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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Contents

A MedicineInsight pharmaco-epidemiological study of osteoporosis medicines

Chidwick K, Naikpanvelkar P[1], Norman S[1], Weston C[1], Elgebaly Z[1], Pollack A[1], Elliott J[1], Thistlethwaite J[1], Seibel M[2]

[1]NPS MedicineWise, [2]University of Sydney, Concord Repatriation General Hospital

Background:

Osteoporosis remains under-diagnosed and under-treated**.** Less than 20% of patients presenting with minimal trauma fractures to hospitals or general practices are investigated or treated for osteoporosis.

Aims:

To estimate the prevalence of a recorded diagnosis of osteoporosis in Australian general practice and identify prescribing patterns for osteoporosis medicines, including cessation and switching of treatment modalities.

Method:

A longitudinal retrospective cohort study over the period 2012-2017, utilising data from MedicineInsight, a national program that extracts longitudinal, de-identified patient data from clinical information systems of participating general practices.

Results:

The estimated prevalence of a recorded diagnosis of osteoporosis in patients aged over 50 years (N = 203,201) was 12.4%. Almost a quarter of patients had no record of a prescription for osteoporosis medicines, even though they had a recorded diagnosis of osteoporosis. Denosumab prescriptions increased incrementally over the study period. Over 40% of patients who ceased bisphosphonates had no subsequent record of prescription for denosumab. Over 80% of patients who ceased denosumab had no subsequent prescription for a bisphosphonate.

Discussion:

The study confirms substantial under-diagnosis of osteoporosis within Australian general practice. A substantial proportion of patients with a confirmed diagnosis of osteoporosis do not receive treatment. The lack of substitution with another osteoporosis medicine in the majority of patients who have ceased denosumab is of concern, as this may expose patients to the risk of rapid bone loss.

Conclusion:

The study highlights a gap in management of osteoporosis in general practice and illustrates the need for clinical education addressing best practice for the management of osteoporosis.

A registrar perspective on Indigenous health education

Vass A1

[1]*Monash University*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

This presentation will explore the general practice trainee experience of learning Indigenous health. As non-Indigenous practitioners, it is essential to use a self-reflective lens, and this includes critically examining our approach to teaching and learning. When Aboriginal and Torres Strait Islander patients continue to report experiences of racism in health care,[2,3] including general practice[4], it becomes necessary to ask, why?

Aboriginal and Torres Strait Islander leaders have been calling for some years now for more culturally safe health care. In response, some effort has been made towards improving Indigenous health education from undergraduate programs through vocational training to post-Fellowship professional development. Yet despite the presence of guidelines and frameworks, including a detailed unit within the RACGP curriculum, it is evident that there is still considerable work to be done.[1,5,6,7,8]

In this presentation, the presenter will weave key findings from the literature, with insights garnered from critical reflection of her own varied experiences of teaching and learning in Indigenous health. She will share stories of her own process of learning and 'un-learning'. She will unpack her experiences of witnessing and responding to racism in health care contexts, and explore the impact of privilege in the therapeutic relationship. She will contemplate the ways in which learning about culture, communication, and the colonial determinants of health, can transform consultation skills. Using story to bring the evidence to life, she aims to add to the discourse on Indigenous health education and inspire GP educators and supervisors to embed more effective approaches.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

GPs play a central role as educators and supervisors in training the next generation of Fellows. Whilst few studies have focussed explicitly on GP educators or supervisors[8], it would appear that some may feel uncertain how to incorporate teaching on Indigenous health, lack confidence to respond to inappropriate comments such as stereotyping made by registrars, or feel they are unqualified (if they are non-Indigenous) to teach this subject matter (or, at worst, perhaps question its necessity). As the responsibility for general practice training returns to the RACGP, it is timely to stop and review how we can best implement effective Indigenous health teaching for upcoming registrars.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

This presentation is best suited to a 30 minute oral presentation, or alternatively a WISE or TedTalk style approach. The presentation will provide an engaging mix of personal stories gathered from the presenters' time spent in urban, rural and remote Aboriginal communities and using, for example, content such as short videos of cultural events she was invited to participate in. If the longer oral presentation is allowed, opportunity will be made for the audience to participate in brief experiential learning activities which the presenter has previously delivered in cultural safety workshops and which will highlight some of the key approaches to embedding effective learning in this space.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

The presenter is currently undertaking a RACGP Academic Post at Monash University, during which she is the chief investigator on the research project titled 'A qualitative study exploring educator perceptions on teaching racism, privilege and cultural self-reflexivity within a general practice teaching program'. As part of this research, she is completing a broad literature review on the current status of Indigenous health and cultural capability education within general practice contexts. The content of the proposed presentation will be grounded in the evidence from this literature review.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

Indigenous health remains an emerging curriculum in medical education[7], including in general practice, and in particular in regards to racism and cultural self-reflexivity[8]. As more comprehensive curricula have begun to be implemented, there has been increasing awareness of the limitations and challenges of teaching this content. What is clear from the literature, is that registrars continue to feel under-prepared for work with Aboriginal and Torres Strait Islander patients and communities[8]. This presentation will provide a timely perspective on the current opportunities for improvement in Indigenous health education in general practice contexts.

References: *(If applicable)*

1. Francis-Cracknell A, Murray M, Palermo C, et al. Indigenous Health Curriculum and Health Professional Learners: A Systematic Review. Med Teach 2018:1-7
2. Jennings W, Bond C, Hill PS. The power of talk and power in talk: a systematic review of Indigenous narratives of culturally safe healthcare communication. Aust J Prim Health 2018;24(2):109-15
3. Kelaher, M, Ferdinand, A & Paradies, Y 2014, 'Experiencing racism in health care: The mental health impacts for Victorian Aboriginal communities', *Medical Journal of Australia,* vol. 201, no. 1, pp. 44–7.
4. Latimore, J. Racism from nurses and GPs hindering treatment, VACCHO says. NITV News. Published 12/11/2018. https://www.sbs.com.au/nitv/nitv-news/article/2018/11/12/racism-nurses-and-gps-hindering-treatment-vaccho-says [accessed 29/04/2019]
5. Lie DA, Lee-Rey E, Gomez A, et al. Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. J Gen Intern Med 2011;26(3):317-25
6. Mills K, Creedy DK, West R. Experiences and outcomes of health professional students undertaking education on Indigenous health: A systematic integrative literature review. Nurse Educ Today 2018;69:149- 58
7. Pitama SG, Palmer SC, Huria T, et al. Implementation and impact of indigenous health curricula: a systematic review. Med Educ 2018
8. Watt K, Abbott P, Reath J. Developing cultural competence in general practitioners: an integrative review of the literature. BMC family practice 2016;17(1):158-58

Advance care planning in general practice

Alam A1

[1]*Monash University Department of General Practice*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

Advance care planning is accepted as an important aspect of medical care planning, but how do we go about it in practice? This poster will provide a practical approach to support GPs in guiding these conversations.

Advance care planning is a process by which a person, their family members and healthcare providers discuss and prepare for future medical care. While the need for enhancing advance care planning is well recognised, there is not much guidance for clinicians on how to put this into practice. Advance Care Planning Australia (ACPA) is the national authority on advance care planning and is funded by the Commonwealth government. ACPA has developed several resources for the general population and practitioners that can assist in this process. In collaboration with ACPA, the presenter has integrated some of ACPA's resources with the 5As model that is well-known to GPs: Ask→Assess→Advise/Agree→Assist→Arrange.

The poster will highlight the 5 steps of the model innovatively applied to advance care planning:

Ask – Consider asking any patient about advance care planning, but especially those who have an advanced chronic or life limiting illness, is at risk of losing competence, has a significant new diagnosis, or is being reviewed after a recent hospital discharge for any significant illness.

Assess – "I try talking to all my patients about what they would want if they became more unwell. Have you ever thought about this?"

Advise/Agree – "Who would you like me to talk to if you were unable to talk to me about important medical treatment decisions?"

Assist – "What does it mean to you to 'live well'? What are your goals at this time?"

Arrange – The patient can be referred to ACPA's website or free National Advisory Service at 1300 208 582 for further information. You can also arrange a follow up appointment to talk further with them once they have had time to obtain further information and have discussions with family.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

RACGP has been calling for advance care planning to be incorporated into routine care since 2012 [1] and general practitioners are ideally placed to initiate advance care planning [2]. The nature of the long-standing relationship between GPs and their patients, as well as better continuity of care compared to acute settings, is part of what makes general practice the best location within the healthcare system for advance care planning.

Despite this, only 3.2% of Australian adults above the age of 65 in Australian general practice had a completed advance care directive [3]. Economic modelling studies within Australia have shown that a nationwide advance care planning program in the primary care setting would be cost effective compared to usual care [4]. The savings would be generated from providing care that is consistent with patient preferences, resulting in fewer hospitalisations and less-intensive care at end-of-life. Therefore, advance care planning in the clinical setting of general practice will not only improve outcomes for individual patients and their family members, but will also have an impact on the health care system.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

The original submission was not accepted for an oral presentation. A poster will be presented in its lieu. The aim to provide an informative and visually appealing poster.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

The poster is a forum for providing educational content that GPs may find helpful. The 5As model has been widely applied in general practice. The content specific to advance are planning was developed by ACPA.

The presenter is currently a 2019 RACGP academic registrar based at Monash University's Department of General Practice. His project will investigate the barriers and enablers of advance care planning among patients with dementia in Australian general practice.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

Yes, it provides an innovative approach to enhancing advance care planning in general practice. To the best of the presenter's knowledge, this is the first time the 5As model has been applied in this context.

References:

1. Royal Australian College of General Practitioners. Position Statement: Advance care planning should be incorporated into routine general practice. RACGP website. (Accessed Apr 28 2019). Available from: https://www.racgp.org.au/download/documents/Policies/Clinical/advancedcareplanning_positionstatement.pdf
2. Tran, M., Grant, M., Clayton, J., Rhee, J.. Advance care decision making and planning. Aust Journ Gen Prac 47, no. 11 (Nov 2018). https://doi.org/10.31128/AJGP-06-18-4613.
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4. Nguyen, K. H., M. Sellars, M. Agar, S. Kurrle, A. Kelly, and T. Comans. An Economic Model of Advance Care Planning in Australia: A Cost-Effective Way to Respect Patient Choice. BMC Health Serv Res 17, no. 1 (Dec 1 2017): 797. http://dx.doi.org/10.1186/s12913-017-2748-4.

After-hours: Supporting patient continuity and access

Smorgon S[1]

[1]*Royal Australian College of General Practitioners,* [2]*Charlestown Medical and Dental Centre*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

After-hours and medical deputising services provide patient care when general practices are not providing patient services, and operate outside of normal opening hours, known as the 'after-hours period'. These services provide patients with access to medical care for conditions that are not life-threatening, but require urgent medical attention in the after-hours. Medical deputising and after-hours services do not undertake routine care of patients, as these services are provided during normal opening hours by the patient's regular GP or practice.

The RACGP *Standards for after-hours and medical deputising services* (5th edition) (AHS&MDS Standards) covers quality and safety standards that are unique to services providing care in the after-hours period.

Patients receiving urgent care in the after-hours should receive the same quality of care as during normal hours from their regular GP. In addition, the patient's regular GP should expect prompt next-day feedback, to enable follow up (where required) and comprehensive care.

To ensure continuity of care, it is important for general practices to put a formal agreement in place with the medical deputising or after-hours services they are using to provide after-hours care for their patients.

The AHS&MDS Standards state that for after-hours services it is desirable for after-hours services to have a formal agreement in place with general practices. However, for the medical deputising services it is a **mandatory** requirement for a formal agreement to be in place.

Formal agreement between services and practices:

- strengthen the networks between services and daytime practices in local areas
- ensure that patients can access care 24 hours a day
- help maintain continuity of care for patients.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

As part of providing access to comprehensive care, general practices require the ability to provide care after-hours to their patients. This may mean the general practice has to engage an after-hours service or medical deputising service to provide the care outside of normal opening hours, on their behalf.

The *Standards for general practices* (5th edition) states:

Indicator GP1.2 ►A Our patients can access home and other visits when safe and reasonable.

Indicator GP1.3 ►B Our patients can access after-hours care.

In these situations, there must be a direct and continuing relationship between the practice's GPs and the nominated after-hours service that performs the after-hours care, home or other visits on their behalf.

This could be done by having:

- formal agreements in place with other providers, such as a medical deputising service, to deliver after-hours care
- an agreement with local healthcare providers that operate outside of your normal opening hours.

If your practice uses other services to provide care, you must agree on and document:

- details of the arrangements
- how and when you receive documentation and information about care provided to your
- patients outside of normal opening hours
- how the providers of after-hours care can contact the practice in an emergency or under
- exceptional circumstances,
- and arrangements to exchange clinical details about the patient's care and any concerns the general practice may have about the visiting clinician's safety.

The RACGP recommends that general practices seek to engage with an after-hours service or medical deputising service that is accredited against the AHS&MDS Standards.

In conjunction with the release of the AHS&MDS Standards the RACGP also provide a support tool for general practice to help establish an agreement with an after-hours service.

This resource, *Supporting continuity and access: A guide to establishing an agreement between your general practice and an after-hours service provider*, also includes an agreement template for the general practice.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

On the positive acceptance of this abstract to facilitate a session, and the format and duration determined as most appropriate for this topic by the selection committee, one or more of the following tools and techniques will be utilised to engage and interact with the audience:

- utilising open questions
- polling the audience on the day to determine their level of understanding of the subject matter
- where possible, provide the ability for delegates to submit scenarios or questions to be discussed
- source multimedia, where appropriate, to support the aims of the session
- provide access to the resources that support the implementation and message of the session.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

The AHS&MDS Standards are based on the best available evidence of how services can provide safe and quality healthcare to their patients.

This evidence is based on two sources:

- relevant studies
- Level IV evidence (where studies are not available). Level IV evidence is also known as evidence from a panel of experts. To ensure that this Level IV evidence is as robust as possible, the AHS&MDS Standards have been tested by Australian after-hours and medical deputising services and consumers, overseen by an expert committee consisting of GPs, academic GPs and nurses, practice managers, and consumer representatives.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

The Indicators in the new suite of RACGP Standards have, where appropriate, been written with a focus on outcomes and patients, instead of prescribed processes. By focusing on outcomes, health services can develop systems and processes that reflect their preferred ways of working and choose how to demonstrate that they meet the intent of each Indicator. Evidence must be provided to show they meet the Indicator, either through inspection or interview. Focusing on outcomes will gives greater ownership of practices and systems, making team members more likely to follow them not only during accreditation, but also before and after.

References:

1. RACGP Standards for after-hours and medical deputising services (5th edition) www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20standards/Standards-for-after-hours-and-medical-deputising-services.pdf
2. Standards for general practices (5th edition) https://www.racgp.org.au/running-a-practice/practice-standards/standards-5th-edition/standards-for-general-practices-5th-ed
3. RACGP Supporting continuity and access: A guide to establishing an agreement between your general practice and an after-hours service provider www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20resources/Supporting-continuity-and-access.pdf

Antibiotic stewardship in skin infections

Gorges H[1], **Clare H[1]**, Van Driel M[2], Tapley A[3], Davis J[4], Davey A[3], Holliday E[5], Ball J[6], Najib N[3], Spike N[7], Fitzgerald K[8], Magin P[5]

[1]James Cook University, College of Medicine and Dentistry , [2]University of Queensland, Faculty of Medicine , [3]GP Synergy , [4]Menzies School of Health Research , [5]School of Medicine and Public Health, University of Newcastle, [6]Hunter Medical Research Institute, [7]Department of General Practice, University of Melbourne, [8]GP Training Tasmania

Background:

Impetigo is a highly contagious superficial skin infection caused by *Streptococcus pyogenes* or *Staphylococcus aureus*, most commonly affecting children aged 0-9 years. Current guidelines recommend antibiotic treatment for all cases of impetigo, with severity guiding the decision between topical or oral therapy. Antimicrobial resistance is a serious global threat to public health and antibiotic misuse in treating impetigo may accelerate the emergence of resistant organisms. GP registrars are of particular interest, as antibiotic prescribing habits established early in practice may be long-lasting.

Aims:

To establish the prevalence of systemic antibiotic prescription for impetigo by general practice (GP) registrars.

Method:

A cross-sectional analysis of data from the Registrar Clinical Encounters in Training (ReCEnT) study.

Results:

*1*741 registrars (response rate 96%) provided data from 246,434 consultations. 683 patients presented with a new diagnosis of impetigo. 38/683 (5.6%) were not prescribed antibiotics; 239/683 (35.0%) were prescribed solely topical antibiotics; 306/683 (44.8%) solely systemic antibiotics and 100/683 (14.6%) both systemic and topical antibiotics. The most common systemic antibiotic prescribed was cephalexin (53.5%).

Discussion:

GP registrars largely managed impetigo according to current Australian guidelines. However, they prescribed systemic antibiotics for a high proportion of initial impetigo presentations, and the majority of these were broad spectrum.

Conclusion:

GP registrar management of impetigo may be a source of antibiotic misuse. To avoid this, guidelines should clearly specify criteria for systemic antibiotic prescription and individual antibiotic choice. The role of non-antibiotic management and topical antiseptics needs to be explored further.

Antimicrobial stewardship components in GP: scoping review

Hawes L[1,2], Buising K[2,3], Mazza D[1,2]

[1]Department of General Practice, Monash University, [2]National Centre for Antimicrobial Stewardship, [3]Victorian Infectious Diseases Service

Background:

Antimicrobial stewardship (AMS) is required to combat the many factors that lead to the development of antimicrobial resistance (AMR). Several factors contribute to poor antibiotic prescribing in general practice, however there is no current framework to support AMS initiatives in general practice.

Aim:

To identify the core components of a potential AMS framework for general practice.

Method:

A scoping review of six medical databases and eight international websites for frameworks applicable to AMS in general practice.

Results:

16 papers met the inclusion criteria. Six multidimensional components were identified as necessary for AMS in general practice: 1. Governance, including creation of a national action plan, prescriber accreditation, and practice level policy and procedures. 2. Education of GPs and the public about AMS and AMR. 3. Consultation support including patient information and shared decision-making tools, antibiotic guidelines and microbiology testing. 4. Allied health involvement – Pharmacy, including antibiotic unit dispensing, review and advice to customers; practice nurse - patient triage and education. 5. Monitoring of prescribing and AMR with feedback to GPs. 6. Research into gaps in AMS, and translation of evidence.

Discussion:

This review summarises core components for AMS in general practice. It requires input from key stakeholders to assess validity and implementability.

Conclusion:

This review highlights a potential framework for AMS in general practice which if instituted may better support GPs to safely improve the quality of antibiotic prescribing.

Barriers faced by GPs in Aboriginal health

Barrett A[1,2], Benson J[1,2], Stocks N[1], Elliott T[2]

[1]University Of Adelaide, [2]GPEx

Aim and intended outcome/education objectives:

There is a need for GPs in Aboriginal Health Services (AHSs) to help reduce the health disparities between Indigenous and non-Indigenous Australians. Providing GP registrars with positive experiences in AHSs may increase the number of GPs working in these services. Part one of this project explored enablers and barriers to working in an AHS by interviewing GPs who still work in these services. Barriers included cultural differences and lack of resources amongst others. However, many graduates who have completed an AHS placement do not choose to work in an AHS post-graduation. The aim of this project is to identify barriers faced, which influence GP graduates' decision not to work in an AHS after Fellowship.

Results:

Semi-structured interviews were completed with Australian General Practice Training Program graduates from South Australia. All graduates completed an AHS placement during registrar training but were not currently working in this field. An inductive thematic analysis will be completed, and the themes emerging will be presented and discussed.

Conclusions:

Results from this study will provide Regional Training Organisations information which may assist to improve support during AHS training placements. Improving registrars' experiences in AHSs may increase the number of GPs in these services, thereby reducing the health inequity between Indigenous and non-Indigenous Australians.

Content:

This poster will contain information on the background, research aims, method, results and discussion/conclusion.

BENzodiazepines: Enhancing compliance for reduced-prescribing in training

Patsan I[1,2], Patsan I[1,2], Tapley A[1,2], van Driel M[3], Davey A[1,2], Bonevski B[2], Holliday E[2], Quain D[2], Holliday S[2,4]

[1]GP Synergy, Regional Training Organisation, NSW & ACT Research and Evaluation Unit, [2]University of Newcastle, School of Medicine and Public Health, [3]University of Queensland, Discipline of General Practice, [4]Albert St Medical Centre

Background:

Decreasing benzodiazepine prescribing and utilising non-pharmacological anxiety/insomnia management is recommended. However, an evidence-practice gap exists in GP registrars' benzodiazepine prescribing.

Aims:

To assess the impact of an educational intervention on GP registrars' benzodiazepine prescribing.

Method:

A pragmatic non-randomised, non-equivalent control group design nested within the ReCEnT cohort study of GP registrars' practice.

The educational intervention, delivered to one of three ReCEnT-participating Regional Training Organisations (RTOs), included a face-to-face registrar session, pre- and post-session readings/resources, supervisor webinar, and optional registrar-supervisor dyad case-based discussions. The intervention stressed non-pharmacological anxiety/insomnia management. The other two (control) RTOs didn't deliver the intervention.

The primary outcome was frequency of benzodiazepine prescription in patients 16-years-and-over and the secondary outcome was initiation of benzodiazepines, both on 'intention-to-treat' (i.e. 'intention-to-educate') analysis. An intervention-control/pre-post interaction term in a multivariable logistic regression was used to assess intervention efficacy.

As well as the intention-to-treat analysis, we conducted an 'on-treatment' analysis including only those intervention RTO registrars who attended the face-to-face education session.

Results:

We didn't find a statistically significant decrease in benzodiazepine prescribing pre-to-post-intervention for intervention versus control group registrars (interaction term OR:0.92; 95%CIs:0.70,1.20) or for initiation of benzodiazepines (interaction term OR:0.88; 95% CIs:0.58,1.35).

Similarly, the 'on-treatment' analysis showed no statistically significant prescribing reduction (OR:0.87: 95%CIs: 0.65,1.16)

Discussion:

We didn't find statistically significant reductions in benzodiazepine prescribing following an educational intervention.

Conclusion:

Further analysis including 2019-20 ReCEnT data is indicated - to allow further bedding-down of intervention elements in the training program and in functioning of the registrar-supervisor dyad.

Breast implant-associated lymphoma

Collett D[1,2]

[1]Market Street Medical Practice, [2]Macquarie University

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

The poster will provide an informative educational update to GP's outlining the disease profile of Breast Implant Associated-Anaplastic Large Cell Lymphoma (BIA-ALCL). BIA-ALCL is a rapidly emerging disease entity, uniquely iatrogenic in nature with indisputable evidence to its direct association with breast implants. Unfortunately, based on our latest research, the incidence and prevalence of BIA-ALCL appears to be on an exponential rise, and is likely to result in significant morbidity and mortality to the population of younger women undergoing cosmetic surgery. Hence it is critical that GP's are aware of the condition and up to date with the disease profile, its presentation, investigations and management approach. With increasing awareness of the disease amongst the general population and with the current boom in cosmetic surgery, accurate advice, follow up and investigations are of the utmost importance at the primary care level.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

BIA-ALCL is a novel emerging disease entity, only recently being recognised as a specific subtype of Lymphoma by the World Health Organisation (WHO), hence in women presenting with early symptoms of the disease it is generally not considered, not recognised and inappropriately managed. Unfortunately, in a number of cases within Australia this has resulted in a significant delay in diagnosis leading to a number of deaths from the disease. Our current research demonstrates a dramatic rise in the incidence and risk of BIA-ALCL especially in light of the current unregulated boom in the cosmetic industry. Women are not appropriately followed up by their surgeons and will often seek advice and help at the primary care level, hence it is imperative that as general practitioners we are aware of this emerging disease entity and feel informed, competent and equipped in managing women where such a diagnosis is considered. As this subtype of lymphoma becomes more apparent primary care physicians will play a critical role in the screening, detection and early management of this disease. In essence the proposed poster will provide a clear outline of BIA-ALCL, its clinical picture, appropriate investigations and a management guideline/ algorithm – to support general practitioners in this role.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

The poster will clearly inform and educate delegates of GP19 with the aid of professional infographics and imagery to depict the disease entity, its prevalence/risk, clinical picture and management guidelines. Information provided on the poster will be clear, precise, and most importantly accurate (based on the current best available evidence). I will be working closely with Ayeesha McComb (scientific illustrator), to enhance the poster with excellent visual representation and to design a clear management guideline/flow chart. References and details of further resources will also be included to provide accurately sourced information and a guide to further reading/information.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

The information provided on the poster will all be supported by the current best available evidence with clear and accurate referencing, with much of the data and information being drawn from the recent BIA-ALCL supplement in PRS journal. I will be utilising my recent research depicting the global epidemiological profile and risk estimates of BIA-ALCL which has recently been published as the cover article in a highly regarded peer reviewed journal (PRS). The data provided in the poster will further be confirmed by Professor Anand Deva who is one of the leading global experts on BIA-ALCL.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

Yes, the poster will showcase a novel emerging disease entity, its clinical picture, etiology, risk profile, detection and management approach.

References: *(If applicable)*

Collett D, Rakhorst H, Lennox P, et al. Current risk estimate of BIA-ALCL in textured breast implants. *Plast Reconstr Surg*. 2019;143(3s):30-40.

Magnusson M, Cooter R, Rakhorst H, et al. Breast Implant Illness: A Way Forward. *Plast Reconstr Surg*. 2019;143(3s):74-81.

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Swerdlow SH, Campo E, Pileri SA, et al. The 2016 revision of the World Health Organization classification of lymphoid neoplasms. *Blood*. 2016;127:2375–2390.

Jacobsen E. Anaplastic large-cell lymphoma, T-/null-cell type. *Oncologist*. 2006;11:831–840.

Clemens MW, Medeiros LJ, Butler CE, et al. Complete surgical excision is essential for the management of patients with breast implant-associated anaplastic large-cell lymphoma. *J Clin Oncol*. 2016;34:160–168.

Further publications/references can be found in the most recent (March) supplement in PRS – A review of BIA-ALCL

Can deep breathing test detect white-coat effect?

Chan K[1]

[1]*Department of Family Medicine and Primary Health Care, United Christian Hospital and Tseung Kwan O Hospital, Hong Kong*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

Deep breathing was shown to be able to lower blood pressure by increasing the baroreceptor reflex sensitivity to vagal stimulation. (1-2) Previous studies had shown that deep breathing over 30 to 60 seconds was useful in detection of the white-coat effect by measuring the difference in systolic blood pressure (SBP) after performing the deep-breathing test (DBT). (3-6)

In a Federico et al study, the DBT resulted in a statistically significant mean SBP drop of 17.8 and 10.9 mm Hg (p <0.001) between the white-coat effect and non white-coat effect patients. (3) In another study by the Marion et al, a 15% drop in SBP corresponded to a 96% specificity (95% CI 79.0 – 100.0) and 94% positive predictive value (95% CI 72.0 – 100.0) in the diagnosis of white-coat hypertension. (4)

Previous evidence also supported a positive correlation between office SBP and white-coat effect. (7,8) In a Taiwanese study which compared the characteristics of white-coat and non white-coat patients as defined by the gold standard 24 hour ABPM, office SBP was found to be significantly correlated with white-coat effect (odd ratio 1.079, 95% CI 1.034-1.125, p <0.001). (7) In another large scale study involving over 2000 patients in Greece, a 1.0mmHg increase in daytime SBP variability was correlated with an increase of 0.589mmHg (95% CI 0.437-0.741) in the systolic white coat effect. (8)

There was also evidence showing that beta-adrenergic blockers might potentiate the baroreflex, possibly through enhancing heart-rate variability and increasing the vagal tone while reducing the sympathetic beta-receptor stimulation and therefore might affect the DBT results. (9-10) However, the effect of beta-adrenergic blockers on DBT was not considered in all the previous mentioned studies in detecting white-coat effect.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

Hypertension is a major constituent to the global burden of non-communicable diseases (11). It is a leading risk factor of cardiovascular diseases which cause significant morbidity and mortality. (12-13) However, only about half of the treated hypertensive patients achieved target blood pressures according to international studies. (14-15) The reasons accounting for suboptimal blood pressure control included inadequate treatment, poor patient adherence, white-coat hypertension, undiagnosed secondary hypertension and true resistant hypertension. (16-17)

White-coat hypertension is defined as persistently raised office blood pressure in ambulatory normotensive patients. (18) It accounts for up to 20 to 30% of patients worldwide. (19-21) White-coat effect refers to a patient with home or ambulatory blood pressure within the hypertensive range but who exhibit a disproportionately raised clinic blood pressure reading. (18) It was reported to account for one in four of the treated hypertensive patients with suboptimal office blood pressure control (21-22) and prevalent among 35-73% of patients with treated hypertension. (20,23-27)

The detection of white-coat effect is important as failure to recognise the condition may lead to unnecessary treatment and undesirable side effects for the patients and also inflating the cost of treatment. (28-30) The current gold standard for the diagnosis of white-coat effect is by the 24-hour ambulatory blood pressure monitoring (ABPM), which requires specific equipment and expertise to operate and may not be available in every primary care setting. (18, 31-32)

In contrast, the DBT is a relatively simple, convenient and inexpensive bed side maneuver. If it could serve as a screening or diagnostic tool for white-coat effect, more rational hypertensive treatment could be allowed without the wait for the use of 24-hour ABPM.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

We would emphasize on how relevant and practical it is our topic of presentation to the day in and day out routine of a GP's work. We would present our research findings in forms of condensed graphics and tables, highlighting the important findings while keeping it simple and short. We would also encourage our audience to raise any queries along the way.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

We performed a cross sectional study in which consecutive patients on anti-hypertensives, attending the Hypertension Clinic of a GOPC and with clinic systolic blood pressure (SBP) ≥140mmHg and/or diastolic blood pressure (DBP) ≥90mmHg during the study period from 1st August 2016 to 30th September 2017 were recruited. Clinic BP was recorded before and after the patients carrying out the DBT for 60 seconds. 24-hour ABPM would be subsequently performed with reports interpreted by family medicine specialists who were blinded to the DBT results. The diagnostic accuracy of the DBT in all recruited patients, patients not taking beta-adrenergic blockers and patients with different clinic SBP cut-off before the DBT by means of area under the receiver operating characteristic (ROC) curve, sensitivity, specificity, positive and negative predictive values were obtained. Among the 178 recruited patients, the ROC curves for systolic and diastolic BP changes after the DBT were statistically non-significant. The ROC curve was statistically significant for SBP change in patients not on beta-adrenergic blockers and with pre-DBT clinic SBP ≥165mmHg (ROC curve area of 0.72, 95% CI 0.53-0.91, p=0.04). The corresponding sensitivity and specificity of the DBT were 40.9% and 90.9% respectively if SBP drop was >30mmHg.

We concluded that the DBT, though could not be clinically applied to all patients, was proven to be a potential screening and diagnostic test for white-coat effect in Chinese hypertensive patients with a pre-test SBP of ≥165mmHg and who were not taking beta-adrenergic blockers.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

No

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Cardiometabolic screening in serious mental illness

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Background:

Patients with serious mental illness die on average 10-15yrs earlier than those without. This is primarily from ischemic heart disease and complications of metabolic syndrome. Guidelines exist regarding screening for cardiometabolic risk factors yet screening rates remain low.

Aims:

The study aimed to investigate the feasibility of an electronic reminder system plus an education session to improve screening rates for cardiometabolic syndrome in patients with serious mental illness.

Method:

A mixed methods approach was taken involving three general practices. Qualitative data were obtained through semi-structured telephone interviews at the conclusion of the study, supplemented by quantitative data obtained pre and post intervention.

Results:

Practice staff had a positive response to the project. There was a lack of awareness regarding the need for screening. The reminder system fitted well with usual practice, was straight-forward to implement and provided perceived benefit to both patients and staff. This was supported by data suggesting a trend towards an increase in cardiometabolic screening measures following the intervention. The sample was insufficient for robust statistical analyses.

Discussion:

The use of an electronic reminder system and education session to improve screening for cardiometabolic risk factors in general practice is acceptable, practical and simple to integrate. However, a randomised control study is required to assess effectiveness and whether this translates to an improvement in cardiometabolic health.

Conclusion:

The use of an electronic reminder system and education session to improve cardiometabolic screening for patients with serious mental illness appears to be both feasible and initial findings support further large scale research of effectiveness.

Caring for methamphetamine users in General Practice

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Aims:

Evidence for harms related to regular use of methamphetamine is growing. Data from the National Drug Strategy Household Survey suggests that while the number of users is not growing, they are possibly exposing themselves to greater risk of adverse health outcomes through the purer crystalline from of the drug (1). We know that people who regularly use methamphetamine (PWRUM) often don't see their drug use as a problem (2). However they do visit their GP more frequently than the general population (3), but there is few data on how they present and whether their needs are met. This study aims to explore the attitudes, beliefs & experiences of both GPs (Phase 1 – ethics approval granted) & PWRUM (Phase 2).

Results:

GP reports of barriers and enablers to the provision of health care to PWRUM will be presented.

Conclusions:

By identifying barriers and enablers faced by PWRUM in the GP setting, we can determine principles and design processes that will enable GPs to improve the healthcare they provide to this vulnerable group.

Content:

The implications of these findings for general practice will be discussed with a view to addressing the adverse health outcomes faced by PWRUM.

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Changes in age-standardised mortality rates from melanoma

Hille D[1]

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Aim and intended outcome/education objectives:

To identify changes in the linear trend of the age-standardised mortality rate of melanoma in Australia for all persons, males, and females. Melanoma is a common cancer in Australia, with General Practitioners often responsible for initial diagnosis.

Results:

Annual age-standardised mortality rates from melanoma data is freely available from the Australian Institute of Health and Welfare[1]. A two-piece piecewise linear regression was fitted to the data. The piecewise breakpoint was varied through an automated, iterative process to determine the model that best fit the data. Statistically significant changes in the trend of the age standardised mortality rate from melanoma in Australia were found for all persons, and males. No statistically significant breakpoint was identified for females. The optimal breakpoint for all persons was at 2013. For males, the optimal breakpoint was at 2014. In both cases, the trend after these breakpoints is negative.

Conclusions:

Melanoma is a significant public health issue in Australia. Incidence continues to increase. However, the mortality rate may be decreasing among certain demographics. It is too early to tell if this trend is likely to be sustained. Further research into these trends is needed.

References:

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Clinical photography: Professional and legal consideration

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Background:

Clinical photography has become a boon to the world of medicine[1]. Regard must be had to the legal and ethical obligations of practitioners to uphold a patient's right to privacy, confidentiality, and autonomy to consent to the use of photographs[2]

Aims:

To explore and explain current professional and legal considerations related to the use of clinical photography in general practice.

- **Legal considerations for GPs:** GPs working in private practice, the Privacy Act 1988 (Cth) requires adherence to the Australian Privacy Principles (APPs)[3].
- **Consent:** Using identifiable clinical photographs without consent, is not only unethical and inappropriate, but also a breach of legal obligations imposed by the APPs[3].
- **De-identification:** Consideration should be given to the metadata contained in electronically captured and stored images[2,4].
- **Storage and security**: Practitioners are legally bound to keep records, including clinical photographs, for several years1.
- **Sharing:** APP 11 requires GPs to take reasonable steps to ensure that patient information is not accessed without authority[6].

Awareness of guidelines & policies:

The Australian Medical Association (AMA) released a comprehensive set of guidelines on use of personal smartphones for clinical photography in 2014[5].

Conclusion:

The ubiquity of digital technology has brought the capacity to capture clinical photographs to the palm of a practitioner's hand. Legislation and guidelines exist to assist practitioners who utilise clinical photography but are not always user friendly.

Further studies regarding current status of GP awareness and utilisation of safeguards in clinical photography, would help to develop more user friendly guidelines and professional development activities.

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Clinician experience of retrospective-CGM in type-2 diabetes

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Background:

Retrospective continuous glucose monitoring (r-CGM) provides insight into glucose profiles to guide appropriate therapeutic intervention. Few studies have explored the influence of r-CGM on collaborative care for people with type 2 diabetes (T2D) from the perspective of primary healthcare professionals (HCPs).

Aims:

To explore the experience and acceptability of r-CGM to HCPs in the 'General Practice Optimising Structured MOnitoring To Improve Clinical outcomes in T2D' (GP-OSMOTIC) randomised controlled trial.

Method:

Semi-structured interviews with HCPs who had at least one participant in the trial intervention arm. All interviews were recorded, transcribed and subjected to thematic analysis.

Results:

15 HCPs (10 GPs, 5 practice nurses; 67% women, 73% metropolitan clinics) participated in interviews mean (range) duration: 21(13-29) minutes. HCPs reported that r-CGM was a beneficial tool for engaging and communicating with people with T2D during consultations. HCPs reported that their therapeutic decisions based on the output were different to those they would have made based on HbA1c alone, and observed that the person with T2D received educational and motivational benefits. Recognising that r-CGM cannot be used by all people with T2D at all times, HCPs recommended use early in the diabetes life-course, and when experiencing challenges to optimal glycaemic management. Some HCPs reported reservations about using the technology and interpreting output, while others were concerned about increased consultation times.

Discussion:

HCPs were overwhelmingly in favour of r-CGM, identifying benefits both to their clinical practice and to people with T2D.

Conclusion:

r-CGM is a valuable adjunct to collaborative and clinical diabetes care.

Comparing melanoma incidence trends between Australian states

Hille D[1]

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Aim and intended outcome/education objectives:

To compare changes in the linear trend of the age-standardised incidence of melanoma between Australian states. It is helpful for General Practitioners to be aware of melanoma incidence trends in their states.

Results:

Data capturing state by state annual age-standardised incidence rates of melanoma is freely available from the Australian Institute of Health and Welfare[1]. A two-piece piecewise linear regression was fitted to the data. The piecewise breakpoint was varied through an automated, iterative process to determine the model that best fit each state's data. Statistically significant changes in the trend of the age standardised incidence rate from melanoma were found for all Australian states. Data from all Australian states showed positive trends in melanoma incidence prior to the breakpoint. The NSW, Queensland, and WA data had positive, yet smaller, trends after the breakpoint. The SA data had a negative trend after the breakpoint. The post-breakpoint trends for Victoria and Tasmania were neither negative nor positive.

Conclusions:

Melanoma is a significant public health issue in Australia. Incidence continues to increase. However, in some Australia states the trends appears to be slowing, and possibly reversing. In others, the trend remains strongly positive.

References:

1. Australian Institute of Health and Welfare (AIHW) 2018. Cancer Data in Australia; Australian Cancer Incidence and Mortality (ACIM) books: melanoma of the skin Canberra: AIHW. <https://www.aihw.gov.au/reports/cancer/cancer-data-in-australia/>.

Compliance Impact of Unintentional Placebo Nocebo Effects

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Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

It is not enough to make the correct diagnosis & offer to provide the appropriate treatment. The patient must be convinced of this to accept & persist with treatment.

While the placebo effect was recognised from the use of inert treatments, it may also exit when the treatment is inappropriate (antibiotics in viral illness) & provide a bonus to effective treatment. The Nocebo effect is the opposite of placebo & because of belief a treatment is harmful they experience a negative effect from an inert treatment (pointing the bone) and a null or adverse effect from an active treatment. The clinical & ethical impacts will be explored. The effects do not work for all conditions, affect 10-50% of a population depending on the condition & last only for a few months. The triggering of these effects may explain the action & impact of bedside Manner.

The reason this is hard to research will be discussed & suggestions for further investigation will be highlighted

Sadly, too often unexplained symptoms are considered to be a Placebo or Nocebo Effect. The criteria for suspecting such Placebo or Nocebo effects will be highlighted rather than to suspect it because there is no other explanation.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

Encouraging patient compliance/ adherence/ the therapeutic relationship it a vital part of General Practice. This offers practical advice that has been gleaned from 40 years of clinical & research experience

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

By offering novel challenges to their current activity & having adequate time for questions & discussion

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

I have extensive references & am able to offer insights not generally considered (due to my years involved in designing & undertaking GP research)

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

A tighter definition of the Placebo & Nocebo Effects, the conditions that can be affected by them & ways to enhance clinical compliance & improve clinical outcomes

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Compliance with FOBt screening through general practice

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[1]*The Gut Foundation,* [2]*Westside Medical Centre*

Aims:

The aim of this study is to assess compliance with FOBt screening when initiated through the Family Practitioner.

Background:

Bowel cancer is the second most common cause of cancer related death. A Cochrane c review concludes that regular screening using FOBt reduces incidence and mortality by 25%.

The National Health and Medical Research Council (NHMRC) recommend biennial screening with faecal occult blood testing (FOBT) for all persons 50 to 74 years of age.

The National Bowel Cancer Screening Program uses population based mail-out augmented with public health campaign. In 2011 and 2012, participation was 35%. The low participation rate suggests that the full public health benefit of FOBt screening is not being realized.

Method:

Appropriate participants were identified and offered an immunochemical FOBt and asked to return completed. Number of FOBt kits offered and the number completed was recorded.

Results:

Data collection commenced on the 1st of July 2015 and ceased 1st of December 2015. During this time, a total of 3647 FOBt kits were offered to participants.

2850 kits were returned completed. 797 kits were not returned. This is a compliance rate of 78.15%.

Discussion:

Across Australia 84.7% of the population visit a Family Practitioner (FP) at least once a year. Effective communication; patient-doctor relationship are potential factors which enable general practice to alleviate participation barriers and lead public health initiatives.

Conclusion:

The study suggests that the primary care physician is ideally placed to lead public health screening initiatives

Cross-sectional study: Early-career GPs types of practice

Tapley A[1,2], Magin P[1,2], Fielding A[1,2], Moad D[1,2], Davey A[1,2], Bentley M[3], Kirby C[4,5]

[1]***GP Synergy, [2]University of Newcastle, School of Medicine and Public Health,*** [3]General Practice Training Tasmania, [4]Eastern Victoria General Practice Training, [5]Monash University Rural Health

Background:

Provision of comprehensive GP care includes after-hours care (AHC), home visits (HV) and nursing home visits (NHV) for the growing ageing population.

Determining clinical characteristics/associations and training program predictors of post-training outcomes helps to understand the utility of the specialist GP training program and aid workforce planning.

Aims:

To establish prevalence and associations of providing AHC, HVs and NHVs in current practice.

Method:

Participants were GPs who fellowed from GP Synergy, Eastern Victoria General Practice Training and General Practice Training Tasmania between January 2016 and July 2018 inclusive.

NEXT-UP is a cross-sectional questionnaire-based study. Participants were asked questions regarding their current practice and associations with training, including whether they provide NHV, HV, or AHC in their current clinical GP role.

Main analyses used multivariable regression.

Results:

354 early-career GPs provided data (response rate 28%). Of these GPs, 34% currently performed NHVs, 41% HVs, and 40% AHC.

GPs were more likely to be currently doing NHV and HV if working regionally/rurally. They were more likely to be doing AHC and HV if these were done during training. Australian medical graduates were more likely to be doing NHV and HV, and females were less likely to be doing NHVs.

Discussion:

These results suggest training experience of HV and AHC can strongly influence future practice. Rurality of practice is also a factor in these types of practice.

Conclusion:

Facilitating training experience may lead to their increased provision by recently fellowed GPs.

CVD risk identification+management in Australian GP

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Background:

Cardiovascular disease (CVD) affects 1 in 6 people in Australia. Studies a decade ago showed large evidence-practice gaps in screening and management of CVD risk.

Aims:

To evaluate change in identification and management of CVD risk in Australian primary care

Method:

De-identified General Practice data was extracted electronically for active patients > 18 years (≥1 visits in last 6 months, and ≥ 3 visits in last 2 years). Participants included Aboriginal and Torres Strait Islander (ATSI) people 35+ years and all others 45+ years. High risk defined as established CVD, clinically high risk conditions or calculated 5-year risk > 15% using absolute risk calculator. Appropriate screening defined as having essential risk factors recorded for CVD risk within recommended timings. Appropriate management defined as: ≥ 1 BP lowering drug and statin for high risk without CVD and with an antiplatelet or anticoagulant agent for established CVD.

Results:

110686 patients included from 98 General Practices (55% female, 1.4% ATSI, 14% smoker, 15% Diabetes). 29% lacked sufficient information to calculate CVD risk. 26% were classified as high risk of which 11% had established CVD. 51% with established CVD were on appropriate treatment, vs 38% of those at high risk but without CVD.

Discussion:

CVD risk screening and management has remained static in the last decade, likely due to contextual issues not being addressed.

Conclusion:

Strategies such as Quality Improvement initiatives to support implementation of guidelines are required.

Deprescribing of inappropriate medicines in the elderly

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Background:

GPs are encouraged to increase their deprescribing of inappropriate medicines in older patients. Deprescribing, however, entails considerable barriers, especially for GP registrars.

Aims:

To assess an educational intervention's impact on GP registrars' deprescribing in older patients.

Method:

A pragmatic non-randomised, non-equivalent control group design nested within the ReCEnT cohort study of GP registrars' practice.

The theory-based (on Michie's Behaviour Change Wheel) educational intervention was delivered in one of three ReCEnT-participating Regional Training Organisations (RTOs). It included: face-to-face registrar session, pre-session on-line module, supervisor webinar, and registrar-supervisor dyad case-based discussions. The other two (control) RTOs did not deliver the intervention.

Primary outcomes were deprescribing, in patients 65-years-and-over, of i) any medicines, and ii) Potentially Inappropriate Medications (PIMs - defined by a composite of existing classification systems). Primary analyses were intention-to-treat. An intervention-control/pre-post interaction term in multivariable logistic regression tested statistical significance of intervention efficacy.

As well as intention-to-treat, we conducted an 'on-treatment' PIMs analysis, including only those intervention RTO registrars who attended the face-to-face education session.

Results:

We did not find a statistically significant increase in all deprescribing pre-to-post-intervention for intervention versus control group registrars (interaction term OR:1.00; 95%CI:0.69,1.46), or deprescribing of PIMs (OR:1.29; 95% CI:0.74,2.24).

The 'on-treatment' analysis showed no statistically significant increase in PIMs deprescribing (OR:1.57: 95%CI: 0.83,2.96)

Discussion:

We did not find increases in deprescribing following an educational intervention.

Conclusion:

Further analysis, including 2019-20 ReCEnT data (when intervention elements in the RTO program and in functioning of the registrar-supervisor dyad will be better established), is indicated.

Developing medical record-based decision support for T2D

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Background:

Type 2 diabetes (T2D) requires progressive treatment intensification to achieve glycaemic targets. This is complex and challenging due to time-constraints, emerging treatment options and the need to individualise treatment.

Aim:

To develop an electronic medical record (EMR) based clinical decision support (CDS) tool ("GlycASSIST") for GPs and people with T2D giving real-time, personalised HbA1c targets and recommendations for intensifying treatment.

Method:

A total of 32 clinicians and people with T2D participated in a range of interviews, focus groups and mock consultations over a two-part co-design process

Results:

All participants felt GlycASSIST would support personalised treatment intensification, on what and how much to include and the ideal format, otimising visibility and utility, but avoiding overburdening people with diabetes and clinicians. Maintaining autonomy was important to GPs, allowing them to override recommendations GlycASSIST made. Clinicians wanted an in-built link to prescribing capabilities, which is a future possibility. The final prototype will be illustrated.

Discussion and Conclusion:

The final prototype has informed a larger project, developing a CDS dashboard across different chronic conditions, to be tested in general practices in Victoria.

Diagnosing and managing work-related mental health conditions

Atchison M, Chakraborty S, Mazza D

Background:

General practitioners (GPs) are frequently involved in the care of patients with work-related mental health conditions (MHC). However, many GPs face clinical challenges in providing this care, and have requested advice to assist them in addressing these challenges.

Aim:

To develop a clinical guideline to assist GPs with diagnosing and managing patients with work-related MHCs.

Method:

The guideline was developed according to National Health and Medical Research Council standards. Guideline development involved: (1) constructing key clinical questions from clinical dilemmas faced in practice; (2) undertaking systematic literature reviews for clinical questions; (3) assessing the evidence according to Grading of Recommendations Assessment, Development and Evaluation; (4) developing a draft guideline; (5) revising the guideline following public consultation; and (6) assessment by independent methodologists and content experts.

Results:

The guideline provides recommendation on the diagnosis and management of work-related MHCs in general practice, specifically regarding:

- tools to assist diagnosis and assessment of severity of a MHC
- assessing if a patient is developing a comorbid or secondary MHC
- assessing if the MHC has arisen from work
- conveying a diagnosis of a MHC to a patient
- management of the condition
- considering if the patient can work
- communicating with the patient's workplace
- managing MHC and comorbid substance misuse
- considering why a MHC is not improving
- managing a MHC that is not improving

Discussion:

This guideline provides GPs with the best-available evidence to assist in diagnosing and managing patients with work-related MHCs.

Conclusion:

Implementation of the guideline will be facilitated through tailored implementation activities.

Does r-CGM affect health service utilisation?

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Background:

There is increasing interest in the use of technology to assist management of type 2 diabetes (T2D). Retrospective continuous glucose monitoring (r-CGM) involves the person with T2D wearing a sensor which measures glucose data every 15 minutes, which is later reviewed with their health professional to guide treatment intensification. It is not clear whether use of this technology is associated with changes in health service utilisation (HSU).

Aims:

In patients with T2D attending general practice, does r-CGM result in different HSU compared to usual care?

Method:

Secondary analysis of GP-OSMOTIC data (randomised controlled trial examining the effect of intermittent r-CGM use on HbA1c in people with T2D in general Practice) linked to MBS and Victorian hospitalisation data (VAED, VEMD) over 18 months (6 months pre-trial, 12 month trial period).

Regression modelling will be used to estimate differences in HSU between the r-CGM and usual care groups.

Results:

299 patients in 25 Victorian general practice with T2D with HbA1c above target, despite prescription of at least two non-insulin hypoglycaemic agents and/or insulin. Data linkage is currently underway, and data analysis will commence July 2019. Preliminary results will be presented.

Discussion:

r-CGM offers the possibility of analysing blood glucose values in new ways. In the next 10 years, it is estimated that about 20% of people with T2D will be using a CGM system. This study will generate evidence of the changes in health service utilisation associated with r-CGM, enabling evidence based clinical and health policy decisions.

Conclusion:

Once data linkage is complete, this study will generate evidence of the changes in health service utilisation associated with r-CGM, enabling evidence based clinical and health policy decisions.

ED2GP: Understanding lower follow-up amongst older women

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Background:

Older women were observed to have substantially lower general practitioner (GP) follow-up rates after an emergency department (ED) discharge compared to men (67% vs 90%, Watson et al. 2017).

Aims:

To describe and understand how older women seek GP follow-up after an ED visit.

Method:

In this predominantly qualitative study, women aged 65 years and older were recruited from a suburban ED in Fairfield NSW. Interviews with structured and semi-structured questions were conducted during the ED visit, and again seven days later by telephone. Data collected included beliefs, attitudes, intentions, and experiences of GP follow-up. Grounded theory was used to construct a potential explanatory model of follow-up behaviours.

Results:

Of the 100 women recruited, 64% had attended GP follow-up by day seven. The perceived cost and benefit of GP follow-up emerged as a useful model to understand how factors influenced follow-up behaviour. Perceived costs included inconvenience caused to self, access to transport options, the perceived inconvenience posed to others, and the availability of the patient's GP. Perceived benefits included previous experiences with the healthcare system, pre-existing health-seeking behaviours, and ED messaging.

Discussion:

Our model suggests that follow-up rates could be potentially improved by increasing the perceived benefit of GP follow-up at the point of ED discharge, in addition to addressing the costs, or the typical "barriers". Approaches might include ensuring that discharge instruction given from the ED are motivating, clearly communicated, and given in the company of family or friends with whom the patient is dependent.

References:

Watson, B, Tam, C, Pellizzon, B, Ban, L, Doan, H (2017) General practitioner follow-up in older patients after an emergency department admission. *Aust Fam Physician* **46**, 521-526.

Effective management of gout in primary care

Chan S[1]

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Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

Gout is one of the most common causes of inflammatory arthritis in adults. Evidence has shown that appropriate and timely management of gout can reduce the risk of further flares, chronic polyarthritis, tophaceous disease, renal impairment and cardiovascular disease. In the past few years, new evidence-based guidelines in the management of gout have been established.

In this presentation, I would like to share my experience in improving the management of gout in a primary care clinic in Hong Kong through performing a clinical audit in 2017-2018. The clinical audit consists of two phases. Areas of deficiencies of care were identified. Changes were implemented including developing clinical guidelines, organizing educational meetings, putting up reminders and introducing a new consultation template. Second phase records were reviewed one year after the implementation of changes. Performances of the two phases were compared. All process criteria showed improvement. The percentage of patients free from gout attacks in the past 4 months, and the percentage of patients on allopurinol achieving target serum urate level (≤0.36 mmol/dL) showed statistically significant improvement.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

Gout is an important health issue worldwide. A study showed the prevalence of gout in adult Australian may be as high as 5.2%.[1] Health care visits, bedridden days, and episodic loss of productivity results in significant economic burden and social impact. The increasing evidence for the association between gout and cardiovascular events, metabolic syndrome, kidney failure and mortality has heightened the realization that gout should never be neglected and should be treated properly. In both Australia and Hong Kong, most patients with gout are managed in primary care.

Despite advanced understanding of the pathophysiology and availability of effective treatment, gout is often misdiagnosed and its treatment is suboptimal. Studies in the United Kingdom showed that management in gout was not concordant with national and international guidelines.[2] Many patients have inadequate control of serum urate level and do not receive adequate lifestyle information. It is important for GPs to be aware of effective management of gout to improve quality of care to patients.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

I would like to adopt an interactive approach to help participants identify their barriers in managing gout patients and find out ways to improve. From my experience, the possible barriers include lack of updated knowledge on management of gout, lack of awareness, lack of clinical guidelines or protocol, time constraint during medical consultations, lack of evaluation and feedback. The possible barriers will be listed out and methods to tackles these barriers will be discussed.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

I have conducted a clinical audit in a primary care clinic in Hong Kong in improve management of gout. Clinical audit is a quality improvement process. A total of 14 process criteria and 2 outcome criteria were adopted with reference to international guidelines on management of gout, including the 2016 updated EULAR evidence-based recommendations for the management of gout[3], and the ACR Guidelines for management of gout. (2012)[4,5]. Important aspects including correct diagnosis , lifestyle modification, assessment of cardiovascular factors, monitoring drug compliance and assessment of gout control, initiating urate lowering therapy when indicated, and titrate to target serum urate level , monitor drug compliance were included in the process criteria.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

In the past few years, evidence-based guidelines in the management of gout have been established. These will be discussed in the presentation.

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Enhancing team care through rural interdisciplinary learning

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Background & Aims:

Rural Generalist Medicine is the future of rural health care in Australia. and is needed to ensure world class delivery of services and best health outcomes for rural Australia. In order to deliver quality care and achieve the best health outcomes, effective team work that builds on the strengths of each team member is crucial. But how is this taught across disciplines?

Welcome to RIPL (Rural Inter-Professional Learning) which is an innovative teaching tool developed by the Western Sydney University Bathurst Rural Clinical School. The end goal, or RIPL (ripple) effect, is to create a health workforce with improved levels of team work, communication and collaboration. Over time, this ripple would become a wave of effective multidisciplinary team care leading to better patient outcomes.

Method:

RIPL is a simulation teaching session that involves several members of the interdisciplinary team (including medical, nursing, social work, paramedicine students) who rotate through differing scenarios as they would do in a normal day at work in a rural community. The simulation sessions look at human factors and improve the working relationships with our colleagues as well as those from different disciplines.

Results:

The presentation will showcase the RIPL program and the evaluation of the effectiveness of this type of teaching, demonstrating how small RIPLs have potential to become a wave of change in delivering the best health outcomes for Rural and Remote Australia.

Conclusion:

Multidisciplinary team care can be enhanced through undergraduate interprofessional education programs such as RIPL.

Evaluation of the Advance Project (Phase 1)

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Australia's ageing population and the growing prevalence of chronic/complex health conditions makes general practices an ideal setting to initiate early advance care planning (ACP) and palliative care (PC). The Advance ProjectTM (www.theadvanceproject.com.au) funded by the Australian Government aims to increase access to ACP/PC. In Phase 1, a suite of resources and multi-component training was developed to enable General Practice Nurses (GPNs) to initiate ACP conversations during routine health assessments with older and/or chronically ill patients; and to assess patients' and carers' palliative/supportive care needs. The training included online modules, workshops, rural scholarships and one-on-one mentoring. Program evaluation included pre/post/follow-up participant surveys and interviews. 823 GPNs enrolled with 536 completing one or more training components. 27 workshops were held across Australia, including 182 regional/rural participants. 585 pre-training, 384 post-training, and 125 follow-up surveys were received. 20 GPNs were interviewed. GPNs highly rated the quality and relevance of the resources/training to their practice and value for their patients/carers. Significant improvements were noted in GPNs' confidence, comfort, knowledge and attitudes towards initiating ACP/PC assessments post-training that was sustained at follow-up. Participants were significantly more likely to have had ACP discussions with their patients at follow-up (81%) compared to baseline (55%, $p<0.001$). GPNs reported positive impacts for their patients/carers. Evaluation showed that complementary training in the Advance model for GPs and practice managers was highly needed for successful implementation. A team-based approach to initiating ACP, and assessing/addressing PC needs in general practices has the potential to fill a gap in GP care delivery.

Experiences of GPs toward the revised NCSP

Foo Y[1], Goswami P[1], Grogin J[1], Hargan E[1], Thangarajah M[1], Mendel S[1], Bailey J[1]

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Background:

Changes to the NCSP include an option for self-sampling. Its tangible implementation through the viewpoints of GPs and their experiences have not yet been examined in the literature.

Aims:

The aim of this study was to explore the experiences and attitudes of GPs in the Central West region of NSW towards the renewed NCSP and the self-sampling option.

Method:

This project is a qualitative study of eleven semi-structured interviews, focused on GPs in the Central West region of NSW with at least two years' experience in providing cervical screening to their community.

Results & Discussion:

Four main themes were identified after analysing the data. Firstly, it found that GPs had limited exposure to self-sampling, with approximately half having direct exposure. Despite this, there was strong indication that GPs would offer it to women whose cultural background, sexual history or personal experience with pap smears could invoke anxiety or discomfort, in particular patients of refugee, and Aboriginal or Torres Strait Islander backgrounds. The main benefit of self-sampling identified by GPs was increased participation, however barriers were identified around unclear understanding about logistics for the process, patient eligibility and education, and concerns about the quality of self-collected samples.

Conclusion:

Understanding of GP perspectives such as these can help support the roll-out of the NCSP, including identifying logistical changes, education improvements and resource provision, for overall improved patient care and provider experiences.

Fetal craniotomy

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Nowadays, even in developing countries Cesarean section is the most common method of delivery for the breech presentation. However, in rural parts of the countries still vaginal route is the only option.

Trauma to the after coming head is the common issue among the contributors of birth trauma during breech delivery. Entrapment of after coming head is an unpredictable obstetrical emergency. If the fetus is alive, options from application of obstetric forceps to giving Dührssen incisions can be kept in choice. Cesarean section is done when all the methods fail to deliver the head. But, when the fetus is not salvageable, delivery of after coming head by craniotomy can reduce unnecessary morbidity of Cesarean section.

In the present report, a case with entrapment of after coming head of dead preterm fetus for 6 hrs of home delivery was described and the management of this condition was reviewed.

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Flexible, stackable, CPD modules for clinical teaching

Regan C, **Regan C**[1]

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Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

This poster will outline the development and content of modules that have been developed in response to the need for appropriate CPD for clinical teaching.[1-3] As well as foundational medical education topics we present newer topics relevant to the changing challenges of teaching in the GP setting.[4] So far there are nine topics (each in two parts) that are presented as stackable modules with flexible learning and delivery options from stand-alone sessions on single topics to modules satisfying ALM criteria or completion of requirements for a certificate, with both face -to-face and online versions.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

There are increasing numbers of learners in general practice and more GPs are becoming involved in teaching in the clinical setting. There are specific challenges for teaching in the clinical setting and even more so in the GP context which must take into account patient safety and the doctor-patient relationship. Many current medical or health education courses are geared toward the hospital or university setting whereas our modules combine both educational theory and practice and practical approaches for the community context. In Australia there are additional challenges of geography. There are many GPs involved in teaching who feel unprepared but would like to expand their skills.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

This is a poster presentation which will allow tailored engagement with learners who will have the opportunity to ask questions of a co-author. The poster is designed to capture attention and provides sufficient information (without cognitive overload) for viewers to be informed regarding the process behind the development of the modules, the topics available and the options for participation. Brochures will be available for them to pursue any unanswered questions.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

Prior to the development of the modules (and certificate) relevant literature[1-3] was examined and a needs analysis was undertaken. A survey and interviews of GPs were undertaken to assess the expressed learning needs of GPs engaged in clinical teaching. The content and nature of similar courses was reviewed and it was ascertained that there was a gap in the provision of appropriate CPD available to GPs who teach undergraduates in particular. Modules were continually modified in response to feedback from GPs during pilot testing, evidence in the literature and discussion within the diverse work group[5].

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

Most educational methods are not new. However, these modules have been developed within the last 12 months as a practical update. They are intended to utilise blended methods of learning and varied delivery options including online presentation and resources as well as interactional methods. They look to the future with a likely need for more multidisciplinary education in primary care.

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Future health today: Co-design of technology platform

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Background:

General practice has a key role in the timely diagnosis and optimal management of chronic disease to reduce the development of complications and improve quality of life. The use of technology to facilitate audit, recall and clinical decision support, has the capacity to optimise these functions.

Aim:

To develop a technology platform (Future Health Today) to streamline and optimise the diagnosis and management of chronic disease using co-design methodology, with an initial focus on chronic kidney disease (CKD).

Methods:

Co-design adopts an inclusive approach that promotes implementation. Six co-design sessions were conducted in February-March 2019 with general practitioners (GPs), practice nurses (PNs), and practice managers (PMs) to design the technology platform with a focus on audit, recall and point-of-care clinical decision support. Three sessions were face-to-face; three were conducted via video-conference for rural participants.

Results/Discussion:

Seventeen participants (8 GPs, 5 PN, 4 PMs) attended the sessions. Key requirements identified and/or designed by participants included: 1)Automated patient recall; 2)Ability to track number of patients at risk of CKD; 3)The ability to focus on conditions relevant to individual practice profiles; 4)Relevant patient pathology results displayed in graphical format to facilitate review; 5)Easy access to relevant guidelines; 6) Incorporation of quality improvement cycles. Elements were designed to fit into the practice workflow.

Conclusion:

The use of co-design methodology has facilitated the development of Future Health Today, a user focused technology platform. The platform will be piloted in two general practices with a view to optimising it prior to evaluation in a cluster randomised controlled trial.

GP Registrars in residential aged care facilities

Hanks A[1], Reeve C[1]

[1]*JCU GP Training*

Aim and intended outcome/education objectives:

This study aims to describe the pattern and attitudes of general practice (GP) registrars visiting residential aged care facilities (RACFs) during their training and the factors associated with this.

Content:

With Australia's ageing population it is expected that the number of people living in RACFs will continue to steadily increase. We are unfortunately however seeing a decline in the rate of RACF visits amongst GPs (1). Younger and recently graduated GPs are the least likely to visit RACFs (1,2) but those who have visited during their training are more likely to continue after fellowship (3). Understanding reasons for participation during training is thus important when looking at ways of improving the sustainability of the GP workforce in providing care for this vulnerable population group.

This poster describes a cross-sectional two-phase mixed methodology study looking at the patterns and attitudes of GP registrars who are currently undertaking training with JCU GP training visiting RACFs. Phase 1 is a web-based questionnaire that all registrars in JCU GP training are invited to participate in. Phase 2 is a face-to-face focus group of a sub-group of GP registrars training within the Cairns region, to further explore the themes and attitudes identified in the questionnaire.

It is expected that knowledge from this study will help to inform on initiatives that encourage participation in RACF care during GP training.

References:

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GP registrars' expectations of a peer-mentoring program

Klein L[1,2], Fielding A[1,2], Taylor J[1], Mulquinney K[1,2], Magin P[1,2]

[1]*Gp Synergy,* [2]*University of Newcastle*

Background:

Since 2013, the GP Synergy Peer Mentorship Program has been offered to new GP registrars to reduce potential professional isolation as they transition from hospital to general practice. The Program seeks to provide support by linking Term1 registrars (mentees) with Term3 registrars nearing the end of training (peer mentors). Although popular, there is limited evidence of the value of mentoring for GP trainees.

Aims:

To explore GP registrars' expectations and experiences of mentoring and how expectations influence the mentor-mentee relationship

Method:

Two focus groups (n=8) and 29 semi-structured telephone interviews were conducted with a purposive sample of mentors and mentees involved in the Program across NSW/ACT from 2015-2018. Audio recordings were transcribed and analysed inductively for key themes.

Results:

Participants' expectations of mentoring varied widely, from vague general support to specific needs identified that were beyond a peer mentor's capability. Engagement in peer mentoring varied along a continuum, with some pairs only exchanging 1-2 emails, while others met regularly, developing an ongoing relationship. The relationship between various expectations and engagement will be illustrated.

Discussion:

Although multiple barriers were identified that influenced the degree of engagement, 'mismatched expectations' appears to reduce the value registrars placed on their mentoring experience. Engagement was enhanced where proactive mentors addressed expectations early.

Conclusion:

Providing guidance to mentors to address mentees' expectations early and explicitly may help to identify mismatches and to clarify what are possible goals within the mentoring relationship.

GP-registrars' interactions with pharmaceutical sales representatives

Davey A[1,3], Tapley A[1], van Driel M[2], Magin P[1,3]

[1]*Gp Synergy,* [2]*University of Queensland,* [3]*University of Newcastle*

Background:

Doctors do not think they are influenced by interactions with pharmaceutical sales representatives (PSRs) and find PSRs a useful source of information for drugs.(1, 2) However, the literature shows that gifts and hospitality increase prescribing of a company's drug.(3)

Aims:

We aimed to describe the interaction of pharmaceutical sales representatives with GP-registrars.

Method:

A cross-sectional analysis of the ReCEnT cohort study. Terms 1-to-3 GP-registrars, training in urban to very remote practices, answered survey questions relating to PSRs and collected data on 60 consecutive patient encounters during each of three six-month training terms.

Results:

877 GP-registrars responded (response rate 96.8%). 74% found pharmaceutical companies' materials/ presentations a useful way to learn about new drugs. 80% did not believe that receiving gifts/hospitality would increase their prescribing of a drug. When starting a drug, 65% never used free drug samples, while 34% did so sometimes. The most common interactions with PSRs were product conversations (67%), receiving clinical decision tools (64%), food/beverage in the workplace (62%), and free drug samples (39%). Multivariable analysis of registrars' actual prescribing and PSR interaction/perceptions regarding PSRs will available for the conference.

Discussion:

Most GP-registrars are exposed to multi-modal interactions with pharmaceutical companies (including education, clinical tools, hospitality and free drug samples). Like their established colleagues, they believe this will not increase their prescribing of a company's drug. Existing literature questions this perception.(1-3)

Conclusion:

Our finding raises the issue of whether GP-registrars' interactions with pharmaceutical companies should be constrained. And, if so, supervisors' and RTOs' roles in this.

References: *(If applicable)*

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Heart failure in Australian primary care study

Audehm R[1], **Audehm R[2]**, Haikerwal D[3,4,5], Lim K[6], **Piazza P[7]**, Parsons R[8], Neville M[8], Liew D[9]

[1]Concord Hospital, [2]Carlton Family Medical, [3]Heart West, [4]Alfred Hospital, [5]Western Health, [6]Novartis Pharmaceuticals Australia Pty Ltd, [6]Five Dock Family Medical Practice, [8]Austrials, [9]School of Public Health and Preventive Medicine, Monash University

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

We conducted a study to delineate the 'real world' status of heart failure (HF) and its management in Australian primary care, with the aim of comparing current management against best practice.

The SHAPE study analysed de-identified data of adult patients seen between 1 July 2013 and 30 June 2018 from a large network of general practices across Australia. We examined structured data (e.g. diagnoses, medications) as well as free text entries in consultation notes for pre-specified, HF-relevant terms. The data were examined for an explicit diagnosis of HF, use of HF-specific medications, HF-diagnostic investigation results (e.g. BNP/NT-proBNP, echocardiography) and typical clinical features of HF. The population was then stratified into those with 'definite HF', 'probable HF', 'possible HF' and 'no HF'.

At GP19, we propose presenting a 4-part oral presentation lasting for 1 hour on the following:

1. A summary of the findings of the SHAPE study, with emphasis on describing the characteristics of patients with definite and probable HF, as well as the possible interventions for improvement in patient care revealed through our study.
2. A summary of the recently released 2018 Australian HF Guidelines (August 2018), with a focus on the role of the GP in managing patients with HF.
3. The SHAPE study's findings on the actual use of General Practice Management Plans (GPMPs), related chronic disease items and GP Mental Health Treatment Plan items in the management of patients with HF.
4. Question and answer session.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

HF is estimated to affect approximately 480,000 Australians, with over 60,000 new diagnoses made each year (Chan 2016). Of those patients hospitalised with HF, only 20% are subsequently enrolled in hospital-based disease management programs, with access especially limited in regional and remote communities (Scott 2013). The remaining 80% of patients receive most of the ongoing management of their HF from their GPs. The continued ageing of the Australian population is expected to further increase the burden of HF on the healthcare system in general, and on primary care more specifically (ABS 2013).

There are data suggesting that many patients with HF are not optimally managed in primary care, with the majority of patients not being on the most appropriate therapies and doses (Krum 2012, Cleland 2016). The findings from the SHAPE study may help GPs better optimise their management of patients with HF, with appropriate use of available Medicare item numbers and developing processes of care / care pathways.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

Uptake of planned care in patients have shown to improve outcomes (Knight 2012, Wickramasinghe 2015). However, use of care planning items is underdone, especially reviews of care plans where most of the outcomes are realised (Dennis 2008). Discussion of importance of planned and systematic care will be a focus.

The presentation will focus on the actual use of GPMPs, related chronic disease items and GP Mental Health Treatment Plan items in the management of patients with HF, and what is considered best practice and in line with the current HF management guidelines.

The presentation is from results of a novel "real world" study of HF in the Australian primary care setting.

We will also present data on the profile of HF patients seen in primary care in Australia.

We will also explore the use of HF-diagnostic pathology testing, the documentation of echocardiography results and referrals to cardiologists.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

The SHAPE study involved 1.93 million adult patients treated within a large network, of which 1.115 million adults visited the practice 3 times or more in a 24-month period. From this population, based on a hierarchy of selection criteria, 16,930 were classified as having 'definite HF', 4873 as having 'probable HF' and 36,517 as having 'possible HF'. Our presentation will focus on the 21,803 patients with a definite or probable diagnosis of HF.

The mean (median) age of the HF population was 69.8 (72) years, 50.6% were female and 1.65% were Aboriginal or Torres Strait Islander.

The prevalence of HF was 1.128% (95% CIs 1.113 – 1.143%). Prevalence increased with age and was more common in males after age 55 years. In the population aged ≥ 85 years, HF prevalence was 12.57% in males and 11.01% in females.

Using the Australian population from 2015 as reference (ABS 2018), the age-standardised prevalence was 1.433% (95% CIs: 1.414-1.452%).

Age-standardised HF incidence was 0.227%/year (95% CIs 0.223-0.231%). Incidence increased with age and was more common in males than females after 55 years of age. In the population aged ≥ 85 years, the incidence was 1.51%/year in males and 1.38%/year in females.

Patients from the group with 'definite' or probable' HF attended their GP practice an average of 13.5 times per annum (median 11), ranging from 10.1 visits per annum for those with no other recorded comorbidities to 27 for those with 6 or more other comorbidities.

Echocardiography results were documented in the notes in 849 of patients, 271 with preserved EF, 397 reduced HF and a further 181 where the EF was not quantified. Cardiology referral (following the diagnosis date) had been undertaken for 9683 patients (44.4%; 45.2% of definite HF, 41.7% of probable HF), 2339 (10.7%; 10.4% of definite HF, 11.9% of probable) patients had been referred to an endocrinologist and 1071 (4.9%; 4.8% of definite HF, 5.5% of probable HF) to a renal physician.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

This will be the first presentation of findings from a large contemporary study of HF in the Australian primary care setting. It will provide GPs with guidance on how best to identify HF patients in their clinic and incorporate contemporary GP specific management recommendations from the 2018 HF guidelines (Atherton et al, 2018).

The 'real world' SHAPE study is instructive on the opportunity for better utilisation of GPMPs and TCAs to support GPs identify and appropriately manage HF patients. Of the definite and probable HF patients identified, 12148 (55.7%) had received a GPMP, 11194 (51.3%) a TCA and 7175 (32.9%) a GPMP/TCA review over the 5-year period of follow up. The use of GPMPs increased with the presence of comorbidities - over 80% of patients with three or more comorbidities had received a GPMP, and 82% of those with diabetes as a

comorbidity had received a GPMP. Of those with three or more comorbidities, 75% had a TCA and 57% had a GPMP/TCA review, and where diabetes was identified as a comorbidity, 79% had a TCA and 57% had a GPMP/TCA review.

References:

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Australian Bureau of Statistics, Population Projections, Australia, 2012 to 2101 (cat. no. 3222.0), November 2013.

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Cleland JGF, Cohen-Solal A, Cosin Aguilar J. Management of heart failure in primary care (the IMPROVEMENT of Heart Failure Programme): an international survey, Lancet 2002; 360: 1631–39

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How do AGPT graduates choose their practice?

Laurence C[2], **Elliott T[1]**, Broderick I[3], Bell J[3], Cook C[1]

[1]Gpex, [2]University of Adelaide, [3]Western Australian General Practice Training (WAGPET)

Background:

Research has shown that parts of GP vocational training are important in influencing practice location choices for Australian General Practice Training (AGPT) graduates. However, we do not understand how and why these aspects were influential, what other factors are important and what factors are important predictors of remaining in a practice location.

Aims:

The aims of this presentation are:

- To understand the factors that influence AGPT graduate decisions regarding practice location,
- To explore the influence of AGPT program experiences in these decisions,
- To consider how training organisations may be able to encourage graduates to consider working in areas of need.

This research follows on from phase one and two of the Graduate Tracking Study presented at GP18.

Method:

Semi structured interviews are being completed with three groups of South Australian and Western Australia AGPT graduates – those who have stayed rural since graduation, those who moved from an urban to a rural location and those who have moved from a rural to urban location. Interview transcripts will be thematically analysed to better understand the personal and professional factors associated with practice choice post-graduation.

Results:

Results will be presented, comparing and contrasting the important influential factors identified and described by each of the three groups targeted by this study.

Discussion:

The results will help training organisations to understand what training experiences are influencing graduate practice location decision-making and to consider how these can be enhanced.

Conclusion:

This research will provide key information to assist to address current workforce shortages.

How do Australian GPs spend their time?

Brown A[1], Enticott J[1], Russell G[1]

[1]*Monash University Department of General Practice*

Background:

Australian GPs have historically been paid via fee-for-service, a system best suited to simple consultations. However, it is known that GPs are required to spend time away from their patients performing clinical and non-clinical work.

Aims:

To determine a) the amount of time Australian GPs spend on professional work away from face-to-face consultations, b) factors associated with more of this non-billable work, and c) whether non-billable work affects job satisfaction.

Method:

Cross-sectional study of GPs practicing >7.5 hours/week in the 2016 Medicine in Australia: Balancing Employment and Life (MABEL) survey (n=3208). The main outcome measure was the amount of non-billable work (indirect patient care, administration or management tasks) performed.

Results:

GPs worked an average 35.91 hours/week, of which 5.07 hours (CI 4.88-5.27) were on non-billable tasks.

Factors associated with more non-billable work included being female (OR=1.78, CI 1.51-2.08), Australian trained (OR=1.43, CI 1.20-1.70), having a college fellowship (OR=1.21, CI 1.03-1.41), or working in regional, remote, very remote (OR=1.52, CI 1.19-1.93) or higher socioeconomic locations (OR=1.41, CI 1.09-1.83).

Job satisfaction was lower for those performing more non-billable work (OR=0.75, CI 0.59-0.95).

Conclusion:

This is the first large representative survey of Australian GPs to identify factors associated with non-billable work. Increasing feminisation and fellowship status of the GP workforce, in association with increasingly comorbid patients, suggests that GPs non-billable workload will likely increase. The lack of reimbursement for much of this work places an additional challenge on the economic viability of an evolving GP workforce.

Identification of palliative patients: Regional/ rural GPs' experiences

Bontje H[1], Somerville M[2], Ball L[2], Fitzmaurice L[2]

[1]*Griffith University,* [2]*Griffith University*

Background:

The quality of patients' last stage of life has been shown to improve with early palliative care. However, Australian regional and rural doctors face many challenges in providing palliative care. Few is known on how these challenges impact their ability to provide such an approach.

Aims:

This study aims to describe regional/rural General Practitioners' (GPs) perceptions, barriers and facilitators about identifying patients whose treatment focus may benefit from changing from active management to palliative intent.

Method:

A qualitative descriptive design was utilised. Regional and rural Queensland GPs were recruited through websites and newsletters of their local Primary Health Network until data saturation. Semi-structured telephone interviews were conducted, transcribed, coded and thematically analysed.

Results:

This study has been granted ethics approval (GU Ref No: 2019/348). Data collection will be completed in September 2019. Preliminary results suggest four themes: (i) hospital admission or specialist review often trigger the beginning of palliative care, (ii) more experienced GPs seem less conscious of the initiation of a palliative approach; (iii) reduced access to care in rural areas allows for earlier palliative discussions; (iv) rural GPs rarely use tools to facilitate early identification of palliative patients.

Discussion:

Preliminary results suggest that changing to a palliative approach is often a subconscious and passive process. Being regional/rural has both positive and negative implications to availability of high quality palliative care.

Conclusion:

With these findings a pre-existing screening tool could be adapted to rural general practice to facilitate easier identification of patients in need of proactive end-of-life planning.

References:

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Immersion therapy, not your usual service

Wilson P[1]

[1]*Determined*[2]

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

I would like the opportunity to share my story and service with the audience, Immersion Therapy which I developed is world first and changing the lives of those accessing it, I would like to share this with GP's and I think they would find it innovative, engaging and interesting.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

My service has the backing of government and insurers like the NDIS, RTWSA, LSA, TAC, WorksafeVic and the DVA it could be useful for GP's to learn about what it is who might benefit and how to make referrals were appropriate, the service could benefit many of their patients.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

I will share with them my personal story overcoming a major injury which led to the innovation of this world first service.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

There is research currently being conducted by the University of South Australia and leading Doctors from SA Health

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

Yes, my presentation will offer new practical knowledge about Immersion Therapy.

Information gathered from older person health assessments

Ramisetty S[1], Mitchell E[1]

[1]*Monash University Rural Health*

Background:

Health assessments for community-dwelling older Australians were introduced for GPs as Medicare Benefits Schedule items in 1999. They are available for Indigenous Australians aged 55 years and older, and non-Indigenous Australians aged 75 years and older.

There is little research regarding the efficacy of these health assessments, particularly regarding the types of conditions identified at assessments and whether assessments identify more conditions when compared to standard GP consultations.

Aims:

To examine what new information is recorded from performing health assessments for older Australians and compare this to information recorded from prior GP consultations.

To assess whether patient demographic characteristics, number of GP visits and number of health assessments per patient influence the conditions identified at assessment.

Method:

A retrospective patient record study methodology is being used. A total of 100 records are being collected from rural Gippsland and Melbourne clinics.

Results:

Data is being collected between May-July 2019 and will be presented at the conference.

Discussion:

Recognising areas where health assessments can identify typically overlooked conditions in older Australians may encourage uptake of these assessments by GPs. It can also inform updates to the Medicare health assessment guideline forms, which have not been updated in the 20 years since their introduction.

Conclusion:

We hypothesise that more new conditions are recorded at health assessments than standard consultations. The number and types of these conditions may be influenced by patient demographic characteristics, length and number of assessments.

Integrating shared care for cancer survivors

Jefford M[3,4,6], Milley K[1,4], **Rhee J[2,4]**, Lisy K[3,4,6], Chan R[4,5], Emery J[1,4]

[1]Department of General Practice, University of Melbourne, [2]School of Medicine, University of Wollongong, [3]Peter MacCallum Cancer Centre, [4]Primary Care Collaborative Cancer Clinical Trials Group (PC4), [5]School of Nursing, Queensland University of Technology, [6]Australian Cancer Survivorship Centre

Aim and intended outcome/education objectives:

- Understand that shared care can be delivered across many aspects of the cancer journey.
- Be aware of the core principles that underpin the implementation of shared-care for cancer patients in primary care.
- Be aware of the current Australian evidence supporting shared care for cancer survivors.
- Discuss the barriers and facilitators to the uptake and implementation of shared care.
- Be aware of emerging models of shared care for cancer survivors.

Results:

Participants will discuss current evidence and barriers and facilitators to implementing shared care.

Conclusions:

Participants will have a better understanding of meeting the needs of cancer survivors through shared care and be provided with practical lessons to facilitate the potential uptake of shared care in their practice in the future.

Format:

This interactive workshop will include all participants outlining their personal learning objectives for the workshop. This will be used to tailor content in real-time. The learning objectives are aligned to specific pieces of work supported by the Primary Care Collaborative Cancer Clinical Trials Group (PC4) and the Australian Cancer Survivorship Centre (ACSC). Small group discussion and real-time polling will be used to facilitate conversations.

Content:

In 2016, PC4 released a principles statement about the implementation of shared care for cancer patients. This workshop will share evidence that highlights the benefits, barriers to uptake and the core principles that underpin the implementation of shared care for cancer in primary care. Our workshop facilitators will build on these principles by presenting current data from recent shared care trials for prostate (1) and colorectal (2) cancer. Participants will identify what they perceive to be the biggest barriers and facilitators to implementing shared care based on their own experience. The results of which will be compared to current evidence in this area. Lastly, we will also discuss emerging models of shared care such as nurse-enabled shared care.

References: *(If applicable)*

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Intimate Partner Violence screening in Primary Care

Douglas R[1], **Creagh A[1]**, Galrao M[1]

[1]*SHQ (Family Planning Association of Western Australia)*

Background:

1 in 3 women Australian women have experienced violence at some stage in their life. Despite this, there are significant practical and psychological barriers to providing effective screening and routine enquiry about intimate partner violence in a primary care setting. SHQ has developed an evidence-based consumer- and clinician-reviewed screening tool to identify victims of intimate partner violence and reproductive coercion in a primary care setting.

Aims:

1) What proportion of women who present to SHQ between March 2019 and July 2020 self-identify as having experienced intimate partner violence (IPV) and/ or reproductive coercion (RC)?
2) Is there a link between cases of IPV and/or RC and unintended pregnancy and STIs presenting to SHQ?

Method:

SHQ have implemented the routine screening of all patients attending to the service for IPV and RC. De-identified data of women who have consented to the study will be used to assess the strength of the relationship between IPV/RC and unintended pregnancy and/or STIs.

Results:

Early findings are that 17% of all women who presented to SHQ identified a history of reproductive coercion and/or intimate partner violence.

Discussion:

SHQ's experience in implementing the tool will be discussed as well as the preliminary results.

Conclusion:

Screening for IPV/RC in a primary care setting is feasible and can identify and support women at risk and reduce the disease burden associated with IPV and RC.

Iodine deficiency in pregnant women

Wegrecki K[1,2,3]

[1]*Liverpool Hospital,* [2]*University of New South Wales,* [3]*University of Notre Dame Australia*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

Folate supplementation for pregnant women has become a ubiquitous intervention in the community for the prevention of preventable neural tube defects, however the importance of iodine supplementation for the prevention of developmental delay may not be as well-known. Mandatory iodine fortification of foods was introduced in 2009 in Australia. This presentation aims to impress upon the audience the positive but hitherto inadequate effect mandatory iodine fortification of food has had on this vulnerable patient population and suggest a strategy that all primary care physicians can adopt to correct the deficiency.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

Screening for risk factors for iodine deficiency and provision of education regarding iodine supplementation to pregnant women is a simple but overlooked intervention that can easily be implemented in the clinical setting.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

I intend to have my presentation punctuated with interactive questions where audience members are quizzed on various aspects of iodine in pregnancy prior to a fuller exposition of the topic and relevant literature. E.g. What are the demonstrated sequelae of iodine deficiency during pregnancy and breastfeeding on offspring? What are the mechanisms underlying pregnant women's increased tendency to developing iodine deficiency? In which state or territory are pregnant women most likely to be iodine deficient? Has fortification of staple foods been enough to correct iodine deficiency in this population? How are dietary habits changing and how does this impact of the efficacy of fortifying foods like milk and bread?

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

My paper is an epidemiological review of iodine status in pregnant women pre- and post- mandatory iodine fortification of staple foods, published in a peer-reviewed journal (see references). Relevant datasets consulted included the Australian Bureau of Statistics and Australian Institute of Health and Welfare, as well as literature search using PubMed.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

No, however this is a frequently neglected niche area in which the community would benefit from opportunistic screening and education on the part of informed GPs and medical practitioners. If the strategies I suggest could be understood and implemented, I believe we would see a significant public health benefit in the long term.

References:

Wegrecki KJ, Sadig RR, Aramideh J, Khan N, Moawad D, Jabbour J, Yaourtis AM, et al. (2017) Iodine Deficiency in Pregnant Women Pre- and Post-Mandatory Iodine Fortification in Australia – An Epidemiological Review. Vitam Miner, 6(4): 171-174. DOI: 10.4172/2376-1318.1000171

Issues in Indigenous incarceration in NT

Edgell C[1]

[1]*Central Australia Health Service Primary Health Care*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

The presentation provides an overview of Prison Health in NT, including the following main topics:

- Demographics and underlying factors of incarceration
- Indigenous death in custody
- Health needs of people in prison
- Health effects of incarceration
- Prescribing in the prison environment
- Case studies

Please explain how this topic or subject is relevant to GPs in a clinical setting?

The presentation is relevant to GPs dealing with the key clinical issues of Indigenous health, cultural awareness and cultural barriers. The presentation is of particular relevance to GPs who see Indigenous men, as there are very high levels of incarceration in this population. The presentation is also relevant when consulting with anyone making the transition from incarceration back to community.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

This is a TED-style presentation, which draws on my personal experience. It includes case studies and time for Q&A.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

The presentation includes summary data on incarceration from identified sources.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

Not applicable

References: *(If applicable)*

Issues with chemical restraint in aged care

Soulsby N[1], Hillen J[1]

[1]*Ward Medication Management*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

We present recent data from Residential Medication Management Reviews (RMMRs) conducted by Ward Medication Management (WardMM) accredited clinical pharmacists over a two-year time frame (2017-2018 inclusive).

WardMM is the largest provider RMMRs and Quality Use of Medicines (QUM) services in Australia and currently looks after approximately 24,000 aged care beds. We employ approximately 20 pharmacists and provided services throughout the country. We are independent of the supply pharmacy.

The data from the last two years records was interrogated. More than 50% of residents were exposed to at least one chemical restraint medication residents were identified as being prescribed either an antipsychotic medication, benzodiazepine, or both. Of those residents, approximately 50% also had a diagnosis of dementia or a dementia related diagnosis and about 28% had a diagnosis of some other psychiatric disorder (not depression). The vast majority were aged between 76 and 99. The most commonly prescribed regularly medication was risperidone and this was in approximately 25% of all residents reviewed on an antipsychotic agent or a benzodiazepine. The most commonly prescribed PRN medication was oxazepam and this was seen in almost 40% of those residents.

Interestingly the trend in prescribing of these medications does not appear to have changed over the 2 years for either the antipsychotics or the benzodiazepines and remains around 30% for antipsychotics and 40% for benzodiazepines.

Comparing our data to international data for the use of antipsychotics, illustrates that our data is in keeping with that reported internationally as well as from Australian data.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

In the lead up to, and since the Royal Commission's first hearing, there has been much talk about the need to investigate the use of chemical restraint and the role of antipsychotic medications and benzodiazepines in aged care facilities.

There are many risks associated with the use of these medications in the frail elderly, including increased risk of a CVA or TIA, a two-fold increase in risk of pneumonia as well as an increased risk of confusion, agitation and unsteady gait.

Chemical restraint can be defined as the use of any type of medication to restrict an individual's movement or freedom. Chemical restraint may be used to manage agitation or aggression or sedating an individual.

All aged care homes have a policy in how to deal with residents exhibiting behavioural and psychological symptoms of dementia (BPSD) which lists the steps to be taken prior to using medication. Although we know that administering a medication is the "last resort" there is clearly a real problem in the perceived over-use of antipsychotics and benzodiazepines for treating BPSD.

The current focus of the Quality Standards Committee when visiting residential aged care facilities (RACF) is to identify which residents have been prescribed one of these medications and what plans are in place to monitor their use.

All doctors currently providing services in to aged care homes need to work collaboratively with their homes and allied health professionals to reduce the overall use of these medications.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

The presentation will include a summary of best practice for managing neuropsychiatric symptoms of dementia, including ensuring appropriate documentation for nursing staff

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

In an article by Ivers et al they reported on the results of a media campaign which described the high prescribing rates off antipsychotic medications in nursing homes. Following the publication of these articles prescribing rates of antipsychotics decreased by 1.28% with a continued decrease rate of 0.2% per month.

In a statement in 2017 in the USA by the Long Term Care Community Coalition they reported that the inappropriate use of antipsychotic drugs among nursing home residents continues to be widespread and immediate action is still needed to protect residents from chemical restraints.

Hillen et al in 2018 published a retrospective cohort study which identified that there was over-use of high risk medications including antipsychotics and benzodiazepines in residential aged care facilities in Australia.

In 2012 Bourgeois et al published an article where they identified the prevalence of benzodiazepine prescribing in Belgian nursing homes and their indication for use. They concluded that efforts needed to be made to reduce the use of benzodiazepines especially those prescribed for insomnia with an emphasis on dose reduction and length of treatment.

In a Canadian study by Kirkham et al they asked the question "Antipsychotic use in dementia: Is there a problem and are there solutions?" the answer to their question was a resounding yes as although they concurred that in some cases there is a role form antipsychotics in treating neuropsychiatric symptoms in persons with dementia, the prescribing rates are still higher than what is likely to be optimal.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

This is a practical knowledge update to ensure prescribing practices in this area are in line with Royal Commission and Quality Standards

References: *(If applicable)*

1. Ivers et al. Public reporting of antipsychotic prescribing in nursing homes: population-based interrupted time series analyses. BMJ Qual Saf: 2018;0:1-11
2. LTTC Submission to the United Nations Universal Periodic Review of the USA Second Cycle Twenty Second session of the UPR Human Rights council April 2018
3. Hillen J, Virty A, Caighey G. Medication-related quality of care in residential aged care: An Australian experience. International Journal for Quality in Health Care: 2018,1-9
4. Bourgeois et al. Benzodiazepine use in Belgian nursing homes: a closer look into indications and dosages. Eur J Clin Pharmacol 2012 68:833-844
5. Kirkham J et al. Antipsychotic Use in Dementia: Is There a Problem and Are There Solutions? 2017: 62 (3): 170-181

Late diagnosis of hepatitis c

Arora C[1], Rafique F[2], Jamil M[3]

[1]*Miranda Medical Centre,* [2]*Narregate Medical Centre,* [3]*World Health Organisation*

Aim and intended outcome/education objectives:

Hepatitis C management in the Australian healthcare sector has been challenging for healthcare professionals. Lack of knowledge about Hepatitis C of the general population and stigma associated with this disease has been resulting in late diagnosis. Our aim is to highlight and causes of late diagnosis of Hepatitis C in General Practitioner (GP) settings.

Results:

The systematic review followed PRISMA guidelines was conducted by using the electronic databases EMBASE, PubMed, and Medline. Initial search of database resulted in 70 relevant research articles. 35 were duplicate and removed. After assessing for relevancy 10 studies were removed and 25 studies were scrutinized. This process resulted in further removal of 13 research articles. Remaining 12 articles contributed to qualitative synthesis.

Conclusions:

The analysis revealed that Australian community lack of awareness about potential symptoms of hepatitis C is one of the most significant factors contributing to late diagnosis of hepatitis. Moreover, due to lack of required health promotional campaigns in the Australian community, the individuals do not opt to undergo screening for hepatitis C.

Increasing awareness and reducing the sense of stigma against hepatitis C is likely to positively contribute to the timely diagnosis and management of hepatitis C in the Australian population.

Medical educators: Where do they come from?

Coxeter P[1], **Stewart R**, Emblen G[1], Preston S[1], Mitchell B[1]

[1]*General Practice Training Queensland*

Background:

There is a growing need to recruit and retain doctors in Medical Education roles (which currently represent <1% of the medical workforce). There is limited evidence about the factors influencing early career transition and career trajectories of medical educators in Australian General Practice Vocational Training.

Aims:

The aim of the study is identify the barriers and enablers to recruiting and retaining general practitioners (GPs) into medical education careers, and opportunities to improve career pathways.

Method:

We used an **e**xploratory sequential mixed-methods design – including focus groups (online and in-person) (n=23), a semi-structured survey (developed from focus group findings) in a nationwide sample of GPs (n=70), and key informant interviews with experienced educators in leadership roles (n=5).

Results:

We identified a variety of pathways into medical education - via examining, supervision, or invitation (ie. 'tap on the shoulder'). Key enablers included role career diversity/flexibility and job satisfaction, and increased clinical/medical education knowledge. Barriers included clinical and family commitments, a perceived lack of confidence and support in the role, and administrative burden. Low awareness of career opportunities, poor remuneration and role uncertainty were also perceived as barriers to commencing or remaining in a medical education career.

Discussion:

Many of the enablers and barriers identified may be modifiable at individual, organisational and institutional levels.

Conclusion:

The findings of this project will provide important guidance to build an adequate and sustainable Medical Educator workforce for Australian General Practice training.

Metamorphosis - Becoming a GP

Howard D[1], Bottrell C[2]

[1]*Mccc Gp Training,* [2]*MCCC GP Training*

Background:

The transition from hospital to primary care is a difficult one, learning to link "the vast amount of accumulated medical knowledge with the art of communication" (Murtagh, Rosenblatt, Coleman, & Murtagh, 2018)

Aims:

This research was designed to follow the journey of a cohort of registrars in their first GP term. Exploring and more fully understanding the lived experience is anticipated to contribute to GP training programs and supervisor professional learning.

Method:

Using a narrative inquiry approach, registrars in their first GP term participated in pre and post term interviews and completed a fortnightly reflection through audio-diary (or written diary). A grounded theory approach was used to analyse the data.

Results:

The change from hospital to independent general practice involves a number of key challenges including becoming a safe independent decision maker; learning to be patient centred; dealing with uncertainty; learning to balance working and learning with other life issues. The narratives that the registrars gave us richly illustrate key learning moments in these challenges.

Discussion:

Understanding the challenges and learning that takes place in the transition from hospital to primary care may help those working in this space, including supervisors; medical educators, and the wider medical education community.

Conclusion:

Becoming a GP is a complex process – a metamorphosis – that is achieved in a unique way by each who undertakes it. There are however, common elements to that journey that this study aims to highlight, with an aim to improving the journey for future generations of general practitioners and their patients.

Motherhood and medicine: A systematic review

Hoffman R[1]

[1]*University of Wollongong*

Context

Worldwide, females are graduating from medical degrees and entering the workforce as doctors in increasing numbers (Joyce et al., 2010). A criticism of the feminisation of the medical workforce is directed towards the dual role, of being a mother and a doctor, and the absences that women often take from their career to child-rear (Brooks, Lapsley, & Butt, 2003). However, there is limited literature and understanding from the mothers' perspectives of the barriers, challenges and supports that they have in navigating the potentially competing roles.

Objective

To consolidate current understandings, and direct further research. We will thematically analyse the studies, primarily qualitative, of the experiences, barriers and supports that doctors, who are also mothers, experience in juggling their dual roles.

Design

Systematic review.

Methods

A systematic search of databases (Cinhal, Medline, Psych Info, Web of Science, Scopus) for studies relevant to the review, published between 2009-2019 was completed. Two researchers selected articles using PRISMA guidelines, data was synthesised and analysed by thematic analysis. Thirty-nine articles were identified, these articles will be thematically analysed and concepts synthesised.

Findings

Thirty-nine studies will be included. These articles are currently undergoing data extraction and analysis.

Implications

This systematic review will synthesis and present data concerning the point of overlap of two socially demanding roles, that of being a mother and that of being a doctor, at a time of heightened awareness of workplace gender equity.

At a personal level, this systematic review will serve to be the first component of a PhD.

Multimorbidity in people with type 2 diabetes

Chiang J[1], Thuraisingam S[1], Furler J[1], Jani B[2], Mair F[2], Nicholl B[2], Manski-Nankervis J[1]

[1]*University Of Melbourne,* [2]*University of Glasgow*

Background:

Multimorbidity (MM) is common in people with T2D (PwT2D) who in Australia receive medical care predominantly in general practice (GP).

Aim:

We explored the association between MM condition count and HbA1c in PwT2D attending Australian GP, using electronic health record (EHR) data.

Method:

Cross-sectional study of 69,718 PwT2D who had a GP encounter between 2013-15 captured in the NPS MedicineInsight dataset. MM condition count was based on coded and free text conditions in the reason for visit, prescription or medical history fields in the EHR. Primary outcome: HbA1c. Multivariable mixed-effects linear regression examined associations between MM counts (total, concordant (T2D-related) and discordant (unrelated)) and HbA1c (%).

Results:

We found statistically significant associations between HbA1c and total and discordant MM counts. Mean HbA1c (95% CI) was lower for those having 1, 2, 3 and 4+ total conditions compared to T2D only, -0.065 (-0.089, -0.041), -0.097 (-0.128, -0.066), -0.089 (-0.133, -0.046), and -0.097 (-0.146, -0.047) respectively, and for discordant conditions -0.085 (-0.108, -0.061), -0.100 (-0.134, -0.065), -0.141 (-0.195, -0.087), and -0.204 (-0.276, -0.133). There was no statistically significant association between HbA1c and increasing concordant count.

Discussion:

The effect of MM on HbA1c remains unclear as the associations we observed are not likely to be clinically significant. The NPS dataset uses routine data entered by clinicians for patient care, rather than epidemiological studies and may thus underestimate the number of multimorbid conditions. While clinicians need to consider the MM burden of PwT2D, this dataset needs further validation, eg through combining with other data sources, in the study of MM.

Conclusion:

This study demonstrated that having MM and discordant conditions are related to decreased HbA1c however the degree in reduction of HbA1c is not likely to be clinically significant.

New Rheumatic heart disease guidelines supporting GPs

Noonan S[1,2], Wyber R[3,4]

[1]*Menzies School of Health Research,* [2]*University of Western Australia,* [3]*The George Institute for Global Health,* [4]*Telethon Kids Institute*

Aim and intended outcome/education objectives:

Acute rheumatic fever (ARF) can be difficult to diagnose and people with rheumatic heart disease (RHD) require life-long complex care. Busy GPs need quick access to best practice information to help navigate the complexities of this disease. The Australian Medical Association's *Call to Action*[1] to prevent new cases of RHD is important for GPs on the front line of preventing, diagnosing and managing the condition.

Results:

The third edition of the Australian ARF/RHD guideline[2] will be published in late 2019 and include expanded clinical content and some new treatment recommendations wrapped in a cultural framework, with practical advice on how to prevent, diagnose and care for people with ARF and RHD in Australia. Case studies will highlight how culture is integral to the experience of Aboriginal and Torres Strait Islander people living with ARF and RHD.

Conclusions:

The national ARF/RHD guideline is being updated and includes new and important information for GPs who care for people with this disease.

Content:

The national recommendations for preventing, diagnosing and managing ARF and RHD in the primary care setting with a focus on changes from the last edition. This includes managing suspected ARF, regimens for secondary prophylaxis, and the principles of RHD management.

References:

1. Australian Medical Association. AMA Report Card on Indigenous Health 2016. Canberra: AMA, 2016.
2. RHDAustralia (ARF/RHD writing group), National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand. Australian guideline for prevention, diagnosis and management of acute rheumatic fever and rheumatic heart disease (2nd edition). 2012

NPS MedicineWise general practice insights report 2017-18

Norman S[1], **Chidwick K[1]**, Pollack A[1], Belcher J[1], Havard A[1], Whitlock B[3], Rayson I[2], Blogg S[1]

[1]*NPS MedicineWise,* [2]*Australian Bureau of Statistics,* [3]*Department of Health*

Presentation title:

The NPS MedicineWise General Practice Insights Report (GPIR) 2017-18 – a patient-centred overview of general practice activity using MedicineInsight data.

Background:

MedicineInsight was established by NPS MedicineWise in 2011, with core funding from the Department of Health. MedicineInsight collects deidentified electronic health record data from participating general practices across Australia to support quality improvement in Australian primary care and post-market surveillance of medicines.

Aims:

The purpose of the General Practice Insights Report (GPIR) 2017–18 is to provide a nationally representative patient-focused overview of the key features of general practice patients and activity in Australia.

Method:

Data on patient characteristics, conditions, prescriptions, pathology tests and risk factors were extracted from 474 general practice sites for eligible patient encounters between 1 July 2017 and 30 June 2018.

Results:

With data from 2.7 million patients and almost 14 million clinical encounters in 2017–18, the GPIR 2017–18 provides a patient-centred overview of different facets of general practice activity. GPs manage large numbers of patients with cardiovascular disease, mental health issues and risk factors such as hypertension and dyslipidaemia. MedicineInsight is a novel source of data for tracking vaccine preventable diseases such as pertussis, and it provides valuable information on prescriptions and pathology testing.

Discussion:

This work builds on the previous GPIR, providing further information from the MedicineInsight program about general practice activity. It supports and facilitates GP quality improvement activities, public health and health services research and contributes evidence for the development of health systems policy and practice.

Conclusion:

The GPIR provides information that cannot be obtained from other sources and covers aspects of general practice for which MedicineInsight data has the capacity to provide unique insights.

Opioid prescribing patterns in Australian general practice

Chidwick K[1], Busingye D[1], Belcher J[1], Meyers J[1], Heaney A[1], Pollack A[1]

[1]*NPS Medicinewise*

Background

There are growing concerns about prescription opioid use and misuse in Australia. MedicineInsight collects deidentified electronic health records from participating general practices across Australia.

Aim

To describe patterns of opioids prescribing in Australian general practice to help inform policy and practice.

Methods

We assessed utilisation of opioids (excluding injectables, antitussives and those solely indicated for substitution therapy) among patients at 426 general practice sites in MedicineInsight between 1 October 2013 and 30 September 2018.

Results

4,006,415 prescriptions for opioids were written for 468,893 (14%) of the total 3,351,958 patients. The most frequently prescribed opioids, including combination products, were oxycodone (37.7%), codeine (15.5%), tramadol (14.4%) and buprenorphine (14.2%), followed by fentanyl patches (5.1%), morphine (4.8%), tapentadol (4.7%), methadone (2.0%), hydromorphone (1.5%). Over 5 years, prescribing rates (as a proportion of total and of opioid prescriptions) increased substantially for tapentadol, decreased for fentanyl patches and morphine, and remained stable for most other opioids. Among new users of fentanyl patches (n = 10,251) 30% were opioid naive. Same-day prescriptions of fentanyl patches with benzodiazepine, zolpidem or zopiclone occurred in 28.4% of patients prescribed fentanyl patches. The likelihood of receiving prescription for opioid increased with patient age, social disadvantage and residential rurality. Females were more likely than males to be prescribed fentanyl patches, buprenorphine or codeine.

Discussion

This study evaluated patterns in prescribing of opioids in general practice as well as sociodemographic characteristics of patients prescribed opioids and highlights potential high-risk use as reported elsewhere.

Conclusion

MedicineInsight contributes evidence for policy and practice.

Opioid prescribing practices of Victorian GP registrars

Prathivadi P[1], Barton C[1], Mazza D[1]

[1]*Monash University Department of General Practice*

Background:

GP registrars work closely with GPs to manage chronic non-cancer pain (CNCP) in Australian primary care [1]. Opioids are frequently used by both groups of practitioners to manage acute and chronic pain; in fact CNCP accounts for 50% of opioid scripts in general practice [2]. The nature of prescribing is markedly different between the junior and senior doctors.

Aims:

To explore the opioid prescribing practices, attitudes and knowledge of Victorian GP registrars.

Method:

20 rural and metropolitan GP registrars enrolled in either the Eastern Victoria GP training or Murray City Country Coast recognised GP training providers were recruited.

Interviews up to 60 minutes in duration were undertaken over the telephone, audio recorded and de-identified. A professional transcriptionist transcribed the recordings verbatim.

Braun & Clarke's 6-phase framework was adopted for thematic analysis of the data and managed using QSR N-Vivo software.

Ethics approval was obtained from Monash University.

Results:

Theme 1: Support and Supervision. Difficult chronic pain consultations, disgruntled patients and drug-seekers caused registrars marked unhappiness. A lack of a supportive supervisor was a major cause of stress and isolation for registrars, as well as a barrier to safe prescribing.

Theme 2: Confidence. Registrars avoided initiating long-term opioids due to lack of confidence. Despite education during GP training, registrars did not feel confident.

Theme 3: Safety. Registrars were generally aware of current recommendations to improve safe prescribing but admitted to rarely implementing these in daily clinical practice for a variety of reasons.

Discussion:

To our knowledge, this is the first study to describe Australian GP registrar attitudes towards supervision and support in managing chronic non-cancer pain with opioids.

Emotionally difficult consultations may be a barrier to managing patients effectively and safely. A wide range of factors contributes to this including poor supervisor support, abusive and demanding patients and lack of confidence in registrars' own prescribing practices. Registrars demonstrated a keen insight into their intentional unsafe or non-evidence based prescribing of opioids.

Conclusion:

Addressing various issues highlighted in this study will improve quality and safety in opioid prescribing in general practice. Interventions targeting prescriber behaviors will likely need to be tailored to registrars and GPs separately.

References: *(If applicable)*

This study was funded by the 2018 RACGP Foundation Charles-Bridges-Webb Memorial Award.

1. Harrison, C.M., et al., Opioid prescribing in Australian general practice. The Medical journal of Australia, 2012. 196(6): p. 380-381.
2. TGA, Prescription strong (Schedule 8) opioid use and misuse in Australia – options for a regulatory response, D.o. Health, Editor. 2018.

Pregabalin prescribing patterns in Australian general practice

Chidwick K[1], Busingye D[1], Gianacas C[1], Blogg S[1]

[1]*NPS Medicinewise*

Title

Pregabalin prescribing patterns in Australian general practice from 2012 to 2018 using MedicineInsight data.

Background

There are concerns about increased prescribing of pregabalin and the potential for misuse and adverse effects. MedicineInsight collects deidentified electronic health records from participating general practices across Australia.

Aim

To determine patterns of pregabalin prescribing in Australian general practice to help inform policy and practice.

Methods

We conducted a drug utilisation study among adult patients at 445 Australian general practice sites in MedicineInsight between 1 March 2012 and 28 February 2018.

Results

Over the 6 years, pregabalin as a proportion of all prescriptions increased 8-fold (0.13% to 1.04%). 114,123 (6.0%) of all 1,891,623 patients were given 404,098 prescriptions for pregabalin. Over 80% of PBS prescriptions for pregabalin had at least one repeat. The likelihood of receiving a prescription for pregabalin increased with patient age, socioeconomic disadvantage and residential rurality. Of patients prescribed pregabalin, 38% had at least one same-day prescription of opioid, and 13% a benzodiazepine. Of patients prescribed pregabalin, 52% had back conditions recorded, 42% neuropathic pain, 29% depression, 12% sciatica, 10% chronic pain and 1% epilepsy. In the last year of the study, 29%, 43%, 20% and 8% of prescriptions were for the 25 mg, 75 mg, 150 mg and 300 mg strengths, respectively.

Discussion

This study has demonstrated increased prescribing of pregabalin following PBS listing and identified potentially at-risk patient groups, due to potential off-label prescribing and co-prescribing with other sedatives.

Conclusion

MedicineInsight contributes evidence around pregabalin prescribing in Australia to inform policy makers and clinicians.

Preventing travel-associated infectious diseases in children

Mazzocato P[1], Leder K[2,3], Britton P[1,4]

[1]*Children's Hospital at Westmead,* [2]*Monash University,* [3]*Royal Melbourne Hospital,* [4]*Marie Bashir Institute, University of Sydney*

Background:

From December 2018, the Children's Hospital at Westmead (CHW) has undertaken prospective surveillance of travel-associated disease in children as a participant in the global Geosentinel network, for which Royal Melbourne Hospital is the coordinating site in Australia.

Aims:

We aimed to document travel-related presentations to CHW, a large paediatric hospital situated in the rapidly growing and culturally diverse region of Western Sydney. Secondarily, we aimed to inform efforts to improve prevention and management of travel-related illness in children.

Method:

Active case ascertainment through weekly screening of emergency department presentations and medical record review of eligible cases with collection of de-identified demographic, clinical and laboratory data.

Results:

In the first 6 months, the most common presenting syndromes in 236 children with travel-related illness were: respiratory (36%), fever (25%), diarrhoea (17%), and injury/bite (7%). Thirty-nine children (16%) had a potentially vaccine-preventable disease, including 19 with influenza. Children travelling to visit friends and relatives (VFR) in their parents' country of birth accounted for all 5 cases of Hepatitis A and 14 of 15 cases of enteric fever, one with extensively drug-resistant (XDR) Typhoid(1). Very few travellers received recommended pre-travel vaccines.

Discussion:

We captured a wide variety of travel-related illness amongst children, some vaccine-preventable. Early data showed a local problem of under-vaccination of children at high risk of enteric fever, in particular children of South Asian VFR travellers.

Conclusion:

Our ongoing surveillance project reinforces how local data can inform better clinical care and practice. GPs are ideally placed to provide opportunistic care and reduce the burden of vaccine-preventable disease in paediatric VFR travellers.

References:

Howard-Jones A, Outhred A, Kesson A, Britton PN. XDR typhoid has arrived in Sydney. Medical Journal of Australia. 2019 *In Press.*

Probiotics for the prevention of antibiotic-associated diarrhoea

Goodman C[1], Levett K[1]

[1]*The University Of Notre Dame Australia*

Background:

Antibiotic-associated diarrhoea (AAD) has a significant impact on length of hospital admissions, morbidity and mortality. Probiotics are thought to protect against disturbance from antibiotics by reducing colonisation by pathogenic bacteria.

Aims:

This review evaluates existing data assessing whether probiotics prevent AAD in adults, and which probiotic species and doses are most effective.

Method:

MEDLINE (Ovid), CINAHL Plus, Web of Science, and Google Scholar were searched for randomised controlled trials that investigated the use of probiotics to prevent AAD in adults. Data extraction followed PRISMA guidelines. The primary outcome was AAD incidence. Sub-group analyses evaluated species-specific and dose-specific responses. Dichotomous outcomes were pooled using a random-effects model to calculate odds ratio (OR) and 95% confidence interval (95% CI).

Results:

Twenty-nine (total 8218 participants) of 849 identified studies met inclusion criteria. Meta-analysis of pooled data suggested that probiotics reduce incidence of AAD by 47% (OR=0.53, p<0.001). Compared with placebo, probiotics reduced incidence of AAD by 43% (OR=0.57, p<0.001). Compared with no treatment, probiotics reduced incidence of AAD by 77% (OR 0.33, p<0.001). AAD incidence was reduced with probiotic species: L. acidophilus (13 studies: OR 0.51, p<0.001), Bifidobacterium spp. (8 studies: OR 0.57, P<0.01), and Lactobacillus spp. (22 studies: OR 0.51, P<0.0001). High dose against low dose of the same probiotic showed a reduction in AAD (OR 0.53, p<0.01).

Conclusion:

Probiotics are effective for preventing AAD. Certain doses and strains show increased effectiveness. This could inform antibiotic prescription guidelines, improve patient outcomes and reduce health service costs.

*Updated review due mid-2019

Recognizing the faces of cutaneous lupus

Saini K[1], Chee P[1]

[1]*John Hunter Hospital*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

Lupus Erythematosus is a common autoimmune disease affecting approximately 20,000 Australians 1, with a predilection for women of ages 20 - 50. With its increasing prevalence, wide spectrum of cutaneous presentations and serious systemic implications, recognising cutaneous manifestations is key in early diagnosis and disease control 2,3.

Learning objectives:

1. Brief overview of Lupus Erythematosus.
2. Recognise that Cutaneous lupus may be categorized into three main entities: chronic cutaneous lupus (CCLE), subacute cutaneous lupus (SCLE) and acute cutaneous lupus (ACLE).
3. Pictorial review highlighting skin features of the subtypes of cutaneous lupus – with emphasis on distinguishing features and chronic skin changes.
4. Importance of avoidance of triggers and exacerbating factors – with a focus on common medications used in general practice.
5. Importance of prompt recognition and early diagnosis in disease control.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

The spectrum of cutaneous manifestations occurring in patients with Lupus is broad. General practitioners are often the first point of contact for patients with skin changes and such manifestations may constitute the initial signs of disease. Therefore, it is important for General Practitioners to be able to recognise some common features of cutaneous forms of Lupus, in order to initiate an appropriate workup and timely referral of affected patients. This will enable optimisation of overall patient health outcomes by gaining early disease control. For patients, particularly young females, this can be of great importance as scarring forms of cutaneous lupus can also lead to poor cosmetic outcomes due to delayed treatment.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

A brief outline of the forms of cutaneous lupus will be discussed. An interactive PowerPoint presentation with an emphasis on pictorial examples of each of the cutaneous subtypes will be used to highlight the distinguishing features of these manifestations. Questions will be asked to the delegates to encourage engagement during the presentation. If time permits a short quiz will also be conducted at the end of the presentation to encourage retention of discussed skin manifestations of cutaneous lupus.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

Extensive search of the current literature regarding cutaneous lupus has been conducted and the most relevant articles are used as a reference source for this presentation. Case examples and pictorial reviews of patients seen at John Hunter Hospital outpatient Dermatology clinics will also be used to highlight features of the different subtypes of cutaneous lupus.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

References:

1. (ASCIA), A. S. o. C. I. a. A. (2019, June 2016). "Systemic Lupus Erythematosus (SLE)." Retrieved 30th April, 2019, from https://allergy.org.au/images/pcc/ASCIA_PCC_Systemic_Lupus_Erythematosus_2016.pdf
2. Ribero, S., et al. (2017). "The Cutaneous Spectrum of Lupus Erythematosus." Clin Rev Allergy Immunol 53(3): 291-305.
3. Kuhn, A., et al. (2007). "Clinical manifestations of cutaneous lupus erythematosus." J Dtsch Dermatol Ges 5(12): 1124-1137.

Reconciliation in an Australian urban general practice

Burke M[1], **Leslie-Henfling L**[2]

[1]*Western Sydney University,* [2]*Winangay Consulting*

Background:

Culturally safe health care environments are integral to the health of Aboriginal and Torres Strait Islander peoples. A strategy towards the provision of culturally safe environments is for organisations to have a Reconciliation Action Plan (RAP). A RAP enables organisations to contribute to reconciliation by encouraging positive relationships; fostering respect for Aboriginal and Torres Strait Islander cultures and communities and developing opportunities within an organisation to improve outcomes (Reconciliation Australia, 2017).

Aims:

The aims of the research are to provide an Aboriginal and non-Aboriginal perspective of collaborating in a team working on a RAP; to provide a set of key learning experiences; to outline a respectful process; and to inspire other private medical practices to work towards their RAP.

Method:

From March to December 2018, a private medical practice in Western Sydney embarked on a 9-month project to produce a RAP. Led by an Aboriginal Project Manager, the 'Reconciliation Sharing Circle' was formed which consisted of both Aboriginal and non-Aboriginal team members.

Results:

This is a reflective stage of an action learning process. The reflections used are from the Project Manager of the working party and a member of the working party and focus on their key learning experiences of collaboration.

Discussion:

Insights are shared on reflections on collaborating on a Reconciliation Action Plan in a private medical practice by an Aboriginal (PhD) Doctor and a non-Aboriginal General Practitioner.

Conclusion:

This research highlights the importance of positive relationships between Aboriginal and non-Aboriginal peoples working in collaboration towards a goal, that is, true reconciliation in practice.

References:

Reconciliation Australia. (2017). Reconciliation Action Plans. Retrieved from https://www.reconciliation.org.au/reconciliation-action-plans/

Refugee perceptions of the Australian healthcare system.

Au M[1], Anandakumar A[1], Preston R[2], Ray R[1], Davis M[3]

[1]*James Cook University,* [2]*Central Queensland University,* [3]*Townsville Multicultural Support Group Incorporated*

Background:

Refugees have significant unmet health needs. Delivering services to refugees continues to be problematic in the Australian healthcare system.

Aims:

To undertake a systematic review of the literature exploring refugee perceptions of the Australian healthcare system.

Method:

*1*610 articles published between 2006 and 2019 were screened, and 147 articles were read in full-text. Articles were appraised with a combination of tools. Using NVivo 11, articles were coded into descriptive themes and synthesised into analytical themes. An explanatory model was used to synthesise findings and confidence was assessed with GRADE-CERQual approach.

Results:

35 articles consisting of one systematic review, 7 mixed methods, and 27 qualitative studies were included. One study was from a regional or rural area. Refugees struggled to engage with health services due to their unfamiliarity. Information sharing is needed but this is not always delivered, resulting in disempowerment and loss of autonomy. Refugees resorted to familiar means, such as family members and their pre-existing cultural knowledge. At times, this perpetuated their unfamiliarity with the broader health system. Access barriers were encountered with trust and privacy as pervasive issues.

Conclusion:

Refugees face barriers in accessing and engaging with healthcare services with implications across all areas of service provision and clinical practice. Health administrators need to consider improving the cultural competency of staff and students. Policymakers should consider engaging communities and upscale the accessibility of language supports. There is limited research in remote areas and evidence is needed in these settings.

Registrars' prescription of type 2 diabetes medication

Mulquiney K[1,2], Magin P[1,2], Tapley A[1,2], Fielding A[1,2], Davey A[1,2], Davoren P[3,4]

[1]GP Synergy, Regional Training Organisation, NSW & ACT Research and Evaluation Unit, [2]University of Newcastle, School of Medicine and Public Health, [3]Department of Diabetes and Endocrinology, Gold Coast University Hospital, [4]Griffith University, School of Medicine

Background:

GPs are responsible for the pharmacological management of patients with Type 2 Diabetes (T2DM). Anecdotally, uptake of "new" diabetes drugs has been rapid. Evidence-based guidelines generally still recommend sulphonylureas as initial add-on therapy to metformin. During their early years of availability of 'new' drugs evidence for substantive improvement in important clinical outcomes was not available.

Aims:

To establish associations of prescribing sulphonylureas versus "new" (DPP-4, SGLT-2, GLP-1) drugs, and any temporal trend in prescribing these medications.

Method:

Cross-sectional and longitudinal multivariable analyses employing ReCEnT study data, an ongoing, multicentre cohort study of registrars' practice.

The outcome factor in logistic regression analyses, including 'any prescription' and 'initiated script', was sulphonylureas versus "new" drugs. Models were adjusted for patient, registrar, practice, and consultation factors.

Results:

1.4% of problems seen by registrars are T2DM. 13.8%(n=835) of these patients were prescribed a sulphonylurea (39.1%n=326) or "new" drug (61.0%n=509) at the index consultation.

In an adjusted model there was a 52% increase in prescribing of "new" drugs compared to sulphonylureas each year (OR=1.52[95%CI 1.38,1.68],p<0.001). For initiation, the OR was 1.77[95%CI 1.30,2.43],p=<0.001.

Multivariable associations of prescribing "new" drugs versus sulphonylureas were the patient being of English-speaking background and registrar training organization.

Discussion:

We found a significant increase over time, 2010-2018, in the prescription of "new" drugs compared to sulphonylureas for T2DM.

Conclusion:

While there is accumulating evidence for improved clinical outcomes in new drugs for patients with CVD, we found uptake of the "new" drugs may be in advance of the evidence and current recommendations.

Reproductive genetic carrier screening in general practice

Leibowitz R[1,2], Archibald A[1,2,3], Lewis S[3], Delatycki M[2,3], Emery J[1]

[1]*University Of Melbourne* , [2]*Victorian Clinical Genetics Services,* [3]*Murdoch Children's Research Institute*

Background:

The Royal Australian and New Zealand College of Obstetrics and Gynaecology now recommends that women contemplating pregnancy or in early pregnancy should be offered carrier screening for at least haemoglobinopathies, cystic fibrosis (CF), fragile X syndrome (FXS) and spinal muscular atrophy (SMA) regardless of whether there is a family history(1). It is widely recognised that general practice is the most appropriate setting in which to undertake genetic carrier screening(2). In light of the new recommendations, investigating GP participation in carrier screening is of vital importance.

A fee-for-service screening program for CF, FXS and SMA (brand name *prepair*), run by the Victorian Clinic Genetics Services, has been available to doctors (obstetricians, GPs etc) since 2012. Carriers are offered genetic counselling and partner testing.

Aims:

To investigate the participation of GPs in the *prepair* screening program.

Method:

The results from 21,172 women, screened between 2013 and 2018, were analysed.

Results:

GPs requested 4283 tests (20%). There were 861 requesting GPs. The number of requests per GP ranged from 1 to 185. Most requesting GPs were from Victoria (84%). Among those tested by GPs: mean age was 33 years, 53% were pregnant at the time of testing and 71% were in the highest socio-economic quartile as measured by residential postcode.

One in 20 women were carriers for at least one condition. No family history of the condition was recorded for over 90% of carriers.

Conclusion:

This data highlights the variable participation of GPs in carrier screening and the inequitable access to genetic carrier screening in the population. The next stage of this study will involve interviewing participating GPs to investigate barriers and enablers to carrier screening in general practice.

References:

1. Genetic Carrier Screening. Royal Australian and New Zealand College of Obstetricians and Gynaecologists; 2019.
2. Delatycki MB, Laing NG, Moore SJ, Emery JD, Archibald AD, Massie J, et al. Preconception and antenatal carrier screening for genetic conditions. AJGP. 2019;48:106-10.

Sharing patient information with researchers: GP perspectives.

Monaghan T[1], Manski-Nankervis J[1], Canaway R[1]

[1]*University of Melbourne*

Background:

There is increasing interest in utilising data from general practice consultations for research which can be used to inform clinical practice and policy. Software is available which can automatically de-identify and extract patient health information from general practice consultations to create large datasets for use in research. For researchers to access this data, general practices must agree to provide it to them. There is, however, little research exploring what the key general practice personnel who may influence this decision think about providing de-identified patient information to researchers.

Aims:

To explore general practitioners', practice nurses' and practice managers': (a) attitudes and beliefs about the sharing and use of de-identified patient health information for the purposes of research; and (b) perceived barriers and facilitators for the provision of de-identified patient health information for the purposes of research.

Method:

This is an exploratory qualitative study which utilised purposeful sampling to recruit 11 participants to undertake a questionnaire and individual semi-structured interview, which will be thematically analysed.

Results:

This is currently a study in progress. All 11 participants have been recruited and we are currently undertaking data collection and thematic analysis. Key findings will be presented at GP19.

Discussion:

Key findings will be discussed at GP19.

Conclusion:

Findings from this study could assist in designing a larger study to help inform policy and practice around the secondary use of de-identified patient health information in research, directly impacting the availability of data for primary care research.

Simulation of a tool for antibiotic prescribing

Manski-Nankervis J[1], Biezen R[1], Boyle D[1], Lo S[1], Clark M[1], Thursky K[2], Buising K[2]

[1]*University Of Melbourne,* [2]*National Centre for Antimicrobial Stewardship*

Background:

There is a high rate of antibiotic prescribing in Australia. Inappropriate prescribing contributes to the development of antimicrobial resistance, over-medicalisation of self-limiting conditions, and places patients at risk of side effects without clinical benefit. As a result, there is growing interest in the development of antimicrobial stewardship (AMS) in general practice. One AMS strategy is to improve access to guidelines for appropriate prescribing at the point of care.

Aims:

To explore the usability and required design features of a clinical decision support (CDS) tool integrated with the electronic medical record (EMR) that provides access to Therapeutic Guidelines and patient resources.

Method:

Simulation study incorporating two clinical cases with simulated patients, questionnaires and Think Aloud Interviews were conducted with eight general practitioners (GPs) in September 2018 across metropolitan Melbourne.

Results/Discussion:

7/8 of the GPs were satisfied with the usability of the CDS tool and all thought the consultations were representative of a general practice consultation. Analysis of the Think-Aloud interviews found: (1) The CDS tool assisted with clinical decision making and informed appropriate prescribing; (2) The tool would be of increased benefit to GPs who were less experienced or not familiar with Therapeutic Guidelines; (3) Demonstrating guidelines was helpful to 'convince' patients when antibiotics were not necessary; (4) The patient information section provided relevant evidence-based information for patients, which enhanced communication between the GP and the patient.

Conclusion:

The CDS tool will be further developed and implemented in a pilot AMS quality improvement program in general practice.

SmartStartAllergy – Food allergies in infants

Leeb A[1], Peters I[2], Orleman K[2]

[1]***Illawarra Medical Centre,*** [2]***SmartX data***

Introduction

Australia has one of the highest incidence of food allergy in the world.

SmartStartAllergy (SSA) offers a unique opportunity to collect and report large scale, real-time data on infant feeding and food allergy.

Methods

SSA was developed to determine the rate of introduction common food allergens, (including peanut) and any associated allergic reactions around 12 months of age.

SSA is an SMS and smartphone application utilising the technology and experience from the SmartVax infrastructure.

Results

An SMS enquiring about the introduction of allergenic foods was sent to parents of 3374 infants (46.9% female), responses received 1994 (59.1%). 54 (1.6%) opted out.

Total of 1940 participants analysed. 836 participants (45.7%) completed surveys.

At 12 months of age, 1673 of 1940 infants had eaten food with peanut (86.2%; 95% CI 84.6 – 87.7%).

Parent reported allergic reaction to any food was 235 of 1831 SMS participants (12.8%; 95% CI 11.3 – 14.5%), Of these 97 (39%) were not associated with typical symptoms suggesting IgE mediated allergic reactions.

Parent reported allergic reactions to dairy (72 of 835, 8.6%, 95% CI 6.8 – 10.7%), egg, fish, peanut, (20 of 764, 2.6%, 95% CI 1.6 – 4.0%), sesame, soy, tree nut, wheat and a collective of other foods.

Conclusion

SmartStartAllergy demonstrates a significant shift over 10 years of infants now consuming peanut in the first year of life.

SSA could contribute to individual patient care through targeted health promotion messages, reporting significant reactions to a child's GP, and facilitating development of locally adaptable, streamlined referral processes.

Specialist referrals for culturally-diverse patients

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[1]Western Sydney University, [2]Notre Dame University

Background:

General Practitioners (GPs) play an important gatekeeper role in the referral process to specialist services. Patients from culturally and linguistically diverse (CALD) backgrounds present with a unique set of challenges that may affect their experience of health services.

Aims:

To explore the perspectives of GPs and CALD patients with the specialist referral process and determine any areas for improvement

Method:

Semi-structured interviews were conducted with culturally-diverse GPs in Greater Western Sydney (GWS) and their patients with prior specialist interactions. The interviews were digitally recorded, transcribed and then analysed using the framework approach.

Results:

Eight GPs and five patients were interviewed. Three broad themes emerged. GPs had numerous considerations beyond language and culture, having to prioritise certain factors over others; including cost, geography, health literacy, and specialist competence. There was an emphasis on the importance of communication between the GP, patient and specialist. There is a noticeable deficiency in the formally implemented means to overcome language barriers.

Discussion:

There were similarities and differences between the GPs' and patients' perspective on the importance of various considerations in the referral process. Shared language and culture may be outweighed by other factors in specialist selection. As such, there is a need for good communication and patient-tailored care to effectively deliver healthcare.

Conclusion:

Cultural factors may not be the most important consideration in the complex interaction between patient and GP in the specialist referral process.

References:

Available on request

Stopping long term topical steroid use

Sheary B[1]

[1]*Royal Randwick Medical Centre*

Aim and intended outcome/education objectives:

The aim of this study was to find out what sort of patients are stopping long-term topical steroid use due to concerns about topical steroid withdrawal (TSW), and what happens to them once they do this.

Results:

Fifty-five adult patients concerned they were experiencing topical steroid withdrawal (TSW) were seen in an Australian suburban practice during the period January 2015-February 2018. 56% of the patients were female and ages ranged from 20 to 66 years (mean, 32.9 years; median, 30.0 years). 76% had an original diagnosis of atopic dermatitis. 60% had used potent topical steroids on the face, and 42% had a history of oral corticosteroid use for skin symptoms. Burning pain was reported in 65%; all had widespread areas of red skin; and so-called “elephant wrinkles” were seen in 56% and “red sleeve” in 40%.

Conclusions:

Patients with a history of long-term topical steroid overuse may experience symptoms and signs described in topical steroid withdrawal (TSW) following cessation of topical steroids. More research is required to determine the impact and duration of these symptoms, in addition to the medium and long term outcomes seen in these patients.

Introduction

There is much interest in social media[1] about red skin syndrome, a potential adverse effect of topical steroid overuse. Despite this being deemed as a controversial diagnosis by some in the medical community, there are patients with a history of chronic topical steroid use, often for eczema, who are choosing to stop using topical steroids due to their concerns about this condition. Stopping topical steroids in this situation is called topical steroid withdrawal, or simply “TSW”. There is little information in the literature about what happens to these patients.

Red skin syndrome, which is managed by stopping topical steroid use – that is, topical steroid withdrawal (TSW) - is not a new diagnosis, but it has been called various names in the literature over the years. These names include red burning skin syndrome2, topical steroid addiction3 and topical corticosteroid addiction/ withdrawal syndrome1. A systematic review of the literature regarding this condition was published in 2015. The authors concluded TSW is a distinct adverse effect of topical steroid overuse, especially where there has been long-term inappropriate use of moderate to potent topical steroid to the face or genital area1. Atopy is considered a risk factor for developing this condition2. Prior to ceasing topical steroids, patients with TSW may have evidence of skin damage such as atrophy with striae and telangiectasia2,3 (see Figure 1a.) Symptoms seen in TSW include burning pain, severe itch, shedding skin/desquamation (see Figure 1b.), oedema, serous exudate/ooze, skin sensitivity, insomnia and depression1-3. While these symptoms are not specific to TSW, their presence, in addition to a classic history, supports the diagnosis.

Methods

Patients presenting with possible topical steroid withdrawal (TSW) following discontinuation of chronic topical steroid overuse were assessed in an Australian suburban general practice by a general practitioner with a special interest in this condition. Suspected cases were reported to the Therapeutic Goods Administration for inclusion in the Australian Adverse Drug Reaction Database. From this record, patients who presented concerned about TSW during the period 1 January 2015 – 28 February 2018 were identified and their medical files reviewed to retrieve demographic data and history. Ethics approval for this study was obtained from the Royal Australian College of General Practitioners National Research and Evaluation Ethics Committee.

Results

Table 1. Characteristics of the study population

Gender	All patients, number =55 (%)
Female	31(56%)
Age 1st presented with concerns about TSW (years)	
18-24	12(22%)
25-34	23(42%)
35-44	12(22%)
45+	8(15%)
Initial indication for topical steroid use	
Atopic dermatitis	42(76%)
Contact dermatitis	8(15%)
Non-specific rash	5(9%)
Location topical steroid use (included, but not limited to)	
Face	46(84%)
Genital area	2(4%)
Potency topical steroid use to face*	
Mild	4 (7%)
Moderate	4 (7%)
Potent	33 (60%)
Unknown	5 (9%)
Use of oral corticosteroids for skin symptoms in past	
Yes	23 (42%)
Age topical steroids 1st used (years)	
5 or less	26(47%)
6-12	8(15%)
13-20	4(7%)
21+	13(24%)
Unknown	4(7%)

*Topical steroid potency was based on the classifications used in the Australian Medicine Handbook 2018

Table 2. Clinical features seen in the study population

Symptoms	All patients, number =55 (%)
Itch	55 (100%)
Sleep disturbance	50(91%)
Shedding skin	41(75%)
Ooze	40(73%)
Burning pain	36(65%)
Swelling	36(65%)
Mood disturbance	33(60%)
Skin sensitivity	26(47%)
Pain, other than burning	17(31%)
Signs	
Red skin	55(100%)
"Elephant wrinkles"	31(56%)
"Red sleeve"	22(40%)
Headlight sign	16(29%)

Discussion

It is difficult to confirm the diagnosis of topical steroid withdrawal (TSW) as diagnostic criteria do not exist, however, patients with a history of long-term topical steroid overuse do experience certain typical symptoms which have been described in TSW. Burning pain was reported in 65%, excessive skin desquamation in 75%, swelling in 65% and skin sensitivity in 47%. Signs that have been reported commonly (but not necessarily exclusively) in TSW were seen in a number of patients: diffusely red skin 100%, "elephant wrinkles" 56%, "red sleeve" 40% and the headlight sign 29%.

Risk factors for topical steroid withdrawal included topical steroid use to the face and oral corticosteroid use for skin symptoms. 84% of patients had used topical steroids to the face and 60% of all patients reported using potent topical steroids to their face. 42% of patients (23/55) had used oral corticosteroids for their skin symptoms, suggesting their skin symptoms had been severe, increasing their risk for overusing topical steroids and therefore developing TSW.

Conclusion

When patients with a long-term history of potent topical steroid use cease treatment, they may experience symptoms not typically reported in patients with eczema such as burning pain, excessive skin exfoliation, swelling and skin sensitivity. They may develop signs such as "red sleeve" and "elephant wrinkles". These are classic features of topical steroid withdrawal (or simply, "TSW").

More research is required to determine the impact and duration of these symptoms, in addition to the medium and long term outcomes seen in these patients.

References

1. Hajar T, Leshem Y, Hanifin JM et al. A systematic review of topical steroid withdrawal (“steroid addiction”) in patients with atopic dermatitis and other dermatoses. J Am Acad Dermatol 72(3);541-548
2. Rapaport M, Rapaport V. The red skin syndromes: corticosteroid addiction and withdrawal Expert Rev. Dermatol. 1(4),2006
3. Fukaya M, Sato K, Sato M et al Topical steroid addiction in atopic dermatitis. Drug, Healthcare and Patient Safety 2014:6 131-138

Systems-based-approach to improving patient outcomes in Optometry

Weisinger H[1]

[1]*Specsavers Optometrists,* [2]*School of Medicine, Deakin University*

Specsavers optometrists see on the order of 3.5 million patients per year in Australia. This is thought to represent some 35-40% of all eye examinations in a primary care setting. At the end of 2018, Specsavers developed changes in its electronic health record and referral systems that include the mandatory capture of patients identifying themselves as having diabetes. We also capture instances in which a patient reports their GP as having suggested or referred them for an eye examination.

Working with a third-party web-based communication platform has enabled the development of automation in which those with diabetes (or those that were sent in by their GP) automatically have a report drafted which can then be sent to the patient's GP.

Data collected in 2019 suggests that Specsavers has seen approximately 90,000 people with diabetes, representing some 6.5% of all patients. Approximately 2% of all patient encounters are at the request of a GP, however, almost none of these patients are formally referred.

As a group, Specsavers optometrists currently issue reports to GPs for around 6% of all patients, half of which are for patients with diabetes.

While this is excellent progress, there is still much to be done to improve patient outcomes by closing the gap in communications between GPs and optometrists.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

Optometrists perform a vital function in providing access to primary eye care in the community. Of particular importance, from the perspective of GPs, is the fact that optometrists perform comprehensive eye examinations for people with diabetes. Optometrists can participate in Team Care Arrangements, and therefore perform part of the diabetes annual cycle of care. Specsavers have recently rolled out OCT fundus imaging across all of its practices in Australia and New Zealand. These changes support integrated care, better communication, timely and appropriate access to care – and should result in better utilisation of specific Medicare items that are designed to improve the health of people living with diabetes.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

This data is completely novel but the take home message is that we can improve patient care by improved communications between optometry and general practice.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

We have large amounts of data, collected systematically through our electronic records systems. Much has been, or will be, published.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

Yes. This is the first large scale (millions) assessment of the prevalence of diabetes presenting to optometry, with further data on reporting and referral patterns – to, and from GPs, respectively.

References: *(If applicable)*

The CPD program in Hong Kong and its contribution to a 'Healthy GP' and 'Healthy Patient'

Miller M[1], Jamal M[2], **Chao D[3]**

[1]RACGP, [2]Academy of Family Physicians of Malaysia, [3]The Hong Kong College of Family Physicians

Aim and intended outcome/education objectives:

The aim is for representatives of the Hong Kong and Malaysian Colleges to present how their CPD program has evolved and how it has contributed to better GPs providing quality care to their patients.

Through an interactive workshop, the objective is that participants are more informed of the programs of the Hong Kong and Malaysian Colleges.

Results:

It is expected that the presentations from Hong Kong and Malaysia will cover the following:

- What are HK and Malaysia CPD program requirements?
- How is participation monitored?
- How has it improved the GPs skills? And by default, how has it improved the health of their patients?
- How is this similar or different to Australian general practice?

Conclusions:

The importance of having GPs supported to undertake continuous learning through a CPD program is recognised. The impact this has on the healthcare of patients is also recognised.

Format:

One hour presentation (30 minutes for HK and 30 minutes for Malaysia) plus 30 minute on the couch type facilitated Q&A session.

Content:

- Overview of the evolution of and focus of the CPD program of the Hong Kong College
- Overview of the evolution of and focus of the CPD program of the Malaysia College
- Content of the CPD programs – modules, topics, workshops etc.
- Monitoring of CPD
- Quality assurance
- Link to patient outcomes through lifelong learning of GPs

Intended audience (including a maximum number of participants)

- International delegates
- RACGP members
- Aim for a maximum of 100 participants

References: *(If applicable)*

The diabetes mellitus exchange programme

Siu P[1]

[1]*Family Medicine and Primary Health Care, United Christian Hospital (UCH)*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

The UCH FMSC currently provides care to type 2 (T2) diabetes mellitus (DM) patients downloaded from UCH General Medical Clinic (GMC). They carry significant degree of DM complexity or co-morbidities which might not be feasible to be managed in GP Clinics. In the past, patients with deteriorating diabetic control or complications which required medical specialist care would be referred back to GMC first for initial care and then to DACC if needed. With increasing patient load, waiting time for such pathway could be up to 2 years. The reverse pathway to discharge patients with stabilized DM control from DACC to GMC and then to FMSC had similar waiting time. In order to better match the level of care to disease complexity for T2DM patients within reasonable waiting time, UCH launched a programme with fast track direct referrals between FMSC and DACC in 2017. Clear and specific referral criteria were established before implementation.

This programme provides more timely and better-matched level of care for T2DM patients in DACC and FMSC. Improvement of clinical outcomes were shown on both groups of patients. Collaboration between Family Physicians and Diabetologists contributed to a more efficient interface between primary and secondary care.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

DM is a common chronic disease encountered in primary care setting. DM is the leading cause of renal failure, blindness, leg amputation, cardiovascular diseases and stroke. With the aging population, more and more DM patients with co-morbidities would be cared by GPs. Evidence showed that the optimal control of blood glucose, blood pressure and hyperlipidaemia by a multidisciplinary team can reduce complications and is cost effective. GPs have important role in promoting healthy lifestyle, adjustment of medications, risk assessment and coordination of services with the endocrinologists.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

I would choose to present the topic to the delegates in the format of poster presentation. A poster with clear and concise content would be prepared.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

Data on all patients exchanged between DACC and FMSC from 1st Feb 2018 to 30th Jun 2018 were analysed to evaluate the effectiveness of this programme.

There were 36 and 23 first attendances at DACC and FMSC respectively. Duration of DM was significantly longer for patients referred to DACC (Mean 21.4 years of patients referred to DACC vs 8.8 years of those referred to FMSC, P<0.001). Median waiting time for first appointment was 3.6 months to DACC and 3.5 months to FMSC. HbA1c was significantly lower after referring to DACC (P value <0.001) with mean HbA1c dropped from 10.3% to 8.8% after average of 2.9 consultations. Systolic blood pressure (SBP) was significantly lower after referring to FMSC (P value <0.001) with mean SBP dropped from 143 to 129 mmHg after average of 2.4 consultations, possibly due to opportunity for more frequent drug titration.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

No

References: *(If applicable)*

The new approach to telehealth

Fine L[1]

[1]*Coviu*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

With 30% of the Australian population residing in rural or remote areas, and the 'perfect storm' of an increasing population and greater reliance on digital technologies, Australians no longer have the ability, time or energy to continue receiving GP care in its traditional form.

Telehealth, used in combination with traditional face-to-face sessions, is the solution that will scale Australia's current and future healthcare needs.

This presentation will provide a step-by-step guide to implementing telehealth software into a GP practice based in real-life success stories. GPs will be equipped with the digital skills to successfully hold video consultations and will learn about the current and future clinical tools and artificial intelligence capabilities available for use within a video call. Delegates will also be informed of how to choose a telehealth software provider with a focus on maintaining privacy and security.

Further, GPs will be taught the specifics of how telehealth allows for increased healthcare access by breaking down barriers such as geographical location, social stigmas, travel time and costs. And the business-side of telehealth will be discussed in depth, including current telehealth rebates, private billing, and how to maximise income and improve work-life balance through offering telehealth. GPs will leave this presentation prepared to choose their own telehealth software and integrate video consultations into their practice.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

In an increasingly digital world, it's not long before telehealth becomes an essential component of general practice. The demand for increased telehealth availability already exists in Australia, as does specialised telehealth software. It is now up to the GPs to equip themselves with the knowledge necessary to prepare their business for change.

Too many GPs are using phone calls, email, Skype or Facetime to conduct private conversations about sensitive patient health data. What they don't realise is the lack of security in using many of these methods, potentially putting their private patient data at risk. Fortunately, there are telehealth solution providers currently available to GPs in Australia, most of which make privacy and security a major priority.

In addition, some of these software providers already integrate with existing practice management systems, making the transition to telehealth even easier for GPs. There are also clinical tools available in these telehealth-specific software platforms, allowing for referrals and clinical forms to be filled in as well as image and document sharing, text chat, screen share and integrated billing, just to name a few. These tools allow clinicians to perform a consult just as they would in their clinic when physical touch is not necessary – including writing referrals, renewing scripts, sharing test results and providing advice.

Essentially, telehealth achieves equal outcomes when physical touch is not required (Tieman., et al 2016, Versleijen.,2015, Husebo & Storm 2014) whilst increasing patient access, reducing no shows and improving GPs work-life balance. It is an updated and improved method of care that GPs can integrate into their clinics relatively easily.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

This will be a hybrid session – lecture + interactive.

A large part of our formal presentation will include a clinician partner who has successfully implemented telehealth software who will relay personal experience, inclusive of the common struggles clinicians face when adopting new technology. Tips and tricks to a smooth transition to telehealth will be included. We've learned it's critical to present a role model for delegates to relate to.

In addition, we will share other patient and clinician case studies and engage delegates by asking about their own experiences with telehealth, what worked for them, what didn't and why they may be afraid to try again. This question and answer segment will allow us to quell any fears and offer solutions.

We will conclude with having delegates 'play' with telehealth through the Coviu platform – experimenting with practice video calls to each other and using the clinical tools. Delegates will also be introduced to PhysioROM, Coviu's artificial intelligence algorithm that allows for remote monitoring of patient range of motion, to give them an idea of the AI progress being made in the telehealth space.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

Telehealth has been the subject of countless research projects, journals and clinical trials, with an overwhelming amount of evidence suggesting its effectiveness is equal to that of face-to-face sessions. For example, a Spanish study in 2017 found telehealth to be an effective means of GP management of patients with chronic conditions such as diabetes, hypertension and heart failure. Patients experienced greater weight loss, improved blood pressure and hemoglobin levels and reduced hospital readmissions (Orozco-Beltran,. Et al 2017).

Numerous studies focused on telehealth usage in rural hospitals, aged and palliative care facilities and in-home care environments not only resulted in equal or better rated outcomes when compared to face to face appointments, but mentioned reduced travel times and associated costs, reduced hospital readmissions and the positive social impact on older populations (Tieman., et al 2016, Versleijen.,2015, Husebo & Storm 2014).

Additionally, telehealth for rehabilitation, such as with hip replacement and knee surgery, has experienced great success. International studies have stated its ability to improve patient health outcomes and reduce hospital readmissions, whilst simultaneously reducing the costs of recovery and the strain on healthcare resources (Jan,. et al 2004, Naylor,. et al 2017, Kairy,. et al 2013).

Coviu, specifically, is supported by evidence of our user success stories, such as with the clinician partner we will have presenting with us. We've also partnered with clinicians to clinically validate and create two peer-reviewed publications proving that a Pearson clinical tool can be used in telehealth with equivalent results as when compared to face-to-face assessment. In addition, Coviu received the Cooperative Research Centres Projects (CRC-P) grant for the clinical validation of PhysioROM, our AI telerehabilitation project. Clinical trials for PhysioROM are under way.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

Technology develops and improves at a rapid rate, therefore telehealth software options and capabilities, such as with artificial intelligence, have changed significantly over the last few years. It is important that GPs stay up to date with the current telehealth environment so they can meet the demand of their patients.

Part of the changes to telehealth include the new and updated MBS rebates, which drastically effect GPs and their patients by making telehealth more affordable through the Drought Communities Programme, Better Access Scheme and Telehealth Patient-End Support Services.

There has also been significant change in terms of hardware for video consultations. Laptops, smartphones and tablets are becoming smaller and lighter and, therefore, more portable, whilst microphones and speakers are almost always built in to the above technologies. Improvement in our networking infrastructure are also fundamental to making video visits with patients viable. In addition, software advances have allowed for video consultations to take place without any downloads required, both for clinicians and patients. For example, Coviu uses WebRTC, allowing access to a video call within a web browser at the click of a link. These advances have led to telehealth becoming simpler, more accessible, and viable, more so now than ever before.

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The role of AFPM in the enhancement of primary care in Malaysia

Khoury J[1], **Jamal M[2]**, Chao D[3]

[1]*RACGP,* [2]*Academy of Family Physicians of Malaysia,* [3]*The Hong Kong College of Family Physicians*

Aim and intended outcome/education objectives:

The aim is for representatives of the Hong Kong and Malaysian Colleges to present how their CPD program has evolved and how it has contributed to better GPs providing quality care to their patients.

Through an interactive workshop, the objective is that participants are more informed of the programs of the Hong Kong and Malaysian Colleges.

Results:

It is expected that the presentations from Hong Kong and Malaysia will cover the following:

- What are HK and Malaysia CPD program requirements?
- How is participation monitored?
- How has it improved the GPs skills? And by default, how has it improved the health of their patients?
- How is this similar or different to Australian general practice?

Conclusions:

The importance of having GPs supported to undertake continuous learning through a CPD program is recognised. The impact this has on the healthcare of patients is also recognised.

Format:

One hour presentation (30 minutes for HK and 30 minutes for Malaysia) plus 30 minute on the couch type facilitated Q&A session.

Content:

- Overview of the evolution of and focus of the CPD program of the Hong Kong College
- Overview of the evolution of and focus of the CPD program of the Malaysia College
- Content of the CPD programs – modules, topics, workshops etc.
- Monitoring of CPD
- Quality assurance
- Link to patient outcomes through lifelong learning of GPs

Intended audience (including a maximum number of participants)

- International delegates
- RACGP members
- Aim for a maximum of 100 participants

References: *(If applicable)*

Triage Clinic for chronic low back pain

Wong S[1], Chan P[1], **Chao D[1]**

[1]*Department of Family Medicine and Primary Health Care, Kowloon East Cluster, Hospital Authority*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

A pilot Family Medicine Triage Clinic was set up in a General Outpatient Clinic in Hong Kong in August 2017 to manage stable patients with predefined orthopaedics conditions referred to Orthopaedics Specialist Outpatient Clinic. Comprehensive assessment and pharmacological treatment by Family Medicine specialists according to evidence-based clinical guidelines mutually agreed between Family Medicine and Orthopaedics specialists, and early non-pharmacological intervention by physiotherapists and occupational therapists are provided. We would like to evaluate the diagnoses and outcomes of patients with chronic low back pain referred to the Family Medicine Triage Clinic.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

The set-up of the Family Medicine Triage Clinic can enhance the gatekeeping role of Family Physicians, reduce the workload of secondary care.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

I would present the information on the poster with the use of colourful graphics and charts.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

106 patients were referred to Family Medicine Triage Clinic for chronic low back pain, with a mean age of 61.6 years old and 63.2% were female.

The most prevalent diagnosis was lumbar disc disorder (34.9%), followed by lumbar spondylosis (28.3%), non-specific back pain (9.4%), vertebral collapse (8.5%) and spondylolisthesis (8.5%). Other less common diagnoses included facet joint disease, back pain due to scoliosis, back muscle pain, sacroiliac joint pain, back sprain, fibromyalgia and piriformis syndrome.

For those who had attended the clinic for more than one visit, 69.5% patients reported symptoms improvement after treatment. Concerning the outcome, 41.5% patients were discharged from the clinic, only 29 (27.4%) patients required referrals to the Orthopaedics SOPC for further management. The indications for referrals were prolapsed intervertebral disc with significant neurology, spinal stenosis, neurogenic tumor in thecal sac, multiple vertebral collapses with lower limbs neurology.

In conclusion, family physician led Triage Clinic could manage adult patients with high prevalent orthopaedics conditions successfully, make accurate diagnosis and timely referrals for those with serious diseases and reduce the workload in secondary care.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

Nil

Voluntary assisted dying: Medico-legal issues for GPs

Legrand H[1]

[1]*Avant Mutual*

Background:

The Voluntary Assisted Dying Act 2017 (Vic) will come into effect on 19 June 2019.

Aims:

To evaluate the ethical and legal issues that arise from the *Voluntary Assisted Dying Act 2017* (Vic) in a General Practice setting.

Method:

A literature review was conducted with a specific focusing on the legal and ethical issues that are relevant for General Practitioners. An analysis of the current laws was presented as research paper as part of the Master of Health and Medical Law program at Melbourne University.

Results:

The Voluntary Assisted Dying Act 2017 (Vic) are controversial and present several challenges to GPs. There is some evidence from international jurisdictions that voluntary assisted dying regimes can be implemented safely. However, these laws present GPs with a complex situation where they may be required to weigh up complex clinical, ethical and medico-legal issues in each case.

Discussion:

Dealing with patient's who request voluntary assisted dying is likely to be challenging for GPs. This presentation will outline the potential issues including determining whether a patient is eligible to access Voluntary Assisted Dying in Victoria. The author will also provide education regarding a GPs legal obligations under the Act and how the regime is being implemented in practice.

Conclusion:

Given the complexity and the implications of these laws, the author concludes that General Practitioners should have a low threshold for specialist input and discuss any concerns with their medical defence organisation.

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VTE prophylaxis and presentation with bleeding

Hanna F[1]

[1]*University of Tasmania, School of Health Science*

Objective:

To assess patients on different venous thromboembolism (VTE) prophylaxis/treatment in form of either anticoagulants or antiplatelet who presented with bleeding at the Launceston General Hospital (LGH) Emergency Department (ED). The aim of this audit is to analyse patients' characteristics, bleeding risk profile and the management provided to cease bleeding. Furthermore, we aimed at studying the different measures to cease bleeding and whether a specific VTE medication reversal/intervention was undertaken. We have also analysed the type of used medications and the length of hospital stay in an adjusted analysis.

Design:

Retrospective medical record review

Setting:

Launceston General Hospital (LGH) Emergency Department (ED).

Participants:

All participants were presented to LGH ED with bleeding in the period between Jan 2016 and June 2018. All study participants were on VTE prophylaxis.

Methods:

A retrospective study included review of medical records of all patients attended the LGH ED with bleeding between Jan 2016 and June 2018. The retrieved records were filtered by the pharmacy to exclude who were not on VTE prophylaxis were excluded. The included participants were on different available VTE prophylaxis such as VKA-antagonist, LMWH or the newer oral anticoagulants with rivaroxaban, apixaban and dabigatran. The data collection included computerised medical records and patients file data. The collected data included the age, gender, organ function, coagulation profile and the length of stay. The medical records data included bleeding type, reason for application of anticoagulants, type of anticoagulant and VTE-prevention or treatment therapy, intervention type, reversal of anticoagulation, blood products used and laboratory investigations. Data analysis included descriptive statistics, χ^2 association and regression (binary, multinomial and Firth logistic as well as linear)

Results:

*1*501 patients had presented by bleeding to the LGH-ED patients presented with bleeding. The study included only those who were on VTE prophylaxis n=144 either in form of anticoagulation or antiplatelet or combination of both of them. Patients were males (*n*=75, 52.1%) and the mean age was mean=76 (*SD*=11.1). GIT bleeding was the most dominant (*n*=48, 35.3%) followed by epistaxis (*n*=32, 23.5%) whereas the main reason for VTE prevention is atrial fibrillation (AF) (*n*=65, 53.7%). Warfarin use was prevalent (*n*=74, 55.2%) while aspirin was used by (*n*=29, 22.2%) as a combination to anticoagulant, apixaban was used by (n=12, 9%) the rivaroxaban was used by (n=26,19.4%). Renal impairment in the form of high creatinine levels

were in (*n*=67,46.5%), normal ALT test while warfarin users have INR above the therapeutic range (adjusted for the condition) (*n*=34,45.9%) and severe anaemia were reported in many patients. Direct acting oral anticoagulants (DOAC) were associated with less need for reversal (*B*=-1.7, P=<.001) as well as less hospital stay (*B*=-4.1, P=.046) when compared with warfarin.

Conclusion:

Warfarin use was prevalent among patients presented with bleeding whereas our findings showed poor control. Additionally, the use of DOAC showed less need for medical reversal as well a shorter hospital stay when compared with warfarin. This finding supports the need for clinicians to prefer the use of DOAC to warfarin VTE prophylaxis.

What is end-of-life care in your practice?

Johnson C[1,2,4], Chua D[3], Cook [4], Ding J[4], Liqurish S[1], Woolford M[1], Deckx L[3], Mitchell G[3]

[1]*Monash University,* [2]*Eastern Health,* [3]*The University of Queensland,* [4]*The University of Western Australia*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

Currently there is no evidence of how GPs actually care for patients at the end of life, and so no real way of addressing practice deficiencies or concerns held by GPs about the delivery of palliative and end of life (EOL) care in the community. This is in contrast to specialist palliative care, where there has been a national minimum dataset in existence for a decade, leading to vast improvements in the quality and consistency of care across the country.

We have developed a means of gathering retrospective data from medical records when a patient is registered as deceased. In addition, we have developed a short drop-down questionnaire that gathers additional information about the quality of care, the challenges the GP faced, and their assessment of how effective the patient's end of life care was. Overall, data on 245 deaths has been collected both prospectively and retrospectively.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

The majority of GPs provide palliative care for their patients with advanced chronic diseases who are approaching EOL, whether they realise it or not. Australia's ageing population is growing which will place increasing demands on the time and resources of GPs. End of life care 'is everyone's business', therefore there is an imperative to provide relevant support to ensure all people approaching death are able to be cared for and die in their place of choice, and to receive equitable care. This research aims to support GPs to provide the best care at the EOL by providing audit and feedback for all deaths, and to explore ways that they may be better supported in providing this care.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

In a workshop style format, we will present key findings, and then ask participants to reflect on what these might mean. How do participating GPs provide EOL care? What are the gaps in skills that need to be addressed in general practice? What support do GPs feel will enhance the care they provide? What are the barriers to patients being care for and dying in the place of choice? How would participants change the care they provide to those at the end of life?

To help inform the next phase of this project, we will seek GPs views about routine data collection for all deaths and the potential for expanding the use of an electronic data query tool to collect clinical and attendance data from GP practice records for the last 12 months of life.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

We conducted a mixed-methods program of research which involved the following stages:

1. A literature review of the relevant data collection methods for EOL care in general practice;(1)
2. A qualitative study to explore the views of GPs, palliative care providers, policymakers and other stakeholders on rural GPs' involvement and challenges in providing palliative and EOL care;(2)

3. A Delphi study to select the most appropriate items for inclusion in the questionnaire;(3)
4. A retrospective and a prospective study using the questionnaire and trial automated system to collect data about the EOL care of deceased patients in general practice; and,
5. A qualitative study of GPs involved in the retrospective pilot study to explore their experiences, concerns and views of the EOL data collection process.

The research team is also involved in a series of five systematic reviews which explore GPs' and practice nurses' involvement in palliative and EOL care. Two have been published in the series to date.(4, 5) A further Issues Brief was published through the Deeble Health Policy Institute.(6) Research for these publications has informed the background and undertaking of this research.

All research was conducted by the presenters, and was funded by the Val Lishman Health Foundation and the RACGP Research Foundation.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

The summary data for this newly completed project will be presented first at GP19 (data analysis and report writing are still underway). The broad findings will also be presented to the Australian Government Department of Health. This workshop will help inform the next stage of the project and will provide GPs with an opportunity to provide advice about both the analysis and interpretation of the results of the current study and the direction of next stage of the development and research program.

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What's new in the Advance Project?

Clayton J[1,4], Arthurs K[1], Nagarajan S[1,4], Rhee J[1,2], Tierman J[5], Mitchell G[3], Detering K[6], Lewis V[7], Halcomb E[2], Phillips J[8], Morton R[4]

[1]*HammondCare* , [2]*University of Wollongong,* [3]*University of Queensland,* [4]*University of Sydney* , [5]*CareSearch, The Flinders University of South Australia,* [6]*Advanced Care Planning Australia,* [7]*LaTrobe University,* [8]*The University of Technology, Sydney*

Please outline the new learnings, innovation, education or hands-on updates to GPs that will form part of your presentation.

The Advance Project™ is a free toolkit of resources and a training package, specifically designed to support GPs, nurses and practice managers in Australian general practices to provide better care through team-based initiation of advance care planning (ACP) and palliative care (PC) in everyday general practice. The project is funded by the Australian Government with training endorsed/accredited by the Royal Australian College of General Practitioners, Australian College for Rural and Remote Medicine, Australian Primary Care Nurses Association (APNA), and Australian Association of Practice Management, and delivered by a national consortium led by HammondCare. The toolkit of resources has been officially recognised as an accepted clinical resource by the Royal Australian College of General Practitioners and endorsed by APNA

This workshop will highlight some of the new resources that are available for GPs and the general practice team through the Advance Project. At the conclusion of the presentation participants will be familiar with the training opportunities and resources available through the project including practical tools for: initiating ACP, identifying patients who might be at risk of deteriorating and dying, and screening and evaluating patients' and carers' palliative and supportive care needs. You can register to access the free online training and resources for clinicians, patients and carers through the project website www.theadvanceproject.com.au Individual tele-mentoring is also available to support successful implementation of the Advance ProjectTM resources into routine practice.

Please explain how this topic or subject is relevant to GPs in a clinical setting?

General practices are in an ideal position to start advance care planning discussions with their patients because of the trusted relationships that develop. The general practice environment enables advance care planning discussions to start early, when a patient is still relatively well, so they don't miss out on the opportunity to plan for their future care.

Many people in Australia are continuing to die with unmet palliative care needs, with figures from Victoria suggesting that up to two-thirds of people who might benefit from palliative care are not receiving it.

General practices have a critical role in caring for patients who are at risk of deteriorating health and dying. GPs and nurses in general practice are ideally placed to identify these patients early so that their palliative and supportive care needs can be assessed and addressed in a timely way.

However, GPs have huge demands on their time, so the Advance Project www.theadvanceproject.com.au has developed a free set of resources to enable GPs, nurses and practice managers to work together to implement a team based approach to initiating advance care planning and palliative care in general practice. The resources are specifically designed for general practice settings.

How do you intend to engage delegates and enhance their learning experience throughout your presentation?

We will provide practical tips for GPs about:

- how to initiate discussions about advance care planning with older and/or chronically ill patients in routine health assessments and standard consultations
- how to identify patients at risk of deteriorating and dying
- how to systematically and efficiently assess patients' palliative and supportive care needs and the needs of their carers
- how to identify patients who might benefit from early referral to specialist palliative care services
- how the general practice team, including nurses and practice managers, can support you to implement the Advance Project resources for the benefit of your patients
- medicare items that can be used to implement the Advance Project resources and assessments in your practice.

There will be opportunities to discuss potential barriers to implementing the Advance Project resources in your practice and strategies to overcome these barriers with two experienced GPs with a special interest in advance care planning and palliative care, a specialist palliative care doctor and a specialist palliative care nurse.

How is the content of your presentation supported by evidence? This may be through a connection with research, clinical trials or other forms of evidence.

The Advance Project toolkit and training package was informed by a literature of the best available evidence, input from our expert national and international advisory group www.theadvanceproject.com.au and extensive stakeholder engagement with GPs, general practice nurses and consumers.

Does your presentation showcase a new (within the last 3 years) skill or practical knowledge update to the primary health environment? If yes, please provide further details.

Yes, the Advance Project Toolkit was newly revised and updated in 2018 with a suite of resources specifically designed for GPs, practice nurses, practice managers, patients and carers. The resources enable general practices to implement a team-based approach to initiating conversations about advance care planning and assessing patients' and carers' palliative and supportive care needs in a time efficient way in general practice settings.

References: *(If applicable)*

The Advance Project www.theadvanceproject.com.au

Would you use this resource?

Lynch E[1], McIntosh J[1], Koczwara B[2], Crowe J[3], **Lynch E[1]**

[1]*The University Of Melbourne,* [2]*Flinders University,* [3]*Deepdene Clinic*

Background:

Approximately 144, 713 new cancer diagnoses are expected to be made in Australia in 2019. (1) The chance of GPs coming into contact with patients on cancer treatment and possibly experiencing side effects of this treatment is therefore high. 'eviQ' is an online cancer treatment protocol database used by cancer centres nationwide, that has recently developed a set of resources to assist GPs in looking after patients on four types of systemic cancer treatment, including managing side effects of newer targeted and immunotherapies.

Aims:

This study aims to explore the opinions of GPs, medical oncologists and oncology nurses about the clinical usefulness of the new resources and specifically explore how GPs would like to receive the resources so they can be incorporated into everyday practice.

Method:

Purposive sampling will be used to recruit up to 20-25 participants to participate in semi-structured, qualitative interviews. Data will be transcribed and thematically analysed.

Results:

This is a study in progress. Recruitment and data collection have started and will continue concurrently with data analysis until approximately November 2019. Key findings or emerging themes will be presented at GP19.

Discussion:

Key findings will be presented at GP19.

Conclusion:

Findings from this study will be used to guide how best to implement the new resources from 'eviQ' and provide insight into how best to communicate with and support GPs in the role of looking after patients on active cancer treatment.

References:

- Cancer Australia. Cancer in Australia statistics [internet]. Surry Hills, NSW (Australia): Cancer Australia (AU); [cited 2019 June 1]. Available from: https://canceraustralia.gov.au/affected-cancer/what-cancer/cancer-australiastatistics

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