dandenong casey
general practice association

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Appointment of Dr Grant Russell as Professor of General Practice

Dandenong Casey General Practice Association (DCGPA), Monash University and Southern Health are delighted to announce the appointment of Dr Grant Russell as the Professor of General Practice and Director for the newly established Primary Care Research and Academic Unit.

DCGPA, Monash University and Southern Health have jointly established the Academic Unit to be located at DCGPA in Dandenong. The unique nature of this partnership brings together three very important providers of health service and education in the outer metropolitan area of Greater Dandenong and Casey.

Dr Grant Russell is a graduate of the University of Western Australia. He completed his GP training with the Family Medicine Program in 1989. He subsequently worked as a GP in Perth, setting up a small, independent general practice with colleagues prior to leaving for Canada in 2005 to work as an academic family physician and clinician investigator at the Department of Family Medicine at the University of Ottawa, Canada. His research program is directed towards understanding and measuring the impact of primary care reform on patients, clinicians and general practices. He was the inaugural Director of the RACGP Research Unit (WA) and holds a Masters of Family Medicine from Monash University and a PhD from UWA.

He and his wife Kathy have three school aged children. Grant tells us that the children have Canadian accents and are still to be convinced of the wisdom of their parents latest career move. He added that he had a characteristically unsuccessful cricket tour of England last year with the University of WA Veteran's XI, and still hopes to be able to see his first Boxing Day Test. It is understood that Grant's AFL team is Fremantle! We look forward to welcoming Grant and his family in early November 2009. ***Dr Nicholas Demediuk***

A message from Grant

It's sometimes unnerving to think about how much change has confronted Australian GPs in the last 20 years. Vocational registration, technology, targets and incentives make general practice seem almost unrecognisable compared to how it was when I finished medical school. Yet, seen through another lens, our work remains as it always was - built on a foundation of trust, continuity and relationships.

My time in Canada has shown me the importance of another sort of relationship - that between key parts of the health care system. For all the successes of Canadian health care, the nation's GPs and other primary care clinicians have minimal opportunities to work together to shape the health of their communities. Family Doctors feel isolated and bewildered as the country makes moves towards new inter-professional models of care. My occasional reading of the Australian medical press reveals some of the same bewilderment from GPs in Australia. However Canada has nothing like Australia's Divisions of General Practice and, as a result, it's almost impossible to find common ground between the needs of clinicians and those of the government.

That common ground seems to exist in Melbourne's South East as the Dandenong Casey GP Association, Southern Health and Monash University School of Primary Care build on a long history of collaboration to take the bold step of opening a new academic unit. I am honoured to be part of this venture and am very optimistic that we can build something of value to the community and for the clinicians who continue to serve them so well.

I look forward to getting started! ***Dr Grant Russell***

Quality Improvement Council

Dandenong Casey
General Practice Association

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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 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:

Important addition to health information displays

Send a message to patients - "Yes, you can talk to us about gambling"

For a patient who is dealing with a gambling problem, be it their own gambling or someone else's, some well-placed information in your practice may be the prompt that finally sees them talk about the issue.

In Australia, problem gambling is more common than stroke and coronary heart disease[1], yet only about 10% of people with a gambling problem seek formal help[2]. The stigma associated with problem gambling can mean that it is kept secret by individuals and family members for months, even years. Without doubt, many patients presenting to general practice with a range of mental and physical health conditions, have related but undisclosed gambling problems.

By displaying information about problem gambling, your practice sends clear messages to patients:

- "Yes, we understand that problem gambling is a health issue."
- "Yes, you can talk to us about problem gambling."

The conversation a patient has at your practice, or the information they pick up, may be the start of them getting their life back on track.

Gambler's Help provides a range of free health information resources, including materials in community languages. They include:

- *'Concerned About Your Gambling'* - Self screening quiz (card format)
- *'Strategies for Change'* - Self help guide (in booklet format) for gamblers, their partners, family members and support people
- *'I can control my gambling'* - Self help booklet
- *'Two-thirds of people seeking help from us end up gambling a lot less'* - Gamblers Help service information brochure
- *'Does someone you care about have a gambling problem?'* - Booklet containing advice for family and friends
- 'Protection for you and your family' - Brochure regarding financial and legal protection in problem gambling situations.
- 'Life After Gambling' - DVD relating true stories of problem gambling, seeking help and recovery.

To order any of these materials, or to find out more, contact Gambler's Help Southern on 9575 5353 or via info@ghsouthern.org.au.

[1] Thomas, S., Piterman, L., & Jackson, A. (2008) Problem gambling: what do general practitioners need to know and do about it?, *Medical Journal of Australia, Volume 189 Number 3, August 4 2008*, p. 135-136.

[2] Delfabbro, P. (2007) *Australasian Gambling Review – Second Edition (1992-2006),* Adelaide, Independent Gambling Authority of South Australia, p.153-154.

Influenza Update: The flu season is not over!

Along with the rest of Australia, Victoria remains in the protect phase as part of the ongoing response to the H1N1 virus.

What does 'protect' mean?

1. A focus on early treatment of people who may be vulnerable to severe outcomes. These people include pregnant women and those with respiratory disease (asthma, COPD), heart disease, diabetes, renal disease, morbid obesity, and immunosuppression, as well as Aboriginal and Torres Strait Islanders.
2. Identification and early treatment of those with moderate or severe disease especially in people with respiratory difficulty.
3. Control of outbreaks in institutional settings, such as special schools.
4. Voluntary home isolation for those with mild disease with supportive treatment only, such as over the counter medication. Antiviral therapy from the national or state medical stockpiles will not be provided to these patients or their household contacts, unless they belong to vulnerable groups or are in institutional settings. Contacts will not be placed into quarantine.
5. Testing would be directed to identification of Pandemic (H1N1) 2009 in people with moderate or severe illness, people more vulnerable to severe illness or those in institutional settings.

For the most up-to-date information:

- Visit www.humanswineflu.health.vic.gov.au or check out our website www.dcgpa.com.au.

Flu Program to be expanded:

The Commonwealth Government has decided to fund the influenza vaccine under the NIP (National Immunisation Program) for people at increased risk of influenza complications from 1 January, 2010.

The additional groups that will become eligible for free influenza vaccines are:

- Pregnant women
- All Aboriginal and Torres Strait Islander people aged 15 to 50 years
- People medically at risk aged six months to 65 years:

The Australian Immunisation Handbook 9th Edition 2009, has a fully comprehensive description of those deemed to have an increased risk of complications from influenza infection on pages 190, 191 and 192.

Any queries please call DCGPA on 8792 1900 or email k.russo@dcgpa.com.au.

CYSTIC FIBROSIS CARRIER SCREENING PROGRAM

www.cfscreening.com.au

Cystic fibrosis is the most common severe genetic condition amongst Caucasians. It causes recurrent chest infections and malabsorption of food. Tragically, it markedly shortens life expectancy. One in 2,500 Caucasian individuals has cystic fibrosis, and one in 25 individuals is a carrier of a cystic fibrosis gene fault. If both members of a couple are healthy carriers of cystic fibrosis gene faults, there is a one in four chance for each of their children to have the condition.

A screening pack for cystic fibrosis carrier testing has been produced. The screening for cystic fibrosis is done from a painless cheek-brush sample. The twelve most common gene faults that result in severe cystic fibrosis are tested. This will diagnose approximately 80% of carriers among the Caucasian community. The screening packs contain all that is required for screening; an information brochure, request form **(which must be signed by a medical practitioner)**, cheek-brush, instructions on sampling and payment forms. Because cystic fibrosis carrier screening is not covered by Medicare, they charge for the testing to cover their costs ($200 per person screened). This cost is about the same as the out of pocket expense for a first trimester screen for Down syndrome. Individuals only need cystic fibrosis testing once, so this cost does not need to be repeated in subsequent pregnancies. Individuals can collect their own sample and mail it to the laboratory in the pre-paid envelope provided. Genetic Health Services Victoria will provide genetic counselling free of charge to any individual identified as a carrier.

The screening program was launched in January 2006 together with Cystic Fibrosis Victoria which is fully supportive of this endeavour in the interest of patient choice. Over 4000 couples have had their risk for cystic fibrosis quantified through the program and eleven couples have been found to both be carriers of a cystic fibrosis gene fault. If both members of a couple are carriers they are offered genetic counselling, support and the opportunity to see a cystic fibrosis specialist. There are a number of options for couples where both are carriers of cystic fibrosis gene faults.

The Victorian Clinical Genetics Service (VCGS) are pleased to answer any questions you may have about the program and/or provide you with a testing pack. To arrange this, contact Vicki Petrou on (03) 8341 6352.

Further information about their program can also be found on their website at **www.cfscreening.com.au.**

Refugee Health

Victorian GP Refugee Health Forum – Saturday 10th October, 2009

DCGPA is co-hosting the annual Victorian GP Refugee Health Forum at Foundation House, Brunswick on Saturday 10th October. This Category 1, full day, educational event will include speakers and workshops on: Infectious Diseases, Immunization catch-up, Nutritional deficiencies, Mental Health, Culture, Health beliefs, Asylum Seekers, Legal aspects and Practice Systems.

GPs, Practice Nurses, Practice Managers and others with an interest in Refugee Health are encouraged to attend. Programs and registration forms will be posted out this month and can also be obtained from DCGPA, The Northern Division of General Practice, Pivot West and Foundation House. For further information, visit the Association website at www.dcgpa.com.au.

Clinical update – 7 Points about Schistosomiasis (Bilharzia) *

- consider screening refugees from Africa.
- infection with the flatworm occurs mainly in Africa through direct contact with fresh water containing cercariae released from intermediate host snails. Cercaria penetrate the skin and migrate through the bloodstream to the hepatic portal system, intestine, bladder and other parts of the body.
- carriers may be asymptomatic or present with pruritic dermatitis, fever, lethargy, myalgia or evidence of complications.
- complications may include: periportal fibrosis leading to portal hypertension, obstructive uropathy leading to renal failure, female lower genital tract lesions, and cerebral or spinal infection.
- screening is with Schistosomiasis serology.
- if serology is positive collect faeces and urine samples for ova to help identify the exact species and refer to an Infectious Diseases specialist.
- treatment is with Praziquantel which is not listed on the PBS and so may be best obtained through a public hospital specialist service.

* Adapted with permission from Foundation House's "Promoting Refugee Health - A guide for doctors and other health care providers caring for people from refugee backgrounds, 2007". Copies are available on the Association website or from Foundation House, 9388 0022. Additional information from the Schistosomiasis Research Group, Cambridge University www.path.cam.ac.uk/~schisto/index.html.

Practice visits

With a recent increase in new Afghan refugee arrivals the Refugee Health Program continues to offer one hour practice visits from an experienced GP to help support practices (GPs, Practice Managers, Receptionists and Practice Nurses) in seeing refugees. Please contact DCGPA to discuss booking a time.

Dr I-Hao Cheng,
Refugee Health Program Coordinator

Smoking causes around 3937 deaths in Victoria each year. Most of these could be prevented.

As a GP, you are in a unique position to offer quitting advice to your patients who currently smoke.

Quit Victoria is currently offering a training DVD and booklet titled 'Just say A-A-A-A-A, the smoking cessation intervention program for general practitioners', to assist GPs support patients to quit smoking. To purchase your copy please complete an order form and fax to Stavroula Zandes on 9635 5510 by the end of September, or email your request to Stavroula.Zandes@cancervic.org.au. Order forms and further information available at www.quit.org.au.

Asbestos Diseases Society of Victoria (ADSVIC)

Support and information for those diagnosed with Mesothelioma and asbestos - related illnesses.

Free services available to anyone effected by an asbestos - related illness include:

- Mesothelioma support groups
- Individual and family counselling (at office, home or hospital)
- Information resources
- Advocacy

No referral necessary. Please call the Counselling and Support line on 1300 659 226, email info@adsvic.org.au or visit their website at www.adsvic.org.au.

Safety and Security Kit for General Practice

This kit was developed to provide people working in general practices with a set of tools to help improve the safety and security of their workplace.

To download a free copy of this kit, visit the 'Hot Resources' section on the Association website home page at www.dcgpa.com.au.

Quality Use of Medicine News

Cows, Rats, and … Home Medicines Review? *Warfarin has come a long way since a mysterious toxin in sweet-clover caused an outbreak of fatal bleeding in cattle in Wisconsin in the 1920s. The toxin was discovered to be dicoumarol. Later research produced warfarin, a synthetic coumarin. Warfarin was initially registered as a rodenticide in 1948, but the story has it that a young man's unsuccessful attempt at suicide with warfarin sparked interest in its use for therapeutic anticoagulation in humans. Although its effect on Vitamin K metabolism was not elucidated until 1978, warfarin's position in pharmacopoeias strengthened when it was prescribed to US president Dwight Eisenhower after a heart attack in 1955.*

Now, in 2009, we know that anticoagulation with warfarin reduces the relative risk of stroke by about 60% in patients with non-valvular atrial fibrillation (NVAF), and is up to three times more effective than aspirin for this indication. We also know that warfarin is greatly underused in NVAF. A hospital study found 46% of English speaking patients with AF were taking warfarin while only 5% of those from non-English speaking backgrounds were doing so.

Warfarin is a difficult medication with wider uptake hampered by both doctor and patient concerns about risks of major bleeding, particularly in the elderly (who also have the highest prevalence of NVAF, about 10% in the over 80s). Yet the 2007 Birmingham Atrial Fibrillation Treatment of the Aged (BAFTA) study demonstrates the safety of warfarin in an elderly cohort (average age, 81.5 years) and that the benefits are generalisable to patients managed in routine clinical practice.

*The GP is left with difficult risk-benefit decisions, balancing an assessment of both bleeding risk and potential benefit in terms of stroke risk reduction in patients with NVAF. The $CHADS_2$ is a risk stratification tool that aids the decision about which patients with NVAF are likely to benefit from warfarin and those for whom aspirin would be more suitable. The $CHADS_2$ scores the predictive risk factors of **C**ongestive heart failure, **H**ypertension, **A**ge, **D**iabetes, and previous **S**troke or TIA.*

*Once the decision to commence warfarin is made, patients require education, access to INR monitoring, ongoing monitoring of diet, co-morbidities and drug interactions, good communication between their care providers, and the capacity to engage in self-management. The GP has a great patient support resource in the form of the **Home Medicines Review** (HMR). The HMR is a tool to provide a picture of patients' organisation and management of their therapy, a complete list of what the patient is actually taking (including complementary and over-the-counter medicine), and an opportunity to reinforce patient education around safe use of warfarin (and other medicines).*

And yes, a patient can have an HMR even if warfarin is the only medicine they are taking! There is no direct charge to the patient for an HMR. (MBS Item 900 fee $140.20 plus bulk-billing Item 10990 $5.50 for eligible patients).

QUM News would like to thank Christine Bellamy and Sue Nettleton from the Melbourne East GP Network for their permission to use the above article.

Graham Sweet is currently visiting DCGPA GPs with the National Prescribing Service program on "Antiplatelet and Antithrombotic Therapy in Stroke Prevention" as well as assisting practices to make Home Medicines Review work for patients *and* GPs. To book your visit phone Graham at the Association on 8792 1900..

Quick Quiz .

1. Which dictator was responsible for the following newspaper headline "*Vicious Spies and Killers under the Mask of Academic Physicians*" and told his Minister of State Security "*if you do not obtain confessions from the doctors we will shorten you by a head.*"?
2. Methyldopa, clonidine, gabapentin and SSRIs have been shown to be equally effective to oestrogen based HRT for the prevention of menopausal symptoms. True or false?
3. A 76 year old male patient with non-valvular AF, no other co-morbidities and a $CHADS_2$ score of zero would be at a low risk of stroke and for this reason treatment with warfarin need not be considered. True or false?
4. Nicotine transdermal patches are now PBS subsidized for aboriginal and Torres Straight islander people. True or false?
5. Olive, canola and soybean oils are a great source of vitamin K. True or false?

August NPS RADAR now out

There are full review articles on Rivaroxaban (Xarelto) for preventing venous thromboembolism after hip or knee replacement surgery and Teriparatide (Forteo) for severe osteoporosis. The brief items covered are:

- Risedronate (Actonel Once-a-month) and summary of anti-resorptive drug listings.
- Clopidogrel (Iscover, Plavix) PBS listing extended to cardiac stent insertion.
- Sitagliptin with metformin (Janumet) fixed-dose combination tablets PBS listed for type 2 diabetes.
- Oxybutynin patch (Oxytrol) PBS listed as an alternative for overactive bladder.
- Aboriginal and Torres Strait Islander peoples PBS listings.
- Praziquantel (Biltricide) tablets PBS listed for schistosomiasis.

For full details go to www.npsradar.org.au.

NPS clinical audits available for the QPI year: 1 May 2009 – 30 April 2010

Topic	Updates
Clinical audit: Management of specific respiratory tract infections	Enrolments are available online at www.nps.org.au/ health_professionals. Submission of initial data collection will close on Friday, 4 September 2009.
Clinical e-Audit: Optimising management of type 2 diabetes	Distribution of CD packs to enrolees continues. This Clinical e-Audit is available until 16 April 2010.
Clinical e-Audit: Review of proton pump inhibitor (PPI) prescribing	Online enrolment will be available in August 2009, with CD packs available in September/October 2009.

These activities have been approved in the 2008–2010 triennium for a total of 40 (Category 1) points by the RACGP QA&CPD Program and 30 points (extended skills) in the ACRRM PD Program.

ADRAC reports August 2009
"Serotonin syndrome with duloxetine", "Fixed drug eruptions", "Is it leflunomide lung?", "Isotretinoin and acquired hearing impairment" and "What to report" are the reports. They are available at http://www.tga.gov.au/adr/aadrb/aadr0908.htm and are an absolute must read for GP prescribers.

Codeine addiction (a true story from the Pharmaceutical Society of Australia).
"AC is the 29-year-old mother of a four-year-old daughter. Both live with AC's mother and brother. AC has suffered from depression and bulimia for four years since the birth of her daughter. She takes large quantities of codeine to vomit as part of her eating disorder, and has been buying or stealing Nurofen Plus, Panafen Plus and Panadeine from pharmacies. She has been admitted to ICU three times this year (almost 20 admissions to hospital in past few years), and almost required a liver transplant after her last Panadeine overdose (taken when an involuntary patient at the hospital and absconded to local pharmacies). She now has renal tubular acidosis causing hypokalaemia (K+1.9) and low bicarbonate and another perforated gastric ulcer (Hb 86) from NSAID abuse.

A psych team is now observing daily dosing of medications but she is still able to obtain codeine containing products at will. Child Protection have been involved. Her treating doctor is concerned she will overdose again and die from Paracetamol overdose/renal failure/perforated ulcer/hypokalaemia and arrhythmia."

This story has been included in the newsletter to help illustrate why the National Drugs and Poisons Schedule Committee made the decisions that it did regarding codeine at its June meeting. At this stage they are recommendations only. They will hopefully be implemented in Victoria and will further restrict the over the counter sale of preparations containing codeine. While preparations marketed for coughs and colds will stay the same, combination analgesic products will be limited to five days supply and the maximum dose of codeine that can be in these preparations will reduced so the current formulations of some products (eg Nurofen Plus) will become prescription only. Advertising of over the counter analgesics containing codeine will not be allowed.

These change are proposed for May 2010 and can't come soon enough as far as QUM news is concerned.

Health agency to test link between flu, vitamin D
This headline appeared in the Globe and Mail, a Canadian newspaper on the 28th of July. An extract from the full article is below:

In an effort to discover new ways to fight the swine flu, the Public Health Agency of Canada intends to test the blood of people contracting the ailment to check their vitamin D levels. The agency is taking the unconventional action to try to find out whether those with mild cases of the flu have more of the sunshine vitamin circulating in their bodies than those who develop severe or even deadly reactions to the H1N1 virus. If researchers determine that the vitamin protects against the swine flu, it will give health authorities another line of attack against the pandemic, besides such common-sense approaches as large-scale vaccinations and hand-washing campaigns.

QUM news has an ongoing interest in this issue and can provide the full article to readers on request. Of interest is that a poor prognosis with a number of infections including tuberculosis have been associated with low 25(OH)D levels. In past times, prior to the availability of drug treatments, the mainstay of treatment for tuberculosis was fresh air and sunshine.

The NPS initiative to optimise Discharge Management of Acute Coronary Syndromes (DMACS)
This is happening in 49 Australian hospitals across 43 Divisions/Networks of General Practice, including the DCGPA. The NPS conducted a GP survey as part of the DMACS project in 2008 which found that about one in four GPs received no discharge summary, about one in five patients received no ongoing patient management plan and only about one in five GPs rated the quality of information supplied to them as excellent.

Follow-up data collection commenced in May and will continue until September 2009 after hospital–wide educational interventions and system changes. You may be surveyed to see if these interventions have been effective or if there is more work to do. Given the importance of good discharge information to GPs QUM news urges any GPs who are surveyed

to send back their opinions.

In the current visiting round on stroke prevention stents and heart valve replacements often enter the discussion. GPs would need to know what kind of valve or stent has been used or what the manufacturers of these valves or stents recommend to aid ongoing patient management decisions. It would seem that this discharge information is for the most part not being sent to GPs.

Quick Quiz answers

1. Joseph Stalin (in 1953). At this time Stalin had become so suspicious of doctors he would only consult with veterinarians about his health. The motivations for his position on doctors were mixed with anti-Semitism and a goodly portion of doctors in the Soviet Union at the time were Jewish. The "Doctor's plot "alluded to by the headline was to be an excuse to send the Jews of the Soviet Union to Siberia. Fortunately this was forestalled by Stalin's death, probably by poisoning with warfarin. The irony being that at the time warfarin had not yet entered mainstream human medicine, was used mostly as rat poison and therefore not inappropriate for a problem where advice could be sought from a veterinarian.
2. False. (NPS Therapeutic choices for menopausal symptoms. Background materials April 2009).
3. False. The A in $CHADS_2$ stands for Age. Any person 75 years old and older therefore has a $CHADS_2$ score of at least one and is considered to be at least at moderate risk of stroke. A $CHADS_2$ of 1 would be associated with a 5 year 10 to 20% risk of stroke and an overall cardiovascular risk* of 20 to 24% (*Australian CV risk calculator).

   Doubly false. For those with a $CHADS_2$ score of 1 warfarin should be considered (as may aspirin). However the results of the BAFTA trial would indicate that those with a $CHADS_2$ score of 1 and aged 75 years and over, with no contraindications to warfarin, will do better on warfarin than aspirin.
4. True. This is an authority prescription and full details are in the August NPS RADAR on www.npsradar.org.au.
5. True and this poses a significant problem. Many of the diets mentioned in materials designed for people taking warfarin were designed in the 1970s ie the meat and 3 vegetable diet. However today we have a multicultural and far more varied diet. Chinese food, Italian food and prepackaged food, often contain olive, canola or soy oil and this not always obvious. The upshot is that for those on warfarin to avoid low INRs dietary advice from a dietician who is current with vitamin K levels in today's diet is required.

Verification of Death by Registered Nurse (Div 1)

Following the review of the Coroners Act 1985, registered nurses and paramedics, with appropriate experience and competency, are able to verify death.

The Department of Human Services (DHS) has developed a "Guidance Note" that clarifies the **verification** of death by registered nurses (Div 1 and 3) and paramedics.

The legal requirement for a registered medical practitioner to **certify** death (a MCCD) under section 37 of the Births Deaths & Marriages Registration Act 1996 and the reporting requirements under the Coroners Act 1985 remains unchanged.

The guidance note for the "verification of death" contains:

- General Information for nurses and paramedics
- Appendix A: Information about which deaths must be reported to the coroner
- Appendix B : Information about the minimum guidelines for the clinical assessment of a body to verify death

There is also a frequently asked questions (FAQs) information sheet.

To access the 'Guidance Note' and FAQs please go to the Practice Managers and Practice Nurses section of our website (www.dcgpa.com.au) and look under the 'Clinical and professional resources' section.

A Proactive Approach to Climate Change

Climate change and its relation to health outcomes is increasingly becoming a focus of conversations.

The City of Greater Dandenong's Aged & Disability Services, with the assistance of Lime Consulting, is in the process of finalising a Climate Change strategy that will assist frail older people and people with disabilities to ameliorate the impact of climate change within their homes through the assistance of our Home Maintenance program.

Some of the work being undertaken by our Home Maintenance service in relation to climate change includes:

- Light globes replaced for energy efficient globes
- Light fittings cleaned to provide better lighting
- Tap repairs and servicing to prevent leaks and to make taps easier to operate
- Draught sealing at external doors
- Installation of water saving showerheads
- Ceiling fans cleaned
- Air conditioning filters cleaned
- Energy consumption of appliances measured

For more information, contact Information and Referral on 8558 7902.

Outpatient Referrals – Victorian Statewide Referral Form (VSRF) Template to be used

The **Victorian Statewide Referral Form (VSRF)** is now the preferred method of referring patients into Southern Health Outpatient Services. **(WITH THE EXCEPTION OF MATERNITY BOOKINGS – THE NEW APPRAISAL FORM MUST STILL BE USED)**

Previously, a specific Southern Health referral template was available; however, this required specific importing. As VSRF is being promoted for other uses, and is integrated in most medical software it will now be the preferred method of referring into Outpatients. Downloadable versions are available from General Practice Victoria for the following software programs: Locum, MedTech, Genie, Practix, and of course a paper-based version is also available. To download these templates, go to http://www.gpv.org.au/resources.asp?type=36.

Central Enquiry Line for Outpatient Services
1300 3 iCARE
(1300 342 273)

The VSRF promotion coincides with the launch of the 1300 3icare central enquiry line for enquiries relating to Outpatient Specialist Clinics, Community Rehabilitation & Speciality Clinics and HITH, PAC and HARP services.

All fax referrals for Outpatient Services* can be directed to 959 iCARE (9594 2273). (**Maternity bookings faxes still to 9594 6298 please)*

Community Rehabilitation & Speciality Clinics - Fax: 9265 1297 *(memory, continence, falls, pain and movement disorders).*

HITH, PAC & HARP - Fax: 9554 8595.

Please check eligibility criteria for these services by viewing service templates on GP Access Website at www.southernhealth.org.au/gp.

Promotional material will be distributed in the coming weeks to enable GPs to keep these details handy.

GP Access Website – Redevelopment

Southern Health are undertaking a massive revamp of the GP Access website – the first and most important task, updating the volume of service information and ensuring we have the latest, most up to date details for each service. Whist previously they have relied on services advising of any changes, they will now be proactively contacting each service bi-annually to ensure the information on the site remains up to date and useful to GPs.

In early September, the website will also change designs to coincide with a major relaunch of Southern Health's internet site. The front page will look dramatically different; however, will hopefully enable more direct access to the information GPs most require.

We will be seeking feedback from GPs prior to the launch to ensure we have got the formula right. If you are interested in participating, please contact Tanya Heaney-Voogt on 0438 513 929.

Osteoarthritis Hip & Knee Service (OAHKS) at Southern Health

Some GPs will already have received information from their patients regarding the completion of a MAPT questionnaire. This questionnaire, used in conjunction with an OAHKS review, helps prioritise patients on outpatient and elective surgery waiting lists.

A DHS initiative, the OA Hip and Knee Service is available at a number of public hospitals in Victoria and is aimed at better coordinating the management of patients with hip or knee osteoarthritis.

Some patients may be discharged back to their GP for conservative management options, and where this is the case, relevant allied health appointments will be coordinated for the patient by the OAHKS Coordinator. Detailed discharge communication will also follow; including re-entry pathways should the patient rapidly deteriorate.

GPs will continue to receive information on the Orthopaedic Wait List (OWL) Project and the OAHKS Service via GP Liaison / Association newsletters, and directly from the OAHKS clinic should their patients be affected.

For more information on the statewide initiative, visit www.health.vic.gov.au/oahks.

The Southern Health OAHKS Musculoskeletal Coordinator, Stuart Cavill, may be contacted via email: stuart.cavill@southernhealth.org.au.

GP LIAISON UNIT 9594 3014

WWW.SOUTHERNHEALTH.ORG.AU/GP

DCGPA Annual Survey

The DCGPA 2009 Annual Survey has been distributed to GPs and Practice Managers. Your feedback is extremely important and assists in evaluating our performance over the last twelve months and planning for future needs of members. We encourage you to complete and return this questionnaire. Should you have any queries, or would like another survey sent to you, please contact Alison Killin on 8792 1900 or a.killin@dcgpa.com.au.

Pen Tip:

Pen and Aboriginal and Torres Strait Islander Health

The ABS estimated in 2006 that Victoria's Aboriginal and Torres Strait Islander (ATSI) population was approximately 31,000, 1569 of whom live in the Greater Dandenong and Casey local government areas (LGAs) – how many of those attend *your* practice? According to the Better Health website, there is a significantly higher incidence of cardiovascular disease, respiratory disease and diabetes amongst the ATSI population compared with the non-ATSI population. In light of this knowledge, it is essential for practices to pay careful attention to the delivery of additional services to their ATSI patients and to be proactive, either in the prevention of these conditions, or after onset. There are also many additional item numbers which can be claimed when treating these patients such as ATSI health checks (items 704-710) and follow up allied health services for ATSI patients (items 81300-81360) and the five Practice nurse or Allied Health Worker services p.a. (item 10987) which unlike item 10997 does not require a prior GPMP or TCA (Items 721 or 725).

So how can Pen help you offer the best treatment to your Aboriginal and Torres Strait Islander patients? In the filter under the 'general' tab, tick the 'ATSI' box; if there is a particular age group you wish to target, for example 15-54 (specifically for item 710) enter the start and end ages in the filter, and click 'recalculate'. Click on the diseases tab to identify which of your ATSI patients are diagnosed with any of the above chronic conditions to help begin planning in advance. Practices are also reminded that Southern Health Community Health and the Dandenong and District Aboriginal Cooperative also offer a range of culturally appropriate services for ATSI people and readily accept referrals from general practice.

The ATSI population are eligible for the Influenza and Pneumococcal vaccines from age 50, and their medically at-risk counterparts are eligible from age 15. Pen can identify which of your ATSI patients are eligible, and out of those, which have not had the above vaccines. (Please note that from January 1, 2010, *all* ATSI patients 15 years and over, will be eligible for free seasonal Influenza vaccine so you will need to identify eligible patients.)

It is important to be mindful that the quality of your Pen data reflects the quality of what is entered into your clinical software system. Refer to the mappings section of the Pen user manual to identify where ATSI status should be documented in your clinical software system in order for your Pen data to accurately reflect your practice's ATSI population.

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.

If you would like to learn more about the ATSI item numbers please contact Peter Larter at the Association on 8792 1900.

Participate in Research for 40 Category 1 QA&CPD points

Deakin University are conducting research funded by Beyond Blue VCOE which aims to evaluate the effectiveness of an internet-based health information resource (Heart Health Online) for improving the psychological and physical well-being of people with coronary artery disease.

We need GPs to refer eligible patients to our study and to provide minimal information about the patient's heart disease (with patient's consent).

GPs will receive $100 for participating, and will be eligible for 40 Category 1 QA&CPD points.

GPs who would like to participate or require further information, please contact Lucy Jackson on 9244 6259 or via email at lucy.jackson@deakin.edu.au.

Date for your diary –

DCGPA 2009 Annual General Meeting
Wednesday 25th November, 2009
Southern Golf Course, Keysborough

Invitations and further information to follow in coming months.

Annual Membership Renewals

DCGPA Annual Membership Renewals for the 2009—2010 financial year have been distributed.

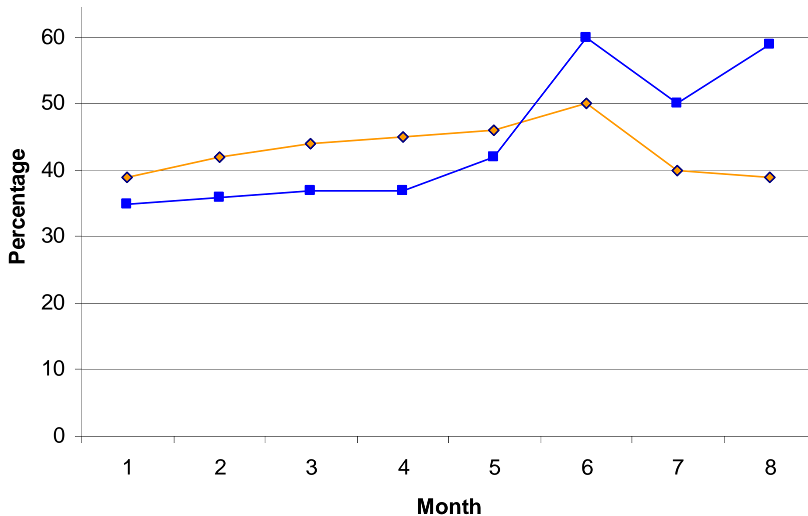
If you have not yet returned your renewal form, please complete and forward these to the Association Office.

If you have misplaced your form, or require further information, please contact Heather on 8792 1900.

Collaboratives Corner

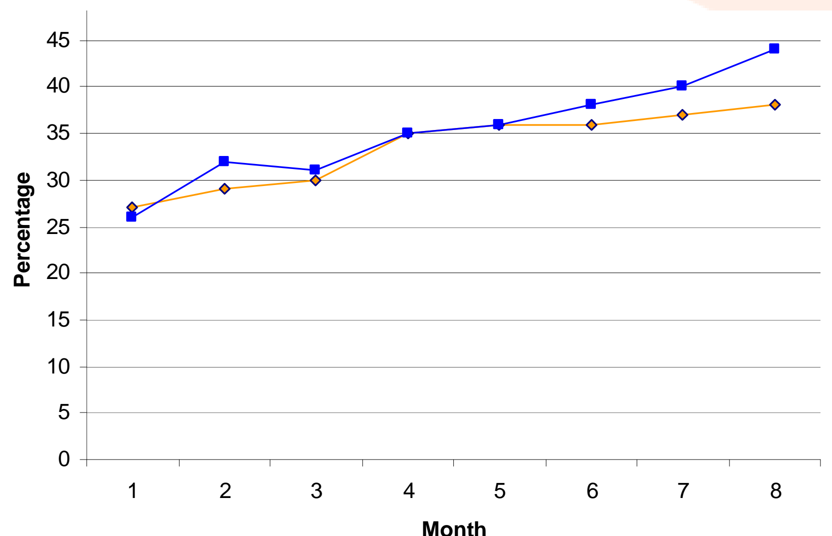
Quick Update – What the Collaboratives has helped our practices achieve!

Our five member practices participating in the State Wave of the APCC program since October 2008 have successfully implemented change within their practice and are enthusiastic about the stronger practice teams developed and the enhancement of practice systems that have emerged from participating in the APCC. Results to date comparing our practices, to other practices involved in Victoria, Tasmania and New South Wales include:



The percentage of patients on the CHD Register with a last recorded blood pressure reading of less than or equal to 140/90 mm Hg within the previous twelve months has increased from 35% to 59%.

The percentage of patients on the Diabetes Register with a recorded HbA1c within the last twelve months less than or equal to 7.0% has increased from 26% to 44%.



Congratulations to all the practices involved, these results are a testament to the efforts being put in to improve practice systems and patient care.

Stephanie Edmonds, Collaboratives Program Manager

The Association is offering member practices the opportunity to be involved in this quality improvement program through a local wave of the Collaboratives. The program will consist of an orientation evening and a series of three local workshops. The workshops give the opportunity to practices to exchange ideas, share experiences and learn about practical quality improvement skills, which can be easily implemented using the successful improvement model.

Don't miss this opportunity to join our five practices already involved. To register your interest, please contact Stephanie Edmonds on 8792 1900 or email s.edmonds@dcgpa.com.au or for further information please visit www.apcc.org.au