# GO2 Health welcomes the invitation to make a submission to the Productivity Commission Inquiry on Compensation and Rehabilitation for Veterans

GO2 Health would like to address how the current compensation and rehabilitation system for veterans operates on the ground, in one of the largest and well-regarded private community veteran health operations in SE Queensland. We would like to provide our advice on how it should operate into the future, and whether it is 'fit for purpose'.

> Many ADF veterans have a significant injury and disease burden that requires veteran-centric, comprehensive and collaborative care across medical, allied and complementary health spaces. The mental health impact of continuous Operations over more than 10 years is not yet fully realised.
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> Remuneration for allied health services is well below sustainable levels for many community clinicians in private practice, especially Psychology. There is already a groundswell occurring of psychologists and other allied health clinicians who are unwilling to treat veterans due to the loss of income and often onerous and non-sensical DVA paperwork requirements.

In making this submission, GO2 Health would like to draw attention to some of the issues raised in a medical and allied health setting. Solving these issues will empower the health professionals to better serve and care for the ADF veteran.

## GO2 Health Background

GO2 Health is a privately owned, multidisciplinary medical centre in Everton Park, Queensland – a 'one stop shop' with 25 practitioners across a range of modalities. The medical arm of GO2 Health is headed by general practitioners - Dr Kieran McCarthy, who is an Army veteran himself with 5 operational deployments, and Dr Ian Fraser OAM (awarded in 2018 for services to veteran's health). Both doctors have dedicated their lives to serving our veteran community and providing the care and support they need to lead meaningful lives.

Ideally situated near Enoggera Army Barracks (Gallipoli Barracks), our GPs provides support to 600 active DVA patients as of June 2018. This number is climbing rapidly. These veterans may also attend a variety of in-house services including medical, nursing, physiotherapy, psychology, dietetics and nutrition and exercise physiology. We also treat a much larger group of veterans who are referred-in for allied health support from external GPs and the ADF. In addition, our medical and allied health teams orchestrate access to, and provide advocacy around external providers (specialists, hospital and other), home care and medical devices. We work closely with the DVA contracted Rehab Providers, private Psychiatric Hospitals, external allied health as well as RSL advocates.

The predominantly younger 'contemporary' demographic of veterans treated by GO2 Health presents a huge future, and ongoing, financial drain on the community, as these people have many years of life ahead of them. GO2 Health believes that without the ongoing care and support for these young veterans as supplied at our facility, many will be overcome by their chronic physical conditions and mental health issues and be forced down the 'TPI' route.

Veteran's health (through DVA) represents almost 60% of the total billing though GO2 Health and is the major focus for our collaborative practice. The majority of the veterans in our care are contemporary (age 25-50); both male and female, with many who have been on multiple deployments but now need to prepare for a vocational change which has been forced upon them by a medical discharge from the ADF. Many have highly complex needs or are at significant risk of self-harm.

## As a submission, GO2 Health would like to address the following:

A. Effective care requires advocacy and provider collaboration that includes the veteran in the decision-making process. Current compensation arrangements do not adequately provide for such team care opportunities and do not reflect best practice with regards to case conferencing, report preparation, telephone communication to care providers etc.

B. Effective care must be holistic in its nature and involve Team Care Arrangements with all treating professionals (paid).

C. Current payment arrangements (including issues with non-attendance) for DVA treatment do not meet threshold for reasonable practice. This in turn impacts on:

- Quality of care
- Quality of treating professional
- Quality of treatment planning
- Quality of outcomes
- Limited accountability and visibility
- Limited access to professionals
- Increased costs over time. Poor value for money outcomes
- Non Attendance to medical appointments

D. Current Advocacy processes are insufficient with control and scope of healthcare options.

E. Transitioning arrangements are not currently streamlined into public/private care causing increased stress and pressure on the veteran. Whilst DVA have made significant inroads to ensuring continuity of care post during and post transition, there remains a risk of veterans falling through the cracks and being lost to follow-up due to the lack of a planned, dedicated pathway into care and Health/Vocational development.

F. Mental health is still the most significant area for development as we rehabilitate the veterans back into 'normal life' and prevent the inter-generational issues from being the most significant burden on the community.

## Detail

### A. Effective Team care

GO2 has spent the last 9 years developing systems to support the patient with a team approach. For effective veteran care, the legislation must support these care arrangements to pay for health advocacy (by treating professionals) and the veteran to meet and discuss ongoing options for care.

The current financial model allows for medical practitioners to charge for case management time. It does not pay for psychologists, physiotherapists and other essential treating professionals to attend these meetings. In private practice, this financial constraint prevents teams from discussing treatment, assessing outcomes and goal planning with the veteran. In a public setting (such as a hospital) all professionals are able to attend meetings such as this but private practice environments are not able to provide such services.

The result is that unless they are under a DVA medical management rehab plan veterans are not included in discussions around their health. Health outcomes from allied health are not discussed and goals are not set, the veterans are then not able to take control of their own treatment and look outside of the system for solutions. Scheduled meetings for the Veteran to meet with the health practitioners leads to better goals, planning and outcomes. It also allows for Accountability measures to be properly assessed and financial waste to be reduced.

Cohesive, integrated care provides better outcomes for the veteran. Addressing this financial shortfall increases the accountability of treatment, increases the communication within a treating team and will improve outcome.

References:

*Cohesive health care teams have 5 key characteristics: clear goals with measurable outcomes, clinical and administrative systems, division of labour, training of all team members, and effective communication.*
Kevin Grumbach, MD; Thomas Bodenheimer, MD. JAMA. 2004;291(10):1246-1251. doi:10.1001/jama.291.10.1246)

*The Primary Care Physician community acknowledges the need for new practice models that provide accessible, comprehensive and Integrated care based on healing relationships over time (Joint principles of the patient-centred medical home. March 1, 2007.* http://www.pcpcc.net/node /14

Current case management cost models (per Medicare) :

MBS numbers 735-758 15 - 30 minute consultations with not more than 5 in a 12 month period.

Generally, these are provided for health professionals to meet, discuss, plan coordinate or make arrangements on behalf of a patient. They are often organised in a RAC facility for elderly patients but can also extend to community consults.

Under current arrangements, most veterans will not have access to these conferences as allied health are not supported to attend.

Without this ongoing support mechanism, care planning is non-existent, outcomes are poor and the model will not work. Financial support must be provided for allied health to meet and discuss cases with the treating medical practitioner.

## B. Holistic care

The scope of treatment for veterans must be increased but with the proviso of accountability for results.

In 2017 the Veterans Affairs Minister attended an international conference to explore the challenges faced by contemporary veterans.

*"We recognise the importance of veterans seeking treatment as early as possible to achieve the best recovery outcomes, which is why in the 2016 Budget the Government expanded eligibility for non-liability health care for certain mental health conditions, post-traumatic stress disorder (PTSD), anxiety, depression, alcohol and substance abuse to anyone with one day of full time service in the Australian Defence Force (ADF)."*

In the 2017–18 Budget the Turnbull Government expanded this to cover all mental health conditions.

The breadth of conditions experienced also means that the number of treating professionals is also increasing to encompass all the veteran needs. This includes psychologists, physiotherapists, assistance dogs, exercise therapy and a variety of other treatments. The challenge faced by the medical fraternity is that no 'one' therapy seems to help and the specific and individual needs of the veteran must be taken into account. More and more veterans are seeking complementary and alternative medicines (CAM) to help symptoms and conditions. Under the guidance of a qualified medical practitioner, CAM modalities introduced into the team care arrangement give more choice back to the veteran and encourage them to take control of their own care. An example would be acupuncture for treatment of chronic pain. Currently this is only available under Medicare if it is delivered by a GP 'trained' in acupuncture. Acupuncture is now a registered health profession with the Chinese Medicine Board of Australia (Australian Health Practitioner Regulation Agency) - degree trained, registered practitioners can produce better outcomes when included in the Holistic plan for care.

Outside of the primary model, veterans are drawn towards treatments without evidence, have to pay for treatment themselves and are not able to communicate results (or lack of) back to their treating professionals. The risk carried around unguided care, adverse pharmaceutical interactions or poor care lead us to create accountability and control measures.

A truly holistic but accountable arrangement provides scope for the positive benefits of CAM care. It provides more choices for the veteran and, may serve to empower them around their own health care journey.

## C. Current Payment Arrangements

GO2 Heath would like to draw attention to the poor payment arrangements for treating practitioners. Under the current DVA payment scheme, the majority of the expected community health care team are poorly remunerated for their hard work supporting the veterans. As a centre that specialises in the care of veterans, GO2 Health is keenly aware of the financial hardship taken on by practitioners who choose to serve the veteran community. Across the entire practice, GO2 health is aware of a 40% reduction in revenue as a direct result of treating veterans, with certain services (psychology) working on a 41% of normal fee model. For veterans to receive the support they need, our best therapists must be brought into the care team. The legislation must be brought into line with other services (such as Workcover) or we will suffer from poor outcomes, a reduction in the number of treating professionals, poor service and poor adherence to best practice models.

http://www.abc.net.au/news/2018-03-26/veterans-with-ptsd-tell-of-being-turned-away-by-psychiatrists/9587106

Example: DVA fee schedule for Allied Health Treatment comparison (GO2 Health)

| | DVA | | | Private Patient | | Standard subsequent treatment |
|---|---|---|---|---|---|---|
| | Item number | 30 -50 minutes | 60 minutes | 30-45 minutes | 60 minute | Financial loss to practitioner |
| Physiotherapy | PH20 | $63.30 | N/A | $88.00 | $128.00 | $24.70 |
| Clinical Psychologist | US01/US04 | $101.45 | $148.95 | $191.00 | $251.00 | $102.05 |
| Psychologist | US11/US14 | $71.85 | $101.45 | $191.00 | $251.00 | $149.55 |
| Dietician | DT20 | $63.30 | N/A | $78.00 | $128.00 | $14.70 |
| Exercise Physiologist | DT30 | $63.30 | N/A | $88.00 | $128.00 | $24.70 |
| Acupuncture | Does not supply | $0.00 | $0.00 | $74.00 | $110.00 | Not currently available |
| | Workers Compensation rate | Workers Compensation rate | | Comparison with DVA | | |
| | Item number | subsequent | 1 hour | Workcover more than DVA | | |
| Physiotherapy | 100006/100101 | (1 condition) $75 | (2 conditions) $107 | 43.70 | | |
| Clinical Psychologist | 400095 | | $176.00 | 27.05 | | |
| Psychologist | 400095 | | $176.00 | 74.55 | | |
| Dietician | | | | N/A | | |
| Exercise Physiologist | 300187 | | $176.00 | 112.70 | | |
| Acupuncture | 300005 | $63.00 | | 63.00 | | |

It is important to note that the Australian Psychology Society advised rate for a psychology follow-up (60 minute) session is $251. The current Department of Veterans Affairs rate is $101.45. This results in a Psychologist losing $149.55 per hour, should they choose to serve our often complex veteran community. The result is that many will not treat DVA patients, you will not get the best therapists and generally care will be provided by recent graduates. Private enterprise represents a significant portion of the treating professionals for veterans. These people are currently significantly underpaid for their work.

Other therapies (than psychology) do not have as significant a difference in fees (although it is still problematic) but without an immediate review of fees, the Department is exposed.

- Quality of care - is reduced by less time and effort being taken by the treating professional. Less remuneration results in less effort
- Quality of treating professional – The highly experienced therapists focus on private patients for financial return, Experience and time in a field builds patient numbers and there are no booking opportunities for poorly remunerated treatment. Only those with less experience will take on veterans as they build their practice.
- Quality of treatment planning – without time (and/or money) the therapists will rarely spend the extra time needed to help the complex cases
- Quality of outcomes – Poor therapy, poor planning results in poor outcomes
- Limited accountability and visibility – poor financial remuneration for treating DVA patients and no payment for case management, results in no communication of results, treatment planning or outcomes. Medical practitioners are not able to assess or recommend treatments, this leads to more hospitalisation and poor mental health outcomes as support teams dwindle.
- Limited access to professionals – There is much evidence of both private medical and allied health professionals closing their books to DVA. The loss of fees is part of the issue. Without a review of this error, we will lose more therapists who simply cannot spend the time to look after our veteran community, or deal with the often onerous and non-sensical paperwork requirements of DVA.
- Increased costs over time. Poor value for money outcomes – With poor community results comes the social costs of poor outcomes. Poor relationships ensue, the breakdown of families, and the increase in the veteran suicide rate. The increased hospitalisation and poor vocational outcomes creates an enormous risk to the ongoing stability of our support mechanisms, and the rehabilitation of the veteran back into stable working life. This increases the burden on the public purse, as costs rise astronomically with increased problems and media.

The last review of Allied Heath fees was effective 1 November 2013.

Special Note: Non-attendance to medical appointments – At GO2 Health, veterans have a non-attendance rate of between 16-18%. The complex nature of the veterans, their multiple conditions and psychological state result in extra care being taken to support them. With compounding financial issues, family breakdown, increased sickness rates and mental health issues, the veteran community do not always attend appointments booked for them. The Department of Veterans Affairs do not have facility to pay for 'No show' appointments.

The ADF and Workcover currently pay non-attendance fees. Whilst we can enforce our cancellation policy, many of our veterans are struggling financially. We do not have the same level of non-attendance with our private patients. Most private clinics have a Non-Attendance Policy, designed to keep patients accountable and support the Practice.

When a patient habitually does not show up for appointments, it creates a significant burden on the health care worker.

1. Appointments could have been given to another person
2. There is a financial loss
3. The veteran in question might be at serious risk but there is no communication point with DVA about this. The department may believe the veteran is getting support but they are not going to support appointments, but no one would know. If there is a process for nomination, it must be financially supported
4. Treatment will eventually be withdrawn for the 'at risk' veteran.

If payment (or part payment) was made in support of the treating environment, more care and attention would be placed on following up the veteran to guarantee safety. Whilst psychologists can perform phone or 'skype' interviews, these are often less than ideal. Other therapies have no opportunity for follow up and the risk to the Veteran is increased.

## D. Current advocacy processes are insufficient with regards to medical outcomes.

The current contemporary veterans are a high-risk group. Current advocacy services for veterans include the services through RSL (for negotiating and planning) and many ESO's. There is a clear need for the services that these organisations supply. However, with regards to medical outcomes, these organisations are often far removed the day to day treatment needs. They do not have the medical training nor completely understand the complex nature of the medical conditions the veteran is faced with.

Chronic and complex care medicine requires enormous time and effort on the part of the treating medical team. To include a medical advocate increases the scope and care for the veteran; the CVC program steps in the right direction for the Gold card holders but the White card holders and non-card holders are at risk without someone taking an interest in their case, their progression and ongoing needs.

A care team, such as GO2 Health, fills the gap for this care but must be supported through allied health case management payments. To ask that a team care approach is taken is inclusive. This increases the veteran's own education and goal orientation towards building a life. The true team would include family, support teams, community support, vocational support, medical and allied health support and ongoing. The ultimate key is to have an advocate at the centre of the model, with the veteran ultimately making informed decisions about how to best move forwards.

The Hub and Spoke model presented by GO2 Health represents a new evolution in private health clinics in the community. Having support programs for the GP to continue their work, surrounded by Allied health workers, improves the day to day outcomes, reduces spend and increased the benefit to society around the Veteran's reintegration.

## E. Transitioning Requirements

Around the country there are a considerable number of medical centres that support veteran care. These are often the result of ex-service personnel working in the environment and being more knowledgeable in the area.

Most of these organisations are small businesses and/or companies.

When a serving ADF member transitions into civilian life, one of the critical initial support structures is the medical team. A doctor who will know them and their psyche, someone to know the family and watch the dynamics for the change in personality, PTSD symptoms arising - sometimes years after their service.

With current rules, the ADF cannot recommend any external private business to an ADF member. The perceived conflict of interests leads to the transitioning member not knowing where to go or who to turn to. They present at GP Super Clinics who may not be equipped to deal with the complex cases and DVA paperwork requirements. Their stories become lost.

It continues to be a significant risk that the ADF cannot officially recommend the most appropriate centres to the people who need it most.

The ongoing nature of Public Private Partnerships solves much of the 'conflict of interest'. Creating opportunity and benefit for dedicated centres of excellence, creates a seamless transition for the Veteran and a clear pathway for their future. We must overcome the inability of ADF and DVA to directly recommend those centres with known outcomes and dedicated services.

## F. Mental health continues to be the number 1 problem

A recent study (https://www.aihw.gov.au/reports-statistics) found 292 certified suicide deaths among serving and ex-serving personnel between 2001 and 2014.

The total included 84 suicide deaths in the serving full-time population, 66 in the reserve population and 142 in the ex-serving population.

Men accounted for more than nine in 10 suicide deaths (272 deaths, 93%) over that period, while women accounted for 20 deaths (7%).

Nearly three in five suicide deaths among serving and ex-serving personnel were of people aged 18–34 (170 deaths, 58%).

Of these, 66 deaths (23%) were among people aged 18–24; 58 (20%) were people aged 25–29; and 46 (16%) were aged 30–34.

15 times more soldiers die getting home than from active duty. The Transitioning Support National Mental Health Commission (2017) highlighted many of the pressures faced by transitioning military personnel, including the psychological transition from being a member of the ADF to becoming a civilian, and noted that some personnel are institutionalised or dependent on the ADF and fear returning to civilian life. Phoenix Australia (2016, p. 3) noted that 'the post-discharge period has been recognised as a period of elevated risk for mental health problems and suicidality'.

Without a considerable effort through dedicated channels of care, this will continue to be the main problem. It is time for the Department to identify community 'Centres of Excellence' around the country who specialise in the care and rehabilitation of veterans. With a sense of urgency, these people deserve for the Country they served to help them rehabilitate and become functional and valuable members of society once more.

The GO2 Health method of collaborative care has been carefully designed over 9 years and, to our knowledge, not a single veteran in our care has taken their own life. The Inquiry must take into account the support of centres like GO2 Health and, in turn, the centres will be more able to support the veteran community.

## Models of Care

The recent movement of Government towards self-directed care through NDIS and CDC programs is integral to the future of veteran wellness.

The key to successful transitioning is to help the veteran develop independence, a sense of future planning, education and the ability to set their own goals. Personal choice gives them the ability to choose the treatment and conditions that best suit them. But the decentralisation of this choice brings the problem of the lack advocacy. The Veterans themselves are not educated enough in their own rehabilitation goals and needs to be able to make good decisions. This needs the proper team of health professionals to help them make those decisions, a vocational team to examine their ongoing redeployment into the workforce and a community to support them on the outside of the ADF.

The GO2 Health model of care supports good choices and the education of our veterans. GO2 provides this in an environment of low resources (the income should meet Workcover rates) and little cohesive direction in the DVA community. Private enterprise is the current and future mechanism for cost effective support for Veterans. The current legislation does not support the Veteran to be able to access the necessary treatment and does not, in turn, support the Centres of Excellence to continue to provide this support.

## Specific Question and Answers

**Is the package of compensation received by veterans adequate, fair and efficient? If not, where are the key shortcomings, and how should these be addressed?**

> This is a difficult question to answer. There is a focus amongst some veterans around 'compo'; and what they're 'entitled' to, however the DVA system of compensation is complex, long and somewhat adversarial. In our opinion an enormous amount of taxpayer dollars is wasted with multiple specialist reports, often derived from medico-legal specialists 'on the DVA payroll' who debunk established diagnoses and therefore reduce compensation payouts.
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> Is access to compensation benefits fair and timely? In particular, are there challenges associated with the requirements in the MRCA and DRCA that impairments be permanent and stable to receive permanent impairment compensation? How could these provisions be improved? P16 Issues paper

**Is health care for veterans, including through the gold and white cards, provided in an effective and efficient manner? Has the non-liability coverage of mental health through the white card been beneficial?**

> As a general statement - yes.

The non-liability coverage for mental health is probably the most significant positive change in recent years – this has made it much easier for veterans to access almost immediate mental health support. The risk is that whilst more veterans gain access to mental health support, the pool of providers diminishes due to poor remuneration, causing reduction of availability and experienced practitioners.

It is important that accountability processes are in place for health care providers (esp allied health) to ensure over treatment or inappropriate treatment is minimised, or does not occur. DVA is not an 'ATM'. There has been recent focus on exercise physiology and it is important that 'cowboy' providers are held accountable. Linking them back to the referring GP is the key, provided the GP has the time to actually case manage or monitor. Unfortunately primary care medicine due to the Medicare freeze is becoming transactional.

**What are the benefits of having generally available income support payments also available to veterans through DVA? What are the costs?**

These payments are a safety net for veterans and their families. They are critical for medically discharged veterans who either can't work or are struggling to find appropriate work, considering they didn't voluntarily discharge. Their 'career change' was forced upon them – a real issue with the older veteran competing in a tight employment market. Vocational assessment and retraining must be the focus – gaining work provides veterans with meaning and makes them feel like a contributing member of society.

It is also important that veterans don't have a sense of entitlement around what DVA should supply. Regardless of how they came to their discharge, they need to move on and re-integrate into the civilian world.

**What are the sources of complexity in the system of veterans' support? What are the reasons and consequences (costs) of this complexity? What changes could be made to make the system of veterans' support less complex and easier for veterans to navigate?**

The main issue is the complex and convoluted process to have their service related conditions and injuries accepted and compensated as appropriate. DVA's antiquated computer systems are well documented; veterans (and GPs) get frustrated by the seemingly endless revolving door of DVA staff processing claims, with lack of continuity or training. Documentation regularly goes missing, and at times the relationship is seen as adversarial by the veteran. There can be a considerable lag for claims to be processed and accepted. DVA is viewed as an 'insurance company'.

**Are transition and rehabilitation services meeting the needs of veterans and their families? Are veterans getting access to the services they need when they need them? What could be done to improve the timeliness of transition and rehabilitation services, and the coordination of services? What changes could be made to make it easier for ADF personnel to transition to civilian life and to find civilian employment that matches their skills and potential?**

Part of the solution lies in direct intervention by the medical teams on base to directly connect with external providers. This creates continuity of care, without allowing the veteran to be lost in the system. This is currently blocked through Legislation. Ideally this occurs 6 weeks prior to discharge – this then allows the civilian GP and allied health to liaise back with Garrison health any issues which could be solved or facilitated prior to actual discharge – especially those medically discharging

Rehabilitation services must be continuous and timely. They must be holistic in nature and more work must be done to support external providers to create the necessary environment for care.

Services are currently uncoordinated due to poor funding and a lack of support for providers. Collaborative care arrangements are unfunded (Allied health) leading to no coordination occurring. There are models of care with accountability measures that can be applied but they must be supported.

Changes to the transitioning team on base to find the best support services externally to continue treatment, education and advocacy services.

**Veterans who are medically discharged are generally in higher needs categories than people who access other rehabilitation and compensation schemes and have exhausted options for return to work in the ADF. How should this be reflected in the design of rehabilitation services for veterans?**

Medically discharged veterans are a high-risk cohort. Rehabilitation services must follow best practice models and there must be more ADF / Private provider communication and cooperation to help the veterans transition. The current blocks in working with private industry results in poor decisions around care and prevents a seamless transition.

With a medically discharged veteran, the key in ongoing health is the medical practitioner who takes on the veteran. We need dedicated privately funded environments of medical practitioners with support teams (allied health) to guarantee emotional stability and care during the time of upheaval. GPs often don't understand the confusing complexity of DVA and their paperwork requirements, or have the time to provide comprehensive care to what can be a very complex individual.

The current ESO environment provides vocational and other useful supports but does not always understand the medical needs. The key support outcome is community around the veteran. There must be support for organisations to work together and freely communicate. Obviously due to the sheer numbers of support organisations this is very difficult to coordinate. As most are charity based they are also competing for a limited pool of funding.

One of the reasons GO2 Health is successful with this cohort is the 'one stop shop' nature of the facility. Veterans can see a range of connected providers under one roof in one visit. It is designed to be a warm environment where the veteran feels safe. This helps to 'de-medicalise' them by avoiding disjointed visits to different providers across a week across a wide geographic area. This is critical as they transition back to work and their free time diminishes.


Submission prepared by:

Rod Martin
Dr Kieran McCarthy

Owners, GO2 Health
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