



2009 Annual General Meeting

The Annual General Meeting for 2009 was held at the Southern Golf Club in Keysborough.

The Chair, Dr Nicholas Demediuk, presented the Annual Report and his annual address. He stated that the time ahead remains challenging and whatever the future, DCGPA will continue to advocate strongly for general practice. As an organisation Dr Demediuk reported that we are well placed, with sound governance, highly skilled Board and staff, solid partnerships and the energy and enthusiasm to move forward.

The Directors of the Board for 2009/10 announced at the AGM were:

Dr Nicholas Demediuk, Dr Graeme Downe, Dr Jacob Dessauer, Dr Sally McDonald, Dr John Meaney, Dr Craig Mulligan, Dr Brett Ogilvie, Dr Roger Smith and Dr Greg Wyatt.

Dr Demediuk announced that regrettably Craig Mulligan was resigning from the Board. Craig has served on the Board since 2002. His portfolios and areas of expertise included GP Education & Training and Aged Care. Craig has been a great contributor to the Board and always worked hard to ensure the realities as compared to the expectations of general practice were addressed. He worked tirelessly on the Aged Care Program and led the way in establishing an excellent model for the Aged Care GP Panels initiative. Sadly this program was discontinued but the relationships between general practice and the aged care facilities remains strong,

largely due to the early work carried out by Craig and his team working on the Aged Care Program.

Craig has a genuine passion for general practice and is an advocate in trying to ensure there is a future general practice workforce that is well trained.

He will be missed from the Board and we hope that he will remain involved as his experience and knowledge will always be valued.

The Board, staff and members of DCGPA wish also to acknowledge Dr Jacqui Barry who had served on the Board since 2001. As a younger GP Jacqui has been able to provide different perspectives which have always been very insightful. As convener of the CPD Sub Committee and member of the Mental Health Advisory Group, Jacqui contributes enormously. We have been assured by Jacqui that she will continue in these roles.

Once the business side of the meeting was concluded everyone enjoyed the dancing and entertainment from the 80's band "Controversy".

Please note that at the December meeting of the Board the office bearers and independent Director were appointed. We congratulate Dr Demediuk as Chair, Dr Graeme Downe as Vice Chair and Dr Greg Wyatt as Treasurer. We were delighted that Mr Roy Sanderson accepted the appointment as Independent Director for a further 12 months.

Anne Peek



↑ The Dandenong Casey General Practice Association Board of Directors for 2010



↙ Association staff in all their 80's regalia



↙ Attendees enjoying the 80's entertainment

**Dandenong Casey
General Practice Association**

314B Thomas Street, Dandenong, 3175
Phone: 8792 1900 Fax: 9793 4050
Email: admin@dcgpa.com.au
Website: www.dcgpa.com.au
Office hours: 8.00a.m. – 5.00p.m.

BOARD OF DIRECTORS:

Chair: *Dr Nicholas Demediuk*
Vice Chair: *Dr Graeme Downe*
Treasurer: *Dr Greg Wyatt*
Directors: *Dr Sally McDonald*
Dr Roger Smith
Dr John Meaney
Dr Jacob Dessauer
Dr Jacqui Barry
Dr Craig Mulligan
Dr Brett Ogilvie
Mr Roy Sanderson

Chief Executive Officer: *Anne Peek*

Quality Use of Medicines Coordinator: *Graham Sweet*
Health Promotion Officer: *Christine Prendergast*
Senior Program Manager: *Christine Crosbie*
DCAS Project Officer: *Candice Crellin*
DCAS Project Officer: *Vivienne Prestidge*
DCAS Project Officer: *Linda Hughes*
Refugee Health Program Coordinator: *Dr I-Hao Cheng*
Mental Health Program Coordinator: *Ron Marshall*
ABHI Regional Coordinator: *Michelle Guille*
Collaboratives Program Officer: *Stephanie Edmonds*
General Practice Support Coordinator: *Rose Griffiths*
General Practice Support Program Officer: *Rowena Mulligan*
General Practice Support Program Officer: *Anne Nunan*
Information Management Program Officer: *Nick Deacon*
Information Management Program Officer: *Diana Milojkovic*
Program Advisor: *Peter Larter*
Business Manager: *Julie Shanahan*
Events Program Officer: *Sharyn Gissara*
CQI Support Officer: *Alison Killin*
Administrative Support: *Heather Simpson*
Marg Toon
Karen Knaus
Lisa Shore

Editorial Subcommittee: *Dr Wes Jame*
Dr Cely Goeltom

To email staff directly: *Initial.surname@dcgpa.com.au*

Deadline for newsletter articles is 10th of each month. Dandenong Casey General Practice Association reserves the right to accept or reject all material submitted for publication. For further information please call the Association.

DISCLAIMER

The views expressed in this newsletter are those of the authors and do not necessarily reflect the official position of the Dandenong Casey General Practice Association.

Enclosures for Members:

2009 Year in Review
2008/2009 Financial Report



Pen Tip:

Latest Pen CAT updates – versions 2.6 and 2.7 release

How long has it been since you've logged on to your Pen Clinical Audit Tool? Be sure to log on periodically and always click 'OK' to installing the application updates when prompted to get the most out of the latest Pen CAT additions. Some of the features that the version 2.6 release brings are:

- New 'months of age' filter
- Alcohol graph, with segments for 'drinker', 'non-drinker', 'nothing recorded', and 'age <10 and nothing recorded'. It is intended that Pen will enhance this graph to include levels of drinking risk in the near future.
- 'Drug abuse' has been added to the conditions filter under 'other' (initially available to Medical Director users only)
- Specifically for Medical Director users with Pracsoft 3 (at this stage) the MBS items tab has had more item numbers added. The MBS Items tab and the 45-49 Health Check tab need to be activated before they can be used. To do this go to Edit > Preferences from the menu bar in Pen, in the Clinical Audit tab ensure MD3 is selected at the application, in the MD3 tab select Pracsoft 3 as the billing software, click OK.

The version 2.7 released late November includes:

- A new swine flu graph under the immunisations tab (initially available to Medical Director users only)
- 'Cardiovascular' (Peripheral Vascular Disease, Carotid Stenosis, Renal Artery Stenosis) and 'renal' (Chronic Renal Failure) are now being collected and are used by the APCC report (also initially available to Medical Director users only)
- Updates to other fields in the APCC report

Ensure that you log on to Pen regularly and collect extracts periodically so that you can monitor your progress with both your data cleaning and with targeting your patients with chronic illness by comparing your extracts.

If you have any questions regarding the Pen Clinical Audit Tool, or if you are interested in a **FREE** installation, contact the Association on 8792 1900.



Berwick GP Super Clinic

The Rudd Government has signed a contract with Dandenong Casey Super Clinic Ltd to establish a \$2.5 million Berwick GP Super Clinic.

Dandenong Casey General Practice Association (DCGPA) has established a separate new legal entity in the form of a Company Limited by Guarantee known as "Dandenong Casey Super Clinic Ltd". It is a not for profit company designed to meet the objectives of the GP Super Clinic policy yet be at arms length from DCGPA. The company is governed by independent separate board of directors, the majority of whom are appointed by DCGPA.

The Berwick GP Super Clinic will establish a multidisciplinary-general practice led clinic incorporating a creative model for teaching and primary care delivery. The clinic will address the community's health care priorities and address the needs for training places and team based chronic disease management in a rapidly growing and diverse community.

The Super Clinic will be complementary to the local general practice community. Rather than be in competition with local GPs it is anticipated that the clinic will enhance and assist surrounding GPs by filling service gaps and providing teaching, training and research opportunities.

The consortium led by Dandenong Casey General Practice Association brings together Monash University, the Victorian Metropolitan Alliance - General Practice Training, Southern Health and will involve other private health providers.

This innovative model for primary health care provision will be a state of the art teaching facility and will actively involve the newly appointed Professor of General Practice, Grant Russell. Professor Russell is Director of Primary Care Research Dandenong Casey region and the Academic Unit located at DCGPA.

The Berwick GP Super Clinic will be located on 1 hectare of land on the grounds of the Berwick campus of Monash University.

Diabetes management is identified as a major local

need and will be an initial priority of the clinic. Services such as self management groups, lifestyle modification programs, allied health services and specialist consultation will be provided on site for patients of the super clinic and surrounding local GPs. Retinal screening is also being considered as an additional service on the Berwick Super Clinic site.

Additionally, development of a specialist Chronic Disease Advisory Clinic within the super clinic for brief contact, i.e. 1-2 patient attendances, supporting general practice will be explored. This will be expected to achieve in the area of Emergency Department diversion. A weekly clinic would expect to see 5-6 complex patients. This will be modelled along the lines of the clinic already operating on site at Dandenong and Casey Hospitals.

The clinic will operate 8.00am to 8.00pm on weekdays and on Saturday mornings. A service contract with an accredited deputising service will supplement after hours care provided by the clinic. Consideration will be given to increase after hours activity as the staffing of the clinic is established.

A close relationship with local GPs will work to ensure that patients referred to the clinic return to their regular GP for ongoing management.

The VMA will commit to Berwick Super Clinic a full-time medical educator and a rotation of up to two registrars per term.

It is anticipated that the Berwick GP Super Clinic will be a major teaching practice for GP registrars providing opportunity for generic and specific registrar training. It is also expected that the VMA will investigate opportunities to create a registrar retention pilot within the region as it has done on the Mornington Peninsula to attract and retain GP registrars and subsequent Fellowship holders.

The establishment of a purpose built structure offers the region an opportunity to deliver quality community care in a multi-disciplinary environment aligned to world's best practice. At present such training structures do not exist within the Australian environment. **Anne Peek**

Academic unit – a focus on primary health care research

Dr Grant Russell has commenced in his role as Director of Primary Health Care Research based at DCGPA. The Academic Unit is a partnership between DCGPA, Monash University and Southern Health. He is being assisted by numerous Divisional staff in establishing an academic unit 'from the ground up.'

The Academic Unit is in the process of finalising how it will work with its 3 parent organisations. We have formed preliminary links with clinicians at Dandenong Hospital hoping to embed multi-disciplinary research into the region. The Unit is facilitating a unique consortium designed to optimise refugee health with numerous state and regional stakeholders. This work has been championed by the Association's refugee health coordinator Dr I-Hao Cheng who is soon to begin work on a PhD in the area of primary care for refugees.



Pictured with Professor Russell (centre) are Dr I-Hao Cheng (left) who is actively involved in refugee health research opportunities and Peter Larter (right), Senior Program Advisor with DCGPA who is assisting in the establishment of the Academic Unit.

Any members of the Association wishing to discuss research ideas with Dr Russell should feel free to contact him on 8792 1900 ext 53.



Immunisation Update

Swine flu vaccine for children approved by the Therapeutic Goods Administration (TGA)

Therapeutic Goods Administration (TGA) has announced that children between 6 months and 9 years of age are approved to receive the Panvax H1N1 vaccine.

The Commonwealth government health emergency website has information to assist. Visit <http://www.healthemergency.gov.au/internet/healthemergency/publishing.nsf/Content/kids-vaccine-gna-toc>.

Things to note for the child Panvax H1N1 vaccine program:

Infants and children 6 months to less than 3 years

- Are given 0.25ml IM
- When the prefilled syringe (Panvax H1N1 Junior) is available, it will contain 0.25ml (7.5ug HA)
- 2 doses are recommended with a minimum of 28 days between doses
- The multi dose vial (MDV) can be used until the prefilled syringe (Panvax H1N1 Junior) is in stock
- 0.25ml must be withdrawn for injection from the MDV for infants and children 6 months to less than 3 years
- MDV contains thiomersal and is safe to be used in this age group (ATAGI recommendation)
- If travelling overseas shortly, a single dose offers very good protection in the short term
- The second dose offers longer lasting protection

Children 3 to 9 years of age

- Are given 0.5ml IM
- 0.5 ml (15ug HA) is withdrawn from the MDV for children 3 to 9 years of age
- 2 doses are recommended with a minimum of 28 days between doses
- Only use the MDV in this age group
- MDV contain thiomersal and is safe to be used in this age group
- If travelling overseas shortly, a single dose offers very good protection in the short term
- The second dose offers longer lasting protection

You can start the child vaccine program now using the MDV. Remember to continue to follow the MDV guideline for safe vaccine administration.

Prefilled syringes of Panvax H1N1 Junior, 0.25ml (7.5ug HA) will be pre-allocated and sent out in the next 1 to 2 weeks.

Any further queries please contact Anne Nunan, Immunisation Program Coordinator at the Association on 8792 1900.

Government funded National HPV Vaccination Program

The Government funded HPV Vaccination catch up program for females 18-26 years is about to end. To be eligible for free vaccine on the National Immunisation Program, females 18 to 26 years must have had their first dose before 30th June and complete all 3 doses by 31st December 2009¹.

There are only a couple of weeks left to ensure eligible girls complete their 2nd and 3rd dose of cervical cancer vaccine.

The HPV Register has released Overdue Dose Reports to providers in Victoria and Victorian GPs will receive an email from the HPV Register to inform them of this. Victorian GPs are welcome to contact the HPV Register (1800 478 734) about this report.

About the Overdue Dose Report:

- It is a listing of consumers overdue for their next dose of the HPV vaccine as at the date the report was run. The run date is located at the top of the report in the header.
- Providers are advised to review the report and to inform the Register of any errors and to arrange appointments for consumers requiring additional doses.
- The report is only available on line so user names and passwords are required.
- An email notification to providers (Vic LGAs and also GPs in Victoria) has been sent, advising users that these reports are available. The user will only locate the report after they have logged into the website.
- The report is located under the "My Reports" tab on the secure website. Note that the latest reports can also be accessed from the home page under the "Latest Report" heading.
- Users can only view consumers where the provider administered the most recent dose.
- The first page of each report contains useful notes and instructions about the report including what to do if information incorrect, a disclaimer and contact details for the Register.
- Reports will routinely be updated and released on a monthly basis with email notification for each.

¹ Department of Health and Ageing 2009 National Immunisation Program Schedule, available at www.immunise.health.gov.au, accessed 23 November 2009

Ensure you have enough Gardasil stock to protect all the eligible women in your clinic

The State Department of Health has advised that there will be no further distribution of HPV vaccine for catch-up program *after* the 31 December, 2009.

However, any stock remaining in clinic fridges after 31 December can and should be used to complete the vaccination course for young women between 13 and 26* years of age. (* Eligible females aged 26 in 2007 will now be 28 years of age.)

The State Department have also advised that they will not restrict HPV vaccine supply to clinics before December 31 provided you can substantiate your order.

General Practice Victoria (GPV) recommends that you audit your clinic's patient database to identify how many eligible women are yet to complete their course, and order appropriately before December 31.

You can utilise your own software system or one of the available HPV audit tools. The PEN Computing System's Clinical Audit Tool has a pre-programmed HPV audit, and the Canning Data Extraction Tool has recently been updated to include an HPV module (and for those who do not have the Canning tool, the HPV Module "demo" can actually be used to import your clinic HPV immunisation data)

If you require advice on auditing your eligible patients or further information regarding the HPV program, please contact Anne Nunan at DCGPA on 8792 1900 or email a.nunan@dcgpa.com.au.

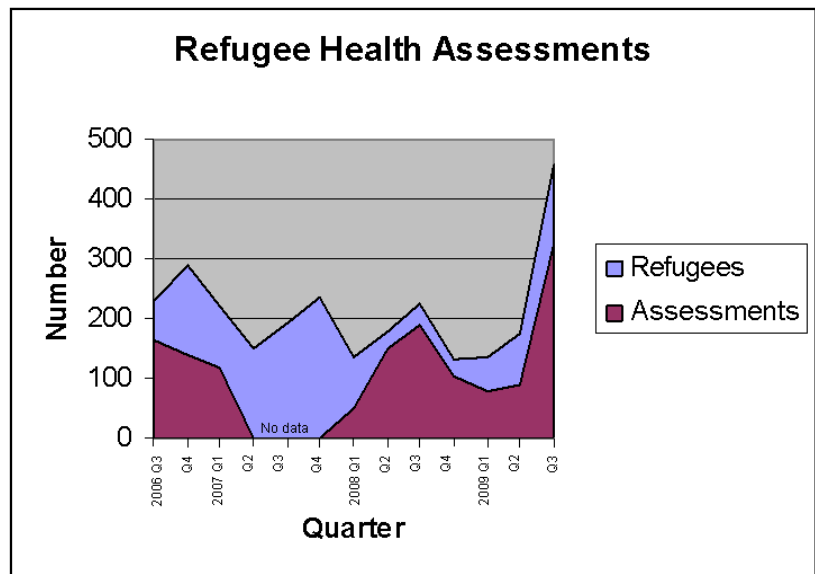
Refugee Health

Refugee Health Assessments

Currently this region is receiving the highest rate of refugee resettlement in Victoria. Statistics show a dramatic rise in new arrivals to 458 for the third quarter of 2009.

At the same time 16 GPs have responded by performing 326 Refugee Health Assessments (MBS Item #714), covering over 71% of new arrivals (see graph). Well done to you.

We understand some GPs are performing refugee health assessments without invoicing Item #714 and accessing the higher rate of remuneration it provides. Training and assistance is available for GPs, nurses and practice managers in performing and invoicing assessments.



Prescribing High Dose Vitamin D

Vitamin D Deficiency is well recognized as a problem in many refugee communities. Current strategies using 100iu, 400iu and 1000iu supplements are only partially effective.

On 19th November, 26 people attended an education evening hosted by the Association looking at the prescribing of "High Dose" (50,000iu) Vitamin D supplements. This was held over a delicious Afghan dinner at the Dandenong International Reception. 13 GPs subsequently applied for Authorised Prescriber status with the Therapeutic Goods Administration (TGA) to prescribe this preparation.

We are now waiting for approval from the TGA and once received will order in stock for dispensing in pharmacies.

If you are interested in joining this initiative, please contact me at the Association on 8792 1900.

Thank you to Southern Health, the Victorian Department of Health, Terry White Chemists and Dr Joanne Gardiner for your assistance at the event.

Medicare

Refugees require more time to be seen by a GP due to issues with health, language and socio-cultural complexities.

A recent meeting was arranged by General Practice Victoria and the Victorian Refugee Health Network with Medicare Australia to address GP concerns about the potential for compliance audits among GPs providing higher proportions of longer consultations to refugee patients. I was able to provide GP Association input into this discussion.

Medicare will work with the group in developing clarity on appropriate billing practices in the setting of refugee complexity and an understanding of the need for different patterns of billing for where there are high numbers of refugees.

We hope to provide additional clarity and confidence for GPs invoicing Medicare for refugee health consultations.

Dr I-Hao Cheng,
Refugee Health Program Coordinator,
i.cheng@dcgpa.com.au or 8792 1900

Quality Use of Medicine News



DCGPA to be an international drug dealer, importing high dose vitamin D. Yes, we plan to import "D-3-50" capsules. This is the trade name for 50,000 I.U. (1.25 mcg) cholecalciferol capsules that are made by Bio-Tech Pharmacal Inc. in Fayetteville, Arkansas, USA (not to be confused with Fayetteville North Carolina or Fayetteville, Georgia).

Bio-Tech's manufacturing facilities are FDA registered and inspected. Manufacturing processes operate under "current Good Manufacturing Practice" approved by the FDA and we have good references from reputable Australian sources. All of this is important because there are no TGA approved 50,000 IU cholecalciferol capsules available to us, so this is a special access scheme medication. Hopefully, this will be rectified in the next year or so.

Why we want to do this was explained by Dr Danielle Bao at a meeting organised by Dr I-Hao Cheng, Coordinator of the DCGPA Refugee Health program. Dr Bao is a paediatrician from Southern Health. She explained the prevalence of D deficiency in the population (particularly our refugees), the problems that this can cause (many more than are generally appreciated) and vitamin D doses that are needed to correct the deficiencies (this is where high dose vitamin D capsules may make things a lot easier).

As this is a special access scheme medication permits must be obtained to prescribe it. Dr Cheng detailed the process (essentially sign a form provided by him) and requirements for prescribing. It should be noted that while this is being set up to aid refugees, prescribers who hold permits are not limited to prescribing the high dose vitamin D only for refugees. For more details, Dr Cheng can be contacted at the Association on 8792 1900.

Local pharmacists also attended the meeting. One has agreed to accept delivery and store the capsules for us (a legal requirement), the others have agreed to ensure that we will have a good distribution throughout our area so that patients will have convenient local supply. As high dose vitamin D is a prescription only medication it can be supplied on prescription. With cooperation between prescribers and local pharmacies we hope to achieve a dispensed price that will allow patients to receive maintenance doses of high dose vitamin D at \$1 per person per month or less. For more details regarding pharmacy supply, pharmacists and GPs can contact Graham Sweet at the DCGPA on 8792 1900.

Quick Quiz

1. "Weary" Dunlop was a famous Australian surgeon, World War 2 hero, sporting great and

gold medal pharmacist – to list just a few of his achievements. What was his first name and why was he nicknamed "Weary"?

2. Hormone Replacement Therapy (HRT) in early post menopausal women may reduce CHD risk. True or false?
3. HRT has been proven to cause breast cancer. True or false?
4. Randomised controlled trials have demonstrated that in early post menopausal women the use of HRT will increase the incidence of stroke. True or false?
5. Venous thromboembolism associated with HRT most commonly occurs within the first 2 years of therapy, is more common in those women who commence therapy later in life, may be dose dependant and may potentially occur at a lesser rate with transdermal compared to oral therapy. True or false?



QUM news would like to wish readers a merry Christmas, a happy and safe new year and express thanks to all who have supported the DCGPA QUM program in 2009.

NPS RADAR - Aspirin + clopidogrel, a new combination product is on the market and if you are not sure of the relative benefits get a balanced view from the RADAR review on http://www.nps.org.au/health_professionals/publications/nps_radar/2009/march_2009/brief_item_clopidogrel.

NPS visits finishing on "Stroke" and starting on "Menopause". The last visits on the stroke prevention topic will be in January 2010 and we will commence visiting on the latest in treating menopause the same month. Now would be a good time to see how the practice is going regarding Quality Prescribing Initiative (QPI) cycle PIP points. If you would like to know more call Graham at the Association on 8792 1900.

NPS clinical e-Audits – [Optimising management of type 2 diabetes](#). Helps GPs review drug therapy and achieve target levels in patients with type 2 diabetes. Recognised for the current QPI cycle (ending 30 April 2010). [Review of proton pump inhibitor \(PPI\) prescribing](#). This e-Audit will assist GPs to review management of patients using PPIs, identify and implement a step-down strategy for suitable patients and review concurrent use of drugs that may induce or exacerbate dyspepsia/ulceration.

Complete before 28 April to be recognised in the QPI year (1 May to 30 April) in which it is completed.

TAIS helps with HMRs. Just how would you find out if the anticonvulsant that your patient was using could be affecting your patient's bones? Well this problem was posed to QUM News when performing a Home Medicines Review (HMR) for a GP recently. In this case the patient has unexplained pain unresponsive to all the regular nociceptive and neuropathic pain medications, has been attending a pain clinic and is still a mess. A quick look at the medications concerned suggested that the anticonvulsant concerned (prescribed in this case as a mood stabiliser as well as for the neuropathic pain) might be involved in causing osteomalacia.

But do all anticonvulsants do this, and if so, to the same extent, and if so, how commonly is this seen? The answer, call TAIS (the NPS's Therapeutic Advice and Information Service for health professionals). They have provided more than enough useful information for an evidence based therapy alternative that with any luck will be of value to this patient. TAIS can be contacted by telephoning 1300 138 677 and if you want to know more about HMRs call Graham Sweet at the Association on 8792 1900.

Quick Quiz answers

1. Ernest – Lieutenant Colonel Sir Ernest Edward "Weary" Dunlop, AC, CMG, OBE. He was nicknamed "Weary" because this is a synonym for being *tired* and his last name *Dunlop* was a brand name for motor vehicle *tyres*.
2. True*. This was seen in observational studies of women using HRT for relief of post menopausal symptoms. Subsequently the Women's Health Initiative (WHI) study was undertaken, the aim was to confirm that HRT could prevent CVD. Both arms of this study were closed early under clouds of adverse publicity. Subsequent analysis revealed that for HRT in early post menopausal women there was a trend (significant in the estrogen only arm) towards reduced CVD risk (confirming the earlier observational studies) but that this was reversed in older women further from menopause. It has now been proposed that HRT given early in life may prevent CVD from occurring while HRT given later in life may

destabilise existing CVD. The usual caveat that more research is needed should be given.

3. False*. It is quite improbable that HRT causes breast cancer. In the oEstrogen Therapy (ET) only arm of the WHI study there was a statistically non significant reduction in breast cancer rates. However the oEstrogen plus Progesterone Therapy (EPT) arm of the study was stopped early because of increased rates of breast cancer. In WHI, increases in breast cancer rates were significantly linked to EPT use before the trial. What has been proposed is that EPT may accelerate the rate of growth of existing breast cancers. It seems from the studies that this acceleration is HRT duration dependant (and also may be dose dependant). What is relevant is that diagnosis of breast cancers increased with ETP use beyond three to five years. This means that the risk of ETP use for less than three years immediately post menopause (at the lowest dose?) is not significant. There is also some interest in an apparent association between the occurrence of breast pain with HRT and breast cancer diagnosis ie this pain may be a marker of risk.
4. False*. Both the EPT and ET arms of the WHI study had an overall increased risk of ischaemic (but not haemorrhagic) stroke and this was one of the reasons for stopping the ET only arm of the study. However this increased rate of stroke was not observed in the 50 to 59 years old age group ie those who would normally be treated for immediate post menopausal symptoms. An increased rate of stroke was not seen in either the Women's Estrogen Stroke Trial or Heart and Estrogen/progestin Replacement Study.
5. True*.

*Estrogen and progestogen use in post menopausal women: July 2008 position statement of the North American Menopause Society available at <http://www.menopause.org/PSHT08.pdf>. This is well worth downloading. The media hype that followed the release of unadjusted WHI figures to the media (rather than adjusted figures to professionals for consideration) has caused unwarranted fear. The position statement is a balanced document that largely dispels the majority of concerns regarding HRT.

congratulations to Heather Simpson—10 years service at DCGPA



At the recent 2009 Annual General Meeting, there was a presentation to Heather Simpson for 10 years excellent service with DCGPA.

Heather Simpson joined DCGPA as an administrative assistant in September 1999. Heather is an incredibly loyal staff member who fits extremely well into a powerful administrative team. Heather's strengths are her warm and caring personality, her reliability, organisational skills and willingness to do that bit extra when required. She is a very good friend to other staff and well liked by all.

Aboriginal and Torres Strait Islander Health

'Closing the Gap'



General practice has an important role to play in efforts to improve the health and wellbeing of Aboriginal and Torres Strait Islander people in partnership with their community-controlled services and other services. MBS item numbers to support comprehensive health assessments for Aboriginal and Torres Strait Islander people in general practice have been introduced (#704, #706, #708, #710), and following Prime Minister Rudd's apology, further government funding is coming. **From May 2010, a range of incentives and arrangements will be introduced that are highly relevant to general practice** – see Box 2 over page.

The need is great - Aboriginal Australians today still have poorer health and poorer access to health care, social services and education than other Australians. This as well as the history of dispossession and exclusion helps to explain the life expectancy gap of 17 years between Aboriginal people and non-Aboriginal Australians. This gap persists in urban areas, including in the Dandenong and Casey areas, as well as rural. There is evidence to show that chronic disease prevention, detection and management for Aboriginal people, in particular for cardiovascular disease, is poor¹.

Despite the enormous impacts of European colonisation on Aboriginal ways of life, Aboriginal people have survived and Aboriginal culture is alive and strong. According to census data, there are at least 1568 Aboriginal people living within the Dandenong Casey area.

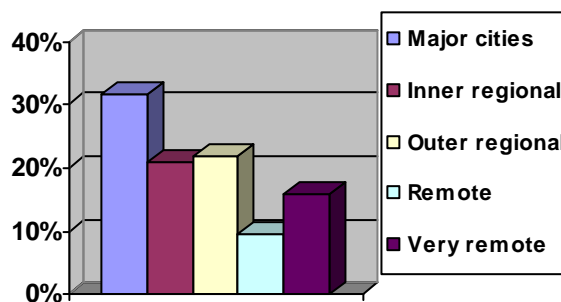
The Bunurong People are the traditional owners of this land and lived in the area for thousands of years before the arrival of Europeans.

A high number of Aboriginal people in the area receive services at the Dandenong & District Aborigines Cooperative and in Southern Health Community Health Services, who both provide culturally safe services.

Myth: Most Aboriginal and Torres Strait Islander people live in rural and remote areas of Australia

Fact: Most live in major cities (31.8%) and inner regional areas (20.9%), as indicated below.

% of Aboriginal and Torres Strait Islander Australians living in particular areas



Source: National health and Hospitals Reform Commission. 2009. *Interim Report*. <http://www.nhhrc.org.au>

Strategies to improve Aboriginal and Torres Strait Islander health

Here are some of the strategies used by practices around Australia that you can employ to 'Close the Gap' in a very practical way:

1. Ask your patients whether they are of Aboriginal or Torres Strait Islander descent, and routinely record this information so that you can proactively plan and deliver care. Current recommendations are to use the words **"Are you of Aboriginal or Torres Strait Islander origin?"**
2. Familiarise yourself with the Aboriginal health check MBS items and offer (or refer for) comprehensive health checks for every Aboriginal person.
3. Seek to improve the 'cultural safety' of your practice for Aboriginal people so that they feel safe and welcome to attend.
4. Become aware of the different vaccine recommendations that apply for Aboriginal patients (p 70-47 of the 9th edition *Australian Immunisation Handbook*). Commencement of the Childhood Immunisation is an appropriate time to ascertain a patient's cultural background to ensure the correct immunisations are administered.
5. Know about the range of services in the area that are specifically tailored for Aboriginal people, including at the local Aborigines Co-operative in Dandenong.

¹ Peiris, et al. 2009. "Cardiovascular disease risk management for Aboriginal and Torres Strait Islander peoples in primary health care settings: Findings from the Kanyini audit". *MJA*. 191(6):304-309.

The Association is happy to help in any way and we have recently been funded to employ a project officer specifically for Aboriginal health.

If you would like a practice visit or assistance in any way, or have suggestions, please do not hesitate to contact Program Advisor Peter Larter on (03) 8792 1900 on Tuesdays or Wednesdays on email p.larter@dcgpa.com.au.

BOX 2

'Closing the Gap' arrangements for general practice, from May 2010

Note – this information is provided only as a guide, and is subject to change. Medicare Australia will write to all PIP practices in early 2010 to advise of the final requirements and to invite practices to participate.

1. PIP Indigenous Health Incentive for practices

- **Sign-on payment:** if practices agree to undertake specified activities to improve Aboriginal health
- **Patient registration payment:** for each eligible Aboriginal patient registered with the practice for chronic disease management
- **Outcomes payment:** for each registered Aboriginal patient when a target level of care is reached

2. Chronic Disease Care Coordination & Supplementary Services

- Aboriginal patients who are registered with their practice may be referred by the GP for intensive care coordination

3. Increasing specialist follow up care

- Supporting specialists to provide outreach services – chronic disease focus

4. PBS co-payment measure

- Will provide PBS co-payment relief to Aboriginal patients with a chronic disease, or a risk factor for a chronic disease
- Normal co-payment of \$32.90 reduced to \$5.30
- Concessional co-payment of \$5.30 reduced to zero
- GPs will be required to be in a practice that participates in the PIP; register patients for the initiative; and annotate PBS prescriptions

5. Clinical practice and decision-support resources

Fair Work information statement released

The Fair Work Ombudsman (FWO) has released the Fair Work Information Statement. All National System Employers - basically all employers in Victoria - must give the Statement to all new employees (including casual employees) from January 1 "before, or as soon as practicable after" they start employment.

The two-page Fair Work Information Statement sets out information on:

- the 10 National Employment Standards (NES) entitlements, including their operation in transfers of business;
- modern awards;
- the agreement-making process;

- individual flexibility arrangements;
- freedom of association and the workplace rights safeguarded by the Fair Work Act's general protections provisions;
- termination of employment;
- right of entry; and
- the functions of the FWO and Fair Work Australia.

The Statement can be accessed via the Fair Work Australia website at: www.fairwork.gov.au/Pay-leave-and-conditions/Conditions-of-employment/Documents/Fair-Work-Information-Statement.pdf.

Source: MacPherson and Kelley Solicitors



creative
ways to care
strategies for carers of
people living with dementia

GPs can refer families/carers to the *Creative Ways to Care*-strategies for carers of people with dementia education and training program. This six session program will be offered across the southern region of Melbourne in February and June 2010 in Caulfield, Dandenong, Brighton, Parkdale and Mornington.

Families/Carers will:

- Learn strategies and techniques to respond to changing behaviour and reduce or prevent behaviours of concern

Dementia Education for Family Carers

Have you got a patient who has dementia or is caring for someone who has?

- Learn how to improve communication and enjoyment of everyday life
- Practice the strategies taught in a relaxed environment
- Receive tools and resources to apply learning at home

This course will be researched by La Trobe University in 2010.

To make a booking or receive promotional material for your surgery contact Alana Szyllit at the Commonwealth Respite Centre Southern Region on 9076 4047.

Financial Pitfalls for Palliative Patients

The GP, as a figure of trust and authority, is often asked about other issues than health related ones in the context of a patient with a terminal illness. This scenario happened recently and had catastrophic outcomes for the patient and his family.

Mr. Z was diagnosed with a terminal illness and received support through his GP. He had immigrated from Korea in 1987 and had a substantial amount of superannuation. He had been married 20 years ago but was now in a de facto relationship with his carer.

The family was worried about income, now that Mr Z was ill and asked the GP for advice. The GP advised them not to withdraw their Super as would lose it.

This was bad advice because if a person is terminally ill, Super and any Total and Permanent Disability/Death component can be drawn tax free with no penalty. For Mr. Z, this had the consequence that he lost his Income Protection of \$800 per month, plus Total and Permanent Disability of \$150000 and the account balance of \$80,000. All this money

would have made Mr Zs life easier in his last few months and provided for his partner after his death.

Following Mr. Z's death, the former partner was the binding beneficiary of the superannuation and received the funds as he had forgotten to change the nominated binding beneficiary after meeting his current partner.

There are a number of learnings from this case:

- Even though we want to help families, we should not give financial advice as it can be detrimental for patients and their families
- There are particular circumstances that apply to terminally ill patients and this requires specifically trained people to assist.
- More information can be found on: www.caresearch.com.au

Dr Sandeep Baghat,
Senior Medical Officer,
South East Palliative Care



The Board of Directors and staff at Dandenong Casey General Practice Association wish all GPs and practice staff a festive holiday season and a safe and prosperous New Year.

Please note the Association Office will close at 2.00pm on Thursday 24th December and will reopen on Monday 4th January, 2010.

A Fresh Start in 2010

With new government initiatives focusing on prevention of chronic disease, the New Year is the perfect time to target patients to make lifestyle changes to reduce their risk of chronic disease in 2010 and beyond.

Does your patient have any of the following risk factors?

- Overweight
- Smoking
- IGT/IFG
- High blood pressure
- Over 40 years of age
- Sedentary lifestyle
- Low intake of fruit and vegetables

If so, they are likely to be eligible to participate in the Life! Taking Action on Diabetes Program which focuses on making long term lifestyle changes to reduce chronic disease risk factors.

DCAS are now taking enrolments for the program, with multiple courses due to commence in the New Year.

To refer, send completed forms to DCAS (see below), or contact Candice Crellin (Ph: 8792 1922 Tuesday - Friday) for further information.

DCAS

using the Victorian Statewide Referral Tool
http://www.dcgpa.com.au/resources/Health_Programs/Diabetes/

Referrals can either be faxed: 9793 9052 or
E-referred via Argus: dddgp_arguspgref@dddgp.com.au

