Thayer County Health Services

Exceptional Health... Close to Home

MEDICARE Preventative Visit & Yearly Wellness Appointments

Per Medicare: "You pay nothing for the "Welcome to Medicare" preventive visit or the yearly "Wellness" visit if your doctor or other qualified health care provider accepts assignment. The Part B deductible doesn't apply. However, you may have to pay coinsurance, and the Part B deductible may apply if:

- Your doctor or other health care provider performs additional tests or services during the same visit.
- These additional tests or services aren't covered under the preventive benefits."

What's included in the Initial Preventive Physical Exam (IPPE)

- Review of medical and social history
- Review of potential (risk factors) for depression
- Review of functional ability and level of safety
- Measurement of height, weight, body mass index, blood pressure, visual acuity screen, and other factors deemed appropriate
- Discussion of end-of-life planning, upon agreement of the individual
- Education, counseling and referrals based on results of review and evaluation services performed during the visit, including a brief written plan such as a checklist, and if appropriate, education counseling and referral for obtaining an electrocardiogram (a.k.a. EKG, ECG)

What's included in the Annual Wellness Visit (AWV)

- Health risk assessment
- Medical/family history
- List of current providers/suppliers
- blood pressure, height, weight, and other routine measurements
- Detection of any cognitive impairment
- Review potential (risk factors) for depression, functional ability, and level of safety
- Establishment of:
  - Written screening schedule (such as a checklist) for the next 5-10 years
  - List of risk factors and conditions where interventions recommended
  - Personalized health advice and referrals for health education and preventive counseling

IPPE/AWV are *Preventive Visits*...Not Physical Exams

• The IPPE/AWV are dedicated preventive visits where a beneficiary and their health care provider may discuss a beneficiary's health status and maximize the preventive services that are available to Medicare beneficiaries

• The IPPE/AWV **are not** head-to-toe physical examinations

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MEDICARE Health Risk Assessment (HRA)

Your name: _____

Your date of birth: _____

Today's date: _____

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

1. What is your age?
○ 65-69 ○ 70-79 ○ 80 or older

2. Are you a male or a female?
○ Male ○ Female

3. During the **past four 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

4. During the **past four 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

5. During the **past four weeks**, how much bodily pain have you generally had?
○ No pain ○ Very Mild pain ○ Mild Pain ○ Moderate pain ○ Sever pain

6. During the **past four weeks**, was someone available to help you if you needed and wanted help?
○ Yes, as much as I wanted ○ Yes, quite a bit ○ Yes, some ○ Yes, a little ○ No, not at all

7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?
○ Very heavy ○ Heavy ○ Moderate ○ Light ○ Very Light

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)
○ Yes ○ No

9. Can you go shopping for groceries or clothes without someone's help?
○ Yes ○ No

10. Can you prepare your own meals?
○ Yes ○ No

11. Can you do your housework without help?
○ Yes ○ No

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
○ Yes ○ No

13. Can you handle your own money without help?
○ Yes ○ No

14. During the **past four weeks**, how would you rate your health in general?
○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

15. How have things been going for you during the **past four weeks**?
○ Excellent ○ Very good ○ Fair ○ Poor ○ Very Poor

16. Are you having difficulties driving your car?
○ Yes, often ○ Sometimes ○ No ○ Not applicable, I do not drive a car.

17. Do you always fasten your seat belt when you are in a car?
○ Yes, usually ○ Yes, sometimes ○ No

18. How often during the past four weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing	○	○	○	○	○
Sexual problems	○	○	○	○	○
Trouble eating well	○	○	○	○	○
Teeth or denture problem	○	○	○	○	○
Problems using the telephone	○	○	○	○	○
Tiredness or fatigue	○	○	○	○	○

19. Have you fallen two or more times in the **past year**?
○ Yes ○ No

20. Are you afraid of falling?
○ Yes ○ No

21. Are you a smoker?
○ Yes ○ No if yes, do you want to quit smoking? _____

22. During the past four week, how many alcoholic beverages did you have?
○ 10 or more per week ○ 6-9 per week ○ 2-5 per week ○ 1 or less per week ○ No alcohol at all

23. 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

24. How often do you take medications?
○ Daily ○ Weekly ○ As needed ○ Never How many medications do you take? _____

25. How often do you have trouble taking medicines the way you have been told to take them?
○ Always ○ Sometimes ○ Never ○ I do not have to take medication

26. Do you find that sometimes you have to choose between buying groceries or medication?
○ Yes ○ No

27. Are you using any street drugs or abusing medications?
○ Yes ○ No

28. Have you ever thought you should cut down your drug or alcohol use?
○ Yes ○ No

29. Have you ever been treated for drug or alcohol abuse?
○ Yes ○ No

30. Have you ever used drugs to ease withdrawal symptoms, or avoid feeling low after using drugs or alcohol?
○ Yes ○ No

31. Have you ever felt guilty or badly about your drug or alcohol use?
○ Yes ○ No

32. Have you ever felt annoyed when people have commented on your drug or alcohol use?
○ Yes ○ No

33. Do you exercise for about 20 minutes three or more days a week?
○ Yes, most of the time ○ Yes, some of the time ○ No, I usually do not exercise this much

34. 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 problems

35. In the past 3 months, how many times did you go to the Emergency Room? _____

36. In the past 6 months, how many times have you had unplanned overnight stays as a patient in a hospital? _____

37. What medical conditions do you have or have you had in the past?

	Anxiety		Dementia		Organ transplant
	Asthma		Depression		Renal/kidney failure
	Bi-polar disorder		Diabetes		Schizophrenia
	Cancer		Hearing/Vision problems		Stroke
	COPD/emphysema		Heart failure		None
	Coronary heart disease		Hypertension		Other

38. Which of the following are you currently receiving treatment for?

	Anxiety		Dementia		Organ transplant
	Asthma		Depression		Renal/kidney failure
	Bi-polar disorder		Diabetes		Schizophrenia
	Cancer		Hearing/Vision problems		Stroke
	COPD/emphysema		Heart failure		None
	Coronary heart disease		Hypertension		Other

39. Has your doctor recently told you that you need to lose weight?
○ Yes ○ No

40. Are you on a special diet recommended by your doctor?
○ Yes ○ No

41. In the past week, how many servings of fruits and vegetables did you typically eat each day?
○ 0 ○ 1-2 ○ 3 ○ 4+

42. In the past week, how many servings of high fiber or whole grain foods did you typically eat each day?
○ 0 ○ 1-2 ○ 3 ○ 4+

43. In the past week, how many servings of fried or high-fat foods did you typically eat each day?
○ 0 ○ 1-2 ○ 3 ○ 4+

44. In the past week, how many sugar-sweetened beverages did you typically consume each day?
○ 0 ○ 1-2 ○ 3 ○ 4+

45. In the past 2 weeks, have you experienced a change in the amount you normally eat, either poor appetite or overeating?
○ Yes ○ No

46. In the past 2 weeks, have you experienced a significant change in the amount you normally sleep, either trouble getting to sleep or sleeping too much?
○ Yes ○ No

Advance Care Planning

47. Do you have a Medical Power of Attorney? (Someone to make medical decisions for you in the event you are unable to)
◯ Yes ◯ No ◯ Don't know/don't remember

48. Do you have a living will/advance directive? (Documents that make your health care wishes known)
◯ Yes ◯ No ◯ Don't know/don't remember

49. Is a copy of your advance directive documents on file at your doctor's office?
◯ Yes ◯ No ◯ Don't know/don't remember

Tell us about you

My health is important to me.	Strongly Disagree	Disagree	Agree	Strongly Agree
I am ultimately the one responsible for taking care of my health.				
It is important for me to take an active role in my health care.				
I am confident I can prevent or reduce problems associated with my health.				
I am confident I know when I need to seek medical care and when I am able to care of myself.				
I am confident I can talk to my doctor about my health concerns even when he/she does not ask.				
I am confident IU can follow through on medical treatments I may need to do at home.				

50. Do you live?
◯ Alone ◯ With spouse ◯ With other family member ◯ With non-relative ◯ Nursing Home or assisted living facility

51. Who completed this survey form?
◯ Myself ◯ Relative of mine ◯ Friend of mine ◯ Professional caregiver of mine