NATIONAL TREATMENT MONITORING COMMITTEE (NATMOC)

51st Meeting

Thursday 27 November 2008

Hobart, Tasmanian

MINUTES

Present	Mr Ian Campbell, (Chair), President, Repatriation Commission
	Mr Ed Killesteyn, Deputy President, Repatriation Commission
	Brigadier Bill Rolfe (Retd) AO, Commissioner, Repatriation Commission
	Mr Ken Douglas, General Manager, Service Delivery
	Mr Barry Telford, General Manager, Policy and Development
	Ms Jennifer Collins, National Manager, Primary Health
	Mr 'Blue' Ryan OAM, Australian Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women
	Mr Simon Agnew, National Legacy
	Air Vice Marshal John Paule Regular Defence Force Welfare Association
	Mr Colin Doust, Australian Veterans and Defence Services Council
	Mrs Audrey Blood, War Widows' Guild of Australia
	Mr Ted Richards, Returned & Services League of Australia
	Ms Donna Reggett, Australian Peacekeeper & Peacemaker Veterans' Association
	Mr Brett Bullians, Vietnam Veterans Association of Australia
	Mr Gerry Mapstone, Vietnam Veterans Federation
	Ms Kate Golotta, NATMOC Coordinator
	Ms Kelly Pring, DVA APS Graduate
Apology	Dr Graeme Killer OAM, Principal Medical Adviser, Department of Veterans' Affairs

1. Opening

1.1 Welcome, apologies, adoption of Agenda

The Chair opened the meeting by welcoming everyone to Hobart for the 51st NATMOC meeting.

The Chair formally welcomed Mrs Audrey Blood National President Widows' Guild of Australia, who has formally replaced Mrs Norma Whitfield as the NATMOC representative for the WWG.

The Chair introduced and welcomed Ms Elizabeth Quinn, Deputy Commissioner Tasmania to the meeting.

The Chair noted that Dr Killer was unable to attend the meeting and wished to extend his apologies.

The members formally adopted the agenda. The Chair noted that Mr Ryan and Ms Reggett had additional agenda items which would be covered by Mr Douglas under agenda item 5. Air Vice Marshal (AVM) Paule noted that he had an additional agenda item on Hearing. The Chair noted that he could address this under agenda item 11 – Other Business.

1.2 Minutes of the previous NATMOC meeting (10/04/07)

The members accepted the minutes of the previous meeting as an accurate record of the meeting. Mr Bullians stated that he had some feedback on the Darwin meeting which he passed to Mr Douglas. The information concerned the scheduling and the times of the Darwin meeting. The Chair noted that with the Minister in Darwin at the same time and the scheduling of flights in and out of Darwin there had to be a re-shuffle of the schedule for the day.

1.3 Matters arising from the previous Minutes

Minutes of the previous NATMOC meeting (29/11/07)

3. DVA / Defence Links

Mr Ryan asked the Chair on the progress of the multiple agencies issue as his understanding was that ComSuper were happy to accept DVA reviews where DVA could show that the TPI had contact with the treating practitioner. Mr Ryan also asked about the level of involvement from the Department of Employment, Education and Workplace Relations (DEEWR) in the process. The Chair noted that he would look into this issue for Mr Ryan. *Action: The Chair to follow-up on the level of involvement of DEEWR in multiple agencies and provide an answer to Mr Ryan.* The Chair informed the Committee that Mr Killesteyn would cover this issue in his briefing in agenda item 3.

6. Mental Health Update

Mr Telford noted that the Suicide Study's draft Terms of Reference were discussed at the last Mental Health and Wellbeing Forum and amended, and the Minister now had the Terms of Reference (TORs) and the amendments. Mr Ryan enquired why all ESOs did not see the TORs. Mr Telford noted that the TORs were only discussed at the forum. Mr Telford offered to forward a copy of the TORs to Mr Ryan. *Action: Mr Telford to provide Mr Ryan with a copy of the Suicide Study's draft Terms of Reference.* Both Mr Ryan and Mr Telford

noted that this action had been completed.

2. Review of the State TMC minutes

Mr Douglas provided an update on the TMCs by noting the comprehensive set of minutes from the various TMCs. Mr Douglas stated that the minutes included the standard items of complaints and compliments. He also noted that at the last TAS TMC meeting, the members had an interesting presentation on Dementia and Mental Health.

AVM Paule noted that in the QLD TMC minutes there was reference to a co-payment for the transfer of files from one doctor to another. Mr Douglas said that this should not have occurred but that if the veteran paid it would become a Medical Expenses Privately Incurred issue (i.e. the veteran could seek reimbursement from the Department) and it does not appear to be a prevalent practice.

Mr Doust queried the NSW TMC minutes and the figures quoted in relation to Lady Davidson Hospital. Mr Douglas commented that the figures were indicative of the increase in availability of access to hospitals. Ms Collins noted that Concord hospital had the greater throughput in NSW and that Lady Davidson is a relatively small hospital with a focus more on rehabilitation.

Mr Doust also sought clarification from the NSW minutes in relation to the suggestion to contact local VAN Offices with any queries. Mr Doust raised the concern that some of the VAN offices may not be able to handle the queries raised. Mr Douglas stated that the suggestion to call is dependent on the type of query and that generally a call to VAN may be the better option for some people. Mr Douglas further added that should the members have any specific concerns about the answering of calls to please forward this through to the Department.

Ms Reggett raised the concern that she had recently put a call through which had been answered by the VSC and the officer refused to speak with her further as she had her phone on 'hands free' so that the client could participate in the conversation as well. The reason given to Ms Reggett was for privacy reasons. Mr Douglas stated that he would follow-up on this, as to whether or not there were privacy implications.

Action: Mr Douglas to follow-up on the privacy implications of conversations between DVA staff and clients on hands-free speaker phones.

Ms Reggett also raised the concern of being transferred by staff through to various sections of the Department during State-specific public holidays. The Chair asked that staff be made aware of this issue when transferring calls. Mr Douglas noted that this type of notification did occur but that it would be reinforced to staff.

Mr Doust sought clarification about the VIC TMC minutes whereby it was stated that there were three occurrences where veterans had been charged additional

fees – these being - pathology tests, administrative surgical fees and additional charges for MRI scans. Mr Douglas informed the members that he would be covering the first two issues under agenda item 5. With regards to the additional fee for MRI scans Mr Douglas noted that MRI scans are covered by the Gold Card and if an issue presented where the Gold Card was not accepted by a facility then this should be brought to the Department's attention.

Ms Reggett raised the issue that a number of doctors' surgeries had advised that they were not aware on how to use the Booked Car With Driver (BCWD) system. Mr Douglas noted that there had been work done surrounding promotion of the system however would take the comments on board and assess other options for raising awareness.

Action: Mr Douglas to investigate the possibility of developing wallet size cards for cardholders to provide as assistance for doctors' surgeries unfamiliar with the BCWD process.

3. DVA / Defence Links

Mr Killesteyn referred to the accompanying information that was provided to members prior to the meeting. Mr Killesteyn noted that he had been now reporting on this agenda item for almost three years now and discussed the three main activities surrounding DVA/Defence Links being the short term practical initiatives; legislative and policy issues and machinery of government issues.

Mr Killesteyn reported that at the Interdepartmental Working Group (IWG) meeting in October, Defence confirmed the ADF ID card as a Category B document for proof of identity purposes worth 40 points and that Defence have written to other Department Secretaries/Chief Executive Officers requesting acceptance of this decision in relation to use of the ADF ID card for identity purposes. Mr Killesteyn note that DVA has already had Commissions' approval to accept the ID card as a Category B document.

Mr Killesteyn informed the Committee that ComSuper have recently completed a data matching exercise and that of the 2000+ cases reviewed, 246 identified were TPI and they will now be advised that ComSuper will permanently defer further reviews. The review of long term MRCA and SRCA incapacity clients against ComSuper clients will commence shortly.

Mr Killesteyn notified the members that the information booklet containing details and contacts for whole of government services was currently in production and planned for distribution to ADF members from December this year.

Mr Killesteyn noted that the Separation Health Examination (SHE) trial commenced in the ACT and Wagga regions on 3 November 2008 and an interim evaluation will be conducted in February/March 2009, and a final evaluation in May 2009.

Mr Killesteyn provided the members with an update on the Policy Working Group, which is currently working on aligning policy and establishing business

rules to ensure agencies are aware of, and able to base decisions on the same or similar policy guidelines ensuring consistency in decisions across agencies. The first policy area being aligned is marriage-like relationships.

Mr Richards sought an update on the progression of providing medical records on disc to ADF personnel. Mr Killesteyn informed the members that this had been raised at the last meeting, where Defence confirmed they were still looking into it. Mr Killesteyn offered to report back to the members on the progression of this at the next meeting. Mr Doust sought clarification of the type of medical records that would be placed on the disc. Mr Killesteyn again undertook to report back on this to next meeting.

Action: Mr Killesteyn to report back to members at the next meeting on the progression of providing medical records on disc to ADF personnel.

Mr Ryan sought an update on the multiple agencies issue especially as regards the complexity of DFISA. Mr Killesteyn informed the members that it is on the agenda for discussion with the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) which has significant responsibility for any policy changes. Mr Killesteyn noted that there were some complexities of shifting the responsibility of payments. The Chair noted that both sides are supportive and are moving forward but want to ensure that it will be undertaken with simplicity and on a cost-neutral basis to Government.

4. Health Studies

Commissioner Rolfe referred to the paper that was provided to all members prior to the meeting and briefly discussed the Family Study program and referred to the table in the papers, noting the number of those participating in the study. Commissioner Rolfe also referred to the additional handouts that the members had received which included copies of the letters and brochures that were sent to participants.

Commissioner Rolfe informed the members that there was work being undertaken in assessing other methods of communication, as well as hope that more press advertisement would also encourage take up of the program. There is recognition that the program has not reached high numbers at this stage but the Centre for Military and Veterans' Health (CMVH) finds the numbers to date are encouraging. Commissioner Rolfe concluded the agenda item by noting that there was a range of research work being undertaken, one of which is assessing the way in which DVA uses the data it collects.

5. Health Service Delivery Update

Mr Douglas provided an update on a number of the Department's Health Service Delivery arrangements and referred to the summary paper provided to the members prior to the meeting.

5.1 New D800 travel reimbursement form/ Booked Car with Driver IT system

Mr Douglas noted that an IT system change resulted in the need to redesign the D800 *Claim for Travelling Expenses* form and so DVA took this opportunity to make the form more user friendly by spacing out the questions and using bold type to highlight key parts of the form. The receipt threshold to substantiate travel has also been increased from $10 to $30 and the form now includes space for a person such as a practice manager, nurse, or receptionist to certify the information on behalf of the health provider. The D800 form now covers travel for treatment under the *Australian Participants in British Nuclear Test (Treatment) Act* 2006, which means that there is only now one form.

Mr Douglas informed the members that focus testing was conducted with members of the veteran community in both a city (Sydney) and non-metropolitan area (Wagga Wagga). Mr Douglas noted that an article advising veterans about the new form appeared in the September edition of *Vetaffairs*, and flyers and letters were also sent to key health provider bodies advising them of the change. Mr Douglas referred to the copy provided to members in their meeting package.

Mr Douglas also informed the members that DVA is undertaking a review over the next few months to identify options for the updating of the BCWD system to ensure that this service is maintained at a high level into the future. Mr Ryan asked if the mileage allowance was regularly reviewed by DVA.

Action: Follow-up on the timeframes for reassessment of the mileage allowance.

5.2 Release of revised RAP National Schedule of Equipment

Mr Douglas briefed the members on the revision of the RAP Schedule. The RAP National Schedule of Equipment lists 269 aids and appliances available on the basis of clinically assessed need. The Schedule also sets out the request procedures and protocols for each item that health providers are required to follow.

Mr Douglas noted that the RAP Reference Committee, in conjunction with DVA staff and advisers, agreed that after five years it was timely to undertake a full-scale review of the Schedule. The Commissions approved the revised Schedule in full on 11 August 2008 and a flyer outlining the outcomes of the Review was distributed to professional organisations in September 2008, and was also provided to the members for their information.

5.3 RAP Retendering

Mr Douglas informed the members that in 2007 – 2008, the value of RAP products supplied under contract was $89 million. An additional $15 million is spent on direct purchasing of specialised and custom-made products under either the Rehabilitation Appliances Program (RAP) or programs additional to RAP such as Medical Grade Footwear (MGF), HomeFront and the Veterans' Home Maintenance Line (VHML).

Mr Douglas noted that many of the current contracts for the supply of RAP products end in 2009 and 2010, and DVA is required to approach the market and

issue a tender to allow suppliers who can meet DVA's requirements to bid for the supply of RAP products. DVA is in the process of analysing the various options for efficiently and effectively procuring RAP products in the future. Currently no final decisions has been made and it is expected a report to the Commissions in the next month will detail the expected steps for the future.

The Chair asked Mr Douglas if RAP had experienced growth and Mr Douglas indicated that the expected peak is in 2008-09. Mr Doust sought clarification about the transportation of RAP products as he recently experienced a few issues when goods were supposed to be delivered and no notes were left from the transportation company. Mr Douglas stated that he would follow up on this to see if there was a large problem or just a small number of cases.

Action: Mr Douglas to follow-up on the transporting of RAP products and seek as to whether there have been other similar issues reported.

5.4 Online Claiming

Mr Douglas briefed the members on the introduction of online claiming which is essentially where the voucher system is being removed and providers are able to claim directly from Medicare Australia (MA). Mr Douglas noted that online claiming is a collaborative project between DVA and MA which enables paperless electronic claiming for DVA Medical, Private Hospitals, Allied Health providers and Community Nurses.

The benefits of online claiming were noted as allowing providers/hospitals to submit DVA claims electronically for processing and payment, reducing practice administration and management costs and allowing for less manual intervention. Mr Douglas informed the members that DVA have met with MA to put together a strategy to promote online claiming with the aim to increasing uptake, and MA have reported medical online claiming has increased from 38% for the January – March quarter to 68% for the July - September quarter 2008. It was noted that online claiming should also mean less complaints from health providers by reducing claim times and delays if lodged electronically. Currently there are two private hospitals using In Hospital Claiming and Allied Health is the latest modality to be developed online.

5.5 VVCS tender update and program update

Mr Douglas referred the members to the material in the summary briefing paper and reported the following matters in relation to VVCS as advised to him by the National Manager, VVCS:

Mr Douglas noted that Quality Improvement Council (QIC) accreditation is being undertaken by VVCS. This is the third round of accreditation with QIC and involved an independent review team visiting the major VVCS locations and assessing VVCS systems and processes against community and mental health standards of service delivery. Mr Douglas informed the members that request for tenders for the Operation Life Workshops have now closed and 23 tenders were received. These tenders are currently being evaluated.

The VVCS audit of group programs has been completed by the Australian Centre for Posttraumatic Mental Health (ACPMH) and the final report is expected in the next two weeks. Evaluations of all Anger, Lifestyle and Health and Wellbeing programs conducted between July 07 and June 08 are being reviewed by each Centre to assess reasons and explanations for variability in results

It was noted that the Stepping Out Program continues to be promoted with the second round of advertising in ADF newspapers about to be placed, but take up is slow and numbers are still small at this stage. Mr Douglas noted that VVCS will participate in the case management and family support trial for ADF members transitioning from Defence. This is being overseen by ACPMH

Mr Douglas briefed the members on the Mental Health Competency Training for community-based mental health providers, which is being developed by ACPMH and being supported by VVCS. DVA and VVCS contracted providers will be the initial target group for new training modules for providers on mental health interventions for veterans and their families. The ADF and VVCS Service Agreement which will enable ADF to refer serving members to VVCS for counselling is about to be finalised. This will be overseen by a joint steering committee and implementation supported with a joint road show to inform ADF and VVCS staff in early 2009.

Ms Reggett sought clarification on the referral to VVCS. Mr Douglas clarified that serving members can access VVCS separately but if Defence refers a member for counselling then VVCS is one of the options for the referral of cases. Ms Reggett also asked about the option to undertake Stepping Out, even if after the 12 month period of leaving the ADF. Mr Douglas suggested that Ms Reggett speak with the individual VVCS Directors since whilst the program is specifically targeted for these members, it may be possible to undertake the program at a later date if it is considered to be appropriate for the client.

AVM Paule asked about the eligibility for accessing VVCS. Mr Douglas informed the members that the eligibility for VVCS is contained within the Treatment Principles of the VEA and to call VVCS where unsure. He noted that, in general, eligibility was based on having operational service Mr Doust sought clarification about the possibility of repeating the lifestyle and heart health programs if already completed by a client. Mr Douglas stated that usually this would not occur but if a VVCS counsellor made a clinical decision and thought it to be appropriate, then access may be granted.

5.6 Medical and Allied Health Update

Mr Douglas spoke to the members about Medical and Allied Health, including the processing of prior approval requests which has been consolidated into the Adelaide office for almost a year now. The decision to consolidate the functions in one location is to gain efficiencies and standardisation which has been achieved, although there were some small teething problems in the initial days.

Mr Douglas noted that there has been an emphasis placed on staff training of

processes and policy and the establishment of close working relationships with their colleagues in associated areas of the Department, together with more structured input from Clinical Advisers, which has meant that the Adelaide M&AH team are now consistently meeting their processing and quality benchmarks.

In September this year, 4 418 prior approval requests were processed and 13 735 phone calls were taken by the team. The top three request categories are specialist consultation approvals including – non-Medicare Benefits Schedule items, dental approvals, and White Card holder approvals - mostly operations.

Mr Douglas referred to the following six items raised by Mr Ryan and provided the members with a briefing on the initial request and DVA's response.

a) GP Payments - Medicare bulk billing items and VAP incentive payments - Item 10991 until the 1st of November attracted a fee of $9-80 via the Gold Card for certain items carried out. Is it correct that this payment has been discontinued?

Items 10990 and 10991 are the Medicare Bulk Billing Incentive Items. In May 2006, the DVA Veteran Access Payment was aligned with these items and paid on the same basis. An incentive payment is made for all GP-related items that are under the categories of professional attendances and services provided by Nurse, Allied and Dental Health Professionals. Incentive payments are not payable for procedures or diagnostic work. This is because as part of the May 2006 changes, GPs were given access to the Repatriation Medical Fee Schedule (RMFS) and paid on the same basis as specialists. For most procedures, this means that they moved from a payment of 115% of the MBS fee + VAP, to 140% of the MBS fee for an out of hospital service. The removal of the incentive payment ensures that specialists and GPs are paid the same fee for the same work.

A GP through the National Advisory Committee of the VVCS and a Practice Manager through the AMA have raised concerns that Incentive Payments are no longer applied to services provided by Practice Nurses and ECGs. It has always been DVA's intention that practice nurse items would continue to attract an incentive payment and feedback from Medicare Australia indicates that this is the case. For ECGs, these are funded under the RMFS arrangements at 140% of the MBS fee and therefore do not attract an incentive payment. The DVA fee is $40.40 whereas Medicare funds the equivalent service at 75% of MBS. GPs should not have been claiming an incentive payment for this item and the system change now ensures that they get paid the same fee as a diagnostic specialist for this service.

b) Gold Card CPI Increase - Is it correct that the Gold Card CPI fee increase for GPs was 2.3% when the yearly CPI was 5% and that the medical CPI accepted level is 8%?

All Australian Government medical and other health fees are indexed by WCI-5. WCI-5 for 2007/08 was 2.3%. The CPI for the same period was 4.5% and the

Health CPI was 4.8%. The Australian Bureau of Statistics (ABS) also notes that the CPI increase to the end of June 2008 excluding housing and financial and insurance services was 3.3%.

c) 12 Month prescriptions – Blister Packs - There was an election commitment to extend prescription to cover a 12 month period and to introduce the use of Blister Packs. Can you provide an update on this?

There was an announcement in the Budget that people with chronic conditions would be able to get extended prescriptions from their doctor for a designated range of pharmaceuticals. This initiative was intended to commence on 1 July this year but is dependent upon an assessment by the Pharmaceutical Benefits Advisory Committee of those pharmaceuticals suitable for this arrangement. This work is well under way and an announcement from the Department of Health and Ageing on this is expected shortly.

Blister packs and the Dose Administration Aid (DAA) have been introduced and there has been a steady increase in the uptake of these. Ms Reggett referred to a case where a fee had been incurred for the use of a blister pack. Mr Douglas noted that there must be a prescription for this otherwise there will be a fee. Mr Telford added there were some cases where a blister pack is not suitable for some medicines and this is at the discretion of a GP. The 12 month prescription initiative is expected within this financial year.

d) Specialist theatre booking fees - This issue relates to two specific cases where a specialist booking fee was charged to veterans undergoing surgery – the first case in Latrobe Private Hospital and the second concerned with an orthopaedic surgeon.

Any contracted hospital charging veterans fees of the sort outlined above is in breach of its contract with DVA. Veterans who are billed in this way should contact the Department who will organise either the withdrawal of the bill or reimbursement by the hospital. The exception to this is where the veteran has agreed to meet the cost of a private room.

Case One: A phone call was made to the Veteran Liaison Offer (VLO) at Latrobe Private Hospital (LPH) on Thursday, 13 November 2008 to investigate the matter. The VLO advised that a visiting doctor books one of the consulting suites at LPH to perform minor procedures on his patients. The patients are not inpatients or day patients of LPH and they do not appear in the hospital records. LPH provides a nurse for the procedures and bills the doctor for the cost of consumables, nurses salary and use of the room.

The $75.00 referred to is a procedure room fee charged by the doctor to his pensioner patients. However, the VLO assures DVA that veterans are not charged this fee on the understanding that the treatment item claimed by the doctor through DVA compensates for the costs incurred in the consulting suite.

The Chair asked that this issue be followed up with the veteran concerned and the VLO at the hospital to investigate as to whether this is a one-off or a systematic problem.

Action: Mr Douglas to follow-up with the veteran and the VLO concerned to investigate as to whether this is a one-off problem or a systematic problem.

Case Two: An orthopaedic surgeon who operates in the Albury area charges patients a theatre booking fee of $350.00 (cash only) which must be paid prior to surgery. The patient is obliged to sign a Theatre Booking Fee form consenting to this payment. The doctor explains on the form that the fee is required because of: "the significant explosion in medical defence fees levied each year".

This doctor is one of three or four specialists who have come to DVA's attention, nationally, for this practice and they are also known to charge the same rate for all patients, regardless of whether they are entitled veterans or not.

When DVA becomes aware of such cases, its practice is to contact the specialist's rooms and attempt to dissuade the charging of the out-of-pocket fee to veterans. In addition assistance is offered to the veteran to access alternative specialists who accept the DVA schedule fee.

DVA's investigations into this issue have found that there are two orthopaedic practices operating in the Albury area; one charging the theatre booking fee and the other not. DVA will work with the Albury Private hospital to ensure that veterans are aware that there is a local option to access a 'no charge' specialist orthopaedic service.

The Chair asked that a letter be sent to the Doctor concerned detailing DVA's position to the additional fee.

Action: Mr Douglas to follow-up via letter with the doctor concerned detailing DVA's position to this situation of additional charges.

e) Specialist fees - Are specialist fees paid at the market rate arrived at as an average of the payments made by the Private Health Funds?

As outlined previously, the indexation approach used follows the general Government approach to health fee indexation.

All of the medical and allied health fees covered by the changes in 2006 are currently indexed by WCI-5 which is the same index used to index the Medicare Benefits Schedule and a range of other Health expenditure areas. A review in 2006 suggested that WCI-5 was a reasonable surrogate in the short term as it paralleled the increase in no-gap and known gap fees paid by health insurers reasonably well.

DVA has had preliminary discussions with the AMA, the Australian Dental Association, pathologists and some of the allied health groups about gathering data on real cost increases so that an accurate picture can be gained of cost increases relative to indexation. Should a gap be established, there is the potential for this data to be used as the basis for a submission to Government seeking an adjustment to restore fees to the equivalent of the 2006 levels in real terms. Current feedback from the AMA and the other provider groups indicates that the arrangements are working well.

f) Diabetes medication - As of January next year, will DVA only pay for 2 individual medications for diabetes control.

DVA has been advised by the Department of Health and Ageing that, on the recommendation of Therapeutic Goods Administration (TGA) and Pharmaceutical Benefits Advisory Committee (PBAC), there have been some changes to the listing of Roziglitazone. This anti-diabetic drug has had some serious side effects reported and indications for its use have been changed on the PBS. Changes were notified on 1 October 2008 and 1 November 2008. The changes involve removal of the drug in triple therapy (in combination with metformin and sulphonylureas). Essentially, people can be on three medications for diabetes treatment but there is concern for people on the three drugs as there are reports of side effects.

Provisions have been made for those people holding repeats for Roziglitazone and the repeats can be dispensed until they run out. In this situation the prescriber (LMO) can change treatment to alternative drugs. If in the rare situation where a prescriber needs to weigh up the risks and benefits of using roziglitazone in difficult to manage diabetic veterans, the advice is that the prescriber should discuss the need with VAPAC. The changes to the PBS are made on expert advice after reports of serious adverse reactions to the drug. The PBS is acting in the interests of patients. If there is an issue advice is to get the veteran and their LMO to contact DVA and VAPAC.

Mr Douglas referred to the following item raised by Ms Reggett and provided the members with a briefing on the initial request and DVA's response.

g) Pathology - There is general concern that pathology companies will begin to charge DVA clients an additional fee for home visit collection.

Under DVA's arrangements for pathology services, DVA pays for all pathology services delivered to DVA entitled persons a fee of 100% of the Medicare Benefits Schedule (MBS). In addition, effective from 1 November 2008, the "coning rule" for pathology items will no longer apply to DVA patients. The "coning rule" limited the payment of pathology items to the three highest value items claimed, where more than three pathology items were requested by a LMO for patients in the community (non-hospital). With the changes implemented by DVA, pathology providers will now be paid for all items requested. While this

change to the business rule for pathology only came into effect on 1 November 2008, under the changes DVA will pay for these previously unpaid services dating back to 1 November 2007. The combined effect of these changes gave pathologists an increase of nearly 20% over the fees that applied prior to November 2006.

In cases where a DVA entitled person is not house bound, they are also able to access DVA's transport arrangements to travel to and from a pathology provider, as well as LMO or specialist.

As with other DVA health services, when health providers treat a veteran under their Gold or White Card they are required to accept the Department's conditions when providing services to veterans. These arrangements include accepting the appropriate fee for service as full payment for their services, and not levying any additional fee on the individual veteran. Discussions with the Australian Association of Pathology Practices has indicated that they remain committed to ensuring that this occurs. Therefore, if a provider who has agreed to provide services under DVA arrangements attempts to charge the veteran a fee, the veteran should not pay the bill and should contact DVA.

5.7 Low vision aids schedule review

Mr Douglas informed the members that a working group, including nominees of the Optical Advisory Group (OAG) and DVA staff, commenced a review of the arrangements for provision of low vision aids in 2007. This review looked at the items in Schedule 3 - Low Vision Aids (the low vision aids schedule) of the Pricing Schedule for Visual Aids and the low vision items on the Rehabilitation Aids and Appliances(RAP) Schedule with an aim to align them with industry practice and standards, and streamline the arrangements for supply.

The review of the low vision aids schedule items has resulted in a range of changes being recommended. Consideration is now being given to the recommended changes and the impact that these may have on the provision of services.

5.8 Veterans' Service Centre Update

Mr Douglas briefed the members on the VSC, which continues to provide phone services to veterans from Victoria, South Australia, Northern Territory and Western Australia. On occasion, the VSC answers calls originating from Tasmania and Queensland when back-up arrangements are required to cover staffing absences in those locations. Significant planning is under way to enable the VSC to answer all veteran calls from all parts of Australia

The VSC enables veterans to access DVA services through a single contact point. The aim of the VSC is to complete 80% of calls at the first point of contact. VSC is currently completing 70% of calls, and this is improving slowly with training and as staff increase in confidence and experience.

Mr Douglas noted that given the undertaking that clients would speak directly

with a person and not a machine that there have been some difficulties in its establishment given the breadth of knowledge that the staff must have, whilst noting that it is a continual and gradual process of improvement.

5.9 Client Liaison Unit Update

Mr Douglas provided the members with an update and background information on the CLU which was established in June 2007 to manage the relationships between those clients who are vulnerable and/or have complex needs and DVA. The CLU, a small National unit in Melbourne, is currently actively managing 32 clients and have details of another 270 plus clients who are being monitored.

The CLU have developed a number of processes and procedures to assist in these relationships between DVA and clients such as processes to notify clients in advance about entitlement changes that are known to trigger client distress. The CLU have also developed highly trained staff in handling complex situations, who have become an invaluable resource for DVA.

Mr Ryan sought clarification about how clients at risk were flagged or referred to the unit. Mr Killesteyn noted that the conditions for referral varied and that officers in the unit were trained to deal specifically with the conditions displayed by the clients. Mr Doust asked whether the unit would be expanded. Mr Killesteyn explained that the CLU operates nationally from Melbourne and was working efficiently and effectively. Mr Killesteyn noted that there had been extensive work undertaken in identifying indicators of people that may be at risk such as potentially accepted disabilities, alcoholism, or the complexity of claims.

6. Mental Health

Mr Telford provided an update on Mental Health to the Committee and referred to the paper that had been provided to the members prior to the meeting.

The implementation of an ADF Mental Health Lifecycle Package where initiatives currently being worked on includes Barriers to Rehabilitation; Improved Treatment Options for Hard to Engage Clients Project; and Transition Case Management and Family Support initiative. Mr Telford informed the members that DVA has commissioned ACPMH to develop, implement and evaluate the national training measures to improve the competencies of community-based mental health practitioners including VVCS and DVA contracted counsellors and social workers in treating veterans with common mental health problems.

A National Suicide Prevention Strategy for the Veteran Community - Operation *Life* will include a pilot program to introduce online counselling and support services for veterans and their families who find it difficult to attend face-to-face counselling, as well as the introduction of web-based or CD ROM resources aimed at increasing suicide awareness and prevention. The pilot project is due to commence in 2009 with new online Operation *Life* services to be launched in 2009-10.

The Terms of Reference for the independent study of suicide in the ex-service

community was announced by the Minister for Veterans' Affairs on 22 August 2008. The study included a call for submissions, consultations with key ex-service organisations and an international literature review, as well as the review of specific cases. Professor David Dunt, public health specialist and epidemiologist was appointed to undertake the study, as well as the Review of Mental Health Care in the Australian Defence Force and transition through discharge. Both reports are due to be presented to the Government shortly.

Mr Telford noted that The Right Mix project and website is currently being updated and an alcohol correspondence program is being developed to enhance the effectiveness of this resource and ensure improved links to other mental health programs. Griffith University is currently finalising research that outlines the last clinical contact suicide victims had with health professionals in order to determine whether this contact offered an opportunity for intervention. Data collection is due to be finish by December 2008. The final report is expected to be available in October 2009.

The PTSD algorithm for health practitioners, developed by ACPMH, is finalised and is currently being disseminated nationally to General Practitioners, Clinical Psychologists and community-based mental health providers.

7. NERTAC

Mr Telford referred to the paper that had been provided to the members prior to the meeting. Mr Telford informed the member's that NERTAC's last meeting was held on 7/8 August in Sydney where the following points were the main issues discussed.

It was agreed that the issue of Affordable Home Care for the Elderly (including rental problems) should be taken up by NERTAC rather than the State committees. Members received a presentation entitled *Towards 2030* by Pamela Rutledge, Executive Director, Office for Ageing, Department of Ageing, Disability and Home Care, who advised the members that ESOs should be reflecting on their role in prevention and early intervention; as a community of interest in promoting innovation and leadership; and as an employer. The evaluation report of Veterans' Home Care by Wollongong University was released on 17 March and the members were updated that the government is still considering the options presented.

One of the other main issues discussed were the Guidelines for Meeting "Special Needs", where terms of reference for a project to providing a practical guide to best practice in meeting "special needs" in aged care are being drawn up.

The Chair of NERTAC has retired since the last meeting.

8. Prime Ministerial Advisory Council Report

The Chair informed the members that the first PMAC meeting was held on 9/10 October in Canberra.

The Chair noted that the PMAC members agreed on Terms of Reference (TORs) and the Minister asked PMAC to consider a number of issues, one being

consultation between the veteran community and DVA.

Ms Reggett, a member of PMAC, noted that the TORs clearly state that the committee is an advisory committee to provide advice on major issues and facilitate better outcomes for the veteran community. Other issues discussed by PMAC were the Clarke Report, consultative processes and the MRCA review. During the first meeting over two days, PMAC received presentations from the Secretary of DVA, the Minister and Professor Dunt.

The Chair referred to the several layers of current consultation between the veteran community and DVA. The Chair noted that whatever the final outcome of the consultative review, there is a commitment for the Commission to hold a forum with the major ESO groups a few times a year which is complimentary to PMAC – as PMAC is not the Commissions' forum. The Chair also noted that he felt there was a gap in the Department since the old Operational Working Group has been disbanded and further noted that NATMOC and the State TMCs were originally created to monitor the divestment of the Repatriation Hospitals over a decade ago, and since that time the forums have changed.

The Chair confirmed that the date for the next NATMOC meeting is still 26 March. However, it is possible that by this time there may be a different configuration of this meeting. The location for this meeting, should it proceed, was confirmed as Canberra.

Mr Ryan sought clarification of the administrative arrangements for the PMAC. Ms Reggett stated that DVA provides the secretariat and administrative support at this stage. The Chair further clarified that Dr Alan Hawke is Chair of the Committee and the committee agreed for DVA to provide the secretariat support at this time. The Minutes for the PMAC meeting are available on the Minister's website.

9. MATES and Neuromonics

Mr Telford referred to the papers that had been prepared by Dr Killer and circulated to the members. Mr Telford informed the members that the next MATES module will be on Warfarin scheduled for release in January 2009.

With regard to the Neuromonics trial, Mr Telford commented that the trial had proved to have significant benefits for people with tinnitus, and if positive and successful outcomes continued, the trial would hopefully be broadened after further assessment and consideration by the Commission.

10. SRCA/MRCA

Mr Douglas briefed the members on SRCA/MRCA performance. Mr Douglas noted that there was improvement in the times taken to process(TTTP) for SRCA and MRCA and that days on hand was less than the 120 day target. For Permanent Impairment claims TTTP for SRCA has again reduced. MRCA TTTP has remained fairly stable. Completion rates for both SRCA and MRCA are exceeding intake across most locations. Reconsiderations received for SRCA have decreased, while MRCA intake has doubled.

The clearance rate of AAT cases remains low. The overall number of new Return to Work (RTW) cases and the percent of successful return to work remains consistent. This is a direct result of the successful implementation of the ADF rehabilitation program and the cooperative working practices between DVA and Defence particularly in transition of members to civilian life.

The Integrated People Support Strategy (IPPS) was rolled out during September to Sydney Central, ACT/NSW, Riverina/Murray Valley, Vic and Sydney West . Further rollouts have taken place during October and the final regions will be Tasmania and Southern Victoria in November . The initial uptake by Defence Transition staff in Sydney Central and Riverina/Murray Valley was disappointing but uptake is improving. There has been a positive trend in Single Access Mechanism (SAM) activity so far this financial year and DVA and Defence SAM teams continue to meet monthly to discuss and document ways in which to improve SAM business activities, with a view to improving request response times.

The members noted that they did not receive the report that Mr Douglas is referred to. *Action: The Secretariat to e-mail the paper to the members.*

Ms Reggett asked for an update on the single claim form. Mr Douglas informed the members that work is still being undertaken on the design and how DVA will screen the form when it comes to the Department for processing. Mr Douglas noted that he is confident the form will be implemented in the first half of next calendar year and that there was a dedicated project officer working through these issues. It was further noted that regarding the review of MRCA, a decision announced by the government prior to the election will be a public process with calls for public submissions and PMAC will only consider this review; it will not be undertaking the actual review.

11. Other Business

The Chair invited the NATMOC members to raise any further issues.

AVM Paule informed the committee that the National Hearing Consultative Committee appeared to still be in limbo and when he was last in touch with the committee he was informed that there were no new appointments even though the nominations to the committee ran out last year. Mr Killesteyn stated that Department of Health and Ageing were still to progress further with the committee and he was waiting for an update on this.

12. Next NATMOC Meeting

The Chair and members noted that the next NATMOC meeting date will be the 26 March 2009 in Canberra.