2023

DISCHARGE PLANNING RESOURCE GUIDE

PLANNING A SUSTAINABLE DISCHARGE FROM HOSPITAL

Australian Government

Department of Veterans' Affairs

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; and
- The discharge planning flow chart.

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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GUIDE TO ACRONYMS

ACAS	Aged Care Assessment Service
ACATs	Aged Care Assessment Teams
ACD	Advance Care Directive, also known as a “Living Will”
ACHA	Assistance with Care and Housing for the Aged program
ADF	Australian Defence Force
APPs	Australian Privacy Principles
ASIST	Applied Suicide Intervention Skills Training
CN	Community Nursing
CCP	Comprehensive Care Plan
CDC	Consumer Directed Care
CHSP	Commonwealth Home Support Program Services
Co-payment	Patient contribution charge
CPAP	Continuous positive airways pressure therapy machines
CTVS	Country Taxi Voucher Scheme
CVC	Coordinated Veterans’ Care Program
Cwth	Commonwealth
DAA	Dose Administration Aid
DTC	Day Therapy Centres program
EoL	End of Life Care
ESTHR	Emergency Short-Term Home Relief
GPs	General Practitioners
HACC	Commonwealth Home and Community Care (HACC) program
MBS	Medicare Benefits Schedule
MFS	Mobility and Functional Support
MMR	Medication Management Reviews
NRCP	National Respite for Carers Program
OAVFC	Open Arms Veterans and Families Counselling (formerly VVCS)
PBS	Pharmaceutical Benefits Scheme
PRS	Personal Response Systems
PTSD	Post-traumatic Stress Disorder

RAP	Rehabilitation Appliances Program
RAP Schedule	National Schedule of Equipment
RAS	My Aged Care Regional Assessment Service
RCF	Residential Care Facility
RPBS	Repatriation Pharmaceutical Benefits Scheme
RTS	Repatriation Transport Scheme
VAPAC	Veterans’ Affairs Pharmaceutical Approvals Centre
VHC	Veterans’ Home Care
VLOs	Veteran Liaison Officers
VVCS (now OAVFC)	Refer to OAVFC - Open Arms Veterans and Families Counselling

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);
- 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 with DVA or the condition covered by DVA arrangements;
- 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 and Aged Care 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 1800 550 457

1.3. DVA Veteran Cards

There are three 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.

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.

1.3.3. White Card for 'Non-Liability health Care"

Non-liability health care allows former and current ADF personnel, depending on their eligibility, to receive treatment for the following conditions whether war caused or not:

- Any mental health condition, including but not limited to;
- Substance use disorder; or
- Alcohol use disorder.

In some circumstances, current and former ADF personnel may also be eligible for non-liability treatment of:

- Malignant cancer (neoplasia); or
- Pulmonary tuberculosis.

More narrow eligibility criteria apply for malignant cancer and pulmonary tuberculosis.

1.3.4. 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.

1.3.5. 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 funded treatment.

1.3.6. Letter of Authorisation

An Entitled Person may be issued with a letter of authorisation from DVA specifying his or her eligibility for treatment. The letter will outline the terms of the authorisation including what conditions are covered by the authorisation. Providers should follow the instructions on the letter when providing treatment and rendering an invoice.

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 related to ADF service may be eligible for treatment under DVA arrangements. They will be issued with their own DVA health card.

1.6. Commonwealth and 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.

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: https://www.oaic.gov.au/

1.8. Feedback (Complaints, Compliments or Suggestions)

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

How does a person lodge a compliment or suggestion to DVA?

You can pass on a compliment or suggestion by contacting the person or section you have been dealing with.

You can also contact DVA's Feedback Management Team (FMT) by:

- Calling 1800 VETERAN (1800 838 372) during EST office hours (if the line is busy, your call will be returned within one working day);
- Emailing feedback@dva.gov.au (please do not use this address to send DVA personal information);
- Writing to the Manager, Feedback Management Team GPO Box 9998 Brisbane QLD 4001: or
- Completing a Feedback Form.

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; and
- 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.

In addition to DVA's discharge planning overview, the National Safety and Quality Health Service (NSQHS) Standards should be followed when discharging an Entitled Person. The NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. Implementation is mandated in all hospitals, day procedure services and public dental services across Australia. When used in assessment they provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

You can find more information for the NSQHS Standards at: https://www.safetyandquality.gov.au/standards.

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 aspects of care that will be required after the patient leaves 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:

Clinicians	Medical specialists	Occupational therapists
Community nursing services	Nurse unit managers (NUM)	Discharge planners
Physiotherapists	Rural liaison nurses	General Practitioner liaison nurses
Hospital and community pharmacists	Other allied health practitioners	Medical practitioners (general and hospital)

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[1], the doctor can be more involved in care coordination prior to and post admission. This is integral when the Entitled Person has complex 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[2] 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.

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[1] 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.

[2] A chronic disease is defined a disease that lasts (or will last) for at least six months or that is terminal.

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 Veterans' 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.

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.

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 (e.g. having high level care needs);
- 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.

Please also refer to the DVA Website for information on mental health support services on how veterans can receive urgent help and support.

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 (ESOs) support for those at risk of homelessness:

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 ESOs 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 DVA via the provider helpline: 1800 550 457 or the main DVA phone number: 1800 VETERAN (1800 838 372) 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 Homelessness Support Services webpage.

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; and
  - 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; and
- 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; and
- 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 or make a referral for community nursing 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;
    - Arrange a referral to a DVA approved Community Nursing provider, if required and eligible. The Panel of providers is available on the DVA website.
- 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;
    - Distance to be travelled for appointments; and
- 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; and/or
- 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.

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

2.11. ON THE DAY OF DISCHARGE

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 nursing provider and GPs, 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.

For Entitled Persons staying overnight, provide them with the **"DVA Patient Experience Survey"** and encourage them to complete and return it.

2.12. DISCHARGE DOCUMENTATION

DVA recommends that all information included in the discharge documentation be verbally 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 community nursing provider (if applicable), within 48 hours of discharge.

A **discharge summary** may include:

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

Community Nursing (CN) services required.	Name of CN provider referral has been sent to.

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 the 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; and
- Contacting the Entitled Person's treating doctor(s) to identify if a Medicine review and/or health assessment has been organised; 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. Veterans' and Families' Hubs

In 2019, a network of Veterans' and Families' Hubs (formerly known as Veteran Wellbeing Centres) were developed across Australia. The hubs deliver integrated support to veterans and families and offer a one-stop shop for local veteran services, including wellbeing support, advocacy, employment and housing advice, social connection and physical and mental health services.

The hubs provide a space for veterans' services and advocacy organisations to co-exist and provide integrated support to current and ex-service personnel and families. Both the existing and future hubs offer a one-stop shop for local veteran services, which may include health and mental health services, wellbeing support, advocacy, employment and housing advice, and social connection.

Lead organisations in each location will either provide, or facilitate access to these services, integrating support to veterans and families in partnership with ex-service organisations, community and other organisations and state and territory governments.

Each hub will provide services and support based on local needs and opportunities. These services may include, but are not limited to:

- Transition and employment support;
- ESO advocacy services;
- Housing and social connectedness;
- Mental and physical health services; and
- Community engagement.

For more information about the Veterans' and Families' Hub Program, please email veteransandfamilieshubs@dva.gov.au or visit the DVA website.

3.2. Allied health services

DVA's funds a range of allied health services to Entitled Persons. Please see the "Health services for the veteran community" page on DVA's website for further information.

With the exception of general dental and optical, DVA's Treatment Cycle referral arrangements apply to allied health services provided to Entitled Persons. Under these arrangements a new referral is required for each new condition and is valid for 12 sessions or 1 year, whichever ends first. Clients can have as many treatment cycles as their GP decides are clinically necessary. Please see the "Allied health treatment cycle" page on DVA's website for further information.

Restrictions may apply to the provision of some services. Contact the **DVA Health Approvals and Home Care Team** on 1800 550 457 or you can email your non-urgent request to health.approval@dva.gov.au

3.3. COMMUNITY NURSING

Community nursing services are available for Entitled Persons to provide clinical and personal care in the immediate post discharge period, including a range of palliative nursing services (see section 3.5) These services are delivered by registered nurses, enrolled nurses and personal care workers, and services are delivered in the client's home.

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.

Community nursing services can include medication, wound care, continence, and hygiene such as showering.

To be eligible to receive community nursing services, an eligible person must have either a Gold Card, or a White Card, with Community Nursing services required for a condition covered under the White Card. Clinical nursing and personal care services must meet a clinical need, and can be accessed on referral from an authorised referral source (see below referral information).

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

The authorised referral sources for community nursing are:

- General Practitioner;
- Treating doctor in a hospital;
- Hospital Discharge Planner;
- Specialist; or
- Nurse Practitioner specialising in a Community Nursing field.

Referrals from hospitals are valid for seven days, after which a referral from the client's GP is required to cover ongoing CN services (for up to 12 months).

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.

On receipt of a referral, a registered nurse from the community nursing provider will assess your need for clinical nursing and personal care services. They will develop a care plan, tailored to your needs, and share a copy of this with you (and your carer, if applicable).

There is no co-payment required for community nursing services delivered by a DVA-contracted community nursing provider.

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 provider, unless the required services cannot be delivered by the previous provider.

If an Entitled Person is in need of community nursing services, they should not be discharged until these services have been arranged (i.e. the CN provider has accepted the referral).

> To locate the nearest DVA contracted community nursing provider, please go to https://www.dva.gov.au/providers/health-programs-and-services-dva-clients/community-nursing/panel-community-nursing

3.4. 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 and is available to all Gold Card holders and to White Card holders where the hospital stay relates to their DVA accepted condition**.

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 residential facility for convalescent care and seek prior financial authorisation from DVA prior to discharge from hospital.

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).

> 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 webpage on "Convalescent Care".

3.5. 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.

DVA's Community Nursing program can also provider palliative nursing services including clinical or personal care for entitled persons in the terminal phase of their disease.

Rehabilitation aids and appliances are also available (see Section 3.6).

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

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

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. For more information go to https://www.advancecareplanning.org.au/#/

3.6. DVA's Rehabilitation Appliances Program

The DVA Rehabilitation Appliances Program (RAP) provides aids and appliances to eligible clients 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. For more information on appliances, head to DVA's RAP webpage at https://www.dva.gov.au/providers/health-programs-and-services-dva-clients/rehabilitation-appliances-program

Contracted RAP Suppliers

RAP product	Company name	Phone
Continence (e.g. pads, catheters)	In Touch	1300 134 260
	Independence Australia	1300 788 855
	BrightSky Australia	1300 968 062
Oxygen (e.g. cylinders, nebulisers)	Air Liquide Healthcare	1300 360 202
	BOC	1800 050 999
Continuous positive airways pressure therapy (CPAP) machines	Air Liquide Healthcare	1300 360 202 (Now a national No.)
	BOC	1800 050 999
	ResMed	1800 737 633
Mobility and function support (e.g. wheelchairs, walking frames, handrails)	Aidacare	1300 133120
	Allianz Global Assistance	(07) 3305 7000
	The Country Care Group	1800 843 884
	BrightSky Australia	1300 8866 01
Personal response systems (PRS)	INS Lifeguard	1800 636 040
	Safety Link	1800 813 617
	Tunstall Healthcare	1800 603 377
	Vitalcall	1300 848 252

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.

For order forms for aids and appliances go to: https://www.dva.gov.au/providers/health-programs-and-services-dva-clients/rehabilitation-appliances-program where a range of order forms can be found, including:

D0904 — DVA request/ referral for LMO use;

D1316 — Recliner chair assessment form;

D1325 — Scooter/ electric wheelchair [Part 2 — assessment form — see also D9300];

D1327 — Home/ access modification assessment form for all major modifications (bathrooms, ramps, lifts etc...);

D9199 — Personal Response System (PRS) assessment form;

D9300 — Scooter/ electric wheelchair [Part 1 — medical questionnaire — see also D1325] (Apply for aids or appliances;

D0804 — Home medical oxygen therapy application form;

D1341 — Essential medical equipment medical confirmation form;

D1382 — Request for communication device — assistive and/or speech pathology application(s);

D9140 — Application for Positive Airways Pressure (PAP) Equipment;

D9160 — Request for exercise bike;

D9166 — Request for thickeners;

D0988 — Continence direct order form;

D0992 — Mobility and functional support (MFS) direct order form;

D9257 — Direct order form RAP low vision products; and

D9356 — Prior Approval Request for Psychiatric Assistance Dog.

For advise on what needs modifying in a client's home:

D1323 — Authority to install/ modify 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).

The RAP National Guidelines can be found on the DVA Website

3.7. Repatriation Pharmaceutical Benefits Scheme (RPBS)

The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides access to a wide range of safe and effective pharmaceuticals at a concessional rate.

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; and/or
- Items not listed on either the PBS or RPBS Schedules, if clinically justified.

Once a patient is discharged, a patient contribution (concessional co-payment) - is payable for each RPBS prescription up to a co-payment threshold, after which items are available without co-payment for the rest of the calendar year. (This is not inclusive of price premiums applicable to some items). Co-payment value is typically adjusted at the beginning of each year.

Prior approval of prescriptions: Prior approval is not needed to prescribe a large range of scheduled pharmaceuticals available under the RPBS.

You do need our prior approval to prescribe:

- Medicines listed as requiring prior approval;
- Greater quantities or repeats than those listed; or
- Medicines or items not listed in either the PBS or RPBS Schedules.

For RPBS prior approvals and enquiries contact the Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC) 24 hours per day on **1800 552 580**

3.7.1. Dose Administration Aid

The DVA Dose Administration Aid (DAA) service provides a DAA at no cost to eligible veterans who hold a Veteran Gold, White or Orange Card and reside in the community.

A DAA is a compartmentalised box or blister pack type device used to aid the administration of solid or oral medications, in accordance with requirements set out by the Pharmaceutical Society of Australia. In conjunction with the treating doctor (e.g. discharge doctor) and pharmacist, the DAA assists veterans to take the right dose of the right medicine at the right time.

To access the DVA DAA service, veterans:

1. Must hold either a Gold, White or Orange Card;
2. Must live in the community and not in a residential care facility or hospital;
3. Should meet the criteria for a Home Medicines Review (refer to MBS item number 900); and
4. Must be likely to benefit from the DAA service.

To learn more about how treating health professionals can prescribe DAAs, refer to Help clients access our medicine organiser service on the DVA website.

3.8. Transport Assistance

Entitled Persons with Veteran Gold or White Cards have access to transport assistance when travelling for approved treatment within Australia. Gold Card holders have access for the treatment of all conditions, while White Card holders have access for treatment of an accepted service-related condition or for treatment of a specific condition covered under Non-liability Health Care.

Travel for treatment assistance is defined under the *Veterans' Entitlements Act 1986* (VEA), the *Military and Rehabilitation and Compensation Act 2004* (MRCA) and the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA), which support travel to and from approved health treatment. Entitlements will vary for Entitled Persons based on the Act their eligibility is under.

Travel must be to the closest practical provider able to deliver the approved treatment. This is not necessarily the provider located closest in distance. Note that DVA may need additional information to confirm 'closest practical provider' status to support some transport assistance requests. If in doubt, Entitled Persons can contact DVA before they travel to confirm if further documentation may be required.

There are a number of transport assistance options available:

- **Reimbursement of travel expenses** is available under the VEA, MRCA and DRCA. For VEA, this could include full reimbursement of fares such as public and community transport and taxis, and payment of allowances for meals and accommodation (when travelling to the closest practical provider). For Entitled Persons under MRCA and DRCA, reimbursement of reasonable travel costs is available when travelling to approved treatment at the nearest suitable provider;
- DVA arranged transport for Entitled Persons under VEA, including **long distance travel** and the **Booked Car with Driver (BCWD) service,** where a local contracted taxi provider may take the Entitled Person to attend treatment or a medical appointment, and return journey home (when travelling to the closest practical provider) with no out-of-pocket expenses to the Entitled Person; and
- **Ambulance transport** (emergency and non-emergency when clinically required) is available for Entitled Persons under VEA, MRCA and DRCA.

Discharge planning staff can visit www.dva.gov.au/providers/travel-clients-treatment to find out more about transport options available and eligibility.

Clients experiencing financial hardship who are unable to pay for their travel to treatment upfront are also encouraged to contact DVA on 1800 VETERAN to discuss their transport needs.

3.8.1. Reimbursement of Travel Expenses

Entitled Persons with eligibility under the VEA have access to the Repatriation Transport Scheme (RTS). Under the RTS, Gold and White Card holders can receive assistance towards travel costs to attend approved treatment within Australia. This is includes contributions to accommodation, meals and a private vehicle kilometre rate. Travel to treatment options available to VEA clients include the full reimbursement of taxi, community transport and public transport fares. White Card holders must be travelling to receive treatment for an accepted service-related condition to be eligible for travel assistance.

For further information on reimbursement under the VEA, discharge planning staff can visit https://www.dva.gov.au/health-and-treatment/local-or-overseas-medical-care/claim-travel-expenses-under-rts

Entitled Persons with eligibility under the MRCA or DRCA also have access to transport assistance when travelling for approved treatment, but this is not under the RTS. Gold or White Card holders under MRCA and DRCA are able to access to transport assistance via reimbursement for the cost of reasonable expenses associated with travelling to attend approved medical treatment delivered by the closest practical provider. White Card holders must be travelling to receive treatment for an accepted service-related condition, or for treatment of a specific condition covered under Non-Liability Health Care (NLHC). Entitled Persons travelling by private vehicle, such as using their own car, the return journey must be more than 50 kilometres in order for their travel costs to be reimbursed under the MRCA or DRCA. For travel by taxi or public transport, there is no minimum distance required in order to be eligible for reimbursement.

For further information on reimbursement under the MRCA and DRCA, discharge planning staff can visit https://www.dva.gov.au/health-and-treatment/local-or-overseas-medical-care/we-may-repay-your-travel-costs-under-mrca-or

Expenses can be claimed by submitting a completed form available on the DVA website at https://www.dva.gov.au/sites/default/files/dvaforms/d0800.pdf or online via "My Account". DVA may request proof of expenses to verify a claim. Entitled Persons should retain receipts of $30 or more for a period of four (4) months from the date the claim is finalised.

3.8.2. DVA Arranged Travel (only available to Entitled Persons under the VEA)

Booked Car with Driver (BCWD) Service

Entitled Persons aged 80 years or over, or those who are legally blind (any age), or are suffering from dementia (any age), or meet one of the specified medical conditions, have access to the BCWD service, where DVA arranges taxi travel on behalf of a client with no out of pocket expenses.

Entitled Persons aged 79 years or younger can access the BCWD service to attend medical treatment if they meet certain criteria. Clients must be travelling to receive treatment of their specific service-related condition or conditions, and are travelling to specified treatment locations including hospitals, hearing services and medical specialists such as psychiatrists. The specified treatment locations do not include general practitioners, dental providers or allied health services (including psychology, clinical psychology or Open Arms – Veterans & Families Counselling).

Authorised health providers can arrange transport on behalf of a client. This can be done by:

- The online transport booking system;
- Phone: 1800 550 455;
- Fax: 07 3223 8382; or
- Email: bcwd.qld@dva.gov.au.

For further information on the BCWD service, discharge planning staff can visit https://www.dva.gov.au/health-and-treatment/local-or-overseas-medical-care/arrange-taxi-or-hire-car

Long Distance Transport (Air/Train)

DVA may arrange air and train transport when necessary to the needs of the Entitled Person, and when it is considered to be the most suitable and economical means of transport. This may include payment towards the costs of meals and accommodation.

Authorised health providers must email DVA at transport.long.distance@dva.gov.au to seek approval for and book long distance transport for Entitled Persons.

3.8.3. Ambulance Transport

Emergency and non-emergency ambulance services are available to Entitled Persons when clinically necessary to travel to and/or from, treatment. White Card holders must be travelling to receive treatment for an accepted service-related condition or for treatment of a specific condition covered under NLHC.

Entitled Persons can access non-emergency ambulance services if they meet one or more of the following criteria:

- Requires transport on a stretcher;
- Requires treatment during transport;
- Is severely disfigured; or
- Is incontinent to a degree that precludes the use of other forms of transport.

Prior approval is essential for all non-emergency ambulance bookings, noting the requirement for entitlement to non-emergency ambulance transport (as stated above) must be met.

All non-emergency ambulance bookings are to be organised by an Authorised Officer prior to the transport. Authorised officers include a health practitioner, hospital physician or discharge planner. Bookings for non-emergency ambulance travel cannot be made directly from the Entitled Person and/or family members.

The treating hospital should seek prior approval from DVA by emailing hsc.transport.policy@dva.gov.au and provide:

- Details of the Entitled Person such as name and DVA file number;
- Transport details: date, pick up and set down locations (name of facility and street address);
- Reason non-emergency transport is required, as per the above criteria.

Once approval has been received, the hospital makes the arrangements directly with a non-emergency ambulance transport provider to provide the service. Once the service is provided DVA is directly billed for that transport.

Discharge planners and hospital staff should contact DVA on 1800 550 455 to check eligibility where this is not clear before arranging non-emergency ambulance transport.

For further information on ambulance services, discharge planning staff can visit https://www.dva.gov.au/health-and-treatment/local-or-overseas-medical-care/ambulance-transport

3.9. Open Arms Veterans and Families Counselling (formerly VVCS)

Open Arms - Veterans and Families Counselling (formerly VVCS) is Australia's leading provider of high quality mental health services for Australian veterans and their families. Open Arms provides free and confidential counselling to anyone who has served at least one day in the ADF.

The Open Arms eligibility criteria also includes:

- Current serving Australian Army, Royal Australian Navy and Royal Australian Air Force personnel;
- ADF Personnel transitioning to civilian life;
- Ex-serving members;

- Partners and children of serving and ex-serving personnel;
- Ex-partners who are co-parenting;
- Reservists with one day continuous full time service or hazardous service; and
- Where there has been a death of a service person, parents and siblings can also access the service.

Open Arms provides free and confidential counselling and support for mental health conditions, such as:

- Posttraumatic stress disorder;
- Anxiety;
- Depression;
- Sleep disturbance;
- Substance misuse
- Anger;
- Relationship difficulties and
- General wellbeing support.

Open Arms counsellors are qualified clinicians 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;
- Services to enhance family functioning and parenting;
- Group programs;
- Information, education and self-help resources;
- Referrals to other services or specialist treatment programs; and
- Support is also available 24/7.

Support is also available 24/7 through Open Arms on 1800 011 046. Open Arms provides free confidential counselling to members of the veteran and ex-service community who need support.

Additionally, DVA can provide access to clinical services and has a website and app to support the mental health and wellbeing of serving and ex-serving ADF members and their families.

3.10. 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.
- **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: 1300 550 450 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 the 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 assistance caring for themself.
- **Respite care** can be provided in the following locations:
    - the Entitled Person's home;
    - a Commonwealth funded RCF (or a combination of both);
    - 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.

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; and
- 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 go to Benefits for prisoners of war and their dependants

- **CVC Social assistance**: Limited short term social assistance as part of the Coordinated Veterans' Care (CVC) Program is also available. . Social assistance is arranged through the VHC Assessment Agency and is only available to CVC participants and those already enrolled in the CVC Program.

For more information on Social Assistance as part of CVC head to the CVC webpage at: https://www.dva.gov.au/providers/health-programs-and-services-our-clients/coordinated-veterans-care/coordinated-veterans-0

3.10.1. 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. Contact should be made from a landline and not a mobile to make sure that the caller is directed to the correct assessment agency.

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. **Contact 1300 550 450.**

Copayments for VHC services:

Entitled Persons may be asked to pay a small contribution to service providers for Veterans' Home Care services as follows:

Service	Cost per hour	Maximum payable (capped)
Personal care	$5.00	$10.00 (per week)
Respite care	No co-payment	Not applicable
Domestic assistance	$5.00	$5.00 (per week)
Home and garden maintenance	$5.00	$75.00 (per year)
Social assistance	$5.00	$5.00 (per week)

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 Application Form for Co-payment waiver

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.

Household Services for Military Compensation Members (MRCA) and Safety Rehabilitation (Defence-Related Claims) Members (DRCA)

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

For information on Household Services available for MRCA and SRCA members, head to DVA Household Services

For information on accessing home assistance and attendant care assistance, head to Attendant Care

3.11. PSYCHIATRIC ASSISTANCE DOGS

The Psychiatric Assistance Dog Program is available to eligible Entitled Persons who have a diagnosis of posttraumatic stress disorder (PTSD). The Program aims to help the veteran meet their clinical recovery goals through having the trained dogs detecting signs of distress and performing tasks to assist with alleviating any symptoms.

To be eligible for a Psychiatric Assistance Dog, Entitled Persons must:

- Have a Veteran Gold or White Card;
- Have a diagnosis of posttraumatic stress disorder (PTSD) from a psychiatrist;
- Have been undergoing treatment with a psychiatrist or psychologist for your PTSD for at least 3 months; and
- Be assessed as having the emotional resilience needed to be involved in the training and care of a psychiatric assistance dog.

If a veteran is found eligible they must have their mental health professional submit the Physiatrist Assistance Dog application form and attach any supporting documentation. The application form can be found at https://www.dva.gov.au/about-us/dva-forms/d9356-request-assistance-dog

Mental health professionals who can prescribe a psychiatric assistance dog include:

- Psychiatrists;
- Psychologists;
- Mental health social workers; and
- Mental health occupational therapists.

DVA does not reimburse for any expenses incurred by DVA clients that have obtained assistance dogs outside of DVA's current processes.

More information regarding the Program can be found at: https://www.dva.gov.au/providers/rehabilitation-appliances-program-rap/rap-national-guidelines/providers-only-assistance

4. COORDINATED VETERANS' CARE (CVC) PROGRAM

Coordinated Veterans' Care (CVC) is a proactive coordinated care program that aims to improve participant quality of life and decrease the risk of unplanned hospitalisation. Delivery of the program is by the participant's GP, and assists Veteran Gold Card holders with chronic conditions and Veteran White Card holders with DVA – accepted mental health conditions to manage their health conditions and reduce unplanned hospitalisations.

The Program achieves this by increasing the participant's understanding of health issues; improving communication between the participant, their GP and other health care professionals; and providing support to self-manage conditions through the development and use of an individual Care Plan. The care team generally comprises of the participant, their GP and a care coordinator.[3]

Eligibility: The CVC Program is for veterans who are at risk of unplanned hospitalisation and hold either:

- A Veteran Gold Card and have one or more chronic health condition/s; or
- A Veteran White Card and have a chronic DVA-accepted mental health condition.

In addition, the individual is likely to also have the following complexities:

- An unstable condition(s) with a high risk of acute exacerbation;
- A condition which is complicated by frailty, age and/or social isolation;
- 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 before enrolling them in the program.

Restrictions: Access to CVC is <u>not available</u> to Veterans if they:

- Live in a Residential Aged Care Facility;

[3] A care coordinator may be a practice nurse in the GP's practice, or an Aboriginal and/or Torres Strait Islander Health Worker, or a community nurse (from a DVA contracted community nursing provider).

- Are a Veteran White Card holder who does not have a DVA-accepted mental health condition. However they can still receive mental health treatment through Non-Liability Health Care (see Section 1.3.3);
- Have been diagnosed with a condition/s that, in their GP's opinion, would likely be terminal within 12 months of initial enrolment; and/or
- Are a current participant in the Department of Health and Aged Care Transition Care Program.

> Where it is seen as beneficial, the hospital may recommend to the Entitled Person that they arrange an appointment with their GP for an assessment for the CVC Program.

4.1. Coordination – Admission to hospital

The Hospital will contact the patient's GP and/or care coordinator (details will be on the Care Plan) to advise them that the patient has been admitted to hospital and discuss the best way to coordinate the discharge process.

The GP/care 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 Care Plan; 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 care coordinator will liaise with the hospital during a **planned admission** and follow up with the participant on discharge.

4.2. Coordination - Discharge from hospital

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

5. *COMMONWEALTH INITIATIVES*

5.1. My Aged Care

"My Aged Care" is the Australian Government's starting point in navigating aged care services. The My Aged Care contact centre team and the My Aged Care website are designed to guide older people to navigate and enter the aged care system in a streamlined way.

The first step is to determine the type of care that is required. This may include home services, short-term/respite care or residential aged care. The second step is to apply for

subsidised aged care by calling the My Aged Care contact centre on 1800 200 422 to arrange an initial discussion with the contact centre staff. The next step may be a face-to-face assessment.

Following the face-to-face assessment, the assessor will make a decision regarding whether the client is eligible for government-funded services – and if so, what services they are eligible for.

There are two types of assessments:

- Home support assessment with a Regional Assessment Service (RAS) which assesses for the Commonwealth Home Support Program; and
- Assessment for a Home Care Package, a short term care option, and/or subsidised aged care home – undertaken through a Comprehensive Aged Care Assessment Team (ACAT) assessment.

Read more about the assessment decisions for:

- Home Care Packages;
- Short-term restorative care;
- Residential respite care;
- Transition care; and
- Aged care homes.

Suggested websites that can be recommended to patients include:

- https://www.myagedcare.gov.au/
- https://agedcare.health.gov.au/

My Aged Care 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 Program (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 My Aged Care website: or by phoning the My Aged Care contact centre on **1800 200 422**

(Mon-Fri: 8.00am to 8.00pm, Sat: 10.00am to 2.00pm).

5.2. Hearing Services

Hearing services are provided to Entitled Persons under the Australian Government Hearing Services Program (HSP). This is managed by the Department of Health and Aged Care, with hearing services provided through a network of public and private contracted providers. Online information is available at: www.hearingservices.gov.au.

Accessing Services:

DVA clients apply directly through the HSP website at www.hearingservices.gov.au. A Local Hearing Services Provider can also complete the application on the veteran's behalf. Please note, veterans will need a medical certificate from their medical practitioner/GP when applying for the first time to confirm that the applicant can be fitted for a hearing device if one is needed.

Service Providers:

Services are provided by over 270 hearing services providers at over 3,000 sites across Australia. To locate a hearing services provider, refer to: http://www.hearingservices.gov.au/locateprovider

For Veteran specific information on Hearing Services, refer to the Department of Health and Aged Care HSP webpage at: http://www.hearingservices.gov.au/veteran specific services

The Hearing Services Program offers Veteran Specific services which may include:

Contact the Department of Health and Aged Care regarding the Australian Government Hearing Services Program directly on **1800 500 726** or

through the National Relay Service (NRS) on **1800 555 660**

- Choice of hearing services provider;
- A comprehensive hearing assessment;
- Ongoing advice and support;
- If needed, access to a range of fully subsidised hearings devices to assist in managing hearing loss, and a contribution to maintenance and repair; and
- Alternative listening devices, such as devices to assist with listening to the TV or the phone.

5.3. 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.[4]

The CHSP commenced on 1 July 2015 and brought together four programs:

- Commonwealth Home and Community Care (HACC) Program;
- Planned respite from the National Respite for Carers Program (NRCP);
- Day Therapy Centres (DTC) Program; and
- Assistance with Care and Housing for the Aged (ACHA) Program.

There are different services under the CHSP to help clients manage their day-to-day activities.

The types of services available, depending on the client's needs to manage their day-to-day activities include, but are not restricted to:

- Transport to appointments and activities;
- Domestic help (e.g. house cleaning, washing clothes);
- Personal care (e.g. help with showering or dressing) y home maintenance (e.g. changing light bulbs, gardening) y home modifications (e.g. getting a grab rail installed);
- Aids and equipment (e.g. bath seat, raised toilet seat, mobility aids);
- Meals, help with food preparation and cooking skills, nutrition advice;
- Nursing (e.g. managing medication);
- Allied health (e.g. podiatry, physiotherapy, occupational therapy);
- Social support (e.g. accompanied activities, group excursions); and
- Respite (care for you while your carer takes a break).

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.

CHSP is accessible to older Australians through the **My Aged Care** website or the **National My Aged Care Contact Centre on 1800 200 422.**

[4] "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.

6. CONTACT INFORMATION

6.1. DVA FUNDED PROGRAMS

DVA General Enquiries (Business Hours)	1800 838 372
DVA Transport Bookings	1300 550 455
Health Approvals and Home Care Health.Approval@dva.gov.au	1800 550 457 *Press 3: Health Prior approvals and enquiries*
Veterans' Affairs Pharmaceutical Approvals Centre (VAPAC)	1800 552 580 (24 hours per day)
Veterans' Home Care Assessment Agency	1300 550 450 (calls from standard landlines only)
Veterans' MATES	1800 500 869 (Prescribers) 1300 556 906 (Veterans)
Counselling Services (OPEN ARMS VETERANS AND FAMILIES COUNSELLING) 24 HOUR Veterans Line	1800 011 046 (24 hour support)

6.2. EXTERNAL CONTACTS

My Aged Care www.myagedcare.gov.au/	1800 200 422 Mon-Fri: 8.00am to 8.00pm Sat: 10.00 to 2.00pm
Aged Care Complaints (Aged Care Quality and Safety Commission) https://www.agedcarequality.gov.au	1800 951 822 Online claim form https://www.agedcarequality.gov.au/making-complaint/lodge-complaint
Commonwealth Department of Social Services www.dss.gov.au	1300 653 227
Councils on the Ageing (COTA) Member Services https://www.cota.org.au/	1300 140 050
Alzheimer's Association Help Line https://www.dementia.org.au/helpline	1800 100 500

Dementia Behaviour Management Advisory Service (24 hour line)	1800 100 500 (24 hours per day)
Carers Australia https://www.carersaustralia.com.au/	1800 422 737
Dementia and Cognition Supplement in Home Care https://www.health.gov.au/topics/aged-care/providing-aged-care-services/funding-for-aged-care-service-providers/dementia-and-cognition-supplement-for-home-care?language=ru	1800 195 206

Veterans' Supplement in Home Care https://www.dva.gov.au/health-and-treatment/care-home-or-aged-care/aged-care/extra-funding-your-home-care-package-provider	1800 550 457
Home Care Packages Program, MyAged Care national contact centre https://www.myagedcare.gov.au/help-at-home/home-care-packages	1800 200 422
Commonwealth Respite and Carelink Centres https://www.myagedcare.gov.au/short-term-care/respite-care	1800 200 422
The Partners of Veterans Association of Australia www.pva.org.au/	1300 553 835
Aged & Community Services Australia https://www.acsa.asn.au/	1300 222 721 Email: info@accpa.asn.au
Hearing Services Program– Department of Health and Aged Care www.hearingservices.gov.au	1800 500 726 Email: hearing@health.gov.au
Reach Out (includes online information for young carers) https://au.reachout.com/	02 8029 7777

Discharge Planning Flow Chart (from pre-admission to discharge)

Confirm Eligibility

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

Identify key people/issues

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

Develop a discharge plan

- Establish a multidisciplinary team by nominating and contacting relevant health service providers
- Involve community health and service personnel
- Review medications - ensure appropriate supply and confidence to use
- Consider need for DVA administered services eg DVA transport, DVA nursing, Veterans' Home Care, VVCS Counselling,
- Arrange an Aged Care Assessment Team (ACAT) visit - if appropriate
- Establish an expected time and date of discharge
- Assess eligibility for non-DVA administered programs

Address common issues

- Manage expectations - recovery time frames and pathways; short term and ongoing changes to health and lifestyle
- Confirm date and time of discharge with the veteran and their carer
- Provide information - self help strategies, local support groups and community services available
- Address common issues raised by veterans
- Arrange assessments & referrals (where required) - e.g. Community Nursing; Veterans' Home Care; Rehabilitation Appliances Program; Counselling services and hearing services

Avoid delays

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

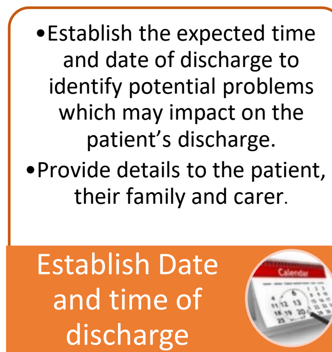
Discharge documentation

- Provide veterans staying overnight with the "DVA Patient Experience Survey"
- Complete "Discharge Advice and Hospital Claim (D653A)
- Ensure veteran and carer readiness to leave hospital at the agreed time.
- Confirm services extablished 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
- Provide private xrays, scans, medical documents, medicines and personal belongings
- Organise transport home and to follow up appointments

Post Discharge monitoring

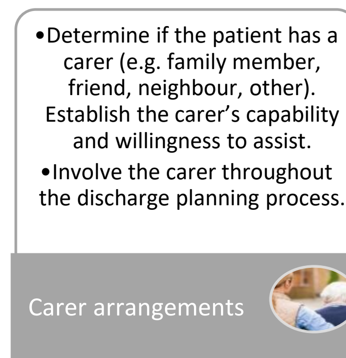
- Contact the Entitled Person to assess their coping ability and to address concerns
- Contact the treating doctor to identify if a medicine review and/or health assessment has been organised etc
- Evaluate discharge procedures

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.

Establish Date and time of discharge

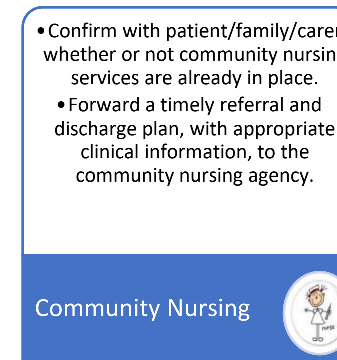


- Determine if the patient has a carer (e.g. family member, friend, neighbour, other). Establish the carer's capability and willingness to assist.
- Involve the carer throughout the discharge planning process.

Carer arrangements

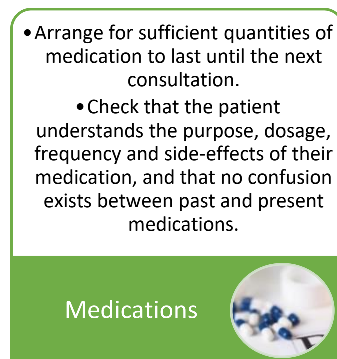
- Consult an Occupational Therapist or other relevant allied health professional to resolve potential mobility issues.
- Discuss the supply of aids and appliances, and the need for any home modifications.
- Assist with providing or arranging instruction on the use of aids or appliances as necessary.

Mobility and independence



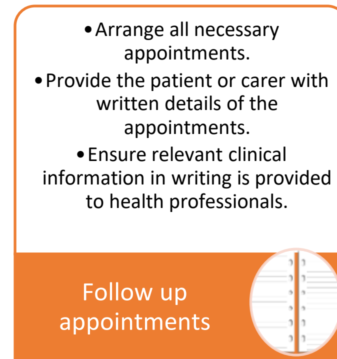
- Confirm with patient/family/carer whether or not community nursing services are already in place.
- Forward a timely referral and discharge plan, with appropriate clinical information, to the community nursing agency.

Community Nursing



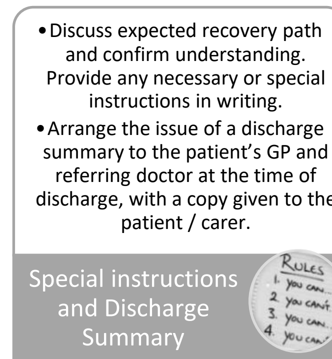
- Arrange for sufficient quantities of medication to last until the next consultation.
- Check that the patient understands the purpose, dosage, frequency and side-effects of their medication, and that no confusion exists between past and present medications.

Medications



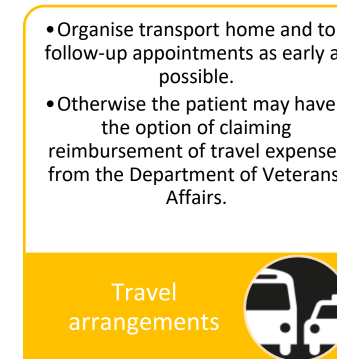
- Arrange all necessary appointments.
- Provide the patient or carer with written details of the appointments.
- Ensure relevant clinical information in writing is provided to health professionals.

Follow up appointments



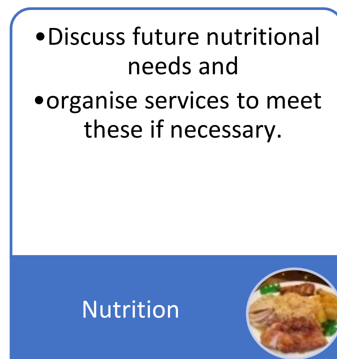
- Discuss expected recovery path and confirm understanding. Provide any necessary or special instructions in writing.
- Arrange the issue of a discharge summary to the patient's GP and referring doctor at the time of discharge, with a copy given to the patient / carer.

Special instructions and Discharge Summary



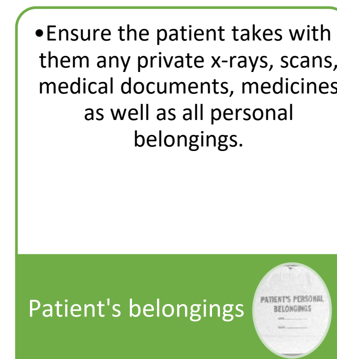
- Organise transport home and to follow-up appointments as early as possible.
- Otherwise the patient may have the option of claiming reimbursement of travel expenses from the Department of Veterans' Affairs.

Travel arrangements



- Discuss future nutritional needs and
- organise services to meet these if necessary.

Nutrition



- Ensure the patient takes with them any private x-rays, scans, medical documents, medicines as well as all personal belongings.

Patient's belongings