CROSSROADS MEDICAL GROUP
A LifeBridge Health Medical Group

CARE BRAVELY

To: **Our Medicare Patients:**

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

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 one 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 yr after the "Welcome to Medicare" exam.
Annual Wellness Visit, Subsequent	Once a year (more than 1 yr + 1 day after the last Wellness Visit).

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

At the Annual Wellness Visit, your doctor and his staff will talk to you about your medical history, review your risk factors, and make a personalized prevention plan to keep you healthy. The cost of the Annual Wellness Visit is fully covered by Medicare, without any co-pay due from you. We believe this is an important part of your health maintenance and quality of life.

The visit does *not* include a hands-on exam or any testing that your doctor may recommend, nor does it include any discussion about any new or current medical problems, conditions, or medications. You may schedule a separate 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 they are performed during the same visit.

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 no-cost 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 to your Annual Wellness Visit:

The names of all your doctors:

Name	Specialty

A list of all your medications

Name of medicine	Dose (if you remember)

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 done recently? (such as lab tests, mammograms, x-rays) ☐ Yes ☐ No

Have you had any recent immunizations? ☐ Yes ☐ No

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

Complete and bring any additional worksheets included with this letter.

Name:_____ Date:_____ Date of Birth:_____

A Checklist for Your Medicare Wellness Annual Visit

Please complete this checklist before seeing your doctor or nurse. 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 distance without help? For example, 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 eating, 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 things 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 telephone	☐	☐	☐	☐	☐
Tired or fatigued	☐	☐	☐	☐	☐

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?

- ☐ No
- ☐ Yes, and I might quit
- ☐ Yes, but I'm not ready to quit

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

- ☐ 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 a 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 medicines the way you have been told to take them?

- ☐ I do not have to take medicine
- ☐ 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?

- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not 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? ☐ Male ☐ Female

What is your race? (check one or more than one)

- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaskan Native
- ☐ Hispanic or Latino origin or descent
- ☐ Other

WOMEN'S PREVENTIVE WELLNESS PLAN

Patient Name_____ Date_____

Preventive Service	Frequency	Last Done
Body Mass Index (BMI)____ Height _____ Weight _____	**Annually**	
Blood Pressure _____/_____	• **Every 2 yrs, if BP </= 120/80 mm hg;** • **Annually, if BP >120-139/80-89 mm hg**	
Vision	• **Every 3 yrs up to age 40;** • **Every 2 yrs aged 40+**	
Breast Cancer Screening (Mammogram)	• **Every 2 yrs, aged 50-74 yrs**	
Cervical Cancer Screening (Pap Smear)	• **Every 3 yrs, aged 21-64 yrs;** • **Every 5 yrs, aged 30-65 with HPV testing**	
Osteoporosis Screening (Bone Density Measurement)	• **Routinely, for women aged 65+** • **Routinely, for women aged 60-64 with risk factors**	
Cholesterol Testing	**Regularly beginning at age 20 with risk factors**	
Diabetes Screening	**With a sustained BP >/= 135/80 mm Hg**	
Colorectal Cancer Screening	• **Annually, Fecal Occult Blood Stool (FOBS);** • **Every 5 yrs, Sigmoidoscopy with FOBS;** • **Every 10 yrs, Colonoscopy**	
Sexually Transmitted Diseases (STD's)	**As necessary for those with risk factors**	
Depression Screening	**As necessary for those with risk factors**	
Alcohol Misuse Screening	**As necessary for those with risk factors**	
Immunizations: **Pneumococcal (Pneumonia) Vaccine** **Influenza (Flu) Vaccine**	• **Pneumonia: 1-2 doses up to age 64;** • **Pneumonia: 1 dose age 65+** • **Influenza: Annually**	
Other		

Your major risk factors:

Family history of _____ Obesity_____ Diabetes_____
Hypertension_____ Fall Risk_____ Smoking Use_____ Other_____

Recommendations for improvement:

Diet_____ Tobacco Cessation_____Weight Management____ Exercise____ Other_____

Referrals

For Staff Use: *[list handouts, referrals, or other followup instructions here]*

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 _____

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Appointment Date: _____

Social Needs Assessment Form

Patient Name: _____ **DOB:** _____

1. **What is your living situation today?**
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but I am worried about losing it in the future
   - ☐ I do not have a steady place to live- I am temporarily staying with others, in a hotel, in a shelter, outside on the street, one a beach, in a car, abandoned building, bus or train station
2. **In the past 12 months, have you:**
   - Had your utilities threatened to be shut off
     - ☐ No
     - ☐ Yes
     - ☐ Already shut off
   - Worried you would run out of food
     - ☐ Never true
     - ☐ Sometimes true
     - ☐ Often true
   - Has a lack of transportation kept you from a medical appointment, meeting, work, etc.
     - ☐ No
     - ☐ Yes
3. **In the past 2 weeks how often do you:** ***Please circle answers***
   - Feel lonely, or isolated from those around you
     - ☐ Never
     - ☐ Rarely
     - ☐ Sometimes
     - ☐ Often
     - ☐ Always
   - Have little interest or pleasure in doing things
     - ☐ Not at all
     - ☐ Several days
     - ☐ More than half the days
     - ☐ Nearly every day
   - Feel down depressed or hopeless
     - ☐ Not at all
     - ☐ Several days
     - ☐ More than half the days
     - ☐ Nearly every day

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CAGE Assessment (Alcohol Use)

Date of visit: _____

Patient Name: _____
Date of Birth: _____

For most people who drink, alcohol is a pleasant addition to eating and to other social activities.

For most adults drinking a moderate amount of alcohol (up to 2 drinks per day for men, and 1 drink per day for women and older people) is not harmful. But, many people get into serious trouble because of their drinking.

This short assessment will help you determine if you might have a problem with alcohol.

(The name "CAGE" is an acronym formed by taking the first letter of key words from each of the following questions).

Have you ever felt you should cut down on your drinking?	☐ Yes	☐ No
Have people annoyed you by criticizing your drinking	☐ Yes	☐ No
Have you ever felt bad or guilty about your drinking?	☐ Yes	☐ No
Have you ever had a drink first thing in the morning (as an "eye opener") to steady your nerves or get rid of a hangover?	☐ Yes	☐ No

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Provider signature _____

Date reviewed: _____

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 guardian of the person as per the authority granted by 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 PHYSICIAN 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. ☐ May use only CPAP or BiPAP for artificial ventilation, as medically 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. ☐ May perform any medical tests indicated to diagnose and/or treat a medical condition.

5b. ☐ Only perform limited medical tests necessary for symptomatic treatment or comfort.

5c. ☐ Do not perform any medical tests for diagnosis or treatment.

6 ANTIBIOTICS

6a. ☐ May use antibiotics (oral, intravenous or intramuscular) as medically indicated.

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

6c. ☐ May use oral antibiotics only when indicated for symptom relief or comfort.

6d. ☐ Do not treat with antibiotics.

7 ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION

7a. ☐ May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.

7b. ☐ May give artificially administered fluids and nutrition, if medically indicated, as a trial.
Time limit_____

7c. ☐ May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition.
Time limit_____

7d. ☐ Do not provide artificially administered fluids or nutrition.

8 DIALYSIS

8a. ☐ May give chronic dialysis for end-stage kidney disease if medically indicated.

8b. ☐ May 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