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GENERAL PRACTICE SUPERVISION AUSTRALIA

FAQ
FREQUENTLY ASKED QUESTIONS

PODCAST WEBINAR

Supporting Your Registrar to Provide Best Practice Disability Care

How should we address disability care with our registrars?

"Having a disability" can mean a lot of different things to different people. Helping your registrar appreciate the broad scope of disability care by looking at a diverse range of people identified as having a disability is a good starting point:

Hannah Gadsby, comedian - Diagnosed with autism as an adult and explains that people with autism have an increased sensitivity to traumatisation due to their difficulty in communicating and regulating emotions.

https://www.theguardian.com/stage/2018/jul/16/hannah-gadsby-trauma-comedy-nanette-standup-netflix

Chris Van Ingen, actor - Has cerebral palsy, and is in a wheelchair. His love of acting comes from the independence he feels while performing and the way it shows his ability, rather than his disability.

https://www.geelongadvertiser.com.au/entertainment/chris-van-ingen-lives-with-cerebral-palsy-and-says-people-with-disabilities-should-portray-disabled-characters/news-story/a95bf0cf3f31174ac8e4541c5146ef6b

Adam Pearson, actor and Changing Faces ambassador - Advocating for film and television to de-villainise characters with facial scarring and disfiguration - has neurofibromatosis, which affects mainly his face.

https://www.changingfaces.org.uk/news/our-call-on-bond-producers/

Kiruna Stamell, UK-based Australian actor - has a rare form of dwarfism and has ben vocal in expressing body positivity messages and campaigning for greater access in use of EFTPOS machines.

https://www.dailymail.co.uk/news/article-2872637/Eastenders-actress-dwarfism-successfully-sues-Post-Office-disability-discrimination-couldn-t-reach-chip-pin-machines.html

Dylan Alcott, first man in tennis to win a Golden Slam after winning four Grand Slam titles and an Olympic gold medal in the same calendar year - born with a spinal tumour, becoming a paraplegic when that was resected.

https://www.tennis.com.au/news/2021/09/13/dylan-alcott-completes-golden-slam

https://au.sports.yahoo.com/australian-open-2021-fans-erupt-dylan-alcott-disgrace-211608579.html

Sam Humphrey, actor - has skeletal dysplasia or dwarfism, and also suffers with Crohn's disease. The latter was so badly impacted by his primary disability that he had to undergo 'high-risk corrective surgery' in 2018 and was reported as fighting for his life, serving as a reminder that a person with a disability might have additional health conditions not always managed well due to the focus given to their disability.

https://www.mirror.co.uk/3am/celebrity-news/greatest-showmans-sam-humphrey-fighting-13206187

What are the statistics around disability in Australia?

Encouraging your registrar to examine the statistics and complex considerations around a patient with a disability will help them see the person as a whole and not just their disability.

It is important to note that many people living with a disability are likely to struggle to participate in both education and the workforce, leading to a higher risk of poverty in adulthood. This is only exacerbated by their higher health costs and reliance on others. Someone with a disability is thus often affected not just in terms of their health but in a range of areas of their life, which can in turn contribute to worsening health over time.

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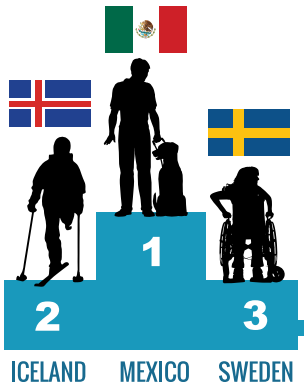
Disability Rights

4 in 10 Australians aged 18 yrs and over report having a disability or long-term health condition



AUSTRALIA RANKS LOWEST

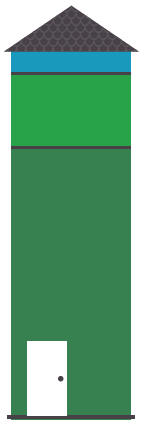
AMONG OECD COUNTRIES FOR THE RELATIVE INCOME OF PEOPLE WITH DISABILITIES

WORKFORCE PARTICIPATION OF PEOPLE WITH DISABILITIES AND WITHOUT DISABILITIES

1.2 million people with disabilities report difficulties using public transport

1 in 4 people who report sexual assault are people with disabilities

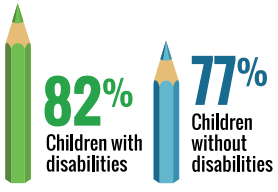
9 in 10 WOMEN WITH INTELLECTUAL DISABILITIES HAVE BEEN SEXUALLY ABUSED



6% Live in non-private dwellings

20% Live independently in private dwellings

74% Live with others in private dwellings



2009 RATES OF PARTICIPATION IN SCHOOL

94% OF PEOPLE WITH DISABILITIES HAVE THE SUPPORT THEY NEED TO LIVE IN PRIVATE RESIDENCES

https://humanrights.gov.au/our-work/education/face-facts-disability-rights

Australian Human Rights Commission

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How is disability defined?

A disability is an impairment or condition that impacts daily activities, communication and/ or mobility, and has lasted or is likely to last for six months or more.

What are the types of disability we should make our registrars aware of?

Disabilities can be differentiated as developmental (presenting in individuals between 0-18 years) and acquired:

Type of Disability	Developmental	Acquired
Physical – affects a person's mobility or dexterity	✔	✔
Intellectual – affects a person's abilities to learn and generally initially appears in 0-18 yrs – Autism and ADD etc are separate sub categories	✔	
Sensory – affects a person's ability to hear or see	✔	✔
Neurological – affects the person's brain and central nervous system i.e. MS, Parkinson's Dx, epilepsy etc.	✔	✔
Psychiatric – affects a person's thinking processes	✔	✔
Speech – Speech loss, impairment or difficulty being understood	✔	✔
Physical disfigurement	✔	
Developmental Delay – children aged 0-5 where no specific diagnosis has been made	✔	
Brain Injury		✔

How can we help our registrars approach disability care with their patients?

It is important to get them to consider - and ask - how the patient's disability or condition might affect them in terms of:

1. Mobility.
2. Ability to provide self-care i.e. ADLs.
3. Learning style.
4. Communication.
5. Self-management i.e. budgeting, ability to make medical decisions.
6. Social interactions.
7. Capacity to make decisions.

From this starting point, they should then consider all likely barriers - physical and societal - to health care:

- Financial
- The doctor
- Your facility
- Administration
- Communication
- Attitudes
- Carers
- Time
- Equipment limitations Location
- Knowledge limitations

What are the potential barriers we should make our registrars aware of in the practice (or town)?

- Access to specialist services.
- Small consulting spaces.
- No lifter available in practice.
- Fixed height of examination bed.
- Poor access - narrow doors and corridors, absence of ramps or railing.
- Inappropriate equipment.
- Lack of awareness about available services to help the patient and/or carer.
- Communication issues.

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Why is communication so important?

Your registrar needs to reflect on the challenges their patient with disabilities might face in the consultation:

- **Motor difficulties** – ability to construct the sounds needed.
- **Motor planning** – sequencing of speech.
- **Cognitive factors** – intellectual or cognitive impairments.
- **Sensory factors** – poor vision, deafness, or oral sensitivity.
- **Confidence** – may be diminished from past experiences.

Reddihough D, Tracy J, de Vries T, Dorfan D, Street N. Cerebral palsy for general practitioners. July 2018. doi:10.25374/MCRI.c.4153910.v1

What should we discuss with our registrars to address communication concerns?

1. How does your practice access an interpreter?
    a) Language interpreter services are free across Australia: the patient needs to be registered, which you should talk through with your registrar as a process.
    b) Sign language interpreter services are not free: the patient needs to apply to the NDIS to access (and pay through their NDIS plan for) sign language interpreters, which can be quite an expensive service and cannot be easily arranged at short notice. There is a National Relay Service that does video consults, but that's of more relevance to Telehealth than in-practice consultations.
2. Asking the patient how they prefer to communicate.
    a) Carers might have strategies to help with communicating, especially with non-verbal patients.
    b) Remember that many deaf people are very skilled at lip reading, but don't assume.
3. Speaking as they would to anyone else of that age and gender.
4. Speaking directly to the patient.
5. Using appropriate volume.
6. Observing for verbal and non-verbal cues.
7. Listening.
8. Checking they have been understood.

NOTE: Masks with clear plastic across the mouth are available to assist with lip reading - it is worth checking if these are on hand in your practice before seeing a patient with communication difficulties.

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What place does preventative health have when we are teaching our registrars about disability care?

- Preventative health is very important and rarely occurs in disability care.
- People with intellectual disabilities have high rates of preventable disease and early deaths.

POSITIVE CARDIOMETABOLIC HEALTH FOR ADULTS WITH AN INTELLECTUAL DISABILITY: AN EARLY INTERVENTION FRAMEWORK

ADAPT YOUR PRACTICE while addressing STANDARD TARGETS Plan for: communication adjustments; engagement with support networks; extra time; consent; teamwork.						
Activity	**Diet, lifestyle, weight/waist**	**Socioecomonic resources**	**Blood pressure**	**Glucose regulation**	**Fasting blood lipids**	**Psychotropic prescription**
150 minutes moderate intensity exercise per week (e.g. 30 minutes 5 days per week) Reduce sedentary behaviour	Non-smoker, balanced diet, minimse alcohol and other drug use BMI[2]. 18.5-24.9 kg/m^2 Waist circumference: <94cm males, <80cm females	Socioeconomic status is associated with cardiometabolic health Ensure adequate access to housing, healthcare, transportation, education and employment opportunities	For most: <140mmmHg systolic and <90mmHg diastolic For people with diabetes or vascular disease: <130/80mmHg	FPG target: <5.5mmol/L Individualise HbA1c targets for people with diabetes, generally <7% (53mmol/mol)[3] For aversion to venepuncture click here	TChol ≤ 5.5 mmol/L LDL ≤4 mmol/L For people with high CV risk (e.g diabetes, hypertension, chronic kidney disease); consider LDL ≤ 2mmol/L Trig ≤ 1.6mmol/L	Evidence based prescription to treat symptoms of defined mental illness and/or when challenging behaviours are severe and non-responsive to other interventions Minimum effective dose and length of treatment
Any values outside of target range: DON'T JUST SCREEN - INTERVENE Tailored intervention brochures can be downloaded from https://3dn.unsw.edu.au/positive-cardiometabolic-health-ID						

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Certain genetic causes of intellectual disability may alter the person's cardiometabolic profile. **It is important to identify the cause of ID where possible and to proactively manage individuals at risk to prevent further complications.** Syndromes with cardiometabolic risk factors include:

Syndrome	Diabetes mellitus	Hypertension	Hypotension	Obesity	Dyslipidaemia
Down	✔		✔	✔	✔
Turner	✔	✔		✔	✔
Tuberous sclerosis		✔			
Williams		✔			
Angelman				✔	
Sotos	✔	✔			
Prader-Willi	✔	✔		✔	✔

Adapted from: Wallace, R.A. (2004). "Risk factors for coronary artery disease among individuals with rare syndrome intellectual disabilities". Journal of Policy and Practice in Intellectual Disabilities 1(1): 42-51.

What are some important points to discuss with the registrar?

- This issue is probably not their disability!
- Looks can be deceiving.
- Encourage your registrar to "check their bias"
  - Is there something stopping them from seeing the bigger picture, or an alternative diagnosis for this patient?
- Think about access issues for investigations e.g. bloods, imaging etc.
- Has the registrar done an appropriate examination
  - How can they improve this in practice and/or the home setting?

Where do we direct our registrars for help understanding the GP's role in navigating the NDIS?

- The resources provided for GPs by the NDIS are readily available on the NDIS website.
- The new GPSA Teaching Plan: Adults with Disabilities adds additional resources to these in a succinct, user-friendly format.

What is the NDIS' role in the patient's disability care?

NDIS is responsible for	NDIS will not fund
• Home modifications • Personal care assistance • Education to improve independence • Allied health involvement • Prosthetics & artificial limbs • Assistive technology e.g. wheel chairs, beds, hearing aids • Behavioural supports • Non- acute care in some circumstances e.g. chronic wounds • Sex therapy	• Diagnosis and assessment • Medication, medical/ dental care, specialist services, hospital, surgery or rehabilitation • Clinical mental health care • Palliative, geriatric or psychogeriatric services* • Sub acute or acute treatments • Discharge from hospital planning • General hearing or vision services unrelated to a disability • Services needed related to a 'medical condition' • Sex workers

* NOTE: The NDIS has a cut-off age OF 165 for new applicants; however, when existing participants reach the age OF 165, they have the option to leave the NDIS and move to My Aged Care, but this is not mandatory. As that participant's GP, the recommendation would be to stay on the NDIS so they have access to much more funding than they would under My Aged Care.

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What are the main things the registrar needs to direct the patient to consider when applying for the NDIS?

When they apply for their NDIS package and subsequent reviews / amendments, the patient needs to consider their needs in terms of three types of supports:

Core - Supports enabling participants to complete ADLs, work towards their goals, and meet their objectives. eg: personal care assistance.

Capital - Investments made to support participants, such as assistance technologies, equipment or home and vehicle modifications.

Capacity building - Supports that enable participants to build their independence and skills, for example exercise physiotherapy.

These supports are viewed by the NDIS through the lens of their relevance to the participant's stated goals and objectives, for example:

- To live independently.
- To develop meaningful relationships.
- To communicate better so they can buy their own groceries.

What are some tips for registrars helping new applicants with the NDIS process?

1. Ask the patient to *nominate them* as their "**Lead Health Professional**".
   - The GP will still never receive any reports, but
   - This does ensure that involved therapists can see who the GP is which can help with communication.
2. Always be very clear about how the patient's condition affects their "**functional ability**".
   - The NDIS is rejecting applications that include elements they think could be covered by a GPMP/TCA or a hospital allied health program: it is crucial to make a clear distinction between the medical condition (not covered by NDIS) and how that medical condition is affecting the patient's **function** and stopping them from achieving their objectives and living the best life possible.
3. Tell the patient to be specific and think as broadly as possible.
   - I.e. "wheelchair maintenance" and "measuring & fitting" for a new powered wheelchair can be >$30,000.

How do we help the registrar provide the required evidence for NDIS?

For each functional domain, the patient provides evidence of the disability and:

1. Impact and severity.
2. Patient capacity to manage.
3. The expected duration.
4. What your patient requires to manage their disability i.e. suggested equipment and supports.
5. If and how quickly your patient is deteriorating in their level of function.

NOTE: GPs can summarise, or attach existing medical reports, from specialists or allied health.

What should we get our registrars to focus on when writing for the NDIS?

A useful tool to refer to when addressing the evidence needed to meet NDIS requirements, "GP Statement of Evidence", can be found on the website of NDIS provider Inclusion Melbourne: https://inclusionmelbourne.org.au/resource/gp-statement-of-evidence-form/. NDIS providers have developed some really useful tools to aid the GP in translating their medical terminology into the language the NDIS needs at the other end.

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	FOCUS (HOW THE 'PROBLEM' IS DEFINED)	ASSOCIATED WORDS & PHRASES	ASSOCIATED DESCRIPTIONS	WRITING FOR THE NDIS
HEALTH CONDITION	An abnormal state of health	Disease Injury Illness Syndrome Condition Fracture Genetic Patient Treatment	"...sustained an acquired brain injury (ABI) subsequent to a cerebral vascular accident (CVA)/ stroke.."	Describe the health condition: "John's acquired brain injury..."
IMPAIRMENT	Problem in body function or body structure	Impaired Decreased Limited Poor Contusion Hemiparesis Patient Rehabilitation	"...sustained left fronto-temporal haematoma with right upper and lower limb hemiparesis... Presents with moderate to severe, permanent cognitive impairment in areas of attention, working memory, impulse control..."	Describe the permanent impairment: "...has resulted in permanent cognitive-communication impairment. He has difficulty with comprehension and verbal communication, and his social functioning is impaired..."
ACTIVITY LIMITATION	Problem with carrying out a task or activity	Aided Needs support with... Unable to... Requires prompting... Skill development Compensatory strategies Patient/Client Rehabilitation	"...unable to safely walk more than 100m unaided...becomes distressed and angry at local shop keeper when he has to wait in line...forgets items to purchase due to memory impairment..."	Describe how the permanent impairment limits the person's activities (functional impairment): "...This permanent impairment is severely limiting John's ability to have conversations as he used to with his children..."
PARTICIPATION	Problem with involvement in life situations	Functional Meaningful activities Everyday situation social roles Participates in... Context specific Valued outcomes Big Things Meaningful goals Client /person/ participant Enabling; maintaining; preventing deterioration; small, slow incremental gains	"...isn't working as continues to forget job interview appointments...socially isolated and stays at home...shopkeeper has indicated that he will be banned from shop if outburst happens again"	Describe how the functional impairment limits the person's ability to fulfil their life roles; the functional limitation to his capacity: "...This is severely impacting on his functional capacity to fulfil his role as father in the way he did pre-injury. John requires ongoing capacity building support from a Speech Pathologist to maintain the gains he has made during rehabilitation in the area of his life, so he can achieve his goal to be a good dad for his children. SP can monitor and update his strategies to maintain his current level of functioning. Currently he is able to..."

DISABILITY – See definition at the bottom of the page

DISABILTY: incorporates impairment, activity limitation and participation for a person. The NDIS' focus is at the participation end of the spectrum, which is about the person's goals, life roles, functional capacity. Your documentation, requests and evidence need to include health condition and impairment but should emphasise limitations in their activity and capacity to participate.

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It is with this need in mind - the need to consider and adapt wording for the intended audience and purpose - that the registrar should address the "evidence of psychosocial disability form" on the NDIS website:

Domain	Description of the impairments present
Social interaction • Making and keeping friends • Interacting with the community • Behaving within limits accepted by others • Coping with feelings and emotions in a social context	
Self-management • Cognitive capacity to organise one's life, to plan and make decisions, and to take responsibility for oneself, including: • Completing daily tasks • Making decisions • Problem solving • Managing finances • Managing tenancy • Are there any community treatment orders/ guardianships/financial administrations in place?	

How should we direct out registrars when abuse is suspected?

- Complaint about an NDIS provider:
  - NDIS Quality & Safeguards Commission[1]
    1800 035 544

    The Commissioner[1] has the power to:
    - *Request further information from a person or body*
    - *Apply for and execute search warrants to collect evidence as part of an investigation*
    - *Request compulsory attendance at meetings and the production of relevant documentation*
    - *Conduct a public enquiry if this is in the public interest.*

    Following an investigation, further action may be taken. This could be making an application to a court or tribunal. The intention is always to improve the safety of the adult and uphold their rights.
- Concerns about abuse or neglect:
  - National Disability Abuse & Neglect Hotline
    1800 880 052

    "The Hotline works with callers to find appropriate ways of dealing with reports of abuse or neglect through referral, information and support. The Hotline will remain impartial – and does not take sides and does not advocate on anyone's behalf."
- Immediate concerns about violence or crime
  - NSW Police - 000

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CASE STUDY

Harry is a new patient to your practice.

- He presents with a carer from his new group home
- The carer is hoping that the registrar will be Harry's GP because "it was easy to get in to see them today".
- The carer also asks if the registrar might consider doing 'home visits'?

More about Harry:

- 46 year-old man with severe cerebral palsy, L hemiparesis and severe epilepsy
- Daily seizures but mostly manageable
- Mobilises in a motorised wheelchair
- Looks thin
- Unable to communicate effectively and thought to have vision impairment

What specific medical and social history should you encourage your registrar to ask about?

FOR NEW (OR UNDER ASSESSED) PATIENTS:	ALSO CONSIDER:
• A full systems review • Areas commonly forgotten: – Mental health or social supports – Pain management – Bone and joint health – Dental – Preventative health – Communication strategies – Nutritional assessment: yearly weight, height, Vit D, B12/ folate – Bowels – constipation common – Sex and relationships	• Home medication review (new and previous) • Hearing and vision assessments • Epilepsy and/or pain management plans • What outside supports or equipment are they using (or need)? • Who is the carer (if there is one)? – Are they paid/ contracted? – If family, are they supported too? – Is there guardianship – who makes medical and financial decisions?

PAST MEDICAL HISTORY	SOCIAL HISTORY
• Hospitalised two years ago with severe aspiration pneumonia • PEG insertion two months ago and aspiration pneumonia post op. – PEG mainly used for medications now • Currently on full thick fluids and puree diet • Other issues in PMHx: Dandy walker syndrome, osteoporosis, scoliosis, constipation, double incontinence and renal stone diagnosed in 2015	• Lives with 4 other residents of a community group home • Regular outings with support agency under NDIS • Requires intensive support for all ADLs • Family involved & make all medical decisions. • Guardian board for financial decisions only

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YOUR REGISTRAR CALLS YOU FROM HARRY'S GROUP HOME, ASKING FOR YOUR ADVICE:

- Harry has been refusing food intermittently for last 24 hrs
- Seems unhappier than usual according to staff
- Your registrar doesn't know what to do - but they have called the family to confirm that Harry's Advanced Care Directive was up to date!

What questions should you ask?	• Normal patient behaviour? • Recurrent UTI? • Pressure area? • Pain? • Aspiration pneumonia? • Constipation? • Carer abuse?
On modified examination	• Afebrile • Looks tired? Pale – slept through most of assessment and no obvious distress • BP 102/69 • HR 92 • Abdo: No masses, not really tender – examined in wheelchair • Urine more smelly than usual • Stools slightly loose today • No obvious issues with skin integrity • No pain on palpation of limbs • Chest clear
What should you recommend?	Possible options include: 1. MCS and start antibiotics for suspected UTI 2. Encourage the registrar to take some bloods for further Ax 3. Watch and wait 4. Covid swab 5. Advise to give feed & fluids via PEG 6. Other?

Follow up condition a few days later	• Hb: 72 • CRP: 200 • WBC: 16 • Urine: Positive for Staphylococcus saprophyticus • In discussion with you and the group home your registrar decides to call an ambulance
In hospital (first time)	• Given two units of blood • IV antibiotics and fluids • No further investigations – assumed urosepsis • Discharged back to group home on antibiotics via PEG
Now what?	• Appears to be ok • CRP still remains around 100 • Registrar decides to order an Ultrasound at the local hospital: – Gross dilatation of right renal calyces – Hydronephrosis – Severe thinning of the renal parenchyma – 2cm renal stone identified • Your registrar calls the local urology registrar • Harry is admitted to hospital again.

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In hospital (second time)	• Stents inserted – significant amount of pus drains from Right kidney • Urology discusses with family: – Renal stone likely there 'for years' – Right kidney is no longer functional – Recommendation to book for Right kidney removal to prevent long-term complications • Discharged back to group home while awaiting surgery • No pain relief prescribed on discharge
Surgery admission	• Right kidney resection went smoothly in hospital • Significant liaison between hospital staff, family, and carers of group home prior to discharge • Discharged 5 days later with clear management plan for wound, pain relief and follow up
Post discharge	• GP Registrar recommended to staff that they take a temperature check every 4 hours for next two weeks • 6 days post discharge was noted to have a high fever on routine temp check at midnight. • Staff noted he was awake and appeared in distress. • Readmitted back to hospital with "sepsis of unknown origin" • Given IV Abx and discharged two days later

HEALTH CARE CHECKLIST FOR AN ADULT WITH DEVELOPMENTAL DISABILITY

Health concern	Review frequency	Practitioner
General health		
Blood pressure	Yearly	GP
Oral health (teeth, gums and oral cavity)	Every 6 months	Dentist
Medication review	At least every 6 to 12 months	Medication review pharmacist
Hearing		
Assessment	Down syndrome – every 2 to 3 years	
	Non down syndrome – every 3 to 5 years	Audiologist
Correct use of hearing aids	Regularly	GP or audiologist
Otoscopy	Opportunistically	GP
Vision		
Assessment	Down syndrome – every 2 to 3 years	
	Non down syndrome – every 3 to 5 years	Optometrist/ophthalmologist
Correct use of glasses	Regularly	GP or optometrist/ophthalmologist

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What should I discuss with my registrar about cerebral palsy?

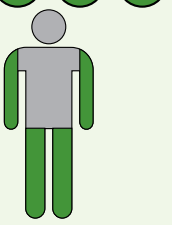
Discuss parts of the body affected in different cases of cerebral palsy (pictured below). Also discuss with the registrar the daily impacts of living with different variations of the disease and supports required for daily living.

PARTS OF THE BODY

Cerebral palsy can affect different parts of the body

QUADRIPLEGIA/ BILATERAL:

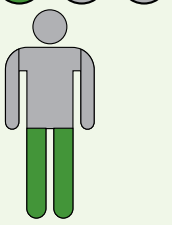
LIMBS AFFECTED 1 2 3 4



Both arms and legs are affected. The muscles of the trunk, face and mouth are often also affected.

DIPLEGIA/ BILATERAL:

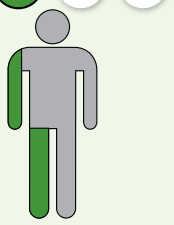
LIMBS AFFECTED 1 2 3 4



Both legs are affected. The arms may be affected to a lesser extent.

HEMIPLEGIA/ UNILATERAL:

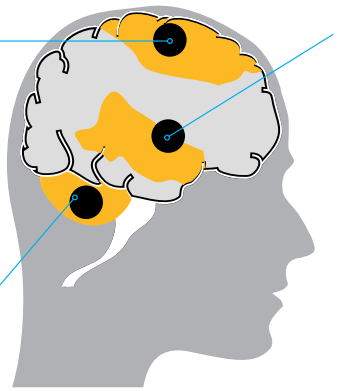
LIMBS AFFECTED 1 2 3 4



One side of the body (one arm and one leg) is affected

MOTOR TYPES

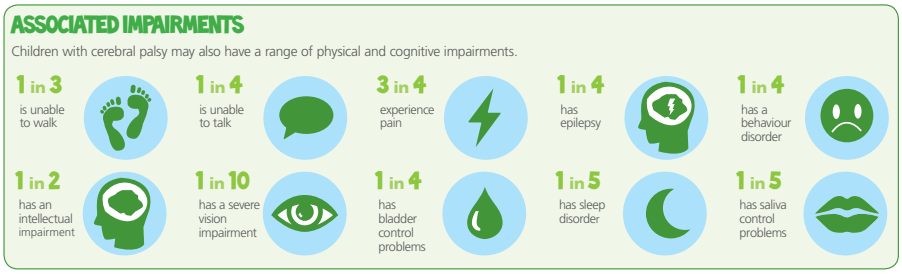
SPASTIC: 70-80%. Most common form. Muscles appear stiff and tight. Arises from Motor Cortex damage.



DYSKINETIC: 6%. Characterised by involuntary movements. Arises from Basal Ganglia damage.

MIXED TYPES: Combination damage.

ATAXIC: 6% Characterised by shaky movements. Affects balance and sense of positioning in space. Arises from Cerebellum damage.



Source: https://cerebralpalsy.org.au/wp-content/uploads/2013/08/WCPD_16_WhatisCP_Infographic_WORLD.pdf

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FAQ

FREQUENTLY ASKED QUESTIONS

What should I discuss with my registrar for individuals living with a disability?

Bone health	• Consider ordering a DXA scan with body composition if one has never been done. • Check baseline: – Vitamin D, Calcium, Phosphate, TSH, PTH +/- Testosterone. • Regular Vit D &/or calcium and nutritional assessment. • Weight bearing exercise. • Referral for specialist management with rheumatology if high risk including minimal trauma fracture. – May be commenced on bisphosphonates long term.
Sexual and reproductive health	• Disabled people are not asexual • All young people need sex education • How your registrar can organise regular cervical smears for their patient • Family planning, STI screening and contraception • Teaching your registrar how to assess capacity to make decisions.
Pain management	• 3:4 people with CP experience regular pain. • Frequently unrecognised as some people appear to show no normal signs of pain. • Important to manage appropriately.
Managing behaviour problems	• Do a proper assessment before relying on any type of "chemical restraint" • Drugs may be appropriate when behaviour is: – Persistent – Pervasive across different situations – Frequent – Not being caused by a correctible issue – Severe: – Causes distress – Causes injury to self or others – Compromises their health – Restricts their activities and community access

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FREQUENTLY ASKED QUESTIONS

WHAT BILLING INFORMATION SHOULD MY REGISTRAR HAVE WITH RESPECT TO DISABILITY CARE?

- While a health assessment for people aged 45–49 years (inclusive) who are at risk of developing chronic disease can be billed just **once**, a health assessment for people with an intellectual disability can be billed and done **annually***.
- Case conferencing teams must include a GP and at least two other health or community care providers, one of whom can be another medical practitioner. Each team member should provide a different kind of care or service to the patient.

Example:

Billing per year for patient with an intellectual disability:

- GPMP + TCA = $262.70
- GPMP + TCA review = $146.40
- Yearly health assessment (Item 705: 45-60mins) = $193.35
- Home medicines review = $157.30
- 20-40min appointment = $73.95 **x 10** = $739.50
- Bulk billing incentive/ visit = $15 **x 10** = $150
- 1 x case conference (20-40mins) = $118.60

Total per 12 months = $1,767.85

It is important to complete regular health assessments for patients living with a disability **each year.*

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FREQUENTLY ASKED QUESTIONS

Resources

GPSA webinars

GPSA guides

GPSA teaching plans

GPSA FAQs

All GPSA resources are available here

- TEACHING PLAN:
  - Adults with Disabilities https://gpsupervisorsaustralia.org.au/download/12882/

- Inclusion Melbourne (disability provider, resources) https://inclusionmelbourne.org.au/
- 'I broke the contract': how Hannah Gadsby's trauma transformed comedy: https://www.theguardian.com/stage/2018/jul/16/hannah-gadsby-trauma-comedy-nanette-standup-netflix
- Disability Types and Description https://www.nds.org.au/disability-types-and-descriptions
- Communication and cerebral palsy: Module 4, Cerebral palsy for general practitioners (fact sheets) https://www.ausacpdm.org.au/resources/cerebral-palsy-for-general-practitioners-fact-sheets/
- NDIS Information for GPs and Health Professionals https://www.ndis.gov.au/applying-access-ndis/how-apply/information-gps-and-health-professionals
- Behaviour support and restrictive practices under the NDIS https://www.ndiscommission.gov.au/providers/understanding-behaviour-support-and-restrictive-practices-providers
- Use of Medication for managing Challenging Behaviours (NSW) https://www.facs.nsw.gov.au/__data/assets/pdf_file/0020/630362/Behaviour-Support-and-the-Use-of-Medication-A-guide-for-practitioners.pdf
- Cerebral Palsy Alliance https://cerebralpalsy.org.au/about-conditions/cerebral-palsy/#1534292840469-5ffb8d03-90d3
- Routine screening for children with Down Syndrome at different ages https://www.rch.org.au/genmed/clinical_resources/Screening_for_children_with_Down_Syndrome/
- https://www.rch.org.au/uploadedFiles/Main/Content/genmed/clinical_resources/Down_syndrome_guideline_final.pdf

Does this resource need to be updated? Contact GPSA: P: 03 9607 8590, E: admin@gpsa.org.au W: gpsa.org.au
GPSA is supported by funding from the Australian Government under the Australian General Practice Training Program 05/09/22