perth primary care network
better health & wellbeing for the community

INFOlink
DECEMBER 2011

Making a Difference: Aboriginal Nurse-Led Clinics

Perth Primary Care Network in collaboration with the *StreetDoctor* service provides Nurse-Led Clinics which offer health assessments to all Aboriginal people. Aboriginal people are entitled to a free health assessment every 9 months.

Cheyne Narrier, getting his height measured as part of his 4 year old health check.

The clinics are based on a "nurse-led" clinic model where the registered nurse is trained to provide comprehensive health checks, health education and promotion to patients under the guidance of the doctor.

The health assessment includes an assessment of the patient's physical, psychological and social wellbeing. It also assesses what preventive health care, education and other assistance should be offered to the patient to improve their health and wellbeing.

Each health check is tailored to individual patient's needs, combined with a strong health promotion message and includes blood pressure, diabetes check, urine test, weight/height, eye test (basic), ear check (Otoscopy), and dental information.

Improving the detection, treatment and management of chronic disease and addressing barriers to accessing health care by Aboriginal people is a priority to Closing the Gap between Aboriginal and non-Indigenous life expectancy. Demographically, some patients have not been accessing primary care and given that the burden of chronic disease in the community is becoming more and more significant, multidisciplinary team work is a priority.

Having a positive team approach and engaging in a culturally appropriate way is essential within our clinics.

The clinic's team approach consists of a doctor, registered nurse and Aboriginal outreach worker.

The Aboriginal Outreach Worker

- Provides Closing the Gap information to help improve Aboriginal Health Outcomes.
- Assists in joining patients up for the PIP Indigenous Health Incentive and the PBS Co-payment measure.
- Gives information on other community services available.

The Nurse

- Completes a comprehensive health assessment.
- Provides health education and promotion.

The Doctor

- Reviews the health assessment via the nurse.
- Offers referral options.

Since July 2011 patients having a health assessment within the nurse-led clinics have steadily increased. Several health issues have been addressed, chronic disease detected and appropriate pathways followed. Results are always followed up by the GP and recalls and reminders are in place.

For clinic locations and further enquiries, please phone 9376 9200 or email reception@ppcn.org.au

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A proud member of

Veteran's Care Program

The Coordinated Veterans' Care (CVC) Program is a new initiative introduced by the Federal Government, to help improve the health and quality of care of chronically ill veteran Gold Card holders.

The program will pay GPs and nursing providers to coordinate care for Gold Card holders who are at risk of hospitalisation. Through improved community-based care, the program is intended to improve the health of participants by:

- Providing ongoing planned and coordinated care from a GP and nurse.
- Educating and empowering participants to self-manage their conditions.
- Encouraging the most socially isolated to participate in community activities.

As part of the program:

- Potential participants are proactively identified.
- GP assesses participant for eligibility to participate in the program.
- If eligible, the GP explains the program and the patient provides informed enrolment consent.
- A comprehensive assessment of the person is carried out by the practice nurse, or the GP if no practice nurse is available.
- An individualised Care Plan is prepared.
- Consideration is also given to the need for social assistance services.
- The GP, practice nurse or community nurse coordinates treatment services set out in the Care Plan.
- The nurse coordinator provides regular feedback to the GP who has overall responsibility for the provision of care.
- The Care Plan is regularly reviewed, updated and renewed.

The CVC program uses a proactive approach in managing ongoing care of participants. The program will focus on Gold Card holders with the following conditions:

- Coronary artery disease
- Congestive heart failure
- Pneumonia
- Diabetes
- Chronic obstructive pulmonary disease

Enrolling a Participant

Identification of potential participants will be disseminated in a number of ways, via the Department of Veterans Affairs (DVA), GP identification, recommendations from other health providers and also Gold Card holders self-identification. Enrolment of a participant in the CVC program is at the discretion of the GP, following a needs assessment against the eligibility criteria.

Benefits for Participants

By participating in the program, participants will feel more confident and capable of self-managing their conditions and less likely to be admitted to hospital.

GPs who decide to be involved in the CVC Program are required to:

- Enrol participants in the program; and
- Provide ongoing care.

Payments for GPs

By enrolling in the program, GPs can claim the following incentive payments through existing payment arrangements with Medicare Australia:

- **Initial Incentive Payment** for enrolling a participant in the program.
  - GP with practice nurse: $400 (item UP01).
  - GP without practice nurse: $250 (item UP02).
- **Quarterly Care Payments** for ongoing care.
  - GP with practice nurse: $417.50 (item UP03).
  - GP without practice nurse: $187.50 (item UP04).
- **Total amounts payable:**
  - GP with practice nurse: Year 1 $2070; Year 2 onwards $1670.
  - GP without practice nurse: ear 1 $1000; Year 2 onwards $750.

Participation in the CVC program is not compulsory and only those eligible Gold Card holders who consent will be enrolled.

For more information, please go to www.dva.gov.au/cvc.htm or contact Shona Bastian on 9376 9200, email rdg05@ppcn.org.au

Aboriginal Health

Introducing a New Program: Care Coordination Supplementary Services (CCSS)

It is estimated that Aboriginal and Torres Strait Islander people experience a burden of disease two and a half times greater than that of non-Indigenous Australians. Chronic disease and their associated risk factors are responsible for approximately two thirds of the life expectancy gap between Indigenous and non-Indigenous Australians. Aboriginal and Torres Strait Islander people are more likely to die from these conditions than non-Indigenous Australians with the same condition.

In general, Aboriginal and Torres Strait Islander people tend to under-use primary health care services and are much more likely to access hospital services with illnesses which may have been avoidable and treatable in primary care settings. Issues such as cost, lack of cultural appropriateness of services, location and transport problems are some of the barriers encountered by Aboriginal and Torres Strait Island people in accessing primary care.

Patients with complex chronic health conditions require care from a range of health services and health professionals. Services provided are free-of-charge to patients by state and territory governments but can have significantly long waiting times. Alternatively, these services may be available in a more timely fashion in the private sector but this can prove to be expensive and can put some of these services out of reach for many Aboriginal and Torres Strait Islander people.

The Commonwealth Government is contributing $805.5 million over 4 years towards the Indigenous Chronic Disease Package. This follows the agreement from the $1.6 billion National Partnership in 2008 on Closing the Gap in Indigenous health outcomes that will reduce chronic disease factors, encourage earlier detention and better management of chronic disease in primary care services, improve follow-up care and increase the capacity of the primary care workforce to deliver effective health care to Aboriginal and Torres Strait Islander people.

Aims and Objectives

The Care Coordination and Supplementary Services (CCSS) program aims to contribute to improved health outcomes for Aboriginal and Torres Strait Islander (ATSI) people with chronic health conditions through better access to coordinated and multidisciplinary care. Effective management of chronic health conditions provides better quality of life and lessens the risk of hospital admissions. The CCSS program also aims to increase support to ATSI patients through their GPs and provide more pro-active management.

Care coordination means working collaboratively with patients, general practices and Aboriginal health services to assist in the provision of care and services that facilitate an Aboriginal person over 15 with a chronic condition to manage their health in a way that will result in the optimum health outcome for them.

What can the Care Coordinator help with?

The care coordinator is a Registered Nurse who can:

- Help to arrange appointments;
- Help to get the patient to and from appointments;
- Help to arrange the services that the patients need;
- Help them understand and follow their care plan;
- Help them understand their chronic disease; and
- Assist patients in adhering to treatment regimes, develop self management skills and connect with community services and support.

Patient eligibility

To be eligible for care coordination under the CCSS program Aboriginal and/or Torres Strait Islander patients must:

- Have a care plan in place (GPMP/TCA).
- Be over the age of 15.
- Be referred by their GP.

Priority will be given to patients most in need of care coordination services to obtain improved health outcomes.

Patients most likely to benefit from the service include:

- Patients who are at greatest risk of experiencing otherwise avoidable (lengthy and/or frequent) hospital admissions.
- Patients not using community-based services appropriately or not all.
- Patients who need assistance to overcome barriers to access services.
- Patients at risk of inappropriate use of services such as hospital emergency presentations

Overview

The program will contribute to improved health outcomes for ATSI people with chronic health conditions through:

1. **Care Coordination** provided by qualified healthcare workers to ATSI patients with a chronic disease. Patients must have a current care plan (GP Management Plan and /or Team Care Arrangement) and be referred by a GP in general practice or Aboriginal Health Service.
2. **Supplementary Services** assisting patients to access medical specialist and allied health services (in accordance with patient's care plan) and to assist with transport to health care appointments.

Additional information about the Australian Government's Indigenous Chronic Disease Package can be found at http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health

For more information please contact Adele Allan, Perth Primary Care Network on 9376 9200

North Street Medical Centre awarded RACGP Western Australia General Practice of the Year Award 2011

Congratulations to North Street Medical Centre, this year's winner of the Royal Australian College of General Practitioners (RACGP) Western Australia General Practice of the Year Award.

The RACGP General Practice of the Year Award is designed to recognise practices for their approach to patients' health and wellbeing. North Street Medical Centre was selected as the winning recipient in Western Australia based on the clinic's ongoing commitment to providing its local community with high quality healthcare.

Located in the heart of Midland, North Street Medical Centre is an established clinic with well equipped doctors' rooms and treatment facilities. The clinic offers a number of services to patients including women's health, immunisations, care planning for diabetes and other chronic conditions, skin cancer photography services and minor surgery.

A very happy Zoe Stevens, Practice Manager, North Street Medical Centre holding the award.

The clinic, comprising six experienced GPs, also includes a pharmacy, physiotherapy and pathology centre and provides patients with access to a variety of allied health professionals, including psychologists, hearing specialists and dieticians.

In addition, North Street Medical Centre is a Western Australia General Practice Education and Training (WAGPET) accredited training facility for medical students - providing positive general practice experience throughout the early stages of a GPs career.

Practice Nursing

The new Practice Nurse Incentive Payment (PNIP) is aimed at assisting practices with the costs of employing a practice nurse and expanding their role working in general practice. Payments are calculated on the practices' Standardised Whole Patient Equivalent (SWPE) value and the current number of nurse working hours.

These new changes are aimed to support nursing in general practice and better recognise the contribution that nurses make to general practice, rather than what is reflected in current Medicare funding. This provides the opportunity for nurses to work to their full scope within the practice and generate more business.

With the introduction of the PNIP it is a good time for practices to review their current business models and make some changes. The PNIP model is not tied to a particular area of clinical work but allows general practice to employ nurses to work collaboratively within a multidisciplinary team in response to the needs of local communities.

Practices may apply to join the PNIP at any time from October 1st 2011. Application forms are now available on the Medicare Australia website at www.medicareaustralia.gov.au/pnip. Medicare will advise practices in writing of receipt of this application form and eligibility of each application will commence 1st January 2012.

Incentive payments are only available to practices that are either accredited or undergoing accreditation. Unaccredited practices that employ a nurse may be eligible for a one-off payment of $5,000 to undergo accreditation.

Practice Nurse Incentive Payment Workshops

Photos from the two successful workshops held by Perth Primary Care Network on Tuesday 18th October at the Boulevard Centre, Floreat and Thursday 10th November at Mercy Conference Centre, Mt Lawley.

Top: Alison Priest (left) and Melody Bulobin from Herdsman Medical.

Karin Tatnell (left) and Wendy Smith from Stirk Medical Group Kalamunda

Top: Jane Butcher (WAGP Network) presenter for both PNIP workshops

From left: Dr Stephen Adams (West Perth Medical Centre) Cherie Dyer and Debi Dearle (Alexander Heights Family Practice and Shirley Teshome (WAGP Network).

Left: Felicia Adeniyi, Kiara Family Practice.

Grandparenting arrangements will be in place until 31st December 2014 to ensure that no practice will be disadvantaged under the new funding model. All practices who employ a nurse can apply for top-up payments if they believe they will be disadvantaged. Before applying for the PNIP practices may like to consider:

- Using practice software to calculate accurately the income generated from the current funding. Include nurse MBS item numbers, The Practice Incentive Payment (PIP) for cervical screening and any patient co-payments received.
- Calculating the new funding level by using the Medicare Australia Ready Reckoner. Try to make the numbers as accurate as possible.
- Practices who can demonstrate they are disadvantaged financially under the PNIP can apply for top-up funding for a period of three years.
- A nurse providing cervical screening, immunisation and wound care allows the GP to see other patients. Calculate the number of appointments this generates for the practice.
- This funding allows payment for a lot of nursing activities that were previously unfunded. Consider other services you can introduce to complement usual nurse activities, eg cervical screening - have Chlamydia screening for women under the age of 26 years. Wound care – hold a diabetes clinic once a week.
- Published research suggests that currently only 6% of nurse activities generate a fee-for-service. The reliance on the MBS covers a small percentage of work. Now nurses will have a larger scope of practice and funding to complete it.

Important dates to remember:

- 1st October 2011 – application for the PNIP opened.
- 1st January 2012 – 6 MBS nurse items and the current Practice Nurse Incentive will be removed. Applications for the new PNIP will be assessed for eligibility.
- 31st January 2012 – Practices seeking the February payment must have submitted their application by this date.
- 30th June 2012 – practices seeking grandparenting payments must have their application submitted by this date. No applications for grandparenting arrangements will be accepted after this date.

For more information on the PNIP, ready reckoner calculator, application forms or payments please visit www.medicareasutralia.gov.au/pnip. For a list of resources and "PNIP before and after" fact sheet please contact Perth Primary Care Network on 9376 9200 or via email on reception@ppcn.org.au.

Resources

- PNIP Guidelines: www.medicareaustralia.gov.au/pnip
- Ready Reckoner: www.medicareasutralia.gov.au/provider/incentives/pnip/calculator.jsp
- Booklet 'Creating Opportunity'/DVD: www.apna.asn.au
- Business Case Tools And Scenarios: www.apna.asn.au or www.agpn.com.au
- Before and After Fact Sheet: www.ppcn.org.au
- Education And Support Orientation Course: www.generalpracticenursing.com.au/education/orientation-program-for-nurses-new-to-general-practice
- Nursing In General Practice Recruitment And Orientation Resource: www.generalpracticenursing.com.au/recruitment/nursing-in-general-practice-recruitment-and-orientation-resource2
- Online Education: www.apna.asn.au

The Relationship Development Group responsible for organising and facilitating the PNIP workshops and your first point of contact regarding queries about the initiative.
From left: Natalie Burgess, Alicia Mason (Manager), Kerry Menaglio, Jacinta Carlisle and Shona Bastian

Mental Health

What is the MindCare Program?

MindCare is a program run by Perth Primary Care Network and funded by the Commonwealth Government. The program provides short-term, affordable counselling through the ATAPS (Access to Allied Psychological Services) funding.. The service is offered at certain GP surgeries or at the counsellor's private rooms.

The MindCare Program is NOT a crisis/emergency or after-hours service and there may be a short waiting period for counselling.

How Long Does Counselling Last?

GPs are able to refer a patient for up to six counselling appointments. At the end of these six sessions, the patient and their counsellor will discuss the possibility of a further six appointments and the counsellor will make a written recommendation to the GP.

The patient is encouraged to see their GP at the end of the first six counselling appointments to discuss this with him/her. If the patient and GP agree that a further six counselling appointments will be helpful, then another referral letter can be written.

How Much Will Counselling Cost?

The MindCare Program assists people on low income to access counselling services. The fees for the service are as follows:

- $25.00 per session—Standard fee.
- $15.00 per session—Health Care Card Holder, or receiving Centrelink income.
- $5.00 per session—Unwaged.
- $0.00 per session— Genuine severe financial hardship.

How is your Patients Privacy Protected?

As the MindCare Program is a Commonwealth Government program, evaluating the program is a necessity. This means that some socio-demographic details (i.e. year of birth, gender, postcode, income, education) and general information about the patient's mental health condition and treatment will be collected, and the patient will be asked to complete a questionnaire at the beginning and end of their counselling.

All data will be "de-identified", meaning their name and any other identifying information will not be recorded on the evaluation form or evaluation report. Personal information such as patient's name, address, phone number and specific information about their condition and the treatment they are receiving is confidential between the GP, patient and counsellor.

The privacy of any information collected about the patient for evaluation purposes is protected by law and these details will be securely stored. If a patient wishes to look at the information that has been collected for evaluation purposes, they may ask. If the patient does not wish to provide information for evaluation purposes, they will be required to inform the GP and counsellor. This will not prevent them from participating in the program.

Further information and resources can been found on the Perth Primary Care Network website www.ppcn.org.au or for any specific queries please contact the MindCare Coordinator on 9376 9200 or po07@ppcn.org.au.

Client Feedback:

"Best form of mental health I have ever received – very happy with outcomes."

"Program has been invaluable. It is almost impossible to receive proper mental health assistance without it costing so much."

Medicare Changes: Mental Health Treatment Plans

From the 1st November 2011, Medicare items 2702 and 2710 for the preparation of a GP Mental Health Treatment Plan will be removed from the Medicare Benefit Schedule and replaced with four new time-tiered items; 2700, 2701, 2715 and 2717. GPs who have completed Level 1 Mental Health Skills Training accredited by the General Practice Mental Health Standards Collaboration (GPMHSC) and who have previously claimed item 2710 will now claim item 2715 (for a consultation between 20 and 39 minutes) or item 2717 (for a consultation of 40 minutes or more). GPs who have not completed accredited Mental Health Skills training and who have previously claimed item 2702 will now claim item 2700 (for a consultation between 20 and 39 minutes) or item 2701 (for a consultation of 40 minutes or more). Below is an outline of the schedule fees for the new mental health treatment plan item numbers:

Item Number	Item Description	Time	Nov 11 Schedule Fee	Nov 11 Rebate
2700	Preparation of a GP Mental Health Treatment Plan by a GP who has not undertaken mental health skill training	20-39 minutes	$69.00	$69.00
2701	Preparation of a GP Mental Health Treatment Plan by a GP who has not undertaken mental health skill training	40 or more minutes	$101.55	$101.55
2712	Review of a GP Mental Health Treatment Plan or review of a psychiatrist's assessment and management plan	Not timed	$69.00	$51.75
2713	GP Mental Health Treatment Consultation	Must be at least 20 minutes in duration	$69.00	$69.00
2715	Preparation of a GP Mental Health Treatment Plan by a GP who has undertaken mental health skill training	20-39 minutes	$87.60	$87.60
2717	Preparation of a GP Mental Health Treatment Plan by a GP who has undertaken mental health skill training	40 or more minutes	$129.00	$129.00

What allied mental health services are patients entitled to receive a rebate for under the Better Access initiative?

Once a GP Mental Health Treatment Plan has been completed patients are eligible to be referred by their GP for services by:

- Clinical psychologist providing psychological therapy services; or
- Allied mental health professionals providing focussed psychological strategies (FPS) services; or
- Appropriately trained GPS providing FPS services.

Previously patients have been able to receive a rebate for 12 individual services and/or 12 group services per calendar year or 18 in exceptional circumstance, as of November 2011 this will change to 10 individual sessions and/or 10 group allied mental health services per calendar year.

Can I still refer patients for allied mental health services under a GP Mental Health Treatment Plan that was in place prior to 1st November 2011 using items 2702 or 2710?

Yes, you are still able to refer patients for allied mental health services under item 2702 or 2710 providing the Mental Health Treatment Plan was in place prior to the 1st November 2011. You do not have to complete another GP Mental Health Treatment Plan using one of the new items if you are already managing a patient's care needs under one of these earlier items.

For all new patients on or after the 1st November 2011 you will need to complete item number 2700 or 2701 if you have not completed mental health skills training or 2715 or 2717 if you have complete mental health skills training.

How can I confirm that I am registered as having completed Mental Health Skills Training so I can claim 2715 and 2717?

If you are unsure whether you have completed Mental Health Skills Training, you should contact the GPMHSC to check whether you have done so on telephone (03) 8699 0554/0556 or by emailing gpmhsc@racgp.org.au.

For questions regarding the new changes please contact Medicare Australia on 132 150 or your Relationship Development Coordinator on 9376 9200.

Mental Health

The not so Jolly Season!

Supporting Patients through the Festive Season

For some people, Christmas and depression go hand-in-hand. How can a time of so much joy and happiness for so many cause fear, loneliness, and dark depression for many others?

For some people, Christmas brings a realisation that the love, camaraderie, gift sharing, and a feeling of togetherness that many will experience, will not be a reality for them. This can fuel sadness and depression. Feeling disconnected with the festive season can easily lead to a mild or moderate depression and for some, can trigger feelings of suicide and self-harm.

Easing the Pain in Practice

Tips for talking to patients about Christmas:

- Acknowledge the reality that Christmas brings a huge expectation of togetherness and pressure to be 'joyful'.
- Reassuring the patient that this is just another day and we don't need to buy in to this expectation and pressure.
- Encouragement that actually the spirit of Christmas is the gift of giving and this can be gained in other ways such as through donating their time to others. Be it to friends, helping a charity organisation on the day or spending time nurturing themselves.
- Ask your patient the important questions:
  - "Are you ok?"
  - "What do you need?"
  - "How much do you hurt?"
  - "Are you thinking of ending it all?"
  - "Are you thinking of killing yourself?"
  - "How can I help you?"

ALIVE - Let's Talk About Suicide

ALIVE (Active Life enhancing InterVEntion) offers a high quality, intensive and active suicide intervention service which offers GPs a specialist pathway for the management of patients at risk of suicide or self-harm. ALIVE employs three highly experienced counsellors providing case consultation, risk assessment, joint case management, crisis and short-term counselling and referrals to appropriate long-term supports. All staff are experienced and have received specialised training in suicide intervention.

The ALIVE program provides:

- Free service for patients 18-65 years.
- Simple access: faxed referral to PPCN (by patient's GP).
- Patient is contacted within 24 hours for risk assessment and appointment.
- Patient aimed to be seen within 72 hours.
- Three counselling locations in Guildford, North Perth and Warwick, close to public transport.
- GP is informed of engagement, Mental Health Assessment is produced and GP informed of ongoing progress of referral.
- Patient is offered face-to-face and telephone contact as many times as is required within 3 month period.
- Counsellors facilitate and coordinate other referrals as required for short and longer term support of patient.

Of those who complete suicide, two thirds had seen a health professional within the previous 3 months.

Assessment and support through the most appropriate referral pathway is vitally important.

The key comparison of an ALIVE referral to generic counselling services is ALIVE's ability to co-case manage suicidal patients. With a low patient to counsellor ratio, no waitlist, immediacy of contact and involvement of the GP in case management and planning, ALIVE offers specialised suicide intervention and support for patients.

- ALIVE offers co-case management of your patient where you can work with the counsellor to develop their care plan.
- ALIVE has Memorandum's of Understanding (MOU's) with Sir Charles Gairdner Hospital and Swan Districts Hospital visiting the hospitals and discussing patients weekly.
- Low case-load means that ALIVE has the resources to effectively manage the needs of your suicidal patient.
- Patients have unlimited contact with counsellors within the three month period.
- Exclusion: Patient must not currently be linked with a mental health service as an outpatient.

ALIVE Contact Details

Phone: 9376 9200
Fax: 6278 2388

Referral forms can be found on Perth Primary Care Network's website www.ppcn.org.au, under *Programs and Services*. Alternatively, phone 9376 9200 for a referral form to be faxed to you.

If there are feelings of suicide and the patient is not currently actively suicidal, then refer to ALIVE. **However, active suicidality is treated by the nearest hospital.**

Please note: PPCN offices are closed between 21st December, 2011 to 1st January, 2012.

NEW SERVICE TO ALIVE PATIENTS!

After Hours Crisis Support Line

Patients who are referred, after hours, to ALIVE can be contacted by a Crisis Support Counsellor 5pm - 9am and 24 hours over weekends and public holidays, including over the Christmas period by calling 1800 859 585. A service specifically attached to the ALIVE program.

Fax referral to ALIVE and then call the number to access this vital support.

More Tips for Surviving Christmas...

Don't swallow the Hollywood hype – Christmas isn't about trying to be perfect or feeling ecstatically happy.

Stay Active Over the Holiday Season – Oxygen and fresh air can lift the holiday blues.

Start NEW Christmas traditions – It can be a time to remember someone you love or lost in ways that honour them. Lighting a candle for them for example.

Be Aware of Your Family Dynamics - If you are aware of the way your family may negatively affect you, you are more likely to avoid getting involved in those thoughts too much or find ways to shorten those experiences that make you feel bad.

Feedback from GPs who have accessed the ALIVE program:

"Very useful not only to prevent suicide but I believe averted almost certain hospitalisation in a patient of mine … and allowed continued community management."

"An important resource."

"Excellent and appropriate help."

"Rapid response, accessibility and flexibility of service."

"Was satisfied with the range of locations … and working relationship between myself and the counselling team."

Emergency Numbers

Ambulance	000
Police	000
MHERL	1300 555 788
Royal Perth Hospital	9224 2244
Sir Charles Gairdner Hospital	9346 7400
Swan Districts Hospital	9347 5244
Poisons Information Service	13 11 26

"(Counsellor) has helped me through a very difficult time in my life! I am very grateful for this wonderful service." - Patient feedback.

After Hours Clinics

Commonwealth Heads of Government Meeting (CHOGM)

Sick Delegates Well Looked After!

Approximately 150 Commonwealth Heads of Government Meeting delegates and visitors sought medical treatment in Perth, with many seeking assistance from the Perth After Hours GP Clinic located opposite Royal Perth Hospital on Lord Street.

The implementation of an after hours clinic that not only maintained its current patient base but also included a possible 400 extra priority-treatment CHOGM delegates was no easy task to organise, and included many months of preparation.

Initially, meetings were held between Perth Primary Care Network (PPCN), the Disaster Preparedness and Management Unit, Disaster Management Regulation and Planning, and the Public Health Division to discuss the broader issues relating to the initiative.

After these preliminary meetings, an internal PPCN committee dealt with organisational issues and implementation, including:

- As the clinic was to be operational between 8am and midnight (usually 6pm to 10.30pm), non-clinic staff were required to be on a standby roster.
- Additional doctor and receptionist required on each shift to maintain workflow.
- Additional documentation required to ensure delegates and support staff were segregated from the clinic's usual patients.
- A Medicare translation and interpreting service required for delegates who may not speak English.
- How to treat and bill service police officers from both WA and all other states, including New Zealand.
- The possibility of an outbreak of epidemic and notifiable communicable diseases due to the diverse backgrounds of delegates and support staff.
- Measures in place to report any CHOGM delegate or visitor who became sick to a special health hotline.
- Catering for staff, as many worked 10 -12 hour shifts to cover the period.
- Extra computers and IT equipment for additional doctor and receptionist.
- Increased cleaning for waste disposal, infectious waste disposal, cleaning of bathrooms, floors and linen removal.
- Additional security and deliveries of linen.
- Established parking increased and alternative parking sourced.
- Additional furniture.

Considering there were thousands of delegates and support staff from around the world in Perth during CHOGM week October 2011, the fact that only 150 required medical attention reflects and acknowledges how well-run the event was.

Our thanks must go to all our dedicated doctors, nurses, reception staff and committee members for their tireless work during this period.

Immunisation

www.vaxiplace.com.au is a free interactive website that offers Australian medical professionals a range of resources, information and news on vaccines and immunisation practices.

Until this month, Vaxiplace was solely for Australian doctors. However, Vaxiplace's new entry portal now offers a second website for registered nurses.

Along with information and advice on the range of childhood immunisations, Vaxiplace offers up-to-the-minute travel health resources.

It features an interactive world map that lets users obtain information on the patient's destination, including vaccinations that should be considered, a malaria profile, current and recent outbreaks, and general travel information.

Vaxiplace is sponsored by vaccine manufacturer Sanofi Pasteur. The General Manager of the company's Australian division, Russell Jacobson, this week announced the appointment of Tonia Buzzolini as moderator of the new site.

Ms Buzzolini holds a Masters Degree in Public Health and Tropical Medicine and has extensive experience in clinic, hospital, and travel immunisation practices. She also lectures at the Australian Practice Nurse Association and at the Australian College of Nursing.

Vaxiplace's resources and forums are tailored for medical professionals: The portal is not open to the public.

By logging on to www.vaxiplace.com.au, accredited medical professionals can register on the GP or RN websites. (Please note, registration can take up to 24 hours.)

For more information on Vaxiplace please contact Isabelle de Casanove on (02) 8666 2711 or email isabelle.decasanove@sanofi.com or Tonia Buzzolini on (07) 5452 7042.

General Practitioner - After Hours Clinics

Perth Primary Care Network (PPCN) is a not-for-profit organisation in the primary health care industry.

PPCN operates the Perth After Hours GP Clinic, located in East Perth and the Swan After Hours GP Clinic, located in Middle Swan. These clinics are general practice centres offering medical services directly to the public and to patients via the overflow from hospital emergency.

The clinics are fully accredited to Royal Australian College of General Practitioner Standards and are open weeknights, weekends and public holidays. The clinics offer a complete range of general practice care, and specialise in emergency and acute care.

We are currently seeking VR GPs to join our committed teams at our Perth and Swan clinics on various shifts. These shifts may be filled by one GP or separated if required.

This position offers an attractive rate, including salary packaging, and a pleasant and professional working environment. For more information, please contact Tracey Snowden, Human Resources Manager on 9376 9200 or visit our website at www.ppcn.org.au. To apply please send your resume to hr@ppcn.org.au.

Scott Jamieson taking details from Rachel Crawford at Perth After Hours GP Clinic during CHOGM week - October 2011

Healthy Directions

CookSmart - Helping People with Diabetes Maintain a Healthy Diet

CookSmart is run by Diabetes WA and facilitated through Perth Primary Care Network's Healthy Directions program.

CookSmart is a 90-minute interactive food preparation session where participants have the opportunity to learn how to prepare healthy snacks and meals without compromising on taste. A variety of healthy, low GI products are also taste-tested during the session.

The Healthy Directions team will triage patients into the most appropriate allied health, exercise or lifestyle programs once a referral has been received from the patient's GP. Typically, patients with type 2 diabetes or Impaired Glucose Tolerance (IGT) will be offered the opportunity of attending a CookSmart session.

CookSmart sessions are generally held every month and are free for the patient but if they wish to bring a guest, a small charge of $20 applies (payable to Diabetes WA).

Sandy Havlin from Diabetes WA demonstrating at the October 2011 CookSmart session

How to Refer a Patient into Healthy Directions

One referral form is all that is needed.

Referral forms are available:

- From PPCN's website www.ppcn.org.au (in rtf version for most clinical software).
- In hard copy - please phone 9376 9200

Please send completed referral form to:
Post: P.O. Box 354, Guildford WA 6935
Fax: 9279 8221
Email: reception@ppcn.org.au

Eligible Patients

- Type 2 diabetes.
- Impaired Glucose Tolerance (IGT).

What Services can Healthy Directions Offer your Practice?

- Patient assessment (if applicable) in your practice dependent on room availability, otherwise at Perth Primary Care Network.
- GP feedback following triage/assessment and at the end of the program.
- Support with GPMP, TCA, and other MBS item numbers related to long-term illnesses.
- Patient referral for follow-up support to appropriate services.
- Individualised motivational phone calls and follow-up support.

For further information, please call the Healthy Directions team on 9376 9200 or email reception@ppcn.org.au

NPS

Better choices ▸ Better health

Educational Visiting on the NPS topic "CVD Risk: Guiding Lipid Management" is winding up, with visiting on the topic scheduled to conclude early 2012.

Below are some comments collected from GPs after doing the NPS topic "CVD Risk: Guiding Lipid Management":

ONE way in which I will change my practice as a result of participation in this activity is:

- Use cardiovascular risk calculator more frequently/more emphasis on risk assessment.
- Use guidelines in commencing lipid lowering therapy.
- Better understanding of combing agents.
- Emphasise lifestyle measures to a greater degree.
- Better understanding of the optimal use of statins.
- Think about reducing statin dose after hospitalisation.
- Review all patients' dosage levels.
- Consider fibrates.
- Choosing appropriate statin and doses.
- Looking at a holistic approach/encourage non-pharmacological approach.
- Go back to Lipitor/monitor with Asian patients.
- Not increase dose of statins excessively.
- Trial Ezetimibe (Ezetrol)/ Initiate Simvastatin at higher doses/ use more atorvastatin.
- Use 2-3 weekly dosing in appropriate patients.
- Importance of regular follow-ups/blood checks.
- Consider the cost of Simvastatin in the prescription for non-HCC holders.
- Tolerate moderately abnormal LFT's.

Interested GPs wanting to book a half hour individual visit (with GP and NPS Educational Visiting Facilitator), or one hour small group case study session (with your GP colleagues and NPS Educational Visiting Facilitator), should contact Coralie Edwards (NPS Facilitator) on phone 9376 9200 or email po09@ppcn.org.au to secure a booking.

Congratulations to Dr Janice Bell 2011 RACGP Rose-Hunt Award Winner!

Dr Janice Bell, a GP in Shenton Park has been awarded The Royal Australian College of General Practitioners (RACGP) most prestigious honour: the Rose-Hunt Award on 5th October, 2011.

The Rose-Hunt Award is the highest accolade awarded by the RACGP. It is presented to an individual who has rendered outstanding service in the promotion of the aims and objectives of the RACGP, either by individual patient care, organisation, education or any other means.

Dr Bell has given her time and expertise to a range of RACGP activities including medical educator, examiner, registrar liaison officer, RACGP WA Faculty Board member, Chair of the RACGP Vocational Training Sub-Committee and member of the RACGP National Standing Committee-Education. She continues to work to bring together medical colleges and regional training providers to ensure that the RACGP's General Practice Vocational Training Standards and accreditation processes enable continued development of a skilled general practice workforce.

Dr Bell, is also the CEO of Western Australian General Practice Education and Training (WAGPET).

“We offer your patients caring and non-judgemental unplanned pregnancy services in WA”

When you refer your patients to us for a termination of pregnancy, we start by understanding their situation and explaining their options including a medical or surgical procedure. We also discuss additional services such as STI checks, long-acting contraception and decision-based counselling. Post procedure we provide a national 24 hour aftercare service with trained registered nurses. Our clinical protocols and procedures are independently assessed by a National Medical Advisory Committee.

Freecall 1800 003 707 or visit www.drmarie.org.au

Midland Centre, 8 Sayer Street, Midland WA 6056

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