41 Time of visit and billing status

Organisation supporting this study: Australian Government Department of Health and Ageing

Issues: The relationship between after-hours status of a consultation and patient billing status.

Sample: 5,546 Medicare-claimable encounters, from 200 GPs; data collection period: 07/05/2002 – 10/06/2002 and 16/07/2002 – 19/08/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

Of the 5,546 Medicare-claimable consultations recorded in these data collection periods in 2002, 69.8% (95% CI: 65.4–74.3) were bulk billed, and 30.2% were patient billed; comparable to previous GPSCU data (June-Oct 2000, *Abstract 16*) with 74.4% (95% CI: 70.4–78.3) of general practice consultations bulk billed.

Consultations with patients aged 75+ were bulk-billed at a significantly higher rate than younger patients; those with patients aged 45–64 were bulk billed at 63.5% (95% CI: 58.0–69.1) of Medicare-claimable encounters compared with 82.1% (95% CI: 76.4–87.9) of those aged 75 or more.

The DoHA definition of after-hours was used, 'standard office hours' includes weekdays 8am to 6pm and Saturday 8am to 1pm, while 'after-hours' is weekday nights 6pm to 8am and Saturday 1pm to Monday 8am. Of the Medicare-claimable encounters, 92.8% (95% CI: 90.9–94.8) occurred during 'standard office hours', while the remaining 7.2% occurred 'after-hours'. The comparable results from 2 years previously were that 7.4% of consultations occurred 'after-hours'.

'After-hours' consultations had a bulk billing rate of 77.1%, compared with 69.3% of consultations during 'standard office hours', and these proportions are not significantly different. Therefore, without adjusting for any other variables, billing status of patient and whether a consultation occurred 'after-hours' were not related.

Simple logistic regression modelling with billing status as the outcome found that whether the consultation occurred during 'standard office' or 'after-hours' was not related to patient billing status. However, the multiple model, including all significant descriptor variables found that 'after-hours' consultations were significantly more likely to be bulk billed than those held during 'standard office' hours (adjusted OR=1.92).

Other significant descriptors in the model were patient age, whether the patient was from a non-English-speaking background, whether they lived in an urban or rural setting, whether they held a health care card and whether they were from a low SES background. A paper fully describing these results is in preparation.

For other related abstracts see: 16 Effect of day and time of GP visit on billing method.

Further reading:

Pegram, R. W. & Valenti, L. 2004, 'Factors influencing billing status in general practice [letter]:, *Medical Journal of Australia,* vol. 181, no. 2, p. 115.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **TIME OF VISIT AND BILLING STATUS.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

This question refers to the day on which the consultation is taking place.

Please indicate by ticking the appropriate box which day of the week this encounter is taking place.

FOR THE DOCTOR

Please indicate by ticking the corresponding box, the time of day during which the consultation is taking place.

FOR THE DOCTOR

If a Medicare item number is applicable to the consultation, please indicate by ticking the appropriate box whether the consultation was bulk billed to the government or whether the patient has been billed.

For this consultation please tick day of week	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	**For this consultation please tick time of day**	☐ 7.00 am - 8.00 am ☐ 8.00 am - 1.00 pm ☐ 1.00 pm - 6.00 pm ☐ 6.00 pm - 8.00 pm ☐ 8.00 pm - 11.00 pm ☐ 11.00 pm - 7.00 am
If a Medicare item number has applied to this consultation please indicate method of billing	☐ Bulk billed ☐ Patient billed		

BL42C

42 Prevalence and management of chronic pain

Organisation supporting this study: Janssen-Cilag Pty Ltd

Issues: The prevalence of chronic pain among general practice patients; the conditions causing chronic pain; the anatomical sites most affected; the managements being utilised by GPs; duration of medication usage; management of medication side effects.

Sample: 2,800 respondents from 99 GPs; data collection period: 11/06/2002 – 15/07/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution of the total BEACH sample with the majority (57.0%) being female and 54.0% aged 45 years or over.

A total of 507 patients (18.1%, 95% CI: 15.4–20.8) were reported as having chronic pain. Prevalence was significantly higher for patients aged 45 years or more (25.8%, 95% CI: 20.5–31.1) than for patients aged less than 45 years (8.8%, 95% CI: 6.7–10.9). There was no significant difference between the prevalence for males (16.3%) and females (19.5%).

Causal conditions were identified for 490 of the 507 chronic pain sufferers. In total, 82 different causal conditions were reported, 41.8% of these (*n*=205) being forms of arthritis including osteoarthritis (30.8%), arthritis not otherwise specified (NOS) (5.9%), and rheumatoid arthritis (5.1%).

Anatomical sites were recorded for 472 patients. A total of 618 responses (multiple sites were affected for some patients) were recorded for 14 different body sites, those most commonly affected being the back (32.5%), knee (12.9%) and the neck/cervical spine (7.9%).

Medication usage was recorded for 495 patients. More than two-thirds (70.3%) took analgesics, either alone or with another medication. One-third (33.1%) took NSAIDs, 8.1% took psychotropics and 7.1% took oral sustained release morphine (OSRM).

For each medication type, the back was the main body site affected (other analgesics–44.2%; NSAIDs–45.8%; psychotropics–30.0%; OSRM–60.0%). Types of arthritis were the main cause of chronic pain for patients in 3 of the medication groups (other analgesics–41.6%; NSAIDs–60.1%; psychotropics–17.5%). The main cause of chronic pain for patients taking OSRM was back problems (28.6%) followed by malignant neoplasm (20.0%) and musculoskeletal conditions (17.1%).

Medication groups were similar across time periods of usage. Forty eight patients took medication to manage side effects. Of 57 medications listed, 66.7% (*n*=38) were laxatives and 8.7% (*n*=5) were omeprazole.

For other related abstracts see: 82 Prevalence and management of chronic pain.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **CHRONIC PAIN.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

Please indicate by ticking the appropriate box whether or not this patient suffers from **chronic pain.**

If 'Yes' continue to the next question.

If 'No' **end the questions here.**

CONDITION & SITE AFFECTED

Please write the **condition** you identify as the being the **cause** of the patient's chronic pain.

Please write the **anatomic site/s** which the patient nominates as being **most affected by pain.**

MEDICATION FOR PAIN MANAGEMENT

Please use the tick boxes to indicate whether the patient is **currently taking** any of the **nominated medications for pain management**. Tick more than one if applicable.

For **each medication** please **circle an option** to indicate the **approximate length of time** the patient has been using **any type of this medication** for management of pain associated with their **current condition** (i.e., the condition nominated in the previous question).

MANAGEMENT OF SIDE EFFECTS

Please advise whether the patient is using any **other medication** for the **management** of any **side effects caused** by the **morphine/other analgesic.**

Does this patient suffer from chronic pain?	If 'Yes' from what condition?	What medications (if any) are currently being used for pain management? For each, please indicate the approximate duration of usage.	What other medication/s is the patient using for management of any side effects of the morphine/ other analgesic?
☐ Yes - continue ➔	_____	☐ Oral Slow Release Morphine _____ wks / mths / yrs	☐ Laxative
☐ No - **end questions**	**The anatomic site/s most affected by pain is/are -**	☐ Other analgesics _____ wks / mths / yrs	☐ Other _____
	_____	☐ Non-steroidal anti-inflammatories _____ wks / mths / yrs	☐ None of the above
BL43B	_____	☐ Psychotropics _____ wks / mths / yrs	
		☐ None of the above (*Tick as many as apply*) (*Please circle*)	

43 Initiation and purpose of pathology orders

Organisation supporting this study: Australian Government Department of Health and Ageing

Issues: There is scant evidence in assessing the effectiveness and appropriateness of pathology ordering by GPs. This study investigated pathology orders at general practice encounters, specifically to determine the initiation of tests (i.e. the proportion of tests suggested by the GP compared with the proportion requested by the patient); the purpose of the tests (i.e. considered investigative, monitoring or preventive by a GP); and whether or not the test was considered 'opportunistic' by the GP (e.g. the GP had decided on a full blood count for the patient, and took the 'opportunity' to have the patient's cholesterol or blood sugar checked).

Sample: 3,001 encounters from 100 GPs; data collection period: 11/06/2002 – 15/07/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to total BEACH sample of general practice encounters, with the majority (56.9%) of encounters with female patients.

There were 491 (16.4%) encounters at which 1,101 pathology test orders were placed, at a rate of 36.7 (95% CI: 31.4–41.9) per 100 encounters and 224.2 (95% CI: 209.0–239.5) per 100 encounters involving pathology.

Of the 1,036 pathology tests for which the GP responded to the initiation question, 84.9% were initiated by the GP and the remainder (15.1%) were requested by the patient. Among the 213 haematology test orders, 199 tests (93.4%) were initiated by the GP. Of the 575 chemistry test orders, 85.9% were initiated by the GP. Within the microbiology group, 80.8% of the 151 microbiology test orders were initiated by the GP. Only 35.6% of the 45 cytopathology tests (mainly pap smear) were initiated by the GP, compared with 100% of the 20 histopathology (mainly skin histology) and 14 immunology tests.

Of the 1,047 pathology test orders for which the GP indicated the purpose of a test, approximately a half (50.8%) were for investigative purposes, one-third (34.8%) for monitoring purposes, and one-sixth (14.4%) for preventive purposes.

Among the 577 chemistry test orders, 258 (44.7%) tests were for monitoring purposes, 232 (40.2%) were investigative and 87 (15.1%) were for preventive purposes. All orders for immunology, histopathology, pregnancy and simple test were considered investigative. The 46 cytopathology tests were mainly ordered for preventive purposes (63.0%) and were less likely to be used for investigative (19.6%) or monitoring purposes (17.4%).

Of the 920 pathology test orders for which the GP responded to the 'opportunistic' question, 18.0% were regarded as opportunistic. Approximately one-quarter (24.7%) of the 518 chemistry test orders were opportunistic. In contrast, among the 139 microbiology test orders, 10 (7.2%) tests were regarded as opportunistic.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATHOLOGY.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

In the 'pathology' section of these forms there is room to record up to **5 different tests** ordered today which are **associated with the problems being managed for this patient at today's encounter.**

For each of the next 30 forms, if you have ordered pathology for the patient, please complete the following questions. **Only complete this section if you have ordered pathology at the encounter.**

INITIATION OF TESTS

For **each** of these tests, please circle an option to indicate whether the test was **suggested by you** or **requested by the patient.**

eg.

Pathology	*Initiated by*
Test 1	GP / (patient)
Test 2	(GP) / patient

PURPOSE OF TEST

For **each pathology test** ordered at today's consultation, please circle an option to indicate whether the **purpose of the test** was to **investigate / diagnose** a new condition, to **monitor** an existing condition, or for **prevention / screening** purposes.

eg

Pathology	*Purpose of test*
Test 1	(investigative) / monitoring / preventive
Test 2	investigative (monitoring) / preventive

OPPORTUNISTIC TESTS

Please circle an option to indicate whether any of today's tests were **'opportunistic'** - for example, having decided on a full blood count for the patient, did you **take the 'opportunity'** to have their cholesterol or blood sugars checked?

eg.

Test 1 - Yes / (No)

Test 2 - (Yes) / No

If pathology tests were ordered today please indicate whether each test was suggested by you or requested by the patient.

Pathology	*Initiated by*
Test 1	GP / patient
Test 2	GP / patient
Test 3	GP / patient
Test 4	GP / patient
Test 5	GP / patient

(*please circle ONE option*)

For each pathology test ordered today, please indicate whether the purpose of the test was investigative/diagnostic for a new condition; monitoring of an existing condition; or for prevention/screening.

Pathology	*Purpose of test*
Test 1	investigative / monitoring / preventive
Test 2	investigative / monitoring / preventive
Test 3	investigative / monitoring / preventive
Test 4	investigative / monitoring / preventive
Test 5	investigative / monitoring / preventive

(*please circle ONE option for each test*)

Were any of today's tests 'opportunistic' e.g. cholesterol added to full blood count?

Test 1 - Yes / No

Test 2 - Yes / No

Test 3 - Yes / No

Test 4 - Yes / No

Test 5 - Yes / No

(*please circle ONE option*)

BL43C

44 Severity of illness

Organisation supporting this study: General Practice Statistics and Classification Unit (GPSCU)

Issues: This study was undertaken to explore the complex interrelationships between the severity of patient health problems managed at the encounter and the frequency of patient visits and length of consultation. These interrelationships cannot be explored using BEACH encounter data or Medicare data.

Sample: 6,742 encounters from 225 GPs. Data collected between 26/02/2002 – 01/04/2002 and 16/07/2002 – 19/08/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: The Duke University Severity of Illness (DUSOI) analogue scale was used to assess the severity of each problem managed at the encounter and to calculate a total score for each encounter.[1] The GP recorded the start and finish time for the encounter and determined the number of GP visits in the preceding 12 months in consultation with the patient.

Summary of results

The age and sex distribution of the 6,742 respondents was similar to the distribution for all BEACH encounters.

The mean total DUSOI score was 5.6 (95% CI: 5.3–5.9) based on 5,612 scored encounters. Encounters with patients aged 65 years and over had a significant higher mean total DUSOI score (6.9, 95% CI: 6.3–7.5) than all scored encounters. There was a significant positive linear relationship between total DUSOI score and number of GP visits reported in the previous 12 months (p<0.001). Patients reporting 11 or more GP visits had the highest mean total score of 6.8, and those reporting nil GP visits had the lowest total mean score of 4.2.

There was a significant positive linear relationship between mean total DUSOI score at the encounter and the length of consultation with the consultation length increasing by 0.5 minute for each one unit increase in DUSOI (p=<0.001). The DUSOI range was 4.26 for consultations of less than 5 minutes to 8.80 for consultations of more than 25 minutes.

The DUSOI from the 8,118 scored problems had a mean and a median of 4.0. Significantly higher DUSOI scores were recorded for the following problems compared with the DUSOI for all problems (mean 4.0, 95% CI: 3.8–4.2): depression (mean 5.4, 95% CI: 5.1–5.8), back complaint (mean 5.3, 95% CI: 4.8–5.7), ischaemic heart disease (mean 5.2, 95% CI: 4.6–5.9) and fracture (mean 4.9, 95% CI: 4.2–5.6).

Significantly lower DUSOI scores were recorded for the following problems: hypertension (mean 3.4, 95% CI: 3.1–3.7), lipid disorder (mean 3.2, 95% CI: 2.7–3.8), acute upper respiratory infection (mean 3.1, 95% CI: 2.8–3.3), menopausal symptom/complaint (mean 3.0, 95% CI: 2.5–3.5), contact/allergic dermatitis (mean 3.0, 95% CI: 2.5–3.4), and solar keratosis/sunburn (mean 2.5, 95% CI: 2.0–3.1).

1 Parkerson GR, Jr., Broadhead WE, Tse CK. The Duke Severity of Illness Checklist (DUSOI) for measurement of severity and comorbidity. J Clin Epidemiol 1993; 46:379–393.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENT SEVERITY OF ILLNESS**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

START Time
:
AM / PM
(please circle)

START time
Record the time the consultation STARTED in hours and mins and circle whether the time was AM or PM.

eg. 9: 10
(AM) PM

GP consultations in the previous year.

Please check with the patient and write in the approximate number of times this patient has consulted you or any other GP at this or any other practice within the past 12 months.

SEVERITY OF ILLNESS - GP estimates for each patient*.

Estimate the severity of illness for **EACH problem managed at this encounter**. Please mark with an 'X' the appropriate place along the line to indicate how you would rate the patient's overall severity of illness **for that problem during the past week**.

Lowest severity applies to the fewest symptoms and complications, the least disability and threat to life, and the best expected response to treatment if needed. ***Lowest severity = '0'.***

Highest severity applies to the most symptoms and complications, the most disability and greatest threat to life, and the worst expected response to treatment. ***Highest severity = '10'.***

*Duke Severity of Illness Analog Scale (DUSOI-A), Parkerson et al, 1993.

FINISH time
Record the time the consultation FINISHED in hours and mins and circle whether the time was AM or PM.

eg. 9: 28
(AM) PM

How many times (approximately) has this patient consulted a GP at any practice in the last 12 months?	Severity of Illness - *GP estimate for each patient.* Please mark with an 'X' the appropriate place along each line to indicate how you would rate the patient's **overall severity of illness** during the past week **for each problem being managed at today's encounter.** *Lowest severity = 0; Highest severity = 10.*	Diagnosis/Problem 1 0 1 2 3 4 5 6 7 8 9 10 Diagnosis/Problem 2 0 1 2 3 4 5 6 7 8 9 10 Diagnosis/Problem 3 0 1 2 3 4 5 6 7 8 9 10 Diagnosis/Problem 4 0 1 2 3 4 5 6 7 8 9 10	FINISH Time : AM / PM (please circle) BL44B
_____			

45 Diabetes mellitus prevalence, management and risk factors

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: Prevalence and treatment of types 1 and 2 diabetes mellitus in general practice patients; cholesterol levels in patients with diabetes; occurrence of risk factors in patients without diabetes.

Sample: 3,165 encounters from 108 GPs; data collection period: 20/08/2002 – 23/09/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH (general practice) encounters, with the majority (58.2%) being female, and a quarter of patients aged over 65 years.

The prevalence of type 1 and type 2 diabetes mellitus was 1.0% (95% CI: 0.5–1.3, *n*=30) and 7.2% (95% CI: 5.9–8.5, *n*=226) respectively with similar rates for male and female patients. Diabetes was most common in patients aged 65 to 74 years at 2.3% for type 1 and 18.4% for type 2.

The most common treatment regimen for type 1 diabetes patients was insulin, either alone or in combination with a diet and exercise program (41.4%). For type 2 diabetes patients, diet and exercise alone was the most frequent treatment (33.3%), followed by an oral anti-diabetic agent (most commonly a biguanide) either alone or in combination with diet and exercise (32.0%).

Among the 25 type 1 diabetes patients, for whom the GPs recorded data on recent cholesterol test results, 56.0% were in the normal range and 32.0% had mixed dyslipidaemia. Recent test results for 38.0% of the 208 type 2 diabetes patients were in the normal range. Fifty-seven per cent of patients had results outside the normal range, most commonly predominant high LDL and/or total cholesterol, while almost 5.0% of patients had never been tested.

Risk factor status was recorded for 2,907 patients without diabetes. Seventy-one per cent of patients had no risk factors, 17.1% had hypertension, 14.1% central obesity, 7.7% dyslipidaemia and 2.0% had abnormal glucose. The highest prevalence of abnormal glucose and dyslipidaemia was in 65 to 74 year olds, while hypertension and central obesity were most prevalent in patients 75 years or older.

For other related abstracts see: 21 Diabetes – prevalence, management and screening, 25 Prevalence of diabetes, medications and control, 40 Type 2 diabetes mellitus, prevalence and management, 86 Diabetes Types 1 and 2 and coronary heart disease, 87 Management of cardiovascular or diabetes related conditions, 94 Type 2 diabetes – investigations and related conditions.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **DIABETES.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

Please indicate by ticking the appropriate box whether or not this patient has **ever been diagnosed** as having **Diabetes.**

If **'Yes'** proceed to the **next question**.

If **'No'** go to the **last question**

From recent tests, please indicate whether the patient has

- **predominant high LDL or Total Cholesterol (TC)** (**LDL** ≥ 3.5 mmol/L and / or **TC** ≥ 5.5 mmol/L)
- **Mixed dyslipidaemia** (**HDL** ≤ 1.0 mmol/L and / or **Triglycerides** (**TG**) ≥ 2.0 mmol/L)
- **Combined** (**LDL** ≥ 3.5 mmol/L and / or Total Cholesterol (**TC**) ≥ 5.5 mmol/L **AND HDL** ≤ 1.0 mmol/L and / or Triglycerides (**TG**) ≥ 2.0 mmol/L)
- been tested, all parameters in a normal range
- never been tested

If the patient has been diagnosed with Diabetes, either today or at a previous encounter, please indicate by ticking the appropriate box **the patient's current treatment regimen for diabetes**.

You **may tick more than one box** if several options apply.

If **none** of these treatments are being used by this patient, tick '**none of the above**'.

If 'NO' to diabetes, please indicate whether or not this patient has ever had, or currently has -

- an abnormal glucose test i.e. impaired fasting glucose (IFG) or impaired glucose tolerance (IGT)
- hypertension
- central obesity
- Mixed dyslipidaemia (HDL ≤ 1.0 mmol/L and / or Triglycerides (TG) ≥ 2.0 mmol/L)

Does this patient have diagnosed diabetes?

- ☐ Yes - Type 1
- ☐ Yes - Type 2
- ☐ No → **last question**

BL45B

If 'YES' what is their current treatment regimen?

- ☐ Diet and/or exercise
- ☐ Biguanide
- ☐ Sulphonylurea
- ☐ Alpha-glucosidase inhibitor
- ☐ Glitazones (PPAR)
- ☐ Insulin
- ☐ Other (specify)

_____

_____

- ☐ None of the above *(tick as many as apply)*

From test results, does this patient have

- ☐ Predominant high LDL and/or TC?
- ☐ Mixed dyslipidaemia (low HDL, high TG)?
- ☐ Combination of the above?
- ☐ Tested, all levels normal?
- ☐ Never been tested?

If 'NO' has this patient ever had, or have they currently

- ☐ An abnormal glucose test i.e. IFG or IGT?
- ☐ Hypertension?
- ☐ Central obesity?
- ☐ Mixed dyslipidaemia (HDL ≤ 1.0 mmol/L and/or TG ≥ 2.0mmol/L)? *(tick as many as apply)*

46 Coronary heart disease, risk factors and lipid lowering medication

Organisation supporting this study: Merck Sharp & Dohme (Australia) Pty Ltd

Issues: The prevalence of coronary heart disease (CHD) and risk factors for CHD among general practice patients; the proportion of patients who had had a cholesterol test; the proportion of patients on lipid lowering medication; the medications being taken and the cholesterol levels at commencement of therapy.

Sample: 3,151 encounters from 108 GPs; data collection period: 20/08/2002 – 23/09/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH encounters, with over half aged 25 to 64 years and the majority (59.5%) being female.

Sixty-seven per cent of patients did not have coronary heart disease or any of six listed risk factors (95% CI: 63.4–69.7). A total of 224 respondents (7.2%) had existing CHD. Of patients without CHD but with risk factors for CHD, 17.7% had hypertension, 7.0% family history of CHD, 5.7% family history of hypercholesterolaemia and 3.8% had diabetes. The risk factors for cerebrovascular disease and peripheral vascular disease accounted for 1.9% and 0.9% respectively.

As expected, CHD or its risk factors were more prevalent in older patients, with a significant increase between 45–64 year olds (43.3% 95% CI: 39.3–47.3) and 65–74 year olds (66.2% 95% CI: 60.3–72.1). The prevalence for patients over 75 years was 73.4% (95% CI: 68.3–78.6). Risk factors were evenly spread between male and female patients. CHD was marginally more common among males (9.1%, 95% CI: 7.0–11.1) than females (5.8%, 95% CI: 4.2–7.4) though the difference did not reach statistical significance.

Of the 3,098 patients who answered the question on cholesterol testing, more than half (52.9%) had previously had a cholesterol test, and of the 2,726 respondents to the question on lipid lowering medication status, 12.7% were either starting or continuing such medication.

The most popular lipid lowering generic medications were Simvastatin, which accounted for 41.8% of lipid lowering medications and Atorvastatin (40.9% of medications). For those on lipid lowering medications the average total cholesterol at the commencement of therapy was 6.9 mmol/L, the mean level of triglycerides was 2.7 mmol/L and HDL 1.5 mmol/L.

For other related abstracts see: 15 Lipid lowering medication, 20 Screening and management of blood cholesterol, 30 Lipid lowering medications and coronary heart disease, 58 Lipid lowering medications: patient eligibility under PBS, 64 Current use of statins by general practice patients, 67 Risk factors of patients on lipid lowering medications, 79 Hypertension and dyslipidaemia – comorbidity and management in general practice patients, 86 Diabetes Types 1 and 2 and coronary heart disease, 97 Statin medication use among high CHD risk patients attending general practice, 99 Lipid management in patients with high risk conditions.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **LIPID LOWERING MEDICATIONS.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

Please indicate by ticking the appropriate boxes whether or not this patient has **existing coronary heart disease** or any of the risk factors listed.

Tick as many as apply.

Please tick the appropriate box to indicate whether this patient will be -

- **commencing lipid lowering medication therapy** as a result of this consultation
- **continuing a current lipid lowering medication** prescribed at a previous consultation **OR changing to another lipid lowering medication** from one previously prescribed
- **will not require lipid lowering medication** following today's consultation

If no lipid lowering medication is required please end the questions here.

Please write the **name and regimen** of any **lipid lowering medication** to be used by the patient **following today's consultation**, regardless of whether it was **prescribed today or at a previous encounter.**

Please advise by ticking the appropriate box whether or not this patient has **ever had their blood cholesterol levels tested**.

Please list the patient's levels of **Total Cholesterol, Triglycerides and HDL at the commencement of their lipid lowering medication therapy**. For patients commencing therapy today, this may be a recent test result. For patients continuing or changing lipid lowering medications, this will be the test result **prior** to their commencement of **any lipid lowering medication.**

Does this patient have? *(tick as many as apply)*

- ☐ Existing CHD
- ☐ Familial hypercholesterolaemia
- ☐ Family history of CHD (1° relative <60yo)
- ☐ Peripheral vascular disease
- ☐ Diabetes mellitus
- ☐ Hypertension *(include treated patients)*
- ☐ Cerebrovascular disease
- ☐ None of the above

Has this patient ever had a cholesterol test

- ☐ Yes
- ☐ No

Is this patient (today)

- ☐ About to commence lipid lowering medication? (to next question ➔)
- ☐ Continuing / changing lipid lowering medication? (to next question ➔)
- ☐ Not requiring lipid lowering medication

If Not required, END QUESTIONS HERE

BL45C

What lipid medication(s) are to be used following today's visit?

	Name & Form	Strength	Dose	Frequency
1.				
2.				

At the commencement of medication what is/ was the level of -

Total Cholesterol _____ mmol/L

Triglycerides _____ mmol/L

HDL _____ mmol/L

47 Management of depression and anxiety

Organisation supporting this study: Merck Sharp and Dohme (Australia) Pty Ltd

Issues: Prevalence of depressive and/or anxiety disorders in general practice patients; medications being taken for management of depression and anxiety disorders; side effects of management medications; management of side effects of antidepressant or anxiolitic medications.

Sample: 2,698 encounters for 92 GPs; data collection period 24/09/2002 – 28/10/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH (general practice) encounters, with the majority (58.1%) of patients being female.

The majority of patients (84.3%, 95% CI: 82.2–86.4) did not have a current anxiety or depressive disorder. The most common Depression/Anxiety disorder being experienced was 'Mixed anxiety/Depressive disorder' reported for 5.5% (95% CI: 4.3–6.6) of respondents. Only 2.5% (95% CI: 1.7–3.2) of respondents were experiencing major depressive disorder. Anxiety and depressive disorders were more common among adults, there were no significant differences in the rates of anxiety or depression between the sexes.

Of those patients experiencing major depressive disorder, 90.9% (95% CI: 84.1–97.8) were taking medication. The disorder with the lowest percentage of patients taking medication was 'Other anxiety/depressive disorder', where 45.1% (95% CI: 31.1–59.1) of these patients were taking medication. The four most commonly prescribed generic medications for anxiety/depressive disorders combined were Citalopram, Sertraline, Diazepam and Venlafaxine.

Of the 169 patients taking a selective serotonin reuptake inhibitor (SSRI) or selective noradrenaline reuptake inhibitor (SNRI), 14 (8.3%) were experiencing nausea and vomiting, 10 (5.9%) had experienced weight gain, 9 (5.3%) had experienced insomnia and 8 (4.7%) had experienced sexual dysfunction as side effects of SSRI/SNRI use. There were no significant differences between side effects in impact on the patients' lives. Of the patients with side effects from SSRI/SNRI use, 24 (63.2%) were not having their side effects managed. Of those patients having side effects managed, four were taking additional medication, eight had changed their medication and one had stopped the medication.

For other related abstracts see: 5 Depression, 23 Depression.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **DEPRESSION.**

*You may **tear out this page** so you can **access the list in Box 1 for the following section of forms.***

INSTRUCTIONS

BOX 1

Criteria for major depression* *DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition).

At least FIVE (5) of the following symptoms for at least TWO WEEKS (symptom 1 or 2 must be present):

(1) Depressed mood
(2) Loss of interest or pleasure
(3) Significant appetite or weight loss or gain
(4) Insomnia or hypersomnia
(5) Psychomotor agitation or retardation
(6) Fatigue or loss of energy
(7) Feelings of worthlessness or excessive guilt
(8) Impaired thinking or concentration; indecisiveness
(9) Suicidal thoughts/thoughts of death

FOR THE DOCTOR

Please indicate by ticking the appropriate box whether or not this patient has **any of the listed depressive or anxiety disorders.**

Use the criteria shown above in Box 1 to help assess whether the patient's depression is a 'MAJOR' depressive disorder.

If **'None of the above' end questions here.**

Medications for anxiety / depressive disorder

Please write the **name and form** of any medications currently being used to treat this patient's anxiety or depressive disorder. Also, please indicate the regimen (i.e. **strength, dose and frequency**) of the medication.

Ask the patient about ...

Side effects of medication

If the patient is using a Selective Seretonin Reuptake Inhibitor **(SSRI)** or a Serotinin Noradrenaline Reuptake Inhibitor **(SNRI)** please use the tick boxes to indicate whether or not the patient is experiencing any of the listed **side effects from taking this medication** recorded in the previous question.

Ask the patient to **rank** each existing side effect according to how it **impacts on their quality of life. Circle a number** on a scale of 1 to 5, where **1 = the least impact and 5 = greatest impact.**

Management of side effects

Please use the tick boxes to indicate how you will attempt to manage any side effects of medication for this patient.

Does this patient currently have a -

- ☐ Generalised depressive disorder
- ☐ Major depressive disorder **(from criteria in Box 1 above)**
- ☐ Mixed anxiety /depressive disorder
- ☐ Other anxiety or depressive disorder
- ☐ None of the above ➔ **end questions**

Please list any medications currently being used to treat the anxiety or depressive disorder.

	Name & Form	Strength	Dose	Frequency
1.				
2.				
3.				

4. None ➔ **end questions**

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If an SSRI or SNRI is being used:

Any side effects from this medication?

If YES, ask the patient to rank the impact of each side effect on their quality of life

	Circle to rank
☐ No side effects	
☐ Nausea and vomiting	1 2 3 4 5
☐ Weight gain	1 2 3 4 5
☐ Insomnia	1 2 3 4 5
☐ Sexual dysfunction	1 2 3 4 5
☐ Other _____	1 2 3 4 5

(tick as many as apply) *(1= least impact; 5= greatest impact)*

How will side effects be managed?

- ☐ additional med'n
- ☐ change med'n
- ☐ stop medication
- ☐ further lab tests
- ☐ No management

48 Asthma prevalence and management

Organisation supporting this study: Australian Government Department of Health and Ageing

Issues: This study investigated the prevalence of asthma in general practice patients; medications taken for asthma management; severity of asthma for adults and children at commencement of Long Acting Beta Agonist (LABA); reason for prescribing a combination product (LABA plus inhaled corticosteroid (ICS)); changes in asthma control since taking combination product; patient preference for product type; patient use of spacer device.

Sample: 2,686 encounters from 92 GPs**;** data collection period: 24/09/2002 – 28/10/2002.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: *Asthma severity was established using the National Asthma Campaign's severity classification, which was provided on a card to participating GPs. This severity classification differs for children (aged <18 years) and adults.*

Summary of results

The age-sex distribution of respondents was similar to the distribution for all BEACH (general practice) encounters, with the majority (59.9%) of patients being female.

The prevalence of asthma among the respondents was 14.5% (95% CI: 12.7–16.2). Prevalence was significantly higher among patients aged 5 to 14 years (24.0%, 95% CI: 17.3–30.7) compared with the patients from the other age groups (13.7%, 95% CI: 12.0–15.5).

Of the 382 patients who answered the question about current medication, 29.8% were taking the combination LABA/ICS product, 22.3% were taking inhaled ICS alone, 3.7% were using both LABA and ICS (2 single drugs), and 3.9% were using LABA alone. The remaining respondents (40.3%) were not taking these medications.

Of the 16 children taking LABA (single or combination), 8 had frequent asthma, 4 had persistent asthma and 4 had infrequent asthma, when LABA was commenced. Of the 113 adults taking LABA (single or combination), 59.3% had moderate asthma, 20.4% had severe asthma, and 20.4% had very mild to mild asthma, when LABA was commenced.

There were 109 responses to 'purpose of prescribing' the combination product. For these, 34.9% (*n*=38) replaced 2 products with one, 30.3% (*n*=33) commenced both medications at the same time, 28.4% (*n*=31) added LABA to therapy, and 6.4% (*n*=7) added ICS to therapy. Asthma control level was 'improved' for 84.4%, 'same as before' for 12.8%, and 'worse' for the remaining 2.8%.

The majority (52.3%, *n*=193) of patients preferred the combination product, 21.8% the single ingredient product, and the remaining 25.9% had no preference.

The question on the use of a spacer device was answered by 176 patients to whom it was relevant. Of these, 52.3% reported that they never used a spacer device and the remainder were equally likely to report its use 'always' or 'sometimes' (23.1% in each case).

For other related abstracts see: 3 Asthma, 22 Asthma – prevalence, severity and management, 39 Severity of asthma, medications and management, 63 Asthma-prevalence, management and medication side-effects, 70 Inhaled corticosteroid use for asthma management, 96 Inhaled corticosteroid use for asthma management, 104 Asthma management and medication use among patients attending general practice.

Further reading:

Henderson, J., Knox, S., Pan, Y., & Britt, H. 2004, 'Changes in asthma management in Australian general practice', *Prim.Care Respir.J*, vol. 13, no. 3, pp. 138–143.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **ASTHMA.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

ASK ALL PATIENTS

Ask each patient if they **currently suffer from asthma.**

If **No** asthma - no further questions

Current medications used

If '**Yes**', please use the tick boxes to indicate whether any of the listed types of **asthma medication** are being used by this patient for their asthma management.

If **none** of these medications are currently being used for asthma management you may **end the questions here**.

Severity of asthma

If the patient is using a Long Acting Beta Agonist (LABA) for asthma management, please indicate the **severity** of their asthma **at the commencement of the LABA**.

Please use the '**Severity of asthma reference card**' included in your research pack to estimate the severity level and tick the appropriate box to indicate the response.

Commencement of Combination product

If the patient is using a combination product, please use the tick boxes to indicate whether it was prescribed to **add Beta 2 Agonist to therapy**, to **add Inhaled Cortio-costeroid to therapy,** to **commence both medications at the same time,** or to **replace 2 single medications with the combined product.**

Assessment of asthma control

Please use the tick boxes to indicate whether the **control of this patient's asthma has improved, worsened or remains the same** since using the combination product.

Changes in dose of ICS in Combination Product use

If the patient is using a combination product, please advise whether you have **changed the dose of inhaled cortioco-steroid** in response to the patient's condition. This may be by changing the puffs per dose or prescribing a different strength combination.

Patient preference

Please use the tick boxes to indicate whether this patient **prefers** the combination product, single ingredient products, or has no preference.

Please indicate how frequently the patient uses a **spacer device to assist with medication delivery**. If a self actuating device is used tick 'Not applicable'.

Does this patient suffer from Asthma?	If 'Yes' their current medication is	If LABA used how severe was the asthma when LABA commenced? (See cards)	If Combination product is used, was it pescribed to	Since starting the Combination product asthma control level is:-	In response to asthma control, dose of the Inhaled Cortiosteroid in the combination product has:	Patient prefers	Patient uses spacer device
☐ Yes →	☐ Long Acting Beta Agonist (LABA)	Child / Adult	☐ add LABA to therapy	☐ Worse	☐ Increased	☐ Combination product	☐ Always
☐ No	☐ Inhaled Cortico-steroid (ICS)	☐ Infrequent ☐ Very mild	☐ add ICS to therapy	☐ Same	☐ Decreased	☐ Single ingredient product	☐ Sometimes
↓	☐ Combination product (LABA + ICS)	☐ Frequent ☐ Mild	☐ start both medications at the same time	☐ Improved	☐ Not changed	☐ No preference	☐ Never
End questions	☐ None of above - END	☐ Persistent ☐ Moderate	☐ replace 2 single drugs with combined product				☐ Not applicable
		☐ Severe					
		BL46C					

Severity of asthma reference card

Children

Severity*	Common features
Infrequent episodic	Episodes 6-8 weeks or more apart and from 1to 2 days up to 1-2 weeks duration; usually triggered by URTI or environmental allergen; attacks generally not severe; symptoms rare between attacks; normal examination and lung function except when symptomatic.
Frequent episodic	Attacks <6 weeks apart; attacks more troublesome; minimal symptoms such as exercise induces wheeze between attacks; normal examination and lung function except when symptomatic; commonly troubled through winter months only.
Persistent	Symptoms most days; nocturnal asthma > 1/wk with sleep disturbance; early morning chest tightness; exercise intolerance and spontaneous wheeze; daily use of beta2 antagonist; abnormal lung function; history of emergency room visits or hospital admissions.

Adults

Severity*	Common features
Very mild	Episodic
Mild	Occasional symptoms (up to 2/wk); exacerbations >6-8 weeks apart; normal FEV_1 when asymptomatic
Moderate	Symptoms most days; exacerbations <6-8 weeks apart which affect day-time activity and sleep; exacerbations last several days; occasional emergency room visit.
Severe	Persistent; limited activity level; nocturnal symptoms > 1/wk; frequent emergency room visits and hospital admission in past year; FEV_1 may be significantly reduced between exacerbations.

* The severity classes are adapted from the NAC Asthma Management Handbook 1998 edition, updated March 2002

49 Health status and management of patients on non-steroidal anti-inflammatory drugs

Organisation supporting this study: Merck Sharp and Dohme (Australia) Pty Ltd

Issues: Prevalence of non-steroidal anti-inflammatory medication (NSAID) use in general practice patients; self-reported general health status of general practice patients taking NSAID medications; prevalence of rheumatoid arthritis among these patients; patient corticosteroid use among these patients; rate of hospitalisation associated with gastrointestinal problems for general practice patients taking NSAID medications; other gastrointestinal side effects for general practice patients taking NSAID medications.

Sample: 5,554 encounters from 192 GPs; data collection period 29/10/2002 – 21/12/2002 and 21/01/2003 – 24/02/2003.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: *Current health status was reported by patients based on five listed categories: excellent, very good, good, fair and poor. Each patient was provided with a card that listed these categories.*

Summary of results

The age-sex distribution of respondents had a somewhat greater proportion of female patients (62.5%, 95% CI: 60.1–64.8) than the total BEACH (general practice) encounters (57.4%, 95% CI: 57.0–58.6).

NSAIDs were taken by 14.3% (792/5554) of respondents—7.8% (95% CI: 6.8–8.8) were taking a cox-2 inhibitors and 6.5% (95% CI: 5.6–7.3) were taking another NSAID. Only two respondents were taking both a cox-2 inhibitor and another NSAID. Over one-third (37%, 294/788) of respondents on NSAIDs were aged between 45 and 64 years, while the age group most likely to be on NSAIDs were respondents aged 65 years and over (27% of those aged over 64 years were taking an NSAID). Of those on NSAIDs 6.8% had rheumatoid arthritis and 13.0% had taken corticosteroids in the previous 12 months, most for less than 1 month's duration.

Of those on NSAIDs, 5.7% (44/796) had previously been hospitalised with a gastrointestinal complaint. Of those previously hospitalised most were currently on cox-2 inhibitors (34/44). A further 31% of respondents on NSAIDs had experienced some adverse gastrointestinal side effects that did not lead to hospitalisation.

Using the Standardised Calculator of Risk Events (SCORE) to assess risk of future gastro-intestinal events, two-thirds of respondents on NSAIDs had a moderately increased risk of a serious GI side effect associated with taking NSAIDs (SCORE > 10). The mean risk levels for respondents on cox-2 inhibitors were significantly higher than for respondents on other NSAIDs (mean SCORE 14.6, 95% CI: 13.9–15.2 versus 10.8 95% CI: 10.0–11.6).

For other related abstracts see: 29 Non-steroidal anti-inflammatory drugs (NSAIDS) and acid suppressant use, 78 NSAID & acid suppressant use in general practice patients, 88 Arthritis rates and NSAID use in general practice patients.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENTS ON NON-STEROIDAL ANTI-INFLAMMATORY MEDICATIONS.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Current NSAID use

Please advise whether this patient is **currently taking a COX 2 inhibitor or any other non-steroidal anti-inflammatory (NSAID) medication.** This includes any Cox 2 or NSAID medication prescribed today or at a previous encounter by you or another GP.

If **'No'** end the questions here.

Ask the Patient

Please show the patient the card of options and ask them to give their opinion of **their current health status** in general terms. Use the tick boxes to indicate the patient's response.

Rheumatoid arthritis

Please indicate whether or not this patient has been diagnosed, either today or at a previous encounter, with **rheumatoid arthritis**.

Patient corticosteroid use

Please advise whether or not this patient has been taking **prednisone** or any other **corticosteroid, orally** or by **injection (but not by oral inhalation)** during the past year.

Duration of corticosteroid use

If **'Yes' to corticosteroid use**, please use the tick boxes to indicate the **approximate length of time** the patient has been taking the corticosteroid.

If there were **several separate occasions** of use, please **combine them for total duration**
e.g. prednisone taken for 10 days in March and 10 days is June = 20 days in total.

Hospitalisation

Please advise whether or not the patient has **ever been hospitalised** for **stomach or intestinal problems** such as **bleeding or an ulcer**?

If **'Yes'** you should **end the questions here**.

Side effects

If **'No'**, please advise whether or not the patient has **ever experienced gastrointestinal side effects** such as heartburn, stomach pain, nausea or vomiting, **while taking NSAIDs**.

Is this patient currently taking -?	If 'Yes', in general would you say your health is (show card)	Does the patient have *rheumatoid* arthritis?	Has the patient taken prednisone or other corticosteroids by mouth (not by oral inhaler) or by injection during the past year?	If 'Yes', how many months have they taken them in the past year?	Has the patient been hospitalised for a stomach or intestinal problem such as bleeding or an ulcer?	If 'No' has the patient ever had gastrointestinal side effects (heartburn, stomach pain, nausea, vomiting)when taking NSAIDs?
☐ a COX 2 inhibitor →	☐ Excellent?	☐ Yes	☐ Yes	☐ < 1month	☐ Yes	☐ Yes
☐ any other NSAID →	☐ Very good?	☐ No	☐ No	☐ 1 - 3 months	☐ No (If 'Yes', end questions here)	☐ No
☐ None of above	☐ Good?			☐ 4 - 6 months		
↓ *End questions*	☐ Fair?			☐ 7 - 10 months		
BL47B	☐ Poor?			☐ 11 - 12 months		

In general would you say your health is -

- Excellent?
- Very good?
- Good?
- Fair?
- Poor?