Coordinated Veterans' Care (CVC) Toolkit
Questionnaires for use in a comprehensive needs assessment

This resource is a guide to conducting a comprehensive needs assessment for the Coordinated Veterans' Care (CVC) Program. It provides direction to four assessment tools (available in the Appendices) which are to be completed with the veteran:

- Partners in Health (PIH) Scale to assess self-management of chronic diseases / conditions
- Kessler 10 (K 10) to assess anxiety and depression.
- SNAP Assessment (Smoking, Nutrition, Alcohol, Physical Activity) optional to assess lifestyle risk factors.
- A Comprehensive Health Needs Assessment Tool (CNAT) for older veterans.

The Department of Veterans' Affairs (DVA) strongly recommends the use of the questionnaires in the CVC Toolkit to assist general practitioners (GPs), practice nurses or Aboriginal health workers to complete a needs assessment.

The second stage of the CVC Program is to develop a Care Plan, or update an existing Care Plan, incorporating self-management information gathered during the needs assessment. Preparing this Care Plan will require other tools as it is an extended version of a General Practitioner Management Plan (GPMP), which is an existing Repatriation Medical Fee Schedule (RMFS) item and is billed as a separate service to the CVC items.

Needs assessment and care planning

The Care Plan provides for medical management to be incorporated with self-management over a 12 month period. This can be integrated with the existing medical Care Plan. It creates a partnership between health care provider and veteran, in which the veteran is the decision maker and the health care provider is facilitator, coach and advisor. This assessment and care planning approach is generic (i.e. can be applied to any single or multiple chronic condition/s). It is based on the seven principles of self-management identified below:

1. Have knowledge of your condition;
2. Follow a treatment plan (Care Plan) agreed with your health professionals;
3. Actively share in decision making with your health professionals;
4. Monitor and manage signs and symptoms of your condition;
5. Manage the impact of the condition on your physical, emotional and social life;
6. Adopt lifestyles that promote health; and
7. Have confidence, access and the ability to use support services.

The CVC Program consists of a set of tools that are completed by both the veteran and the health care professional, working together as a team. These needs assessment and care planning tools provide a formal, systematic approach to assessing self-management capacity and care planning. The tools for the CVC program include:

- Partners In Health Scale
- Cue and Response Interview
- Problem and Goals Assessment (and Problem and Goals Monitoring Record).

CVC Program Care Plan templates for a comprehensive and patient friendly version of a care Plan have been developed incorporating the self-management.

Care planning process and tools to meet the CVC Program requirements are covered fully in Module Two Care Planning and Coordination with the CVC Program. The four education and training modules are available online. Module One and Two are also available in hardcopy formats. For details go to http://cvceducationresources.dva.gov.au .

Prior to conducting the needs assessment

Before the needs assessment is conducted, the GP will have used the following to assess the veteran's eligibility for the Program for current Gold Card holders:

- Who are living in the community (not in a residential aged care facility);
- Who have been diagnosed with one or more chronic diseases or conditions, especially:
  - Congestive heart failure
  - Coronary artery disease
  - Pneumonia
  - Chronic obstructive pulmonary disease and
  - Diabetes
- Who have been, or are at risk of being admitted or readmitted to hospital;
- Who have complex care needs; and
- Who meet all the eligibility criteria for the CVC Program.

For more detail on the eligibility criteria go to
http://www.dva.gov.au/HEALTH_AND_WELLBEING/HEALTH_PROGRAMS/CVC/Pages/default.aspx

Conducting the needs assessment

Where the practice nurse or Aboriginal health worker is the care coordinator, DVA recommends that the care coordinator:

- Conducts the needs assessment either at the practice or preferably in the patient's home and
- Works with the GP on the preparation of the plan.

Where a GP has arranged for a community nurse to be the care coordinator, the GP will conduct the needs assessment.

Supporting the assessment process

Setting the scene:

- Explain that the veteran's completion of the questionnaires will provide useful information to help you prepare their Care Plan and their agreed health goals.
- 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.

- Explain that, in the first instance, the information will be used for individual treatment planning and may also be used in a de-identified form for service development and research activities.

Supporting the veteran during the assessment:

- Stress there is no right or wrong answer and the importance of filling out the questionnaires including filling out all unanswered questions;
- Do not answer the questions for the veteran or tell them how you feel they should answer;
- Provide basic assistance in reading the questions or circling responses, if the veteran requests this; inform them that they may be asked to fill out the questionnaires again at a later date.

Where a veteran wants to participate in the CVC Program but will not complete the questionnaires, alternative means of assessing their needs can be used.

Needs assessment tools

Partners in Health

The Partners in Health Scale is a questionnaire that is based on the principles of self-management. The veteran completes the questionnaire by assessing his or her self-management skills and scoring their response to each question on a nine point scale, zero being the worst response and eight being the best.

Refer to Appendix A for blank Partners in Health Scale. Appendix B contains an example of a completed Partners in Health Scale based on the case study of Roger. Access the online training to read Roger's full case study http://cvceducationresources.dva.gov.au .

Kessler 10

The Kessler 10 is an internationally validated tool for assessing mental health and wellbeing and is an effective tool for detecting depression and anxiety which can often be overlooked in primary health care settings. This is especially so for veterans with complex health and social needs which may overshadow an underlying mental health condition.

Refer to Appendix C for a blank K 10 questionnaire.

The SNAP Assessment (Smoking, Nutrition, Alcohol, Physical Activity) - optional

The SNAP assessment is designed to assist general practitioners and practice staff to work with veterans on the lifestyle risk factors of Smoking, Nutrition, Alcohol and Physical activity. These risk factors may be important to assess in patients, in particular those with complex health and social needs, which may have an adverse impact on these lifestyle issues.

A Comprehensive Health Needs Assessment Tool (CNAT) for older veterans

The CNAT is a health assessment for older veterans developed by Professor Richard Reed from Flinders University. It focuses on health problems more frequently identified in older veterans and their spouses. It will generally be most applicable to veterans aged 60 and over.

Links to these resources are provided in Appendix D & E.

The CVC Program training modules include the case study of Roger

Roger is an 82 year old married veteran with type 2 diabetes and heart disease who lives with his wife. He has high cholesterol, high blood pressure, obesity, low activity levels, a poor diet and smokes. He complains of tiredness and lack of support around the management of his diabetes.

UR No:	.....
Name:	.....
DOB	.....
Date:	.....

Affix Veteran Identification Label Here.

APPENDIX A: PARTNERS IN HEALTH SCALE

Person with the Chronic Health Condition to Complete
Please circle the number that most closely fits for you

1 Overall, what I know about my health condition(s) is:

0	1	2	3	4	5	6	7	8
Very little				**Something**				**A lot**

2 Overall, what I know about my treatment, including medications of my health condition(s) is:

0	1	2	3	4	5	6	7	8
Very little				**Something**				**A lot**

3 I take medications or carry out the treatments asked by my doctor or health worker:

0	1	2	3	4	5	6	7	8
Never				**Sometimes**				**Always**

4 I share in decisions made about my health condition(s) with my doctor or health worker:

0	1	2	3	4	5	6	7	8
Never				**Sometimes**				**Always**

5 I am able to deal with health professionals to get the services I need that fit with my culture, values and beliefs:

0	1	2	3	4	5	6	7	8
Never				**Sometimes**				**Always**

6 I attend appointments as asked by my doctor or health worker:

0 1 2 3 4 5 6 7 8

Never **Sometimes** **Always**

7 I keep track of my symptoms and early warning signs (e.g. blood sugar levels, peak flow, weight, shortness of breath, pain, sleep problems, mood):

0 1 2 3 4 5 6 7 8

Never **Sometimes** **Always**

8 I take action when my early warning signs and symptoms get worse:

0 1 2 3 4 5 6 7 8

Never **Sometimes** **Always**

9 I manage the effect of my health condition(s) on *my physical activity* (i.e. walking, household tasks):

0 1 2 3 4 5 6 7 8

Not very well **Fairly well** **Very well**

10 I manage the effect of my health condition(s) on *how I feel* (i.e. my emotions and spiritual wellbeing):

0 1 2 3 4 5 6 7 8

Not very well **Fairly well** **Very well**

11 I manage the effect of my health condition(s) on *my social life* (i.e. how I mix with other people):

0 1 2 3 4 5 6 7 8

Not very well **Fairly well** **Very well**

12 Overall, I manage to live a healthy life (e.g. no smoking, moderate alcohol, healthy food, regular physical activity, manage stress):

0 1 2 3 4 5 6 7 8

Not very well **Fairly well** **Very well**

Appendix B: 'Roger's' completed Partners in Health scale

Question	Comment, including recommended intervention or self-management strategy	Circled
1. Knowledge of condition(s):	Some understanding only of diabetes & heart disease INTERVENTION: GP; diabetes educator; Chronic Disease Self-Management Course (CDSM -Stanford).	**4**
2. Knowledge of treatment:	Limited understanding of medications INTERVENTION: GP; provide handout; diabetes educator.	**2**
3. Management of medications & treatment:	Takes medication as asked. Doesn't understand how medications help. INTERVENTION: GP; pharmacist; diabetes educator; CDSM course.	**4**
4. Ability to share in decisions:	Agrees with health professional. Doesn't ask a lot of questions. INTERVENTION: Nurse to coach veteran to ask questions of GP & other health professionals.	**4**
5. Ability to access services:	Doctor not far away.	**6**
6. Ability to attend appointments:	Reasonable, usually arranges & attends appointments.	**6**
7. Ability to monitor symptoms:	Takes blood sugar recordings intermittently with limited understanding of why he should measure. INTERVENTION: GP; CDSM course; educator; Monitoring Diary.	**2**
8. Ability to follow recommended actions:	Often does not take appropriate action. INTERVENTION: Encourage wife to attend diabetes update course; diabetes educator; Symptom Action Plan. Coping Strategies Stanford course.	**4**
9. Ability to manage the impact of the condition on physical activity:	Very tired, sits a lot & dozes. Also has had increasing difficulties cutting toenails. INTERVENTION: podiatrist; relaxation tapes or course.	**3**
10. Ability to manage the impact of the condition on emotions & spiritual well-being:	Feeling depressed. INTERVENTION: GP assess depression; *BeyondBlue* materials.	**3**
11. Ability to manage the impact of the condition on social aspects of life:	Not getting out much, would like to have more energy & time. INTERVENTION: Assist with re-connection with veterans groups; discuss social activities that he can recommence.	**3**
12. Progress towards adopting habits that improve my health & quality of life:	Not willing to discuss diet, exercise or smoking at this point. INTERVENTION: Review later - query use Motivational Interviewing.	**0**

Appendix C: Kessler 10 (K 10)

The Kessler 10 is an internationally validated tool for assessing mental health and wellbeing and is an effective tool for detecting depression and anxiety which can often be overlooked in primary health care settings. This is especially so for veterans with complex health and social needs which may overshadow an underlying mental health condition. For each item, there are five response options which are based on the frequency with which the respondent experienced the particular problem. After summing the scores across the 10 items, the range of possible scores on the K 10 is 10 to 50, with a low score indicating no or low psychological distress and a high score indicating high distress.

The approach used most often for national surveys (such as the National Health surveys and the National Drug Strategy Household Survey) is to group scores into four categories:

- Low (score of 10 to 15);
- Moderate (score of 16 to 21);
- High (score of 22 to 29); and
- Very high (score of 30 to 50).

It is important that those veterans who score within the moderate to high range are supported to seek a mental health assessment, to be undertaken by the general practitioner or mental health professional, particularly if there is suicidal ideation present. It is generally accepted that those scoring very high are likely to have a severe mental illness and should seek prompt professional help.

Direct permission for use of the Kessler 10 for the CVC Program is provided by Professor Ronald C Kessler of the Department of Health Care Policy, Harvard Medical School who we thank and acknowledge for the development of this tool. 25/04/2011

Notes for the Health Professional

This is a questionnaire for veterans to complete. It is a measure of psychological distress. The numbers attached to the veterans 10 responses are added up and the total score is the score on the Kessler Psychological Distress Scale (K10). Scores will range from 10 to 50. People seen in primary care who

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

13% of the adult population will score 20 and over and about 1 in 4 veterans seen in primary care will score 20 and over. This is a screening instrument and practitioners should make a clinical judgement as to whether a person needs treatment. Scores usually decline with effective treatment. Veterans whose scores remain above 24 after treatment should be reviewed and specialist referral considered.

References:

Kessler R, Andrews G, Colpe L, Hiripi E, Mroczek D, Normand S, Walters E, Zaslavsky A (2002) Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*, 32, 959-956.

Andrews G, Slade T (2001) Interpreting scores on the Kessler Psychological Distress Scale (K10). *Australian and New Zealand Journal of Public Health*, 25, 494-497.

Kessler 10: These questions concern how you have been feeling over the past 4 weeks. Circle the option that best represents how you have been.

1. In the past four weeks, about how often did you feel tired out for no good reason?

1	2	3	4	5
None of the time	A little of the time	Some of the time	Most of the time	All of the time

2. In the past four weeks, about how often did you feel nervous?

1	2	3	4	5
None of the time	A little of the time	Some of the time	Most of the time	All of the time

3. In the past four weeks, about how often did you feel so nervous that nothing could calm you down?

1	2	3	4	5
None of the time	A little of the time	Some of the time	Most of the time	All of the time

4. In the past four weeks, about how often did you feel hopeless?

1	2	3	4	5
None of the time	A little of the time	Some of the time	Most of the time	All of the time

5. In the past four weeks, about how often did you feel restless or fidgety?

1	2	3	4	5
None of the time	A little of the time	Some of the time	Most of the time	All of the time

6. In the past four weeks, about how often did you feel so restless that you could not sit still?

1	2	3	4	5
None of the time	A little of the time	Some of the time	Most of the time	All of the time

7. In the past four weeks, about how often did you feel depressed?

1	2	3	4	5
None of the time	A little of the time	Some of the time	Most of the time	All of the time

8. In the past four weeks, about how often did you feel that everything was an effort?

1	2	3	4	5
None of the time	A little of the time	Some of the time	Most of the time	All of the time

9. In the past four weeks, about how often did you feel so sad that nothing could cheer you up?

1	2	3	4	5
None of the time	A little of the time	Some of the time	Most of the time	All of the time

10. In the past four weeks, about how often did you feel worthless?

1	2	3	4	5
None of the time	A little of the time	Some of the time	Most of the time	All of the time

Appendix D: SNAP Assessment

The SNAP Assessment (Smoking, Nutrition, Alcohol, Physical Activity)

The SNAP assessment is designed to assist general practitioners and practice staff to work with veterans on the lifestyle risk factors of Smoking, Nutrition, Alcohol and Physical activity. These risk factors may be important to assess in patients, in particular those with complex health and social needs, which may have an adverse impact on these lifestyle issues.

Many general practice settings will already be familiar with assessment tools within each risk factor domain and the five main roles for assisting veterans (adapted from the 5As approach developed by the US Department of Health) which are similar across all SNAP risk factors:

Ask **(1)** identify patients with risk factors

Assess **(2)** level of risk factor, its relevance to the individual in terms of health readiness to change /motivation

Advise **(3)** provide written information and a lifestyle prescription, brief advice and motivational interviewing

Assist **(4)** with pharmacotherapies and support for self-monitoring

Arrange **(5)** referral to special services social support groups, phone information / counselling services and follow up with the GP.

For more information, and to download the *RACGP SNAP Guidelines 2004*, go to:

http://www.racgp.org.au/your-practice/guidelines/snap/

Appendix E: CNAT

A Comprehensive Health Needs Assessment Tool (CNAT) for older veterans

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.

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. This assessment is primarily intended to occur in the home but could be modified to the clinical setting if required.

For more information and to download the CNAT, Quick Reference Guide and Reference Manual go to: http://fjnvpucvcprog01.acu.edu.au/?page_id=1980