Primary Health Care Activities Phase 2003-04
Summary of approved Projects

(These projects are currently being undertaken following application of the measure and share formula to EDQUM activity in the 2002-2003 financial year)

Approved Project
Information Management and Population Health Demonstration • Establishment of a defined IT/IM platform to enable the collection of a baseline data set; • Develop and formalise consumer involvement in the collection and utilisation of population health data; • Identify and further develop the capacity of existing software and hardware products to handle the collection, transfer, and interpretation of practitioner and patient data; • Test the capacity of GPs to collect data in a meaningful manner and make it available to the Division for collation and return. • Establish Division level capacity to develop and maintain capacity to collect, collate and return GP clinical data in a way that informs GP clinical quality improvement.
To support General Practice to manage their practice population in a systematic and long-term manner; and to build practice capability. Increase and promote the use of practice population data through: • Consistent disease coding • Recalls, reminders • Practice wide data analysis using targeted data (development of practice profile report) Increase practice capability through implementation of practice wide education strategies aimed at effective management of the practice population, including: • Practice visits • Small groups • Practice nurse networks.
1. Enhanced data management in practices improves annual cycles of care - Divisions Data Query tool is used to mine and marry practice data from different sources to improve and monitor patients with chronic disease on annual cycles of care. 2. Enhanced electronic data management in nursing homes leads to improved prescribing for residents - Private nursing homes are approached and the model explained and the division resources nursing homes with expertise.
1. To develop a model of support for GPs to analyse their management of a number or chronic disease states; and 2. Test GP acceptance of a quality improvement approach using GP desktop data.
1. To increase GP awareness of and compliance with criteria for drugs listed on PBS 2. To improve access by GPs to independent evidence based information on cost effectiveness of medications; 3. To build practice capacity to utilise practice health information systems to improve quality prescribing and patient care; and 4. To support GPs / practices to utilise continuous improvement methodology to improve quality prescribing.
To improve the quality of life and health outcomes for Far North Queensland's population suffering from Arthritis by establishing an effective sustainable Chronic Disease Self-Management program on a partnership between the person with the disease, their families and health professionals. • Monitor and manage symptoms and signs of arthritis; • Manage the impacts of illness on their lifestyle, emotions and interpersonal relationships; • Adhere to treatment regimens; • Encourage Arthritic patients to use the health care system more effectively and efficiently; and • Assist General practitioners and Allied health professionals in management of patients of living with Arthritis.

Approved Project
Providing additional primary healthcare of GPs patients, including improving local patients access to non-pharmacological options. The emphasis will be on: 1. Obese patients, on either (or both) medications for cardio-vascular disease and peptic ulcer related conditions, who require these medications because they cannot achieve a behavioural change without support. GPs would select those patients interested in changing their behaviour and who would benefit from advice sessions with a Dietitian. 2. Patients who would benefit from an increased level of understanding about when they should be seeking a script for antibiotics from their GP.
1. Continue to facilitate integrated models of health service delivery with six local Health Service Districts; and 2. Support the introduction and implementation of the continuity of care planning (CCP) framework for Qld
1. To guide and support general practice to review clinical practice systems and assist practices to develop and implement sustainable system changes enabling the adoption of an integrated health prevention approach addressing diabetes. 2. Assist in the implementation of sustainable, evidence based health prevention practices addressing lifestyle factors influencing diabetes including nutrition, physical activity and smoking. 3. Assist practices in the effective use of information systems to supplement current chronic disease management activities
Implement primary health care activities which target: 1. Development of GP, Practice or consumer resources; and 2. IT development to support current chronic disease management activities (eg. promote the establishment and use of practice registers / recall systems or increase the usage of electronic health records to improve systematic approaches to CDM)
Promote quality prescribing of proton pump inhibitors (PPIs) in Gastro-Oesophageal Reflux Disease utilising a multi-pronged intervention with existing resources, and providing a novel approach for data interrogation, and intervention at point of prescribing.