Message from the Tonic Media Network Editorial Committee*

Welcome to another edition of Practice Connect - a newsletter designed for you, your practice and your patients with up-to-date news and information.

MyMedicare is coming: How to get ready for patient registrations now

MyMedicare is a new voluntary patient registration model. It aims to strengthen the relationship between patients, their general practice, general practitioner, and primary care teams. It zeroes in on a crucial aspect of our healthcare system, continuity of care – particularly in the face of an ageing population and the increasing prevalence of chronic diseases.

MyMedicare is only at the early stages of development, so it will take some time for practices to get all the answers you need.

According to the Federal Department of Health and Aged Care:

MyMedicare patients will have access to:

- greater continuity of care with their registered practice, improving health outcomes.
- longer MBS-funded telephone calls (Levels C and D) with their usual general practice.
- triple bulk billing incentive for longer MBS telehealth consultations (Levels C, D and E) for children under 16, pensioners, and concession card holders.

MyMedicare practices will have access to:

- more information about regular patients, making it easier to tailor services to fit the patient's needs.
- the new longer telehealth items linked to MyMedicare outlined above.
- the General Practice in Aged Care Incentive from 1 August 2024, which will support regular health assessments, care plans and regular GP visits for people in residential aged care homes.
- new blended funding payments to support better care in the community for people with complex, chronic disease who frequently attend hospitals. These arrangements will roll out progressively across the country over three years from FY2024–25.
- Chronic Disease Management items linked to a patient's registration in MyMedicare from November 2024, to support continuity of care for people with chronic and complex conditions.

Patients who are not registered in MyMedicare will still be able to receive Chronic Disease Management items from their usual GP.

Registration

General practices can now begin the MyMedicare registration process and patients can register for MyMedicare from **1 October 2023**.

For further information about MyMedicare including eligibility, how to register and frequently asked questions visit here

So, what can practices do now to get ready for MyMedicare?

Leading Practice Intelligence Platform provider Cubiko has shared their insights about what you can do now to prepare for MyMedicare.

- **Know your patients.** The first step to preparing for MyMedicare effectively is understanding your patient base.
- **Strengthen patient-practitioner relationships**. MyMedicare places a premium on the relationship between patients and healthcare providers. It rewards proactive and preventive care, encourages extended telehealth consultations, and incentivises GPs to register frequent hospital attendees.
- **Engage patients in care with GP Management Plans (GPMP).** A GPMP and Chronic Disease Management (CDM) is a great way to provide continuous patient care and be incentivised appropriately by Medicare for those services.
- **Champion 10997 & 10987s across your practice.** Ensure that the wider care team is involved with the health initiatives you've put in place.
- **Provide proactive Care for Patient Health Assessments.** Under MyMedicare, proactive care has become more important than ever. Health assessments for specific age groups, like those aged between 40-49 years for diabetes risk or 45 – 49 health assessments, are opportunities to provide proactive health care.

For further detail including how Cubiko can help your practice visit
https://www.cubiko.com.au/blog/what-you-can-do-now-to-prepare-for-mymedicare/

Is social prescribing just what the doctor ordered?

Social prescribing is the practice where health professionals, including GPs, have the resources and infrastructure to refer and/or link patients to a range of local, non-clinical social services, or even social activities groups – in a bid to address the social determinants contributing to poor health, and stave off the epidemic of loneliness and social isolation.

One of the leading advocates of social prescribing in Australia is Tracey Johnson, CEO of Inala Primary Care in Queensland.

According to Tracey social prescribing has been occurring between doctors and patients since 'Adam was a lad'. "Doctors have always had a role in helping people understand their community and how to be well". Tracey explained that social prescribing is widespread, occurring in neighbourhood centres, mental health support organisations, schools and health and community organisations. "It helps a person to live their best life by supporting them to navigate to the most appropriate places, spaces and activities where their goals can be fulfilled and improve their health and wellbeing".

Tracey has been calling for social prescribing and allied health to be incorporated as core pillars in our Medicare system. She highlighted that the evidence base for social prescribing is growing at a rate of knots. "That's why the NHS, the largest social prescribing system in the world, is now funding social prescribing workers and health volunteers and health visitors in general practices across the country.

Thousands of social prescribing people are working across tens of thousands of practices in the NHS. Why are they doing that? Because there's an evidence base there".

The Federal Government has been considering social prescribing as a national program option and it's in the National Preventative Health Strategy, launched in December 2021.
In Tonic Media Network's exclusive GP webinar series, General Practice in a Rapidly Changing World, Health Minister, Mark Butler noted the value of social prescribing and pointed to some pilot programs currently occurring in Queensland.

"The Minister mentioned that Primary Health Networks will be encouraged to utilise new team-based care and innovation funding to support initiatives in social prescribing as these are valued by some general practices," said Tracey.

"Bring it on! The evidence is clear. Social prescribing works and every general practice who wants to engage with the link worker workforce should be encouraged to do so," Tracey added.

Further information

https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Advocacy/Social-prescribing-report-and-recommendation.pdf - The recommendations of an Australian forum co-convened by the RACGP into what should occur with social prescribing

https://chf.org.au/node/1741 - What consumers' experience is in terms of social prescribing from their healthcare team

The breastfeeding aversion response explained

Breastfeeding is a natural way for a mother to feed her baby and it provides the nutrition a baby needs during their first 6 months. However, there are a range of obstacles that can make it hard – everything from parental exhaustion to lack of knowledge and even, in some cases, community stigma.

A new study from researchers at the University of Technology Sydney looked at experiences of these challenges in mothers and the newly-named "breastfeeding aversion response" which includes having particular negative feelings, often coupled with intrusive thoughts, when an infant is latched and suckling at the breast.

The survey included 5000 women who were aged 18 or over and had breastfed. Their average age was 35 and most were tertiary-educated. Participants were asked about their breastfeeding experience with up to four children, the challenges in breastfeeding they experienced and whether they'd had a "breastfeeding aversion response". They were also asked about the value and availability of breastfeeding support.

The researchers found that most women reported some challenges with breastfeeding, with just 4.5% reporting no breastfeeding difficulties. Common difficulties included breast pain, oversupply, mastitis and poor latching, each reported by at least a third of women. One in five women reported experiencing a breastfeeding aversion response, most often with a mother's first child. That said, despite the many challenges reported, most women reported a 'good' (38%) or 'very good' (49%) overall experience of breastfeeding.

The authors say the concept of a breastfeeding aversion response is still being researched, but that these findings help to characterise the issue and understand how we might address it – with types of meditation, magnesium supplements and finding distractions while breastfeeding all associated with relieving the aversion response. It found this response tended to be seen in people with lower income and lower levels of education, which may help alert doctors when seeing patients who are breastfeeding.

Further information

The prevalence of breastfeeding aversion response in Australia: A national cross-sectional survey: Wiley Online

Breast feeding your baby: mydr.com.au

Australian Breastfeeding Association: a range of resources

'Smart drugs' not so smart when it comes to complex problems

Recent reports suggest stimulant drugs, usually used to treat ADHD are being taken by students and employees to increase their academic and work productivity. These drugs include methylphenidate, dextroamphetamine and modafinil. While we know they are effective in treating the conditions they are prescribed for, the literature on their effects in people who don't have ADHD is mixed.

In a new study, 40 people aged between 18 and 35 were randomised to receive a standard adult dose of methylphenidate, dextroamphetamine, modafinil or a placebo. Then they were asked to solve eight different instances of the 'knapsack test.' In this test, people have to choose which of a list of items of certain value and weight they'll include in a knapsack of a specific weight capacity. The goal of the test is to maximise the value of the items you choose, while keeping under the weight capacity of the knapsack. This was intended to simulate a challenging, modern-day workplace where you might be weighing up multiple goals or calculating several things at once. For each test, the capacity of the knapsack changed so participants had to adapt their thinking each time.

The researchers found that while those taking these drugs performed about as well as the placebo group in finding the correct solution to a knapsack problem (getting the most value), the non-placebo participants tended to take more time on the problem and expended more effort and activity during the problem (they moved items in or out of the virtual knapsack more often and tended to make moves with less of an impact than the placebo group).

The authors suggest that using these smart drugs outside their intended treatment purpose may not be so clever – given they made little difference to performance (and in many cases made people worse) and led only to a significantly elevated level of frantic activity.

Education intervention targets link between alcohol and breast cancer

Breast cancer has several risk factors, in particular age and genetics. Drinking alcohol is also a significant risk factor but evidence suggests that some women aren't aware of it. Considering a rising prevalence of risky drinking among middle-aged and older women, a recent study conducted at a breast screening clinic in Melbourne aimed to evaluate the effectiveness of a brief alcohol education and awareness intervention. They wanted to improve awareness of alcohol as a risk factor for breast cancer and potentially reduce alcohol consumption among women attending routine breast screening.

The study was a randomised controlled trial of women aged 40 years or older who attended the clinic for mammography between February and August 2021. Of the more than 500 participants, 82 per cent said they recently consumed alcohol. They were divided into two groups: an 'active arm' and a 'control arm".

The active arm watched a four-minute animation that included a brief alcohol intervention, followed by a three-minute lifestyle health promotion. The control arm just watched the three-minute lifestyle health promotion.

Before the study, only one fifth of participants were aware that alcohol use increased the risk of breast cancer. But four weeks after the intervention, there was a significant increase in the proportion of people who identified alcohol as a clear risk factor for breast cancer.

In the active intervention group, awareness rose to 65 per cent, while the control group also saw an increase, though it was lower, to 38 per cent. But they also looked at whether people changed their

alcohol consumption because of this knowledge, finding that there was no reduction in the use of alcohol in the weeks following the intervention for either group.

The intervention was useful in raising awareness and knowledge about the connection between alcohol and breast cancer. But it didn't make a measurable change to what people did. This is often the case for interventions targeting knowledge, attitudes and behaviour and suggests either that women accept some risk related to alcohol or that more work is needed to help enable real-world reductions in alcohol consumption.

Further information

A brief intervention for improving alcohol literacy and reducing harmful alcohol use by women attending a breast screening service: a randomised controlled trial: Medical Journal of Australia

https://mydr.com.au/category/breast-cancer/ myDr.com.au

Dental cavities in Aboriginal and non-Aboriginal children

As we know, Aboriginal and Torres Strait Islander peoples have a huge disparity in health outcomes compared to non-Indigenous Australians. In fact, the Department of Health highlights that the burden of disease for Aboriginal and Torres Strait Islander people is 2.3 times that of non-Indigenous Australians.

When it comes to oral health, almost half of Indigenous children have at least one baby tooth with a cavity compared to about a quarter of non-Indigenous children, and Indigenous children in some areas have five times the prevalence of dental disease compared to non-Indigenous children. But what risks and factors contribute to these disparities?

To look at this question, researchers used data from the National Child Oral Health Study 2012-2014 (NCOHS), which is a cross-sectional survey of Australian kids between the ages of 5 and 14. The detailed survey included about 1500 Indigenous children and 30,000 non-Indigenous children, and involves dental examinations of those kids surveyed, questionnaires for their parents, and collection of all data for later analysis. The main outcome they were interested in was the number of tooth surfaces with untreated decay.

The researchers found that at the broadest level, the drivers of tooth decay were similar between Indigenous and non-Indigenous children: sugary drink consumption, household income and living in an area where the water is fluoridated. But digging deeper, there were also differences, and the proportion each risk factor contributed varied between these groups. In particular, toothbrushing frequency was more of a contributing factor for Indigenous children and time of last dental visit was more of a factor for non-Indigenous children.

The authors say these are important findings in understanding the disparity in dental cavities between Aboriginal and non-Aboriginal children. It's not just about socioeconomic circumstance, but also varied social and cultural factors that leave dental caries to go untreated. They provide targets for future interventions in dental care.

Further information

National Child Oral Health Study 2012-2014: Open Access

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