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# The Highland Doctor

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May 2007

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*Newsletter of the Southern Highlands Division of General Practice*

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## *From the Chair*

I must say that it only feels like a few months since Sally last asked me for the Chairman's Column for the *Highland Doctor* – but it is about eight years ago! When searching for inspiration for my column, I looked back at the pieces I had written from 1996 to 1999 – and was interested to contemplate the issues that concerned us then (when Dr Wooldridge was Minister for Health and George Blackwell was the local hospital CEO) as compared to the present.

Some of the issues discussed have been long forgotten (e.g. the Relative Value Study), some moved right along (e.g. most of our GP surgeries were predominantly bulkbilling and the idea of a co-payment had just been proposed), some dropped from view (e.g. the Home Detox program) and some have been a great concept until recently ceased (DocFax). Some activities (especially Jill and her Diabetes Program) have surged from strength to strength – and continue to excel and grow.

In this period the concept of accreditation grew, the PIP (Practice Incentive Program) commenced and then the two became intrinsically linked. Apart from the odd complaint about the unreachable Pap Smear target, we now take this almost for granted. And then it was becoming obvious that the growing amount of Health Department paperwork (followed closely by Tax Department paperwork and the BAS in 2000) was an inappropriate focus of doctors' time. Enter the Practice Manager and soon afterward the Practice Nurse – initially in the larger group practices, but increasingly in most smaller practices. These roles are now held as critical

in our future need to expand chronic disease management capacity.

Computer use in practices was then in its infancy – three practices used computers clinically – and assistance with IT adoption and upskilling rapidly became a Division interest. Now virtually all our practices are using computer prescribing and computerised accounting packages (many linked to HIC Online), many using computerised records, and a few almost paperless – and who would have thought that our Imaging (not a word used then!) and Pathology would be electronic?

A vigorous debate was taking place about the possibility of more co-operation in the After Hours roster – and many were opposed to the possibility of co-operative after hours clinic!

Mental Health assumed a role in the Division after a sad cluster of suicides in Bundanoon. Who could have foreseen our current Mental Health program – with our Psychologist Program, Teams of Two meetings and wonderful inspired co-ordination first from Olivia and then Astrid?

Immunisation was getting more attention – the Schedule was getting a little more complex and we were yet to get immunisation feedback and immunisation PIPs. In the intervening years the Government has rightly upped the ante on immunisation – but the Immunisation Schedule has achieved a complexity that requires every doctor to look up every shot!

Back then we had three Division staff members – now about a dozen including our After Hours Clinic staff. We have about 20

more members – though more part-time and more female. We have become more concerned at workforce issues – scarcely a concern then. We are on average ageing – many of our new GPs coming to the area are mature tree-changers. To address these concerns, we are increasingly engaged in vocational training of registrars (three new Basic Registrars – the first Basic to train in our district - started this year) and in the future, training of students from the Graduate School of Medicine at Wollongong University.

These issues (and many others beside) underline the proud record of this Division in meeting the needs of our doctors and our patients in this area. My meander through the past decade only increased my admiration for the staff and the doctors of this Division – for what they have achieved with only small resources. I look forward to helping to again steer this Division and our practices into what promises to be a challenging but interesting future. Welcome along for the ride!

*Vince Roche*

## *From the CEO*

### **University of Wollongong**

The Graduate School of Medicine (GSM) at Wollongong accepted its first students at the beginning of this year.

The four year course begins with 18 months concentrating on basic sciences, plus learning clinical skills in general practice and hospitals (Phase I). The second year is principally in hospitals (Phase II), with the following 12 months in integrated GP and hospital placements – some of which will be with GPs in the Southern Highlands (Phase III).

In June this year, the first Phase I students will have three weeks of intensive clinical experience in Bowral with Community Health and the Mental Health Service.

In Phase III in 2009, the students will be attached to a general practice for a full year. This time includes operation assists, confinements etc. The practice will need a dedicated room for students and the recent

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Federal Budget has confirmed financial support for practices to provide these facilities.

The Division and the GSM are collaborating closely on these exciting new strategies for medical education, and this includes the employment (with university funding) of a part time administrative assistant and later, a part time GP Clinical Co-ordinator, both to be based in our area.

### **Practice Support**

We were pleased to be successful recently in our application for one of the Commonwealth's "Round the Clock" grants for after hours services. This frees up the Workforce Support funds that had previously been subsidising our After Hours Service. Members will recall the discussions at our general meeting in March about the uses of these funds.

The main activity decided upon by the Board is to introduce a support network for practice administrative staff, especially practice managers. Julie Huntington will manage the program, and the first step is to bring the staff members together to discuss their needs. We envisage the network will feature lectures and advice sessions with appropriate speakers arranged by Julie.

### **Activity Program in Primary Schools**

The Division has sponsored a program called 'Blueearth' in two of our local primary schools this year. They are Colo Vale and Moss Vale Primaries. We saw this program running in a school in the Liverpool area and were greatly impressed. The Program targets 8 and 9 year olds and is directed at lifestyle changes through activity in general.

We believe this is one of the best approaches to childhood obesity, which is of course a precursor of later type II diabetes.

The reports from the two schools are highly favourable to the extent that we have applied for funding to extend the program in new directions. The first is to develop links between the program and local sporting clubs so that the children are encouraged to maintain their culture of activity. Secondly, we will try to source funding to implement the program in more schools next year.

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#### **Diabetes service**

At its April meeting, the Board agreed in principle to beef up our pre-diabetes service by recruiting a nurse to work with Jill Snow. The nurse will be trained to undertake counselling work for people in the pre-diabetes phase. The proposal is to locate this nurse in Jill's rooms in Bowral Street plus Bargo and Bundanoon.

#### **Mental Health**

Astrid Toscan and Jill Snow have collaborated in an extension of the Diabetes Program to assist people who are suffering from mental health issues associated with their diabetes. This is a well recognised problem. Later, Astrid is keen to expand this activity to include other chronic illnesses.

Olivia Waters has advised that she is not returning from maternity leave, and so I am pleased to announce that Astrid is staying with us. This has allowed Astrid to plan for her services on a long term basis. She is to be relieved of some of the administrative work involved in the BOMH program, which will allow her to develop a service targeting older adolescents and young adults with mental health problems.

In recent weeks, the Commonwealth has announced new funding for mental health nurses in general practice – we will keep you posted on this when more information is available.

#### **Bowral Hospital GP VMO matters**

The Division, as a part of our ongoing relationship with the Hospital, has been discussing issues in relation to GP VMOs. What has been concerning Vince Roche and others is that cases which do not come under specialist services here are admitted under the GP VMO. This relates to head injuries, mental health, urology and ENT cases. Often these cases are outside of GP expertise and they therefore need to be transferred to Campbelltown or Liverpool.

The problem that has increasingly been occurring is that the GP VMO has to find a bed for these patients. In one recent episode, this involved one of our GPs spending an entire morning on the telephone while other members of his practice attended to his patients. The

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situation also recently led to the resignation of a valued GP VMO.

The Division is insisting that SSWAHS takes the responsibility for finding beds since it is SSWAHS's decision not to provide certain specialist services here nor RMO staff to arrange transfers etc.

#### **Health Insurance changes**

The Government has recently passed new legislation to permit Health Funds to pay benefits from hospital insurances tables in respect of non hospital based services – in other words, for home based ambulatory care programs where patients do not go through a hospital.

This would open up opportunities for GPs and Divisions to mount new services. However, the wording of the legislation is complex and there are apparently some 45 regulations. I am taking advice from an expert on health insurance – watch this space.

#### **Cancer Council activities**

Our interface with the Cancer Council this year will have several facets.

As a result of the efforts of the Southern Highlands in the 'Relay for Life' a year ago, the Council wishes to spend some of the proceeds in our area. They have supplied a lengthy list of proposed activities for which they may offer funding, including

- Support groups, therapy groups
- Help for carers of cancer patients
- Better access to oncologists, specialist cancer services, diagnostic services and equipment
- Palliative care issues

These will be considered by the Board at its next meeting. The Board will also discuss our involvement in next year's 'Relay for Life'.

In conjunction with the Cancer Council, we are arranging an education session for GPs in skin cancer care. The objective is to provide an alternative source of expert care to that being offered in various skin cancer clinics. This upskilling will be presented by Dr Duncan Stanford, a dermatologist from the South Coast, and we will advise a date as soon as this is finalised.

*Warwick Ruscoe*

## Glycaemic Highlights

### Pre-diabetes

Two million Australians are thought to have pre-diabetes and left untreated may develop into type 2 diabetes within 5 - 10 years.

Cardiab shows that registrations of pre-diabetes is happening. GPs on both sides of the river have comparable numbers.

As you are aware, at the time of diagnosis of T2DM, the pancreas has lost 50% of its beta cell function with a further 25% loss in the following six years.

In my mind this is good enough reason to screen for pre-diabetes. The bottom line of management is to **normalise triglycerides and reduce waist circumference**.

Those with the highest risk amongst the pre-diabetes population are those people on atypical anti-psychotics.

People with schizophrenia have a higher risk of metabolic syndrome than the general population. Metabolic syndrome is a cluster of related symptoms that puts the individual at increased risk of diabetes and cardiovascular disease such as heart attack and stroke. Metabolic syndrome generally includes some or all of the following: elevated blood pressure; abdominal obesity; diabetes or "pre-diabetes" (impaired glucose tolerance, impaired fasting glucose or insulin resistance); dyslipidaemia (high levels of triglycerides and / or HDL - the "bad" cholesterol); and inflammatory markers. It is the leading natural cause of increased rate of death in people with schizophrenia.

An article by Dr. Jonathan M. Meyer MD, in *The Psychiatric Times* summarises new findings exploring the link between metabolic syndrome and schizophrenia, and presents recent consensus recommendations for preventing and monitoring metabolic syndrome or "dysfunction". He states that minimisation of cardiovascular risk remains a major clinical goal during anti-psychotic therapy of schizophrenia.

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Dr. Meyer points out that in spite of the high rate of metabolic syndrome (28%-54% depending on the study) in patients with schizophrenia, results from "Clinical Anti-psychotic Trials of Intervention Effectiveness" (CATIE) studies showed an association between metabolic syndrome and poor perceived health, and of great concern - low rates of treatment for metabolic syndrome. Studies so far have not ruled out a natural predisposition to metabolic syndrome in people with schizophrenia, but most evidence to date points to the treatments for schizophrenia as being an important causative factor in the high incidence of metabolic dysfunction.

Expert opinion from the CATIE trials is that olanzapine and clozapine are the anti-psychotic agents with the highest risk for metabolic dysfunction. Ziprasidone appears to be metabolically neutral. Long-term prospective studies (26 & 52 weeks) show that aripiprazole has a benign metabolic profile comparable to that for ziprasidone. Metabolic risk of the other anti-psychotics were not discussed.

Guidelines suggest that metabolic risk factors be monitored. At baseline (initially) the following risk factors should be determined:

*Family history*

*Weight and body mass index (BMI)*

*Waist circumference*

*Blood pressure*

*Fasting lipids*

*Fasting glucose*

After that, these risk factors (other than family history) should be monitored regularly, with the fasting lipids and fasting glucose (which require blood testing) re-evaluated every three months.

The parameters that define the metabolic syndrome provide useful markers for determining when to intervene. In the case of weight gain, Dr. Meyer says the American Diabetes Association (ADA) consensus panel

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recommends "intervention when the patient experiences a 5% weight gain, since most individuals have difficulty in losing more than 5% on their own".

Dr. Meyer then points out a problem that exists in implementing the suggestions of both the ADA consensus panel and National Cholesterol Education Program for intervention once metabolic abnormalities are identified - lack of programs being widely available to patients with schizophrenia. The intervention recommended is a trial of lifestyle modifications for up to three months. The interventions must be reassessed for effectiveness after this time.

Other strategies must be pursued if lifestyle interventions fail. These strategies can include medications for the metabolic symptoms or even switching anti-psychotic medications, if possible.

*The Psychiatric Times* goes on to report that although the exact mechanism of weight gain associated with atypical anti-psychotics is unknown, patients complain about an increase in appetite and a decrease in fullness. With an increase in total caloric intake, weight gain quickly ensues.

Based on the success of other programs, the University of California (Irvine) designed a diet to minimise atypical anti-psychotic induced weight gain at the acute psychiatric ward at the University. The diet includes four simple nutritional changes:

- (1) the elimination of second servings
- (2) the replacement of high-calorie snacks with fruits and vegetables
- (3) the elimination of desserts
- (4) the substitution of water for sodas and juices

Implementation of this diet resulted in improved weight and body mass index (BMI) profiles in 143 patients who had schizophrenia or schizoaffective disorder treated with olanzapine.

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The first step for our Division would be to identify this group through a Medical Director query and check if an OGTT has been performed. The monitoring parameters above should be included in the GP management plan.

The REO Program has shown great success in helping people on anti-psychotic medications implement changes to the behavioural risk-factor of **inactivity**. Nearly all these patients already have diabetes. We are looking for more funding to improve access for people commencing anti-psychotics to receive early intervention with inactivity.

Of note, Dr Geoff Sparkes has a patient with schizophrenia who has successfully come off insulin and is being managed on diet only. It can be done. Good work Geoff!

REO can also provide a one-off functional assessment and exercise plan for any individual on a private basis. The cost is around \$125. This has shown to be quite useful for patients and for GPs as it gives a total look at the individual's strength, stamina, speed and flexibility. There have been quite a number of unexpected "fall risks" identified through this process. Referral by letter and copy of any management plan is satisfactory.

### Diabetes and Travel

I have been receiving a lot of enquiries from people with diabetes about what to do when travelling by plane. Heightened security measures surrounding airline travel in recent times are a source of anxiety for many people. The Australian Government Federal Department of Transport and Regional Services classifies syringes, pen needles and lancets as prohibited items.

However they may be carried on board if they can be verified as medically necessary.

People travelling with diabetes may now also request a private screening room to discuss their condition when passing through security.

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The Airport Security Supervisor or Airport Manager can be accessed if problems arise.

The following advice is offered to those travelling with diabetes:

- Carry a medical practitioner's letter outlining your diabetes, necessary medications and a description of prohibited items such as sharps required for diabetes management;
- Have your current NDSS card as back up;
- Pen needles, blood glucose monitors, lancets and medications should be stored in hand luggage according to manufacturer's directions, preferably in a clear, sealable plastic bag that is available for security inspection;
- All medications should be carried in their original packaging and labelled with the name of the person travelling with diabetes;
- Spare supplies are recommended, preferably carried by a co-traveller if possible;
- Insulin pumps are not classed as prohibited items, however screening procedures require staff to ask where the pump is located and request it be shown for inspection. At no time should it be requested that the insulin pump be detached, taken apart or the batteries be removed.

*Jill Snow*

## MENTAL HEALTH MATTERS

At present there are quite a few things happening in the mental health world of the Division. The major development is the **Psychological and Behavioural Support for Chronic Illness (PABSCI) program**. This has been devised by Jill Snow and myself to assist individuals in the management of chronic illness, with the first target being diabetes.

Essentially, the PABSCI program focuses on self-care behaviour through motivational interviewing and basic CBT techniques to assist high risk individuals to adopt better self-care strategies. Further, it enables patients to discuss other personal issues that may be at

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the centre of poor self care. Acknowledgement of these issues allows the progression to the motivational interviewing stage where the individual's stage of change is assessed, and the gradual development of patient-centred generation of strategies for self care management occurs. This promotes a sense of self-efficacy which in turn should ultimately be reflected in the management of their disease. This is not a magic wand but a method of intervention that engages the individual to consider their situation and incrementally implement change.

At this stage it is a small pilot program and I am conducting the therapy sessions myself. It is anticipated that this service will be of great benefit to the individual and the GP. If it is assessed as viable, it may be rolled out via the Better Outcomes in Mental Health program to encompass other chronic disease such as cardiac disease.

The other arm of the PABSCI program is to target individuals who are taking anti-psychotics and drugs such as Epilim. Jill and I recently attended a one-day workshop that focused on diabetes and mental health. Recent research suggests that atypical antipsychotic drugs can quickly lead to symptoms of pre-diabetes via excessive weight gain. Although this is a superficial explanation, the underlying message is that we need to be monitoring this population for pre-diabetes and diabetes.

Jill and I are excited about the development of the PABSCI program and we are working hard to develop the concept, educate ourselves and write proposals to attract funding to develop the program and possibly conduct research. If you are interested in finding out more about the PABSCI program, please call either Jill or Astrid at the Division on 4861 6084.

Aside from PABSCI, I am currently looking at the Commonwealth Government funding through COAG for Mental Health Nurses to work closely with GPs and private Psychiatrists. This provides a wonderful opportunity for quality management of patients who experience complex mental

health issues. These matters are being explored in terms of how this initiative may be of assistance to general practice.

Currently, I am half-way through an Emergency Mental Health course which is being trialled through Newcastle University. It has afforded me the opportunity to revisit issues surrounding the Mental Health Act, risk management, consumer rights etc as well as enabling me to engage in learning activities with other mental health professionals from around the State.

The Better Outcomes in Mental Health program is chugging along well. I am currently assessing the financial status of the program to decide whether there needs to be any demand strategies put in place. As well, I am streamlining the process at the Division and hopefully will have a personal assistant in the near future to assist with administration duties, thereby freeing me up to concentrate on mental health issues.

Our latest 'Teams of Two' was another success. To date, we have explored Cannabis, Mental Health and Youth and more recently, we learned about Amphetamines and Psychosis, where close to 80 health professionals heard Dr Adam Winstock discuss this topic. The feedback has been very positive and from each session I learn some lessons. The next session will be on Drugs, Sexual Health and Pregnancy. It will be held towards the end of June and invitations will be sent out closer to the date.

*Astrid Toscan*

**Teams of Two  
"Sexual Health, Drugs and  
Pregnancy"**

**June 26, 2007  
at  
Craigieburn  
Save the date!**

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### QUALITY USE OF MEDICINES

It is now possible to do both NPS Case Studies and NPS Clinical Audits electronically.

#### NPS Clinical e-Audit

GPs can now participate in a paperless NPS Clinical e-Audit that gives immediate patient-specific feedback on best practice clinical indicators and assists with implementing changes in practice to improve patient care.

GPs who participated in a previous clinical audit (paper-based) identified that 86% of patients with ischaemic heart disease who were able to use an antiplatelet agent were using an antiplatelet agent, and 60% of patients with a previous myocardial infarction were using a beta blocker.

The Clinical e-Audit has been approved by the RACGP QA&CPD Program (30 Category 1 points) in the 2005-2007 triennium and the ACRRM PD Program (27 clinical audit points including 20 mandatory points). The activity is recognised for the Quality Prescribing Initiative (QPI) of the PIP year ending April 2008.

The Clinical e-Audit: *Optimising drug use in ischaemic heart disease* is now open for enrolment. Completing the audit gives GPs an opportunity to:

- review drug use in patients with ischaemic heart disease
- optimise reduction of risk of future cardiovascular events
- optimise symptom control in angina
- assess and manage coexisting dyslipidaemia and hypertension
- review strategies for optimal patient compliance with drug treatment.

▶ **Enrol** at [www.nps.org.au/healthpro](http://www.nps.org.au/healthpro) to receive the free Clinical e-Audit on CD (installation requires Windows 2000 or above).

▶ **Submit** de-identified data for 20 patients with ischaemic heart disease securely online by **1 June 2007** (using an internet connection).

▶ **Complete** the review phase (accessible 12 weeks after submission of initial data) by **5 October 2007**. The review phase identifies individual patients for review, allows GPs to reflect on their improvements in clinical practice and to compare practice to other participants.

## NPS Online Case Studies

Case studies are one of the educational and quality assurance activities provided free of charge by NPS to GPs, pharmacists, nurses and other health professionals. Case studies present a clinical scenario accompanied by a set of questions that are designed to help participants refine their clinical decision-making skills. All participants will receive a feedback report that includes expert commentaries on the case study along with aggregated responses that provide a snapshot of your colleagues' responses. The expert commentaries are usually provided by a specialist physician and a GP with a special interest in the area who provide comment on the aggregate responses of 200 GPs. Online participants can choose to receive these reports by email.

From February 2007, NPS is presenting each case study in two formats: a printed version inserted with NPS News and an online version. Each version is the same. To complete the on-line case study – go to [www.casestudy.nps.org.au](http://www.casestudy.nps.org.au)

There is a list of frequently asked questions regarding on-line case studies on this web page.

## NPS Visits

The new NPS topic is **Analgesics in Persistent Pain**. If you have not had a one-to-one visit from Gail Forlonge and would like one, please ring the Division for an appointment. The visits are in your surgery and take about 20 minutes to provide an update of current evidence-based practice (RACGP points and PIP apply).

## Home Medicines Review Item 900 attracts RACGP points

Thanks to the efforts of the Pharmaceutical Society of Australia (NSW Branch) and the Pharmacy Guild it is now possible to obtain **RACGP points for completing HMRs**. Under RACGP's Active Learning Modules, GPs will be encouraged to consider what they have learnt from HMRs. GPs can then complete a very brief form (available from Gail at the Division).

Reflecting on learning from HMRs has been allocated Category 2 points by RACGP QA & CPD Program for the 2005-7 triennium and will be awarded by the RACGP for **learning experience** while completing Home Medicines Reviews (HMR). It is suggested that a number of HMRs be completed and reflected upon before each claim. The claim can be made by completing the simple

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form available from Gail, attaching a copy of your recent HMR claims and sending it to Gail to ensure the points are allocated.

In addition to this activity, GPs will have the opportunity to attend local Case Studies focusing on HMR and these will assist GPs to get the best out of HMRs and add to the RACGP points available. The case studies are developed by the Pharmaceutical Society of Australia and will be advertised by flyer over the next few months – these events will also attract Category 2 points (2 pts per hour). For more information about these new aspects of HMR please contact me at the Division.

*Gail Forlonge*

## AGED CARE News and Views

### GP input established in all the Aged Care facilities in the Wingecarribee Shire

The response to this initiative has been very positive. All groups have identified areas for further discussion and development. These include input to policy development, a palliative approach to care in nursing homes, Advance Care Planning /end of life wishes, IT systems to assist GPs - computer generated scripts, medication charts and clinical notes

#### Your GP representatives are:

HarbisonCare John Barnett, Vince Roche and Terry Flynn. Nursing staff from the nursing home and both hostels, the Continuous Improvement Co-ordinator, pharmacist and these GPs meet every three months.

Thompson Health Care (The Abbey and Kenilworth) – John Barnett and Vince Roche meet every three months with senior nursing staff and the pharmacist.

Mt Warrigal Linkside Geoff Sparkes, Con Mouroukas and Terry Flynn and nursing staff meet every 2nd month.

#### Aged Care Item Numbers:

Comprehensive Medical Assessments (CMA). Item #712 (\$187.65-100% fee) is suggested for all new residents and for yearly review of existing residents. (Forms on your own Medical Director, ideal as this

includes medications, allergies, PMH etc or available from the Nursing Home)

At the same time as you are asked to do a CMA, you may also contribute to the Care Plan – Item #731 (\$43.40), which is usually being simultaneously prepared by the nursing home. Don't forget that you can bill for a review of contribution to care plan (Item #731) up to three times a year, as well as the actual item number for the RACF visit.

Residential Medication Management Review (RMMR). Item #903 (\$91.85-100% fee) discusses and seeks consent for a RMMR for a new or existing resident, review and report from a pharmacist, development of a medication plan by the GP (also on Medical Director).

Make working in Residential Aged Care Facilities easier by:

- Organising to review your residents at a scheduled time or using clinic sessions at HarbisonCare hostels. If pre-arranged, the residents will be organised to come to the clinic room. Very soon there will be provision of a PC and printer for GP use.
- Asking practice staff to phone the facility before your visit. The registered nurses will have files and medication charts ready for you. Even 10 minutes notice would be enough to get everything ready and save you time.
- There is an expectation that GPs see their residents every 3 months and review and rewrite medication charts every 6 months in the hostels and in nursing homes.
- If a GP decides to change a medication strength/dosage or start a new medication (either after a call from RACF staff or a surgery visit from a hostel patient), the best procedure is to ask your staff to fax the script to the Nursing Home/ Hostel (as opposed to the Pharmacy). This way RACF staff has the correct information about the changes, and will take the responsibility for letting the Pharmacy know. If there are changes needed to the medication chart, they will fax it back to you for alteration and fax back.

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If a Hostel resident visits a GP in your surgery – and forgets to bring their hostel notes with them – we suggest you print off your progress notes at the end of the consultation and ask the resident to take them back to the hostel.

Did you know – HarbisonCare Hostels are classified as Residential Aged Care Facilities.

Other aged care villas and villages – Kenilworth, Annesley, Mt. Eymard and Henley Brae are “community” and our usual surgery item numbers and EPC apply.

Please look at the green sheet (enclosed with this newsletter) which has been devised by staff in aged care facilities to assist them in having relevant information at their fingertips before they phone a GP. This has been developed in conjunction with the Division Aged Care Panel to achieve optimum operational efficiency (and minimise GP frustration!)

**Alzheimer's Australia (NSW)** provides education, information about dementia and resources for carers. Short term counselling sessions can also be organised.

Contact: Angela Lowman, Dementia Advisor  
Ph: 4861 6581

Email: [alowman@alznsw.asn.au](mailto:alowman@alznsw.asn.au)

Web: [www.alznsw.asn.au](http://www.alznsw.asn.au)

**Advance Care Directives.** An easy to read workbook “My Health, My Future, My Choice” can be purchased for \$14 from Advance Care Directive Association  
Ph: 0423 157 003.

For further information, please call me at the Division.

*Margaret Maff*

**"A new take on some common conditions in Geriatric Medicine"**  
with  
**Drs John Barnett and Vince Roche**  
**June 7, 2007**  
**at Bowral Golf Club**

## After Hours Service

The Easter weekend proved to be a very busy one at the After Hours Clinic. Patient attendance numbers were high, so perhaps busier weekends than we have experienced in the first few months of this year will return.

As the next roster period is approaching, a review of current Clinic and roster conditions has been undertaken. Members will have received surveys regarding some of the review suggestions and whilst some responses are yet to be received, preliminary results are as follows:

- ❖ Changing afternoon hours of all Clinic sessions from 4-6.00pm to 3-5.00pm. The reason for this recommendation is that the numbers of patients attending the Clinic tend to reduce considerably for the last hour, especially in the winter months. It was deemed these new hours would be more patient-friendly.  
*Majority agreed*
- ❖ Combining outside call and Clinic GP on Saturdays for a six month trial.  
*Majority agreed*
- ❖ Another general meeting needed to discuss issues further. *Majority disagreed.*

The Board will consider the survey results once all responses are received. If the Board resolves to make the above changes, they will be implemented with the new roster commencing in August 2007.

Another amendment to rostering in the Clinic is the Board resolution that as a general rule, in order for a GP to work in the Clinic, he or she must have 12 months FTE experience working in Australian general practice. The sessional loads of GPs who do not satisfy this criteria will not be counted towards a practice's total load in calculating roster participation.

This decision of the Board is open for review on a case by case basis.

We have always had a protocol to follow in the Clinic should the rostered GP not arrive for work (the receptionist calls the outside call GP or failing that, a member of the AHS Board), however we recently had an occasion when the receptionist did not arrive.

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As the GP, the most important point to keep in mind is to try to get the session started and patients attended to.

The primary steps to take are:

- Don't wait longer than 10 minutes
- Ring the call service on 4861 6433 and let them know so that they can call me or another receptionist to come to work
- Proceed to Banksia Ward in the Private Hospital and ask a Private Hospital staff member to assist with retrieving keys to unlock day surgery
- Explain the situation to the patients and inform them that they will be seen in the order that they arrive
- Start consulting
- Don't worry about billing - we will mail accounts to any patients you see before a receptionist arrives to bill correctly.

Hopefully this information will not be needed and a reception staff member will always be in attendance!

A complaint has been received from a GP in regard to one of his patients with an addiction problem. Drugs of addiction were prescribed from the Clinic on more than one occasion. The patient's regular GP had listed boldly in the warning section of Medical Director on the Clinic computer that the patient had an addiction problem and listed those medications involved. The progress notes also contained a request that the patient not be given such scripts, and yet the scripts were still issued.

Please check the warning section of Medical Director and read previous progress notes of all patients when working in the Clinic. The After Hours Board has suggested that as a general rule, if the patient is not being seen by their usual GP, S8 medications not be prescribed.

*Julie Huntington*



## Immunisation Update

### Budget Summary

The Government has committed a total of \$579.3 million from 2006-07 to 2010-11 for the HPV vaccination program.

Funding is provided to include rotavirus vaccine on the national immunisation program at a cost of \$124.4 million over five years.

The Government will provide a total of \$16.6 million over five years to ensure ongoing supply of Q fever vaccine.

### Meningococcal C Vaccines

**The funding for the Men C catch-up program will cease at the end of June 2007.** Men C will remain on the National Immunisation Program for 12 month old children only.

### Fluvax and Pneumovax 23

Whilst Fluvax has a good uptake by the older community each year, the Pneumovax 23 uptake has not been as successful. Both vaccines are free for 65 year olds and older.

### HPV School-based Immunisation Program

This began throughout the Southern Highlands late April for students in Year 10, 11 & 12. Years 7, 8, 9 & 10 will be vaccinated in 2008.

### Low Immunisation Coverage Rates for 4 year olds

The Southern Highlands still has an overall low rate of immunisation for 4 year olds. The Division has decided to offer Preschools and Childcare centres throughout the highlands an opportunity to host an Immunisation Update Evening for staff and parents. So far, 4 centres have accepted our offer.

### Overdue Children for Immunisation

The Division will continue to data-sort those children overdue for immunisation for practices with coverage rates below 90%. Practices with coverage rates above 90% will not receive data from the Division unless requested.

### NSW Occupational Screening, Assessment and Vaccination against infectious diseases

New requirements for provision of Boostrix for Health Care Workers (this includes 3<sup>rd</sup> year nursing students). Particularly note the *Information for Immunisation Providers* as this provides guidelines for what vaccination records are required for this group and how to assist patients to acquire these. Go to web site [www.health.nsw.gov.au/ohs\\_vaccination/index.html](http://www.health.nsw.gov.au/ohs_vaccination/index.html)

*Cheryl Jones*

## The Highland Doctor Cardiac Assessment Unit

The team at CAU has undertaken a study to investigate the incidence of hypertension in patients on the Cardiac Rehabilitation Program, their management and the referral patterns for those with BP readings which fell outside the NHF Guidelines (2004).

Almost one third of patients who had a history of hypertension and were on medication were found to be hypertensive during the program. These patients were referred back to their doctors for review.

This study highlighted the number of patients who had hypertension which was found to be outside the NHF guidelines, increasing their risk of cardiovascular and other diseases.

The findings of the study will be presented by the CAU staff at the 55<sup>th</sup> Scientific Meeting of the Cardiac Society of Australia and New Zealand in Christchurch, NZ in August in a paper titled "Hypertension: Are the Guidelines Being Followed." This study was

The CAU staff have met with Warwick Ruscoe and are soon to meet with Jill Snow to discuss how to better integrate the services offered by the CAU into the long term management plans of patients with cardiovascular disease. The Cardiac Assessment Unit provides:

- Exercise Stress Testing on Tuesdays with Dr Grant,
- Pacemaker Clinic,
- Cardiac Rehabilitation Program,
- Inpatient cardiac education and lifestyle management,
- Group education sessions,
- Individual education and risk factor modification sessions.

We have it on 'good authority' that Bowral Hospital is intending to enforce the parking restrictions around the Hospital, including in the turning circle in front of the Division office, which will involve fines through the State Traffic Infringement Bureau.  
Be warned!

# NOTICES

## WINTERGARDEN MEDICAL CENTRE

*This practice will soon have a vacancy for a part-time or full-time VR GP. Please contact the practice manager if you know of any interested doctors.*

*We will consider employing advanced GP trainees, if they will agree to stay with our practice for at least 18 months.*

*For further information, please phone Sonia on 4862 1344*

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Dr Nicholas Hartnell, Orthopaedic Surgeon has commenced as a VMO at Bowral and District Hospital. He is consulting from Dr Harbison's rooms, 21 St Jude Street, Bowral

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## 'Wellbeing'

**2007 International Doctors' Health Conference will be held in Sydney**

**at the Sheraton on the Park Hotel  
October 24-27, 2007**

**For information or registration, phone 02 99028135 or go to [www.doctorshealthsydney2007.org](http://www.doctorshealthsydney2007.org)**

## Men's Health

Andrology Australia has resources, information and GP education available online, as well as consumer guides. Fact sheets can be downloaded or hard copies ordered. The online Active Learning Module (ALM) is fully accredited for ACRRM/RACGP points (30 Category 1 points).

The series of four interactive case studies comprises the ALM on 'Young Men's Health' that are being released to provide updates on male reproductive health: male physical examination, androgen deficiency, Klinefelter's syndrome, male infertility, testicular cancer, prostatitis, premature ejaculation and erectile dysfunction.

Contact Andrology Australia on 1300 303 878, or [www.andrologyaustralia.org](http://www.andrologyaustralia.org)

## Practical Paediatrics for GPs

The Paediatric Postgraduate Weekend for GPs is a two day course held at the

Children's Hospital Westmead  
on August 4 & 5, 2007.

The conference includes a wide variety of topics to update knowledge and skills in paediatrics for the GP. The focus is to highlight current advances in research and practice and to cover changes in the management of paediatric problems. This activity has been approved by the RACGP and ACRRM.

For more details contact the Education Centre on (02) 9845 2091 or via e-mail [edcent@chw.edu.au](mailto:edcent@chw.edu.au) or the website [www.chw.edu.au](http://www.chw.edu.au)

## Southern Highlands Division of General Practice Inc

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