



*Participants of the DCGPA Receptionist Forum*

## Receptionist Forum

DCGPA hosted a very successful half day Receptionist Forum at Pin Oak Receptions in Hallam on the Thursday 26<sup>th</sup> March, 2009. The forum was facilitated by Sue Harmer from Chisholm Institute of TAFE. Sue brought with her some very valuable and practicable insights working in the challenging area of general practice. 52 participants attended including some participants from as far as Mt Martha and Beaumaris.

Some topics discussed during this forum included:

- Front desk etiquette and first impressions (consisting of personal presentation, body language, telephone etiquette, professional/privacy etiquette, social and cultural diversity and the do's and don'ts of the front desk);
- The relationship between how we think, how we communicate and our patterns of behaviour and emotion;
- Dealing with various personality traits of patients/colleagues

Various tips and tricks were provided for participants to take back to their practice to utilise.

This type of forum provides a valuable opportunity for our dedicated receptionists to learn new skills, have the chance to meet others in a similar role and at the same time have a bit of fun.

The participants enjoyed a terrific morning tea and light lunch before they headed back to their practices for the afternoon shift.

As this proved to be such a successful event, it is highly likely we will be providing more of these types of activities in the future.

A big thank you to Sharyn Gissara (Events Program Officer) and Lisa Shore (Administration Assistant) for their assistance in the planning and administration of this forum.

Julie Shanahan, Business Manager



*Sue Harmer (Speaker) with participants*

## Dandenong Casey General Practice Association

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Deadline for newsletter articles is 10<sup>th</sup> 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:

Invitation - Explaining Diabetes: Using Professional Interpreters to Improve Patient Outcomes  
Request to Email Newsletter Flyer

## Simpler Administrative Arrangements for Allied Health

### Allied health Medicare items for people with chronic and complex medical conditions (MBS items 10950 – 10970 and 81100 - 81125).

On 1<sup>st</sup> January 2009, the requirement that a Medicare rebate for the prerequisite Chronic Disease Management (CDM) care planning items must be claimed before associated allied health services can be provided and claimed was removed.

These new arrangements will overcome delays experienced by patients and allied health providers when they claim the Medicare rebate for an allied health service where they have a valid referral, but where a claim for the CDM item(s) has/have not been processed.

It is important to note, that the eligibility requirements for these allied health services have not changed. Patients must still have a chronic medical condition and complex care needs and be managed by their GP under a GP Management Plan (MBS item 721) and Team Care Arrangements (MBS item 723). Where the patient is a resident of an aged care facility, the GP must have provided MBS item 731 by contributing to a care plan developed by the facility.

The Health Insurance (Allied Health Services) Determination 2008 **still requires that:**

- Medicare benefits for allied health services only be available to eligible patients on referral from a GP;
- The GP must first complete the necessary care planning services;
- Allied health services must be recommended in the patient's care plans; and
- Allied health providers must have a signed referral form from a GP before they are legally able to provide allied health services that are eligible for a Medicare benefit. This form requires the GP to indicate the number and type of allied health services required.

If there are any further questions about these changes, please contact Medicare Australia on 132 150 or the Department of Health and Ageing on (02) 6289 4297 or visit their website at <http://www.health.gov.au>.

## Vale

### Andrew Mulligan

The Board, members and staff of DCGPA are deeply saddened by the sudden death of Craig and Rowena Mulligan's 17 year old son, Andrew. Andrew died after a heart attack while running at Akoonah Park in Berwick. He was Vice-Captain of Haileybury College in Keysborough and was a gentle, intelligent and compassionate young man who excelled in music, sport and debating. Andrew was the recipient of many academic awards and was considering a career in medical science or law.

Our sincere sympathy to Rowena, Craig and Ben.

**Fact:** 53% of Australian GPs have considered leaving general practice because of work stress<sup>1</sup>.

**Stress (strain felt by somebody):** Mental, emotional, or physical strain caused, eg. by anxiety or overwork. It may cause such symptoms as raised blood pressure or depression<sup>2</sup>.

**Health (general physical condition):** Having the function of maintaining physical and mental wellbeing among the general public and the administration of medical and related services<sup>2</sup>.

**Watch this space** for ways to improve your stress, health & wellness.

<sup>1</sup> Schattner PL, Coman GJ. The stress of metropolitan general practice. *Med Journal of Australia* 1998;169:133-7  
<sup>2</sup> Encarta Dictionary: English (UK)

*Brought to you by the GP Health and Wellness Working Group*

## Medical Record Bloopers!

The following statements were recorded in hospital medical records:

- The patient's medical history has been remarkably insignificant with only a 40 pound (18 kg) weight gain in the past three days.
- She is numb from her toes down.
- While in ER, she was examined, X-rated and sent home.
- Occasional constant infrequent headaches.
- She stated that she had been constipated for most of her life, until she got a divorce.
- Rectal examination revealed a normal-sized thyroid.
- The skin was moist and dry.
- I saw your patient today, who is still under our car for physical therapy.
- Both breasts are equal and reactive to light and accommodation.
- The patient was to have a bowel resection. However, took a job as a stockbroker instead.



## Immunisation Update

### Timely Reporting to ACIR (Australian Childhood Immunisation Register)

With the recent changes to the four year old immunisation overdue status, timely ACIR (Australian Childhood Immunisation Register) reporting is now even more important. The greater the efficiency used in transferring the data to ACIR the more current the database will be. This provides all users - Medicare, Centrelink, Doctors, Nurse Immunisers and parents with the most current data available, and avoids issues of unwarranted parental concern about their child's well being and potential financial penalties.

From the 1<sup>st</sup> January, 2009 a four year old child is considered overdue for their immunisations at four years and one month. If the child has not been immunised by four years and one month, parents will receive a letter from the government informing them that in 63 days their Child Care Benefits will be paused, until immunisation has been completed.

If a child is immunised but the data has not been sent to ACIR, the parents will receive the letter from the government. This may result in concerned parents contacting the practice. If the child is immunised in the 63 day period following the letter and the data is not provided to ACIR the parents Centrelink payments will be paused.

This can all be avoided by timely and accurate ACIR reporting. There are a number of options for achieving this:

- The ideal option is to have the clinics computer software linked to ACIR. This allows for instantaneous sending of information, with rapid return of any data that is incomplete or incorrect, allowing it to be corrected and resent efficiently. There are only a few software combinations that allow for this. Pracsoft with MD is the most commonly used. Using both ZedMed products also enables the data to be sent.
- Another option is accessing the ACIR website and inputting the data directly to the site. This has the benefits of being instantaneous, but requires more time and effort from the clinic.
- Printing the immunisation data from your clinical program and faxing to ACIR, is not as efficient as the electronic options, but is quick and eliminates the handwriting interpretation concerns.

If no other option is available to the clinic, the use of manual vouchers is still acceptable. Often when data is transferred to ACIR manually via the coupons, there can be errors in either the writing or reading of the information. This information is then sent back to the practitioner for clarification, and then resent again to ACIR. This process is laborious and time consuming, with the child's data being correctly documented weeks or months after the event.



## Permit Requirements to Prescribe Schedule 8 Poisons as from 1<sup>st</sup> March 2009

This summary has been prepared by the Drugs and Poisons Regulation Group (DPRG) to assist in understanding recently amended permit requirements for prescribing Schedule 8 poisons. Refer to the Drugs, Poisons and Controlled Substances Act 1981 and Regulations 2006 (at [www.legislation.vic.gov.au](http://www.legislation.vic.gov.au)) for full details. The DPRG website ([www.health.vic.gov.au/dpu](http://www.health.vic.gov.au/dpu)) contains summaries of other key requirements plus a link to the Poisons Standard, which contains a full list of all scheduled poisons.

### Schedule 8 poisons

**Schedule 8 poisons** (labelled *Controlled Drug*) have stricter legislative controls than other "prescription-only medications"; they include pethidine, morphine (Kapanol, MSContin, Sevredol), oxycodone (OxyContin, Oxynorm, Endone), hydromorphone (Dilaudid), methadone (Physeptone), flunitrazepam (Hypnodorm), fentanyl (Durogesic), buprenorphine (Subutex, Suboxone, Norspan), dexamphetamine, methylphenidate (Attenta, Concerta, Ritalin).

### Drug-seeking behaviour

A patient with a valid therapeutic need for Schedule 8 poisons should have a principal medical practitioner to monitor and manage his/her medication regimen to minimise the likelihood of an iatrogenic dependence. Concurrent prescribing by other medical practitioners may be detrimental, especially if the principal prescriber is unaware of that prescribing.

#### **Note:**

- Drug-seeking behaviour is not limited to users of illicit drugs.
- A person with a genuine medical condition is not immune to becoming drug-dependent.
- Drug-seeking activity may be associated with diversion and sale of prescription drugs.

### Permits for Schedule 8 poisons

To ensure Schedule 8 poisons are available to patients with genuine therapeutic needs whilst minimising the extent of concurrent prescribing and drug-seeking behaviour, medical practitioners must obtain a permit (section 34A(1)) from DPRG:

- Before treating a drug-dependent person with any Schedule 8 poison. (Permits to prescribe pharmacotherapy to treat opioid-dependence may be issued to medical practitioners who have been specifically approved by the DPRG).

- To treat a person, who is not drug-dependent, with any Schedule 8 poison for a period greater than 8 weeks (Refer to page 2 for further clarification).

**Note:** A PBS Authority prescription for a Schedule 8 poison indicates that the Commonwealth will subsidise the cost of the medication; **permit requirements are still applicable.**

### Methadone, dexamphetamine and methylphenidate

Although there are some exceptions\* to the requirement to hold a permit, most medical practitioners are still required to obtain a permit before prescribing dexamphetamine, methylphenidate or methadone for any person.

A permit to prescribe any of these three drugs is required unless a clear exception applies.

**\*Details of exceptions to permit requirements are shown on page 2**

### Clarifying "The 8-Week Rule"

The 8-week period (before obtaining a permit to treat a person who is not drug-dependent) is intended to allow a medical practitioner to initiate urgent treatment with a Schedule 8 poison without delay.

**Note:** The 8-week period relates to the duration of treatment and not the dates of consultations. A single prescription, for sufficient medication to provide treatment for more than 8 weeks, would require a permit.

### Patients already being treated with Schedule 8 poisons

To address circumstances where a patient might be receiving or seeking treatment from multiple practitioners, the 8-week period now includes any preceding period of treatment by other medical practitioners.

A medical practitioner who considers it necessary to prescribe a Schedule 8 poison for a person (who is not drug-dependent) must immediately apply for a permit if there is reason to believe that his/her prescription will result in the patient being treated for a continuous period greater than 8 weeks when the preceding period of treatment is taken into consideration. This provision is intended to include patients (with or without documentation) who:

- claim to be relocating from another clinic or visiting from a distant or interstate location
- claim that the regular treating practitioner is unavailable

- are treated by multiple practitioners (none of whom hold a permit) at the same clinic

Although a permit application must be submitted immediately, to avoid delaying treatment for a genuine patient, a medical practitioner is authorised to continue treating the patient until the outcome of his/her permit application has been determined.

## EXCEPTIONS TO PERMIT REQUIREMENTS

### Cancer pain and childhood ADHD

Under certain conditions and circumstances a permit is not required to treat a person (who is not drug-dependent) for cancer pain or childhood attention deficit disorder provided the medical practitioner gives written notice to DPRG in the required form - by submitting the permit application form and completing section 3.

### General exceptions (prisons, residential aged care services, in-patients)

In circumstances where a person is confined and not personally managing their medications, the risk of concurrent prescribing is significantly reduced. Accordingly a permit is not required to prescribe Schedule 8 poisons for prisoners being treated in a prison, residents being treated in a residential aged care service and patients receiving in-patient treatment in a hospital (not including day procedure

centres).

### Multi-practitioner clinics

In recognition of the fact that more than one medical practitioner at a clinic might be involved in the management of some patients, each practitioner is not required to obtain a permit provided a valid permit is held by one practitioner at the clinic and the prescribing is consistent with and does not exceed any limits of the permit.

**Note:** To ensure compliance it is recommended that details of permits, including maximum dosage plus expiry or cancellation dates, are prominently displayed within patient records.

### Exceptions relating to methadone or dexamphetamine and methylphenidate

The additional permit requirement, to obtain a permit before prescribing methadone, does not apply where a medical practitioner is treating a person who is an in-patient of a hospital, a patient at an oncology clinic, a patient under the care of a palliative care service or a patient at a pain clinic at a hospital.

The additional permit requirement, to obtain a permit before prescribing dexamphetamine or methylphenidate, does not apply where a medical practitioner is a paediatrician or psychiatrist who is treating a person with attention deficit disorder.

**For further information** about suspected drug-seeking patients or permit requirements, contact the **DPRG Help Line - 1300 364 545** (to avoid delays - **select option 1**).

## Refugee Health

### **Australian Society for Infectious Diseases Guidelines**

Evidence based guidelines for the "Diagnosis, Management and Prevention of Infections in Recently Arrived Refugees" have been added to the DCGPA website. Look under Resources/Health Programs/Refugee Health/Infectious Diseases.

### **Dandenong Hospital Refugee Health Clinic – New Asylum Seeker Services**

The Dandenong Hospital Refugee Health Clinic is now providing free GP (new position commenced), Paediatrician, Infectious Disease Physician and referral services to Asylum Seekers. To be eligible Asylum Seekers must provide evidence of a current "E" class bridging visa or a letter from an Asylum Seeker organization (such as the Red Cross, the Asylum Seeker Resource Centre or the Hotham Mission) to confirm Asylum Seeking Status.

Referrals from GPs and other agencies should identify the patient as an Asylum Seeker and be faxed to 9554 8554. They should include: the reason

for the referral, relevant background information, patient contact details, interpreter requirements and documentary evidence of Asylum Seeker status where available.

Appointment enquiries can be made by telephone on 9554 1108.

Further enquiries can be made to Dr Andrew Block (Head of the Dandenong Refugee Health Service) 9554 8195, or Dr I-Hao Cheng (Refugee Health Program Coordinator, DCGPA) 8792 1900.

### **National Primary Health Care Strategy**

Thank you to everyone who assisted in preparing the regional refugee health submission to the National Primary Health Care Strategy. Some of the key recommendations made to the Reference Group were to: support the sustainability and growth of services, support organizations providing coordination, build interpreter capacity, build cultural competence, develop educational materials, develop electronic resources and build research capacity.

## Maximising the use of secure electronic clinical exchange

# ARGUS

Argus is a program that provides secure transfer of clinical and patient data via email. It runs on any GPs computer alongside existing clinical software and enhances internet email with additional features for clinical needs such as security through use of PKI encryption.

We are able to provide support to all the practices that are either currently using Argus but require further assistance, or for practices that would like to have Argus installed.

Please contact the Association on 8792 1900 if your practice requires further information or assistance with Argus.

### Referring to the Diabetes Coordination & Assessment Service using ARGUS

The Diabetes Coordination and Assessment Service (DCAS) now have the capabilities to receive referrals from GPs using Argus. All GPs are encouraged to refer to DCAS using the Victorian Statewide Referral Form via Argus. The email address for referral is [dddgp\\_arguspgref@dddgp.com.au](mailto:dddgp_arguspgref@dddgp.com.au).

If you need further information or are having trouble referring into DCAS please call 9792 1550.



### PSA testing, new interim research findings released

In Australia one in eleven men will develop prostate cancer before the age of 75. In Victoria 3,970 men were diagnosed with prostate cancer in 2005, with an estimated 22,000 Victorian men currently living with a prostate cancer diagnosis.

There has been much international debate about Prostate Specific Antigen (PSA) testing and its suitability for use as a population screening tool. Findings from the first randomised controlled trials on PSA screening from USA (<http://content.nejm.org/cgi/content/full/NEJMoa0810696>) and Europe (<http://content.nejm.org/cgi/content/full/NEJMoa0810084>) have been published in the New England Journal of Medicine.

The USA trial showed no mortality benefit from population screening, while the European trial suggests a 20% reduction in mortality from prostate cancer. There are however confounding factors.

*Both of these reports are interim reports. No significant results regarding the effectiveness or ineffectiveness of the PSA test as a population screening tool or otherwise can yet be drawn from these studies. Further research to find a better test for prostate cancer is needed.*

As discussed in the NMJ's Perspective Roundtable: Screening for Prostate Cancer PSA, testing can lead to over diagnosis and over treatment. The full transcripts of the Roundtable which summarises both research papers, and analyses their findings can be found at <http://www.nejm.org/perspective-roundtable/screening-for-prostate-cancer/>.

Cancer Council Victoria encourages men who have a family history or who are concerned about prostate cancer to discuss with their doctors and make an informed choice about the benefits, risks, limitations and uncertainties of testing.

The PSA test may be used to assist in the diagnosis of prostate cancer for men with signs or symptoms of disease. However, evidence does not support the use of this test to screen well men for the early detection of prostate cancer. The PSA test is not a reliable enough test for population screening as PSA levels can rise due to cancer or to benign (non-cancerous) conditions or levels may be low in the presence of prostate cancer. To view the Prostate Cancer Screening Position Statement by the Cancer Council Australia, visit: <http://www.cancer.org.au/File/PolicyPublications/PSProstatecancerscreeningupdatedApril2008.pdf>

A practical guide is available to assist GPs discuss PSA testing with their patients. Titled "Early detection of prostate cancer in General Practice: supporting patient choice", this guide can be downloaded from the Cancer Council Australia website at: <http://www.cancer.org.au/File/HealthProfessionals/GPprostateshowcard.pdf>.

## Quality Use of Medicine News



**Post war mums were not so dumb.** QUM news was born in 1946 and can still remember the taste of Hypol®\*, a proprietary cold liver oil emulsion. Back in those post war years many mums would give their kids a daily dose of Hypol® to ward off colds and ‘flu. These were the times when the “sunsmart” message had not yet been invented and our idea of the best thing to put on your skin when going out into the sun was coconut oil. Kids did spend a lot of time outdoors then, as not only had computers not been invented, but TV did not arrive until 1956 and it was a few years before it got into the majority of households. So as a group, when I grew up, Aussie kids were probably not vitamin D deficient and bit of extra vitamin D, via Hypol®, each winter was probably all that was needed to top up our D levels to something close to adequate. That was then, the dose of Hypol® that today’s child would need to get to adequate levels could, for some, \*cause vitamin A toxicity.



The post card above, from the state library of Victoria circa 1908, shows what most children thought of cod liver oil emulsions. So it was of interest when the following article from the *Archives of Internal Medicine* appeared on my desk. Maybe mum was not so silly after all.

**“Association Between Serum 25-Hydroxyvitamin D Level and Upper Respiratory Tract Infection in the Third National Health and Nutrition Examination Survey.** Adit A. Ginde, MD, MPH; Jonathan M. Mansbach, MD; Carlos A. Camargo Jr, MD, DrPH

**Background:** Recent studies suggest a role for vitamin D in innate immunity, including the prevention of respiratory tract infections (RTIs). We

hypothesize that serum 25-hydroxyvitamin D (25[OH]D) levels are inversely associated with self-reported recent upper RTI (URTI).

**Methods:** We performed a secondary analysis of the Third National Health and Nutrition Examination Survey, a probability survey of the US population conducted between 1988 and 1994. We examined the association between 25(OH)D level and recent URTI in 18 883 participants 12 years and older. The analysis adjusted for demographics and clinical factors (season, body mass index, smoking history, asthma, and chronic obstructive pulmonary disease).

**Results:** The median serum 25(OH)D level was 29 ng/mL (to convert to nanomoles per liter, multiply by 2.496) (interquartile range, 21-37 ng/mL), and 19% (95% confidence interval [CI], 18%-20%) of participants reported a recent URTI. Recent URTI was reported by 24% of participants with 25(OH)D levels less than 10 ng/mL, by 20% with levels of 10 to less than 30 ng/mL, and by 17% with levels of 30 ng/mL or more ( $P_{.001}$ ). Even after adjusting for demographic and clinical characteristics, lower 25(OH)D levels were independently associated with recent URTI (compared with 25[OH]D levels of 30 ng/mL: odds ratio [OR], 1.36; 95% CI, 1.01-1.84 for  $<10$  ng/mL and 1.24; 1.07-1.43 for 10 to 30ng/mL). The association between 25(OH)D level and URTI seemed to be stronger in individuals with asthma and chronic obstructive pulmonary disease (OR, 5.67 and 2.26, respectively).

**Conclusions:** Serum 25(OH)D levels are inversely associated with recent URTI. This association may be stronger in those with respiratory tract diseases. Randomized controlled trials are warranted to explore the effects of vitamin D supplementation on RTI. *Arch Intern Med.* 2009;169(4):384-390.”

\*This product is still on the market and each 10 ml contains vitamin A 15000 IU and vitamin D 150 IU and omega 3’s.

### Quick Quiz

1. Non-pharmacological interventions are not useful for management of behavioural symptoms in late stages of dementia. True or false?
2. Although the response can be unpredictable, 37 – 41% of patients show clinical improvement (measured by ADAS-cog) from cholinesterase inhibitors and memantine used in dementia. True or false?
3. For every 16 patients treated with cholinesterase inhibitors for dementia, 1 patient will experience an adverse event serious enough to cease the treatment. True or false?
4. Warfarin is considered as first line anti stroke therapy for most of those who have permanent or persistent atrial fibrillation, but is considered necessary for those who only have paroxysmal atrial fibrillation. True or false?

5. Why is vitamin K called vitamin K and what was the full name of the link between vitamin K and warfarin?

**25(OH)D challenge.** QUM news has still not met a GP whose level of 25(OH)D exceeds 75 nmol/l. The last GP who revealed their 25(OH)D level was male and had a level of 19 nmol/l. Most of the lady GPs who have told me their levels were between 25 and 50 nmol/l. QUM news will give the first GP who provides a pathology test result dated from March 2009 of 75 nmol/l or greater, for themselves, a bottle of Red Hill estate 2005 Briars cabernet.

**“Treating the Symptoms of dementia” to be followed by “Antiplatelet and anticoagulant therapy in stroke prevention”.** Normally it’s stroke first and maybe dementia (vascular?) afterwards but we’ve decided to do it backwards. Our visiting round on dementia started in late 2008 and has been very well received. The stroke topic will commence in April. Bookings for both of these topics are currently open and as usual qualify for QPI PIP, for RACGP and ACCRM points. Additionally they count towards practice accreditation.

Call Graham Sweet at the Association on 8792 1900 and book your personal or group visit on either of these topics today.

**Steroids vs weight loss – this months HMR story.** *“What do you think about the prednisolone tablets?”* said the consumer. This was a ticklish situation, pharmacists have to be very careful with comments about GP’s prescribing. Anything that is negative should only be taken up with the GP directly. But consumers frequently ask these questions. The answer was *“why were they prescribed?”*

*“Inflammation in me knees, shocking pain, nothing touched it, I could barely walk before, I’m going back to Dr XXXXX today to talk about the tablets”* said the consumer. This was the opening that the pharmacist was looking for, he knew that this GP would not be continuing a daily dose of prednisolone 50mg for long as it was strictly to resolve an acute

situation. He also knew that the GP was very concerned that his patient (177cm tall, weight 121 kg) was badly overweight.

*“OK”* said the pharmacist *“now I know why he prescribed them and under the circumstances it was entirely appropriate .... however if you want to decrease pain and inflammation in your knees why not try and loose some weight?”*. This allowed the pharmacist to talk to the consumer regarding the limitations of drug therapy versus the gains that could be made via lifestyle change and thus reinforce a favourite message of this GP (and also the consumer’s wife). While the outcome is not known our consumer did seem keen to try.

Want to know more about how you can use HMR’s to reinforce your messages. Give Graham Sweet a call at the Association on 8792 1900.

**Zolendronic acid (Aclasta®) for osteoporosis.** The Association has been receiving enquiries from nursing staff who have been asked to give IV zolendronic acid for osteoporosis (ie Aclasta®). It is a new indication for a drug that has been about for some time for treatment of bone cancers. It should be noted that this is a very long acting drug and for this reason additional care is warranted when prescribing.

Only Division 1 registered nurses are authorised to administer IV medication. Division 2 nurses, even if medication endorsed, are not permitted to administer medications via the IV route. The nurse has a professional responsibility to ensure competency in IV management and all other aspects of administration of this medication, including any recommended pathology results and patient information or follow-up. The practice should establish written protocols and or checklists. DPU regulations require a written order from the GP for a nurse to administer non urgent medications. Most nurses will require a GP to establish IV access. Nursing documentation in the medical record should include details of administration and, any other relevant information, such as evidence of

**NPS clinical audits available for the QPI year: 1<sup>st</sup> May, 2009 – 30<sup>th</sup> April, 2010.**

Topic	Updates
<b>Clinical audit: Antiplatelet and anticoagulant therapy in stroke prevention.</b>	Audits packs will be available early March 2009. Enrolments are now available online at <a href="http://www.nps.org.au/health_professionals/activities">http://www.nps.org.au/health_professionals/activities</a> Flyers for enrolments will be circulated shortly.
<b>Clinical audit: Review of proton pump inhibitor prescribing.</b>	Audit packs will be available early May 2009.
<b>Clinical audit: Targeted use of antibiotics in respiratory tract infections.</b>	Audit packs will be available in July 2009.
<b>Clinical e-Audit: Optimising management of type 2 diabetes.</b>	Distribution of CD packs to enrolees continues. The Clinical e-Audit will be available until 16 <sup>th</sup> April 2010.
<b>Clinical e-Audit: Review of proton pump inhibitor prescribing.</b>	CD packs will be available October 2009.

adherence to protocols, assessment of the IV site, informed consent and any information or follow-up instructions or advice. For information on nurse decision making regarding determining competency, please contact Rose Griffiths at the Association on 8792 1900.

It is suggested that all patients be given Consumer Medicines information, and the chance to read it, before they are given the infusion, these can be obtained from [http://nps.org.au/search\\_by\\_medicine\\_name/cmi/Aclasta](http://nps.org.au/search_by_medicine_name/cmi/Aclasta) or the pharmacy that dispenses the prescription. It is also suggested that a very balanced view of this product may be obtained from [http://nps.org.au/health\\_professionals/publications/nps\\_radar/issues/current/december\\_2008/zoledronic\\_acid](http://nps.org.au/health_professionals/publications/nps_radar/issues/current/december_2008/zoledronic_acid) and that all GPs should read this before prescribing zoledronic acid for osteoporosis.

The manufacturers have also produced a physicians guide (Novartis - phone number: 02 9805 3555) which should be read together with the approved product information (in MIMs or from Novartis) before prescribing. QUM news has copies of both of these documents.

Among the main advantages are a lack of GI adverse effects (common with the oral bisphosphonates) and compliance. But the compliance advantage may be limited as patients will still have to take calcium and vitamin D supplements and their compliance with these become more not less critical as the limited knowledge that we do have regarding the product is in an environment of adequate vitamin D and calcium. As with all new products QUM news would urge caution with prescribing. The old saying of *"never be the first to prescribe a new drugs nor the last"* does make good common sense.

**Used TAIS yet?** This is another free service from the NPS, it is the Therapeutic Information and Advice Service which give health professionals access to unbiased drug information at local call rates – just dial 1300 138 677. Note: There is also an equivalent

service for consumers ie. Medicines line which may be accessed on 1300 888 763, Graham Sweet at the Association has free 'fridge magnets with this number on it for your patients, that you may wish to give to them as a better alternative for reliable medications information than the internet!

#### Quick Quiz answers

1. False.
2. False. 37 to 41% will show a response to treatment with an acetylcholine inhibitor but only one in every twelve will show a clinically significant improvement. As for memantine, the average response for those with severe moderate Alzheimer's disease is three points on the 100 point Severe Impairment Battery (SIB), a scale for which a clinically significant response has not been established.
3. True.
4. False. The evidence suggests that patients with paroxysmal or persistent atrial fibrillation have a similar risk of thromboembolism to patients with permanent atrial fibrillation. eTG.
5. Vitamin K came from the german "*Koagulations-Vitamin*". Adequate levels of vitamin K are required for blood to coagulate. The link between vitamin K and warfarin was Karl Paul Link who together with his students at the **Wisconsin Alumni Research Foundation** originally developed coumARIN and later **WARFARIN** for use as rodenticides which worked by inhibiting the actions of vitamin K metabolites. To complete the trivia featuring names one of the first recipients of the medical benefits of warfarin was US president Dwight Eisenhower, who was prescribed the drug after having a heart attack ([http://en.wikipedia.org/wiki/Myocardial\\_infarction](http://en.wikipedia.org/wiki/Myocardial_infarction)) in 1955. And one of its first victims was rumored to be Joseph Stalin courtesy of unsolicited prescribing by Laventy Beria (head of the KGB) and Nikita Kruschev (Stalin's successor).



## Community Care Posters

You may have recently been visited by a City of Greater Dandenong Community Care staff member dropping off promotional posters with tear-off slips.

These posters provide information about how to contact council if your patients need Aged and Disability Services.

If you did not receive a poster and would like one, or if you would like replacement pads to attach to the poster, contact Richard or Kerry on the number below.

They are also more than happy to come out and speak with you and your team if you have any queries.

Don't hesitate to call them on **(03) 8558 7902**.



## Are Your Patients Fighting the Weight Battle?

With Australia identified as one of the fattest nations in the world, it is no secret that a large proportion of the population are battling weight problems. So what is the best way to support your patients through this process? With a large number of fad diets taking up a significant portion of the weight loss market, how can we expect patients to successfully achieve and maintain weight loss?

What we need to help patients understand is that fad diets are usually difficult to maintain and will lead to weight regain once the diet period is complete. Gradual lifestyle changes are more likely to lead to lifelong changes in eating behaviours and therefore longer term weight loss which can reduce patient's risk of developing chronic disease.

If your patient is overweight they are likely to have additional risk factors for the development of chronic disease like Type 2 Diabetes. The AUSDRISK Tool can be used to assist with the identification of those at high risk (score >15) (<http://www.health.gov.au/internet/main/publishing.nsf/Content/Diabetes-Risk-Evaluation>). The Medicare Item 713 (Diabetes Risk Evaluation) can be used in patients 40-49 years of age to identify and assess those who have a high risk.

These high risk patients are eligible to participate in a subsidised Lifestyle Modification Program. This program assists patients to make and sustain lifestyle changes and have been shown to reduce the risk of developing Type 2 Diabetes by 58%.

If you are looking to support your patient through their weight loss journey, a referral to a Lifestyle Modification Program can help them to achieve their goals.



Fax: 9793 9052

All referrals to Lifestyle Modification Programs to:

DCAS

using the Victorian Statewide Referral Tool.

This template can be accessed at:

[http://www.dcgpa.com.au/resources/Health\\_Programs/Diabetes/](http://www.dcgpa.com.au/resources/Health_Programs/Diabetes/)

## Collaboratives Corner

### Results in HL7 – helping keep you chronic disease registers up to date!

Health Level Seven (HL7) is a format for the transfer of electronic results to your practice. The advantage of HL7 results is that, once you have reviewed the incoming result, a copy of its contents is distributed throughout the patient's electronic record. The result is then able to be included in a search. In simpler terms, if a result contains an HbA1c value, this is automatically placed in the correct field in the patient's diabetic record. It saves you the trouble of manually transferring the result value to the correct place in the patient notes.

There are two steps to make the change to HL7 downloads, firstly you need to ensure that your medical software supports HL7 investigations. Most clinical software does support HL7 investigation results but due to variations and changes it is advised to check with your software or IT support. Secondly you need to ensure that your pathology service providers are able to provide HL7 investigation result downloads. We understand that not all service providers are able to, so contact **all** your pathology service providers to confirm this and request that they send the electronic results to your practice in HL7 format.

For further information on HL7 please visit [www.hl7.org.au](http://www.hl7.org.au) or contact the Association on 8792 1900.



### Measure of the Month



The Association would like to congratulate one of our practices involved in the Collaboratives for the 'Measure of the Month'. One of the monthly measures the practices must submit is the percentage of diabetes patients that have had a SIP claimed. The diabetes SIP recognises accredited general practices that provide comprehensive quality care to patients with diabetes. This practice began the program with 65% of patients having a SIP claimed, this has now increased to 98%. This is a huge improvement and a benefit most importantly to the patients but also to the practice.

Keep a look out for next months Collaboratives Corner which will feature more ideas for improvements that could be made in your practice and another 'Measure of the Month'!

**Stephanie Edmonds,**  
**Collaboratives Program Manager**

### GP Collaboration In Maternity Care

On the 25<sup>th</sup> February, GP Liaison Services in conjunction with Maternity Services held an evening education session for GPs and maternity staff at Dandenong Hospital.

This session, focusing on the Management of Hypertension & Pre-eclampsia and addressing the issue of Obesity in Pregnancy was overwhelmingly successful with 58 participants attending.

This education event is one of a series held every 3-4 months for GPs who provide antenatal care for Southern Health patients and enables GPs to maintain their accreditation to practice shared antenatal care with Southern Health. For further information regarding the education offered to our shared care GPs please contact Dr Rebecca Fradkin at the GPLU Office on 9594 3014.

### Accessing Accurate GP Details

GP Liaison Services at Southern Health recently conducted a review and cross check of GP details on the Human Services Directory (HSD), the State on-line database. Over 700 GP entries for practices which fall within the Southern Health catchment were checked and updated.

**It is essential GPs and practices are on the HSD to receive vital patient information, not only from Southern Health, but most public hospitals in Victoria.** The patient management systems which hospitals use to communicate information about the patient rely on data from the HSD.

Some helpful resources on how to obtain a login for the HSD and how to add or edit details on the HSD will be mailed to Divisions in the coming weeks.

### Emergency Medicine for GPs

Look out for an exciting upcoming education session on Emergency Medicine to be held at Monash Medical Centre, Clayton on Thursday 29<sup>th</sup> April from 7.00pm - 9.30pm. Topics will include Acute Coronary Syndrome, Anaphylaxis, Asthma, Seizures and Paediatrics. Mark this date in your diaries! Registration flyers will be mailed out later this month.

For more information please contact Toni Lamarche, Monash Division on 9570 3727.

### Totally SmokeFree Day – 31<sup>st</sup> May, 2009

From the 31<sup>st</sup> May there will be no designated smoking areas on any Southern Health properties. As this may impact on some of your patients please be advised of the following support structures being implemented:

We are taking a holistic approach to this transition which will include:

Admission: seek information from the patient on nicotine dependency  
 Support: offer cost price NRT during hospital stay  
 Discharge: (if the patient indicates a desire to quit smoking) review medication list and include at least seven (7) days NRT; fax referral to QUIT and advise you.

We will also be encouraging staff who are smokers to consider quitting, including suggesting they consult with their local GP for a *life script* as part of their quit process.

### ‘Patient Streaming’ Across Southern Health Sites

This principle has recently been endorsed by the Executive Team and noted by the Southern Health Board and stipulates that: ...In order to support timely and effective care for all patients, it is necessary to ensure that patients are placed at the site best suited to their clinical needs. This will mean that patients may be placed at a site other than that which is closest to their home and family, or may be transferred to a different Southern Health site to the one at which they initially presented. .... the overriding principle for decision-making regarding admission to a particular site will be clinical need and the availability of any specialist services that may be required, rather than geographical proximity to home.

### Contact Us:

#### Tanya Heaney-Voogt,

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 Acute Ambulatory Services  
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#### Personal Assistant:

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#### Dr Charles Roth

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 P 9594 3014, F 9594 6063, M 0488 642 956

#### Dr Rebecca Fradkin

GPLO Maternity Services  
 GP Liaison Unit  
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 P 9594 3014, F 9594 6063, NB: Wednesdays Only

#### Christine Prendergast

Project Officer – GP Liaison Services  
 Dandenong Casey GP Association  
 (Via Association or GPLU Phone on 9594 3014)

#### Simone Mitchell

Project Officer – GP Liaison Services  
 Monash Division of General Practice  
 (Via Division or GPLU Phone on 9594 3014)

#### Josie Ciotta

Communications Officer - GP Liaison Services  
[Josie.ciotta@southernhealth.org.au](mailto:Josie.ciotta@southernhealth.org.au)  
 P 9594 3014, F 9594 6063

## Work smarter, not harder: Data Extraction Tools

Currently there are two data extraction tools available to general practices; Pen Clinical Audit Tool and The Canning Data Extraction Tool. Both are compatible with Medical Director 2 and 3 and Best Practice clinical software. Pen can also be used with Genie, and The Canning Tool is also compatible with Practix, MedTech32 and Medical Spectrum Classic. Both vendors are continually working on expanding this list, so if your clinical software is not currently compatible, it may not be long before you too can start to reap the benefits.

Although some clinical software packages do have the capacity to retrieve data, these functions can sometimes be difficult to use and limited in their

capabilities. Using a tool which is exclusively designed to perform data extraction functions provides faster, simpler and more comprehensive search results. Both programs also have the ability to export data to Excel enabling clinicians to target lists of patients for follow-up in areas of concern regarding chronic conditions, and to improve their clinical data quality which can assist with accreditation and incentive payments.

If you have any questions regarding either of these clinical audit tool systems or if you are interested in having one installed **FREE OF CHARGE**, contact the Association on 8792 1900.



## Physical Activity Recommendations for Older Australians



For the first time, the Australian Government has developed physical activity recommendations specifically for older Australians.

Under the new recommendations, older Australians are urged to accumulate at least 30 minutes of moderate physical activity a day, as a slight increase in activity can make a difference to a person's overall health and wellbeing.

Australians now have one of the world's longest life expectancies. The current life expectancy is 81.4 years and, by 2060, an Australian woman can expect – on average – to reach the age of 90.

Currently, there are some 2.8 million Australians – about 13 per cent of the population – aged 65 and over. This number is expected to triple in 40 years.

The new recommendations apply to older people across all levels of health and ability, be they living at home or in an aged care home.

The National Physical Activity Recommendations for Older Australians were developed by the National Ageing Research Institute – based in Melbourne.

The new physical activity recommendations include that older Australians:

- Should do some form of physical activity – no matter what their age, weight, health problems or abilities;
- Should accumulate at least 30 minutes of moderate intensity physical activity on most, preferably all days;
- Should be active every day in as many ways as possible, doing a range of physical activities that

incorporate fitness, strength, balance and flexibility; and

- Who have stopped physical activity, or who are starting a new physical activity, should start at a level that is easily manageable and gradually build up the recommended amount, type and frequency of activity.

Specific examples of physical activity include:

- Moderate fitness activities such as brisk walking, vacuuming or golf;
- Strength activities such as carrying groceries, moderate yard work or taking the stairs instead of the lift;
- Flexibility activities such as tai chi, bowls or yoga; and
- Balancing activities such as walking heel to toe.

The recommendations will be developed into a brochure. In the meantime, further information and suggestions for how older Australians can follow the new recommendations can be obtained in the *Choose Health: Be Active* booklet.

This booklet offers helpful tips and advice on how older people can engage in moderate activity to improve their lives and health. It was first developed in 2005 for older Australians in conjunction with the Department of Veterans Affairs and Sports Medicine Australia.

There are 155,000 free copies of the *Choose Health: Be Active* booklet available.

*These can be ordered free of charge by calling 1800 500 853.*