



Is Your Practice Ready for Coordinated Veterans' Care?

The Department of Veterans' Affairs (DVA) has funded the new Coordinated Veterans' Care Program (CVC Program) which commenced on 1 May 2011.

"DVA are providing new payments to GPs for initial and ongoing care as outlined in the program".

PGPN has a number of gold card veterans living within our catchment (n=3690: July 2010). GPs may have received or had a patient present a letter recommending participation in the CVC program based on an individual's previous hospital

presentations or risk of future hospitalisation due to complex chronic illness and conditions.

The CVC Program, uses a proactive approach to improve the management of a patient's chronic disease and care through team based coordination of care by a general practitioner plus a nurse coordinator, who work with the patient (and their carer if applicable) to manage their ongoing care.

"GPs may have received or had a patient present a letter recommending participation in the CVC program".

DVA are providing new payments to GPs for initial and ongoing care as outlined in the program, additional to MBS items already claimed for routine consultations & patient care.

By participating in the program, GPs utilising a practice nurse can claim the following payments through existing arrangements with Medicare Australia:

- Initial \$400 Incentive Payment for enrolling a participant in the program
- \$417.50 Quarterly Care Payments for ongoing care.

That equates to \$2070 in the first year for each patient engaged within the CVC program, additional to routine MBS payments.

"PGPN has allocated staff to assist all practices through the various aspects required to successfully participate in this program"

Prior to commencing it is recommended that practices review the **"Guide for General Practice"**, which provides a step by step description of how to progress through each stage of the program. The guide can be viewed from the

Department of Veterans' Affairs (DVA) website;

http://www.dva.gov.au/health_and_wellbeing/health_programs/cvc/gp/guide_gp/Pages/GGP.aspx

PGPN has allocated staff to assist all practices through the various aspects required to successfully participate in this program.

For further information on the CVC Program please see article on page 10 and 11

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In the meantime....

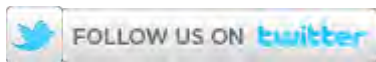
KATH FERRY
CEO PGPN



We had hoped to bring you the news of the outcome of the Medicare Local application process but it was not to be...It appears we will learn whether we are in the second or third tranche at the end of October, probably when this newsletter is published!!

We will put out a special edition with news and plans after the announcement.

In the meantime, on the sports front... after the win by Peter Brookhouse of the inaugural PGPN footy tipping competition, we have just had the demise of Scotland, following by the 'auld enemy' England in the Rugby World Cup, no prospect of Australia being in the final unfortunately...has Harry Kewell struck a chord with Victory supporters in the soccer or was it Brett Emerton's lack of finesse in Sydneys' team on recent performances??? Yes I'm afraid your CEO has a bit of a sports interest, can't play anything but a keen spectator!



I hope all you social networkers out there have noticed that PGPN is on facebook and twitter and we post regularly so get on there and 'like' and 'follow' us.....

We look forward to seeing those of our members who can come along to our AGM next week. You'll have the opportunity to meet our transitional

Peninsula Medicare Local Board to ask any questions you may have about the transition.

One staff change this edition; we farewell Helen Jarvis, our resident Psychologist who has been with PGPN for over 8 years providing clinical

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services through the ATAPS program. Helen is reducing her workload to look after herself and we all wish her all the best for the future, she will be very much missed.

I'm still keen to hear from you about what you think of our communications to you, our members. Is it getting through to you all, are you missing vital information or are we OK ???...

Happy reading.....

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Consumer feedback: Contact the CEO, Kath Ferry on T:(03) 9708 8019 or email: contact@pgpn.org.au or download a *Consumer Feedback form* from our website & mail to 33 Jacksons Road , Mt Eliza VIC, 3930.

Submission of material or advertising: contact the network on: 03)9708 8019 or email: s.guthrie@pgpn.org.au.

Deadline for the next issue is: 23 November 2011

Disclaimer: The views expressed in this newsletter are those of the authors and do not necessarily reflect the official position of the Peninsula GP Network. Any editorial comment expressed in the Newsletter is the opinion of the editor only, and does not represent the views of the Network.

New opportunities & feedback inform PGPN program activities

LEISL JACKSON
PGPN Program Manager



We have just reached the 3 month mark of the current work plan for program and project staff. In a particularly buoyant and changing environment for both general practice, primary care across our region and PGPN staff our priority has been to consult, undertake a needs assessment and collect valuable data to re-establish a baseline of the capacity and needs of our general practices and staff.

General Practice Consultation:

Our program staff has been proactively engaging with a significant number of practices gathering information and identifying priorities in the areas of workforce, education, clinical up-skilling and population health data, together with the recruitment of practices and staff to participate in the many programs currently in place.

Results of consultation to date highlight;

- Improved data quality and an increased proportion of patients meeting clinical targets. Practices providing data will have received more specific details and comparison to the previous 12 months. We thank those practices who supported us in creating this valuable data source representing approximately 58% of our local population.
- Identification of specific workforce shortage issues, recruitment needs across disciplines and input to how PGPN workforce program may be able to assist. This information will be further explored and targeted strategies developed via the practice managers' network.
- Many practice nurses have provided valuable input to professional development needs, presenting professional issues, student nursing placements together with their capacity and interest in advancing current roles within primary care.

Community Engagement:

In recent weeks, PGPN staff have actively engaged with local community members through our participation at the Bay Mob Health & Education day, Ageing Well Expo and a Consumer Focus Group.

Participation within such activities offers an opportunity to raise the profile of PGPN within the broader community, promote the benefits of

establishing a relationship with a regular GP and practice, together with the dissemination of preventative health information and resources relevant to the groups being interacted with.

The outcomes of the risk screening activities are provided within articles in this edition of the newsletter. Having undertaken the same activities at both expo events, it allows for data to be compared between our ageing and Aboriginal community groups. I encourage you to consider requesting a visit and support from our Close the Gap and/or Practice Enhancement teams to assist proactive and coordinated chronic disease management and preventative health care in your practice or with specific practice team members.

A small focus group was facilitated in collaboration with Peninsula Health Community Health and the Gay, Lesbian, Bi-sexual, Transgender and Intersexes (GLBTI) Consumer Advisory Group (CAG). Issues raised over the past 12 months within this CAG, have had a significant focus on access to GLBTI friendly GPs and practices, sexual health issues and lack of specific clinical services available locally.

Focus group questions and discussion informed fears and barriers for group members in engaging with general practice locally, disclosure of personal and medical information, what needs are being met locally and which are being sought out of area and why.

A report of the event proceedings and outcomes will be created and communicated where relevant and appropriate. Any GPs with an interest in sexual health and/or HIV who may have the capacity to provide some session work or act in a GP advisory capacity to address these clinical service gaps in our region are requested to make contact with me directly to discuss further.

New Program Funding:

We have been successful in recent times to attract some additional funds to support;

1. DVA funded **Coordinated Veterans' Care** program. This program focuses on supported coordination of DVA gold card holders who are at risk of hospitalisation and who have chronic conditions.

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Changes to GP Mental Health Treatment Plan rebates from 1 November 2011

SHAREEN PEARSON
PGPN Program Officer



GPs will now be paid based on the time it takes to prepare a Mental Health Treatment Plan

Name of Service	Description	MBS Item & Rebate	Time Based Consultation	MBS Item & Rebate
		Pre 01/11/11		Post 01/11/11
GP Mental Health Treatment Plan	Prepared by a GP who has undertaken Mental Health Skills Training	2710	20-39 mins	New Item - TBC \$85.92
		\$163.35	40 + mins	New Item - TBC \$126.43
GP Mental Health Treatment Plan	Prepared by a GP who has not undertaken Mental Health Skills Training	2702	20-39 mins	New Item - TBC \$67.65
		\$128.20	40 + mins	New Item - TBC \$99.55
GP Mental Health Review	Reviewed after 1 – 6 months	\$108.90	-	\$67.65
GP Mental Health Consultation	Consult with patient RE: ongoing mental health disorder	\$71.85	20 + mins	\$67.65

Patients can access 10 individual allied mental health services per calendar year, reduced from 12. (**BETTER ACCESS PROGRAM ONLY**)

Following the initial 6 sessions, patients may be referred for an additional 4 sessions (to a maximum of 10 per calendar year) Patients currently receiving services under Better Access will be able to access up to 12 sessions up until 1 November 2011

Patients who have already received 10 or more individual and 10 or more group sessions by 1 November 2011 will not be eligible for further services until 1st January 2012. Please note these patients are unable to access services provided under ATAPS between 1 November and 31 December 2011.

ATAPS (Access to Allied Psychological Services) also known as (“BOMHs”) Better Outcomes in Mental Health

ATAPS – Standard

Eligibility

*Mental Health diagnosis.
Age requirement 12+ years.
No or low income; health care card holder*

Referral

Complete and fax a GP Mental Health Treatment Plan (MBS Item 2710 or 2702) to PGPN on 9708 8157

PGPN will contact an ATAPS registered provider. The provider will contact the patient.

PGPN will fax a copy of the ATAPS referral letter to the GP as acknowledgement.

PLEASE NOTE: due to limited funding this referral must be approved by PGPN before patient makes an appointment with your preferred provider.

The ATAPS provider provides a report to the GP after the sixth and/or final visit with recommendations. After the sixth visit, the GP reviews the patient and sends the mental health review and (if required) recommendation for another 6 sessions to PGPN.

ATAPS – Perinatal

Eligibility

*Mental Health diagnosis.
Age requirement 12+ years.
Not means tested*

Referral

As per ATAPS—Standard referral

ATAPS – Suicide & Self Harm Eligibility

*All patients are eligible
Mental Health diagnosis not required
No age restrictions*

Referral

Referral letter from GP; fax to PGPN on 9708 8157



RING, RING...this is the Maternal and Child Health Nurse Calling

SUZANNE HEPELL
PGPN Project Officer



PGPN has partnered with the Frankston & Mornington Peninsula Maternal and Child Health Services to have an ATAPS Perinatal Clinician, Linda Biddle, in each area on a weekly basis to assist with women who score 13 or more on the Edinburgh Postnatal Depression Scale or have significant psychosocial risk factors.

Linda's role will be to provide support in:

- completion of a mental health assessment;
- make a referral (if appropriate) to Perinatal ATAPS
- assist with linkages to a GP to access a Mental Health Treatment Plan.



PGPN are maintaining a data base of GPs who are prepared to accept by negotiation, ante and post natal women engaged with maternity services locally but who do not have a GP. ***If you would like to be included on the data base or require further information, please contact Suzanne at PGPN on 9708 8019.***

No it is not Master Chef, it is our CHAMPS graduates, the 'Champions!'



The CHAMPS Program evaluation showed significant improvement in the psychological well being of the children who participated in the CHAMPS programs through increased self esteem, an increase in connecting with peers, establishment of friendships, and reported reduced emotional difficulties.

But then what?

In follow up, it was identified that the children required continued support to maintain the positive changes they had made. The CHAMPIONS group was established in response and launched on 19 September. This will be held on a regular basis in the future.

The aim of the CHAMPIONS group is to provide a supportive family environment that incorporates life skills, family

connectedness and promotes friendships. All those who have participated in the CHAMPS program become a 'CHAMPION'.

The Rotary Club of Frankston instructed ten participating children with basic cooking skills. A scrumptious meal of spaghetti bolognaise, garlic bread & apple crumble was then served to their families and support personal.

Whilst the children were cooking, the parents were involved in a parenting skills workshop. The event was a resounding success for both the children and the parents with everyone looking forward to next time.

CHAMPS in Term 4 will be held in Rosebud from Thursday October 13th. **Referrals welcome now.** CHAMPS is a support group for children 8-12 years whose parent/s have a mental illness. The program is held once a week for eight weeks within a school term. CHAMPS is held 3:30pm- 5:00pm in either Frankston, Mornington, Rosebud or Hastings.



CHAMPIONS group and helper's in the kitchen

Ageing well Expo 2011

LEISL JACKSON
PGPN Program Manager



PGPN Program Officer Lynda French measuring up

PGPN were engaged for the 6th year at the annual 'Ageing Well' community event and expo held in Mt Martha. The day was a huge success with 1,000 people attending with positive participant feedback, with many people saying they liked having access to the 62 displays and information on offer, available in the one place.

Participation at this event allows us the opportunity to network with other service providers and identify the broad range of services and programs available for residents on the Mornington Peninsula supporting health and wellbeing for our ageing population.

Our priority on the day is to proactively engage with local ageing or older community folk, providing an opportunity to promote the work of PGPN and general practice whilst face to face interactions provides an opportunity to discuss issues that the community may have in relation to their health and well being. Key messages highlight the importance of establishing a relationship with a regular GP, having regular health checks, understanding the implications of family history and acting proactively to prevent the onset of chronic disease or complications of chronic illness.

PGPN provided each participant with the opportunity to complete a diabetes risk assessment and biomedical screening undertaken by our nurses with the following outcomes.

- 89% completed an AUSDRISK assessment tool
- 0% of participants undertaking a health check on the day identified as Aboriginal.
- 26% were identified as being at high risk of developing Type 2 diabetes (scored 12 or more on AUSDRISK), with an average score of 12.9
- 8% had a diagnosis of Diabetes already.
- 89% were aged 50 years or older with 29% greater than 75 years.



PGPN Program Officer Ailsa Gregory

Table 1: Results of Risk screening / health checks (n = 35)

	Age (years)	No GP	AUSDRISK	BMI (kg/m ²)	WAIST (cm)	BP (mm/Hg)
Average	71.6	0%	12.9	26.7	97.7	137/84

Table 2: High risk parameters of population screening (n = 35)

No GP	at risk T2Diabetes	Obese (BMI >30)	WAIST (>100 cm)	BP (>130/80)
0%	26%	30%	24%	59%

Upcoming Events:

With MBS changes looming on 1 November, an **MBS update** is scheduled for 23 November at Toorak College. The program will provide an overview of specific changes to the schedule including the Better Start initiative, Telehealth and CDM / Allied Health Items. Depending of event participation numbers small group or a panel session will cover Mental Health items and referral pathways, Practice Nurse Incentive Program (PNIP) and time based health check items for multiple population groups.

Flyers will be circulated very shortly and registrations can be made via the events page on our website www.pgpn.org.au



Bay Mob Health & Education Day

PGPN were engaged at the recent ‘Bay Mob Health & Education’ community event held at Monash University Frankston campus.

Approximately 200 participants attended on the day participating in interactive and informational activities facilitated by 48 health and educational service providers and organisations.

Our priority of the day was to proactively engage with local Indigenous community folk and pass on our key Close the Gap messages; the importance of having a regular GP and self identification, together with the benefit of a regular health check, understanding the implications of family history and acting proactively to prevent the onset of chronic disease or manage existing chronic illness.



PGPN Program Officer Karan Kent



PGPN provided each participant with the opportunity to complete a diabetes risk assessment and biomedical testing undertaken by our nurses with the following outcomes.

- 72% completed an AUSDRISK assessment tool
- 67% were identified as being at high risk of developing Type 2 diabetes (scored 12 or more on AUSDRISK), with an average score of 17.7.
- 68% of participants undertaking a health check on the day identified as Aboriginal.
- 8% had a diagnosis of Diabetes already.
- 50% were aged 50 years or older, 18% aged 40 – 49 years and 32% aged between 18 & 39 years.



Please reflect on the significant difference of results noted between this community cohort and the community members engaged at the Ageing Well Expo a week later. (refer to opposite page).

Table 1: Results of Risk screening / health checks (n = 25)

	Age (years)	No GP	AUS-DRISK	BMI (kg/m ²)	WAIST (cm)	BP (mm/Hg)
Average	47.2	12%	17.7	31.8	102.25	128/81

Table 2: High risk parameters of population screening (n = 25)

No GP	at risk T2Diabetes	Obese (BMI >30)	WAIST (>100 cm)	BP (>130/80)
12%	67%	54%	46%	43%

Buzzing around the Bay

LISA COPPE
PGPN Outreach Worker



Sisters Day Out

These past couple of months I have been a busy bee with my weekly attendance at Koori Kitchen in Frankston and Hastings Community activity group keeping the Close the Gap face in community and I have, to date five clients registered with Close the Gap program requiring assistance and support for medical appointments.

We have a Close the Gap table at Bay Mob Health Expo held at Monash Uni and taking this opportunity to spread the Close the Gap message to ATSI and non – ATSI community, I envisage recruiting more clients and G.P.'s registering for the Practice Incentive Program (P.I.P).

Good news for the Frankston ATSI community recently, Frankston City Shire officially announced that the Frankston Gathering Place for ATSI community has been approved, the site in which two portables will be located at the northern corner of Jubilee Park in Frankston will be utilised for ATSI community to meet, Koori kitchen, youth group activities, arts, a space for myself and other Outreach Workers to meet community.

I attended the Sisters Day Out; a well – being workshop for ATSI women held in Dandenong in early September, the Aboriginal Family Violence Prevention & Legal Service of Victoria host these workshops all over Victoria; again another chance to network with organisations within the ATSI community. The day is one of education, networking and pampering.

continued from page 3.

New opportunities & feedback inform PGPN program activities

LEISL JACKSON
PGPN Program Manager



Funding to practices participating in this program acknowledges the additional non MBS funded time required to facilitate quality care coordination practices and bolsters funding for nurses in the care coordinator role.

2. **Bowel Cancer Screening** in people 50 – 75 years. PEN clinical audit tool in its next scheduled update will have a tab for Bowel Cancer screening (based on FOBT results) available to identify and track the outcomes of this program. Additional functionality will include 2 further tabs for Breast & Cervical Cancer screening based on PAP and Mammography results. Practices using MD3 or Best practice and receiving electronic pathology results will be invited to participate in this program supported by PGPN staff. More information will be forthcoming in the coming month to all practices.
3. A **Mind the Gap: physical and mental health co morbidities education and training package** grant has been awarded to implement a collaborative nurse education program. Practice nurses together with mental health nurses contracted in the MHNIP and those practicing within Peninsula Health Mental Health will be provided with access to this education package, assessment tools with decision support and practice based support as required

The next 6 months will focus on program activities across the catchment and specifically with interested general practice, GPs and staff. I look forward to reporting on the positive outcomes being achieved over the coming months. Please make contact with me directly or relevant program staff if you would like to know more about any of the programs being offered or support you may require.



A complete Directory in one!

AILSA GREGORY
PGPN Project Officer



The Human Services Directory (HSD) aims to provide Practitioners and Service Providers with access to accurate and up-to-date information about health, social & disability services in Victoria.

This information may be used to both inform patients and to communicate with other practitioners, including referring patients to other services.

You can search for information or include your service information on the directory simply go to the PGPN website to find how to!
www.pgpn.org.au



Not sure where to find the Victorian State-wide Referral Form?

The VSRF is available as a supplied clinical template in most software packages or as a template for downloading. Remember when using this form it will auto populate much of the information required by the referral service then just add special information.

Any questions contact Ailsa Gregory 97088019 Mon – Thurs or email on a.gregory@pgpn.org.au

Lifestyle Modification Programs

Over the past 15 months staff at PGPN have enthusiastically informed practices about the LMP programs available to your patients 40 and above.

“Exercise is just part of my life now and I feel so much better for it. I leave food on my plate for the first time in my life”.

In this time we saw a significant increase in the number of patients attending, this highly motivational program that has in many cases turned their life around.

Some of the feedback from patients went like this”

now I think about what I am eating” “Exercise is just part of my life now and I feel so much better for it” I leave food on my plate for the first time in my life”.

So I am delighted to *remind* you that all facilitators across the Peninsula continue to run the program and funding for your patients to attend the sessions is still available.

So keep referring your patients so they too can benefit from this free and innovative program

For information on where the programs are run head to the PGPN web site www.pgpn.org.au

Not sure how to refer give Ailsa Gregory a call on 9708 8019 or email her a.gregory@pgpn.org.au



Practice Enhancement

Currently we are supporting practices with the utilisation of the Practice Health Atlas and the PEN Clinical Audit Tool to enhance their search mechanism when recalling patients for particular health issues. If you would like to know how to better utilise PHA or PEN CAT tools for planning and clinical purposes please contact Jackie Bange on 9709 8019 or j.bange@pgpn.org.au

We would like to thank the 35 practices, representing 218 GPs for the annual data collection undertaken recently. Data provided a snap shot for over 160,000 active patients (attendance 3 times in 2yrs) with 80% attending at least once in the past 12 months. The proportion of patients achieving HbA1c and BP targets has increased significantly from last year.

Participating practices will receive a report benchmarking their data against the aggregated average. Data cleaning advice and support can also be provided to interested practices please contact Rose Burns for more information r.burns@pgpn.org.au

Coordinated Veterans' Care Program

LEISL JACKSON
PGPN Program Manager



The Department of Veterans' Affairs (DVA) has funded the new Coordinated Veterans' Care Program (CVC Program) which commenced on 1 May 2011.

Eligibility

The program is aimed at veterans, war widows, war widowers and dependants who are Gold Card holders and are at risk of being admitted or readmitted to hospital.

GPs can enrol participants in the program if they:

- pass an eligibility assessment
- give their informed consent to be involved in the program

Key roles and stages

GPs play a lead role in the CVC program and are required to commit sufficient time and resources.

The nurse coordinator (NC) can be one of the following:

- Practice nurse (PN) – this is either a registered nurse or enrolled nurse, and can include a nurse practitioner
- Aboriginal health worker (AHW)
- Community nurse from a DVA contracted community nursing provider (CN).

The GP and nurse coordinator have different roles in the three stages of the CVC Program.

Prior to commencing it is recommended that practices review the "Guide for General Practice", which provides a step by step description of how to progress through each stage.

http://www.dva.gov.au/health_and_wellbeing/health_programs/cvc/gp/guide_gp/Pages/GGP.aspx

Prepare for the CVC Program

Action	Role
1. Appoint a Nurse Coordinator, ie PN, AHW or CN.	GP/PM
2. Prepare your practice for the CVC Program.	GP/PN

GP Enrol participant in the program

Action	Role
3. Identify potential participants.	DVA/GP
4. Assess their eligibility for the program.	GP/PN
5. Gain the participant's informed consent.	GP
6. Conduct a needs assessment.	GP/PN
7. Prepare a Care Plan.	GP/PN
8. Finalise the Care Plan.	GP
9. Consider the need for social assistance.	GP/PN

Provide ongoing care

Action	Role
10. Coordinate treatment services as per the Care Plan	GP/NC
11. Regularly review, update and renew the Care Plan.	GP/NC

Module One is available now: "Is your service ready?"

A CPD program created to support implementation of care coordination amongst the practice team.

- Is designed as a flexible, self-paced learning tool enabling individuals to design their own study timetable.
- Is accredited for RACGP QI & CPD, ACRRM PDP and has been endorsed by RCNA and APNA. A Certificate of Completion is awarded upon successful completion of this module.
- Has five sections and will take approximately six hours to complete: (Introducing the Chronic Care Model, The Health System, Improving Quality of Chronic Condition Care, Chronic Condition Self Management Support & Community Sector Support).
- You do not have to complete this module in one session, it may be completed over a number of sessions.

To access this online module please go to: www.cvcprogram.net.au and follow the link to the training page.

Prior to starting Module One it is recommended Coordinated Veterans' Care Program: A Guide for General Practice is read.

Ref; Dept. Of Veteran Affairs CVC Program, "A Guide for General Practice" P5

Continues opposite

Community Nurse – Intellectual Disability Update



BERNADETTE ADAMS
Community Nurse-Intellectual Disability Officer

I have created in conjunction with Deakin University, a series of surveys with the hope that GP's, Practice Managers, Nurses and reception staff will consider participating.

The aim of this survey is to gather information on the knowledge and understanding of General Practice staff regarding the needs of patients with an intellectual disability in order to develop and implement support and resources.

The project is currently undertaking the development of a website. The purpose of the website is to offer information about current research in the field of Intellectual Disability, a directory of services on the Mornington Peninsula, encourage people to make contact, create links from the website to other service providers and in general make it easier for family, carers, people living with and Intellectual Disability, and professionals in the field, to find information and services.

Bernadette Adams can be contacted on her mobile: 0488 553811, Mon-Fri 8.30am – 5pm

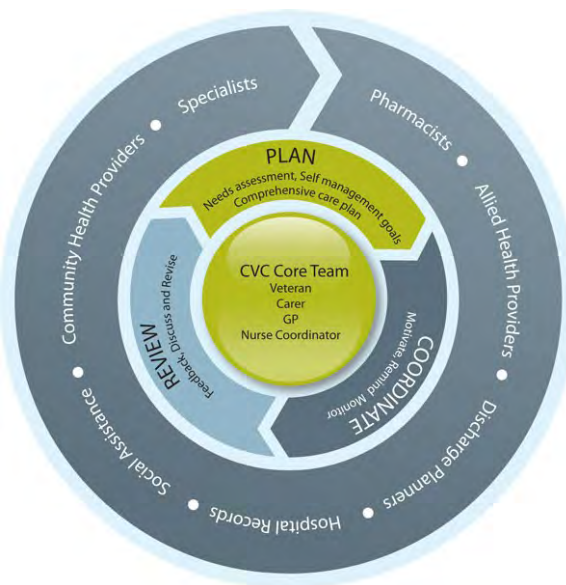
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CVC Program Model of Care

The Model of Care for the CVC Program is based on the core team, which includes the veteran, the veteran's carer (if applicable), the GP and the nurse coordinator, who is either a practice nurse, Aboriginal health worker or community nurse.

The sharing of health information is a key feature of the CVC Program. The future availability of electronic health records and use of electronic communication will greatly assist the CVC Program in the sharing of health information amongst all providers of health care for CVC participants.

As these capabilities develop, DVA expects that electronic health records and communication will be a key part of the CVC Model of Care. Regular communication, empowerment and coaching are key to the success of the team. The care planning cycle is continuous and most participants going on the program will stay on the program. The team uses care planning, coordination and review as the tool to focus on better management and self management of the participant's health and to incorporate the multidisciplinary team



Benefits for participants

As a result of the program, participants will become:

- healthier, with less need to be admitted to hospital
- more educated and empowered to self manage their conditions

Benefits for health professionals

As a result of the program, health professionals will benefit in numerous ways:

- GPs receive recognition and compensation, including for non face-to-face time spent in providing comprehensive care to eligible participants
- help improve the quality of care of participants
- enhanced opportunity for nurses to work in partnership with the GP
- efficient alignment of nursing roles with nursing skills
- receive training and resources for chronic disease management

We would be keen to assist any practice who has DVA Gold Card Holders who would benefit from this new initiative. If you believe your current nurses do not have the capacity to pick up another program or your practice does not currently have a nurse, we have some options you may like to consider. Funding available has the potential to supplement considerably the PNIP due to commence in January 2012.

If you or your practice would be interested in further information or support to initiate this program please contact either Ailsa Gregory: a.gregory@pgpn.org.au or Leisl Jackson: l.jackson@pgpn.org.au, or phone the PGPN Office: 9708 8019

Bachelor of Nursing students in general practice: a community nursing focus

By Arlene Parry and Associate Professor Anthony O'Brien



With the increasing number of students enrolled in undergraduate nursing degrees and the need to source clinical placements, education providers are increasingly using the primary health care clinical setting.

General practice is one community based environment and the rise in numbers of practice nurses has recently increased the value of general practice clinical placement.

General practice offers the potential to provide valuable clinical practice hours for student nurses, while increasing their exposure to, and understanding of, nursing in the primary health care setting. Student nurses often assume they have to be placed in fast paced acute settings to learn the necessary skills to become a registered nurse. However other settings allow student nurses to develop the diverse skills required to meet the needs of patients who enter different entry points to the health care system.

A theoretical shift in curricula at Monash University School of Nursing and Midwifery, which incorporates acute, community and chronic illness settings, seeks to meet scope of practice needs and the emerging skill set of new graduates who will increasingly be working across the health care system. This need has been recognised by academics at Monash University, who have developed a Bachelor of Nursing (Community Health) to commence in 2012. Nurses graduating from this course will have a larger scope of practice covering community and acute centre settings.

GPs are also realising the potential benefits of student nurses in their practices and are actively forming relationships with education providers in medicine, occupational therapy, physiotherapy, and nursing and midwifery. The workforce in practice nursing is currently largely part-time and the placement of student nurses in this environment is an extremely important workforce strategy (HWA 2010).

The shift to placing student nurses in general practice is in its infancy and universities and general practice need to work to reshape scope of practice to meet community health needs. Resources need to be developed to assist practice staff in the supervision of students, and also to ensure that students can meet the learning objectives of the placement.

General Practice offers the potential to provide valuable clinical practice hours for student nurses, while increasing their exposure to, and understanding of, nursing in the primary health care setting.

REFERENCE

Health Workforce Australia Communique. 2010. Clinical Training Funding - Upcoming Request for Proposals. [Accessed online 12 August 2011] www.hwa.gov.au/sites/uploads/communique110510...2j.pdf

Arlene Parry and Associate Professor Anthony O'Brien are from Monash University School of Nursing and Midwifery

Workforce

GP Position Frankston South

Position: GP full or part time vocationally registered GP (with/without view to partnership)

An exciting position is available in a well regarded and established practice serving the Mt Eliza/Frankston South area. The practice is a privately billing purpose built facility with on-site pathology and soon a pharmacy. We are ideally located near at least one public and four private hospitals with excellent specialist services in the area.

The practice is situated in a pleasant location which allows easy access to the beautiful Mornington Peninsula.

We offer full nursing and administrative support and would be nurturing of a new Doctor wishing to establish a quality privately billing practice in a beautiful area close to many excellent school.

Remuneration is negotiable and will be rewarding.

Contact: The Practice Manager Jackie via email
JackieW@HumphriesRoadMC.com.au

DR JAYANTHA RUPASINGHE is moving to

**Frankston Private Hospital
Level 3 24-28
Frankston Flinders Road
Frankston 3199**

**from
Monday 1 October 2011**

**Telephone: 9781 5244
Fax: 9770 5792**



General Practitioners-

Raising awareness for the potential of organ and tissue donation

As a general practitioner you may be required to educate, discuss or disseminate information about organ and tissue donation with your patients. Peninsula Health has employed a dedicated Senior Nurse and Medical Consultant as part of the national reform for organ and tissue donation, to raise awareness and to ensure a national, coordinated approach to organ and tissue donation.

Nationally there are about 1800 patients waiting for a transplant at any one time and of these approximately 300 will die each year.

Most organ donors are people who have died as a result of a serious head injury, usually in a hospital intensive care unit, and currently on a ventilator

Most major religions support organ and tissue donation

Organs that can be donated include kidneys, heart, lungs, liver, pancreas, stomach and intestines.

Tissue donation can include corneas, whole eye, heart valves, skin, tendons and bone.

An important research finding is the need for individuals to discuss organ and tissue donation with their family, informing each other of their wishes.

There is no age limit on the donation of some organs and tissue

The age and medical history of a potential donor will be considered at the time of donation but people should not assume that they may be too old or not healthy enough to donate organs.

If you or any of your patients would like some more information then please contact:
Jodi Vuat, Senior Nurse for Organ and Tissue Donation, Peninsula Health on 9784 7509, or on jodivuat@gmail.com

Alternatively, information can be accessed via the following;

Australian Organ Donor Register

<http://www.medicareaustralia.gov.au/public/services/aodr/register.isp>

Donateline – Australian Organ and Tissue Donation and Transplantation Authority

<http://www.donateline.gov.au>

Lions Eye Donation Service

<http://www.cera.org.au/our-work/lions-eye-donation-service>

Donor Tissue Bank of Victoria

<http://www.vifm.org/n135.html>



Quicker and easier way to submit Centrelink forms via HPOS



General Practitioners (GPs) can now complete and submit medical reports for the Centrelink Disability Support Pension electronically through Medicare's Health Professional Online Services (HPOS).

Through HPOS, the *Medical Report – Disability Support Pension* form can be completed and submitted online. The form is easy to complete and includes helpful tips along the way. Incomplete reports can be saved for up to 90 days.

The submitted medical report is sent through HPOS to Centrelink through a secure channel and automatically links to the customer's Centrelink record. The completed form can be printed for the records of the GP and patient.

Using the online form is quicker and easier for GPs and saves the patient time, as they don't need to return the form to Centrelink.

You need a Public Key Infrastructure (PKI) individual certificate to access the full range of HPOS services. To register for PKI or for more information on HPOS go to www.medicare.gov.au then For health professionals > HPOS.



Latest News from the GP Liaison Unit



Dr Joanne Newton & Jennifer Sidwell
GP Liaison Consultants

This edition we have asked two of our colleagues to provide updates on the new electronic clinical systems at Rosebud and Frankston Hospital and the successful completion of the first HITH residential care blood transfusion.

Peninsula Health's new electronic clinical system

Lyn Jamieson, Director of Clinical Systems Project

Stage 1 of the Statewide HealthSMART clinical information system was launched at Rosebud Hospital in June this year with Frankston Hospital changing to this new clinical system in early September.

"Mental Health inpatient services and the Emergency Department at Frankston Hospital have also commenced using electronic discharge summaries for the first time".

This new system allows electronic ordering of pathology and radiology, electronic viewing of results, electronic discharge summaries and discharge medications.

General Practitioners who have had patients discharged from Rosebud Hospital (since June) or Frankston Hospital (since September) should now be receiving these new discharge summaries.

Mental Health inpatient services and the Emergency Department at Frankston Hospital have also commenced using electronic discharge summaries for the first time.

Clinicians are still learning to use the new discharge summary and it is especially challenging for our ED and Mental Health clinicians who have never previously used an electronic discharge summary. It is expected that with the introduction

of any new system, there will be teething problems but overall the Go-Lives at both Frankston and Rosebud have gone relatively smoothly with very good clinician engagement.

Monitoring of discharge summary compliance (ensuring all discharges requiring a discharge summary have a discharge summary) is on-going. There are also systems in place to monitor the delivery method of discharge summaries (eg. Electronic transfer or auto fax) and successful transmission of a discharge summary at its selected destination.

The contact number to request a copy of a discharge summary remains unchanged. Contact Health Information Services on Ph. 9784 7446. To provide feedback on the new discharge sum-

"This new system allows electronic ordering of pathology and radiology, electronic viewing of results, electronic discharge summaries and discharge medications"

mary, email Clover@phcn.vic.gov.au
The next roll-out of Stage 1 will be Frankston Hospital outpatients on October 17 and the Sub-acute sites of Golf Links Road and The Mornington Centre in November this year. Stage 2, which is electronic prescribing and an electronic drug chart, will commence in the first quarter of 2012.



Frankston smokefree areas reduce secondhand smoke and litter.

Quit and Peninsula Health can help you stop or cut down smoking.

Local quit courses and support
1300 665 781

Quitline 137848



To help with cravings while you're quitting
try the 4Ds

- **Delay...** for at least five minutes, the urge will pass
- **Deep Breathe...** breathe slowly and deeply
- **Do something else...** keep your hands busy
- **Drink water...** take 'time out', sip slowly

Quitline 137848



A First for the Peninsula Blood Transfusions in Residential Care

Melanie Melbourne - Blood Transfusion Clinical Nurse Consultant.



Mr Mulcahy, Registered Nurse Nory Allison and Dr Martin Jackson

In July 2011 Peninsula Health's Hospital in the Home (HITH) service reached a milestone. The service gave their first blood transfusion to an elderly resident in a community residential care facility.

"If a resident requires a blood transfusion they will be offered the procedure at the facility so as not to disrupt their normal routine"

The service was developed to provide safe blood transfusions for residents in Residential Care Facilities and involves a HITH doctor and nurse being present to facilitate the procedure.

This community focused initiative has been the result of extensive collaboration between the Peninsula Health Transfusion Nurse and the

Hospital in the Home Team (HITH).

If a resident requires a blood transfusion they will be offered the procedure at the facility so as not to disrupt their normal routine. This can be very important for elderly residents who can suffer from agitation and experience stress when moved from their familiar surroundings.

The Transfusion took place at Capel Sands Aged Care Facility in Rosebud West. Dr Martin Jackson was present for the first half an hour of the transfusion and Registered Nurse Nory Allison stayed with Mr Mulcahy throughout the transfusion.

"The service gave their first blood transfusion to an elderly resident in a community residential care facility"

Referrals can be made by

- Phone- HITH Consultant on 0416 123 315
- Fax- HITH Unit 9784 7242.

More information can be found in the Blood Transfusion section of the Peninsula Health GP Liaison website (peninsulahealth.org.au) including the following:

- [Residential Care Blood Transfusion Service Flow Chart](#)
- [Hospital in the Home Blood Transfusion Service](#)
- [Referral Form – HITH Blood Transfusion Service](#)
- [Post transfusion observations and fact sheet](#)

ALERT!

The new Peninsula Health Clinical System uploads GP details from the

Human Services Directory (HSD).



Please make sure your details are listed correctly.



Cervical cancer vaccine

Supporting HPV Immunisation in General Practice

In November 2006, the Australian Government announced funding for a HPV vaccination program. The HPV vaccination program is listed on the National Immunisation Program (NIP) Schedule and funded under the Immunise Australia Program.

An ongoing school-based program is routinely delivered to girls in the first year of secondary school. Girls in Victoria who commence the HPV immunisation course in Year 7 have until the end of Year 8 to complete the three-dose course free-of-charge. In addition to school settings, immunisations can also be obtained via public council immunisation sessions or a general practitioner. Therefore General Practice clinics in Victoria are required to provide the HPV vaccine (doses one, two and three) for free to all girls who meet these criteria. Older girls requesting HPV immunisation must purchase the vaccine at approximately \$150 per dose.

General Practice orders for the HPV vaccine need to be made through the Department of Health on 1300 882 008 and the National HPV Vaccination Program Register needs to be notified of each dose given. The Register can be contacted on 1800 478 734.

Vaccine coverage rates released by the Register show that in Victoria, only 73% of school girls are completing the full three doses required.

This is a drop-off of around 10% of girls who have the first injection.

In order to increase uptake and completion of the HPV immunisation course, it's imperative that we continue to educate girls and their parents on the importance of the vaccine in helping to prevent cervical cancer, and to remind them of the time restriction they have to complete the course at no cost.

Cancer Council Victoria is currently rolling out a Department of Health-funded communications initiative to help address this issue. General Practices can assist by proactively promoting these key messages to girls in Years 7 and 8 and their parents, and by encouraging them to complete all three vaccine doses.

As part of the communications drive, Cancer Council Victoria has distributed to all Victorian secondary schools an article to be included in their newsletter and a letter to all parents of girls in Year 8. These items are available on the website and may be utilised to help guide you in initiating discussions with girls and their parents.

For more information please visit www.cervicalcancervaccine.org.au.



Preceptorship - helping today's nursing students become tomorrow's nurses!

Monash University School of Nursing and Midwifery is pleased to offer the "Introduction to Preceptorship" Professional Development Program.

This program will explore the roles of the preceptor as a role model, educator, facilitator and evaluator.

The aim of this program is to develop clinicians' understanding of the adult learning process, as well as increasing skills in effective communication, evaluating progress, giving feedback and conflict resolution

Facilitators: Professor Wendy Cross & Dr Cheryle Moss

Dates: Saturday 12 November 2011, 9.00am - 4.00pm

Thursday 16 February 2012, 6.00pm - 9.00pm

Cost: Attendance at this program is supported by Health Workforce Australia at no cost to participants. A light lunch and refreshments are included.

<http://www.med.monash.edu.au/nursing/professional-development/preceptorship.html> For more information please contact: Shortcourses-sonm@monash.edu or call 9905 3467



DID YOU KNOW.???.....

Insulin Dependent Diabetes is now a recognised disability for Carer Allowance for all children under 16 years.

As part of the Federal Government's National Carer Strategy, from 1 July 2011 all children under 16 years with Insulin Dependent Diabetes are assessed as having a recognised disability for Carer Allowance. This is a change from the previous arrangements where Insulin Dependent Diabetes was recognised for automatic qualification for Carer Allowance only until the child turned 10. This change recognises that Type 1 Diabetes is a life-long condition for which there is currently no cure, and provides parents and carers with recognition for the care they provide. For more information please visit Centrelink website at:

http://www.centrelink.gov.au/internet/internet.nsf/individuals/national_carers_strategy_faq.htm

Centrelink payments for carers and the role of the GP

Centrelink has two primary payments for carers, Carer Payment and Carer Allowance. A person may be eligible for one or both of these payments. Carer Payment is an income support payment which has an income and assets test the same as other pensions. Carer Allowance has no income or assets test and can be paid in addition to wages or other Centrelink payments.

Personalised medical reports are issued with claims for Carer Payment and Carer Allowance, however not every claim requires a new medical report. A carer should always contact Centrelink to determine if a medical report is required for their claim before asking their doctor to complete one. Medical reports are available on the Centrelink website for Treating Health Professionals, if the carer is unable to access a personalised medical form. Carer Payment and/or Carer Allowance Medical Report for a person 16 years or over can be found at:

[http://www.centrelink.gov.au/internet/internet.nsf/filestores/sa332a_1007/\\$file/sa332a_1007en.pdf](http://www.centrelink.gov.au/internet/internet.nsf/filestores/sa332a_1007/$file/sa332a_1007en.pdf)

Carer Payment and Carer Allowance Medical Report (for a child under 16 years) can be found at:

[http://www.centrelink.gov.au/internet/internet.nsf/filestores/sa431_1109/\\$file/sa431_1109en_f.pdf](http://www.centrelink.gov.au/internet/internet.nsf/filestores/sa431_1109/$file/sa431_1109en_f.pdf)

Practitioners provide an important service to their patients when they fill in these forms, which are required to support new claims and reviews for carer payments. Medicare Australia has a Provider Enquiry phone line to support practitioners providing this service to their patients. For assistance in completing Centrelink medical forms call 13 2150 and select option 3.

More information on payments for carers can be found at:

http://www.centrelink.gov.au/internet/internet.nsf/individuals/carers_index.htm

Declining mammography rates linked to drop in HRT use



Menopausal women who cease using hormone replacement therapy (HRT) are also likely to miss regular mammogram screening according to a recently published US study.

Since the release of the 2002 WHI study, HRT use has been in decline. However researchers have also found the change in HRT use was associated with a drop in mammogram screening for women aged 50-64 years. The researchers believed that because HRT was prescribed by GPs, women using the treatment made more regular visits to their doctor and so heard constant reminders about having mammograms.

While Australian women aged over 40 are entitled to have free mammograms every two years, BreastScreen Victoria actively recruits women aged between 50-69 years by sending invitation letters and reminder letters. Screening is considered crucial for 50-69 year olds because half of all breast cancers diagnosed are detected in that age group.

For more information on how BreastScreen Victoria can support your practice please contact your local Screening and Assessment Service- <http://www.breastscreen.org.au/> or call Jenny Williams on 992 88760.

The Royal Children's Hospital is on the move



The new Royal Children's Hospital (RCH) opens on 30 November 2011. The new RCH, which is right next door to the current hospital in Parkville, will provide wonderful facilities for patients, families and staff.

To ensure the move to the new RCH goes smoothly, a Move Plan has been developed in consultation with the Department of Health, new RCH Project consortium, staff and families.

Here is some useful information about the move.

Patient Move Day is Wednesday 30 November

Inpatients will be moved in one day, mid-week in daylight hours.

Referral process will stay the same

The referral process will stay the same in the new hospital. A referral form is available on the GP website.

www.rch.org.au/kidsconnect) or via a number of GP Practice software programs



Hospital contact details will stay the same

Hospital phone numbers, fax numbers and address will stay the same during and after the move.



- RCH Switchboard: 9345 5522
- Patient outpatient-related questions: 9345 6180
- GP hotline: 9345 7060
- GP / Primary Care Liaison: 9345 4645
- Fax number for referrals: 9345 5034
- Department fax numbers will be forwarded to their new fax machines
- Address: 50 Flemington Road, Parkville 3052

Outpatients will be known as Specialist Clinics

All outpatient services will be centrally located in the new hospital and known as Specialist Clinics. A way finding strategy has been developed for the new hospital, making it easy for patients, families and staff to find their way around.

More information

You can get more information about the new RCH and the move at www.rch.org.au/rchonthemove. Patients and families will be briefed prior to the Move.

“I've helped protect my newborn by protecting myself.”

Have you had your adult whooping cough vaccination?

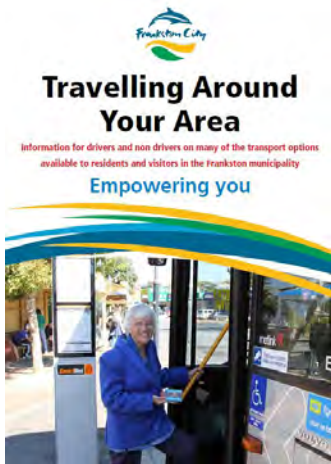
A photograph of a woman with long dark hair holding a newborn baby. The woman is smiling and looking at the baby. The background is a solid pink color.

Travelling Around Your Area Booklet



This month all surgeries within the Frankton municipality will have received a booklet titled "Travelling Around Your Area". The booklet was developed by the Aged Services Department at Frankston City Council and is a direct result of consultation with senior residents. It became about through the consultation process, highlighting a strong need to better inform the community on available transport options within the municipality.

The aim of the booklet is to make it easier for people who are transport disadvantaged to stay connected with their communities and maintain a high quality of life. It contains information for drivers and non-drivers on the different types of transport provisions available to residents and visitors in the Frankston Municipality.



The booklet is relevant to all residents but in particular seniors as it touches on many topics including,

- determining if it is safe to continue driving,
- the impact of medications on driving,
- public transport options and timetables,
- how to catch a bus or train,
- community transport options and
- Medical transport options.

As this booklet is the only one of its type for the Frankston area, it is a valuable resource for community services organisations, residents and your patients. The booklet has been distributed to general practice together with all retirement villages, seniors clubs, community houses and large shopping precinct in the area and to date has been very well received. To ensure the information reaches the people who need it most we are asking that you display the booklet in your waiting room and advise all the practise staff of its availability and provide a copy to patients that would find the resource useful.

The ability to access transport is vital to ensure people stay connected to their community and maintain a high quality of life so please let people know this resource is available to them.

If you have any questions about the booklet or would like to order more, please do not hesitate to contact Carly Currall at Frankston City Council on 9784 1046.

www.whoopingcough.com.au launches in Australia

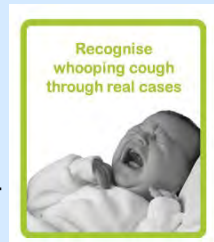


Australian healthcare professionals, public health workers and patients now have another weapon in the fight against whooping cough, with the launch of www.whoopingcough.com.au

With more notifications of whooping cough in Australia than ever before and fifty-one per cent higher than 2010 YTD¹, the need for comprehensive, up-to-date and engaging information about whooping cough has never been more critical.

The site has been developed by vaccines manufacturer Sanofi Pasteur and offers easy to use and interactive tools such as an Australian map with information tailored by State, a 10 question quiz and Facebook sharing in order to help spread the message.

If new parents or other close contacts of a newborn have questions about how to prevent whooping cough, they should visit www.whoopingcough.com.au and combine this with a visit to their family doctor for professional advice.



References: 1. Australian Government DoHA, National Notifiable Disease Surveillance System. Accessed on 1 August, 2011 at http://www9.health.gov.au/cda/Source/Rpt_3.cfm.



Peninsula Drug & Alcohol Program (PenDAP) & Youth Services Information for GPs

PenDAP & Youth Services offer services to people of all ages who experience difficulties with their alcohol and other drug use, and to young people experiencing a range of difficulties. We see clients at our sites, in their home or at other safe and accessible locations. Services are available across Hastings, Mornington, Rosebud and Frankston. All staff are trained to work with clients with co-occurring alcohol and drug and mental health issues.

PenDAP clinicians discuss changing alcohol and other drug use, stopping completely and using more safely. Youth workers focus on a range of issues including family and relationship problems, housing and finances, family violence, school and work, mental health or alcohol and drug use concerns. Services are free, with exception being Drink & Drug Drive program.

How we work with GPs?

4% of our referrals are directly from GPs. Where possible we work in collaboration with GPs in relation to assessment, care planning and discharge planning. GPs are vitally important in care coordination, particularly where clients face problematic substance use involving prescription medications, are seeking to withdrawal from substance use and have physical and mental health issues.

What services are available?

Counselling

Counsellors provide advocacy, casework, counselling where clients identify alcohol and/or drug use negatively impacting on their health and wellbeing.

Aboriginal & Torres Strait Islanders (ATSI)

ATSI workers provide support to the ATSI community and their friends and family members about their alcohol and other drugs.

Youth

Youth Workers support young people aged 12-25 years and their friends and family.

Forensic

Forensic services support clients referred by Community Offenders Advice and Treatment Service (COATS) or the court, police diversion program and solicitors.

Outpatient & Home Based Withdrawal

Clinicians provide short term treatment to help clients' withdrawal symptoms when they stop and/or want to cut down the use of alcohol and other drugs.

Withdrawal clinicians have close working relationships with local hospitals, detox units & GPs.

SHARPS

Needle & Syringe Program:

Services include:

- Client area with access to internet, fax and phone.
- Safe area for disposal of syringes
- On site Hep C nurse (fixed site only)
- Education and health information
- Sterile injecting equipment and safe disposal service

SHARPS Location:

20 Young Street Frankston
Week days 9.00am-5.00pm
Phone: 9781 1622

MOBILE OUTREACH:

6.30-9.45pm, 7 nights a week.
Phone: 1800 642 287(free call)
Service provides sterile needles, syringes, injecting equipment and condoms.

Group Programs

Our group programs are free except for the Drink and Drink Drive groups. Clients can call the Community Health Access Worker on 9784 8100.

Groups include:

Caution with Cannabis: an education program providing information about cannabis and its effects.


Thinking About Drinking: an education program providing information about alcohol and its effects.

RESET: for adults who are in recovery from alcohol and drug use.

New Directions: for people who want to change their alcohol and other drug use.

SMART Recovery: for people who are in recovery for drug and alcohol use (a self help model)

Hep C Support Group: for people with Hep C.

Continues opposite 

Windana Drug & Alcohol Recovery Frankston Peer Support Group

Windana Drug & Alcohol Recovery Peer Support is a weekly group meeting that provides the opportunity to speak about things that may affect you during your recovery from harmful drug and/or alcohol use.

It is a safe and informal environment in which to gain insight and strength from shared experiences.

Please attend group unaffected by any substance.

St. Paul's Anglican Church
Cnr Bay St. Sth & High St.
Frankston
('the blue room' - next to office)
Commencing June 16th 2011

Further information :

Windana Drug and Alcohol Recovery Ph: 95297955
Annette (group facilitator) mob: 0414589235

Continued from page 20

LOCATIONS

To access our services call or drop in to your local Community Health Service and ask to speak with an Access Worker.

Hastings Community Health
185 High Street, Hastings 3915
Phone: 5971 9100
Melways Ref: 154 F11

Rosebud Community Health
38 Braidwood Avenue, Rosebud, 3939
Phone: 5986 9250
Melways Ref: 170 A2

Mornington Community Health
62 Tanti Avenue, Mornington, 3931
Phone: 5970 2000
Melways Ref: 104 F11

Frankston Community Health
Frankston Integrated Health Centre
Hastings Road, Frankston, 3199
Phone: 9784 8100
Melways Ref: 100A G11



"NEW" Burns clinical practice guidelines

Victorian State wide Burns Clinical Practice Guidelines developed by the Victorian Adult Burns Service (VABS) at The Alfred, in conjunction with the Royal Children's Hospital Burns Unit are now available.

You can view them at:
www.vicburns.org.au

Of particular interest for GPs are:

- downloadable Wound Care Charts and Burns Surface Area assessment charts
- Patient Information Sheets for skin care following burn injury;
- care of minor facial burns at home information regarding return to work for professional
- patients referral information for both burns services (both urgent and outpatient) analgesic guidelines for minor burns (targeting GP needs)

Healthcare Identifiers – Preparing Your Practice

From 1 July 2012 members of the public will be able to apply for their Personally Controlled Electronic Health Record (PCEHR). Now is the time for practices to start preparing for the time when patients will arrive requesting their PCEHR.

An important building block for the PCEHR system is the national Healthcare Identifiers (HI) Service which helps to identify people and organisations involved in healthcare across Australia through the allocation of a unique number (healthcare identifier) to each individuals and healthcare provider. The HI Service which is operated by Medicare Australia will give individuals and healthcare providers confidence that the right health information is associated with the right individual at the point of care.

The HI Service allocates three types of Healthcare Identifiers:

1. Individual Healthcare Identifier (IHI)

The IHI is a 16 digit number allocated to all individuals enrolled in the Medicare program or those who are issued with a Department of Veterans' Affairs (DVA) treatment card and others who seek healthcare in Australia. IHIs do not replace Medicare or DVA numbers and do not affect the way medical benefits are claimed. IHIs are not health records, the information held is limited to demographic information (such as name, date of birth and sex) which is needed to uniquely identify an individual.

2. Healthcare Provider Identifier - Individual (HPI-I)

The HPI-I is a number allocated to each healthcare provider involved in providing patient care. If you are registered with the Australian Health Practitioner Regulation Agency (AHPRA), the agency will allocate you with a HPI-I and advise you of the number. You can check this number by looking at your AHPRA renewal notice.

3. Healthcare Provider Identifier - Organisation (HPI-O)

The HPI-O uniquely identifies each organisation where healthcare services are provided for example medical practices, pharmacies, hospitals. Practices will need to apply for their HPI-O via Medicare Australia.

- Information about the HPI-O registration process and forms are available via the Medicare website at <http://www.medicareaustralia.gov.au/provider/health-identifier/index.jsp>
- Cradle Coast Electronic Health Information

Exchange has also put together a useful guide and checklist to assist practices with the HPI-O application process it can be accessed via http://www.cradle-coast-ehealth.org.au/_data/assets/pdf_file/0005/108932/Howto-HPI-O-Health-Provider-Identifier-for-Organisations-v1.4.pdf

Suggested actions

- For a useful overview read the HI Service brochure tailored to healthcare providers available at <http://ehealthinfo.gov.au/assets/HI%20Brochure.pdf>
- Check your HPI-I (see your AHPRA letter)
- Find your PKI (Public Key Infrastructure) details and confirm that it is current
- Review the Cradle Coast checklist referred to above in preparation for applying for an HPI-O for your practice

For more information from Medicare on Health Identifiers call **1300 361 457** or email healthcare-identifiers@medicareaustralia.gov.au

Resourced from the GPV weekly update



**SUSAN YOUNG
CONSULTING**

Mental Health Social Worker

**Ten years experience in the Mental Health field.
ATAPS and Medicare registered**

Consulting in Rosebud and offering expertise in the following areas:

- Stress and anxiety
- Depression
- PTSD
- Managing and monitoring serious mental illness
- Individual counselling
- Relationship counselling
- Parenting
- Families affected by Autism Spectrum Disorder
- Families affected by Mental Illness
- Well-being and self awareness

Suite 3, 1243 Point Nepean Road
Rosebud Vic 3939
M: 0403 266 989

E: susanyoungconsulting@gmail.com
Medicare rebates available



Professional

Balancing benefits and harms of antipsychotic therapy

Peninsula GP Network, in partnership with NPS, is offering a program on the safe and effective use of antipsychotic therapy in schizophrenia, bipolar disorder and behavioural and psychological symptoms of dementia.

This program provides a valuable opportunity to discuss up-to-date, independent, practical, evidence-based information on current therapeutic issues with a highly skilled NPS facilitator and other general practitioners.

This program will focus on:

- An individualised approach in assessing benefits and harms of antipsychotic therapy
- Tips to engage patients/carers in recognising and managing adverse effect
- Ways to reinforce to patients the importance of adherence to antipsychotics when prescribed
- A planned approach to assess the ongoing need for antipsychotics for behavioural symptoms of dementia

What's in it for me?

- An opportunity to discuss evidence-based information and access key resources
- Time-efficient education with the NPS facilitator
- A Quality Prescribing Initiative (QPI) activity within the Practice Incentives Program and eligible for RACGP QA & CPD and/or ACRRM program points

If you would like any further information regarding this program or to book a 30 minute Educational Visit please contact ;

**Jane Spence,
NPS Facilitator
Via email j.spence@pgpn.org.au
or 0407 844 736.**

With your name, practice, contact details and preferred day and time.



Peninsula Health Community Health Service Waiting Times

Service	Average Waiting Time
Cardiac Rehabilitation	1-2 weeks
Counselling	2 weeks
Diabetes Education (Group)	Monthly
Diabetes Education (Individual)	1-2 weeks
Dietetics	3-4 weeks
Occupational Therapy (Adult)	3-4 weeks
PENDAP Withdrawal	2-3 weeks
PENDAP Counselling	3-4 weeks
Physiotherapy	4-5 weeks
Podiatry	2-3 weeks
Strength Training assessment	2-3 weeks
Agestrong Program	4 weeks

Peninsula Health Community Health Service
Waiting Times end September 2012

These waiting times are estimates only and can vary depending on the location of service.

These waiting times apply to routine service enquiries only. All service requests are prioritized and earlier appointments are available for category 1 and urgent referrals.

We are currently experiencing heavy demand and long delays for children's' service appointments.

Contact CH via their new number for further information : 1300 665 781.

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Diabetes Federation Recommends Early Gastric Banding



Diabetes is the term used to describe the combination of the diabetes and obesity epidemics taking hold across the world and those whose goal it is to prevent even more people developing these conditions state the scale of the problem in no uncertain terms.

March 2011—The International Diabetes Federation issued what it calls a radical statement at an International Conference today.

The Federation says the gastric banding and similar surgeries should no longer be the last resort for severely obese people with type 2 diabetes.

Director for the Baker Heart and Diabetes Institute in Melbourne, Professor Paul Zimmet, says

“diabetes is the biggest epidemic in human history. “It is recommending that surgery be considered at a much earlier stage.”

“A lot of people have always regarded it as a last resort and we’re saying no it shouldn't be the last resort., it should be considered much earlier because the earlier it’s done, the more chance there is of success of the procedure.”

There was a paper presented in New York in March 2011 from a major study in Sweden which showed that you could almost get 70 to 80 per cent remission of diabetes, providing the duration of the diabetes was less than 10 years”, Professor Zimmet said. “But if the duration was much longer, those people would probably only see 30 to 40 per cent remission.”

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