



NORTH EAST VICTORIAN DIVISION OF GENERAL PRACTICE

INSIGHT

CHAIRS REPORT

Hot off the press! The Commonwealth Government has finally made a decision about the establishment of the remaining Medicare Locals. In partnership with Albury Wodonga Regional GP network we have been asked to form the Hume ML from 1st July next year.

Under the circumstances this is probably the best outcome for us. The timing of this suits our plans as we hoped to combine the two Divisions into one organisation prior to transition to a Medicare Local. The Board believe that this is the best way to ensure a smooth transition for members and staff with continuity of the services currently delivered to practices.

So it will be a busy time ahead for the Boards and executive to ensure that everything is in place for the transition next year.

The Annual General Meeting at Lindenwarrah last week was a very pleasant evening. Thank you to those who attended and I hope everyone enjoyed the good meal, excellent company and very short speeches.

Dr. Wendy Connor

Chair - North East Victorian Division of General Practice

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2011 / 2012 BOARD OF DIRECTORS

The Division held a very successful and well attended Annual General Meeting on Thursday 27th October 2011.

As a result of the Special meeting of the Board after the AGM the Executive of the Board was appointed and consists of Dr. Wendy Connor – Chair, Dr Libby Garoni – Deputy Chair and Dr Paul Duff – Treasurer. Dr Greg Louis, Dr Pradeep Dissanayake and Dr. Doug Devereux were also elected to the Board.



From L to R: Dr. Doug Devereux, Dr Paul Duff, Dr. Brian Hollins, Dr Greg Louis, Dr. Olivia Stuart, Dr Libby Garoni, Dr. Matt Byrne, Dr. Wendy Connor & Dr Pradeep Dissanayake
Absent: Ms. Nikki Melville, Associate Director.



DISTRICT OF WORKFORCE SHORTAGE

There may recently have been some changes to your town in regard to it being an area of District Workforce Shortage (DWS).

A town's eligibility can change on any single day, without any correspondence or notification. For those of you in an area of DWS it is important that you regularly check and keep a copy of the last day you were declared a DWS, as you get a 3 month grace period from this date.

It may be appropriate to set a reminder to check this at least once a month.

This can be done by going to <http://www.doctorconnect.gov.au/> and just printing off the page that you were a DWS on that particular date, and of course keeping a record of these.

A DWS is an area of Australia in which the population's need for healthcare has not been met and DWS is a key mechanism that the Australian Government uses to achieve an equitable distribution of medical services across Australia.

International Medical Graduates (IMG) and Foreign Graduates of an Accredited Medical School (FGAMS) who are restricted by section 19AB of the *Health Insurance Act 1973* (the Act) are affected by DWS restrictions.

All IMGs or FGAMS who started working as a doctor in Australia after 1 November 1996 are subject to section 19AB of the Act.

Section 19AB of the Act restricts access to Medicare provider numbers and requires IMGs and FGAMS to work in a DWS in order to access Medicare benefits.

International Medical Graduates and FGAMS can apply for a Medicare provider number through Medicare Australia. Medicare Australia is responsible for applying for a section 19AB exemption on behalf of a doctor. DWS is determined by the Department of Health and Ageing (the Department) using both Australian Bureau of Statistics population data and Medicare Australia billing data.

In general, a location is deemed to be a DWS if it falls below the national average for the provision of medical services. Population needs for health care are deemed to be unmet if a district has less access to medical services than the national average.

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International Medical Graduates and FGAMS must work in a DWS for a period of 10 years. This is commonly referred to as 'the 10 year moratorium'.

An IMG or FGAMS 10 year moratorium begins when they gain their first medical registration in Australia.

If a doctor hasn't obtained Australian permanent residency or citizenship by the end of the 10-year moratorium, they'll still need a section 19AB exemption in order to continue to access Medicare benefits arrangements.

Towns in our area that are considered an area of District of Workforce Shortage

- | | |
|---|---|
| <ul style="list-style-type: none"> • Beechworth • Chiltern • Corowa • Tallangatta | <ul style="list-style-type: none"> • Wangaratta • Yackandandah • Yea |
|---|---|

What this means:

If a doctor is being recruited at the time the DWS is changed you apply for a Preliminary Assessment of a District of Workforce Shortage (PADWS) stating that the recruitment process for the doctor is ongoing and more time is needed to complete the full process to registration and provider number. It is suggested you enclose a copy of the DWS printout as proof stating the name of the doctor concerned. The PADWS then states the doctor's name so if you are unsure whether the recruitment will go ahead try for a non-specific one first.

You can't just apply for a generic PADWS – you must have grounds – please contact me on 0437 197 133 if you need help with this process.

Peter Wyman
Workforce Consultant

2011 DIVISION ANNUAL GENERAL MEETING

Photo Gallery



Dr Pradeep Dissanayake & Dr Tianming Wang



Dr. Libby Garoni



Dr. Doug Devereux



Dr Paul Duff, Dr Ross Jenner and
Dr Carolyn de Poi



Dr Richard de Crespigny, Dr Brian Hollins &
Dr John Lambert



Dr Matt Byrne

CALCIUM REQUIREMENTS

CALCIUM REQUIREMENTS

Less than 50% of the Australian population meet their daily requirements for calcium⁽¹⁾.
With the growing epidemic of osteoporosis and increased life expectancy this is a real cause for concern.

DAILY CALCIUM REQUIREMENTS:

Population	Age	Recommended Daily Intake (mg)
Children	1-3	500mg
	4-8	700mg
	9-13	1000-1300mg
	14-18	1300mg
Women Pregnancy / Lactation	19-50	1000mg
	51-70+	1300mg
	14-18	1300mg
	19+	1000mg
Men	19-70	1000mg
	70+	1300mg

CALCIUM SOURCES:



Low fat milk 250mL / calcium fortified soy milk	300-350mg
Low fat yoghurt 200mg	315mg
Calcium fortified soy yoghurt 175gm	215mg
Low fat cheese 40mg (2 slices)	325mg
Canned sardines 100gm	380mg
Canned salmon, red 100gm (including bones)	220mg
Calcium fortified breakfast cereal 1 cup	200mg
Calcium fortified orange juice ½ cup	80mg
Bread, 2 slices	200mg



To reach 1300mg/day 3-4 serves of calcium rich foods are recommended:

500mL milk = 700mg

200gm yoghurt = 315mg

2 slices cheese = 325mg

Note:

Calcium absorption can be inhibited by: excess caffeine, alcohol, carbonated beverages, high protein diets and high fibre diets for example vegetarian diets^(1,3).

Conditions which can also cause problems with calcium absorption include achlorhydria, long term glucocorticoid therapy and vitamin D deficiency⁽³⁾.

Absorption rate declines with age⁽¹⁾.

CALCIUM REQUIREMENTS CONT.

SUPPLEMENTS:

If requirements cannot be met with dietary sources, supplementation should be considered as it is generally safe and effective for most people.

Supplement	Ingredient	Elemental Calcium	Additional vitamins / minerals	Est. Cost
Calcia 1000mg 1 chewable tablet	2500mg calcium carbonate	1000mg	-	24c/ea \$7/30
Caltrate 1 tablet	1500mg calcium carbonate	600mg	-	7.5c/ea \$9/120
CalSource 1 effervescent tablet	2300mg calcium lactate gluconate 1800mg calcium carbonate	1000gm	-	60c/ea \$6/10
CalSup 1 chewable tablet	1250mg calcium carbonate	500mg	-	16c/ea \$10/60
Citracal 1 tablet	1190mg calcium citrate	250mg	-	8.5c/ea \$10/120
Bio Organics Calcium 600 + Vit D3 400 1 tablet	1500mg calcium carbonate	600mg	400IU vitamin D	9c/ea \$11/120
Blackmore's Cal-D 1 tablet	1500mg calcium carbonate	600mg	500IU vitamin D	16c/ea \$16/100
Caltrate Plus 1 tablet / 1 chewable tablet	Calcium carbonate	600mg	400IU vitamin D 50mg magnesium 7.5mg zinc 1mg copper 1.8mg manganese 20mcg vitamin K ₁	12c/ea \$24/200
Genovis Mega Calcium & D	Calcium carbonate	600mg	400IU vitamin D 4.9mg magnesium 1.6mg manganese 10mcg iron	9c/ea \$18/200
Herron Calcium Plus	1500mg calcium carbonate	600mg	200IU vitamin D 100mg magnesium oxide 13.2mg borax 250mcg folic acid	14c/ea \$7/50
Ostelin Vitamin D & Calcium 1 chewable tablet	1500mg calcium carbonate	600mg	500IU vitamin D	18c/ea \$11/60
Swisse Ultiboost calcium & vitamin D 1 tablet	1590mg calcium citrate	333mg	333IU vitamin D	21c/ea \$13/60

Continued Page 6

CALCIUM REQUIREMENTS CONT.

Note:

- Calcium carbonate = ~40% elemental calcium⁽³⁾.
- Calcium citrate = ~20% elemental calcium however due to solubility has 25% greater bioavailability⁽³⁾.
- Calcium citrate doesn't require an acid environment for absorption⁽³⁾.
- Calcium citrate may be preferred in patients who have a history of kidney stones because oxalate precipitation is inhibited by the presence of citrate⁽³⁾.
- Calcium supplements can inhibit absorption of other medicines⁽¹⁾, such as bisphosphonates and thyroxine so consider timing of supplements⁽³⁾. For example several hours apart.
- Tablets can be large, so for patients who find them difficult to swallow choose chewable varieties⁽¹⁾.
- Supplements can cause gastrointestinal upsets including bloating and constipation. Trialing an alternative supplement or reducing doses may alleviate these side effects^(1,3).
- Supplementation is contraindicated in hypocalcaemia or hypercalciuria and for patients receiving calcitriol therapy⁽³⁾.

References:

www.osteoporosis.org.au

NHMRC Nutrient Reference Values: www.nrv.gov.au/

Wark, J D. et al. Calcium supplementation: the bare bones. Australian Prescriber 2003;26:126-12

Prices from Chemist Warehouse - www.chemistwarehouse.com.au

*Jo Morshead
Clinical Dietitian*

PRACTICE NURSE NETWORK

The Division held a Practice Nurse network meeting on 27 October 2011 and some of the topics covered were:

Asthma Management**Presented by Maureen Klinberg, Albury Wodonga Health**

Maureen presented an extremely interesting session clarifying Asthma Management in General Practice. Maureen elaborated on what Asthma is, symptoms, diagnosis, and medication.

We received explanations and demonstrations on the use of devices and first aid and in addition to information on Action Plans some useful web sites and links.

Tackling the Challenges of CVD in General Practice**Presented by Tracey Dyt from The Heart Foundation**

Although mortality from heart disease has declined the prevalence of heart disease in our community has increased making the presentation of great interest to our nurses who work with this chronic condition. Guidelines for risk assessment, risk categories and the implications were expanded upon. A Motivational Interviewing and PD Kit were distributed to participants to compliment the Cardiovascular Care Resource Kit.

Useful links and resource sites were also passed on to participants.

Mental Health – Jenny Ahrens, Stefan Anderson, Natalie Orgias

The area of Mental Health is quite broad and therefore the presentation provided an overview of Integrated Primary Mental Health Services.

Jenny, Stefan and Natalie briefly outlined some mental health disorders, and information on what nurses can do if they come across a patient showing signs. Risk factors, assessment and warnings were clarified. Who/What is available in Mental Health in the area – Demonstration of the NO Wrong Door Website and referral pathways were all topics well explained to participants.

A very successful event with positive feedback from presenters and participants!

*Roslyn Makin
Business Development Team*

BUDGET CHANGES TO MENTAL HEALTH ITEMS

The changes to the MBS Mental Health Items for GPs announced in the Federal Budget came into effect 1 November 2011. They include:

- New time based Items for the development of a GP Mental Health Treatment Plan with an incentive for GPs who have completed Mental Health Skills Training
- Reduction in the schedule fees for a review of a GP Mental Health Treatment Plan
- Reduction in the schedule fee for GP Mental Health Consultation

The new items are detailed below:

Item Number	Item description	Time	Nov 11 Schedule Fee*	Nov 11 Rebate*
2700	Preparation of a GP Mental Health Treatment Plan by a GP who has not undertaken mental health skills training.	Must be at least 20 minutes but less than 40 minutes.	\$69.00	\$69.00
2701	Preparation of a GP Mental Health Treatment Plan by a GP who has not undertaken mental health skills training.	Must be at least 40 minutes in duration.	\$101.55	\$101.55
2712	Review of a GP Mental Health Treatment Plan or review of a psychiatrist's assessment and	Not timed.	\$69.00	\$51.75
2713	GP Mental Health Treatment Consultation	Must be at least 20 minutes in duration.	\$69.00	\$69.00
2715	Preparation of a GP Mental Health Treatment Plan by a GP who has undertaken mental health skills training.	Must be at least 20 minutes but less than 40 minutes.	\$87.60	\$87.60
2717	Preparation of a GP Mental Health Treatment Plan by a GP who has undertaken mental health skills training.	Must be at least 40 minutes in duration.	\$129.00	\$129.00

There is also a reduction in the number of sessions that will be available to patients from Better Access providers for focused psychological services. The number of sessions will be reduced from 12 per calendar year to 10 (6 sessions initially plus an additional 4 if required). No additional sessions in "exceptional circumstances" will be permitted. Patients will also be eligible for a total of 10 group sessions per calendar year in addition to their individual sessions.

More information is available from the fact sheets at <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-fact-gp>

Natalie Orgias

POST NATAL DEPRESSION



Post Natal Depression Awareness Week

13 – 19 November 2011

PND Awareness week is a National Campaign aimed at increasing community awareness of PND in both men and women and decreasing the stigma associated with PND. In 2007 in Victoria over 11,900 women were diagnosed with postnatal depression and over 7,000 men were diagnosed with postnatal depression. PND can have long term effects on the mother, her infant and children and on the couple and family relationships. A range of patient fact sheets on PND are available on the Post and Antenatal Depression Association Inc (PANDA) website panda.org.au.

TYPE 2 DIABETES

SELF MONITORING BLOOD GLUCOSE IN PEOPLE WITH TYPE 2 DIABETES

Entering into the debate as to the utility of self monitoring in people with type 2 diabetes, rarely evolves around the individual, rather, the pharmaceuticals they are taking.

Unequivocally, glycaemic management helps to reduce the development and progression of diabetes related complications. For many people this requires intensive treatment using insulin therapy and active self management. Insulin therapy is more commonly used in people with type 2 diabetes, once the active period of oral agents has expired, approximately 10-15 years.

The availability of low cost blood glucose meters improves the ability of people with diabetes to intensively monitor and allows the person to become actively involved in the management of their disease, leading to improved blood glucose levels, however, before self blood glucose monitoring be initiated, the person with diabetes needs to:

- understand the 'numbers' documenting and observing the patterns then
- know when and how to 'act' on the results.

A record diary meticulously completed with 3-4 results a day, can be misleading. The most recent which springs to mind, displayed regular hypos of 1-4 mmol/L mid afternoon. This pattern occurred over months... however the patient did not think to decrease his insulin, nor did he seek help from his GP. Another example, people on oral hypoglycaemic agents, present with fasting blood glucose readings between 10 – 15mmol/L, without connecting the need to increase activity levels, look for nocturnal hypoglycaemia and to make an appointment with their health care professional to discuss the elevated results.

The most interesting 'testers' are those who "check blood regularly" however don't write down the results - tests are 'kept' in the blood glucose meter and memory recall is unable to identify patterns in results, eating out, frequent hypos and useful feedback.

Self monitoring blood glucose (SMBG) levels can reinforce beneficial health behaviours and increase compliance with medication if understood. The immediate feedback provided by self monitoring helps to establish short term blood glucose patterns, as long as the patient has had appropriate education, to reap the self benefits by interpreting real time results, and acting on the patterns. Instead, patients wait for 'the Test' the three month average, at times are scolded by their GP, regardless of whether results may be skewed by infection or swinging from rebound hypos.

The positive benefits of SMBG are seen mostly where people with diabetes understand, interpret and troubleshoot the results, establishing a change of action to improve results. Self monitoring blood glucose in addition to awareness of hypo symptoms can influence day to day decisions regarding therapy, timing of GP reviews, appropriate insulin dose adjustment and management of hypoglycaemia and sick days.

Although HbA1c results are limited, if the patient is not prepared to check, write, interpret and act on blood glucose

TYPE 2 DIABETES

Exert from the ADEA Position Statement on the Use of Blood Glucose Meters

ADEA POSITION STATEMENT

Use of Blood Glucose Meters

The Australian Diabetes Educators Association (ADEA) promotes the reliable and accurate use of blood glucose meters within the health care setting and in diabetes self management.

ADEA recommends:

- **Blood glucose meters not be used as a method of screening for diabetes.**
- Testing at the point of care may be appropriate in defined circumstances, such as in remote indigenous communities where laboratory testing is unavailable and postponement of treatment would be potentially harmful for the individual. The meter used at the point of care must have a vigorous quality improvement program in use.
- Outside of the acute clinical setting, blood glucose meters only be used to **monitor blood glucose levels in people with a confirmed diagnosis of diabetes.**
- Appropriateness of self blood glucose monitoring be assessed on an individual basis, taking into consideration the person's disease and co-morbidity status, age, culture, dexterity and physical and intellectual capabilities, identified glycaemic targets, current medication regimen, potential confounders that may interfere with the accuracy of results obtained, and level of motivation.
- All people with diabetes using insulin therapy are encouraged to perform blood glucose monitoring.
- Individuals using blood glucose meters have access to a health professional deemed competent in the use of the meter.
- Further diabetes education is essential to ensure self management behaviors' are underpinned by a sound knowledge of how dietary intake, physical activity, medication, stress and illness all interact to affect blood glucose levels.
- Although some blood glucose meters allow the measurement of glucose levels from small samples of blood from the forearm and other sites, blood taken from the capillary bed of the fingertip is the preferred sample, particularly when blood glucose levels are changing rapidly.
- Health professionals only use blood glucose meters after successfully completing an education program that results in the attainment of competency in meter operation, control testing and problem solving.
- **Quality improvement practices are implemented within clinical settings** to ensure both blood glucose monitoring equipment and operators meet high standards of performance and process.
- All health services using blood glucose meters provide:
 - a well-defined policy and procedure
 - a training program for personnel performing the tests
 - quality improvement procedures
 - regular equipment maintenance
 - external auditing of meters
 - appropriate lancet devices that meet infection control considerations.
 - In certain clinical situations different strip technology may be more appropriate than others, such as in the care of patients using icodextrin dialysate solution, or patients receiving intravenous preparations containing maltose. In these situations it is essential to consult product information and/or the manufacturer of the glucose meter and test strip to ensure icodextrin and maltose do not interfere with blood glucose readings.
- Blood glucose measurement using portable blood glucose meters not be used in isolation when evaluating the glycaemic control of people with diabetes.

Janet Lagstrom

Credentialed Diabetes Educator



TELEHEALTH CHECKLIST

(To be used in conjunction with the RACGP guidelines)

This checklist has been developed based on the RACGP implementation guidelines for video consultations in general practice version 2.0 – October 2011. A copy of this can be sourced from www.racgp.org.au/telehealth.

The Business Development Team has developed this checklist v.2.

It is the responsibility of the practice to check the information before undertaking any actions.

*Page numbers refer to The RACGP implementation guidelines for video consultations in general practice version 2.0 – October 2011.

- Choose an appropriate video consultation technology option.**
*The options are; 1. Web based conferencing, 2. Computer based video conferencing, 3. Tablet video conferencing, 4. Desktop video conference appliance, 5. Video conference room appliance and 6. Immersive video conference solution. *For more details, go to page 16.*
- Check your Internet connectivity speed.**
*Your Internet upload and download minimum speed need to be approximately 384 kbit/s in each direction; this is generally required for standard definition connections. *For more details, go to page 13 and 14. To find out your Internet speed, go to www.speedtest.net and click on 'begin test'.*
- Check the technology option of the healthcare provider/s at the other end.**
The success of video consultations also depends on the user at the other end. It is therefore important to ensure the other provider (e.g.; specialists) has an efficient interoperable system that satisfies the technical and security requirements.
- Check 'the security and privacy requirements' and 'the quality of the audio and video' for transmission.**
*The data transmission for video consultation should be encrypted. The security system should also satisfy availability, integrity and confidentiality of information. *For more details, go to page 11 and 12. The audio should be encoded at a minimum of 16 kbit/s and the video frame rate 30 frames per second; the round-trip latency should be less than 300 ms. *For more details go to page 17.*
- Check your system and software requirements for the option.**
*It is also important to make sure your system and software requirements meet the current needs of the option that you have chosen. *For more details, go to page 19 and 20.*
- Plan the real environment for the option.**
*You have to understand the real environment of this new technology and plan the set up of all details including the network wiring, organisation policies and any other physical requirements needed. *For more details, go to page 8, 9, 19 and 21.*
- Check all possible costs related to the option.**
Once you decide all of the above, it is important to know the cost. You need to identify all possible costs related to the option including new equipment, change management, ongoing support and maintenance, training/education, technical support, further IT support, etc and make sure the practice can manage the overall cost.

Vimal Pasupathy
eHealth Coordinator



NATIONAL PRESCRIBING SERVICE



North East Victorian Division of General Practice, in partnership with NPS – Better choices, Better health is offering the following educational programs on best practice for:

- Cardiovascular Disease Risk – Guiding Lipid Management
- Balancing benefits and harms of Antipsychotic Therapy

These programs provide 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.

Participation in the program will include:

Cardiovascular Disease Risk – Guiding Lipid Management

- The importance of early assessment of absolute cardiovascular risk
- Discussing cardiovascular risk with patients to encourage lifestyle changes
- Factors to consider when prescribing statins, including dose, based on recent trial evidence
- The place of ezetimibe in lipid modifying therapy
- Tips to encourage long term adherence to lifestyle and lipid modifying therapy

Balancing benefits and harms of Antipsychotic Therapy

- 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 you?

- 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

Holli Davis

Business Development Team

PRACTICE IT AUDITS

The Business Development Team (BDT) is available to conduct an IT Audit for your Practice if you have not yet been included in this activity. This is a free service from the Division and the report that is developed following the audit will be relevant for your Practice's accreditation.

An IT Audit includes investigation of your Practices: hardware, software, network, internet and email, information security, anti-virus, back-ups, contingency plan and disaster management, power back-ups and change management areas and provides possible recommendations in all of these areas.

If you would like to have an IT Audit completed for your practice please contact Vimal on (03) 5762 2444 or email: vimal@nevicdgp.org.au.

BOARD OF DIRECTORS

Chair:	Dr Wendy Connor	(03) 5728 1566
Deputy Chair:	Dr Libby Garoni	(03) 5754 3400
Treasurer:	Dr Paul Duff	(03) 5750 1000

BOARD MEMBERS

Dr Matt Byrne	(03) 5721 2176
Dr Brian Hollins	(03) 5762 1022
Dr Olivia Stuart	(03) 5750 1000
Dr Greg Louis	(03) 5772 1444
Dr Pradeep Dissanyake	(03) 5722 1500
Dr. Doug Devereux	(03) 5750 1000
Ms Nicki Melville	(02) 6021 1739

MOUNT BEAUTY OFFICE

P.O. Box 500 Mount Beauty Vic 3699

Phone: (03) 5754 1226

Fax: (03) 5754 1225

Chief Executive Officer	David Dart
Finance Officer	Carol Dale
Personal / Administration Assistant & Web Site Manager	Heather Stones
Clinical Risk Manager	Mandy Ditcham

BENALLA OFFICE

P.O. Box 666, Benalla Vic 3672

Phone: (03) 5762 2444

Fax: (03) 5762 8444

Mental Health Program Manager	Natalie Orgias
Administration Assistant	Helen Mansfield
Youth Health Manager	Anne Shaw
Clinical Dietitian	Jo Morshead
Credentialed Diabetes Educator	Janet Lagstrom

Business Development Team (BDT)

Education & Immunisation Coordinator	Holli Davis
e-health Coordinator	Vimal Pasupathy
Practice Management, Practice Nurse & Chronic Disease Coordinator	Rosslyn Makin

WALWA OFFICE

Walwa Bush Nursing Centre Main St, Walwa Vic 3709

Phone: (02) 6037 1405

Fax: (02) 6037 1480

Allied Health & Aged Care Manager, Quality Coordinator & BDT Team Leader	Sandra Beirs
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OFF SITE

Medical Workforce Officer	Peter Wyman
Phone:	0437 197 133

THE NEW ROYAL CHILDREN'S HOSPITAL

Her Majesty, the Queen, officially opened the new Royal Children's Hospital on Wednesday 26 October although the new hospital does not officially open for service to the public until Wednesday 30 November.

The new hospital has been built right next door to the current hospital on Flemington Road in Parkville and will provide wonderful world-class facilities for patients, families and staff.

Highlights of the new RCH

- Two-storey coral reef aquarium
- Beanbag movie theatre
- 85 per cent single inpatient rooms
- A central outpatient area, with all services in the one spot
- Bigger and better Family Resource Centre
- Lots of natural light
- Parkland surroundings, allowing easy access to Royal Park, gardens and court yards
- Parkland views from 80 per cent of inpatient rooms

For more information regarding the Royal Children's Hospital please visit: www.rch.org.au

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Complaints Mechanism NEVICDGP

If General Practitioners, Practice Staff, Members of the Public wish to view the policies regarding complaint/ grievance process or they wish to lodge a complaint against the North East Victorian Division of General Practice, please contact the Executive Officer, David Dart on 03 5754 1226. They may also contact the Office of the Health Services Commissioner on 1800 136 066

Privacy Policy

If General Practitioners, Practice Staff, Members of the Public wish to view the privacy policy of the North East Victorian Division of General Practice, please contact the Executive Officer, David Dart on 03 5754 1226. They may also contact the Office of the Federal Privacy Commissioner on 1800 136 066