctor can act as an additional resource for the Entitled Person and their carer so provide written information to them (for instance, information about medications or community services to be arranged).

Arrange assessments for Veteran Home Care (VHC) program services, Rehabilitation Aids and Appliances Program (RAP), if required, to ensure that services are in place when the Entitled Person is discharged.

A copy of DVA Factsheet HSV74 “Hospital Services” must be provided to the Entitled Person at least 48 hours prior to admission for elective admissions, and on admission for emergency admissions.

### 2.7. Flags – Potentially problematic discharge

Early identification of an Entitled Person with flags that pose a potential risk for safe, efficient and/or effective discharge will reduce problems associated with arranging and implementing appropriate discharge plans.

\(^3\) A chronic disease is defined a disease that lasts (or will last) for at least six months or that is terminal.
Indicators or ‘flags’, that may help to identify an Entitled Person who needs additional assistance post discharge include:

- Living alone;
- Not having regular accommodation
- Being frail and/or aged;
- Having multiple and/or poorly managed mental or physical health problems;
- Being released after a suicide attempt or intentional self-harm.
- Having multiple health problems and not having prior community health and support services in place;
- Not having a regular treating practitioner;
- When health care is shared by a number of medical practitioners;
- The presence of an ill, frail or incapable carer;
- When the Entitled Person cares for someone else;
- When the Entitled Person is unwilling to participate in making discharge plans;
- Being unrealistic about ability to manage in the community post discharge;
- Family conflict about the Entitled Person’s ongoing independent community living arrangements;
- When a Entitled Person is taking multiple medications; and/or
- When there are potential problems with compliance (including impaired cognition or dexterity difficulties).

2.8. Discharge from hospital after attempted suicide or intentional self-harm

For those clients who have been admitted due to a suicide attempt or intentional self-harm, the provider should follow appropriate clinical guidelines established in the local jurisdiction. For additional information, please refer to the DVA Mental Health section of the DVA Website for information on veteran suicide prevention.

2.9. Clients who are homeless or at risk of homelessness

Apart from residential aged care, DVA does not provide or fund housing or accommodation services, but may be able to provide some support and assistance to veterans who are homeless or at risk of homelessness. For more information, refer to the DVA website which provides information on DVA and Ex-Service organisation support for those at risk of homelessness: http://www.dva.gov.au/health-and-wellbeing/home-and-care/homelessness-dva-and-ex-service-organisation-support

There are also various services available for people at risk of, or experiencing, homelessness, in Australia. State, Territory and local Governments, as well as many community sector organisations, operate telephone services which are a good first point of information and referral. A number of ex-service organisations have also provided advice on specific support to ex-ADF members and, in some cases, their families, when they are at risk of homelessness or are homeless.

Hospitals should make every effort to link clients who are at risk of homelessness with their local VAN office in order to investigate what assistance they may be able to access. Hospital providers and Discharge Planning staff should make themselves aware of the types of services and supports that are available to veterans on the DVA and ESO Homelessness Support webpage. Additional information can be obtained by phoning the Veterans’ Access Network (VAN) on 133 254* (metro) or 1800 555 254* (regional).
2.10. During the hospital stay

Providers and discharge planning staff should use the hospital stay to assess how the Entitled Person will manage safely in the community following discharge. Where concerns are held by the Entitled Person, their carer or hospital staff, appropriate health professionals should be involved in discharge planning to address specific problems. They should, in particular:

- Inform the Entitled Person and their carer about:
  - what to expect during the recovery period, including what will happen in hospital and provide written information for reference during and after hospitalisation;
  - realistic recovery timeframes and pathways, and outline clear expectations for short-term and ongoing changes to health and lifestyle;
  - what they can do to assist recovery after returning home.
- Meet regularly with the Entitled Person and their carer during the hospital stay to ensure that their needs and concerns are recognised and are being managed.
- Confirm the date and time of discharge with the Entitled Person and their carer, and health care professionals in the community (where required).
- Discuss and/or provide written information about self-help strategies, including gentle exercise routines, meditation and relaxation, deep breathing and active participation in activities of daily living (where appropriate).
- Provide information about local support groups, where appropriate. Support groups can provide a wealth of information and guidance about managing a health problem and can also provide access to others who have similar experiences. While Entitled Persons and their carers may not be emotionally ready for support group involvement in the early days post discharge, knowledge about the availability of such groups will empower them to assume self-management when the time is right.
- Inform the Entitled Person and their carer about local community services available including DVA administered health care and health programs.
- Contact DVA to arrange supply (subject to the requirements of the RAP schedule) of aids and appliances required on discharge.

The Hospital is expected to arrange all clinically required services as part of its discharge planning.

2.10.1. Common issues raised by Entitled Persons

Common questions raised tend to relate to:
- Expected date of discharge;
- Medication management at home;
- Prognosis;
- The role of the carer in the short and long terms;
- Likely impacts on physical, mental or emotional health and social status;
- Equipment and other physical supports in the home and community to assist with changed physical capability;
- Additional home-based services that may be required to manage at home;
- Community support to assist with changed social, mental or emotional health status.
2.10.2. The days before discharge

Research has shown that delays with leaving on the day of discharge have a detrimental effect on the patient and carer confidence for successfully managing at their place of residence and in the community. To mitigate potential delays from hospital:

- ensure no last minute delays to hospital discharge procedures by being aware of the intended discharge date and time.
- complete arrangements for community health and support services. Arrange an assessment for VHC services, if required. (Arrange as soon as possible after admission to ensure services are in place when the Entitled Person is discharged). Advise the Entitled Person when appointments for these services have been made. If immediate assistance from the community or support services are required, make the services personnel aware of the time of the Entitled Person’s discharge.
- give consideration to the Entitled Person and their carer’s safety, including medication management; ambulation; hygiene; food preparation and diet; occupational health and safety issues; and domestic environmental safety and falls prevention.
- If the Entitled Person is not independently ambulating, give special consideration to suitability of transport home and the level of assistance required from others to assist the Entitled Person to enter and manoeuvre around the home.
- confirm that equipment is in place in the home or supplied to the Entitled Person in hospital before the day of discharge and that the Entitled Person and their carer are confident in using the equipment. For aids and appliances required on discharge, contact DVA to arrange supply (subject to the requirements of the RAP schedule.
- organise supply of all new medications and sufficient education sessions with the Entitled Person and their carer to ensure confidence in using prescribed medication.
- arrange follow up appointments with consideration to:
  - timing of appointments with multiple health providers;
  - the health status of the Entitled Person and their carer; and
  - distance to be travelled for appointments.
- Where the treating doctor is required to undertake/organise specific tests post discharge, phone the treating doctor prior to the Entitled Person leaving hospital.

2.10.3. Follow up appointments

Provide the Entitled Person and their carer with written information about the time and date of appointments, the name and contact details of the consulting health professional, and the purpose of the relevant appointment. Provide relevant clinical information to any health professionals with whom appointments have been made in time for the appointment.

Alternative options to a personal appointment at a hospital or specialist rooms might include:

- A telephone call
- Home visit
- Organising an appointment with a visiting specialist to a country area.

Where travel to a follow up appointment is considered essential, provide information to the Entitled Person and their carer about eligibility for travel assistance.
2.11. On the day of discharge

Complete the form D653A “Discharge Advice and Hospital Claim” and have the Entitled Person certify that they have received the services described.

On the day of discharge, ensure that the **Entitled Person and their carer** are ready to leave the hospital at the agreed time and are sufficiently prepared to return to the community with confidence.

Confirm that their health and social needs have been recognised; services have been put in place to assist with independent living; and that they have been provided with the knowledge to independently arrange services post-discharge.

Forward a discharge summary to the **treating doctor** which includes information about:
- the Entitled Person’s admission to hospital;
- the outcome of relevant test results;
- current medication management and reasons for any changes (Medilist);
- discharge plan;
- details, including follow up appointments and community supports organised;
- the surgical procedure(s) performed; and
- any instructions provided to the patient (see 2.12 Discharge documentation).

Provide a contact name and number for the designated hospital staff member responsible for the Entitled Person’s discharge.

To ensure continuity of care, provide a summary of discharge to the Entitled Person’s pharmacist and service providers such as community nurses, including others accepting responsibility for the Entitled Person’s care after discharge.

On the day of discharge, there should be little need to impart new information and very few community services will remain to be organised.

2.12. Discharge documentation

For Entitled Persons staying overnight, provide them with the “**DVA Patient Satisfaction Survey Questionnaire**” and encourage them to complete and return it.

DVA recommends that all information included in the discharge documentation be orally communicated to the patient and their carer, and discharge documentation be provided to them in writing on the day of discharge.

Send a copy of this documentation to the treating medical practitioner, pharmacist and nurse coordinator (if the Entitled Person is a participant in CVC) within 48 hours of discharge.
A discharge summary may include:

<table>
<thead>
<tr>
<th>Discharge diagnoses and prognosis.</th>
<th>Medication report including frequency, length of course, planned dose changes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications and scripts supplied and instructions for taking the medication.</td>
<td>Outstanding medical or social issues at discharge.</td>
</tr>
<tr>
<td>Information about possible complications and other warning signs.</td>
<td>Emergency contact numbers for ambulance and hospital (and when to use them).</td>
</tr>
<tr>
<td>Relevant past history.</td>
<td>Functional ability.</td>
</tr>
<tr>
<td>Secondary conditions.</td>
<td>Assessments arranged e.g. ACAT.</td>
</tr>
<tr>
<td>Details of after care services arranged including scheduled follow-up appointments.</td>
<td>Transport arrangements from hospital to the Entitled Person’s home and to treatment appointments.</td>
</tr>
<tr>
<td>Home modifications arranged.</td>
<td>Community services arranged.</td>
</tr>
<tr>
<td>Dietary requirements.</td>
<td>Therapeutic procedures and rest.</td>
</tr>
</tbody>
</table>

For audit and claims investigation purposes, retain a copy of the D653A “Discharge Advice and Hospital Claim form” and any accompanying certification.

2.13. Medication matters

Medication errors are common when elderly patients are discharged from hospital. Medication reviews conducted by a clinical pharmacist or a doctor (other than the Entitled Person’s treating doctor) aim to reduce these errors. A medication review is not required for a hospital stay of 48 hours or less however it is recommended that it be conducted if there has been a significant change in medication or if there are signs that the patient is having difficulties managing their medication.

A Medication review must be conducted for an Entitled Person:

- Who requires the administration of:
  - four (4) or more different medications; or
  - more than twelve (12) doses of medication daily (for all medication taken by the Entitled Person);
- When a change in prescription has occurred during the hospital stay; or
- Where anticoagulant treatment has been commenced during the hospital stay.

The Medication review must focus on an Entitled Person who:

- May have difficulty managing their own medications;
- May be exhibiting symptoms suggestive of an adverse drug reaction; and/or
- Has been prescribed medications with a narrow therapeutic index or those requiring therapeutic monitoring.

The review must take the form of:

- Documentation of the Medication Review by the reviewer on an appropriate form, such as that supplied by the National Prescribing Service;
- Provision of information and a list of the required medications to the Entitled Person on an appropriate list such as Medilist; and
- Provision of education to the Entitled Person and/or their carer(s)/family including, but not limited to, education about doses, administration, side-effects, contraindications etc. relating to their medication.
A copy of the Medication Review documentation, including any recommendations for change, must be provided to the doctor having principle responsibility for prescribing medication to the Entitled Person while an in-patient, and prior to their discharge.

A copy of the list of required medications must be forwarded to the Entitled Person’s doctors.

2.14. Post Discharge (24-48 hour period)

This period has been identified as the critical time for determining a post discharge Entitled Person’s capacity to care for themselves. Problems arising during this time can have a major impact on the confidence experienced by the Entitled Person and their carer in relation to managing independently in the community.

Issues that commonly cause concern include:

- the need for adequate short-term medication supplies;
- confidence in administering medications;
- managing the Entitled Person’s dependants (if appropriate);
- adequate food supplies, organising and eating meals;
- negotiating the home environment safely;
- sleeping and sitting arrangements;
- care of pets;
- changing dressing or undertaking other wound care; and
- regular dressing and bathing.

Consider other ways to assist Entitled Persons and their carer(s) in the immediate post discharge period to make the transition from hospital to community as smooth as possible, including:

- follow up phone call to discuss progress and any problems experienced;
- suggesting a family member or friend stays with the Entitled Person for the immediate post discharge period;
- encouraging contact with the treating doctor as soon as possible after discharge;
- contacting the Entitled Person’s treating doctor(s) to identify if a Medicine review and/or health assessment has been organised; whether CVC has been utilised; and to check that the Entitled Person has been attending medical appointments.

2.15. Evaluation of discharge procedures

The quality and safety of hospital services provided to Entitled Persons is a key priority for DVA and may be monitored through the experiences of Entitled Persons. Hospitals are required to report annually on outcomes of patient experience surveys, complaints and other agreed quality measures. Ongoing evaluation of hospital discharge procedures regularly and where necessary, after each Entitled Person’s discharge, will improve quality in relation to discharge planning.
3. **DVA funded services and health programs**

DVA funded services are mostly provided at no cost to Entitled Persons. Access is dependent on the availability of the service in the community and on the skills and specialisation of the local health practitioner.

### 3.1. Allied health services

Allied health services are broadly available in the public sector and generally available where contracted with DVA across the private sector.

Allied health services funded by DVA may include:
- acupuncture performed by a medical practitioner who is registered with Medicare Australia to provide this treatment;
- chiropractic services;
- community nursing services;
- dental services (no referral required for general dental);
- diabetes educator services;
- dietetic services;
- exercise physiology services;
- hearing services;
- medication reviews;
- occupational therapy;
- optical services and supplies (no referral required for general optical);
- orthotic services;
- osteopathic services;
- physiotherapy services;
- podiatry and medical grade footwear;
- psychology, including hypnotherapy;
- social work;
- speech pathology services;
- VVCS – Veterans and Veterans’ Families Counselling Service.

**Please note:**
1. All services provided are subject to clinical need.
2. Massage is not covered as a treatment type on its own, but may be paid for by DVA if it is delivered and billed as part of a consultation with a physiotherapist, chiropractor or osteopath.


**Referrals for Allied Health services:** With the exception of general dental and optical, a referral is required for an Entitled Person to receive DVA funded allied health care services. A new referral is required for each new condition and is valid for 12 months, unless an ongoing referral is provided by the Entitled Person’s treating doctor.
Allied Health referrals can be provided by:
- medical practitioners;
- medical specialists;
- hospital discharge planners;
- health care providers with a current referral transferring the Entitled Person to another health care provider of the same speciality.

For additional information (See DVA publication “Notes for allied health providers” which is available on the DVA website). A new referral is required for each new condition.

The referral must be written on either a D904 ‘DVA Request/Referral Form’ or using the letterhead of the referring health care provider. All referrals must include the following information:

- name and DVA file number (as shown on the DVA Health Card);
- the treatment entitlement, i.e. Gold Card or White Card (include accepted conditions, if known, for White Card);
- residency e.g. Residential Care Facility (RCF), level of care that they are funded to receive and the date the funding began;
- provider name and number of the referring health care provider;
- date of the referral;
- clinical details (including recent illnesses, injuries and current medication); and
- condition(s) to be treated.

Restrictions may apply to the provision of some services.
Contact the DVA Health Approvals and Home Care Team: 1300 550 457 or you may fax your non-urgent request to (08) 8290 0422.

3.2. Community Nursing

Community nursing services can attend Entitled Persons at home to provide clinical and personal care in the immediate post discharge period. These services are delivered by registered nurses, enrolled nurses and nursing support staff.

Community nursing services do not include domestic help services such as cooking, shopping, cleaning, laundry, transport or companionship. These services are provided under the Veterans’ Home Care Program See: Section 3.9

Referrals: A Community Nursing provider cannot deliver community nursing services to an Entitled Person without a valid referral from an authorised referral source.

The five authorised referral sources for community nursing are:
- Local Medical Officer (LMO) or other General Practitioner;
- Treating doctor in a hospital;
- Hospital Discharge Planner;
- Nurse Practitioner specialising in a Community Nursing field; or
- Veterans’ Home Care (VHC) Assessment Agency.

Referrals are to be made to a DVA-contracted community nursing provider only. Contact DVA if there are any difficulties locating a contracted provider to provide care upon discharge.

Entitled Persons residing in a Commonwealth funded RCF are not eligible for community nursing through DVA.
Where nursing care is being provided before admission and ongoing nursing care will be required post-discharge, the Entitled Person is to be discharged to their previous community nursing organisation, unless the required services are not available.

Refer to DVA Factsheet: HIP06 Community Nursing Providers
And HSV16 Community Nursing Services
Contact Community Nursing on 1300 550 457.

To locate the nearest DVA contracted community nursing provider, please go to http://www.dva.gov.au/providers/community-nursing/panel-dva-contracted-community-nursing-providers

3.3. Convalescent care

Convalescent care refers to a DVA funded period of non-acute care provided to Entitled Persons in an authorised facility (including hospitals), with an aim of assisting with recovery from an illness or operation. It immediately follows an acute or sub-acute hospital admission.

Discharge Planners have a central role in arranging convalescent care for Entitled Persons as they are included in the list of authorised requestors who can request approval for convalescent care on behalf of a veteran patient in their hospital.

Convalescent care can be provided in a public hospital, a private hospital (where the hospital is contracted for this care type) or in a residential care facility or SRS in Victoria.

When convalescent care is provided in a residential care facility, DVA may fund up to 21 days per financial year. The discharge planner’s role is to locate a suitable and approved residential facility for convalescent care and seek prior financial authorisation from DVA prior to discharge from hospital.

Convalescent care is not available in the home. It is not be used as a substitute for long term or permanent residential care. See DVA Factsheet HSV77 “Convalescent Care”.

If suitable residential care is not available then discharge planning staff should arrange for the Entitled Person’s status to be reassigned to non-acute or referred to a Hospital contracted by DVA to provide convalescent care. Where convalescent care is provided by a hospital contracted to provide convalescent care, there is no requirement for prior approval to be sought and the 21 day limit does not apply.

Authorised requestors and arrangers of convalescent care include:
- hospital discharge planner,
- treating doctor or
- professional hospital staff (including hospital social worker or charge nurse)

3.4. End of Life Care

End of life care (EoL), which encompasses palliative care, is coordinated specialist medical, nursing and allied health care, and social support provided for people living with a progressive and incurable condition, and for whom the primary goal is quality of life. EoL care is relevant to patients
approaching the end stages of life, including deterioration from ageing, and is not only for conditions such as cancer.

EoL care services can be delivered in the most appropriate setting, preferably in an environment of the Entitled Person’s choice, including:

- the Entitled Person’s home;
- public hospitals and hospices;
- DVA-contracted private hospitals and hospices; and
- residential care facilities.

If an Entitled Person is living in their own home, a small amount of domestic assistance, personal care, respite care, and safety-related home and garden maintenance is available through VHC. Community nursing services (see Section 3.2) are also available to the Entitled Person at home to provide clinical and personal care, including short-term overnight clinical nursing care. Rehabilitation aids and appliances are also available (see Section 3.5).

**How can DVA clients make their final wishes known?**

Every person has the right to make choices about the type of care and medical interventions they want at the end of their life such as being hospitalised or being resuscitated.

An Advance Care Directive (ACD), also known as a ‘Living Will’, is a legal document that records an individual’s wishes for their future health care. Entitled Persons should complete an ACD so that family, carers and health professionals know their preferences for care and medical interventions before the stage where illness or injury may affect communication.

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**Advance Care Planning Australia** provides information and a DIY Kit to help with planning for future health care and treatment.

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### 3.5. Rehabilitation Appliances Program

The Rehabilitation Appliances Program (RAP) provides aids and appliances to minimise the impact of disabilities and maximise quality of life. The RAP National Schedule of Equipment (The Schedule) lists available equipment and outlines the criteria for its provision, including whether prior approval is applicable.

---

## Contracted RAP Suppliers

<table>
<thead>
<tr>
<th>RAP product</th>
<th>Company name</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continence (e.g. pads, catheters)</td>
<td>In Touch</td>
<td>1300 134 260</td>
<td>1300 369 065</td>
</tr>
<tr>
<td></td>
<td>Independence Australia</td>
<td>1300 788 855</td>
<td>1300 788 811</td>
</tr>
<tr>
<td></td>
<td>BrightSky Australia</td>
<td>1300 968 062</td>
<td>1300 968 063</td>
</tr>
<tr>
<td>Oxygen (e.g. cylinders, nebulisers)</td>
<td>Air Liquide Healthcare</td>
<td>1300 360 202</td>
<td>ACT &amp; NSW – (02) 9364 7476</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>QLD – (02) 9364 7497</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SA – (02) 9364 7477</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>VIC &amp; TAS – (02) 9364 7482</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>WA &amp; NT – (08) 9312 9757</td>
</tr>
<tr>
<td></td>
<td>BOC</td>
<td>1800 050 999</td>
<td>1800 624 149</td>
</tr>
<tr>
<td>Continuous positive airways pressure therapy (CPAP) machines</td>
<td>Air Liquide Healthcare</td>
<td>1300 360 202</td>
<td>ACT &amp; NSW – (02) 9364 7476</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>QLD – (02) 9364 7497</td>
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<td>WA &amp; NT – (08) 9312 9757</td>
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<tr>
<td></td>
<td>BOC</td>
<td>1800 050 999</td>
<td>1800 624 149</td>
</tr>
<tr>
<td></td>
<td>ResMed</td>
<td>1800 625 088</td>
<td>1800 647 259</td>
</tr>
<tr>
<td>Mobility and function support (e.g. wheelchairs, walking frames, handrails)</td>
<td>Aidacare</td>
<td>1300 888 052</td>
<td>1300 787 052</td>
</tr>
<tr>
<td></td>
<td>Allianz Global Assistance</td>
<td>1800 857 715</td>
<td>1800 653 556</td>
</tr>
<tr>
<td></td>
<td>The Country Care Group</td>
<td>1800 727 382</td>
<td>1800 329 382</td>
</tr>
<tr>
<td></td>
<td>BrightSky Australia</td>
<td>1300 799 243</td>
<td>1300 799 253</td>
</tr>
<tr>
<td>Personal response systems (PRS)</td>
<td>INS Lifeguard</td>
<td>1800 636 226</td>
<td>1300 770 730</td>
</tr>
<tr>
<td></td>
<td>Safety Link</td>
<td>1800 813 617</td>
<td>1800 193 233</td>
</tr>
<tr>
<td></td>
<td>Tunstall Healthcare</td>
<td>1800 603 377</td>
<td>07) 3637 2255</td>
</tr>
<tr>
<td></td>
<td>Vitalcall</td>
<td>1300 360 808</td>
<td>1300 554 481</td>
</tr>
</tbody>
</table>

### Accessing RAP:
Provision of services, aids and equipment is based on the Entitled Person’s clinical need and requires assessment by an appropriate health care provider. The Schedule details the appropriate health prescriber, supplier and prior approval requirements. The relevant “Product Direct Order Form” and/or “Other RAP Assessment Form” must be completed by the assessor and forwarded to a DVA-contracted supplier to finalise.

### Direct Order Forms
- **D0988**: Continence direct order form
- **D0992**: Mobility and Functional Support (MFS) direct order form

### Other RAP Assessment Forms
- **D0804**: Home Medical Oxygen Therapy form
- **D1316**: Recliner chair assessment form
- **D1323**: Authority to install/modify form
- **D1327**: Home/access modifications assessment form
- **D9140**: Application for CPAP/Bi-level therapy equipment
- **D9160**: Request for exercise bike form
- **D9199**: Personal Response System (PRS) assessment form

There are specific RAP National Guidelines for complex equipment, including adjustable electrical beds and home modifications. The Guidelines provide eligibility criteria and explain the assessment process.
Non listed items: One-off requests for items that are not listed on the Schedule may be considered where there is an assessed clinical need. The assessing health professional must send a written request detailing why the item is required to: The Director - RAP, Department of Veterans’ Affairs, GPO Box 9998 (In your capital city).

RAP National Guidelines can be found on the DVA Website [www.dva.gov.au](http://www.dva.gov.au)
Or via the link: RAP National Guidelines

See DVA Factsheet HIP72 Providers Rehabilitation Appliances Program and HSV107 “Rehabilitation Appliance Program”

3.6. Repatriation Pharmaceutical Benefits Scheme (RPBS)

The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides access to an appropriate range of safe and effective quality pharmaceuticals.

Under the RPBS, eligible Entitled Persons may receive:
- items listed for supply in the Pharmaceutical Benefits Scheme (PBS)
- items listed under the RPBS, including wound care products
- items not listed on either the PBS or RPBS Schedules, if clinically justified.

A patient contribution charge (co-payment) is payable for each prescription and is adjusted at the beginning of each year in line with inflation. If the Entitled Person has the Dose Administration Aid (see section 4.6.3) delivered by the pharmacy, they will need to pay any delivery charges.

Prior approval of prescriptions: Obtain prior approval from DVA using a PBS/RPBS Authority prescription and provide clinical justification to prescribe:
- greater quantities and/or repeats of items listed on the PBS and RPBS Schedules;
- items listed on both the PBS and RPBS Schedules that are “Authority required”;
- items not listed on either the PBS or RPBS Schedules.

All approvals will be issued a unique RPBS authority number and will need to be endorsed on all copies of the Authority prescription. Requests for non-scheduled items rejected by the Veterans’ Affairs Pharmaceutical Approvals Centre (VAPAC) may be referred for review to the Repatriation Pharmaceutical Reference Committee.

For RPBS prior approvals and enquiries contact the Veterans’ Affairs Pharmaceutical Approvals Centre (VAPAC) 24 hours per day on 1800 552 580 or fax: 07 3223 8651.
3.6.1. Medication Management Reviews

The goals of Medication Management Reviews (MMR) are to maximise an individual’s benefit from their medication regimen and prevent medication related problems through a team approach involving the treating doctor and a preferred community pharmacy.

Under the Medicare Benefits Schedule (MBS) a medication management review may be initiated through the treating doctor after assessing the Entitled Person’s needs. MMR are conducted by an accredited pharmacist.\(^4\)

- **Domiciliary Medication Management Review (DMMR)** also known as a Home Management Review is a collaborative medication review for people in the community (item number 900). A pharmacist will visit the Entitled Person’s home and conduct a comprehensive review of their medication. The pharmacist’s report and findings are discussed with the Entitled Person and a medication management plan is established.

- **Residential Medication Management Review (RMMR)** is for permanent residents of care facilities (item number 903). It involves collaboration between a GP and a pharmacist and targets Entitled persons for whom use of medicines may be an issue.

3.6.2. Veterans' Medicines Advice and Therapeutics Education Services

Veterans’ Medicines Advice and Therapeutics Education Services (Veterans’ MATES) program provides information for health professionals to assist Entitled Persons to manage their medical conditions through appropriate medicine use. Using RPBS data, the program identifies and helps to address the most common medication related problems. Information is also provided to other health professionals depending on the particular topic. For more information on Veterans’ MATES and professional development programs available, visit the Veterans’ MATES website.

Prescriber helpline: 1800 500 869   Veteran helpline: 1300 556 906.

3.6.3. Dose Administration Aid

A Dose Administration Aid (DAA) is a compartmentalised device that stores multiple medications according to a dose schedule. In conjunction with the treating doctor and pharmacist, the DAA assists Entitled Persons to take the right dose of the right medicine at the right time.

**Access to a DAA requires:**
- an assessment by a medical practitioner and may also involve a referral to a pharmacist for an MMR;
- a six-monthly review by a medical practitioner and pharmacist to ensure continued benefit to the Entitled Person.

For more information see DVA factsheet: HSV93 - Dose Administration Aid Service

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\(^4\) There is no requirement for pharmacists to register with DVA prior to providing a medication management review service for a veteran.
3.7. Repatriation Transport Scheme (RTS)

The Repatriation Transport Scheme is the program under which funding and/or transport arrangements for Entitled Persons to attend treatment fall. There are a range of provisions for transport available for Entitled Persons including the Booked Car Scheme, Long Distance Transport, Ambulance Transport, the Country Taxi Voucher Scheme (NSW only) and Reimbursement of Travel Expenses.

Discharge planning staff should make themselves aware of the transport assistance that is available depending in the circumstances of the Entitled Person as they are admitted to and discharged from hospital. For a broad overview of transport assistance under the Repatriation Transport Scheme, refer to Factsheet HIP80 - Health Providers - Veterans’ Transport Information.

3.7.1. Booked Car Scheme (BCS)

The Booked Car Scheme (BCS) DVA Arranged Transport assists aged and frail Entitled Persons with their travel to medical treatment. Under BCS, DVA may arrange taxi or hire care transport (including wheelchair accessible vehicles), between the Entitled Person’s permanent residence (or temporary residence if the person requires medical treatment when travelling away from home) and approved treatment locations. The BCS provides a quality, timely and reliable service, using DVA-contracted local transport providers who are committed to providing trained drivers aware of the needs of the veteran community, especially aged and frail veterans and war widows.

Eligibility for BCS:
- Entitled Persons aged 80 years or over are entitled to a DVA arranged car with driver (BCS) to attend all approved treatment locations;
- Entitled Persons suffering from dementia or who are legally blind to attend all treatment locations;
- Entitled persons aged 79 years or less with the medical conditions listed below are entitled to a DVA arranged car with driver. Medical conditions include:
  - Psychosis; Hemiplegia or Ataxia;
  - Respiratory insufficiency severely limiting independent activity;
  - Cardiac failure severely limiting independence;
  - Recent coronary occlusion severely limiting independence;
  - Peripheral vascular disease severely limiting independence;
  - Amputation severely limiting independence;
  - Arthritis severely limiting independence;
  - Recent surgery severely affecting capacity to use public transport;
  - Conditions that would cause grave embarrassment or that are unacceptable to other passengers on public transport, such as bladder or bowel incontinence, or severe deformity or disfigurement;
  - Significant trauma or Frailty that severely limits independence.

Approved treatment locations for Entitled Persons who are either over 79 or who meet the criteria listed above include:
- former Repatriation General Hospitals;
- public and private hospitals, including outpatient services;
- providers of prosthetics, surgical footwear and orthotics;
- Office of Hearing Services accredited providers;
- medical specialist rooms; and
- radiology, imaging and pathology services.
**Medically required attendant:** may travel with an Entitled Person on a DVA arranged journey.

**Right of return:** Generally the transport provider that transported the Entitled Person to the treatment appointment will transport them home (it may not be the same driver). Drivers are encouraged to provide a “return journey” business card with a direct number to call when the appointment is over and the Entitled Person is ready to travel home.

**Transport Bookings:** Health providers can arrange transport for Entitled Persons to and from medical appointments. Provision is available within the online booking system to make future, same day and “ready now bookings” as well as to request return journeys.

To make a transport booking phone: **1300 550 455 (Metro) 1800 550 455 (Rural/Remote)**

### 3.7.2. Ambulance

- **Emergency ambulance:** DVA accepts financial liability for the emergency use of an ambulance where immediate treatment is required and there is a serious threat to life or health:
  - To the nearest facility able to cater to the medical need;
  - When a treating doctor is not available;
  - For white card holders when the need for the emergency ambulance relates to an accepted disability.

- **Non-emergency ambulance:** DVA will pay for non-emergency ambulance transport to the nearest clinical facility from the Entitled Person’s residence, if the Entitled Person meets the following criteria:
  - Requires transport on a stretcher;
  - Requires treatment while in the ambulance;
  - Is severely disfigured;
  - Is incontinent to a degree that precludes the use of other forms of transport.

A GP, hospital physician or hospital discharge planner can arrange non-emergency ambulance transport by contacting the ambulance provider in the relevant state or territory. For non-emergency Ambulance transport in South Australia prior approval is required. Discharge planners and hospital staff in SA should contact DVA on 133254 to seek authorisation before arranging non-emergency Ambulance travel in South Australia.

See DVA Factsheet HSV120 - Ambulance Services and DVA Factsheet HIP 80 Health Providers and Veterans’ Transport

### 3.7.3. Long distance transport (Air/Train)

Air or train transport, including payment towards the costs of meals and accommodation, may be arranged when it is considered to be the most suitable and economical means of transport. Prior approval is required.

See DVA Factsheet HIP 80 Health Providers and Veterans’ Transport
3.7.4. **Reimbursement of travel expenses**

Travel expenses for the use of private vehicles, privately arranged taxi transport, air/train travel and public or community transport may be reimbursed under the RTS. To receive the maximum allowable assistance towards their travelling expenses, Entitled Persons need to attend the closest practical provider (CPP) to their residence or temporary place of residence. If Entitled Persons attend a health provider who is not their CPP and is more than 50 km from their residence, DVA will limit the reimbursement to a distance equal to the closest practical provider or 100 km, whichever is the greater. If the distance from the Entitled Person's residence to the CPP is less than or equal to 50km, then the Entitled Person will be reimbursed all of the kilometres.

Expenses can be claimed by submitting a completed [D800 form](http://www.dva.gov.au/sites/default/files/dvaforms/D0800.pdf) available on the DVA website at [http://www.dva.gov.au/sites/default/files/dvaforms/D0800.pdf](http://www.dva.gov.au/sites/default/files/dvaforms/D0800.pdf) or online via “My Account”. Claims must be lodged within 12 months for travel for treatment and within three months for travel associated with a Disability or Income Support claim. DVA may request proof of expenses to verify a claim. Veterans should retain receipts of $30 or more for a period of four (4) months from the date the claim is finalised.

**Fact Sheet HSV02 “Claiming travelling expenses under the Repatriation Transport Scheme”.**

3.7.5. **Country Taxi Voucher Scheme – NSW only**

The Country Taxi Voucher Scheme operates only in regional NSW and enables a local medical officer to issue taxi vouchers to an Entitled Person who requires assistance to travel to medical appointments. It is not available for travel to treatment outside of NSW or to the Sydney metropolitan area.

Where Entitled Persons require urgent travel for treatment outside of normal DVA business hours and a NSW country taxi voucher is not available, transport may be arranged with a local DVA contracted transport provider by advising them of the journey details and DVA file number. DVA will arrange payment of this journey directly with the transport provider.

**To make a transport booking or to make an enquiry phone:**

1300 550 455 (Metro) 1800 550 455 (Rural/Remote)
3.8. Veterans and Veterans’ Families Counselling Service (VVCS)

Veterans and Veterans Families Counselling Service (VVCS) provides counselling and support for service-related mental health conditions, such as Post-traumatic Stress Disorder (PTSD), anxiety, depression, sleep disturbance, anger, and alcohol and substance misuse. Support is also available for relationship and family matters that can arise due to the unique nature of military life.

VVCS counsellors are qualified psychologists or social workers who have an understanding of military culture and can provide effective solutions for improved mental health and wellbeing.

Services provided:
- individual, couple and family counselling/support for those with more complex needs;
- services to enhance family functioning and parenting;
- after-hours crisis telephone counselling through Veterans Line;
- group programs - connecting with others and developing self-management skills;
- information, education and self-help resources; and
- referrals to other services or specialist treatment programs.

3.8.1. Eligibility:
- Veterans, whether current or former, serving with the ADF;
- Other current and former ADF members who have:
  - served in domestic or international disaster relief operations;
  - served in border protection operations;
  - served in the Royal Australian Navy as a submariner;
  - been medically discharged; or
  - been involved in a training accident that resulted in serious injury to any person.
- Participants in the Veterans’ Vocational Rehabilitation Scheme;
- Certain United Nations and Australian Police approved peacekeepers;
- The partners and dependent children (up to age 26) of those members listed above;
- The ex-partners of Vietnam veterans within five years of separation;
- Sons and daughters (of any age) of Vietnam veterans;
- War widow(er)s;
- Those with a DVA health card – for all conditions (Gold);
- Those with a DVA health card – for specific conditions (White) for specified mental health conditions;
- The partners, dependent children and parents of members killed in service-related incidents;
- Participants in the “Study of Health Outcomes in Aircraft Maintenance Personnel”; and
- Current serving members who are referred to VVCS by the ADF under an “Agreement for Services”.

3.8.2. Referral:
- DVA clients, peacekeepers and members of their families can self-refer;
- Current serving ADF members may request a referral from their ADF health provider or self-refer if they meet VVCS eligibility criteria;
- Medical practitioners, or an allied mental health professional may refer;
- Welfare and ex-service organisations are encouraged to support self-referral.
3.8.3. Relevant DVA Factsheets:

<table>
<thead>
<tr>
<th>VCS01</th>
<th>Veterans and Veterans Families Counselling Service (VVCS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCS02</td>
<td>Effects of mental health concerns on veterans and their families</td>
</tr>
<tr>
<td>VCS03</td>
<td>The effects of PTSD</td>
</tr>
<tr>
<td>VCS05</td>
<td>Transition to civilian life</td>
</tr>
<tr>
<td>HSV99</td>
<td>Mental health support</td>
</tr>
</tbody>
</table>

Call VVCS between 9:00 am and 5:00 pm (weekdays) on **1800 011 046** to confirm eligibility or visit the website: [www.vvcs.gov.au](http://www.vvcs.gov.au).

3.8.4. Other DVA and VVCS help available

- **Complex needs client support**: A VVCS case management service which can help to ensure coordinated and targeted care to clients with complex and/or multiple needs. A VVCS counsellor can assist with access to support and services required to improve mental health and wellbeing. This may include medical, pharmaceutical, psychological, psychiatric, social, family, vocational and financial services.

- **Suicide Awareness and Prevention**: DVA provides suicide awareness and prevention support for veterans, former ADF personnel and their families who are experiencing or have been affected by the thoughts or actions of suicide. DVA’s comprehensive suicide awareness and prevention strategy is known as Operation Life.

- **Operation Life workshops** are run Australia-wide by VVCS. These workshops equip the ex-service community with the skills and confidence to identify the signs of suicide, start the conversation about suicide, and link people into appropriate help. The workshops are available free to anyone in the ex-service community. To register interest, call **1800 011 046** in business hours or visit the VVCS website.

The Operation Life Online website is designed to help people understand the warning signs of suicide and provides information and resources to help people keep calm and take action to stay safe, advice on how to offer help to someone else and stories from those touched by suicide. Information and support options are also available on the site for those affected by suicide. Please visit [http://at-ease.dva.gov.au/suicideprevention](http://at-ease.dva.gov.au/suicideprevention).

The Operation Life mobile app is designed to help those at risk deal with suicidal thoughts and is recommended to be used with the support of a clinician. The app provides on-the-go access to emergency and professional support and self-help tools to help people regain control, keep calm and take action to stay safe. The app also contains web links to online resources, including information on suicide awareness, prevention training and counselling. The app is available free from the App Store or Google Play.
3.9.  Veterans’ Home Care (including Respite Care)

VHC is a low level program designed to assist Entitled Persons who require a small amount of practical help to continue living independently in their home. Services under this program include:

- **Domestic assistance**: support with a range of basic household tasks including household cleaning like dish washing and wiping of kitchen benches; vacuuming and mopping; bed making and linen changing; clothes washing and/or ironing; assistance with (but not total preparation of) meals; shopping (unaccompanied); bill paying; and collection of firewood in rural and remote areas. The service is provided on a weekly or fortnightly basis, depending on assessed needs.

- **Personal care**: basic assistance with self-care tasks such as bathing, showering and toileting, dressing/grooming, and eating; application of non-medicated skin care creams and lotions; pressure area prevention aids; protective bandaging; and fitting of aids/appliances such as splints, callipers and stockings. There is a limit to the amount of care provided. Usually services are provided up to one-and-a-half (1.5) hours per week. Personal Care Services in excess of this are provided under the DVA Community Nursing Program. For more information refer to the DVA factsheet HSV16 - Community nursing services for personal care involving registered nursing staff

- **Safety Related home and garden maintenance**: includes minor maintenance or repair work which can be carried out by a handyperson, but that does not require a qualified tradesperson. Tasks include: replacing light bulbs and tap washers; installing batteries in smoke alarms; gutter and window cleaning; minor home maintenance; pruning, grass cutting or weeding (only where a hazard exists); clearing of debris following natural disasters; collection and/or cutting of firewood in rural and remote areas; and one-off garden clean ups in specific circumstances.

Safety Related home and garden maintenance does not include:
- Major home repairs such as gutter replacement, landscaping and garden tasks such as branch lopping, tree felling or tree removal;
- Routine, cosmetic or ornamental gardening services such as regular mowing, weeding and maintenance of flowerbeds or rose pruning.

**In any 12 month period, up to 15 hours of safety related home and garden maintenance is available, depending on assessed needs.**

Entitled Persons will be responsible for the cost of materials and any additional costs associated with providing the service, such as batteries for smoke detectors or light globes, special equipment hire or removal of large quantities of rubbish.

Where additional costs are involved, payment arrangements should be arranged between the veteran and the service provider before work commences.
• **Respite care**: provides temporary relief for a carer who has responsibility for an Entitled Person who requires ongoing care, attention and support.

• Discharge Planners and hospital staff should note that respite care is not usually used for Entitled Persons straight from hospital. For residential care following hospitalisation Convalescent Care is available and should be utilised (Refer to Section 3.3 Convalescent Care).

• **DVA Respite care arrangements are administered through the Veterans’ Home Care program.** Admissions into respite care are usually community based and occur from home to respite and back home again. Approval for DVA Respite care provided by the DVA contracted VHC Assessment Agency. Assessments are phone based and the designated number for assessments is: 1300550450 from a landline.

• The phone assessment for respite care approval is completed between the Assessment Agency and the Entitled Person or their spouse or carer (where permission is given by the Entitled Person for their spouse or carer speak on their behalf).

• Respite care can be provided either in-home or in a residential setting. It may be provided in-home to give a carer of an Entitled Person a break from their caring role, or can be provided in a residential setting for a self-carer needing a break from their caring role or for an Entitled Person who needs a

• **Respite care** can be provided in the following locations:
  - the Entitled Person’s home; or
  - a Commonwealth funded RCF (or a combination of both); or
  - in a private hospital (where the hospital is contracted to provide this care type) or
  - in a public hospital (where there is a respite bed available).

  Respite can also be provided in an emergency under Emergency Short-Term Home Relief (ESTHR) – short-term and emergency respite.

For information about DVA’s respite care provisions, see [DVA Factsheet HSV06, “Respite care and carer support”](#)

There are limits on the number of hours that DVA will fund for respite care. In any one financial year, DVA will fund:

• up to 196 hours of in-home respite care,
• 28 days of residential respite care, or a combination of both for each Entitled person, subject to clinical need.
• In addition, DVA will fund up to 72 hours per episode of ESTHR care to a total of 216 hours per financial year in emergency situations.

For Australian former prisoners of war and Victoria Cross recipients, DVA will pay for 63 days of residential respite care. For more information, please see DVA Factsheet: [POW01 Benefits available to Australian prisoners of war and their dependants](#)
• **CVC Social assistance**: Limited short term social assistance as part of CVC is also available (see p 41). Social assistance is arranged through the VHC Program and is only available to CVC participants and those already enrolled in the VHC program.

For more information on Social Assistance as part of CVC see [DVA Factsheet HCS10, “Coordinated Veterans’ Care – Social assistance”](#).

### 3.9.1. Accessing VHC Home Care

A doctor or discharge planner should refer an Entitled Person for an assessment of their home care assistance needs before they can receive services. Entitled Persons should be advised to contact the Veterans’ Home Care Assessment Team on 1300 550 450 for an assessment.

**Veterans’ Home Care Assessments**: A VHC assessment is undertaken by a DVA-contracted agency with the Entitled Person by telephone. Approvals for services are for a defined period. All Entitled Persons are subsequently re-assessed and further approvals are dependent on the outcome of that assessment.

**To be assessed for respite care, domestic care, personal care or safety related home and garden maintenance, entitled persons should contact a VHC Assessment Agency on 1300 550 450. NOTE**: Calls should be made from a standard landline telephone, as calls from mobiles may not connect to the correct VHC assessment agency.

**Co-payments**: Entitled Persons may be asked to pay a small contribution to service providers for Veterans’ Home Care services as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost per hour</th>
<th>Maximum payable (capped)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care</td>
<td>$5.00</td>
<td>$10.00 (per week)</td>
</tr>
<tr>
<td>Respite care</td>
<td>No co-payment</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Domestic assistance</td>
<td>$5.00</td>
<td>$5.00 (per week)</td>
</tr>
<tr>
<td>Home and garden maintenance</td>
<td>$5.00</td>
<td>$75.00 (per year)</td>
</tr>
<tr>
<td>Social assistance</td>
<td>$5.00</td>
<td>$5.00 (per week)</td>
</tr>
</tbody>
</table>

**Co-payment Waiver**: Entitled Persons with difficulties affording the co-payment as well as those who have one or more dependent children may apply for a waiver of the co-payment.

Entitled person who have difficulties affording the co-payment and those with dependent children should be advised to contact DVA to apply for the waiver. See [DVA factsheet HCS05 - Waiver of co-payment](#).

**Continuation of services following the death of an Entitled Person**: If at the time of death the Entitled Person was receiving domestic assistance or safety related home and garden maintenance, an eligible person who lived with the Entitled Person immediately beforehand may continue to receive these services for a period of up to 12 weeks following the death.

People who may be eligible for continuation of services are:

- A widow/widower of the deceased Entitled Person;
- A child of the Entitled Person;
- An adult child of the Entitled Person with a serious disability; or
- An adult child of the Entitled Person who was a full-time carer for the Entitled Person.

Claims for war widow/widower pensions lodged during this 12 week period may extend access to VHC services. Contact the VHC Assessment Agency for more information.

For a comprehensive overview of services available under the VHC programme, refer to: [DVA Factsheet HCS01 “Veterans’ Home Care”](#).

**Household Services for Military Compensation Members (MRCA) and Safety Rehabilitation Members (SRCA)**

DVA members who have service related disabilities accepted under the *Military Rehabilitation and Compensation Act* and/or the *Safety Rehabilitation and Compensation Act, 1988* may be eligible to receive some services.

For information on Household Services available for MRCA and SRCA members, see [DVA Factsheet MRC42 Household-services](#).

For information on accessing home assistance and attendant care assistance, see DVA factsheet: [MRC34 - Needs Assessment](#).

### 3.10. Hearing Services

Hearing services are provided to Entitled Persons under the Australian Government’s Hearing Services Program. This is managed by the Office of Hearing Services, with hearing services provided through a network of public and private contracted providers.

**Services include:**
- choice of hearing services provider;
- a hearing assessment;
- advice and support about hearing loss; and
- if needed, the fitting of an appropriate hearing device and a contribution to maintenance and repair of hearing devices.

**The Hearing Services program offers:**
- a large range of free devices;
- top up devices with additional non-essential features\(^5\) and
- alternative listening devices, such as devices to assist with listening to the TV or the phone.

A hearing device or an alternative listening device is available **BUT** not both. Refer [DVA Factsheet HSV22, “Hearing Services”](#).

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\(^5\) The program will only cover part of the cost for top-ups; payment for the additional costs is required.
Access to hearing services:
A GP can arrange hearing services by completing a referral form, available from the website at www.hearingservices.gov.au. A welcome pack will be sent to the Entitled Person with a list of up to 20 providers in their area. A directory of contracted local hearing service providers is also available on the website.

If the hearing test recommends a hearing device, the provider will select the most suitable model for the Entitled Person’s needs and goals. Hearing loss develops over time and people can forget how certain things sound. The provider can advise ways to get used to these sounds and to the feel of the device. This process may take several months.

Top-up devices: The provider must offer a suitable free-to-client or non-standard device option. There is no requirement to purchase a top-up device under the program.

Device maintenance: DVA will pay the maintenance fee to the provider each year to cover services, repairs and batteries on free-to-client devices. If a top-up device is chosen, the Entitled Person will need to pay the costs above the standard fee. The program may also contribute separately to these costs. The fee should be paid on the first follow-up visit and then every year on the same date that the hearing device was first fitted.

Minor maintenance: Includes ear mold renewal and repair, ear mold cleaning and replacing minor parts such as tubing. Replacing major electronic parts and supplying batteries is not included. There is no annual maintenance fee for these services.

Replacement fees: If a hearing device is lost or damaged, contact the provider. A statutory declaration form will need to be completed detailing the circumstances. In the event that the device is damaged beyond repair, the provider must supply the Office of Hearing Services with a supporting letter from the manufacturer. They will then consider the application for a replacement. Entitled Persons will not be required to pay a fee for replacement of free-to-client devices.

Rehab Plus: An advisory service available to those being fitted with a free-to-client device for the first time. Includes information about managing hearing loss and provides tips to help get the most out of the device. Speak to the hearing services provider.

Contact Australian Hearing Services on 1300 412 512. www.hearing.com.au
4. Commonwealth Initiatives

4.1. My Aged Care

My Aged Care contact centre and website is an information and services resource designed to help older people navigate the aged care system more easily. It provides information for individuals, their families and carers, those already receiving aged care services and those looking to receive aged care services.

Services include:

- A central point of access for information, assessment and referral to Commonwealth funded aged care services;
- A centralised Aged Care Client Record, to facilitate the collection and sharing of client information;
- The My Aged Care Regional Assessment Service (RAS) to conduct face-to-face assessments for clients seeking to access the Commonwealth Home Support Programme (CHSP) services;
- A national screening and assessment form to ensure nationally consistent and holistic screening and assessment processes for all mainstream aged care programs;
- Web based portals for clients, assessors and service providers. This enables clients to view and update their details. Assessors and providers can manage electronic referrals, service information and update client records; and
- Enhanced service finders that include information about non-Commonwealth funded services for clients.

My Aged Care can be accessed through the website: myagedcare.gov.au or by phoning the National Contract Centre on 1800 200 422 (Mon-Fri: 8.00am to 8.00pm, Sat: 10.00am to 2.00pm).

4.2. Commonwealth Home Support Program

The Commonwealth Home Support Program provides entry-level home support for people aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) who need assistance with daily activities to keep them living independently at home and in their community.\(^7\)

\(^7\) “Entry Level” refers to home support services provided at a low intensity on a short term or ongoing basis, or higher intensity services delivered on a short-term or episodic basis. The defining feature is that services delivered are, in total, generally lower than the cost or volume provided in a Home Care Package per annum.
**Services funded under the Commonwealth Home Support Program:**

<table>
<thead>
<tr>
<th>Domestic assistance (general house cleaning, unaccompanied shopping – delivered to home, linen services).</th>
<th>Personal care (assistance with self-care, assistance with client self-administration of medicine).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social support individual (visiting, phone/web contact, accompanied activities).</td>
<td>Other food services (food advice, lessons, training, food safety, food preparation in the home).</td>
</tr>
<tr>
<td>Home maintenance (minor and major home maintenance and repairs, garden maintenance).</td>
<td>Goods, equipment and assistive technology (self-care aids, support and mobility aids, medical care aids, communication aids, other goods and equipment, reading aids, car modifications).</td>
</tr>
<tr>
<td>Meals (at home, at centre).</td>
<td>Transport (driver is volunteer or worker), Indirect (through vouchers or subsidies).</td>
</tr>
<tr>
<td>Assistance with care and housing (assessment – referrals etc., advocacy – financial, legal etc.).</td>
<td>Specialised support services (continence advisory services, dementia advisory services, vision services, hearing services, other support services, client advocacy, carer support).</td>
</tr>
<tr>
<td>Allied health and therapy services (podiatry, occupational therapy, physiotherapy, social work, speech pathology, accredited practising dietician or nutritionist, health worker, psychologist, restorative care services, diversional therapy, exercise physiologist, other allied health and therapy services).</td>
<td>Flexible respite (in-home day respite, in-home overnight respite, host family day respite, host family overnight respite, community access – individual respite, other planned respite, mobile respite).</td>
</tr>
<tr>
<td>Cottage respite (overnight community respite).</td>
<td>Centre-based home care respite (Centre based day respite, community access – Group, residential day respite).</td>
</tr>
<tr>
<td>Other support services as agreed between the Dept Social Services and the service provider.</td>
<td></td>
</tr>
</tbody>
</table>

Entitled Persons and their carers are able to access CHSP services in the same way as the general population. Access is determined by their eligibility, assessed need and any service being provided by other government programs.

Eligibility for DVA funded services such as VHC, Community Nursing, Transport or Respite does not preclude that person from accessing services under the CHSP, so long as they are eligible for the services, the support required under the CHSP is entry-level and there is no duplication in the specific services/assistance being provided.

For example, a person may access VHC for low-level domestic assistance and personal care, but also receive transport assistance and delivered meals through the CHSP.

The CHSP is accessible to older Australians through the My Aged Care website or the National Contact Centre on 1800 200 422.
4.3. Consumer Directed Care in Home Care Packages

Consumer Directed Care (CDC) puts the consumer in control of the services they receive, to the extent they are capable and wish to do so.

Home Care Packages are in place to assist older people who need additional help to stay safe and well at home. The packages provide eligible individuals with higher levels of assistance than is available under CHSP or DVA’s entry level care programs such as VHC and Community Nursing.

A Home Care Package provides coordinated services tailored to meet specific care needs and includes services like cleaning and preparing meals, gardening and assistance with showering, or transport so that individuals can shop or attend appointments.

CDC as applied to Home Care Packages enables an individual in receipt of services to have a greater say in the types and delivery of care services they receive. Eligible older Australians (including Entitled Persons) will be provided with a personalised budget so they can see how much funding is available for services and be involved in making decisions on how the money will be spent.

4.4. Aged Care Assessment Teams

The Aged Care Assessment Program is administered by the Department of Social Services (DSS). The program is a cooperative working arrangement between the Commonwealth, State and Territory governments to operate Aged Care Assessment Teams (ACATs) across Australia.\(^8\)

Based in hospitals or in the local community, ACATs may include doctors, nurses, social workers or other health professionals.

The program assesses the care needs of older people (including Entitled Persons) and helps them gain access to the most appropriate types of care, including approval for Commonwealth government subsidised care services.

ACATs help to determine the most suitable care needs for an individual and may recommend one or more of the following:
- Residential care, including residential respite care;
- Home Care Package;
- Flexible or transitional care.

The assessment process is wholly government funded. An ACAT member will:
- Visit the Entitled Person’s home or hospital to determine the best care option for their situation, including the amount and type of care required to conduct daily and personal activities;
- With approval, contact the treating doctor to obtain information about the Entitled Person’s medical and medication history;
- Discuss the most suitable care options and identify those services available in the area;
- Encourage the involvement of carers, relatives or close friends;
- Discuss the results of assessment and arrange referrals to either home or community care services, or a place in residential care.

An ACAT cannot make recommendations about individual residential care facilities or community services but they can provide information to assist decision making.

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\(^8\) In Victoria, Aged Care Assessment teams (ACAT) is referred to as Aged Care Assessment Service (ACAS).
5. Better Discharge Planning program

The Better Discharge Planning program (BDP) is additional to hospitals’ standard discharge planning services for all DVA Entitled Person admissions. DVA recognises that some at risk members of the ageing veteran population require additional support following discharge from hospital to ensure that there is a seamless transfer of care from the hospital to the community setting.

BDP is intended to prevent unplanned hospital re-admissions, provide additional support to Entitled Persons managing their chronic medical conditions at home and contribute to the overall wellbeing of those receiving the service.

Access: The hospital assesses the needs of eligible ‘at risk’ Entitled Persons and assists them in accessing the required post discharge services and ongoing care.

- Services might include, but are not limited to, monitoring the Entitled Person’s access to health care services in the community for up to two weeks post discharge, and liaising with the Entitled Person’s treating doctor and other community-based providers.
- Other activities may include working with the Entitled Person to ensure that they understand their medication management plan and, where required, confirming that home modifications have occurred.

CVC Program participants are not eligible for BDP services.

DVA will pay a fixed fee case payment to the hospital on discharge for the delivery of BDP.

Eligibility: A hospital may provide BDP services to Entitled Persons who meet the eligibility criteria and are assessed as ‘at risk’ of unplanned re-admission to hospital or premature entry to residential care. It is intended that BDP would be appropriate for a limited number of Entitled Persons.

To be eligible an Entitled Person must meet ALL of the following criteria:
- Be an inpatient of the hospital;
- Have a chronic medical condition;
- Have multiple co-morbidities;
- Have a pattern of repeated unplanned re-admissions to hospital and/or non-compliance with medication regimes;
- Live alone, or with someone who has been assessed by the hospital as not in a position to provide sufficient assistance to the client upon discharge due to their frailty or incapacity; and
- Not be enrolled in CVC (see p 41);

Who is not eligible for BDP?
- outpatients;
- same day patients or overnight patients admitted for less than 48 hours;
- rehabilitation patients,9
- Hospital in the Home patients;
- dental patients;
- CVC participants

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9 This includes, but is not limited to, the following DRG item codes: Z60A, Z60B, Z60C.
patients being transferred to another facility for rehabilitation or other sub- or non-acute treatment;
patients being discharged to residential aged care, or where spouse, carer and/or family support is adequate to ensure the patient is able to successfully transfer to the required care within the community, as identified in the discharge plan;
where the patient’s discharge plan can be effected under standard discharge planning arrangements.

The hospital’s role
All BDP services must be provided in the facility where the admission occurred and must not be outsourced to a third party who has not been involved in the patient’s treatment.

In the two week post discharge period, depending of the needs of the patient, the hospital’s role includes:

- Stepping the patient through the discharge plan;
- Ensuring the patient’s Local Medical Officer or GP is involved in the aftercare planning, and receives a copy of the patient’s discharge plan;
- Ensuring appropriate services are being accessed, and if not, arranging those services;
- Ensuring a medication review is undertaken where indicated;
- Ensuring that the patient understands the medications to be taken;
- Arranging community nursing services, appointments to allied health services, follow-up medical appointments and/or referral to VHC Assessment Agency where required;
- Confirming that any required home modifications are undertaken;
- Confirming that the delivery of Aids and Appliances has occurred;
- Monitoring the patient’s wellbeing;
- Liaising with DVA where appropriate.

DVA has a Post Payment Monitoring regime in place for BDP claims, and reserves the right to review the hospital’s medical files to ensure compliance with service delivery and documentation requirements.
6. **Coordinated Veterans’ Care**

Coordinated Veterans’ Care (CVC) is a team-based program designed to reduce unplanned hospital admissions by increasing support for Gold Card holders with one or more identified chronic conditions and complex case needs.

CVC uses a proactive coordinated model of care to improve self-management of chronic conditions and quality of life. It achieves this by increasing understanding of health issues; improving communication between the patient, their GP and other health care professionals; and providing support to self-manage conditions using a Comprehensive Care Plan (CCP). The care team generally comprises the Gold Card holder, a GP and a nurse coordinator.\(^\text{10}\)

**Eligibility:** The individual must be a current Gold Card holder and must meet all of the following criteria:

- Be living in the community (not in an aged care facility);
- Be diagnosed with one or more chronic conditions that complicate treatment, including:
  - Congestive heart failure
  - Coronary artery disease
  - Pneumonia
  - Chronic obstructive pulmonary disease, or
  - Diabetes.
- Have an unstable condition(s) with a high risk of acute exacerbation;
- Have a condition which is complicated by frailty, age and/or social isolation;
- Have limitations in self-managing and monitoring their condition(s); and
- Require a treatment regimen that involves one or more of the following complexities of ongoing care:
  - multiple care providers
  - complex medication regimen
  - frequent monitoring and review, and/or
  - support with self-management and self-monitoring.

**Access:** Participation in CVC is voluntary, but GPs must assess a patient’s eligibility and enrol them in the program.

**Restrictions:** Access to CVC is **not available** to Gold Card holders if they:

- live in a Residential Care Facility that provides:
  - nursing or personal care; meals, cleaning services, furnishings, furniture and equipment and appropriate staffing.
  - NOTE: This does not include a hospital, psychiatric facility or services provided in a person’s private home.
- have been diagnosed with a medical condition that, in the opinion of the GP, would in all likelihood be terminal within 12 months (does not apply where the diagnosis occurs after admission to CVC); or
- are participating in a similar coordinated care programme provided by the Commonwealth Department of Health and Ageing.

**The process:**

- After enrolment, and with the patient’s involvement, the GP and nurse coordinator will develop a personalised Comprehensive Care Plan (CCP) for coordinating and monitoring ongoing health care.

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\(^{10}\) A nurse coordinator may be a practice nurse or Aboriginal health worker employed by the GP’s practice, or a community nurse (from a DVA contracted community nursing provider).
• A “patient friendly” copy of the CCP will be provided to the patient, the carer and/or a dependant.
• Consideration will be given to the benefits of social inclusion in supporting good health such as short term assistance to encourage involvement in community or other social activities. (see p 41)
• If appropriate, the GP may refer the patient to a VHC Assessment Agency (see p 33).
• The nurse coordinator will coordinate ongoing health care and contact the patient regularly to:
  - assist them to make appointments with other health professionals involved in their care;
  - remind them of appointments;
  - monitor conditions and address any concerns;
  - coach and assist them to achieve health goals; and
  - provide any feedback to the GP.

Where it is seen as beneficial the hospital may recommend in the discharge planning summary that the GP enrolls the entitled person in the CVC program.

The Comprehensive Care Plan includes:
• A detailed medical history;
• Goals and strategies for managing the condition(s);
• Details of medications, dosage, frequency and medication reviews
• Symptoms to watch for;
• Appointments to specialists and other allied health providers;
• Cost: There is no cost to enrol in or remain a participant in CVC. However, co-payments may exist for other DVA services that form part of the Comprehensive Care Plan.

See DVA Factsheet HSV101 “Coordinated Veterans’ Care Program”

6.1. Coordination – Admission to hospital

The Hospital: Contact the patient’s GP and/or nurse coordinator (details will be on the CPP) to advise them that the patient has been admitted to hospital and discuss the best way to coordinate the discharge process.

The GP/nurse coordinator, having learned of a client’s unplanned admission to hospital will:
• contact the hospital and advise that the inpatient is a CVC participant and has a CCP; and
• request to be advised of the discharge date, to receive a copy of the discharge papers and if appropriate, to be involved in the discharge planning process.

Where appropriate, the GP or nurse coordinator will liaise with the hospital during a planned admission and follow up with the participant on discharge.

6.2. Coordination - Discharge from hospital

Where the GP or nurse coordinator has been involved in the discharge planning process, they will follow the discharge plan. At a minimum, the GP or nurse coordinator will contact the
participant and/or carer one to two days after discharge to arrange for an appointment with the GP to review the participant’s condition and review the Comprehensive Care Plan.

6.3. Coordinated Veterans’ Care (CVC) – Social Assistance

CVC – Social Assistance is a 12 week service designed to (re)connect socially isolated CVC participants into community life, strengthening their sense of wellbeing and belonging. The community based activities focus on building confidence and independence, as well as developing social support networks.

**Eligibility:** The patient must be:
- Enrolled as a CVC participant
- Be identified by their LMO/GP as socially isolated or at risk of becoming socially isolated

Entitled persons are not eligible for CVC Social Assistance if they are not a CVC participant or do not have a referral for an assessment from their LMO/GP.

**Access:** An assessment by a VHC Assessment Agency is required to determine the patient’s social assistance needs. Most assessments are undertaken over the telephone. An assessment can only be conducted for CVC Social Assistance where there is a valid referral for Social Assistance from a GP/LMO. This referral does not guarantee that the CVC participant will be assessed as requiring CVC Social Assistance services by the VHC Assessment Agency, but it will result in an assessment being undertaken.

**Process:** At the completion of an assessment and where services have been approved, the VHC Assessment Agency will create the Social Assistance Service Plan detailing the agreed social assistance activities to be provided. The Service Plan is automatically forwarded to the VHC Service Provider. The VHC Assessment Agency will also create and send a VHC Care Plan to the CVC participant together with the DVA Factsheet *CVC Social Assistance (HCS10)* and other supporting material. The Assessment Agency will advise the LMO/GP of the assessment outcome. The allocated VHC service provider will call the patient to discuss a suitable time to provide their services then provide activities regularly over a 12 week period in accordance with the Plan to assist the patient to self-manage.

CVC Social Assistance Activities approval upper amounts are:
- Home based socialisation: 2 hours per week for 12 weeks.
- Community based socialisation: 4 hours per week for 12 weeks.
- Accompanied outings (in limited circumstances): 4 hours per week for 12 weeks.
- Other (combination of two of the above): 6-8 hours per week for 12 weeks.

**Cost:** The VHC Service Plan will show if a co-payment is required. The co-payment is usually $5.00 per week. If outings and activities constitute part of the service provided, there may be added costs such as admission fees that need to be paid by the CVC participant.

For long term social support services, contact: My Aged Care on 1800 200 422.
## 7. CONTACT INFORMATION

### 7.1. DVA funded programs

<table>
<thead>
<tr>
<th>Service</th>
<th>Information/Contact</th>
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<tbody>
<tr>
<td>Aged Care Assessment Team (ACAT)</td>
<td><a href="http://www.myagedcare.gov.au/eligibility-and-assessment/acat-assessments">www.myagedcare.gov.au/eligibility-and-assessment/acat-assessments</a></td>
</tr>
<tr>
<td>Community Nursing</td>
<td><a href="http://www.dva.gov.au/providers/community-nursing">www.dva.gov.au/providers/community-nursing</a></td>
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<tr>
<td>DVA General Enquiries</td>
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<td></td>
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<tr>
<td>DVA Transport Bookings</td>
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<td></td>
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<tr>
<td>Health Approvals and Home Care</td>
<td></td>
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<tr>
<td>Hearing Services Program—Department of Health</td>
<td></td>
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<tr>
<td><a href="http://www.hearingservices.gov.au">www.hearingservices.gov.au</a></td>
<td></td>
</tr>
<tr>
<td>Veterans’ Affairs Pharmaceutical Approvals Centre</td>
<td></td>
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<tr>
<td>(VAPAC)</td>
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<tr>
<td>Veterans’ Home Care Assessment Agency</td>
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<td>Veterans’ MATES</td>
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<tr>
<td>Veterans &amp; Veterans’ Families Counselling Services</td>
<td></td>
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<tr>
<td>(VVCS)</td>
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<tr>
<td>Veterans Line</td>
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</tbody>
</table>
## 7.2. External Contacts

<table>
<thead>
<tr>
<th>Service</th>
<th>Website/Link</th>
<th>Phone tapered</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Aged Care</td>
<td><a href="http://www.myagedcare.gov.au/">www.myagedcare.gov.au/</a></td>
<td>1800 200 422</td>
<td>Mon-Fri: 8.00am to 8.00pm, Sat: 10.00 to 2.00pm</td>
</tr>
<tr>
<td>Councils on the Ageing (COTA)</td>
<td><a href="http://www.cota.org.au/australia/">http://www.cota.org.au/australia/</a></td>
<td>1300 140 050</td>
<td></td>
</tr>
<tr>
<td>Alzheimer’s Association Help Line</td>
<td>fightdementia.org.au/services/helpline</td>
<td>1800 639 331</td>
<td>(24 hours per day)</td>
</tr>
<tr>
<td>Dementia and Cognition Supplement in Home Care</td>
<td><a href="http://www.humanservices.gov.au/health-professionals/forms/ac014">www.humanservices.gov.au/health-professionals/forms/ac014</a></td>
<td>1800 195 206</td>
<td></td>
</tr>
<tr>
<td>Home Care Packages Program</td>
<td>Home Care Packages Programme</td>
<td>Department of Social Services, Australian Government</td>
<td>1300 653 227</td>
</tr>
<tr>
<td>Partners of Veterans Association of Australia</td>
<td><a href="http://www.pva.org.au/">www.pva.org.au/</a></td>
<td></td>
<td>local call cost 132 717</td>
</tr>
<tr>
<td>Aged &amp; Community Services Australia</td>
<td><a href="http://www.agedcare.org.au/">www.agedcare.org.au/</a></td>
<td>1800 200 422</td>
<td></td>
</tr>
<tr>
<td>Reach Out (information for young carers)</td>
<td>au.reachout.com/</td>
<td>02 8029 7777</td>
<td></td>
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</tbody>
</table>
Discharge Planning Flow Chart (from pre-admission to discharge)

Confirm Eligibility

- Check the colour and expiry date of the DVA Entitlements Card (See p 6-7)
- Is Entitled Person a White Card holder? Check eligibility for services? (See p 7)
- Is the treatment related to a compensation incapacity? (See p 6)
- Engage the Entitled Person in discussions about discharge from hospital (See p 10)

Identify key people/issues

- Does the veteran have a carer? (See p 11)
- Identify the veteran’s treating doctor (See p 11)
- If the veteran has any dependants is emergency accommodation and/or home care required for those dependants prior to admission? (See p 12)
- Are there special considerations/issues that need consideration? (See pp 12-13)
- Is the veteran on the Coordinated Veteran Care (CVC) Program? (See p 42)
- Provide written information to the veteran and their carer regarding what they might expect during the hospital stay, surgery, recovery & rehabilitation. (See p 16)
- Provide written information to the treating doctor. (See p 16)

Develop a discharge plan

- Establish a multidisciplinary team by nominating and contacting relevant health service providers
- Involve community health and service personnel (See p 20)
- Review medication needs - ensure appropriate supply and confidence to use (See p 18)
- Consider need for DVA administered services eg transport (See p 26-28), rehabilitation appliances (See p 34); community nursing (See p 20) etc.
- Arrange an Aged Care Assessment Team (ACAT) visit - if appropriate
- Establish an expected time and date of discharge (See p 14)
- Assess eligibility for other DVA administered program eg Better Discharge Planning programme (See p 37) and non-DVA administered programs (See p 34)

Address common issues

- Manage expectations - recovery time frames and pathways; short term and ongoing changes to health and lifestyle (See p 14)
- Confirm date and time of discharge with the veteran and their carer (See pp 13 & 14)
- Provide information - self help strategies, local support groups and community services available (See pp 12 & 13)
- Address common issues raised by veterans (See p 14)
- Arrange assessments & referrals (where required) - e.g. Community Nursing (See p20); Veterans’ Home Care (p31); Rehabilitation Appliances Program (See p 34); VVCS services (See p 29) and hearing services (See p 34) etc
Avoid delays

- Complete arrangements for community health services (see p 31-33)
- Consider issues of safety e.g. medication management (See p 18 and p 25); Veterans’ MATES (See p 26); Dose Administration Aid (See p 26).
- Arrange transportation (See p 27)
- Confirm home modifications and equipment arranged (See p 23)
- Obtain all test results to avoid last minute changes to discharge plans (See p 17)
- Organise supply of all new medications and education sessions (See p 17)
- Arrange follow up appointments (See p 15)
- Advise the treating doctor of any tests required post discharge (See pp 15 & 16).
- Provide contact information - hospital; community and support groups etc (See pp 15-16)
- Discuss expected recovery path and confirm understanding (See p 17)
- Discuss nutritional needs and make referrals where required

Discharge documentation

- Provide veterans staying overnight with the “DVA Patient Satisfaction Survey Questionnaire”.
- Complete “Discharge Advice and Hospital Claim (D653A) (See p 16)
- Ensure veteran and carer readiness to leave hospital at the agreed time.
- Confirm services established to assist with independent living inc health and social needs.
- Forward discharge summary to the treating doctor
- Provide a contact name and number for the hospital staff member responsible for discharge (See p 16)
- Provide private xrays, scans, medical documents, medicines and personal belongings (See p 16)
- Organise transport home and to follow up appointments (See p 27)

Post Discharge monitoring

- Contact the Entitled Person to assess their coping ability and to address concerns (See p 19)
- Contact the treating doctor to identify if a medicine review and/or health assessment has been organised etc (See p 19)
- Evaluate discharge procedures (see p 19)
Effective Discharge Planning Checklist

- Establish the expected time and date of discharge to identify potential problems which may impact on the patient’s discharge.
- Provide details to the patient, their family and carer.
- Determine if the patient has a carer (e.g. family member, friend, neighbour, other). Establish the carer’s capability and willingness to assist.
- Involve the carer throughout the discharge planning process.
- Consult an Occupational Therapist or other relevant allied health professional to resolve potential mobility issues.
- Discuss the supply of aids and appliances, and the need for any home modifications.
- Assist with providing or arranging instruction on the use of aids or appliances as necessary.
- Confirm with patient/family/carer whether or not community nursing services are already in place.
- Forward a timely referral and discharge plan, with appropriate clinical information, to the community nursing agency.
- Establish Date and time of discharge.
- Determine if the patient has a carer (e.g. family member, friend, neighbour, other). Establish the carer’s capability and willingness to assist.
- Involve the carer throughout the discharge planning process.
- Consult an Occupational Therapist or other relevant allied health professional to resolve potential mobility issues.
- Discuss the supply of aids and appliances, and the need for any home modifications.
- Assist with providing or arranging instruction on the use of aids or appliances as necessary.
- Carer arrangements.
- Mobility and independence.
- Consult an Occupational Therapist or other relevant allied health professional to resolve potential mobility issues.
- Discuss the supply of aids and appliances, and the need for any home modifications.
- Assist with providing or arranging instruction on the use of aids or appliances as necessary.
- Organise transport home and to follow-up appointments as early as possible.
- Otherwise the patient may have the option of claiming reimbursement of travel expenses from the Department of Veterans’ Affairs.
- Settle lifeline arrangements.
- Medications.
- Arrange for sufficient quantities of medication to last until the next consultation.
- Check that the patient understands the purpose, dosage, frequency and side-effects of their medication, and that no confusion exists between past and present medications.
- Follow up appointments.
- Arrange all necessary appointments.
- Provide the patient or carer with written details of the appointments. Ensure relevant clinical information in writing is provided to health professionals.
- Discuss expected recovery path and confirm understanding. Provide any necessary or special instructions in writing.
- Arrange the issue of a discharge summary to the patient’s GP and referring doctor at the time of discharge, with a copy given to the patient / carer.
- Special instructions and Discharge Summary.
- Discuss future nutritional needs and organise services to meet these if necessary.
- Ensure the patient takes with them any private x-rays, scans, medical documents, medicines as well as all personal belongings.
- Nutrition.
- Patient’s belongings.