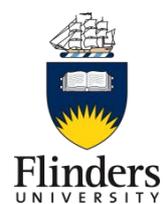


Reference Manual

A comprehensive health needs assessment to promote coordinated care of older veterans by primary health care teams

May 2013 (updated April 2014)

Discipline of General Practice



A comprehensive health needs assessment to promote coordinated care of older veterans by primary health care teams: reference manual

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Introduction

This reference manual accompanies the comprehensive health needs assessment tool (CNAT) for older veterans developed by the Discipline of General Practice at Flinders University.

We wish to acknowledge the support of the Department of Veterans' Affairs through the Applied Research Program (ARP 1121).

The acceptability of the CNAT to veterans, war widows and staff in general practice has been assessed through observation and interviews of veterans receiving this assessment. Most participants were enrolled in the Coordinated Veterans Care (CVC) Program and the average age was 86 years (range 73-96 years).

Rationale

- health assessments have been associated with improved health outcomes for older people (1)
- current practices of need identification may be improved by the adoption of more standardised assessment questions
- valid and reliable functional assessments promote early intervention and proactive care planning
- serial assessments can indicate an individual's rate of decline and prognosis

Who was the CNAT developed for?

The CNAT is a health assessment for older veterans, including those in the CVC Program. It focuses on health problems more frequently identified in older veterans and their spouses (e.g. Vietnam War, Korean War and World War II veterans). It will generally be most applicable to veterans aged 60 and above.

What do we know about Veteran health?

Veterans have higher rates of health risk factors compared to their non-veteran counterparts, including:

- lack of exercise;
- obesity; and
- long term use of cigarettes and alcohol.

Veterans are more likely to:

- experience a short or long term illness;
- develop cancer
- suffer from diseases of the digestive, nervous, circulatory and musculoskeletal systems
- be prescribed more medications than non-veterans, even allowing for disabilities.
- Have increased rates of mental health problems. More than a quarter of the **treatment population** (defined as a veteran or war widow/er issued with a Repatriation Gold or White health card) have mental health conditions, about half of which are accepted as being due to military service. Veterans have much higher rates of conditions such as posttraumatic stress disorder, although this diagnosis might not have been made in older veterans. War-related memories may have a negative effect on those with dementia (2) and this issue should be considered in care planning for older veterans.

The impact of war-related memories associated with ageing processes such as grief and loss, depression, social isolation and dementia can be significant. The combination of Posttraumatic Stress Disorder (PTSD) with a dementia related illness is especially challenging for the sufferer as well as for family members and staff who care for them.

Veteran demographics

As at 31 December 2010, there were 251,887 veterans or war widows/widowers issued with a Repatriation Gold or White health card, with an average age of 76.4 years. Of this cohort, 42.4% or 106,894 were aged 85 years of age or over. Nearly half the Australian male population over 80 years of age are veterans. The number of Gold Card holders is around 170,000 and about half are war widows (2).

Gold, white or orange card – what are the differences?

Access to some services may depend on the colour of the Repatriation Health Card. Gold Repatriation Health Card entitles the holder to treatment for all conditions. White card holders are entitled to treatment for conditions accepted by DVA. An Orange card is issued to Commonwealth and allied veterans and mariners who have qualifying service from World War 1 or World War 2, are aged 70 or over and have been resident in Australia for 10 years or more. Orange cards are for pharmaceuticals only. Further information about treatment cards is available on the DVA website (3).

Health service use

Gold Card holders' use of health care services varies with age, gender and service-related disability (as reflected by the type of disability service pension). After adjusting for these factors, there is little difference between Gold Card holders' use of hospital services, medical services and pharmaceuticals, compared with the rest of the community (4).

Role of the CNAT in General Practice

This tool was developed to facilitate health assessments of veterans enrolled in the Coordinated Veterans Care (CVC) Program but includes many of the required elements of a 75+ health assessment and can be used more generally for older veterans who are not eligible for the CVC program but could benefit from a comprehensive assessment. It includes items of high prevalence for older veterans in general practice which if identified and successfully managed might result in improved health care outcomes, better quality of life or potentially longer survival. The domains of health that are assessed are those that potentially all veterans and war widows are likely to have. This assessment is primarily intended to occur in the home but could be modified to the clinical setting if required. It does not assess specific diseases which commonly occur in this setting such as COPD, heart failure, or diabetes. For further information on how these diseases might be managed in older veterans, the specific diseases module of the training program for the CVC program (module three) provides additional on-line information on the five most frequent reasons for admission to the hospital by older veterans (COPD, heart failure, diabetes mellitus, coronary artery disease and pneumonia).

Further information about CVC training is available at: www.cvcprogram.net.au/training.

Administering the CNAT

Health assessments for specific age groups and populations are common in general practice and Medicare has reimbursed a senior health assessment (commonly referred to as a 75+ assessment) for more than a decade. A comprehensive needs assessment is also one of the requirements of the Coordinated Veterans Care (CVC) Program (5). The CNAT has been developed to meet the specific needs of older veterans, including those enrolled in the CVC Program.

Who should administer the CNAT and how long will it take?

The CNAT can be administered by general practitioners or practice nurses. Administration time varies according to the complexity of the patient's needs, the presence of cognitive impairment and clinician. Administration times during pilot testing ranged from 25-75 minutes.

Preparing for the home visit

For the CVC program, the needs assessment is recommended to be performed in the home. For some primary health care staff, conducting a needs assessment in a person's home may be a new experience. There are a number of guidelines that have been developed to guide how a home visit should be conducted, below are two examples that you may wish to familiarise yourself with.

Nurse Home Visit Guidelines

The Australian Practice Nurse Association (APNA) has developed guidelines for the primary health care nurse working in a general practice setting providing nursing services to a patient in their own home. The guidelines covers some of the processes of conducting home visits including planning, implementing and reviewing, and makes suggestions for issues to consider when developing, implementing or reviewing a nurse home visit policy within your workplace (6).

Assessing the patient in the home – guidelines for the CVC Program

Specific guidelines are available for the practice nurse or Aboriginal health worker who is undertaking a home visit to conduct a comprehensive needs assessment for a patient who is enrolling on the (CVC) Program (7).

Conducting the home visit - Setting the scene

Explain that the assessment will provide useful information to help you prepare their Care Plan. Assure the veteran that the information will be treated as confidential and shared only by those health professionals involved directly in their care, and treated in the same way as all other information held within the medical record.

After the CNAT – what are the next steps?

The needs assessment is a first step in the process of care planning, implementation and review. Several of the tools in the CNAT – including cognition, distress and posttraumatic mental health - have scoring guidelines for further assessment and referral.

The assessment domains

The CNAT is composed of a series of questions to detect problems of high prevalence in older veterans. Some of these problems – such as mental health, sexual dysfunction, and alcohol and substance use disorders are commonly seen in veterans. Problems associated with ageing, such as incontinence, falls and functional limitations have a high prevalence in both veteran and non-veteran populations.

Overall health and well being

Why ask about overall health and wellbeing?

Self-rated health (SRH) is a predictor of older adults' health trajectories, including major health outcomes such as stroke, disability, health care use and mortality (8).

Self-rated health is a dynamic measure and incorporates past health experience with current health conditions and future health expectations (9).

As a decline in self-rated health over time is a more powerful predictor of mortality compared to a single measure (8), it may be informative to compare the person's response in this assessment, with their responses in previous health assessments that have included SRH.

Who developed the self-rated health measure?

The question about self-rated health was used in the Rand medical outcomes study (10) and forms part of the short form-36 (SF-36), the most widely used multi-item, multi-dimensional health status measure of all (9).

What to do if self-rated health is low or declining

A substantial body of international research has reported the item to be significantly and independently associated with specific health problems, use of health services, changes in functional status, recovery from episodes of ill health, mortality, and socio-demographic characteristics of respondents (references for individual studies are cited in 9). Lower self-rated health may serve as an indicator of low or declining overall health status and might indicate that these individuals have generally higher needs. However, the finding of low self-rated health needs to be interpreted cautiously and on an individual basis.

Cognition

Why ask about cognition?

The prevalence of dementia increases with age, doubling every 5 years between the ages of 60 and 85 years (11). Detection and diagnosis and disclosure of dementia have been identified as potential evidence gaps in general practice in Australia (12) and internationally. Part of the challenge is that patients frequently do not report problems until symptoms are obvious and well advanced (13). It is estimated that only 25% of patients with mild cognitive impairment (MCI) or Alzheimer's disease are recognized in general practice (14).

In Australia, symptoms of dementia are noticed by families an average of 1.9 years prior to the first health professional consultation and there is an average of 3.1 years before a firm diagnosis is made (15). This finding is consistent with other overseas studies.

GPs are often reluctant to diagnose a disease which lacks a known cure and causes suffering to those who have it, and their families (16). Delays in diagnosis, however, result in lost opportunities for earlier medical and social interventions for those with dementia and their families (17).

Cognitive impairment, and more specifically dementia, impacts on many aspects of functioning including: memory, comprehension, learning, social interaction, reasoning, planning, decision making and emotional responses. Deficits such as these impact on the individual's ability to carry out day-to-day activities, such as managing medications and appointments, self-monitoring blood glucose and other technical skills.

The GPCOG

Drawing upon previous reviews, Phillips and colleagues (17, p. 33) identified the General Practitioner Assessment of Cognition (GPCOG) as one of three dementia screening tools suitable to use in the primary care setting.

The GPCOG is a brief screening tool comprising a patient cognitive test and questions to an informant. The GPCOG was developed for use in general practice in Australia (18) and is currently being used as part of a large randomised clinical trial to examine the effectiveness of peer education on GP diagnostic assessment and management of dementia (19). Further assessment of the reliability and validity of the GPCOG (inter-rater reliability, test-retest reliability and comparison with the MMSE) is being undertaken as part of the current Australian trial (19).

The GPCOG is considered superior to other screening instruments such as the MMSE because of its brevity, psychometric properties and its use of informant report in borderline cases (20).

The GPCOG can be completed online (www.gpcog.com.au) and a training video is available at www.gpcog.com.au/video.php (21).

What to do if the screen is positive

The GPCOG includes questions for an informant if the patient scores between 5 and 8. It is recommended that practice staff discuss and agree on the approach to be taken (i.e. who will seek patient consent, how the appropriate informant will be identified and who will complete the informant interview). The informant questions are included at the end of the CNAT.

A positive screen requires further mental status testing to confirm this finding as the GPCOG is a screening test only. If subsequently confirmed from clinical and more detailed cognitive status testing, further medical assessment to exclude reversible causes of cognitive impairment is required (22).

For clients who have an existing diagnosis of mild cognitive impairment (MCI) or dementia, educational and psychosocial interventions to improve the quality of life of the patient and carer (e.g. socialisation, counselling) should be considered as part of the **care plan**. Further assessment of the safety of the home environment, safety associated with driving, legal capacity and legal matters (e.g. advance care directives, enduring guardianship and enduring power of attorney and the availability and use of firearms) may be required for persons with an existing diagnosis of dementia, and those in whom further testing confirms a diagnosis of mild cognitive impairment or dementia (17).

Hearing

Why ask about hearing?

Age-related hearing loss is the most common cause of hearing loss in older adults. Hearing loss is typically gradual, progressive, and bilateral. The disease initially affects the higher frequencies before progressing to the lower

frequencies. Hearing loss in older adults is multifactorial. In addition to age-related degeneration, other contributing factors include genetic factors, exposure to loud noises, exposure to ototoxic agents, history of inner ear infections, and presence of systemic diseases such as diabetes mellitus (23). In adults ages 80 years and older, the prevalence of hearing loss is over 80%.

Many veterans have a history of exposure to loud noises and are at increased risk of hearing loss. Hearing loss can have a negative effect on quality of life, independent function, and social interaction (24).

Annual questioning about hearing impairment is recommended with people aged 65 years and over (25). Simple screening methods, such as hearing a whispered voice and a single-question screening seem to be nearly as accurate for detecting hearing loss as more detailed questionnaires or handheld audiometers (23).

What to do if the screen is positive

Usually more extensive testing is performed to confirm the screening test such as audiometry – typically performed by an audiologist. Hearing aids can improve self-reported hearing, communication, and social functioning for some adults with age-related hearing loss (24).

Despite the high prevalence of hearing loss, only 10 to 20% of those with hearing loss have ever used hearing aids, and 20 to 29% of patients who have used hearing aids at some point stop using them (23). Patients often experience dissatisfaction with hearing aids due to their appearance, background noise, discomfort, difficulty handling, and unmet expectations regarding effects on hearing impairment (23).

Because not everyone who might benefit from hearing aids will choose to use them, it is important that the older person's preferences for follow-up and treatment are elicited.

Pain

Why ask about pain?

Up to 50% of community dwelling older adults report pain on most days for at least 3 consecutive months. Causes of chronic pain in older adults include: arthritis, neuropathies, vertebral compression fractures, cancer and cancer treatments, and end-stage heart, lung, and kidney disease (26). With advancing age, chronic pain is less likely to be recognised and adequately treated (27).

Among older women, pain is the most common reported cause of impairment in activities of daily living. Untreated, chronic pain can lead to decreased social participation and quality of life, depression, impaired sleep, difficulties with walking and increased falls (26).

What to do if the screen is positive

If moderate, severe or very severe pain is reported, consider a more in depth assessment. The Australian Pain Society recommends the Brief Pain Inventory (28) and the Resident's Verbal Brief Pain Inventory (29, 30). The Brief Pain Inventory uses a 10-point visual analogue scale (which some older adults find difficult), whereas the latter tool uses verbal descriptors.

Once chronic pain is identified, the cause of the pain needs to be diagnosed. Treatment of pain can be tailored to the cause, which does not always require analgesic medications.

Social support

Why ask about social support?

Social isolation is a significant problem among veterans. An Australian study in 1996-98 found that 10% of World War II veterans were socially isolated. For the purpose of the research, social isolation was defined as a low level of social participation (objective) and veterans' self-report that their level of social activity was inadequate, or they felt bored, lonely or unhappy. Fourteen per cent of World War II veterans reported fewer than two social contacts a week. Fewer war widows were socially isolated (5%) however, 20% reported loneliness, boredom or unhappiness. Predictors of social isolation were poor self-rated health and a decline in social activity over the preceding five years (31). Social isolation is a risk factor in developing or exacerbating mental health problems in vulnerable people (32).

Social isolation, patient-perceived physical health and anxiety are identified as significant risk factors for re-hospitalization (33).

A 3-item loneliness scale

A 3-item loneliness scale was derived from the 20-item Revised UCLA Loneliness Scale (34) to facilitate use as part of large social surveys. The wording of the original items was revised and the number of response options was reduced to make the items more suitable for telephone administration (35).

What to do if the screen is positive

Although higher scores indicate greater loneliness, there is no threshold to indicate a "positive" score. Consider options for social support. If the person is a CVC participant they may be eligible for short-term support through the Social Assistance Program. A GP letter of referral is required and eligibility is assessed through the Veterans' Home Care Assessment Agency, telephone 1300 550 450.

Distress

Why ask about distress?

Older veterans are at higher risk than the general population for mental disorders, including depression, post-traumatic stress disorder (PTSD), and suicide.

According to the Veterans Affairs (VA) National Registry for Depression, 11% of Veterans aged 65 years and older have a diagnosis of major depressive disorder, a rate more than twice that found in the general population of adults aged 65 and older (36). Approximately one-third (35.9%) of the depressed older adults (aged 50 years and older) in the VA health care system did not receive any treatment. Moreover, the odds of receiving depression treatment decreased with increasing age (37).

PTSD can continue for years or can re-occur in old age (38, 39).

Older veterans (aged 75 years or older) appear to have a suicide rate 36% greater than older adults who did not serve in the military. Amongst the youngest veterans (age 17-24 years), the relative risk of suicide was 3.84 compared with age-matched men without military service. Between the ages of 25 to 75 years, the relative risk was fairly constant at approximately 1.5 and then decreased to 1.36 for veterans aged 75 years or older (40).

Clinicians recognise between one third (36%) and just over one half (56%) of depression cases in primary care (41, 42), and are better at 'ruling out' people who are not depressed (43). Barriers to detection are related to patients and clinicians. Patients frequently do not recognise their own symptoms as depression and present with physical

complaints in as many as 70–80% of cases (44, 45). GPs may have a low index of suspicion for depression, particularly if patients with depression do not mention sign-post symptoms (46). Patients with multiple chronic conditions present additional challenges for GP recognition of depression (47).

The K10

The K10 is a 10-item questionnaire intended to yield a global measure of psychological distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4 week period. The K10 was developed by Kessler (48). It is widely recommended as a simple measure of outcome following treatment for common mental disorders (49).

The K10 scale has been chosen for routine public health telephone surveys in a number of Australian States, for the ABS regular survey of Australian health and for routine use in patients in contact with mental health services. The K10 is one of the tools recommended for use as part of the comprehensive needs assessment when enrolling a patient in the CVC Program (www.cvcprogram.net.au/resources).

Scoring the K10

Each item is scored from one, which is used to indicate 'none of the time', to five to indicate 'all of the time'. Scores of the ten items are added together, yielding a minimum score of ten and a maximum score of 50. Low scores indicate low levels of psychological distress, and high scores indicate high levels of psychological distress. Questions 3 and 6 are not asked if the answer to the preceding question was 'none of the time', in which case questions 3 and 6 automatically receive a score of 1.

Two different categories or groupings for K 10 scores are commonly used in Australia depending on the purpose of administration and the setting in which the K 10 is delivered. The following guide has been sourced from the Mental Health Advice Book for Practitioners: Helping Veterans with Common Mental Health Problems (50) and is consistent with that used by the Clinical Research Unit for Anxiety and Depression (51), GPcare (52) and the 'Better Outcomes in Mental Health Care' and 'Better Access' initiatives in Australia.

People seen in primary care who score:

- under 20 are likely to be well
- 20 - 24 are likely to have a mild mental health disorder
- 25 - 29 are likely to have moderate mental health disorder
- 30 and over are likely to have a severe mental health disorder.

Thirteen per cent of the adult population will score 20 and over, and approximately 1 in 4 patients seen in primary care will score 20 and over. This is a screening instrument, and practitioners should make a clinical judgment as to whether a person needs treatment (49, 53-55).

What to do if the screen is positive

As a guide, when veterans score 20 or above on the K10, further clinical assessment should be undertaken to identify, more precisely, the nature of the psychological distress they are experiencing (e.g. depression, social anxiety, PTSD) and to assess the risk of self-harm and suicide. The DVA 'At Ease' portal includes links to a range of assessment measures for specific mental health disorders experienced by veterans (56).

If responses to further screening indicates the possible presence of one or more mental health disorders, a diagnostic assessment for that disorder(s) should be undertaken, guided by the Diagnostic and Statistical Manual of mental disorders, 5th edition (American Psychiatric Association, 2013) diagnostic criteria.

Resources and specialist referral

In addition to its value as a screening tool, the K10 may also be used as a tracking tool to measure a veteran's progress over the next few weeks or months. K10 scores usually decline with effective treatment. Veterans whose scores remain above 24 after treatment should be reviewed and specialist referral considered (50).

Mental health information and resources for veterans and their families are available at DVA's At-Ease website (www.at-ease.dva.gov.au). Self-assessment and self-help modules for mental health are available at the Wellbeing Toolbox (www.wellbeingtoolbox.net.au), and information and help to achieve a balance with alcohol and a healthy lifestyle are available at The Right Mix website (www.therightmix.gov.au).

Help is also available through the Veterans and Veterans Families Counselling Service (VVCS). VVCS provides counselling and group programs to veterans, peacekeepers and eligible family members. It is a specialised, free and confidential Australia-wide service and may be contacted 24 hours a day on 1800 011 046.

Posttraumatic mental health

Why ask about posttraumatic mental health?

Over a quarter of a million Australians experience Post Traumatic Stress Disorder (PTSD) in any one year. Without effective treatment PTSD can be a chronic and debilitating condition. It carries a higher suicide risk than any other anxiety disorder (57) .

Military personnel and veterans are at increased risk of PTSD. Military deployment almost invariably involves exposure to real or threatened death and serious physical injury that can lead to PTSD. Furthermore, the nature of traumatic events experienced on deployment can challenge fundamental beliefs about the self, the world, and humanity (57) .

Amongst Australia's Vietnam veterans, the six month and lifetime prevalence of PTSD (i.e., percentage of the population who have had PTSD in the past six months, or at some time in their lives) is reported to be 11.6 per cent, and 20.9 per cent respectively (58). Comparable, or slightly lower, rates have been found among veterans of other conflicts both in Australia and overseas (59).

Veterans have high rates of *chronic* PTSD. Amongst Australia's Vietnam veterans, about half of those who reported having a diagnosis of PTSD at some point in their lifetime still had the disorder decades later (58).

Those with PTSD are also at heightened risk for dementia. It is unclear whether this is due to a common risk factor underlying PTSD and dementia, or to PTSD being a risk factor for dementia (60). Cognitive impairment may also impact on behaviour and symptoms of PTSD (32).

Chronic PTSD symptoms and trauma exposure impact on family relationships. Studies of combat veterans with chronic PTSD have found that, of the PTSD symptom clusters, avoidance/numbing symptoms are relatively more strongly associated with dissatisfaction in intimate as well as parenting relationships (see, for example, the review by 61). A veteran's inability to experience and express emotions and to engage with others, or difficulty in regulating anger, can have a significant negative impact on other family members. It is important that health professionals are sensitive to the psychosocial needs of war widows/widowers and dependents.

The Primary Care PTSD (PC-PTSD) screen

The PC-PTSD was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the Veterans Administration (USA). The questions were sourced from the Australian Guidelines

for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (57), approved by NHMRC and endorsed by the RACGP, RANZCP, and APS. The scale was developed in the US (62, 63).

What to do if the screen is positive

In primary care settings, patients with a score of 2 or higher should be further assessed (63, 64). The PTSD checklist (PCL) - Civilian version is a good scale for further assessment and is available on the DVA 'At Ease' website (64). The PCL (65) assesses the 17 DSM-IV PTSD symptoms, with each rated on a five-point scale from 'not at all' to 'extremely'. The scale takes only five minutes to complete and possesses excellent psychometric qualities. A score of 50 is recommended as the diagnostic cut-off. Separate forms are available for military (M), specific (S) and civilian (C) stressors. The PCL is one of the few self-report measures in the public domain and is useful for diagnostic purposes and monitoring change over time (57).

Referral options for PTSD

- **GP referral to DVA:** Clinical psychology and counselling services are available on referral by the treating doctor. There are also limited numbers of DVA-contracted social workers/clinical counsellors available. Telephone 1300 550 457.
- **Veterans**, their families, war widows/widowers **can self-refer** to the Veterans and Veterans Families Counselling Service (VVCS), telephone 1800 011 046. During business hours this number connects to the nearest VVCS centre (there are 15 centres nationally). After hours, this number connects to the 24-hour hotline (*Veterans Line*). Treatment can include counselling, including trauma focused cognitive behaviour therapy, various relaxation-based therapies, anger and anxiety management techniques or group programs.
- **GP referrals** to psychiatry, psychology and allied health professionals can be made under **Medicare** arrangements which may include completion of a mental health care plan.

Evidence-based therapies

- When referring for psychological interventions, consider referring to practitioners trained in trauma-focussed interventions. Trauma-focussed cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR) are the most effective treatments for veterans with PTSD (57). Cognitive processing therapy (CPT) is a promising new treatment approach to PTSD (57).

Sexual Health

Why ask about sexual health?

Veterans have been found to be at high risk for a number of mental and physical health problems however one problem that may not be discussed as commonly is sexual problems. The high level of anxiety that results from traumatic exposure may contribute to sexual problems. One population that can have extensive exposure to traumatic experiences is military veterans (66).

Most studies on sexual dysfunction among veterans with PTSD have looked at Vietnam veterans. In those studies, rates of sexual dysfunction were as high as 80% (67, 68). PTSD independently contributes to sexual dysfunction (69) and SSRI medications can further reduce sexual desire (70, 71). Amongst Iraq/Afghanistan veterans aged over 40 years, PTSD and hypertension were significant correlates of sexual dysfunction (72). Additionally, aircraft maintenance staff involved in F-111 fuel tank deseal/reseal programs have an increased risk of sexual dysfunction (73).

There are many risk factors for sexual dysfunction that may impact on older veterans, including:

- age, low levels of physical activity, obesity

- smoking
- hypertension or treatment for hypertension,
- diabetes, heart or vascular disease
- neurological disorders
- kidney or liver failure
- history of alcohol or drug abuse,
- exposure to solvents or lead (military or civilian)
- hormonal imbalance
- a wide range of medications
- prostate surgery or treatment (anti-androgens) (74)

Psychological factors associated with sexual dysfunction include stress and anxiety, depression, marital or relationship problems, concern about sexual performance and feelings of guilt. An older veteran with multiple chronic conditions and several prescribed medications is likely to have multiple risk factors for sexual dysfunction.

In men, both prevalence and severity of sexual dysfunction increase significantly with age, especially after the age of 50 years. A population-based study in Western Australia reported that 68.9% of males aged 70 years or older were classified as having erectile dysfunction (ED) according to the 5-item International Index of Erectile Function (IIEF-5). Despite almost 90% of the affected participants having experienced ED for more than one year, only 14.1% reported having ever received any treatment for ED (75).

It is important not to assume older adults are sexually inactive; older persons can engage in satisfying sexual relationships. Equally, they can experience problems with sexual function that concern them.

The Western Australia Men's Health Study (75) found that a significant proportion of the elderly participants (42.6% of those aged ≥ 60 years and 25.7% of those aged ≥ 70 years) continued to be sexually active.

One reason that sexual dysfunction is often neglected in health care settings is that patients are unlikely to discuss it with their health care providers unless asked. Simple questions about sexual function can be useful in helping patients discuss the problem and may signal the need for further evaluation.

The sexual health questions are adapted from the Brief Sexual Symptom Checklist (76).

What to do if the screen is positive

A person who expresses dissatisfaction with their sexual function should be encouraged to speak to their GP, for further assessment, treatment or referral.

Informal care

Why ask about informal care?

The Australian Bureau of Statistics (ABS) defines a 'carer' as follows:

A 'carer' is a person of any age who provides any informal assistance, in terms of help or supervision, to persons with disabilities or long-term conditions or persons who are elderly (i.e. aged 60 years and over). This assistance has to be ongoing, or likely to be ongoing, for at least six months (77). Assistance relates to 'everyday types of activities', including cognition or emotion; communication; health care; household chores; meal preparation; mobility; property maintenance; reading or writing; self-care; or transport.

For older couples, caring may be reciprocal or one spouse may require more assistance. While caring may be rewarding, carers may also experience social isolation, physical and emotional strain. For these reasons, the CNAT asks about the caring responsibilities of the older veteran as well as asking if the veteran has a carer.

Informal carers provide the majority of direct care to older Australians and often play a key role in the co-ordination of formal care services (78). It is important that primary care staff involve carers in care planning, with the consent of the older veteran.

It is also important that primary care staff are alert to potential problems in the informal care relationship, including the potential for elder abuse. This is why the CNAT asks if there is any aspect of the veteran's relationship with their carer that they would like to discuss.

What to do if the screen is positive

A "positive screen" is a veteran who is caring for someone else, **or** has a carer, **and** would like some information or support.

If the older veteran is a caregiver, they may require information and support in this role.

If the veteran is a care recipient and wishes to discuss an aspect of their relationship with their carer – and their carer is present - this should be flagged for follow-up at a subsequent appointment. The Aged Rights Advocacy Service (ARAS) may be an appropriate referral avenue. ARAS has an Abuse Prevention Program to assist older people who are at risk of, or experiencing abuse from those with whom they are in a relationship of trust, such as family members or friends. Contact details and further information is available at: www.sa.agedrights.asn.au/.

Smoking

Why ask about smoking?

Smoking is an important risk factor for a range of health problems and it is important to assess smoking status in all older veterans. The question about smoking was taken from the Patient Practice Prevention Survey (79).

What to do if the screen is positive

Offer help based on the person's readiness to change. This principle applies equally to alcohol and other substance use, nutrition and physical activity.

The RACGP 'Smoking Cessation Guidelines for Australian General Practice' (2011, updated 2012) incorporate the 5As structure for health professionals for smoking cessation; – Ask, Assess, Advise, Assist, and Arrange follow up (80). The Guidelines and accompanying treatment algorithm are available online at <http://www.racgp.org.au/your-practice/guidelines/smoking-cessation/>.

Alcohol use

Why ask about alcohol use?

Military experience increases the risk of alcohol abuse and dependence. A study published in 1988 found that Vietnam combat veterans (i.e. those deployed to a combat zone) were significantly more likely to meet the criteria for alcohol abuse or dependence (13.7%) and depression (4.5%) compared with men who enlisted in the US army between 1965 and 1971 but were not Vietnam veterans (9.2% and 2.3%, respectively), (81).

Alcohol problems often remain undetected in primary care. A recent study (82) examined the sensitivity, specificity, and predictive value of clinicians' instincts as compared with screening instruments. The study shows that physicians are quite good at identifying patients who do **not** have an alcohol problem, and when physicians are concerned that a patient has a hazardous drinking pattern, they usually are right. On the other hand, physician intuition has poor sensitivity compared with validated screening tools; clinicians miss most (more than 70%) of the patients with a potential alcohol problem. The results of this, and similar studies, provide support for alcohol screening as part of routine care.

The alcohol consumption screening test

The CNAT uses the alcohol consumption screening questions developed by Bush and colleagues (83). In men, a score of 4 or more is considered positive, in women a score of 3 or more is considered positive for hazardous drinking or active alcohol use disorders. The higher the score, the more likely the patient's drinking is affecting his or her safety.

For older men, one or two alcohol-free days per week are suggested after an Australian study by McLaughlin and colleagues (84) found that the lowest mortality risk is associated with an alcohol intake of up to four standard drinks per day, accompanied by one or two alcohol-free days per week.

What to do if the screen is positive

It is recommended that patients with positive scores have further testing. A recommended follow-up is the full Alcohol Use Disorders Identification Test (AUDIT) which is available on the DVA 'At Ease' portal (85) under 'Assessment and Measures'.

Simple completion of the AUDIT questionnaire has been shown to result in a reported 15-20% reduction in alcohol consumption at follow-up (86).

Although screening and brief intervention have been shown to reduce alcohol consumption by 15-30% for at least 12 months (see 87 for the primary references), it is unclear what the "brief intervention" should comprise and how "brief" it can be and still be effective. A trial comparing the effectiveness of three interventions: a patient information leaflet, the addition of five minutes of structured brief advice, and the extra addition of 20 minutes of lifestyle counseling based on motivational interviewing techniques, found no difference between groups in the proportion of participants who scored less than 8 on the AUDIT at six months. All groups reported a reduction in hazardous or harmful drinking at follow-up. Participants allocated to the most intense intervention reported slightly greater satisfaction with treatment and slightly increased readiness to change than those in the other two arms (88). The importance of the latter finding is unclear, as there does not seem to be a correlation between reported readiness to change and subsequent behaviour change, specifically addictive behaviour (89, 90). West recommends asking people about their desire to change and ability to change whilst recognizing that these are affected by a range of personal and situational factors, including addiction (90).

A study by Kaner et al. (2013) supports screening and identifying problem drinkers, with simple feedback and provision of written information. Veterans with more extensive needs may require referral to specialist services.

Other substances

Why ask about other substances?

Around one third of Australians use illicit drugs at some point in their lives. Cannabis is the most commonly used, followed by ecstasy, amphetamines and cocaine. Misuse of prescription medication, especially pain medication, appears to be a growing problem amongst veterans (85).

Close to 3% of Australian Vietnam veterans experience other substance use problems in their lifetime (58). Co-morbid mental health problems are common, particularly depression, alcohol abuse, anxiety and PTSD (85).

What to do if the screen is positive

Further assessment tools, including the Drug Abuse Screening Test (DAST), and information about treatment options are available on the DVA 'At Ease' website (85).

Nutrition

Why ask about nutrition?

The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) revised their position statement on under-nutrition and older adults in 2007. The ANZSGM summarise the key findings relating to under-nutrition in older people as follows:

Under-nutrition in older people is common and the prevalence increases with increasing frailty. It is associated with poor health outcomes and increased health care costs and has a physiological basis, with reduced smell and taste contributing to decreased appetite and weight loss in older people. Non-physiological factors such as poverty, depression and isolation can be identified and managed. Nutritional supplementation has been shown to be beneficial in older, unwell (hospitalized) and under-nourished older people (91).

While older persons are at risk of debility from under-nutrition, being overweight or obese can also impact on quality of life (92). Many older people already have limited mobility, and obesity is likely to aggravate the problem and increase the risk of further functional limitation (93). A large cross-sectional study of 8966 elderly community dwellers in France (65–101 years) reported a strong association between obesity and limitations in Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL) and mobility (94). A recent systematic review and meta-analysis also reported an association between obesity and ADL in both cross-sectional and longitudinal studies (95). Reduced mobility can affect people's social lives, increase dependence on others and affect mental health (93).

Recent research suggests that for older adults, sedentary behaviour rather than BMI is the appropriate target for intervention. The effect of excess weight on comorbidities such as type 2 diabetes can also reduce the ability of older people to participate in social and physical activities (84).

The nutrition questions

The nutrition questions and scoring guidelines were sourced from the Veterans' Home Care Assessment Form as at May 2011 and include both core and supplementary items. An additional question about food security was sourced from the Australian National Health Survey 2001 - Adult Form (96).

What to do if the screen is positive

Nutritional support may include dietetic services, meal services and supplementation. Other factors such as social isolation and depression may require further assessment and referral.

As with other lifestyle behaviours, guidelines for the management of overweight and obesity in primary care (92) recommend discussion of the person's readiness to change their behaviours as part of the 5As structure; - Ask, Assess, Advise, Assist, and Arrange follow up. Further information is available at: <http://www.nhmrc.gov.au/guidelines/publications/n57>

For DVA dietetic services, telephone 1300 550 457. Nutritional supplements (if recommended by a dietician) are available via an authority prescription. Telephone the Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC) on 1800 552 580.

Physical activity

Why ask about physical activity?

The National Physical Activity Guidelines for Older Australians (97) suggest that older adults should perform some form of physical activity, suitable to their age and health status, on as many days of the week as possible. Specifically, older adults are advised to accumulate at least 30 minutes of moderate intensity physical activity on most days (98).

Evidence from two large-scale, longitudinal studies (the Australian Longitudinal Study on Women's Health involving a national sample of women born between 1921 and 1926, and the Health in Men Study involving older men from Perth), demonstrated that women may gain more benefit than men for the same level of physical activity. Being sedentary doubled the mortality risk in women across all levels of BMI, but resulted in only a one-third greater risk for men (99).

Of significance for patient education is the finding that across all levels of BMI, even low levels of physical activity are associated with lower mortality risk compared with being sedentary (99).

Definitions

- *Physical activity*: Physical activity includes everyday activities like walking to the shop or gardening through to a wide range of organised activities, such as exercise classes.
- *Moderate level physical activities*: Physical activity at a level that causes the heart to beat faster and some shortness of breath, but that you can still talk comfortably while doing (100).

The physical activity screening question in the CNAT

Smith and colleagues (101) evaluated two brief (2-3 item) physical activity assessment tools in general practice. Eligible patients were aged 18 years and older and did not have problems with mobility or dementia. Most of the patients recruited to the study (60%), were aged 55 years or less.

From the 2-item assessment tool preferred by doctors, the CNAT retains the question about the frequency of moderate-intensity physical activity. A question about the frequency of participation in vigorous activity was not included, given the age and health profile of CVC participants.

Scoring physical activity in older adults

The patient's self-reported level of physical activity needs to be interpreted in the context of the individual's health status and medical conditions as well as the national recommendations for older Australians of 30 minutes or more of moderate-intensity physical activity on most days.

Supervised physical activity (physiotherapist or exercise physiologist) may be of benefit for older people with heart, respiratory or neurological problems as well as those with moderately severe arthritis, dementia, or at high risk of falls (98). The National Heart Foundation of Australia's publication 'Physical activity recommendations for people with cardiovascular disease' (102) and physical activity algorithm for people with stable CVD (103) are useful resources.

What to do if the screen is positive

Increased physical activity may be one of the goals included in the care plan after a careful assessment of the person's ability to safely engage in increased exercise (98). As with all health-related behaviours, an assessment of the patient's preferences and readiness to act are key steps towards developing an effective intervention. Prior to

initiating an exercise program, a review by the patient's doctor is required to be sure that this can be undertaken safely. GPs may consider a referral to Heartmoves¹ or other physical activity programs designed for people who are living with health conditions. For DVA exercise physiology services, telephone 1300 550 457.

Health literacy

Why ask about health literacy?

Health Literacy is defined in the Institute of Medicine report *Health Literacy: A Prescription to End Confusion* as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (104).

Health literacy issues and ineffective communications place patients at greater risk of preventable adverse events. If a patient does not understand the implications of her or his diagnosis and the importance of prevention and treatment plans, an untoward event may occur (105). Older adults face particular challenges, as they access health services more often, have more health problems and are prescribed more medications than younger adults.

Health professionals often misjudge patients' health literacy.

The health literacy question

Chew and colleagues undertook a validation study of three screening questions for limited health literacy in a random sample of outpatients from four Veterans Administration medical centres in the USA (106). The researchers reported that each of the 3 questions was effective for detecting limited health literacy in the VA population when their performance was compared with formal health literacy assessments, including the Rapid Estimate of Adult Literacy in Medicine (REALM) and the Short Test of Functional Health Literacy in Adults (S-TOFHLA) measures.

What to do if the screen is positive

Clinicians should regularly assess adequate recall and comprehension of information to promote high quality and safe delivery of health care. Various interventions, such as simplified information and illustrations, avoiding health jargon, "teach back" methods and encouraging patients' questions, have been shown to improve health behaviors in persons with low health literacy. A useful resource for clinicians is 'Health literacy and patient safety: Help patients understand' which is available online(107).

Veterans with complex medication schedules or cognitive impairment may benefit from dose administration aids and/or personalised educational interventions such as home medicine review.

Immunisation

Why ask about immunisation?

¹ 'Heartmoves' is a low-to-moderate intensity exercise program developed by the Heart Foundation for people living with long-term health conditions such as heart disease, diabetes or obesity. Further information is available at: <http://heartmoves.heartfoundation.org.au/>

Immunisations are an important aspect of preventive care and should be up-to-date for all consenting older adults. A review of immunisations is also required for the 75+ health assessment. Questions regarding immunisations are included in the CNAT but if accurate records are kept at the veteran's general practice, these questions do not need to be asked.

Current recommendations for immunisation for older adults

Current immunisation recommendations made by the Australian Immunisation Handbook of the Department of Health (108) and listed in the most recent edition of Guidelines for Prevention in General Practice of the RACGP (25) for older adults include:

- Annual influenza vaccination in the pre-flu season months for people age 65 and above. For aboriginal people, annual influenza vaccine is recommended starting at age 15.
- Pneumococcal polysaccharide vaccination (23vPPV) for the prevention of invasive pneumococcal disease, at age 65. One dose is currently recommended except for those who have a condition that predisposes them to an increased risk of invasive pneumococcal disease (109). Special effort should be made to provide a dose to anyone aged >65 years who has not previously received a dose of 23vPPV.
- Pneumococcal vaccine is recommended to be offered to aboriginal people between age 15 and 49 for some at high risk (108). At age 50 all aboriginal people are recommended to have the 23vPPV if they have not received this earlier. Revaccination is recommended 5 years after the 1st dose for those first vaccinated at ≥50 years of age, and a further revaccination is recommended in some circumstances (108).
- Vaccination for herpes Zoster is recommended to be given once as a single dose of Zoster virus live vaccine (e.g. Zostavax) for prevention of shingles for adults aged 60 years and over (108). Vaccination can be given at the same time as influenza vaccine, using separate syringes and injection sites. Simultaneous administration of Zoster vaccine with pneumococcal polysaccharide vaccine is not routinely recommended; if possible the two vaccines should be given at least 4 weeks apart. Special consideration is required if the patient is immunocompromised or might become immunocompromised (108).
- The Australian Immunisations Handbook recommends that all adults who reach the age of 50 years without having received a booster dose of dT in the previous 10 years should receive a further tetanus booster dose. This should be given as a reduced antigen preparation formulated for adolescents and adults and to include immunisation for pertussis (dTpa,).

It should be noted that both use of dTpa and Zoster vaccine are not on the National Immunisation Program Schedule (NIPS) lists of recommended funded vaccines (25).

Care should be taken regarding giving immunisations including taking a careful history prior to given the immunisation, having an anaphylaxis response plan, maintaining a cold chain, obtaining valid consent, and pre-vaccination screening which are all described in the Australian Immunisation Handbook (108). In this handbook, a pre-screening checklist is provided which can be very useful.

Medications

Why ask about medications?

The Australian veteran population is on average 83 years of age with 5 or more chronic conditions. Recognising that this results in veterans having complex medication needs, the DVA has developed the Veterans' Medicines Advice and Therapeutics Education Services (Veterans' MATES) to assist in managing medicine use in the veteran community. Veterans' MATES provides up-to-date health and medicine information for health professionals and

veterans. A team of clinical experts contribute to the writing of this information which is specifically tailored for veterans and their health professionals (110). Recent topics include Chronic Musculoskeletal Pain, Oral Anticoagulants, Statins, Neuropathic Pain and the Diabetes Cycle of Care.

The CNAT includes questions about medication adherence, side effects and discontinued medications as well as over the counter medications. Many factors can contribute to older adults discontinuing a medication before the course of therapy is complete, or taking more or less of a medication than prescribed. Asking veterans about side effects, discontinued medications and over-the-counter medications can provide valuable information about the older person's experience, personal beliefs and preferences.

What to do if the screen is positive

Any response that indicates problems with medication adherence or management is considered a positive screen. Additionally, older adults who are taking five or more medications are considered to be at risk of adverse events (111).

Veterans who are currently taking five or more regular medicines, with significant changes to their medicine regimen within the last 3 months, including discharge from hospital, attend a number of different doctors, or who report problems in adherence or difficulty managing their medications may benefit from a Home Medicines Review (112). If this is not available, a careful review of medication use by the veteran or widow/er's GP is indicated.

A Dose Administration Aid (DAA) Service is available for veterans and war widows/widowers who hold either a Gold, White or Orange Repatriation Card, meet the criteria for a Home Medicines Review, and are likely to benefit from a DAA service. Telephone 1800 552 580

Falls

Why ask about falls?

Falls in older people are costly (from a health system perspective) and contribute to significant morbidity and mortality. Fractures of the hip are a relatively common and serious consequence of falls. Most hip fractures occur as a result of minimal trauma, such as a fall from standing height. One in three older people who survive a hip fracture return to their previous level of independence, 50% require long-term help with routine activities and cannot walk unaided, and 25% require full-time nursing-home care (113). Approximately 15-20% of patients die within 1 year of fracture.

Approximately 30% of people aged 65 years or older experience one or more falls in the last 12 months (25), however older adults may underestimate their falls risk and be resistant to falls prevention messages (114). The RACGP recommends falls screening for people aged 65 years and older (25).

The screening questions in the CNAT were adapted from Zijlstra and colleagues (115). The word "fall" was defined and a question about injury was added in order to assess the severity of fall(s).

What to do if the screen is positive

A history of 2+ falls in the previous year and taking 6 or more medications is predictive of future falls. If the patient reports falls, or fear of falling, consider a referral for a **HomeFront** environmental assessment and/or balance and gait testing. Explore potential hazards inside and outside the home that could put them at risk of a fall.

HomeFront is a falls prevention program that assists veterans and war widows/widowers to maintain independent living in their own homes. DVA Gold and White card holders are eligible for a free annual home assessment to identify and minimise hazards that could cause injury. Telephone 1800 801 945

DVA physiotherapy services can be arranged by calling 1300 550 457.

The 'Guidelines for preventive activities in general practice, 8th edition' (25) provides the following recommendations for older adults who screen positive to one or more of the following screening criteria: two or more falls in the past 12 months, present following a fall, or report having difficulty with walking or balance.

- obtain relevant medical history, complete a physical examination, and perform cognitive and functional assessments
- determine multifactorial fall risk :
 - history of falls
 - multiple medications, and specific medications (e.g. psychotropic medications, opiate-containing analgesic agents)
 - impaired gait, balance and mobility
 - impaired visual acuity, including cataracts
 - issues with bifocal or multifocal spectacle use
 - reduced visual fields
 - other neurological impairment
 - muscle weakness
 - cardiac dysrhythmias
 - postural hypotension
 - foot pain and deformities and unsafe footwear
 - home hazards
 - vitamin D deficiency

Activities of daily living

Why ask about activities of daily living?

The term "activities of daily living," or ADLs, refers to the basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring. When people are unable to perform these activities, they require assistance from others and/or technical aids.

Dependence occurs when the adaptation of the environment or the use of technical aids cannot compensate disability and the help of a third person is needed to carry out activities of daily living. Dependence is the main factor which impacts on health and quality of life, not only for the older person but also for carers (116).

Many older persons experience difficulties in performing one or more ADLs and the prevalence of ADL problems rises steeply for persons aged 85 and over (117). An assessment of ADLs is a required element of the 75+ health assessment.

What to do if the screen is positive

Problems in performing activities of daily living may require a review or adjustment of the care plan.

Assistance with ADLs, including home modifications and technical aids, is provided to eligible members of the veteran community through a range of DVA services. These include community nursing, allied health services, for

example physiotherapy and podiatry, counselling services, transport for health care, home modifications and appliances through the Rehabilitation Appliances Program (RAP) and the HomeFront falls and accident prevention program.

Veterans' Home Care (VHC) is designed to assist those veterans and war widows/widowers who wish to continue living at home, but who need a small amount of practical help. Domestic assistance, personal care, safety-related home and garden maintenance, and respite care is available (118).

The Rehabilitation Appliances Program (RAP) provides aids and appliances to eligible members of the veteran community to help them maintain functional independence in their homes. Product groups include continence, mobility and functional support, home medical oxygen, diabetes, personal response systems and continuous positive airway pressure (CPAP). Further information is available on the DVA website (119).

Instrumental activities of daily living

Why ask about instrumental activities of daily living?

ADLs are defined as those activities essential for an independent life, while performing IADLs – using the telephone, shopping and preparing meals, managing medications and finances, transport and housekeeping - are more complex tasks. IADLs require decision-making capacity as well as a greater interaction with the environment (116). Based on these differences, deficits in IADL normally precede deficits in ADL (120).

What to do if the screen is positive

Some of the DVA services described in 2.19 can compensate for problems with IADLs. Interventions should be tailored to the specific needs of the individual and may include a broad range of health services and supports for independent living. Treatment of chronic pain and occupational therapy to improve fine motor skills, for example, may increase independence in a range of self-care and instrumental tasks. Dental treatment, dose administration aids and other pharmaceutical services, optometry and hearing services and speech pathology are other interventions that can enhance functional status, independence and quality of life. Information about a broad range of health care and support services is available on the DVA website (121).

Continence

Why ask about continence?

Incontinence affects 1 in 10 Australians over the age of 75. Women who are overweight and people with diabetes, stroke, heart conditions, neurological disorders, recent surgery, respiratory conditions, and prostate problems are at high risk of continence problems.

Urinary incontinence affects approximately 38% women and 10% of men and can affect people's quality of life (122) and social participation.

A study conducted by St John and colleagues reported that “clients want good information about urinary incontinence and the prognosis of their condition. They also need an opportunity to discuss their feelings about their condition, the burden it creates in their daily lives, how they feel about themselves and better ways to self-manage” (123, p. 2).

Incontinence also has an impact on the wellbeing of carers. A greater proportion of carers who assist with managing another person's incontinence, report a change in their physical or emotional wellbeing, weariness and lack of

energy, or frequent worry or depression due to their caring role, compared with carers who do not assist with managing another person's incontinence (124).

What to do if the screen is positive

Further assessment should be considered if the screen is positive. The Revised Faecal Incontinence Scale (125) and the Revised Urinary Incontinence Scale (126) have been validated in the Australian population (127) and are available online. Referral to a continence practitioner is recommended if screening using the RFIS or RUIS is positive.

Resources for health professionals

A 2007 resource developed as part of the National Continence Management Strategy and entitled '... What now? Helping clients live positively with urinary incontinence' describes practical strategies for people living with continence problems. The resource is available on the Department of Health and Ageing website (123).

The DVA provides a range of continence products to eligible members of the veteran community through the Rehabilitation Appliances Program (RAP), telephone 1300 550 457

The Continence Foundation of Australia (CFA) provides a team of continence nurse advisors providing free, confidential advice about bladder and bowel control, plus local referrals, a range of leaflets and product information. A nationwide service for people of all ages with incontinence, their carers, parents and families, clinicians, pharmacists, allied health professionals and the wider community. Australia-wide free call 1800 33 00 66.

Summary page

Some clinicians find it useful to prepare a quick summary of the assessment so that they can quickly see what follow-up actions are required. The CNAT provides a summary sheet for this purpose.

Summary: what to do if a screen is positive

The Discipline of General Practice has developed a quick reference guide for clinicians that summarises key actions and considerations for veterans who screen positive on one or more of the assessment items in the CNAT. The quick reference guide provides hyperlinks to some of the references that are cited in this document.

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