



Academic Unit in Primary Health Care Strategic Planning Workshop



*A/Professor Danielle Mazza, Dr Andrew Block,
Professor Barry McGrath, Dr I-Hao Cheng,
Dr Graeme Downe and Mr Greg Young*



*Donna Cohen (facilitator) with Dr
Grant Russell, Director of Primary
Care Research*

A strategic planning workshop for the newly established Academic Unit in Primary Health Care was held on Thursday 18 March 2010 at the Sandown Regency Motor Inn in Noble Park. The workshop was facilitated by Donna Cohen.

The Dandenong Casey General Practice Association (DCGPA), Monash University and Southern Health have jointly established the Academic Unit, to further primary health care research and education in the Dandenong Casey region.

Unit Director Grant Russell welcomed 22 participants including representatives from Southern Health, Monash & Melbourne Universities and DCGPA.

The agenda for this workshop was fairly ambitious. In just over four hours of discussion, almost all of the key elements of a strategic plan were addressed: *mission, vision, goals and objectives, identification of strategic issues and formulation of strategies*. Although we did not complete all aspects of an analysis, we did identify major issues and possible solutions, and also arrive at some principles from which the strategic plan will be drafted.

The newness of the unit meant there was little to discuss in relation to *where we are*, however, since the difference between a *plan* and a *strategic plan* is *context*, then we did want to understand the environment in which the Academic Unit is being established. For this reason, the first session was spent discussing stakeholder perspectives and conducting a SWOC analysis. SWOC (= Strengths, Weaknesses, Opportunities, Challenges). This analysis provided a *reality check* for setting goals and objectives and formulating strategies to deal with issues.

The stakeholder analysis provided important information about the perspectives, needs and expectations of all who have an interest in the Unit, not just the three partners.

On behalf of the partners in the Academic Unit we wish to thank all participants for their energy, enthusiasm and valuable contribution. All agreed that it is an exciting time to be at the cutting edge of primary health care research in Australia. **Anne Peek**

**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.

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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

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:

St John of God Hospital Newsletter



Pen Tip:

Pen Clinical Audit Tool latest update – version 2.8

The latest Pen update, version 2.8 is currently available when you log in anytime after the 1st of March. It is important to always click 'yes' to updates when prompted to do so by Pen to get the most out of the clinical audit tool. The features that come with this upgrade include:

- Scheduled collections (not available for Genie users) – a separate application installed on only one PC at the practice which is configured to schedule collections at a convenient time or at regular intervals.
- Deidentify tool for deidentifying data extracts. Available as a menu option: Tools > Deidentify dataset. Load the data extract you wish to deidentify before running the tool; a new deidentified dataset will appear in your list of extracts.
- A 'select all' checkbox has been added to all charts allowing you to select all the segments on a chart; useful for practices utilising the cross-tabulation 'Report' button.

Also, with this update some 'bugs' have been corrected; these include:

- 'Visits in the last 6 months' filter will now work if you type in a numerical value rather than selecting it from the drop-down list, however only values that exist in the drop-down can actually be used, otherwise you will be alerted with an error.
- Dementia filter was incorrectly available for older data sets; however this will now grey-out when unavailable.
- Medications graph – the stimulants medication segment was incorrectly showing as antipsychotics in the filter text – this has been corrected.

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.

Prostate Cancer Telephone Groups

Cancer Council Victoria is currently recruiting for their **Prostate Cancer Telephone Groups**. The groups are for:

- Men with advanced prostate cancer
- Younger men
- Family and carers of men with prostate cancer

The project is a partnership with Mensline Australia, funded by Beyond Blue and the Prostate Cancer Foundation Australia.

The groups will run for 1.5 hours for six weeks and are professionally facilitated. If you have patients who would benefit from these groups please contact Robyn Metcalfe at Cancer Council Victoria on 9635 5590.

WorkHealth: How does your health stand up?

Are you seeing an increased number of patients enquiring about their risk of type 2 diabetes or cardiovascular disease (CVD) after having participated in a WorkHealth check in their workplace?

Many Victorians believe they are healthier than they really are. The focus of WorkHealth checks is to identify risk for type 2 diabetes and CVD in Victorian workers, in order to help prevent these conditions.

Take-up of the WorkHealth program has been positive so far, with more than 76,000 checks delivered. Some of the recent findings of the program include:

- 40% indicating a 'high' or 'very high' risk of developing diabetes or CVD
- 34% who thought they were in 'excellent' health were actually at 'high' or 'very high' risk of diabetes or CVD
- 42% of workers had low levels of HDL cholesterol
- 26% had a waist measurement indicating a greatly increased risk of type 2 diabetes
- 93% reported eating less than the daily recommended intake of fruit and vegetables
- 74% reported inadequate physical exercise

Workers identified at high risk are advised to see their GP. Workers are also given information and advice on how to reduce certain risk factors, such as improving nutrition, quitting smoking and increasing physical activity.

WorkHealth checks may support general practices to identify existing chronic conditions such cardiovascular disease and diabetes that can be treated under GP Management Plans and Team Care Arrangements.

To support patients, a referral to a Lifestyle Modification program can be made.

Send referrals to:



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

Contact DCAS on 8792 1922 for further information.

For further information on the WorkHealth initiative or referring patients to Lifestyle Modification Programs, please contact: Dandenong Casey General Practice Association on 8792 1900.

You can also visit the WorkHealth website at www.workhealth.vic.gov.au to learn about what's involved in a WorkHealth check.



Immunisation Update

Extension of pertussis prevention program for parents of new babies ends June 2010.

Until the 30th June 2010, Victoria has a supply of free Boostrix® vaccine for parents with a baby born since 15th June 2009. Please continue to offer Boostrix vaccine to these parents as soon as possible after birth.

The time limited supply of Boostrix vaccine has been extended in response to the current outbreak of Pertussis infection.

Parents under 22 years of age may have been given Boostrix in year 10 (commenced in 2004) and do not require a further dose.

Babies are at risk from Pertussis as no protection is passed from the mother to the newborn baby. Babies do not develop sufficient pertussis protection until the three dose course of pertussis containing vaccine is

completed. Pertussis is most serious in babies less than six months of age and around one in every 200 babies under six months of age who catches pertussis will die.

The information pamphlet for parents of new babies and a specific order form for supplies can be ordered on line at www.health.vic.gov.au/immunisation.

If you require further information regarding Boostrix vaccine ordering, please call the immunisation program on 1300 882 008.

- Free Boostrix vaccine for parents of new babies born from 15th June 2009
- Program available until 30th June 2010
- Boostrix is safe to be given to the breastfeeding mother
- Order Boostrix vaccine by using the government form on the webpage.

Immunisation Program Newsletter

The February 2010 issue of the Immunisation Program newsletter is available online at: <http://www.health.vic.gov.au/immunisation/general/newsletter>.

Newsletter Contents

- Extension of the pertussis prevention program
- Panvax(r) H1N1 vaccination program
- Seasonal influenza vaccine in 2010
- SAEFVIC
- Criteria for use of government vaccine
- What criteria have changed?
- HPV vaccine program
- COMVAX(r) stock now expired
- Updated resources
- New email address
- Faxed vaccine order lost?
- Further reading

HPV register ending 31st March, 2010

Time is now running out to receive payments for HPV vaccinations notified to the HPV Vaccination Register. To ensure you receive notification payments for outstanding vaccination data (\$6 per dose notified), notifications must be received by 31st March, 2010.

Payments can only be made for HPV vaccinations given to eligible consumers when the data is received

in an accepted format with all complete mandatory information (*GP Provider number, patient name and address details, date of birth, Medicare number, vaccination date and dose number*). GPs must be registered with the HPV Register in order to receive payment as they require your banking details.

Important: Please do not resubmit notifications which you have already provided to the Register as this will delay processing and payment of other notifications.

If you would like assistance with how to submit your notifications, or wish to check if they have already received your notifications, please call them on 1800 478 734 (1800 HPV REG).

2010 Seasonal Flu will not be available on PBS

Please be advised that we have heard that the 2010 Seasonal Flu will not be available on PBS.

Seasonal flu vaccine can be supplied directly by the GPs therefore no PBS listing. It can still be done on a private script for about \$22 upwards which is a similar price to the PBS price for general (ie not pensioner or repat) customers.

As yet, we have no further information than this, except clinic's may need to stock more private vaccines, and clients on a pension without a chronic illness will no longer receive this at a reduced price.

We will forward more information as it comes to hand.

Refugee Health

Southern Health Refugee Health Nurse

The Southern Health Refugee Health Nurses continue to assist refugees to access services and to assist GPs with their care. The nurses are happy to give GPs information about appropriate referral services and to assist individuals and refugee families with their health needs and coordination in the community.

The region is sad to see Refugee Health Nurse Gayle Comyn move to Canberra, but Sue Willey continues to provide services and can be contacted on 0420 301 634.

Dandenong Hospital Refugee Health Clinic

The Refugee Health Clinic continues to offer specialist Infectious Disease Physician and Paediatrician services to refugees. Referrals can be made via the dedicated fax 9554 8554 only.

Referral information should include: the specific clinical reason for referral (the clinic does not do general refugee health screening), relevant background, interpreter requirements and the contact phone number for the patient or representative. Investigation and immunisation details should also be attached to avoid duplication. The clinic recommends using Southern Cross Pathology and Southern Health Imaging where possible so that investigation results will be immediately available on computer to the clinic doctors.

The clinic also offers fee-free GP services to Medicare ineligible Asylum Seekers. The clinic welcomes Dr Gowri Ratnavel and Dr Kelvin Lau to this position and farewells Dr I-Hao Cheng. Asylum Seekers can be referred using the same fax number. They should be identified as an Asylum Seeker on the referral and will need to provide documentary evidence of asylum seeking status such as copy of their visa or letter from an Asylum Seeker support organisation.

Complex Case Support

The Department of Immigration and Citizenship offers intensive case management services to individual refugees and humanitarian entrants with exceptional needs. Such needs might include serious physical or mental health issues, family violence or the need for specialised and coordinated services for children and youth. Case managers are assigned to assist.

Enquiries and referrals can be made by telephone 1300 855 669 or online: <http://www.immi.gov.au/living-in-australia/delivering-assistance/government-programs/settlement-programs/ccs.htm>

Dr I-Hao Cheng
Refugee Health Program Coordinator
Phone: 8792 1900
Email: IHao.Cheng@dcgpa.com.au

Quality Use of Medicine News



There is no such thing as a “sleeping tablet”. QUM news would like to give an award for to the person who invented the idea of “sleeping tablets, which is just a concept because no such medication exists.

No medication marketed today (including melatonin) has been demonstrated to produce natural sleep. They produce a range of effects including sedation. Sedation is not sleep but may allow sleep to occur. Short term use excepted, use of these drugs will inevitably lead to serious problems for the overwhelming majority of patients. There are two major predictors for problems – duration of use and older age.

It is easy avoid these serious problems by not prescribing so called “sleeping tablets” for:

- more than temporary use.
- persons who are older.

So what have these products been found to do? Initially they will cause some reduction in the time that it takes to fall asleep (sleep latency) and a small increase in the time spent sleeping but these effects wear off in a few weeks. They also cause daytime sedation (much more so in the older person due to slower metabolism) resulting in reduced physical activity (to provide the tired body that would normally aid sleep) and mental alertness (with attendant safety considerations, behavioural problems and depression). These effects compound over time and the onset of adverse effects may be insidious. Paradoxically, over a period “sleeping tablets” will actually cause poor sleep (rebound insomnia).

QUM News has been drug dealing since 1963 and dispensed them all – bromides, chloral hydrate, antihistamines, barbiturates, benzos (admittedly less deadly than the barbiturates) and now the z-drugs. They are all dirty drugs with lots of adverse reactions and all may cause addiction, habituation and tolerance. It was interesting to watch as one customer actually went to sleep in the pharmacy while waiting for his “sleeping tablets” to be dispensed. This also demonstrated the crux of the problem, most people actually don’t have any trouble sleeping, they just don’t know how and when to do it.

Trying to sleep too long, sleeping in the daytime, lack of tiring exercise, inappropriate sleeping environment, stimulants before bed and irregular lifestyle habits can all be addressed with cognitive and behavioural therapies to improve sleep hygiene. Trials have shown the onset of effect is not rapid but is persistent. What has to change is attitude. Most people believe in “sleeping tablets” and have no faith that they can be taught to sleep. The evidence is the opposite. Additionally evidence and clinical experience show “sleeping tablets” do not solve problems, they create them.

The irony about this is that most of us have actually taught others to sleep, ie children. We make sure that they exercise throughout the day, avoid stimulating them at night, treat pain if present, turn off their lights when they are in bed and make sure their hours (particularly bedtime) are regular. This works. Furthermore the community would regard the regular sedation of children to achieve sleep as abuse.

GPs have an important part to play in this, it is not easy and it will be time consuming. What is needed is for GPs to take the time to educate patients about sleep and sleep hygiene. Pharmacotherapy should be reserved for precipitating factors such as pain or depression or circadian changes. The NPS has developed a program “Management options to maximise sleep” and GPs are urged to participate.

As usual this will qualify for RACGP points and the QPI PIP. For more details or to book a visit call Graham Sweet on 8792 1900.

Quick quiz. The quick quiz in honour of sedatives.

1. A *Mickey Finn* or to *slip someone a Mickey*, describes the practice of drink spiking that was pioneered by a Chicago barman, Mickey Finn to rob his patrons. What was the drug used by Finn to spike their drinks?
2. The first benzodiazepine on the market (in 1960) was chlordiazepoxide. What was its trade name?
3. You have a patient that requests “sleeping tablets” so that they may sleep on a flight to London and because they sometimes have trouble sleeping when on holidays. Overall the request is reasonable, they are a younger person and well aware that sedatives to aid sleeping should be used judiciously. What additional advice do you give them regarding the potential risks of taking a sedative while travelling on an aircraft?
4. Who said “cricket is basically baseball on Valium”? (Clue it was the actor who played the role of the doctor, Patch Adams, in the 1998 movie of that name.)
5. St. Barbara was beheaded by her father for becoming a Christian whereupon her father was struck down by lightning. This caused her to be associated with explosions and hence the patron saint of miners and artillerymen. Adolph Baeyer (the founder of the Bayer drug company) celebrated the synthesis of malonylurea, which became the basis for many sedative drugs with some artillerymen and named the compound after her. What was the name of the compound and the sedative drugs group?

Paroxetine use during tamoxifen treatment is associated with an increased risk of death from breast cancer. 8 February 2010, BMJ 2010;340:c693. From *Selective serotonin reuptake inhibitors and breast cancer mortality in women receiving tamoxifen: a population based cohort study* by Catherine M Kelly et al.

Results from a population based cohort study of women living in Ontario aged 66 years or older between 1993 and 2005.

Of 2430 women treated with tamoxifen and a single SSRI, 374 (15.4%) died of breast cancer during follow-up (mean follow-up 2.38 years, SD 2.59). After adjustment for age, duration of tamoxifen treatment, and other potential confounders, absolute increases of 25%, 50%, and 75% in the proportion of time on tamoxifen with overlapping use of paroxetine (an irreversible inhibitor of CYP2D6) were associated with 24%, 54%, and 91% increases in the risk of death from breast cancer, respectively ($P < 0.05$ for each comparison). By contrast, no such risk was seen with other antidepressants. We estimate that use of paroxetine for 41% of tamoxifen treatment (the median overlap in our sample) would result in one additional breast cancer death within five years of cessation of tamoxifen for every 19.7 (95% confidence interval 12.5 to 46.3) patients so treated; the risk with more extensive overlap would be greater.

Somebody had to do it! This little gem was found on the internet where they are selling *Universal Placebos* for AUD\$15.00 per bottle + AUD\$5.00 postage. It should be noted that one of the designers of these pilules is Brian, a homeopath, who according to their site *“was immediately interested because of the resonance of the placebo idea with the nature and intent of homeopathy and other so-called complementary therapies, the placebo being a refinement and simplification of the metaphysical approach to healing”*. QUM news has no argument with the value of the placebo but does think that this says a lot about *“homeopathy and other s o - c a l l e d c o m p l i m e n t a r y therapies”*.



How to get the best out of Home Medicine Reviews (HMRs). It's just like any other referral, more information and clear identification of concerns will enable a better final outcome. For example, if

your reason for ordering a HMR is that you think the patient might benefit from once a day aspirin but you are not sure if the patient is taking other medications that may increase their bleeding risks, ask the pharmacist to check this out for you on the referral. Similarly you may be unsure whether a patient is not responding to their asthma medications because they are not using them, they are not using them correctly or their asthma has deteriorated. Be specific on the referral, ask the pharmacist to check compliance and inhaler technique. Many HMRs may have failed to give satisfaction as the pharmacist is not exactly sure of what the GP wants investigated and this may result in a broad brush review that just attempts to tell the GP a lot that they already know. HMRs can be a powerful tool to better inform GPs just what their patients are doing with their medicines and the best results are gained by the best referrals. Want to know more about HMRs? Call Graham Sweet at the Association on 8792 1900.

Quick Quiz answers

1. Chloral hydrate, that like other modern sedatives can also cause anterograde amnesia, which is a nice effect as far as drink spikers are concerned.
2. Librium.
3. There are at least 3 potential additional risks in this situation:
 - The falls risk associated with sedatives is often seen when people have to go to the toilet at night. This is likely to be worse in an unfamiliar environment with an unsteady floor (an aircraft).
 - An emergency evacuation from an aircraft is liable to be more difficult for those who are sedated.
 - On long flights regular leg exercises are recommended to avoid Venous Thrombo Embolisms (VTEs) and such exercises may be impaired while sedated.
4. Robin Williams.
5. Barbituric acid was the compound and barbiturates were the sedative drugs group. The irony here is that St. Barbara's father was struck down by lightning and barbiturates are also used as anticonvulsants (epileptic convulsions being associated with unusual electrical patterns in the brain) so it really does seem that she could have the ability to control electrical discharge.

Berwick GP Super Clinic Update

There will be a regular, brief item in the DCGPA newsletter to keep members up to date as the Berwick GP Super Clinic moves from planning and construction to fully operational.

Feb-March 2010

- Detailed planning is underway to ensure the layout of the clinic maximises use of the available space and creates an environment conducive to professional interaction and community access.

- In order to decide on the best mix of services to be provided by the clinic, discussions will be held with a range of health care providers, including medical, allied health and diagnostic services.
- Creative skills are being tested in the quest for a distinctive name for the clinic.

If you would like further information about any aspect of the Berwick GP Super Clinic, please contact Mary Mathews on (03) 8792 1900 or via email m.mathews@dcpa.com.au.

Questions and Answers regarding Use of the Telephone Interpreting Service (TIS) Doctors Priority Line for Interpreters

Information gathered from the Victorian GP Refugee Health Working Group.

Question: Can block bookings be made under the Doctors Priority Line (for example: every Thursday morning for 4 weeks ahead) either for on-site or telephone interpreters?

Answer: Block bookings for fee free agency providers (such as GPs) may be available under the following conditions:

- the medical practitioner will need evidence that they have confirmed appointments with patients of a given language/dialect for the duration of the booking period. A list of patients with appointments will be required to make the booking.
- in the event that the interpreter will not be fully utilised for the full booking period, TIS National will need to be notified with more than 24 hours notice. A more appropriate service or timeframe can then be arranged.
- in the event that the block booking is cancelled, TIS National should be notified immediately; there is a financial cost to the Commonwealth if services are cancelled within 24 hours.
- block bookings will be subject to interpreter availability and normal limits to on-site services.

The reason for these conditions is that having interpreters attend for block appointments (and/or potentially waiting on stand-by) reduces the overall availability of interpreters to undertake other on-site and telephone jobs. There is a finite number of interpreters in Australia. We need to allocate their resources effectively as possible to meet all our clients' needs.

In addition, whilst interpreting services are 'free' to approved medical practitioners, they actually incur a cost to the Department. In allocating interpreters to interpreting assignments, we need to be mindful of appropriate expenditure of government funds.

To register a job, TIS National requires the Client Code of the attending doctor, the name of the non English speaker/s, the intended duration of the assignment, and (for on-site) the address of the clinic.

Question: A GP in Shepparton was told she had to pay \$500 to have an interpreter on site in Shepparton as it is more than 100km from Melbourne. She would have to pay in advance and could try to have it refunded later. Could this be clarified?

Answer: If the GP was receiving services under the fee free policy, there would be no reason why they should be charged travel costs. It is possible that the on-site officer did not realise the client was receiving fee free services when they provided this advice.

If ever there is confusion about fee free service issues, please contact the Client Liaison and Promotions team for clarification on 1300 655 820.

Question: Are phone interpreters used by TIS required to conduct their interpreting in an office or 'quiet place'. We received some reports about it being very difficult to hear because of the background noise of a public place.

Answer: We do, on occasion, receive feedback about background noise. We ask our interpreters to always move to a quiet, private place when undertaking telephone interpreting work. However, we do accept that some interpreters take calls on their mobiles phones, and this can result in disruptive background noise. We are looking into strategies to resolve these issues.

In the meantime, I would encourage clients who have a poor experience of our service to please advise our contractor managers directly. As we do not record phone calls, it is important that we receive feedback when there are concerns about the quality of our service. If possible, it really helps us if the client can quote the job number, or their client code and the date/time of the service. We can then address the concerns directly with the interpreter, and identify any patterns of unsatisfactory performance. Our contractor managers can be contacted on 1300 132 621 or at interpreters@immi.gov.au

Question: It seems that telephone interpreting is preferred to on-site by TIS. Is this correct and if so, does that mean there would be more availability of telephone interpreters than on-site?

Answer: TIS National prefers doctors to use telephone interpreting where possible - especially in cases where the consultation is likely to be of short duration or relating to a simple health matter. On-site interpreting is more expensive and much more resource intensive, so we ask practitioners to use discretion when determining if the client needs a face to face interpreting experience. Using telephone interpreters where possible frees up interpreters for more complex consultations, and allows TIS National more effective allocation of on-site interpreter resources.

Telephone interpreting services offer many benefits to GPs and specialists:

- It's fast! TIS National connects to an interpreter in a major community language within three minutes on 90% of occasions (in fact, 99% in November 2009).
- The Doctors Priority Line is an immediate service - there is no need to book a telephone interpreter (unless you want the guarantee of availability at a set time, or your client speaks a high demand or new and emerging language). You simply call when you need us.
- The Doctors Priority Line allows GPs and Specialists priority access to operators - in effect, they jump the call queue.

However, the biggest benefit of telephone interpreting for GPs and Specialists is that we are able to connect to a national pool of interpreters - not just those residing in the local area. In most languages, this significantly increases interpreter availability. In addition, and this can be a real benefit to small communities, it reduces the likelihood that the interpreter will be personally known to the client - thereby offering the client a greater assurance of privacy and anonymity.

Question: Does an on-site interpreter have to be booked for 90 minutes minimum?

Answer: Yes. 90 minutes is our minimum booking period for on-site interpreting.

For further information phone Louise Crowe at Foundation for Survivors of Torture and Trauma 9389 8909 or email crowel@foundationhouse.org.au



Aboriginal and Torres Strait Islander Health

National Close the Gap Day 2010



Chronic illness accounts for approximately 70 per cent of the 17 year life expectancy gap between Aboriginal and Torres Strait Islander people and other Australians. It is inexcusable that as a first world nation we have allowed this gap to widen. Within this generation, by 2030 we can commit to Close the Gap by providing accessible, informative and culturally safe health care in partnership with Aboriginal and Torres Strait Islander people.

Close the Gap is Australia's largest campaign to improve Aboriginal and Torres Strait Islander health. As well as chronic illness, factors such as inaccessibility and lack of cultural safety contribute to the health gap in Australia. A coalition of Indigenous and non-Indigenous and human rights organisations are committed to working with Federal, State and Territory governments to close the gap in Aboriginal and Torres Strait Islander health inequality to address these factors. The fourth annual Close the Gap day will be held on Thursday the 25th of March, the theme this year titled "Lets get it right," which focuses on the need to develop a sustainable long term plan of action to Close the Gap.

If you would like to host an event to raise awareness among your friends, peers or colleagues please register on the Oxfam website at www.oxfam.org.au/nation-day and Oxfam will send you all the materials you'll need to host a successful event including a short 8 minute 2010 Close the Gap DVD. To improve the services to Aboriginal and Torres Strait Islanders in your practice familiarise yourself with the comprehensive health checks and systematically offer them to your patients: GP Aboriginal child health check (#708), GP Aboriginal adult health check (#710), GP Aboriginal older person's health check – in a consulting room (#704) and GP Aboriginal older person's health check – outside a consulting room (#706). Watch out for your fax invite to the MBS workshop held on the 27th of April which will solidify the new (simpler) policy and inform you about PIP! This workshop will provide valuable knowledge in order to move towards closing the gap.

There are five priority reform areas defined by the National Aboriginal Health Partnership, one of which is "Making Indigenous health everyone's business" - if Australia adopts this attitude we will come one step further towards closing the gap!

Introducing...

Amali Aluthgamage



Amali has recently been employed by the Association to work with practices and the Aboriginal and Torres Strait Islander community to improve their health. She can help you:

- Identify Aboriginal patients
- Understand Aboriginal health checks and MBS subsidised allied health services
- Know where to refer eg: to the Aboriginal health service

We are very pleased to have Amali - she has worked in a variety of roles such as a research assistant in Aboriginal health at Charles Darwin University; a volunteer for Hope International in Colombia (infectious disease control); and liaison worker for migrants in the National Health Service in the UK.

If you would like a practice visit or assistance regarding Aboriginal health, please contact Amali on (03) 8792 1900 or email amali@dcgpa.com.au