SICHC

To: **Our Medicare Patients**

Subject: **Medicare Annual Wellness and Other Preventive Visits**

Beginning January 1, 2011, Medicare covers an "Annual Wellness Visit" in addition to the one-time "Welcome to Medicare" exam. The "Welcome to Medicare" exam occurs only once during your first twelve months as a Medicare patient. You may receive your "Annual Wellness Visit" after you have been with Medicare for more than one year, or it has been at least on year since your "Welcome to Medicare" exam.

Initial Preventive Physical Exam (IPPE)	"Welcome to Medicare" is only for NEW Medicare patients. This must be done in the 1st year as a Medicare patient.
Annual Wellness Visit, Initial	At least 1 year after the "Welcome to Medicare" exam.
Annual Wellness Visit, Subsequent	Once a year (more than 1yr + 1 day after the last Wellness visit).

The Annual Wellness Visit is not the same thing as what many people refer to as their yearly physical exam. Medicare is very specific about the "Annual Wellness Visit" includes and excludes.

At the Annual Wellness Visit, your doctor will talk to you about your medical history, review your risk factors, and make a personalized prevention plan to keep you healthy. The visit does NOT include a hands-on exam or any test that your doctor may recommend, nor does it include any discussion about any new or current medical problems, conditions, or medications. You may schedule another visit to address those issues or your doctor may charge the usual Medicare fees for such services that are beyond the scope of the Annual Wellness Visit.

If you would like to schedule an Annual Physical, including any lab work or other diagnostic testing, medication management, vaccinations, and other services, please understand that these will be charged and covered according to Medicare's usual coverage guidelines. However, you may still develop a care plan based on the Annual Wellness Visit criteria.

We appreciate the trust you put in us to take care of your health care needs and hope that you will take advantage of this new benefit to work with your physician in creating your personalized prevention plan.

See the attached list to bring with you to your appointment.

WHAT YOU SHOULD BRING WITH YOU TO YOUR APPOINTMENT:

The names of all of your doctors:

Name	Specialty

A list of all your medications:

Name of Medication	Dosage

Have any of your close relatives had any health changes? ____ Yes ____ No

Has your mood changed? ____ Yes ____ No

Do you worry about falling? ____ Yes ____ No

Are you worried about your memory? ____ Yes ____ No

Are there any preventive tests you have had done recently? ____ Yes ____No
(such as lab tests, mammograms, x-rays)

Have you had any recent immunizations? ____ Yes ____No

Do you have a living will or advance directive? ____ Yes ____ No
(If you have one, *please bring a copy of it with you.*

Name: _____ Date: _____ Date of Birth: _____

A Checklist for Your Medicare Annual Wellness Visit

Please complete this checklist before seeing your doctor or nurse practitioner. Your answers will help you receive the best health care possible.

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

2. During the past 4 weeks, has your physical and emotional health limited your social activities with family, friends, neighbors or groups?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

3. During the past 4 weeks, how much bodily pain have you generally had?
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain

4. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.
   - ☐ Yes, as much as I wanted
   - ☐ Yes, quite a bit
   - ☐ Yes, some
   - ☐ Yes, a little
   - ☐ No, not at all

5. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
   - ☐ Very Heavy
   - ☐ Heavy
   - ☐ Moderate
   - ☐ Light
   - ☐ Very Light

	Yes	No
6. Can you get places out of walking Can you travel alone, by bus, taxi, or Drive your own car?		
7. Can you shop for groceries or Clothes without help?		
8. Can you prepare your own meals?		
9. Can you do your own housework Without help?		
10. Can you handle your own money Without help?		
11. Do you need help feeding yourself, Bathing, dressing, or getting around Your home?		

12. During the past 4 weeks, how would you rate your health in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

13. How have thing been going for you during the past 4 weeks?
   - ☐ Very well- could hardly be better
   - ☐ Pretty good
   - ☐ Good and bad parts about equal
   - ☐ Pretty bad
   - ☐ Very bad- could hardly be worse

14. Are you having difficulties driving your car?

☐ Yes, often
☐ Sometimes
☐ No
☐ Not applicable, I do not use a car

15. Do you always fasten your seat belt when you are in a car?

☐ Yes, usually ☐ Yes, sometimes ☐ No

16. How often during the past 4 weeks, have you been bothered by any of the following problems?

	NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS
Fall or dizzy when standing up					
Sexual problems					
Trouble eating well					
Teeth or dentures					
Problems using the phone					
Tired or fatigue					

17. Have you fallen 2 or more times in the past year?

☐ Yes ☐ No

18. Are you afraid of falling?

☐ Yes ☐ No

19. Are you a smoker or do you chew tobacco?

☐ Yes ☐ No

20. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you consume?

☐ 10 or more per week
☐ 6-9 per week
☐ 2-5 per week
☐ 1 drink or less per week
☐ No alcohol at all

21. Do you exercise for about 20 minutes 3 or more days per week?

☐ Yes, most of the time
☐ Yes, some of the time
☐ No, I usually do not exercise this much

22. Have you been given any information to help you with the following:

- Hazards in your house that might hurt you?

☐ Yes ☐ No

- Keeping track of your medications?

☐ Yes ☐ No

23. How often do you have trouble taking your medications the way you have been told to take them?

☐ I do not take any medications
☐ I always take them as prescribed
☐ Sometimes I take them as prescribed
☐ I seldom take them as prescribed

24. How confident are you that you can control and manage most of your health problems?

☐ Somewhat confident
☐ Not very confident
☐ Very confident
☐ I do not have any health problems

How old are you?
☐ 65-69 ☐70-79 ☐ 80 or older

Are you ☐ Male or ☐ Female?

What is your race? (check one or more)
☐ White
☐ Black/African American
☐ Asian
☐Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaskan Native
☐ Hispanic or Latino origin or descent
☐ Other

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME_____DATE_____

Instructions: How often have you been bothered by each of the following symptoms **during the past 2 weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half The Days	(3) Nearly Every Day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, feeling that you are a failure, or that you have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more Than usual				
Thoughts that you would be better off dead, or of hurting yourself				

. If you checked off **any problems**, how **difficult** Have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all** _____ **Somewhat difficult**_____ **Very difficult** _____ **Extremely difficult** _____

TRAUMA TOOL: HOME SAFETY CHECKLIST

Because older adults most often fall at home, PREVENTION is the key. Perform the home safety review below to discover how safe your loved one's home really is. The suggested small changes can greatly reduce risk—and help keep your parent or family member healthy and independent longer.

	NO	YES	WHAT TO DO IF "YES" WAS CHECKED
IN EACH ROOM:			
Do you have to walk around furniture?			Move furniture so that there are clear paths.
Are there throw rugs on the floor?			Remove throw rugs or use non-slip backing. Throw rugs are often tripped over, and lead to falls.
Are there papers, books, magazines, shoes or other items on the floor?			Pick up things on the floor. Always keep the floor clear.
Are there wood floors?			Wear shoes or slippers (not just socks) to prevent slipping on the floor. Avoid the use of 'slip on' shoes.
Do you have to walk around wires or cords?			Coil or tape cords and wires along the wall so that you won't trip over them. Consider adding an electrical outlet.
STAIRS AND STEPS:			
Is the light missing over the stairway?			Replace bulbs or place a lighting fixture over staircases. Stairs are a common place to fall.
Is there only one light switch for the stairs? Either at the top or the bottom?			Have an electrician put in a light switch that can be used from the top or the bottom of the stairs. Consider a switch that glows.
Do doors at the top of the stairs open inward, to the staircase?			Doors at staircases should open outward into the hall/room and not the stair. If it does not, consider remounting the door.
Is the carpet loose or torn?			Make sure the carpet is firmly attached to every step.
Is the handrail missing for any length of the staircase?			Install a handrail the length of the whole staircase. Consider use of a handrail on each side of the staircase.
BATHROOM:			
Are there no grab bars in the tub/shower area?			Install one or two grab bars in the tub/shower area.
Is the tub or shower slippery?			Install a non-slip rubber mat or self-stick strips in the tub or shower area.
Is the room dark at night?			Use of a night light can reduce the risk of falling.