Welcome to another edition of Tropical Ear from the Townsville-Mackay Medicare Local. Since the last edition we have experienced further upheavals in Canberra and we await the impact of the Federal Budget on our patients and clinical practice. The country works in an atmosphere of uncertainty as the political process grinds on. It appears that one cannot predict what the next headline will say or what effect the political fray will have on us, our patients or our care of them.

Lost among all the lurid headlines is the impending implementation of the Electronic Medical Record (EMR) held by the person themselves, Personally Held EMR (PHEMR).

The PHEMR has its genesis in a recommendation from the National Health and Hospital Reforms report to government in 2009. It certainly has many advantages for patient care into the future but as many experts have pointed out, an equal number of drawbacks. There are as many opinions on the expected success of this rollout as there are varying medical record systems and different computer systems on which patient data is held.

The advantages are simple to enumerate. Patients are more mobile now than they ever were in our nation's history. Serving as we do in North Queensland, a large mobile mining, military, tourism, and public service base many of our patients will have in excess of a dozen different GP's or Primary care givers during their formative and working years and even in retirement may travel for recreation or to visit children and grandchildren. Each time they move under the present system they need to either orally transmit their past medical information or give permission to a previous practitioner to transfer past notes via fax or mail. It would all appear easier if it were on a card or otherwise transferable. This, the proponents say, would lead to savings in better care, less doubling up on tests, both imaging and pathology, and faster access of treating practitioners to patient information. A total of $466 million was budgeted for the rollout over two years from July 1 2012, in the 2010-11 budget.

The disadvantages are argued as strongly as the advantages. The PHEMR will be a voluntary system so people will need to opt in to the system. It is estimated that due to concerns about privacy in media polls, the PHEMR will have a low take up of between 50% and 60% of the population. This take up projection, if it eventuates, will not provide the cost benefit gains that were budgeted. Another concern is privacy of data, and this is contentious in eHealth expert circles. Some say it will be safe, others say that it will not be. Some patients may elect only to have some of their record on the database, while others may be sufficiently comfortable to have it all, including warts, recorded. Many people remain uneasy about all their records being on a database.

This is a mere introduction to the PHEMR, and I would be interested in any thoughts or comments from our clinicians who are reading this on their thoughts as eHealth experts, clinicians, or indeed as patients on the concepts I have discussed above.

While Anzac Day is still fresh in our memory, let us think of all the Primary Care clinicians, nurses and doctors who have served and given their lives or health, and who continue to serve in theatres of war in the Australian Defence forces as they do their duty.

Dr Michael Murray - Editor
CHAIR’S REPORT

Well, we now are moving rapidly ahead in the field of National Health Reform. From the July 1, 2012 we will have all the Medicare Locals and all the LHNs operational across Australia. The LHNs in Queensland will be known as Local Health and Hospital Networks (LHHNs) and we will have both Townsville and Mackay LHHNs in our region.

The Federal Government is also supplying a portion of the monies towards Hospital Care from this date onwards. There is a complicated funding formula for this with lots of variables by State, Indigenous status, region, etc. It will be a real challenge for the new “Governing Councils” of the LHHNs to get their heads around as the new funding will be linked to activity (ie linked to episodes of care of patients) rather than by institution.

Some aspects of care within the hospital, such as outpatient appointments and outpatient based testing may not be covered by this system and yet other things outside the hospital such as Hospital in the Home, Hospital Avoidance Programmes etc, may well be covered.

Special cases, such as Mental Health Services are still being sorted out as to how or if the Federal Government contributes funding.

I recently attended a think-tank on the roles of MLs, LHNs and Multi-purpose Services within the new National Health Reforms, especially in Regional, Rural and Remote Australia. The general feeling was that the new reforms may well have benefits, but only if all parties collaborate with a spirit of willingness.

We had a speaker from the National Pricing Authority who tried to explain the new Federal Funding arrangements for the new system. A National Efficient Price will be determined for all services provided. This apparently will be adjusted State by State to allow for historical differences in State funding and then variations will be applied as appropriate.

I don’t know how this is going to work in practice, but it sounds like a horrendous case of complexity for the sake of complexity to me. This will keep many Public Servants in employment for years to come. It almost sounds as complex as Medicare!

Kevin Arlett
Chair

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Referrals to TTH

There have recently been requests from the Townsville Hospital to GPs seeking referral documentation changes, specifically the addition of specialist names to referrals. There are a couple of points to note; referrals should always be directed to a Clinician and not a Clinic (e.g. Dr Smith at Colposcopy Clinic, not Dear Colposcopy Clinic). It is difficult for the GP community to keep up with the current TTH specialist list and so an up to date list of all specialists working at TTH needs to be provided to all practices.

We will be sending out a current list of TTH directors of departments and staff specialists to all practices. The list will also be stored on the website on the home page of TTH Special Clinics www.tmml.com.au/specialclinics. Please also enter it into your contact database. You may refer to the Director of the department or a specific specialist in the department. At all times it is your choice who you refer your patient to, however if you have no particular preference it may improve patient access if you send a named referral to the director of the department and include the names of other specialists who are acceptable to you and the patient. This may facilitate improved patient access in the next available appointment via the use of bulked bill clinics.

Directors of Departments at Townsville Hospital

Cancer Clinic:
Haematology – Dr Ian Irving
Medical Oncology – Dr Sabe Sabesan
Radiation Oncology – Dr Susan Hewitt

Medicine:
Gastroenterology – Dr Enrico Roche
Aged Care Medicine – Dr Paul Goldstraw
Renal Medicine – Dr George Kan
Rheumatology – Dr Jason Ly
Respiratory – Dr Tony Matthiessson
Cardiology – Dr Raibhan Yadav

Pain – Dr Matthew Bryant
Palliative Care – Dr Will Cairns
Internal Medicine & Endocrinology – Dr Kunwarjit Sangla

Mental Health:
Townsville Institute of Mental Health Services / ATODS: – Dr John Reilly
Acute Mental Health Service – Dr Savio Sardinha
Secure and Forensic Mental Health – Dr Bruce Kahn
Child and Youth Mental Health – Dr David Hartman

Surgery:
General Surgery – Dr John Hack
Ear Nose Throat – Dr Andrew Swanston
Maxillo-Facial – A/Prof Bob Jones
Neurosurgery – Dr Eric Guazzo
Ophthalmology – Dr Maria Moon
Orthopaedics – Dr Rhys Edwards
Plastic Surgery – Dr Ian Tassan
Cardiac & Thoracic – Dr Robert Tam
Urology – Dr Rajan Narula
Vascular – Dr Jon Golledge

Women & Children’s:
Paediatrics – Dr Andrew White
Gynaecology – Dr Louis MacPherson

Clinical Handover Clinician to Clinician
Most practices seem to have an appropriate strategy for managing incoming calls from clinicians who are currently managing their patients. It probably takes some effort for outside treating clinicians to contact GPs. They probably only ring if they have something of interest to say. A recent instance has prompted a request for a discussion of this issue with the GP community. The points that have been outlined to me are that most patients will probably tolerate the occasional, brief, and focused interruption. They understand that such an interruption may be of benefit to them one day. A lot of time can be taken
up trying to track down referring and receiving doctors. Please discuss your management of clinical handover calls to your practice, so the best outcome is achieved for you and your patients.

**GPLO Handover**

As my role as GP Liaison Officer for Townsville-Mackay Medicare Local has finished at the end of April, this will be my last report for Tropical Ear. It has been a very interesting time and I would like to especially thank the GP community who have engaged in some significant change management solutions, particularly the improvement of access to specialist clinics for their patients.

We no longer have waiting lists of five to eight years and the aim is to further reduce waiting times to eighteen months. There is discussion around the number of new patients seen compared to review patients. We have had great improvement in the area of patient access and it has been rewarding to be part of the change process.

I would also like to thank my co-workers at Townsville-Mackay Medicare Local, other primary health care providers, TTH specialists and the TTH staff who have all liaised with me to achieve these outcomes in the last five years.

Dr Lesley Stainkey
GPLO

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**MEN’S HEALTH COLLABORATIVE**

TMML has been facilitating Collaborative Quality Improvement Programs since 2005. The latest one that has just become available for General Practices to join is the “Men’s Health Collaborative”.

The aim of this collaborative is improving the number of Health Assessments for men between the ages of 45-49 years by 20%. Base line data will collected via the pencat tool and then regularly throughout the program.

**Data collected will be:**

- The number of men in the general practice aged between 45-49 years
- The number of health assessments
- BP’s taken
- BP’s to target
- Cholesterol
- BMI
- Waist measurements
- Alcohol & smoking assessments.

This data will provide a snapshot of the target areas to give the practice a starting point with which to measure the results of any changes made within the practice.

The Improvement Model will be used to instigate change within the practice which will assist to make improvements necessary to enhance Men’s Health. Education regarding the Improvement Model will be given at the workshops.

The program will consist of three learning workshops and two activity periods. Learning workshop 1 will be a webinar which TMML will deliver. Learning workshop 2 is face to face and Learning workshop 3 will be in house.

The learning workshops will provide practices with the information and tools required to assist them in making small changes to achieve their goals. The workshops also provide an opportunity for the practices to network and exchange ideas and their experiences. The activity periods will be when the practice will implement their ideas and make small changes using PDSA cycles that the improvement model is based on.

Ten practices from the Townsville Mackay Medicare Local area will be able to participate in a program to improve Men’s Health.

RACGP (Cat 1)/ACCRM points will be available for attending all or RACGP (Cat 2)/ACCRM points for some of the workshops, Nurses will receive CNE points.

Our role at the TMML will be to deliver the workshops and to provide support to the practices throughout the program.

Natalie Kerrigan
Practice Support Officer
WHY ALL THE FUSS ABOUT MEN’S HEALTH?

During my general practice training men’s health was not an issue that received any particular attention despite statistical indicators of men’s health significantly lagging behind those of women’s health.

The determinants of physical and emotional wellbeing are undoubtedly a complex mix of genetic and environmental factors not all of which are modifiable. Nonetheless current life expectancy in Australia is almost five years less for men compared to women, death rates from all cancers combined and all circulatory diseases combined are almost double for men compared with women. Suicide rates long recognised as an indicator of social cohesiveness are almost four times greater for men.

Some assume a very narrow view of men’s health as purely related to conditions affecting the male reproductive organs. As GP’s we are well versed in managing “risk factors” such as BP, Smoking, Lipid Profiles, Diabetes, Obesity etc. and not bad at giving lifestyle advice in areas such as diet, and exercise. However the key determinants of men’s health may relate more to men’s social environments and sense of male identity and belonging.

Indeed these environments are a focus for this year’s Men’s Health Week which will run from June 11 - 17. To be healthy “men need to work live and play in environments that support health and wellbeing.” (See http://www.menshealthweek.org.au) Social connectedness through family relationships, friendships, hobbies and pastimes, along with getting outdoors, getting active and back to nature are important in creating holistic environments and balance in men’s lives. Encouragement in these areas can easily be promoted in general practice.

The workplace remains an area of danger for many men who account for 93% of workplace deaths and suffer from workplace related serious injuries and illness at twice the rate of women. Workplaces do however also have great potential for encouraging a culture of wellbeing and implementing programs to facilitate the health of all employees.

Whilst this may be considered more the domain of public health organisations, for those of us in management or who own our practices, perhaps we could look at how our work cultures contribute to the health of our employees?

Fatherhood is changing and men are assuming a greater role in childcare/child supervision and the division of domestic duties. The Australian Bureau of Statistics reported in 2007 that 16.3% of men and 14.6% of women felt that work and family responsibilities were rarely or never in balance. Regrettably relationship failure is common with almost 50% of marriages / long term de-facto relationships eventually breaking down.

Where children are involved, old stereotypes see mothers most often assume or be awarded “primary caregiver” or residency status, with increasing marginalisation of fathers, who despite restricted or no contact with their children still shoulder significant financial responsibility for their care. Relationship troubles, separation/divorce and their aftermath are a high-risk time for men’s mental health and suicide risk.

It is also worth noting that increasing fatherlessness is strongly associated with poorer educational and social outcomes for our children, especially boys.

Although men and women are equally susceptible to mental health problems, men tend to seek help less frequently then women and are more likely to self medicate via drug or alcohol misuse.

Significant improvements have been made with a number of prominent men speaking out about their experiences with depression and supporting the Beyond Blue campaign http://www.beyondblue.org.au but we need to be aware that men may present with depression in quite atypical ways and remain under diagnosed and undertreated.

The impact of violence or risk of violence is often underestimated in men’s lives. This includes exposure to violence and trauma in the workplace and community settings but unfortunately also involves family violence. Whilst much has rightly been said and done to address violence against women, the fact remains that men are more frequently victims of violence in general and account for one in three victims of family violence. (See www.oneinthree.com.au)

Regrettably no or very limited services are available to address these issues for men, and although existing Domestic Violence services ostensibly cater to men and women the reality is that they are governed by an entrenched ideology that domestic violence is a gendered phenomenon (the Duluth Model) where men are only seen as perpetrators and women only as victims.

Men approaching such services are more likely to be re-victimised by being branded as perpetrators and offered a perpetrator treatment program rather than the help they and their family actually need.

There also remains certain groups of men whose access to health services is limited: rural men, indigenous men, non-heterosexual men, men from non-English speaking backgrounds, differently abled men, single men, poor men, men in jail and coming out of jail and homeless men. Improving access for these groups is one of the key concerns of the Australian Governments Male Health Policy released in 2010.

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I hope that healthcare providers and practices might take a moment to pause and consider “how are we doing with respect to the health of our male patients, and what can we do to improve?” Perhaps it can go on the agenda for your next practice meeting, please consider becoming involved in promoting this year’s Men’s Health Week, and later in the year I will be providing details of our proposed activities to support men’s health and celebrate International Men’s Day in November. (http://www.international-mens-day.com)

Dr. Greg Canning - GP

Referrals for Dental Services under Medicare for people with Chronic and Complex conditions

The Medicare rebatable Dental service is an invaluable resource for a GP when caring for those patients who have chronic or complex conditions. As we know people living with chronic conditions incur not only the cost to personal health – mind and body but also the financial burden of disease, medication, treatments, allied health care etc. Therefore the GP can assist by referring the patient to dental services under Medicare where the primary objective of the treatment is to improve oral health or function.

To be eligible the patient must:

- Have a chronic medical condition. The patient’s oral health must also be impacting on, or likely to impact on, their general health. (This is a clinical judgement for the GP to make taking into account the patient’s condition and needs).
- Be referred by usual GP
- Have a current GP Management Plan (GPMP) and Team Care Arrangement (TCA)

The GP must:

- Provide the dental service with a Referral Form for Dental Services under Medicare. This GP referral entitles eligible patients to receive up to $4,250 in Medicare benefits for dental services over two consecutive calendar years. (From the date of the patient’s first dental visit) The form can be downloaded from www.health.gov.au/dental
- Inform the patient that dental services may not be bulk billed and there may be an out-of-pocket expense not covered by Medicare

The dentist must:

- Provide a copy or summary of the patient’s treatment plan to the referring GP before beginning the course of treatment.
- Provide a written quote or cost estimate to the patient prior to commencing a course of treatment
- It is recommended before providing any services to the patient, the dental practitioner(or receptionist) phones Medicare Australia on 132 150 to check that the relevant GP care planning items have been claimed and paid for the patient-even where the patient has a referral form signed by their GP

Further information:

- The Medicare Benefits Schedule is available at www.health.gov.au/mbsonline
- GPs can call the Medicare Provider Enquiry Line on 132 150 for further information about the referral process and patient entitlements

Also guidelines and referral available on the TMML website: www.tmml.com.au
PERIDONTAL THERAPY

Hospitalisations And Medical Care Costs In Diabetics Reduced

During the 41st Annual Meeting & Exhibition of the American Association for Dental Research (AADR), held in conjunction with the 36th Annual Meeting of the Canadian Association for Dental Research, an abstract titled “Periodontal Therapy Reduces Hospitalisations and Medical Care Costs in Diabetics” to determine if periodontal treatment was associated with the number of hospitalisations and cost of medical care among diabetics with periodontal disease.

A longitudinal study compared medical costs for diabetic subjects with periodontal disease who received periodontal treatment versus periodontally untreated controls over a three year period. Subjects were enrolled in Highmark (Blue Cross) medical and United Concordia Companies, Inc. dental plans, and received medical and dental services. The periodontal treatment group was treated in the first year and maintained thereafter. The control group had received incomplete periodontal therapy prior to baseline and did not receive regular maintenance during the study.

“There have been emerging links between oral infections and systemic diseases such as diabetes, which is increasingly prevalent in our population,” said lead researcher Marjorie Jeffcoat, Professor and Dean Emeritus of the University of Pennsylvania School of Dental Medicine. “My research team and I had looked at other datasets and we knew that health care costs could be reduced, but we wanted to look at the hospitalisations and see how those could be reduced. This study provided direct insight as to how lower hospitalisations could be achieved through periodontal therapy, and we will further this study by analyzing other chronic diseases and conditions such as heart attacks, strokes and pregnancy with pre-term birth.”

Periodontal treatment was associated with a significant decrease in hospital admissions, physician visits and overall cost of medical care in diabetics. Savings averaged $1,814 per patient in a single year. A 33% decrease in hospital admissions was observed.

REFERENCES: Abstract #753 titled “Periodontal Therapy Reduces Hospitalisations and Medical Care Costs in Diabetics,” presented by M. Jeffcoat, J. Blum and F. Merkel during the 41st Annual Meeting of the American Association for Dental Research. This study was supported by United Concordia Companies, Inc. International & American Associations for Dental Research.
Townsville Hospital Emergency Doctors Peter Aitken and Brett Hoggard have been honoured by the city of Christchurch for their work during last year’s catastrophic earthquake.

Christchurch City Council has awarded a Christchurch Earthquake Award to the 24-strong Australian Medical Assistance Team Queensland (AusMAT-Qld) which was deployed in the early hours of February 22 last year to support medical efforts in the devastated city.

Dr Hoggard travelled to Christchurch to assist medical efforts on the ground while Dr Aitken acted as AusMAT liaison.

Queensland Health Director-General Dr Tony O’Connell said the team did a fantastic job in very trying circumstances.

“The work this team undertook in the face of very confronting scenes was remarkable,” he said.

“This award shows how much their help meant to their colleagues and the residents of Christchurch,” he said.

When the team arrived, only 30 per cent of the city’s medical services and pharmacies were functional and there were public health concerns about potential outbreaks of gastroenteritis and diarrhoea.

“These individuals were called upon with little warning,” he said.

“They gave up their time to help our neighbours who were in need,” Dr O’Connell said.

Dr Aitken has also recently returned from Japan, which suffered its own devastating earthquake and tsunami last year, where he delivered the keynote address at a disaster management conference.

Dr Aitken said his overriding message to the conference was ‘be prepared’.

“A response to any humanitarian emergency - be it a tsunami, cyclone or mass casualty event like a plane crash or train derailment - is being ready to respond,” he said.

“I talked about the importance of disaster management plans and of testing a response to a catastrophe.

“I also reminded delegates about personal preparedness.

“Emergency workers can’t focus on the job at hand if they’re worried about their families or homes.”
A specialist recently contacted Townsville-Mackay Medicare Local requesting that we open a discussion on the transfer of medical notes from a Specialist to a GP requesting notes on behalf of the patient. I was asked as Editor of Tropical Ear to seek opinions from the clinical readership and will give my personal view of this conundrum.

I must admit to occasionally requesting information from Specialists rather than treating GP’s, mainly for patients who have so many treating GP’s it is more useful to go straight to the source, or perhaps patients do not want their new doctor to know that they are still seeing me, as they may want to return to the original GP. You will agree this is an ethical minefield, but the patients well-being always comes first. And that is how I approach it.

This is essentially a consequence of the patient’s freedom to choose to have a doctor of choice and to move on to another for advice, or to fragment their care and/or to have a doctor for whatever particular part of their anatomy, physiology or psychology they feel that doctor is best suited, or with whom they are most comfortable.

To my knowledge a patient does not own their own notes. They do however possess the right to access a copy of their notes. They also possess the right to request that a copy of their notes be transferred to another doctor.

From my reading of the AMA and RACGP guidelines, there is a responsibility on the requested doctor to transfer the information, or a summary, subject to consent being given by the patient.

A cost may be borne by the patient by the transfer of files via fax or mail and I believe the patient may be billed for this by the transferring doctor.

The ethical problem of a GP requesting information from a specialist does not have a simple solution, and is not set in guidelines as is the legal issue I have quoted above.

I enclose links to further reading from the AMA and the RACGP on this issue, which also discusses on the RACGP link privacy and responsibility of practice staff in transferring data and billing information to insurers and others of that communion.

Dr Michael Murray - GP


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Jean Hailes for Women’s Health is a national not-for-profit organisation providing a range of important health services for Australian women. Governed by an independent Board of Directors, the organisation is comprised of Research, Education and Clinical Care.

Who was Jean Hailes?
Dr Jean Hailes was a renowned Australian general practitioner who dedicated her career to the health of women. The organisation was created in her memory and established in 1992.

How is Jean Hailes funded?
All funding is unrestricted and is obtained from government, philanthropic organisations, private individuals and commercial entities. Grants and donations are only accepted on the basis of full academic freedom.

Jean Hailes works extremely hard to make the most of every dollar received. If you would like to discuss a donation, bequest or grant, please call Janet Hailes Michelmore on 1800 JEAN HAILES (532 642) or visit our website at www.jeanhailes.org.au.

Specialist Women’s Health Clinic
The Jean Hailes Medical Centre for women is based in Clayton, Victoria. The team includes a range of practitioners with expertise in the following areas:

- preventative healthcare
- menopause management
- menstrual problems
- contraception
- pelvic floor physiotherapy - for incontinence, pelvic pain
- assessment and management of diabetes, gestational diabetes, cardiovascular risks
- polycystic ovary syndrome (PCOS) (including PCOS Service)
- management of osteoporosis/osteopaenia
- counselling - management of mood disorders such as anxiety and depression
- weight management
- nutrition/dietary advice
- complementary therapies including herbal therapies, naturopathy
- endometriosis
- Women’s health checks

Research
Recognised both nationally and internationally for innovative work in women’s health, Jean Hailes’ research focuses on areas that impact the quality of life as well as longevity for women, including:

- metabolic conditions such as
- cardiovascular disease
- insulin resistance
- diabetes
- polycystic ovary syndrome (PCOS)
- menopause (including menopause after breast cancer)
- anxiety and depression
- nutrition, physical activity and weight gain prevention
- reproductive mental health
- Indigenous women’s health

Education
Jean Hailes Education works alongside clinicians and researchers to translate the latest findings into user friendly, practical information and programs for both the community and health professionals. This includes:

- informative websites
- a range of resources including fact sheets and magazine
- professional development activities (Jean Hailes is an accredited provider for the RACGP QI&CPD program)

Browse their 8 websites for women’s health information:

www.jeanhailes.org.au
www.ageingwell.org.au
www.bonehealthforlife.org.au
www.earlymenopause.org.au
www.endometriosis.org.au
www.healthforwomen.org.au
www.managingmenopause.org.au
www.managingpcos.org.au
NOMINATIONS OPEN FOR RACGP AWARDS

The beauty of the awards lies in the fact that recipients are nominated by fellow members of the profession; although in certain categories, members of the community can also nominate their local GP or practice team,” Professor Stocks said.

Last year’s RACGP General Practitioner of the Year, Dr Jenny Wray of Narooma, New South Wales, said being announced the recipient of this highly prestigious College award was an unexpected honour and a proud achievement in her 34-year career working in general practice.

“I love being a GP. I love feeling connected to my practice team, our patients and the community. The RACGP awards are a wonderful opportunity to celebrate our great profession – a profession that has an enormous positive impact on the health and well-being of all people living in Australia,” Dr Wray said.

Nominations for the RACGP awards are open from April 10 – June 8 2012. 2012 RACGP Award categories

- General Practitioner of the Year Award
- General Practice of the Year Award
- General Practice Supervisor of the Year Award
- General Practice Registrar of the Year Award
- National Rural Faculty - Brian Williams Award
- National Faculty of Aboriginal and Torres Strait Islander Health - Standing Strong Together Award
- Rose-Hunt Award
- RACGP Life Fellowship
- RACGP Honorary Fellowship
- RACGP Honorary Membership

Further information and nomination forms are available at: www.racgp.org.au/awards.

The Royal Australian College of General Practitioners (RACGP) is proud to officially open the nomination period for the 2012 College awards, including GP supervisor, registrar and practice of the year. The awards recognise and celebrate outstanding contributions made by general practitioners (GPs) and general practice teams to the health and wellbeing of all Australians.

Award categories are designed to reflect a wide cross-section of exemplary work undertaken across a number of key facets within general practice, including:

- Excellence in local community service provision (both individual practitioner and whole-of-practice awards)
- Meritorious commitment to living and promoting RACGP values
- Training and mentoring roles
- Indigenous health promotion
- Supporting personal and professional welfare and wellbeing of rural doctors.

Professor Nigel Stocks, RACGP Chair of Council and Chair of the Awards Committee of Council, said the awards provided the opportunity to shine light on some of Australia’s true primary healthcare champions.

*With over 125 million general practice consultations taking place in Australia every year, GPs and their practice teams play an integral role in supporting individuals, families and their communities maintain their health.

*The RACGP awards are about recognising those working hard in our local communities to ensure the best possible health outcomes are achieved for individuals and their families.
My name is Maudesta Ahmat and I am employed by the Townsville-Mackay Medicare Local as an Administration/Support Officer in the New Direction Bubba’s Business Program.

I am a Torres Strait Islander and have a sound knowledge of our culture. Before coming to Townsville 13 years ago I worked as an administration/laboratory assistant in a mining town. After moving to Townsville I began working as a medical receptionist for Townsville Aboriginal Islander Health Services and then in Private Practice.

I now have the position of Support/Administration Assistant to the Coordinator of a new program, “New Direction, Bubba’s Business”. This is a new service for Aboriginal and Torres Strait Islander Women. The aim of the program is to provide a home visiting program for mothers and their babies that links them to their General Practice and other complementary programs and services.

This will ensure that the women and children will have access to excellent antenatal care during pregnancy and intensive follow up for their children. The aim is not to duplicate existing services, but to fill an existing void. The program will link services and develop pathways to support better outcomes for Indigenous families by supporting the mothers, babies and children.
In February 2012 Townsville-Mackay Medicare Local (TMML) became the service provider for the Refugee Health nurse in Townsville.

As the Refugee Health nurse I am responsible for initiating and completing the Health assessments for newly arrived refugees.

Health assessments are conducted in the general practice (in the past this has been done elsewhere) therefore encouraging a holistic approach to patient care.

The clients are able to familiarise themselves with the general practice environment, staff and processes. For example, knowing what to do when they arrive and leave an appointment, meeting practice staff, receptionists, doctors and the practice nurse who administers the immunisation catch-up schedule.

Some practices offer the convenience of on-site services such as a mental health nurse and pathology.

When consulting with the refugee client interpreting services are usually required. General practice can access this free service by:

- Registering for the Doctors Priority Line - visit the ‘Free services’ page from www.immi.gov.au/tis complete the form online or fax to 1300 654 151, you will receive a unique client code.
- Or register with Translating and Interpreting Service (TIS) when you make your first call on 131 450 – just allow a few extra minutes for processing initial practice details.
- You or your receptionist can pre-book telephone interpreting services when required, just quote your client code, you will generally be provided within three minutes for common community languages.

There are many organisations within our community that assist with the needs of the refugee client, TMML works closely with the Townsville Multicultural Support Group (TMSG). This organisation notifies TMML when a Refugee (Humanitarian Entrant) is due to arrive in the district and provides direct support to them for the first 6-12 months after settlement.

This support includes coordinating services, medical consultations, assisting clients to attend appointments at pathology, respiratory clinic, dental clinic and any follow up identified in the Health assessment.

Should you require further information please contact Julie Twomey Refugee Health Nurse TMML Phone 0438 105530 or 4421 7759
The Townsville-Mackay Medicare Local is an independent, not-for-profit organisation with its own board made up of community and health professionals with business and management expertise.

We have almost 100 staff made up of GPs, clinical staff, primary health care professionals and program managers.

We work in areas such as health system integration, mental health service delivery within the primary health care sector, Closing the Gap initiatives, after hours general practice services, quality improvement programs within general practices, and provide administrative support.

The Townsville–Mackay Medicare Local has responsibility for an area that covers Townsville and surrounds, west to Richmond, north to Cardwell and south past Mackay / Sarina to the central Queensland communities of Dysart and Clermont.

Our Vision - Leading strong, effective primary health care

Our Mission - Delivering local primary health care solutions through General Practice and other primary health care providers

Contact us if you’d like to know more.
Contact@tmml.com.au
Ph: 07 47258915

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