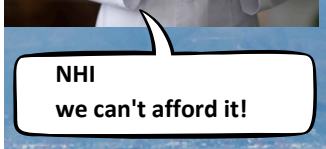
July 2025



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QualiCare

Newsletter

QUALICARE revisits the OHSC Manuals

The deadline for the commencement of general practice inspections by the OHSC, scheduled for the 30th of June 2025, has now passed.

As far as we are aware, no practices have been inspected and as we reflect on some of the bulletins which we published over the past 30 days, we are again left with the same original opinion, namely that senior officials within the OHSC overextended themselves by announcing an unattainable commencement date for practice inspections as well as releasing an unachievable set of criteria in the time allowed! This was most destructive and unfortunate.

Our duty in Qualicare, is to inform our members whenever there is an urgent matter which impacts on their ability to practice. The OHSC precipitous announcement of General Practitioner inspections commencing on the 30th of June 2025 was indeed such an example.

NEXT

QUALICARE revisits .....continue to page 2

Inside this issue

QUALICARE revisits the OHSC Manuals ..... *pg 1- 4*

Worcester Open Day 2025 ..... *pg 4*

REGULATORY GENERAL PRACTICE INSPECTION TOOL A Quik Guide for General Practitioners ..... *pg 7-9,11-13,15-17 19-21,23-24*

Survey /OHSC Feedback ..... *pg 26,27-29,31-33*

Pathcare News: Preventing Invasive Cryptococcal Disease Through Active Screening For Cryptococcal Antigenemia In People Living With Advanced HIV ..... *pg 35*

Don't Let the Fire Extinguisher Expire ..... *pg 36*

CPD problems: June 2025 deadline: Qualicare addresses the HPCSA ..... *pg 37-39*

GEORGE OPEN DAY BROCHURE, SATURDAY, 19 July 2025 ..... *pg 41-43,45-53*

Invitation to Dentists, Physiotherapists and Allied Health Care Professionals to become an Associate Member of CPC/Qualicare ... *pg 54-55*

Medscheme Corner ..... *pg 56*

Qualicare Electronic Doctor Network ..... *pg 57-58*

Web Traffic ..... *pg 59*

Facebook ..... *pg 60*

Disclaimer ..... *pg 61*

The release of their 2 highly complex and technical manuals, with far reaching and certain unachievable goals and requirements, combined with an impossibly short deadline, has given the OHSC no credit in the eyes of the General Practitioner.

We are all fully aware that the OHSC has been created in terms of the National Health Act, and as such is an organ of state with extensive responsibilities.

As IPA movements, we have all welcomed the need for standardization of the delivery of healthcare at all levels, starting from the most basic clinic, up to tertiary hospital specializations.

Their rushed announcement of a deadline for the implementation of guidelines, merely created mass panic throughout the private and public primary healthcare sectors, and as such was greeted with pushbacks and ridicule.

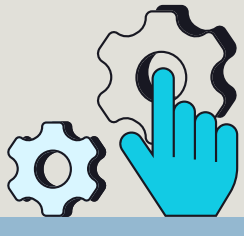
To be quite clear, we do not support ridicule of National Quality Standards and have long recognized and supported the need for standardization at all points of entry and continuity of the healthcare cycle.

We have long admired the manner in the UK's National Health Service addressed standardization of practices many years ago as this very matter was noted early in the development of the National Health Service of the United Kingdom.

In sharp contrast however, the Family and General Practitioners of the UK, were extensively assisted by the UK government, both financially, as well as collegially.

The UK government quickly accepted that in order to standardize Primary Health care at General Practitioner level, it would require extensive investment into the infrastructure of general practice throughout the country. They proceeded to make significant funds available to General Practitioners to upgrade their surgeries as well as cover the costs of extra staff required in both the private and public sectors of medical service delivery.

This was done over a considerable period of time before introducing the Care Quality Commission (CQC), to control quality, assist, improve and if necessary, admonish General Practitioners. The OHSC in RSA is very similar to the CQC in the UK bug very different from the South African scenario where the need for compliance was announced 30 days before it went live at all at the cost of the private General Practitioner!



QUALICARE revisits .....continue to page 3

So where are we now?

Over the past month there have been numerous worried and anxious General Practitioners. Our field force of 5 consultants has fielded numerous questions such as:

1. When do the inspections begin?
2. What happens if I fail an inspection?
3. Will I still be able to see my patients if I fail an inspection?
4. What period of time do I have to become compliant following a failed inspection?
5. Will the medical aids be informed that they should not reimburse me if I fail an inspection?
6. Do I have to have an OHSC clearance certificate to continue in practice?
7. Is an OHSC practice clearance certificate only necessary to see a future National Health insurance patient?
8. Can I elect not to see National Health insurance patients if I am in possession of an OHSC clearance certificate?

We have posed these questions to various individuals and obtained a variety of dissimilar answers, so these very little clarity at present. We will, of course, publish recommendations/answers to the above queries as soon as we are able to get definitive responses.

What is clear however is that the OHSC does not have sufficient inspectors to go around. The inspections which have been conducted on numerous state facilities have returned a failure rate of over 85%!

The OHSC requires extensive input from the profession, especially from general Practitioners and this is being offered via the UFFP (The United Forum of Family Practitioners) of which Qualicare is an executive member.

Currently the OHSC requires every Practitioner to register with them. This is a preliminary step to forming a national database of General Practitioners prior to comprehensive inspections.

Looking at the registration page of the OHSC, and the scope of information required for registration, we have noted various omissions. As such we do NOT currently encourage Practitioners to register early and until the OHSC registration pages are more comprehensive. By way of example, it currently omits asking for your MP number and only has 2 choices for your style of practice. You will all probably recall the chaos that ensued when the POPI website was first launched and the difficulties with early registration.

QUALICARE revisits .....continue to page 4

To be clear we are NOT saying "do not ever register!", we however advise circumspection and a wait and see approach when using the current registration online as it does not appear to be complete.

We will report back on the progress of correction of this registration page, as and when it happens and will then encourage registration.

In the meanwhile, I have carefully interrogated the 2 manuals released by the OHSC and summarized, condensed and abridged them to make them more easily understandable, more GP friendly and comprehensible, without leaving out important details.

These will be made available behind our Qualicare /Docweb firewall to members and shareholders only. I have, however, published them in this edition of our newsletter, as it is urgent that these reach you.

I encourage you to work through the two reacted manuals and mark off what is already in place in your practice, what you may be able to introduce without excessive time or effort or costs, and the highlight and inform your Qualicare consultants, the items which are unaffordable, unattainable or esoteric.

Items such as Oxygen Cylinders and AEDs are up for discussion with the OHSC and the DOH, due to their prohibitive acquisition cost and complex maintenance.

Non re-packaging of medicines is also being interrogated and re-evaluated. The UFFP will be meeting with the OHSC and feeding back our recommendations to them on a regular basis.

Finally, in the same way that Rome was not built in a day, General Practice will not be able to comply with OHSC recommendations overnight. It's a gradual process, and whilst we all share the same wants, needs and aspirations, we will all continue to walk the same road to eventual Quality Assurance, and practice excellence. It's just the walking speed which may vary!

The Qualicare motto shows clearly that we stand for quality, affordable, effective, efficient, non- discriminatory healthcare for all.

Dr Tony Behrman and the Qualicare team

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REGULATORY GENERAL PRACTICE INSPECTION TOOL.

A QUICK GUIDE FOR GENERAL PRACTITIONERS

Preamble:
The National Health Act, 2003 (Act No. 61 of 2003) provides for quality requirements and standards in respect of health services provided by practices to the public. The main objective is to promote and protect the health and safety of the users of health services and contribute to improved outcomes and improved population health.

To achieve this mandate standardised inspection tools aligned to Norms and Standards Regulations applicable to different categories of practices promulgated by the Minister of Health in 2018 have been developed for General Practices.

CLINICAL CARE AND SUPPORT

USER RIGHTS and USER INFORMATION
The practice must ensure that users are provided with adequate information about the health care services available at the practice and information about accessing those services.

- The practice must provide users with information relating to the health care services provided by the practice.
- Services could include but is not limited to management of minor ailments, minor surgical procedures, chronic disease management, travel health, reproductive health and provision of Sonars.
- The information may be available or displayed at the entrance of a practice.
- The information can be on a poster, manual or electronic notice board, booklets or pamphlets or a notice indicating that the information is available on the practice's website.
- Users must be informed about the practice operating hours.

A QUICK GUIDE .....continue to page 8

USER COMPLAINTS
The practice must provide users with information relating to the complaints, compliments and suggestions management system. A system to provide users with information on the complaints management procedure must be publicly available.

USER FEES
The practice must provide users with information relating to any fees that are payable for health care services, insofar it being practical to do so before the commencement of the provision of health care services.

- This requirement refers to an indicative, not definitive cost and applies to interventions to be provided by the practice.
- This requirement reflects S6(1)(c) of the National Health Act.
- Routine costs, e.g. private consult tariff, consultation costs, & can be communicated by means of a poster or notice at reception or a notice indicating the information about the costs on the practice's website. Additional costs

USER SURVEY RESULTS
The practice must display the results of user experience of care surveys conducted within the past twelve months.

ACCESS TO CARE
The practice must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition.

TRIAGE
The practice must implement a system of triage.

- This system could include the availability of a health care personnel (such as a doctor or a nurse or a receptionist) to identify users that require urgent care, or a notice displayed in waiting areas or an electronic display or any other system.
- Healthcare personnel must be familiar with the system to prioritise users

A QUICK GUIDE .....continue to page 9

EMERGENCY MEDICAL TRANSPORT

- The practice must ensure access to emergency medical transport for users requiring urgent transfer to another practice, and that they are accompanied by a health care provider.
- Emergency Medical Service contact number(s) are available.
- The practice must provide users with information on how to access emergency care when the practice is closed.
- Users are provided with emergency contact details.
- The practice must have a system to inform users on how to access emergency care outside the operating hours of the practice.

REFERRALS

- The practice must maintain a system of referral as established by the responsible authority. & must ensure that a copy of the referral document is kept in the user's health record.
- This will include but is not limited to presenting complaint(s), examination findings, investigations conducted, diagnosis or provisional diagnosis, and treatment provided.
- The practice must implement a system for the referral of users to other service providers both state and private.

CLINICAL GOVERNANCE AND CLINICAL CARE: HEALTH RECORDS

- The practice must ensure that health records of health care users are protected, managed and
- kept confidential in line with section 14, 15 and 17 of the Act.
- The practice must have a health record filing, archiving, disposing, storage and retrieval system which complies with the law. The health records must be kept secured this will include but not limited to a security gate which is lockable or access control measures, e.g. a tag/card, lockable cabinets.
- Electronic records must be safeguarded with passwords or any other security measures.

CONFIDENTIALITY OF HEALTH RECORDS

- The practice must ensure confidentiality of health records.
- The Protection of Personal Information Act (POPI Act) must be displayed.
- Confidentiality of health records must be maintained and managed in line with section 14 of the National Health Act and determine whether unauthorised individuals would be able to access the information in the health records.
- The practice must create and maintain a system of health records of users in accordance with the requirements of section 13 of the Act.
- The practice must record the biographical data of the user and the identification and contact information of the user and his or her next of kin in the user health record.
- Records should be kept in non-erasable ink and erasure fluid should not be used. Not applicable where electronic records are used.

A QUICK GUIDE .....continue to page 11

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References: 1. Current DoH price file. 2. Lawate P, et al; Effectiveness of Rabeprazole and Other Proton Pump Inhibitors in Managing GERD with Varying Severity: A Retrospective, Real-world EMR-based Study (POWER GERD Study); Journal of the Association of Physicians of India (2023): 10.59556/japi.71.0366.

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The requirement is in line with HPCSA Booklet 9 section 4.2.

- The practice must record information relating to the examination and health care interventions of users.
- The clinical assessment and management plan for the user must be recorded in the user health record.

The following must be recorded in the notes:

1. Date of consultation.
2. Time of consultation.
3. Allergies (where applicable).
4. Assessment of the user's condition.
5. Clinical management plan of the user.
6. Medication prescribed (where applicable).
7. Details of referrals (where applicable).
8. Adverse effects to treatment or medication (where applicable).
9. Results of investigations requested. (where applicable).
10. Follow-up requirements are agreed with users and documented in the user record (where applicable)
11. Records should be kept in non-erasable ink and erasure fluid should not be used. Not applicable where electronic records are used.
12. Each entry signed by health care provider.
13. Diagnostic investigation results must be available in the user's health record.

INFORMED CONSENT

A documented procedure which describes the information to be collected and discussed during the process to obtain informed consent must be implemented, in accordance with Chapter 2 of the National Health Act (Section 7). This must include:

1. User full name(s) and surname.
2. The user's age, date of birth or identity number.
3. The consent form is dated. The exact nature of the procedure or treatment.
4. A consent form is signed by the user, the legal guardian or any person legally responsible for the user.
5. The consent form is signed by the health care provider.

Where this is not practicable, health care provider may delegate the function to another health care provider.

A QUICK GUIDE .....continue to page 12

CLINICAL MANAGEMENT SYSTEMS

- The practice must establish and maintain clinical management systems, structures and procedures that give effect to national policies and guidelines for priority health conditions.
- These are issued by the national department are available and communicated to health care personnel.
- Clinical guidelines must be available in consultation rooms.
- This includes but is not limited to National Department of Health clinical guidelines or other evidence-based clinical guidelines.
- A practice must establish and maintain systems, structures and programs to manage clinical risk

CLEANLINESS:

Disinfectants, cleaning materials and equipment must be available.

Disinfectant and cleaning materials.

1. Chlorine releasing agent - hypochlorite (e.g. Biocide D or Clorox)
2. Alcohol based agent (70%-90%)
3. Detergents – neutral pH
4. Cleaning solutions are labelled cleaning equipment
5. Colour labelled mop - Red for toilets and bathrooms
6. Colour labelled mop - Blue for Clinical and non-clinical service areas
7. Mop labelled for cleaning exterior areas (where applicable)
8. Green bucket and cloths for bathroom and consulting room hand washing basins
9. Red bucket and cloths for toilet
10. White cloths for kitchen
11. Blue bucket and cloths for clinical areas and non-clinical service areas
12. Mop sweeper or soft-platform broom

A QUICK GUIDE .....continue to page 13

The practice is observed to be clean.
Observe general cleanliness in all areas of the practice. Cleanliness could include but not limited to whether the area is free of dirt and dust.

USERS MUST BE INVOLVED IN DECISION-MAKING IN RELATION TO THEIR CARE.
Users are informed of their diagnosis.

Patient interview - Risk rating: Essential measure

Three users will be interviewed who have been seen by the general practitioner to verify whether they have been informed about their diagnosis.

RESUSCITATION
The practice must have the following elements & systems in place to ensure users requiring resuscitation receive an immediate response by health care providers trained in resuscitation.

Either an emergency bag or an emergency trolley is stocked with the following medicines, medical supplies and equipment.

Devices to open and protect airway.
1. Oropharyngeal airway (a minimum of two different sizes one for adult and one for pediatric users)

Devices to deliver oxygen/ventilate users.
2. Oxygen cylinder or oxygen concentrator x1
3. Manual resuscitator device or bag and valve mask (adult) x1
4. Manual resuscitator device or bag and valve mask (paediatric) x1
5. Oxygen Masks - re-breather (adult) x1
6. Oxygen Mask - re-breather (pediatric) x1
7. Nebulising mask (Adult) x1
8. Nebulising mask (Pediatric) x1
9. Pulse oximeter (must be available in the vicinity not necessarily on the trolley) x1

Devices to gain intravascular access and administer intravenous fluids
10. Intravenous administration sets x2 sets
11. Intravenous cannulae (a minimum of three different sizes that accommodate both adult and pediatric users)
12. NaCl 0,9% IV solution 1000ml (a minimum of x1 vaculiter)
13. Ringers or Balsol IV solution 1000ml (a minimum of x1 vaculiter)
14. Half Darrows solution 200ml or 500 ml (a minimum of x1 vaculiter)
15. Equipment to provide cardiac compressions/Cardiac resuscitation board x1

Emergency treatment for anaphylaxis/initiating resuscitation
16. Adrenaline 1mg ampoule (a minimum of x1 ampoule)
17. Water for injection 10ml (a minimum of x1 ampoule)
18. Hydrocortisone 100mg/2ml (a minimum of x1 ampoule)
19. Promethazine 25mg/ml or 2ml ampoule. (a minimum of x1 ampoule of each item above).
20. Aspirin 300mg tablet (a minimum of x1 tablet)
21. Salbutamol inhalation ampules (a minimum of x1 ampoule)
22. Diazepam 1x 10 mg ampoule or other suitable Benzodiazepine.
23. Dextrose 5% 50ml or 100ml or 200ml (a minimum of x1 vacoliter)
24. Naloxone 1 x 0,4mg ampoule

A QUICK GUIDE .....continue to page 15

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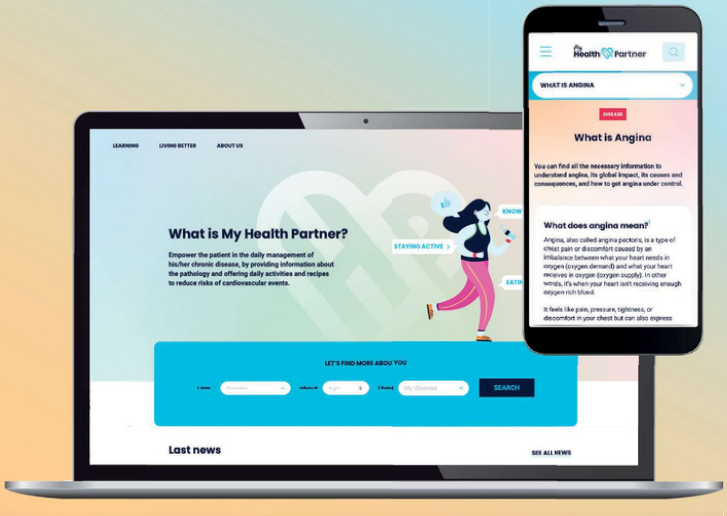

Angina | Diabetes | Heart Failure | High Cholesterol | Hypertension

The following are also required

1. Gloves, sterile and non-sterile
2. Syringes (a minimum of two syringes of any size,2ml or 5ml or 10ml or 20ml)
3. Needles (a minimum of three different sizes that accommodate both adult and pediatric users)
4. Alcohol swab
5. Plaster to secure intravenous cannulae
6. Resuscitation protocol or Resuscitation Algorithm

Equipment to diagnose and treat cardiac dysrhythmias and cardiac arrest

7. Automated External Defibrillator (AED) or defibrillator with pads, paddles and Electrodes and service record.

INFECTION PREVENTION AND CONTROL PROGRAMMES

The practice must maintain an environment, which minimises the risk of disease outbreaks, the transmission of infection to users, health care personnel and visitors.

The practice must ensure that there are hand washing facilities in every service area.

Hand washing facilities are available including:

1. Functional hand wash basin.

Explanatory note: The basin should not be blocked, broken or have cracks.

2. Taps are functional and not broken
3. Plain liquid soap or wall - mounted soap dispenser.
4. Paper towel dispenser with disposable hand paper towels
5. General waste container.
6. An alcohol-based hand rub is available.
7. Posters on hand hygiene are displayed.

LINEN REQUIREMENTS

The practice must ensure there is clean linen to meet the needs of users.

- Check whether clean linen is available as determined by the practice requirements. This can be cloth or disposable linen.
- There must be a designated area or cupboard for storage of clean linen.
- The practice has a designated area for the temporary storage of dirty linen.

A QUICK GUIDE .....continue to page 16

PERSONAL PROTECTIVE EQUIPMENT

The practice must ensure that health care personnel are protected from acquiring infections through the use of personal protective equipment and prophylactic immunisations.

- Health care personnel are informed about prophylactic immunisations for high-risk infections.
- Decontamination processes must provide safe, effective decontamination of medical devices.
- Health care personnel responsible for decontamination must be able to explain the procedure.

Aspects include:

1. Personal protective equipment to be worn.
2. Clean sink or bowel to be filled with water and detergent.
3. Detergent solution to be constituted and replaced in accordance with manufacturer's instructions.
4. Instruments to be fully immersed in solution.
5. Instruments to be brushed, to remove all visible material.
6. Instruments to be rinsed.
7. Instruments to be dried before disinfecting.
8. Sterile packaging to be done according to procedure.
9. In-pack chemical indicator to be placed in all sets and towels.
10. Tracking system indicators to be marked on packs and sets.
11. Packing is done in wraps or containers according to the manufacturer's instructions and SANS standards (ISO 11607.
12. Storage to ensure the integrity of materials.

The manner in which sterile packs are stored must prevent physical damage to packages, avoid exposure of packages to moisture.

WASTE MANAGEMENT

The practice must ensure that waste is handled, stored, and disposed of safely in accordance with the law. The practice must implement procedures for the collection, handling, storage and disposal of waste.

Health care waste is managed in line with waste management practices as follows:

1. Practices must have Health care risk waste disposal bins with functional lid or health care risk waste box.
2. Health care risk waste disposal bins or boxes lined with red colour plastic bags
3. Health care risk waste disposal bins or boxes contain only health care waste
4. Sharps container. Explanatory note: Sharps are disposed of in impenetrable, tamperproof containers that is not overflowing.
5. Expired or obsolete medicine is placed in a dark green container marked with the words pharmaceutical waste liquid or solid.
   Explanatory note: The container can also be located in the Medicine storage or dispensing area.
6. General waste container.

This could be disposable or reusable vessels or bins in which waste is placed and must have an appropriate liner (black, beige, white, or transparent packaging can be used)

A QUICK GUIDE .....continue to page 17

CLINICAL SUPPORT SERVICES

Medicines and medical supplies: The practice must comply with the provisions of the Pharmacy Act, 1974 and the Medicines and Related Substances Act, 1965.

- The practice must implement and maintain a stock control system for medicine and medical supplies.
- The practice has a system to order medicines and medical supplies.
- Observe if there is a system to order medicine and medical supplies in place. The system can be manual or electronic.

The following Basic medical supplies /consumables must be available. and not expired (where applicable):

1. Non-sterile gloves
2. Sterile gloves.
   - Only applicable where sterile procedures are performed.
3. Disposable gowns or aprons
4. N95 or KN95 or FFP2 respirators or approved equivalent
5. Oxygen face mask or reservoir mask or nasal cannula (prongs) for oxygen, Nebuliser mask (Adult)
6. Nebuliser mask (Paediatric)
7. Intravenous cannulae
8. Intravenous administration set
9. Suture material
10. Basic dressing pack
11. Scalpel blades
12. Disposable eye patches
13. Gauze swabs
14. Cotton wool balls
15. Bandage crepe
16. Alcohol swabs
17. Syringes
18. Needles
19. Plaster roll or Adhesive micro-porous surgical tape
20. Spatula
21. Lancets
22. Blood glucose strips
23. Urine dipsticks
24. Pregnancy tests
25. Urine specimen jar or flask
26. Vacutainer blood collection tubes.
27. Venepuncture needles.
28. Vacutainer needle holder.
29. Pap smear collection materials.

- The practice monitors stock levels of medical supplies & medicines.
- The practice monitors stock levels of medicine.
- The levels must be recorded on the bin cards, or any other system used by the practice. In non-dispensing practices, this will be the emergency medicines held as stock.
- The practice must ensure the availability of medicines and medical supplies for the delivery of services.
- Practices must have the list of medicines for the practice. In non-dispensing practices, this will be the emergency medicines held as stock and be able to offer 5 randomly sampled items.
- Should medicines be out of stock, substitutions will be accepted where medicine list or guidelines used by the practice recommends equivalent medicines for treatment.

A QUICK GUIDE .....continue to page 19

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Reference: Medicines and Related Substances Act, 1965 General Regulations 22(4) d.

THE COLD CHAIN FOR THERMOLABILE MEDICINES IS MAINTAINED.

- Medicine refrigerator is available.
  1. The medicine fridge must not contain any food items or beverages.
  2. The temperature of the refrigerator is monitored.
- The temperature of the refrigerator must be monitored twice a day, 7-12 hours apart, and maintained between 2 and 8 degrees Celsius. The temperature monitoring could be done manually or using an electronic device and should be recorded. Check records from the previous three months, for electronic monitoring historic readings must be made available for review.
- The temperature where medicine is stored is recorded daily. Temperature monitoring sheets from the previous
- three months are required.
- The practice must implement controls for the management, recording and distribution of medicines listed in Schedules 5 and 6 of the Medicines and Related Substances Act.
- No repackaging of medicines is allowed on the practice premises.
- Schedule 5 and 6 medication storage area is kept locked.
- The entries in the schedule 5 and 6 drug register are complete.
- All columns in the registers must be completed comprehensively. Any omitted information noted during the review of the register will result in a non-compliant score.
- Schedule 5 and 6 medicines in stock must correspond with the balance recorded in the register.
- Medicines must be stored and managed in compliance with the Pharmacy Act 53 of 1974, the Medicines and Related Substances Act 101 of 1965 and the relevant rules and regulations.
- Medicines in the practice are stored and managed in accordance with Good Pharmacy Practice in South Africa.
- The temperature of the medicine storage area must be between15 and 25 degrees Celsius

Check whether the practice complies with the requirements listed below:

1. Shelves or cupboards or medicine trolley allows for rotation of medicines.
2. Shelves or cupboards or medicine trolley are clean
3. Medicines are stored according to a classification system. Explanatory note: Verify the classification system used by the practice, including but not limited to storage by formulation, physiological system, alphabetical order, or another method, and confirm that the selected system is followed.
4. There are security and access control measures in the medicine storage area Explanatory note: The medicine storage area will include but is not limited to a medicine trolley, medicine room, or medicine cupboard.
5. System is in place to prevent the expiry of medicines
6. Observe whether there is a system to check expiry dates. This will include but is not limited to a colour-coded system for items that expire in a certain month, documentation of expiry dates in a book,
7. First expired First out (FEFO) or any other system.
8. No expired medicines are observed in the practice

- There are no medicines stored in direct contact with the floor.
- There are no medicines/ medicine boxes stored in direct contact with the floor.
- Acceptable storage methods will include but are not limited to, shelves, cupboards,
- or storage on wooden palisades.

A QUICK GUIDE .....continue to page 20

THE PRACTICE MUST ENSURE THAT MEDICATION IS PRESCRIBED IN ACCORDANCE WITH LEGISLATION AND BEST PRACTICE GUIDELINES.

- Are Users informed about their medicines.
- 3 users who have received medicines will be interviewed to verify whether they have been informed about the aspects listed below.

Aspects Score Comment:

1. The user is informed about what each medicine is for.
2. The user is informed when to take the medicine.
3. The user is informed about how to take each medication (the route)
4. The user is informed whether to take the medicine with or without food.
5. The user is informed about the most common side-effects they could expect from the medicine
6. The user is provided with an opportunity to ask any questions or discuss any concerns about their medicine.

- The practice must ensure that medication is dispensed in accordance with legislation, and to minimise the risk of user harm.
- Are Medicines dispensed for users labelled as per applicable legislation.
- 3 users will be asked to have their medication to assessed to ensure that the medicine that has been dispensed to them on the day of the inspection.

The following will be checked :

1. The label includes the name of the user
2. The label includes the name of the medicine.
3. The label includes the strength of the medicine.
4. The label includes the dosage of the medicine
5. The label includes the route of administration for the medicine
6. The label includes the frequency with which the medicine should be taken
7. The label includes the duration for which the medicine should be taken (where applicable)
8. The expiry date of the medicine is visible. Medicines may only be dispensed by licensed health care providers.

Observe whether medicine is dispensed to users by a licensed health care provider in terms of Medicines and Related Substances Act, 1965 General Regulations section 14(4).

A QUICK GUIDE .....continue to page 21

MEDICAL EQUIPMENT

Practices must ensure that the medical equipment is available and functional in compliance with the law.

Essential basic equipment listed in this section must be available in the practice.

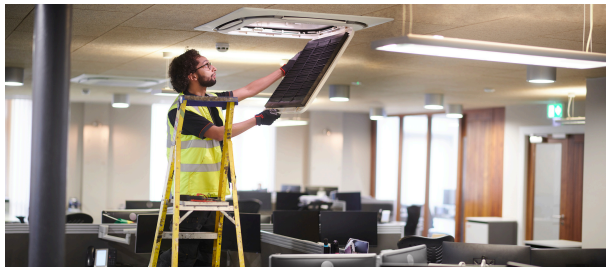
1. Stethoscope
2. Blood pressure machine (manual or electronic/digital)
3. Stadiometer (to measure height)
4. Adult weighing scale
5. Baby weighing scale
6. Diagnostic sets, including ophthalmic pieces (wall-mounted or portable)
7. Tape measure
8. Thermometer
9. Gestation calculator (Manual or electronic).
10. Foetal stethoscope or handheld Doppler or Sonar
11. Eye chart (Snellen or equivalent), alphabet/illiterate
12. Patella hammer
13. Tuning fork
14. Cusco speculum or disposable vaginal speculum.
15. Examination couch/table
16. Bed steps
17. Peak flow meter-adult
18. Peak flow meter-paediatric
19. Nebuliser machine.
20. Glucometer
21. Ceiling or wall mounted or portable examination light.
22. Suture pack
23. Dressing cart/trolley
24. Electrocautery machine
25. Forceps
26. Suture holder
27. Swab holder
28. Scalpel/BP handle

FACILITIES AND INFRASTRUCTURE

The practice and their grounds must meet the requirements of the building regulations.
The practice must as appropriate for the type of buildings and grounds of the establishment, have all the required compliance certificates in terms of the building regulations. & have a maintenance plan for buildings and the grounds.

The practice building must be maintained.

1. Walls are intact and not damaged
2. The ceiling is intact and not damaged.
3. Gutters or PVC pipes are intact and not damaged.
4. The doors are in working condition and not damaged.
5. Lights are functional and not broken.



A QUICK GUIDE .....continue to page 23

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6. Windows are in working condition (Glass or handles are not broken).
7. The floor is intact and not damaged.
8. The toilets are functional and not broken.

The practice must, as appropriate for the type of buildings and grounds of the establishment, have ventilation systems that maintain the inflow of fresh air, temperature, humidity and purity of the air within specified limits set for different service areas such as theatres, kitchen and isolation units either natural ventilation or functional mechanical ventilation.

Each fire extinguishing device must be serviced annually and should have a label indicating the date that it was serviced and the date that the next service is due.

Engineering services

- The practice must ensure that engineering services are in place.
- The practice must have 24-hour electrical power, lighting, medical gas, water supply and sewerage disposal system.
- The practice has a functional piped water supply system. The water supply for the practice must be connected to the reticulation system.
- Emergency water supply is available, including but not limited to containers with lids or water tanks e.g. JoJo tank, Roto tank or water supplied by service providers.
- The sewerage system is functional.
- Rudimentary visual inspections of the sewerage system are carried out to check if there are no overflowing sewerage drains, leaking pipes or other potential hazards.
- An oxygen cylinder is available in the practice.
- Verify whether an oxygen cylinder with a functional gauge is available, oxygen levels must not be below the minimum level indicated in the gauge OR an Oxygen concentrator is available and functional, but a backup electricity supply must be available to ensure that the unit will be functional during interruptions in electricity supply. Not applicable: Where oxygen cylinders are used.

A QUICK GUIDE .....continue to page 24

SECURITY SERVICES

The practice must have systems to protect users, health care personnel and property from security threats and risks. The practice must ensure that security staff are capacitated to deal with security incidents, threats and risks.

- Systems are in place to ensure safety in the practice
- Verify whether a security system is in place. Security systems could include but are not limited to physical security personnel or systems (security gate with controlled access, boom gates, biometrics, contracted armed response).

SURVEY /OHSC FEEDBACK

Suggested Pointers:

Doctor 1:

1. Low income and high expenditure are a big issue in our profession.
2. Several low medical schemes are coming out with low payment for per patient consultation, including or excluding medical schemes, that it difficult to work
   With the increasing price of medicines, electricity (about 11.31%), water and other materials.
3. The lowest one was brought by the Discovery Medical scheme of R381/- per consultation, including VAT. The actual payment is only R 320.00 per consultation.
4. The National Medical Scheme is giving authorisation to run these low-cost medical schemes. It looks like they are unaware of reality.
5. I wish Qualicare would raise this issue on behalf of over 500 members.
6. I wrote a letter sometime before and did a rough calculation that a GP needs at least R750.00 per consultation to run his practice.
7. Our patients' attendance is also decreased due to an oversupply of doctors in low-income group areas of Cape Town.

Survey /OHSC Feedback .....continue to page 27

CNS

A calming touch

Introducing CLOBAZAM ADCO

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Clobazam ADCO

Clobazam

*The dosage of CLOBAZAM ADCO should be determined by monitoring the EEG and plasma levels of the other medicines.[1]

References: 1. CLOZABAM ADCO 10 & 20 mg tablets Professional Information, 27 June 2023. 2. Faulkner MA. Comprehensive overview: efficacy, tolerability, and cost-effectiveness of clobazam in Lennox-Gastaut syndrome. *Ther and Clin Risk Manage* 2015;11:905-914. 3. Generics dictionary. http://www.generic.co.za/frontend/generics?utf8=%E2%9C%93&q%5Bactive_ingredient_name_eq%5D=CLOBAZAM (Accessed: 03 October 2023).

For full prescribing information please refer to the Professional Information approved by SAHPRA (South African Health Products Regulatory Authority).

SS CLOBAZAM 10 ADCO. Each tablet contains 10 mg of clobazam. Reg. No.: 55/2.6/0546. SS CLOBAZAM 20 ADCO. Each tablet contains 20 mg of clobazam. Reg. No.: 55/2.6/0547.

Adcock Ingram Limited. Reg. No.: 1949/034385/06. Private Bag X69, Bryanston, 2021. Customer Care: 0860 ADCOCK/232625. www.adcock.com
202308110303342. August 2023.

17919

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Doctor 2:

Regarding the OHSC requirements for a "perfect practice," he commented that even government clinics wouldn't meet the standards.

He also said that his mop might not be fully green or pink compliant, he believes he would still pass an inspection. He is aware of the requirements and is working on making improvements where possible.

Doctor 3:

Unnecessary: NO-NOs" from doctors for the Dossier (i.e., unaffordable, or impractical requirements)

1)CPR board

As GP's we have firm examination couches, as firm as bed in a EC: one can't use a CPR board on a firm bed, CPR board is needed in a hospital setting in the wards where the beds and mattresses are quite soft and one can't compress chest on those beds without a board.

We will probably cause more bruising, etc, if we use the board on a firm bed, as we would be compressing a chest into the board on a bed that has no 'give': One hard surface is required not a hard surface on a hard surface.

Drugs

2) naloxone

I have worked in ECs for 20 years never have I used this> impractical for us to buy , they expire and lastly, we have to buy a pack of ten , pharmacies won't break it up for us .

3) Solucortef

Not an emergency drug , also must buy pack of 5 : I have discarded many of these through the years

4) promethazine

This would make sense in a GP setting , but one must buy a pack of ten , hardly ever use this :

All the other drugs I have and always keep as those make sense from an emergency perspective .

With regards to the drugs above : if they are going to insist, they must find a way to reduce cost and that we can purchase 1 unit as is needed or reimburse us or someway for us to replace stock once it has expired and we know we are never going to use it.

Survey /OHSC Feedback .....continue to page 28

Other issues :-

4) please clarify what disposal is required of sanitary waste: in homes it is disposed of via municipal waste , but no clarity in the documents regarding sanitary waste: if we include this in our medical or anatomical waste the fees will be exorbitant, and we would not be able to afford this.

5) insisting on complaints/surveys/Google reviews

Many of us know our patients and if we continually ask them to post and review , we know that this will give biased results as it is more likely to be the complainer that will write a negative review, and this will impact on our practices . I don't feel we should be encouraging this and having survey boxes on our desks and actively asking patients to rate us . once we have a few negative reviews that we encouraged patients to do on google etc , we will lose business though our front doors.

6) They want to look at our folders, copies of referral letters etc.

We would need consent from patients for them to view this, completely against the Popi act : we need more clarity on how this will work**.**

7) They have to give us a definite date as to when they come , if we are on leave etc

An inspection of this nature cannot be done by a locum or support staff, and we would need to be reimbursed for our time or something, as we cant not see patients for a full day for them to inspect.

8) In terms of fire protocol/ fire safety :

This is quite a big policy/protocol that needs to be drawn up : can we have assistance with this: I have my fire extinguishers serviced every year etc, just not sure legislatively do we have to have smoke detectors, etc.

Doctor 4:

Please START implementing this at the Government institutions!! Patients have had horrible experiences at some of the institutions & hospitals (also as reported in daily newspapers & on TV!!)

Doctor 5:

- Fortunate to have so many facilities around them that provide EMERGENCY SERVICES (ER-24s, hospitals, etc.)
- What is ALL this equipment (AED / trolley with oxygen, etc.) for in urban areas?
- Adrenaline is EXPENSIVE & also expires!

Doctor 6:

How to make outgoing emails 'password' protected? IMPRACTICAL!

Doctor 7:

'Triage' in a private practice?

We look after EVERYONE in practice as per appointment & emergencies are given priority

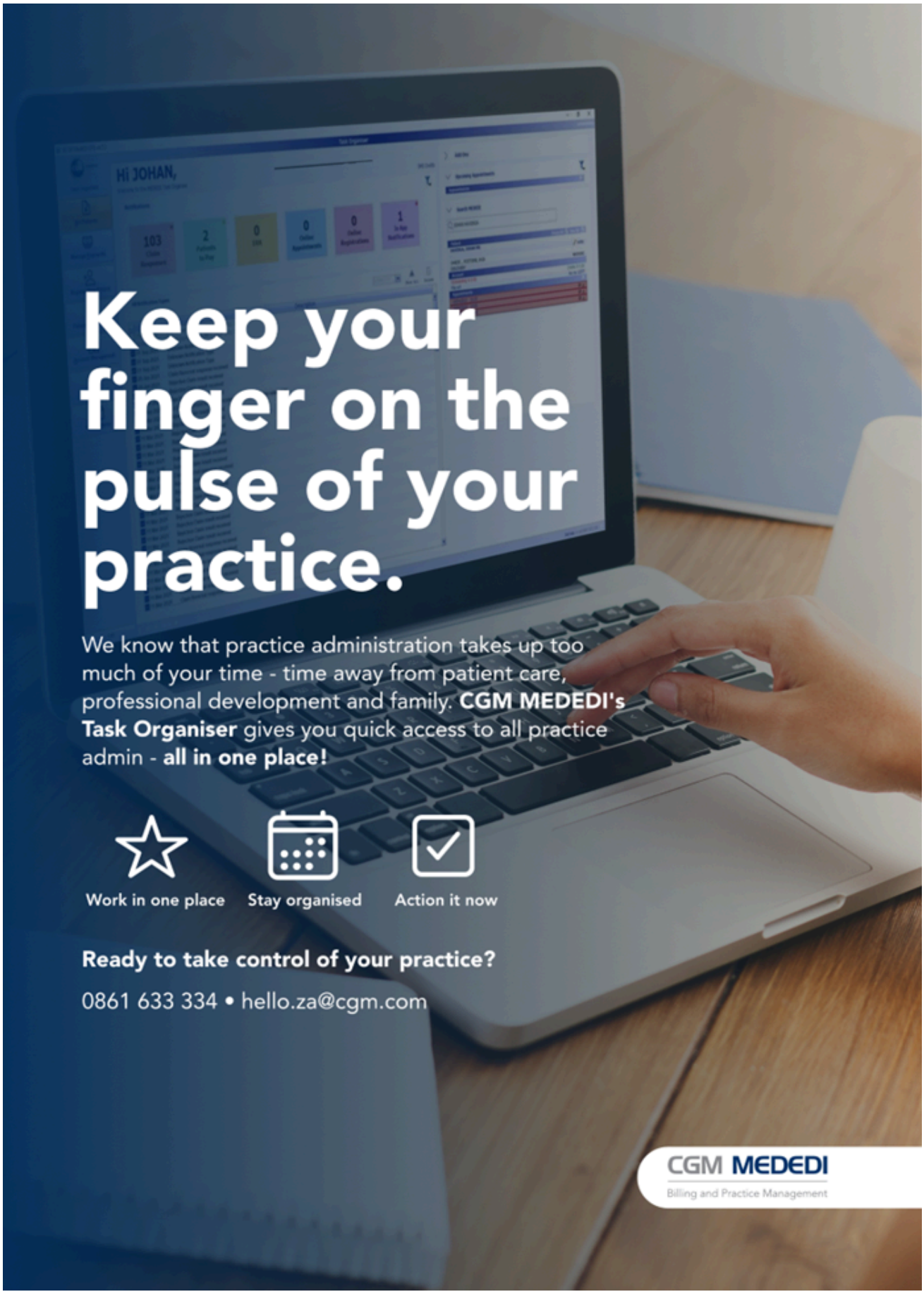
Doctor 8:

OHSC: They hire the pr. – Really: Should they put up notes in the bathroom to wash hands & HOW to wash hands?! (can't stick 'stickers' everywhere?!)

Doctor 9:

- OHSC: THANK YOU for 'mass mail' – thought it was 'outrageous' to be conducting inspections NOW!
- Will adjust what is necessary BUT
- They have so many facilities around them that provide EMERGENCY SERVICES (ER-24s, hospitals, etc.) NO need for AED machine!

Survey /OHSC Feedback .....continue to page 31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Doctor 10:

We were inspected a few weeks ago by an official from the City of Cape Town checking our sharps and medical waste disposal. They also checked for soap and towels in the bathrooms. We do not have any problems with medical aids at present.

With regards to the OHCS inspection I think they have very expensive expectations for GP practices. Having oxygen and defibrillators is going to be an expensive exercise.

If it is expected of us to have this, it will also be expected of the GP to be able to do a full resus.

Then I expect that every GP would have to do ACLS course every 2 years.

This also has time and cost implications. Also medio legal implications. Also, for a single GP to run a full resus unaided has its challenges.

The expectation for transporting patients is also impossible.

How can the doctor provide the transport and the appropriate staff to go with the patient? Who will cover that cost?

Doctor 11:

My 2 No-No's (similar I'm sure to many others):

- The AED
- Oxygen canister

As a solo GP, neither of these are necessary in my practice.

Doctor 12:

That is quite a document to work through.

Is this relevant to all practices? No matter how small? And in the private sector?

Doctor 13:

As confirmed by the other doctors, we only received information from CPC.

I am not willing to pay for and do the dispensing course. In a city with access to pharmacies, I feel it is unethical to dispense medication if patients have easy access elsewhere.

One will need to receive a list of needed essentials and then time to become compliant. The cost of all these things is expensive, and we only receive a small annual increase and practice expenses are already very high.

We provide a very high level of care at the practice.

Survey /OHSC Feedback .....continue to page 32

Doctor 14:

I agree with **** completely.

Your email was the first info I received about these plans

I would not be able to afford the AED and full resus trolley, although it would be nice to have at our disposal. Also, would not be able to afford to appoint more staff.

I do not mind dispensing and being part of this if we have more detail about costs, remuneration, criteria etc. Sorry just an afterthought.

I am not prepared to run a clinic on a walk-in basis. We have an appointment system.

The entire part of how to clean practise is impractical. We have medical waste separate (BCL) but only one broom and mop for general cleaning.

I also cannot employ more staff like cleaners, pharmacists and nurses.

Doctor 15:

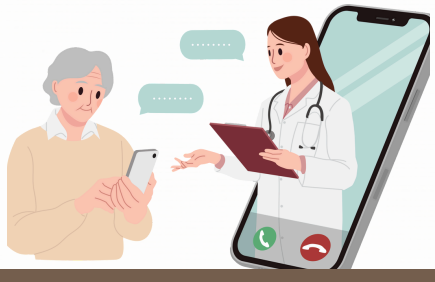
I also wanted to ask you about the OHSC visit- I am a bit nervous about that- could I request someone to come and vet the practice- see if we are doing everything right before the official OHSC visit?

Doctor 16:

Feels better after Qualicare have regularly sent information to the practices to assist with guidance in getting ready for OHCS Inspections.

Doctor 17:

Hi just a heads up from ***** she called to say she listened to the OHSC talk and took out from it that they will give the doctors a 7-day warning ahead of time of inspection. Also, they don't have enough people to go around to everyone and will take them years to get to everyone. They can only visit those whose information they have on file... so if you registered... they tricked people saying they have 5 minutes to register... and when you do then they have your info.



Doctor 18:

IOHSC gave all his opinions of how he was always compliant in his practice for all these years, he feels better after speaking to me about it that he is not the only concerned doctor. I told him his concerns are valid but not to panic as we know more, we will share more. Its best to be calm and handle the request if and when the need arises. The traumas doctor has to handle at his practice; ambulance called 4 times they don't respond almost lost a young nurse patient miscarried in his practice. Spoke about the Vula Referral system – which hospital and which areas are borderline for them can they get lists of this.

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THE PATHCARE NEWS

PREVENTING INVASIVE CRYPTOCOCCAL DISEASE THROUGH ACTIVE SCREENING FOR CRYPTOCOCCAL ANTIGENEMIA IN PEOPLE LIVING WITH ADVANCED HIV

Cryptococcal meningitis remains a significant cause of morbidity and mortality among people living with HIV (PLHIV), particularly in resource-limited settings. In South Africa, it is estimated that cryptococcal meningitis accounts for approximately 15% of AIDS-related deaths, underscoring its significant health burden. Despite advances in antiretroviral therapy (ART), individuals with CD4 counts below 200 cells/mm^3 remain at elevated risk for opportunistic infections, including cryptococcal disease caused by *Cryptococcus neoformans* (and rarely, *Cryptococcus gattii*). Cryptococcal fungi are found worldwide in soil, bird droppings, associated with trees and found in decaying organic matter. Cryptococcal disease mostly occurs in people with defective T-cell mediated immunity, with HIV infection, the major risk factor. Other risk factors include solid organ transplant recipients, and individuals taking immunosuppressive drugs.

Cryptococcal antigenaemia precedes the development of cryptococcal meningitis by weeks to months. Early identification of cryptococcal antigenaemia and intervention are thus critical to improving patient outcomes. Reflex cryptococcal antigen (CrAg) testing for people living with HIV with low CD4 cell counts (CD4 <200 cells/mm^3) has proven to be an effective strategy in reducing the burden of cryptococcal meningitis through early detection and preemptive treatment. Reflex CrAg testing is the standard of care in the public health sector and is recommended in both national guidelines (SA HIV Clinicians Society), and international guidelines like the global 2022 WHO and 2024 European Confederation of Medical Myology, American Society of Microbiology, International Society for Human and Animal Mycology guidelines, to name a few.

Studies conducted in South Africa have demonstrated that early CrAg testing and treatment are beneficial. It significantly reduces the mortality rate and preemptive fluconazole therapy is cost-saving compared to the high costs associated with hospitalization and treatment during the management of patients with established cryptococcal meningitis. Modeling studies have demonstrated that reflex testing is highly cost-effective, particularly in regions with a high prevalence of cryptococcal disease. PathCare's CrAg testing statistics demonstrates a cryptococcal antigenaemia prevalence in people with HIV and CD4 <100 cells/mm^3 of between 6-8%, and a 1-2% prevalence in those with CD4 <200 cells/mm^3 – nearly identical to those of patients accessing the public health sector.

Everyone testing positive for serum or plasma (or whole blood) CrAg during screening should be carefully evaluated for signs and symptoms of meningitis. Those with signs or symptoms of meningitis should have a lumbar puncture and, where feasible, those without signs or symptoms of meningitis should also have a lumbar puncture, with CSF examination and CSF CrAg testing to exclude active cryptococcal disease.

In keeping with local and global recommendations, PathCare will be performing REFLEX CRYPTOCOCCAL ANTIGEN TESTING IN ALL PEOPLE WITH ADVANCED HIV WITH CD4 CELL COUNTS <100 cells/ mm^3 in order to:

- Enable early identification of cryptococcal antigenaemia.
- Enable rapid clinical follow-up, performance of routine lumbar puncture and exclusion of cryptococcal meningitis.
- Early initiation of appropriate antifungal therapy in those with cryptococcal antigenaemia with/ without meningitis.
    - Serum CrAg screen (+) positive, CSF CrAg negative: Fluconazole 1200mg po daily as induction treatment
    - Serum CrAg screen (+) positive, CSF CrAg positive: initial induction therapy of 2 weeks:
        - **Preferred: IV liposomal Amphotericin B 3-4mg/kg/day + Flucytosine 100mg/kg in 4 divided doses preferred.**
        - **Alternative: IV liposomal amphotericin B + fluconazole 800 - 1200mg po daily**
    - Induction therapy is followed by the consolidation phase with Fluconazole 800 mg daily for 8 weeks then maintenance therapy with fluconazole 200 mg daily for a minimum of 1 year in total.
    - Fluconazole maintenance therapy can be discontinued when a patient has had at least one CD4 count > 200 cells/ mm^3 and confirmed HIV virologic suppression.
- Reduce overall cryptococcal disease-associated morbidity and mortality

Please click/scan the QR link to update your special instruction to include reflex CrAg testing in people living with HIV when the CD4 cell count is <200 cells/mm3.

References are available upon request.

Compiled by:
Dr Dawood da Costa, Clinical Microbiologist, PathCare Reference Laboratory
Email: dawood.dacosta@pathcare.net
February 2025

Don't Let the Fire Extinguisher Expire

From an insurance perspective, maintaining fire extinguishers is crucial for medical practices. Failure to do so can lead to denied claims or policy cancellations.

Here's what you need to know:

- Many insurance policies require regular inspection and maintenance of fire extinguishers in your homes as well as in your practices.
- Non-compliance can result in denied insurance claims or policy cancellations.
- If a fire occurs and your extinguisher is not functioning due to lack of maintenance, has expired (the expiry date is stamped into the metal of the fire extinguisher casing) your insurance company may totally deny your claim.
- Repeated non-compliance can lead to policy cancellations, leaving your practice vulnerable to financial losses.

By prioritizing fire extinguisher maintenance, you can ensure compliance with insurance requirements and protect your practice from potential risks and potential lawsuits

CPD PROBLEMS: JUNE 2025 DEADLINE: QUALICARE ADDRESSES THE HPCSA

CPC /Qualicare and our 5 Qualicare Consultants have, over the past 45 days received myriads of questions from members on their CPD/HPCSA compliance.

Most of the members state that, despite CPD points have been submitted to the HPCSA timeously by the Hosts of CPD functions, as well as being sent to the accreditation authorities, the relevant CPD do not appear on the Council's website.

This is made more urgent by the Council's threat to deregister non CPD compliant doctors after the 30th of June 2025.

We have been engaging with the Council on this matter since February 2025 and the following communication was sent to them on 01 07 2025 in connection with the June 30th extended deadline.

CPD problems .....continue to page 37

QualiCare
Boland Bank Building, 5th Floor, Suite 501, 18 Lower Burg Street, Cape Town, 8000
PO Box 15633, Vlaeberg 8018
Tel: (021) 426 4777 Fax: (021) 426 5502
E-mail: tony@cpcqualicare.co.za
Website: www.docweb.co.za

01 July 2025

Attention: .....

Dear ……..,

Thank you for your email.

I re-confirm our correct understanding of the updated HPCSA stance, replacing the period of 24 months for CPD collection, to 12 months, rolling.

You will recall that the period for 2024 was due to expire on 28 Feb 2025, however your announcement to the profession was made extremely late which resulted in the HPCSA granting a further 3-month grace extension period to accumulate and register the required 30 CPD points for 2024.

Regarding 2024 points earned by our doctors:

Many of our doctors who attended our 2024 CPD day accumulated 23 points (with the related reading material, as well as the full attendance for the day) , however they did not receive timeous confirmation from the HPCSA that their points had been uploaded for the 2024 event.

We experience huge call volumes from worried doctors who thought that we had failed to submit the points to the HPCSA. We assured that they we had followed your instructions faithfully.

Eventually some of these were loaded albeit late, which has prejudiced our doctors as these should have been loaded by the HPCSA during 2024, however by Feb 2025, the full points for our open day attendance and related reading were still not loaded on your website.

Again, I reiterate that Points submitted from August 2024 – February 2025 did not reflect timeously under the doctors' profiles even after this was brought to the attention of and checked by checked by and re-checked by Mr Mpho and his team.

We therefore again sent you a data file for Feb 2025, containing the 2024 CPD points acquisition by our doctors which did not reflect on your website, by 28th Feb 2025.

HPCSA then appears to have then loaded some of the doctors' 2024 points during the grace period but then indicated that these points were past the deadline for 2024. This seems to be because you only loaded them after the cutoff date of Feb 2025. In other words, you loaded some of our doctors 2024 points during the 3-moth grace period and then declared them stale, when you should have loaded them before the end of Feb 2025 when they would have counted toward the 2024 compliance deadline.

If these 2024 points were captured timeously and correctly by the HPCSA, our doctors would have been listed as compliant under their 2024 HPCSA profile.

Turning to the next year , 2025 , our CPD day was held on May 17th 2025 and the attendees CPD submissions, were sent as prescribed, both to HPCSA as well as to Stellmed , but again these were only partially captured or not captured at all, again suggesting that your capturing process is not being done

CPD problems .....continue to page 38

efficiently nor on time and this, after our doctors points were re-submitted on the 2nd of June and 19 June 2025.

A case in point is my own CPD points for the 17th of May 2025 were only loaded by you on the 30th of June 2025 and confirmed to me by way of SMS by the HPCSA, more than, 1 (one) full month after the event and the relevant submissions to you, further proof of inefficient capturing.

We are not an isolated case, as several administrators have reported similar issues with CPD points not being allocated or allocated correctly. This appears to be a systemic problem that requires attention and resolution.

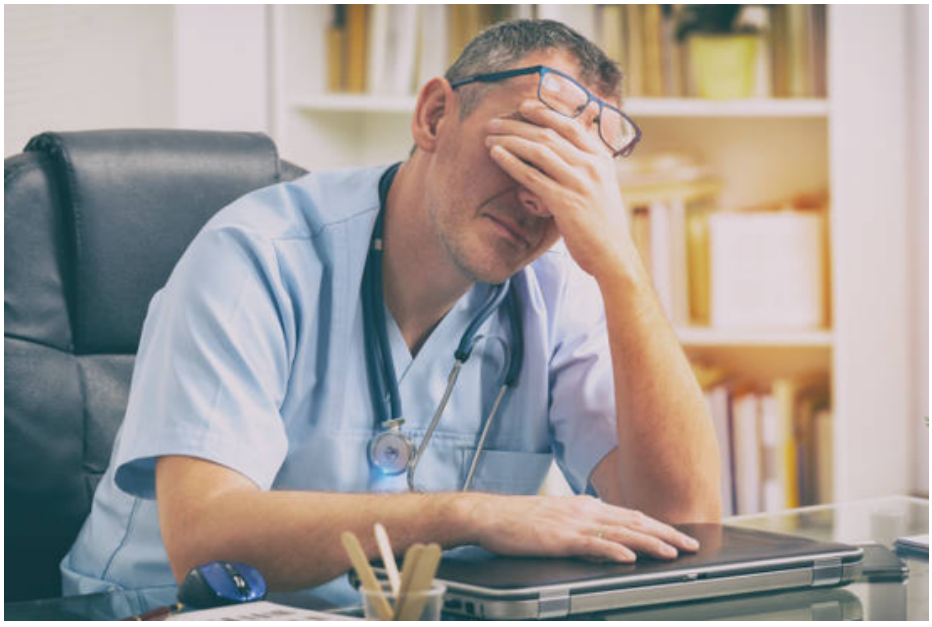
We, as administrators, often bear the brunt of criticism for issues with CPD point allocation, when in fact, the root cause lies with the HPCSA's system. The discrepancies and delays in point allocation led to frustration.

We have resubmitted the discrepancies again and as per your confirmation, all required submissions have been completed.

It will therefore be appreciated if the HPCSA implements a more efficient system to ensure a better working relationship between the HPCSA and administrative staff and their doctors, who bear the brunt of the slow capturing of their CPD points especially now that the 12-month deadline is effective.

Thank you and warm regards,

DR A D Behrman
MBChB, DOH, DNS , Mediator, FFLFM (RCP)
CEO CPC /Qualicare
0832707439
tony@cpcqualicare.co.za



When staying-power counts

LASTS UP TO **36h**[1,2]

TADALAFIL ADCO for the treatment of ED[1]

- Demonstrates improvement in EF for up to 36 hours post-dose[1,2]
- Tadalafil improves psychological outcomes[2]
- Preferred by patients and their partners over sildenafil[2]

new

Tadalafil Adco

Tadalafil 5 mg/20 mg tablets

The patient's choice for ED[2*]

*In a meta-analysis comparing tadalafil with sildenafil for the treatment of ED.

ED – erectile dysfunction; EF – erectile function

References: 1. TADALAFIL ADCO Professional Information, October 2022. 2. Gong B, Ma M, Xie W, *et al.* Direct comparison of tadalafil with sildenafil for the treatment of erectile dysfunction: a systemic review and meta-analysis. *Int Urol Nephrol* 2017;49:1731-1740.

For full prescribing information please refer to the Professional Information approved by SAHPRA (South African Health Products Regulatory Authority).

S4 TADALAFIL 5 mg ADCO. Each film-coated tablet contains 5 mg tadalafil. Reg No.: 52/7.1.5/0084.080. S4 TADALAFIL 20 mg ADCO. Each film-coated tablet contains 20 mg tadalafil. Reg No.: 52/7.1.5/0085.081.

Adcock Ingram Limited. Co. Reg. No.: 1949/034385/06. Private Bag X69, Bryanston, 2021. Customer Care: 0860 ADCOCK/232625. www.adcock.com
20230629102938 36. July 2023.

adcock ingram generics

16822

GEORGE OPEN DAY, SATURDAY

QualiCare

GPS COORDINATES:

(-33° 960396 “S , 22° 456244 “E)

2025 CPC/QualiCare Open Day

SATURDAY 19 July 2025

- THANK YOU -

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MACLEODS Challenging Frontiers in Healthcare

elle simplifying practice management

Medical Protection

PathCare

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SOUTH AFRICAN MEDICAL ASSOCIATION UNITING DOCTORS FOR THE HEALTH OF THE NATION

Standard Bank

embecta

AGENDA TOPICS

GEORGE OPEN DAY AGENDA 2025
Commencing11am,19 July,2025
Pine Lodge George Resort, Knysna Road, George, 6530

NB: This Agenda may be subject to amendment without notice

3Clinical & 1 Ethical - Applied for the attendance (Please watch your emails)

TIME	TOPIC	SPONSOR	SPEAKER
11hr00 – 11hr30	**Registration – Tea & Rusks – Browsing at Exhibitors**		
11hr30 -11hr50	Respiratory Syncytial Virus – RSV vaccination and prevention.	Pfizer	Prof Angela Dramowski
11hr50 - 12hr10	The Hidden Cost of Hypoglycaemia: Why Your Diabetic Patients Are Secretly Suffering	Sanofi	Dr. Amith Ramcharan
12hr10 - 12hr30	Navigating Weight Management in T2DM: Practical Approaches for Primary Care	Aspen	Dr Hannes Coetser
12hr30 - 12hr50	Intelligent yet Ethical Banking for medical practitioners	Standard bank	Ms.Corrinne Groenewald
12hr50 – 13hr50	**Lunch Served & Visit Exhibitors Stalls**		
13hr50 - 14hr10	Dyslipidemia, managing LDL in high-risk patients with combination therapy	Abbott	Dr Shaifali Joshi Dr
14hr10 - 14hr30	Hormonal Treatment	Abbott	Douglas N Seton
14hr30 - 14hr50	BPH update 2025	MacLeods	Dr David Smart
14hr50 - 15hr10	Targeting the Mast cell makes a Difference	Glenmark	Dr Corli Lodder
15hr10 – 15hr40	**Tea Served**		
15hr40 - 16hr00	Renal Replacement Therapy - A Real-World Update	Life Bay View Hospital	Dr Leigh Johannes
16hr00 - 16hr20	Lung Cancer Screening	Life Bay View Hospital	Dr James Fulton
16hr20 - 16hr40	Update on Ethics behind National Health Insurance (NHI), plus Draft Exemption Bill	QualiCare	Dr Tony Behrman
16hr40 - 17hr00	Ethics of Dealing with difficult patients	MPS	Dr Tony Behrman
	Questions and Answers on Clinical & Ethical Topics		
	Prize Giving & Closing		

VENUE

PINE LODGE

GPS Coordinates -33.960396 S, 22.456244 E

CLICK HERE to access Google Maps

PINE LODGE, Corner of Knysna Road and Madiba Drive, George East, George, 6530

FREE PARKING

Agenda Unveiled, Venue Set! Don't miss out!

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Speakers

Pfizer Biopharmaceuticals Group

Speaker: **Prof Angela Dramowski**

Topic : RSV Prevention.

Angela Dramowski is Professor and Head of Clinical Unit for General Paediatrics at Stellenbosch University-Tygerberg Hospital in Cape Town, South Africa. As an infectious disease paediatrician and infection preventionist, she is inspired by the broad range of clinical challenges she has encountered in her 25 years of public health service. Her research interests include neonatal sepsis, antibiotic resistance, infection prevention, childhood and healthcare worker vaccination. She is passionate about patient safety and data-driven quality improvement in the care of hospitalised neonates and children.

Sanofi

Speaker: **Dr. Amith Ramahaaran**

Topic : The Hidden Cost of Hypoglycemia: Why Your Diabetic Patients Are Secretly Suffering

Paediatric Endocrinologist

Dr Amith Ramcharan is a highly skilled Paediatric Endocrinologist based in Cape Town, South Africa, with over 15 years of experience in paediatric care. He obtained his medical degree from the University of the Witwatersrand in 2004 and specialised in paediatrics, earning his Fellowship in Pediatrics in 2011. Further sub-specialisation led to a Certificate in Paediatric Endocrinology and Metabolism in 2014. Currently, Dr Ramcharan serves as a Consultant in Paediatric Endocrinology at Red Cross War Memorial Children's Hospital, where he manages complex endocrine disorders in children, including diabetes, growth disorders, and thyroid conditions. He also provides teaching and examiner roles for both the University of Cape Town and Colleges of Medicine of South Africa. His previous roles include a Clinical Fellowship in Metabolic Medicine at Great Ormond Street Hospital in London and specialist positions at Stanger Regional and Edendale Hospitals. An active academic, Dr Ramcharan has presented at numerous international conferences, including the European Society for Paediatric Endocrinology and the Society for Endocrinology, Metabolism, and Diabetes of South Africa. He is committed to community outreach, having participated in humanitarian missions with Gift of the Givers in Somalia.

Speakers continue to page 46

Speakers continued from page 4

ASPEN

Speaker **Dr. Hannes Coetser**

Topic : Navigating Weight Management in T2DM: Practical Approaches for Primary Care

Dr Hannes Coetser is a specialist physician in private general practice at George Mediclinic.He completed his undergraduate and postgraduate degrees at the University of the Free State

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Standard Bank

Speaker **Ms. Corrinne Groenewald**

Topic : Intelligent yet Ethical banking for medical practitioners

Corrinne Groenewald – Senior Banking Professional | Specialist in Medical Banking | Advocate for Affordable Healthcare
Corrinne is a seasoned banking professional with 30 years of experience in the financial services industry, including a two-year international stint in the UK. Her career spans Retail, Small Business, and Business Banking, with the last 9 years dedicated to serving medical professionals—a niche in which she has developed deep expertise and a strong reputation.

She holds a Bachelors' Degree in Commerce and an Associate Diploma in Banking, and has spent the past four years excelling in her current leadership role. Corrinne's commitment to excellence was recognized when she was named Top Achiever in South Africa for Medical Banking, a prestigious accolade that highlights her impact and performance in the sector.

Corrinne is passionate about enabling access to affordable healthcare and believes in the power of financial solutions to support healthcare providers and improve community well-being. Her work bridges the gap between banking and healthcare, helping practitioners grow sustainable practices while expanding access to care.

Outside of her professional life, Corrinne enjoys reading and participating in sports, maintaining a balanced and active lifestyle.

Speakers continue to page 47

Abbott

Speaker **Dr Shaifali Joshi**

Topic : Cardiovascular /Dyslipidemia -managing LDL in high-risk patients with combination therapy

MB ChB; University of Pretoria, Gauteng, South Africa. 1999
PALS (Paediatric Advanced Life Support); Academy of Advanced Life Support; Pretoria South Africa, 2001
HIV Management Course – Discovery Health, Sandton South Africa 2002
Research Methodology- Medunsa, Pretoria South Africa. 2003
Managing Diabetes – Joslin Diabetes Center, Boston, USA 2005
MSc (Med) Pharm; Medunsa Pretoria South Africa 2006
Post Grad Diploma in Diabetes – Cardiff University, United Kingdom, 2009
Masters in Diabetes –Cardiff University, UK, 2013

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Abbott

Speaker **Dr. Douglas Norman Seton**

Topic : Hormonal Treatment

INTERESTS
Professional: Menopause, Osteoporosis, Urogynaecology, Laparascopic Gynaecological Surgery.

Extra-curricular: Outdoors activities, poetry and philosophy Fencing Provincial & South African University Colours Economic upliftment and social development projects. Creating employment opportunities & developing companies.

In my current practice, I conducts 20-25 deliveries per month, medium to high risk.

The full spectrum of natural and operative deliveries is conducted. We have a full epidural service available at the unit and are used to managing patients with epidural analgesia.

Gynaecological procedures performed are varied due to my practice being rural specialist practice. The spectrum of work includes abdominal & vaginal hysterectomies, laparoscopic management of endometriosis, ectopic pregnancy & varied adnexal pathology. Urogynaecology (Burch, TVT & IVS) and genital prolapse surgery.

I tend to use micro hysteroscopy for endometrial and myometrial procedures and have, by and large abandoned endometrial resections in favour of thermal ablation techniques. A large portion of my time is dedicated to the management of the menopause & I direct the local bone densitometry unit. Osteoporosis is a special interest of mine and I often give lectures on the subject.

Over the next 2 years, I aim to qualify myself in Functional Medicine, which entails a return to basic cellular physiology and energy regulation.

I was born in the UK and attempt to remain abreast of specialist practice in that country performing occasional locums at senior registrar level as the opportunity arises.

DIAMOND SPONSOR

MACLEODS

Challenging Frontiers in Healthcare

Macleods Pharmaceucals SA (Pty) Ltds

Speaker **Dr. D Smart**

Topic : BPH Update 2025

Dr Smart is a distinguished urologist with a wealth of experience and credentials. He earned his degree from the University of Cape Town in 1986 and became a Fellow of the South African College of Urologists in November 1995. His extensive involvement in clinical trials from 1998 to 2012 highlights his commitment to advancing medical research and patient care.

Dr Smart has served on the advisory boards of several leading pharmaceutical companies, including Pfizer, Astellas, Janssen, Lily, Allegan, and Litha. His leadership roles extend to his tenure on the Executive Committee of the South African Urological Association from 2008 to 2018, and he currently presides over the association.

Speakers continue to page 49

Additionally, Dr Smart is a member of the Council of the College of Urologists and has held the position of Secretary of the College of Urology at the Colleges of Medicine of South Africa.

His contributions to healthcare governance include chairing the Clinical Hospital Committee at Pietermaritzburg Mediclinic from 2006 to 2016 and serving as a director and board member of the same institution from 2015 to 2018 and again from 2018 to 2021.

An active participant in the medical community, Dr Smart is the former editor of Urology Today, a quarterly journal. Since 2002, he has been dedicated to private practice as a urologist in Pietermaritzburg, recently relocated to Plettenberg Bay, providing expert care to his patients.

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Glenmark Pharmaceuticals South Africa (Pty) Ltd

Speaker **Dr. Corli Lodder**

Topic 1: Targeting the Mast cell makes a Difference

Intro Bio: Dr Corli Lodder (Cornelia M Lodder) is the founder of the Allergy and Asthma clinic in George, Western Cape. She is a GP with a special interest in allergic diseases.

In 2003 she received the Diploma in Allergology at the SA College of Medicine.

As member of “The SA Allergic Rhinitis Working Group” since 2006, she is involved in Allergic Rhinitis treatment guideline development. The lasts Review was published in Nov 2023 in SA Family Practice.

In 2007 she was appointed as part time researcher in the Department of Immunology at the University of Pretoria. The results of her research were presented at congresses both locally and internationally and resulted in four publications in International Journals. She was awarded a PhD in Nov 2011. The title of her PhD is: “Investigation of the neutrophil-directed anti-inflammatory properties of the cysteinyl leukotriene receptor antagonist, montelukast.”

After practising in Boksburg on the East Rand for 24 years, as a GP and running an Allergy clinic in the practice, she relocated to George in April 2019. In April 2021, her dedicated Allergy and Asthma clinic opened in George focusing on Allergology and Asthma and Immune deficiencies.She is actively involved in lecturing at CME events for general practitioners and pharmacists, doing webinars and face-to-face talks as well as writing scientific articles.

Speakers continue to page 50

IShe has a passion to spread education regarding treatment of allergic conditions and especially asthma treatment that would enable patients to live a normal life. Her latest involvement regarding asthma education was at the 2024 World Asthma Day event, running an Art's competition at the Carpe Diem School in George for the National Education Program of SA. The Theme for 2024 World Asthma Day was: Education for All.

She also consults with allergic and asthmatic patients in Gqeberha once a month.

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Life Healthcare

Life Bay View Hospital

Speaker **Dr. L eigh Johannes**

Topic : Renal Replacement Therapy - a real-world update

Specialist Physician and Nephrologist, recently joined Life Knysna Hospital, bringing her expertise and passion for renal health to the team.

The choice of this multi-disciplinary hospital for her practice was driven by the desire to make a difference in the lives of patients by ensuring everyone receives the medical care they require, especially those with hypertension and diabetes.

Her academic journey began at Stellenbosch University, where she completed a Bachelor of Medicine and Bachelor of Surgery in 2013. This was followed by a Diploma in HIV Management in 2017 and a Master of Medicine in Internal Medicine from the University of the Witwatersrand in 2021 along with her Fellowship as a Physician. She further specialized in nephrology, obtaining her Certificate in Nephrology of the College of Physicians (SA) in 2023.

.....

Expertise that Inspires, Knowledge that Empowers

Life Bay View Hospital

Speaker **Dr. James Oliver Fulton**

Topic : Lung Cancer Screening

Qualifications:

- MBChB
- FCS (Cardio)
- M.Med (Cape Town)

Special Interests:

- Aortic surgery
- Coronary artery surgery
- Mitral valve repair surgery
- ECMO (Extracorporeal Membrane Oxygenation)
- Thoracic oncology surgery

Biography:

Dr. James Fulton completed his cardiothoracic surgical training at Groote Schuur and Red Cross Children's Hospital in 1996. He then pursued fellowships in Melbourne, Australia, and held consultant positions at Greenlane Hospital in Auckland and the University Hospital of Wales in Cardiff.

Dr. Fulton started his private practice in Vereeniging and Morningside, Johannesburg, with Prof Rob Kinsley before relocating to Pietermaritzburg in 2007. Recently, he worked with Dr. Martin Sussman at Milpark Hospital in Johannesburg for 18 months, focusing on ECMO, thoracic organ transplantation, and LVAD (Left Ventricular Assist Device) implantation.

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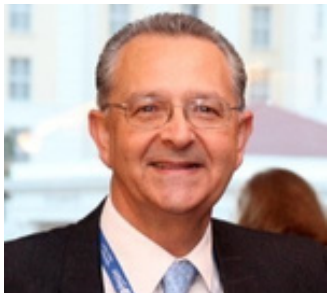
Discover, Learn
Grow with Us

CPC/Qualicare

Medical Protection Society



Speaker **Dr Tony Behrman**

Topic 1 Update on Ethics behind National Health Insurance (NHI) , plus Draft Exemption Bill

Topic 2 Ethics of Dealing with difficult patients

Degrees/Fellowships

- M.B.Ch B. (1970 to 1975) UNIVERSITY OF CAPE TOWN.
- DIPLOMA in OCCUPATIONAL HEALTH (1995 to 1997) U.C.T.
- FOUNDATION FELLOW of the Faculty of FORENSIC and LEGAL MEDICINE (Royal College of Physicians) UK 2005 (FFLFM)
- Accredited DISAC Mediator UCT Law @ work, Legal Faculty UCT 2014.

Current Positions held:

- Chief Executive Officer of CAPE PRIMARY CARE / QUALICARE IPA, WESTERN CAPE 1990 to date comprising 600 Family Practitioner members.
- Director of the IPA Foundation of RSA
- Director of the SAMCC
- Member of Executive Committee of the UFFP
- Business and Medicolegal Consultant to Medical Protection Society 1998 to 2012 and again 2018 to date

Personal:

- Married, with 2 children and 5 grandchildren
- Cyclist and Walker
- Recreational Pianist and Guitarist

Speakers continue to page 53

GEORGE
OPEN DAY 19 July 2025

QualiCare

THANK YOU TO OUR PARTICIPATING COMPANIES FOR THEIR SUPPORT.

Medscheme CORNER

MEDSCHEME Portal issues

Q: 6 Providers having Medscheme Portal issues

A: Medscheme has contacted and engaged with the 6 providers and resolved the issues.

1. assisted with username and password reset, provided overall navigation and functionality education
2. assisted with step-by-step navigation, however she tends to jump ahead and jump through the navigation, we've offered a full training session with the PR and are awaiting confirmation of date/time
3. went through specialist referral process and she is very comfortable; she would like for us to engage with all 5 staff at the PR and will send us date/time for this
4. main challenge was Chronic applications
5. step by step process for specialist referral carried out and she is now comfortable with the process
6. assisted with username and password reset, educated on general navigation across portal functionalities

MEDSCHEME

Q: Does Medscheme have E Contracting available on the new Portal

A: Currently we are working with hard copies, e-contracting not yet available on the website:

Good day,

Thank you for your interest shown in participating in our Networks.

Please note our that there is no longer E-contracting, agreements are available for downloading on the Provider Portal under your documents.

Please send a request to nc@medscheme.co.za, with your BHF practice number in order to be assisted efficiently. Note that this query is now closed.

The new HCP Portal offers various features that benefit our valued Healthcare Professional community. We aim to ensure that you and your staff have an improved customer experience and can access relevant information to make informed decisions.

If you require assistance using the new HCP Portal, please email providerportalqueries@medscheme.co.za or contact us on 086 111 2666.

Medscheme Corner ..... continue to page 55

Medscheme

19 March 2025

Dear Doctor

OPMED Medical Scheme members to benefit from the POLMED Specialist Network

As your practice is currently contracted onto the POLMED Specialist Network, Medscheme would like to notify you of the mutual agreement undertaken between POLMED (the South African Police Service Medical Scheme) and OPMED Medical Scheme (the Optimum Medical Scheme), medical scheme for the State Security Agency [SSA] members. This agreement facilitates the extension of the existing POLMED Specialist Network to OPMED Scheme members.

The extension in respect of access to the POLMED Specialist Network to the OPMED Scheme members will provide their members the opportunity to access the Network Specialists at the current 2025 POLMED network rates, of which the same terms and conditions will apply.

As a current contracted Specialist to the POLMED Specialist Network this will mean the following for your practice:

- SSA members, managed via the OPMED Medical Scheme, will be encouraged to use the services of the providers on the POLMED Specialist Network. This opens a larger volume of patients within the network.
- Your practice becomes a Designated Service Provider (DSP) for OPMED Medical Scheme members.
- The 2025 POLMED Network rates, terms and conditions will apply for both in and out-of-hospital services.

Please note: There will be no change in the claim submission process for OPMED Medical Scheme members as the claims will continue to be managed by OPMED, via their current processes. As previously highlighted, claims will need to be submitted in line with the POLMED Specialist Network tariffs, which your practice is currently contracted into. Medscheme's role continues in respect of managing the Specialist Network on behalf of POLMED as the contracted administrator to the scheme for this function.

Claims submission and Authorisations process for OPMED member claims:

- Claims – kindly submit all claims via electronic batch processing
- Alternatively, via:
  - Email submissions can be made via: opmed@ssa.gov.za
  - Postal submissions can be made via: Private Bag X850, Pretoria, 0001
- Authorisations
  - PPSHA (OPMED's Hospital Management Programme) on **0860 247 633**

Should you have any questions, please do not hesitate to contact OPMED via the following channels: Telephonically via **012 427 5333** or email via opmed@ssa.gov.za.

Kind regards

Health Professional Strategic Unit
Medscheme

Invitation to Dentists, Physiotherapists and Allied Health Care Professionals to become an Associate Member of CPC/QUALICARE

Dear Colleagues,

As we approach the new era of increased Government involvement in Health Care Delivery, we anticipate an increase in the speed of implementation of NHI Holding membership of the CPC/Qualicare Network, the largest and most widely representative Medical Network of Healthcare Providers in the Western Cape comprising Doctors, Dentist and Allied Health Care Professionals alike will, we believe, stand in good stead as Government looks to setting up the new Health Care Delivery system for South Africa.

Associate members of CPC/Qualicare offers you the following opportunities:

- Full access to our Monthly newsletter in electronic format.
- Free advertising in our monthly newsletter of your practice related information (max 200 words).
- Free advertising for a locum service, with no commission charges payable.
- Reduced fees to attend our CPC/Qualicare function, at Associate Member's rate.
  (Approximately 30% lower than Non-members rates)
- CPC/Qualicare is committed to providing our members and shareholders with all of their CPC requirements each year. Associate Members receive reduced cost of CPD offerings and other CME offerings compared to non-ember rates.
  (Approximately 30% lower than non-member rates).
- Free listing your practice as part of CPC/Qualicare's Western Cap Electronic Network, your practice will be listed as part of CPC/Qualicare at no charge. (Worth R6000.00 per annum)
- 2 Free stationary items worth R150.00 per month in the form of 1 Prescription pad - 100 leaves, 1 Sick certificate pad - 100 leaves and the ability to purchase further stationary at 30% below current market prices.
- Preferential rates on certain Practice management software systems depending on vendor.
- Inclusion into the CPC/Qualicare Mass email service to receive important health care updates.
- Certain personal banking offerings from commercial banks.
- NHI future possibilities for your practice...Watch this space as NHI starts to roll out!!
- Preferred wholesale and facilitation of opening new accounts with them.
- Assistance with registration of an Integrated Pollution and Waste Information System IPWIS off the Western Cape Government.
- Assist with late medical aid payments, claw-backs, and withholds, as well as advice on practice admin and responses to forensic investigations.

Cost of Associate Membership

- Dentist R332.00 VAT inclusive, per month
- Allied Health Care Professionals R332.00 VAT inclusive, per month

All fees payable by debit order only. Minimum membership period is 12 months with a 3-month notice period thereafter.

Please note that we also offer reduced membership fees for **first time Medical Practitioners** (GP's) in **private practice** for their first year of membership.

Should you be interested in this offering, please email Louna at pa@cpcqualicare.co.za and one of our 5 consultants will make contact with you shortly.

Warm regards,

Dr. Tony Behrman, CEO of CPC/Qualicare
Dr. Solly Lison, Chairman of CPC/Qualicare

Qualicare Electronic Doctor Network.

Free electronic listing (valued at R6,000.00 per year) of your practice, geographic location, special areas of interest and pictures of your practice can be featured on our Electronic Doctor Network which is only available to CPC/Qualicare Members and Shareholders!!

Our highly successful electronic doctors network see www.qualicaredoctors.co.za has rapidly expanded across the Western Cape Province, and to date has approximately 200 doctors.

As a Member or Shareholder you are still entitled, **at NO charge**, to list your practice on the "EDN" showing your name, practice name, GPS coordinates, areas of special interests, and any specific features which you would like to bring to the attention to prospective patients then please complete and return the form below at your earliest convenience should you be interested to join the growing network.

This is a limited offer open only to Shareholders and Members which is worth over R6,000.00 per year and is brought to you as a member or shareholder benefit at no charge.

Practitioners Details * Compulsory to complete – for a successful listing.

*First Name: _____

*Surname: _____

*Professional Degrees e.g. M.B.ChB._____

_____

Professional Body Memberships: _____

_____

*HPCSA Number: _____

*Board of HealthCare Funders PCNS Number: _____

DOH Disp Lic Number (if applicable): _____

Areas of Special Interest and Focus: e.g. Paediatrics, Bariatrics, Occupational Health: _____

_____

Contact Details

*Contact Number: (Practice)_____

*Email Address: _____

*Alternative Number: _____

Fax number: _____

Practice Details

*Practice Name: _____

Group PCNS: _____

*Practice Address: _____

_____

GPS Location: _____

Qualicare EDN ..... continue to page 58

Please also provide:

1. **Photo of yourself** - So that the patient can familiarize themselves with the Dr they are going to see.

2. **Photo of the outside of the Practice** – So the patient will recognize the correct building and know what to look out for when coming to visit the practice.

3. **A short bio – interests, hobbies & education** – This gives the patient some trust as they will feel they know you and will feel at home.

Please feel free to contact Annerè van Pletsen CPC/Qualicare Consultant at annere@cpcqualicare.co.za

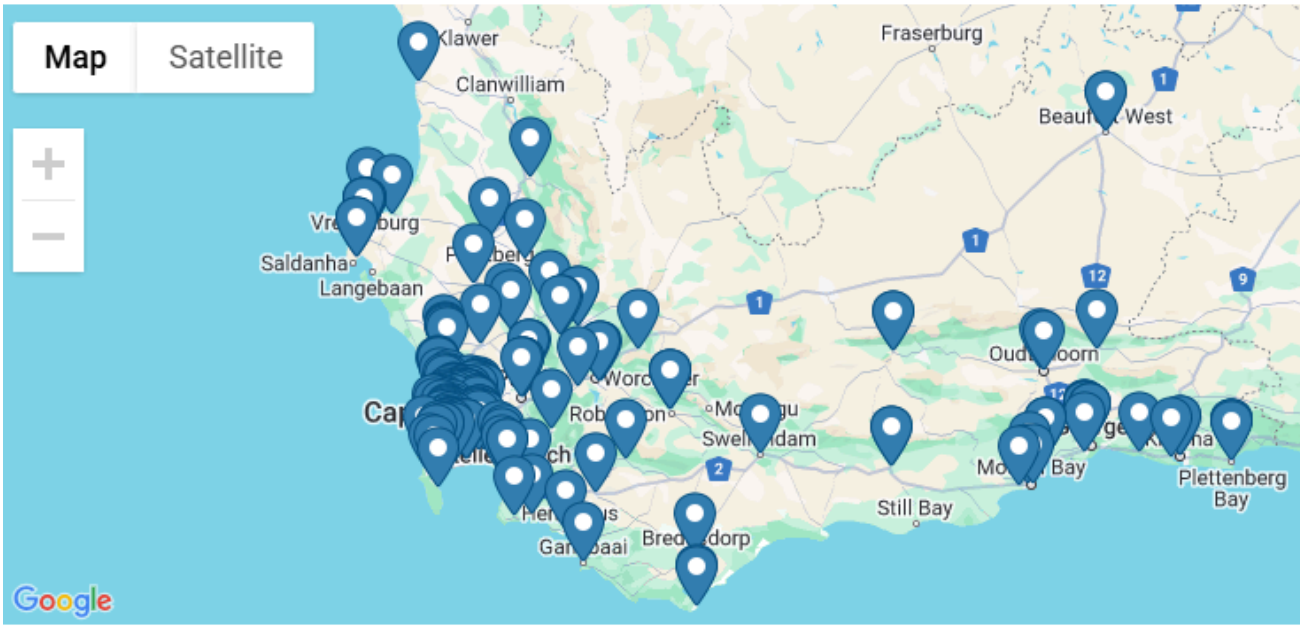
I permit CPC/Qualicare to list my name, surname, the name of my practice, my practice details, and further details provided by me in this application, and my GPS Coordinates on the *"Electronic CPC/Qualicare Doctor Network"* at no cost to me or my practice (tick the appropriate block).

Yes I do agree to the above, in terms of POPIA Act 4 of 2013

☐

Click on the link to complete the form:

https://www.qualicaredoctors.co.za/new-form/



QualiCare

WWW.DOCWEB.CO.ZA

DOCWEB

01 June 2025 - 30 June 2025

Summary					
Reported period Month June 2025 **First visit** 01 June 2025 - 00:16 **Last visit** 30 June 2025 - 23:54					
	Unique visitors	Number of visits	Pages	Hits	Bandwidth
Viewed traffic *	**1,881**	**2,87**	**11,17**	**52,996**	**10.10GB**
		(1.52 visits/visitor)	(3.89 Pages/Visit)	(18.46 Hits/Visit)	(3691.69 KB/Visit)
Not viewed traffic *			**8,866**	**20,457**	**10.20 MB**

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www.qualicaredoctors.co.za

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CPC Qualicare

Views

Views	291
3-second views	0
1-minute views	0
Watch time	0s
Reach	114

Interactions

Content interactions	12
Link clicks	3

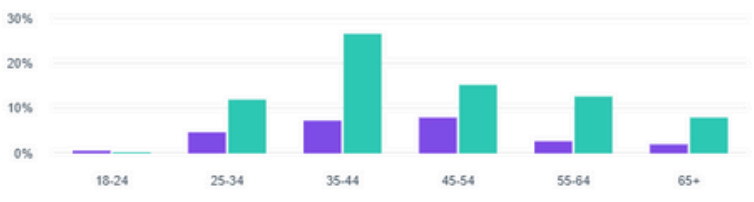
Demographics

Lifetime

Followers	154

Age and gender

Men	25.30%
Women	74.70%



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Due to the fluency of the situation, information changes daily. Please visit our website for more updated information.

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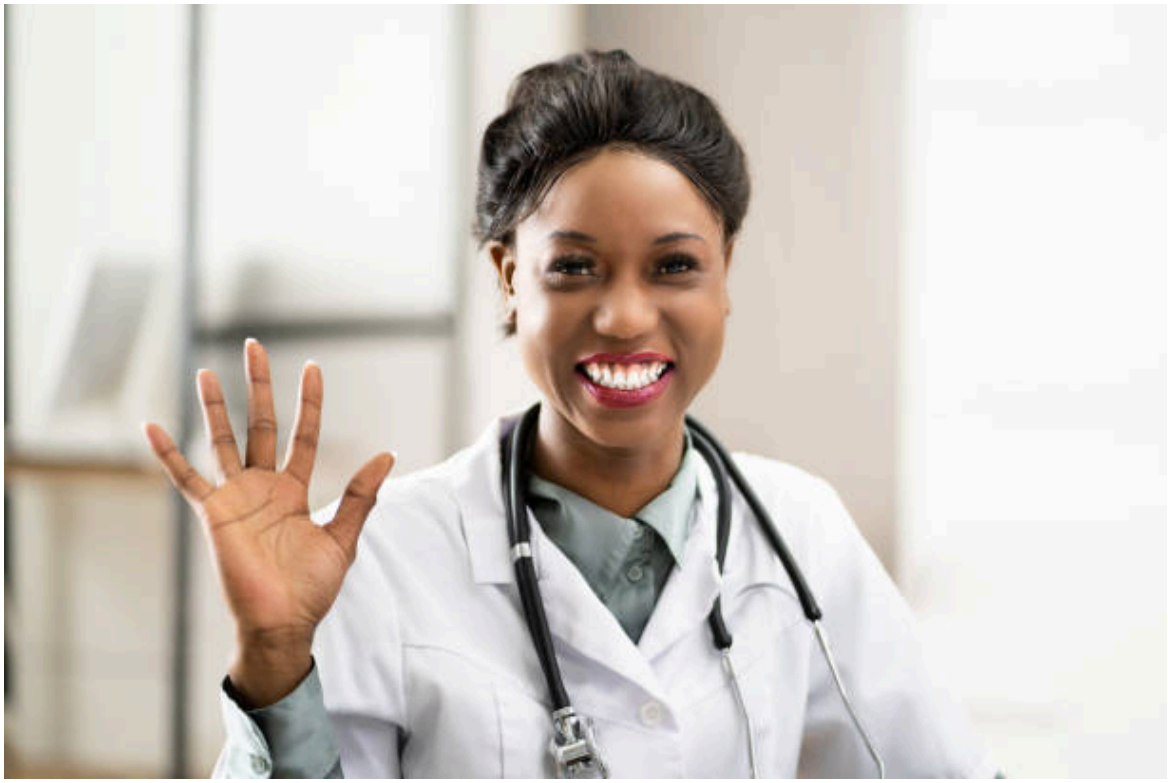

THE END