Medicare Annual Wellness Visit Patient Questionnaire

Patient Name:_____ D.O.B: ____/_____/_____
Date of Visit: _____ Account #:_____

List of Supplements:

Name	Dose	Reason for taking

List all of other providers/ Specialists you see:

Doctor's Name	Specialty	Phone Number

Preventative Screening: Please circle yes or no as appropriate.

Do you have trouble hearing?	☐Yes ☐No
Do you wear a hearing aid?	☐Yes ☐No
Do you have trouble seeing?	☐Yes ☐No
Do you wear glasses?	☐Yes ☐No
Do you wear contact lenses?	☐Yes ☐No
Do you smoke? If yes, have you tried to quit? Yes/ No	☐Yes ☐No
Do you drink alcohol? If *yes*, how much alcohol intake and do you want to quit?	Yes ☐No

When was your last visit with an optometrist or ophthalmologist?
_____

Do you have an Advanced Directive (Living Will)? Yes/No

Name of your Power of Attorney:
_____

Routine Tasks; Please indicate if you do or do not need help performing the following by circling yes or no.

		If yes, list the person who helps you:
Feeding yourself	☐Yes ☐No	
Getting from bed to chair	☐Yes ☐No	
Getting to toilet	☐Yes ☐No	
Getting dressed	☐Yes ☐No	
Bathing or Showering	☐Yes ☐No	
Walking across the room (includes using cane/ walker)	☐Yes ☐No	
Using the telephone	☐Yes ☐No	
Taking your medications	☐Yes ☐No	
Preparing meals	☐Yes ☐No	
Managing money (keeping track/paying bill, etc.)	☐Yes ☐No	
Moderately strenuous homework (laundry, etc.)	☐Yes ☐No	
Shopping for personal items like toiletries or meds	☐Yes ☐No	
Shopping for groceries	☐Yes ☐No	
Driving	☐Yes ☐No	
Climbing a flight of stairs	☐Yes ☐No	

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite —being so figety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or of hurting yourself	☐ 0	☐ 1	☐ 2	☐ 3
Add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. 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 _____

Health-Related Social Needs Assessment

Patient Name:_____DOB:_____Date:_____

Living Situation

1. **What is your living situation today?** [1]

   ☐ I have a steady place to live (0)

   ☐ I have a place to live today, but I am worried about losing it in the future (1)

   ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) (2)

2. **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?**

   ☐ No (0)
   ☐ Yes (1)
   ☐ Already shut off (2)

Food

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**[2]

   ☐ Never true (0)
   ☐ Sometimes true (1)
   ☐ 0 Often true (2)

Transportation

4. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**[3]

   ☐ No (0)
   ☐ Yes (1)

Mental Health

5. How often do you feel lonely or isolated from those around you?

- ☐ Never (0)
- ☐ Rarely (1)
- ☐ Sometimes (2)
- ☐ Often (3)
- ☐ Always (4)

6. Over the past 2 weeks, how often have you been bothered by any of the following problems?[4]

a. Little interest or pleasure in doing things?

- ☐ Not at all (0)
- ☐ Several days (1)
- ☐ More than half the days (2) □
- ☐ Nearly every day (3)

b. Feeling down, depressed, or hopeless?

- ☐ 0 Not at all (0)
- ☐ Several days (1)
- ☐ More than half the days (2)
- ☐ Nearly every day (3)

Please forward completed assessments with a score of 3 or more to your identified Care Coordination Team for further screening.

Risk Level	Score
Low Risk	0 - 7
Moderate risk	8 - 12
High Risk	13 - 17

[1] National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Aslan Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http: // www.nachc.org/research-and-data/ p rapare/

[2] Hager, E. R., Qulgg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-ltem Screen to Identify Families at Risk for Food Insecurity, Pediatrics, 126(1), 26-32. dol:10.1542/peds.2009-3146

[3] National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Aslan Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE.

[4] Kroenke, K., Spitzer, R. L, & Williams, J. B. (2003). The Patient Health Questionnalre-2: validity of a two-item depression screener. Medical Care, 41(11), 1284-1292.

The above questions represent a subset of screening questions In the Accountable Healthy Communities HRSN Screening Tool developed by Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI).

Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial	Date of Birth	☐ Male ☐ Female

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician, nurse practitioner (NP), or physician assistant (PA) must accurately and legibly complete the form and then sign and date it. The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient, if any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

_____ the patient; or

_____ the patient's health care agent as named in the patient's advance directive; or

_____ the patient's quardian of the person as per the authority qranted bv a court order: or

_____ the patient's surrogate as per the authority granted by the Heath Care Decisions Act; or

_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

_____ instructions in the patient's advance directive: or

_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

_____ Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary. If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

1	**CPR (RESUSCITATION) STATUS:** EMS providers must follow the Maryland Medical Protocols for EMS Providers. _____ **Attempt CPR:** If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function. [If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]
	No CPR, Option A, Comprehensive Efforts to Prevent Arrest: Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally. _____ **Option A-1, Intubate:** Comprehensive efforts may include intubation and artificial ventilation. _____ **Option A-2, Do Not Intubate (DNI):** Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.
	_____ **No CPR, Option B, Palliative and Supportive Care**: Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSCIAN ASSISTANT (Signature and date are required to validate order)		
Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date
Patient's Last Name, First, Middle Initial	Date of Birth	☐ Male ☐ Female

Orders in Sections 2-9 below do not apply to EMS providers and are for situations other than cardiopulmonary arrest. Only complete applicable items in Sections 2 through 8, and only select one choice per applicable Section.

2 — ARTIFICIAL VENTILATION

2a. _____ May use intubation and artificial ventilation indefinitely, if medically indicated.

2b. _____ May use intubation and artificial ventilation as a limited therapeutic trial.
Time limit _____

2c. _____ Mav use onlv CPAP or BiPAP for artificial ventilation, as medicallv indicated.
Time limit_____

2d. _____ Do not use any artificial ventilation (no intubation, CPAP or BiPAP)

3 — BLOOD TRANSFUSION

3a. _____ May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated

3b. _____ Do not give any blood products

4 — HOSPITAL TRANSFER

4a. _____ Transfer to hospital for any situation requiring hospital-level care.

4b. _____ Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise.

4c. _____ Do not transfer to hospital, but treat with options available outside the hospital.

5 — MEDICAL WORKUP

5a. _____ Mav perform anv medical tests indicated to diagnose and/or treat a medical condition.

5b. _____ Onlv perform limited medical tests necessary for symptomatic treatment or comfort

5c. _____ Do not perform anv medical tests for diagnosis or treatment

6 — ANTIBIOTICS

6a. _____ May use anllbiotics (oral, intravenous or intramuscular) as medically indicated.

6b. _____ Mav use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics.

6c. _____ Mav use oral antibiotics onlv when indicated for symptom relief or comfort.

6d. _____ Do not treat with antibiotics

7 — ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION

7a. _____ Mav give artificially administered fluids and nutrition, even indefinitely, if medically indicated.

7b. _____ Mav give artificiallv administered fluids and nutrition, if medically indicated, as a trial.
Time limit_____

	7c. _____Mav give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition. Time limit_____	7d._____ Do not provide artificiallv administered fluids or nutrition.
8	**DIALYSIS** 8a. _____Mav qive chronic dialvsis for end-stage kidney disease if medically indicated.	8b. _____Mav give dialysis for a limited period. Time limit_____ 8c._____Do not provide acute or chronic dialysis.
9	**OTHER ORDERS** _____ _____ _____ _____ _____	

SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

INSTRUCTIONS

Completing the Form: The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. Use Section 9 to document any other orders related to life-sustaining treatments. The order form is not valid until a physician, NP, or PA signs and dates it. Each page that contains orders must be signed and dated. A copy or the original of every completed MOLST form must be given to a competent patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

Selecting CPR (Resuscitation) Status: EMS Option A-1 - Intubate, Option A-2 - Do Not Intubate, and Option B include a set of medical interventions. You cannot alter the set of interventions associated with any of these options and cannot override or alter the interventions with orders in Section 9.

- **No-CPR Option A; Comprehensive Efforts to Prevent Cardiac and/or Respiratory Arrest IDNR if Arrest - No CPR. This choice may be made either with or without intubation as a treatment option.** Prior to arrest, all interventions allowed under The Maryland Medical Protocols for EMS Providers. Depending on the choice, intubation may or may not be utilized to try to prevent arrest. Otherwise, CPAP or BiPAP will be the only devices used for ventilatory assistance. In ail cases, comfort measures will also be provided. No CPR if arrest occurs.

- **No-CPR Option B: Supportive Care Prior to Cardiac and/or Respiratory Arrest DNR if Arrest Occurs - No CPR**. Prior to arrest, interventions may include opening the airway by non-invasive means, providing passive oxygen, controlling external bleeding, positioning and other comfort measures, splinting, pain medications by orders obtained from a physician (e.g., by phone or electronically), and transport as appropriate. No CPR if arrest occurs.

The DNR A-1, DNR A-2 (DNI) and DNR B options will be authorized by this original order form, a copy or a fax of this form, or a bracelet or necklace with the DNR emblem. EMS providers or medical personnel who see these orders are to provide care in accordance with these orders and the applicable Maryland Medical Protocols for EMS Providers. Unless a subsequent order relating to resuscitation has been issued or unless the health care provider reasonably believes a DNR order has been revoked, every health care provider, facility, and program shall provide, withhold, or withdraw treatment according to these orders in case of a patient's impending cardiac or respiratory arrest.

Location of Form: The original or a copy of this form shall accompany patients when transferred or discharged from a facility or program. Health care facilities and programs shall maintain this order form (or a copy of it) with other active medical orders or in a section designated for MOLST and related documents in the patient's active medical record. At the patient's home, this form should be kept in a safe and readily available place and retrieved for responding EMS and health care providers before their arrival. The original, a copy, and a faxed MOLST form are ail valid orders. There is no expiration date for the MOLST or EMS DNR orders in Maryland.

Reviewing the Form: These medical orders are based on this individual's current medical condition and wishes. Patients, their authorized decision makers and attending physicians, NPs, or PAs shall review and update, if appropriate, the MOLST orders annually and whenever the patient is transferred between health care facilities or programs, is discharged, has a substantial change in health status, loses capacity to make health care decisions, or changes his or her wishes.

Updating the Form: The MOLST form shall be voided and a new MOLST form prepared when there is a change to any of (he orders. If modified, the physician, NP, or PA shall void the old form and complete, sign, and date a new MOLST form.

Voiding the Form: To void this medical order form, the physician, NP, or PA shall draw a diagonal line through the sheet, write "VOID" in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician, NP, or PA to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record.

Revoking the Form's DNR Order: In an emergency situation involving EMS providers, the DNR order in Section 1 may be revoked at any time by a competent patient's request for resuscitation made directly to responding EMS providers.

Bracelets and Necklaces: If desired, complete the paper form at the bottom of this page, cut out the bracelet portion below, and place it in a protective cover to wear around the wrist or neck or pinned to clothing, if a metal bracelet or necklace is desired, contact Medic Alert at 1-800-432-5378. Medic Alert requires a copy of this order along with an application to process the request.

How to Obtain This Form: Call 410-706-4367 or go to marylandmolst.org

Use of an EMS DNR bracelet is OPTIONAL and at the discretion of the patient or authorized decision maker. Print legibly, have physician, NP, or PA sign, cut off strip, fold, and insert in bracelet or necklace.

DNR A-1 Intubate DNR A-2 Do Not Intubate DNR B

Pt. Name_____ DOB_____
Practitioner Name_____ Date_____
Practitioner Signature_____ Phone_____

Medicare Shared Savings Program
Accountable Care Organizations

Your Provider participating in Lifebridge Health ACO, LLC, an Accountable Care Organization (ACO). An ACO is a group of doctors, hospitals, and/or other health care providers that work together to improve the quality and experience of care you receive. ACOs receive a portion of any savings that result from reducing costs and meeting
quality requirements.

- Medicare evaluates how well each ACO meets these goals every year. Those ACOs that do a good job can earn a financial bonus. ACOs that earn a bonus may use the payment to invest more in your care or share a portion directly with your provider. ACOs may owe a penalty if their care increase costs.

- Your Provider's participation in Lifebridge Health ACO, LLC doesn't limit your choice of health care providers. Your Medicare benefits are not changing. You still have the right to visit any doctor. Hospital, or other provider that accepts Medicare any time, just like you do now.

- To help us coordinate your health care better, Medicare shares information about your care with your providers. If you don't want Medicare to share your health care information, call 1-800-MEDICARE (1-800-633-4227)

How do ACOs work?

- An ACO **isn't** a Medicare Advantage plan which is an "all in one" alternative to Original Medicare, offered by private companies approved by Medicare. An ACO **isn't** and HMO plan, or an insurance plan of any kind.

Important!

- ACOs have agreements with Medicare to be financially accountable for the quality, cost, and experience of care you receive.

- Coordinated care can avoid wasted time and cost for repeated tests and unneeded appoints. It may make it easier to spot potential problems before they become more serious – like drugs interactions that can happen if one doctor isn't aware of what another has prescribed.

- AC0s may use electronic health records, case managers, and electronic prescriptions to help you stay healthy. Some ACOs have special programs to encourage you to have a primary care visit or use their care management team. Participation in these programs is optional.

LIFEBRIDGE HEALTH
Medical Group

CARE BRAVELY

What information will be shared about me?

- Medicare shares information about your care with your health care providers; like dates and times you visited a health care provider, your medical conditions and a list of past and current prescriptions. This information helps Lifebridge Health ACO, LLC track care an test that you've already had.

- Sharing your data helps make sure all the providers involved in your care have access to your health information when and where they need it.

- **We value your privacy.** ACOs must put important safeguards in place to make sure all your health care. We respect your choice on how your health care information is used for care coordination and quality improvement. If you want Medicare to share your health care information with Lifebridge Health ACO, LLC or other ACOs in which your health care providers participate, there's nothing more you need to do.

- If you **don't** want Medicate to share your health care information, **call 1-800-MEDICARE** (1-800-633-4227). Tell the representative that your health care provider is part of an ACO you don't want Medicare to share your health care information. TTY users should call 1-877-486-2048

- If you change your mind and want to let Medicare share your health information again call 1-800-MEDICARE to let Medicare know. We aren't allowed to tell Medicare for you.

- Even if you change your mind and want to let Medicare share your health care information, Medicare will still use your information for some purpose, like assessing the financial and quality of care performance of the health care providers participating in ACOs. Also, Medicare may share some of your health care information with ACOs when measuring the quality of care given by health care providers participating in those ACOs.

How can I make the most of getting care from an ACO?

- Ask your clinician if they have a secure online portal that gives you 24-hour access to your personal health information, including lab results and provider recommendations. This will help you make informed decisions about your health care, track your treatment, and monitor your health outcomes

For step-by step instructions on how to select or change your "main doctor," refer to the choosing a Primary Clinician video (https://youtu.be/HgRe4VCH2_I)

LIFEBRIDGE HEALTH
Medical Group

CARE BRAVELY

- As an Medicare beneficiary, you can choose or change your primary clinician or “main doctor” at any time. Your primary clinician is the health care provider that you believe is responsible for coordinating your overall care. You can learn more in the Voluntary Alignment Beneficiary Fact sheet.

What if have concerns about being part of an ACO?

- If you have concerns about the quality of care or other services you receive from your ACO or provider, you can contact your Medicare Beneficiary Ombudsman who can assist you with Medicare-related questions, concerns, and challenges. The Medicare Beneficiary Ombudsman works closely with the Medicare program, including Medicare.gov, 1-800-MEDICARE, and State Health Insurance Assistance Program (SHIPs), to help make sure information on how the Medicare Beneficiary Ombudsman can help you.

- If you suspect Medicare fraud or abuse from your ACO or any Medicare provider, we encourage you to make a report by contacting the HHS Office of Inspector General (1-800-HHS-TIPS) or your local Senior Medicare Patrol (SMP).

Signature: _____ Date: _____

Witness: _____ Date: _____

LIFEBRIDGE HEALTH
Medical Group

CARE BRAVELY