PERMIAN INTERNAL MEDICINE ASSOCIATES

403 PITTSBURG AVENUE, ODESSA, TEXAS 79761
PHONE: (432) 332-3400 FAX: (432) 332-6500

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 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/PA/Nurses 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 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 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 services 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.

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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) OR provide list

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

Has your mood changed? ___ Yes ___ No

Do you worry about falling and safety at home? ___ Yes ___ No

Are you worried about your memory? ___ Yes ___ No

Are there any preventive tests you have 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*.)

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OFFICE USE ONLY
IPPE / AWV: Practice Checklist

Before the visit:

- ☐ Verify eligibility: [ ] Medicare [ ] Not eligible for Welcome to Medicare Visit
  [ ] More than 365 days since initial AWV
- ☐ Explain the Annual Wellness Visit to the patient
- ☐ Is the problem list complete?
- ☐ Is the medication list complete?
- ☐ Is the family history complete?
- ☐ Do we have a list of the patient's other physicians?

During the visit:

- ☐ Have the patient complete a depression screen ***(PHQ-9)***
- ☐ Have the patient complete **functional** assessment / **Fall** questionnaire
- ☐ Measure BP, weight, BMI and/or waist measurement
- ☐ Complete list of risk factors.
- ☐ Update immunization record and order immunizations and other preventative check list (See attached **Adult Preventive/ Quality Measure/Screening form)**
- ☐ Cognitive Testing (**6-CIT)**
  [ ] No impairment [ ] Mild cognitive impairment [ ] Further NEURO-psychological testing needed of score above **10.**

  Covered MC Diagnosis: _____ 96103 ☐ 96120 ☐
- ☐ Make new schedule of preventive and early detection interventions.
- ☐ Make new schedule appointment to discuss with physician for any abnormal finding/ labs etc.
- ☐ Vision and hearing evaluation/ referral
- ☐ Discuss Advance care planning/ directive (Pt has DNR / NOT DNR).

Suresh Prasad MD_____ Kalpana Prasad MD_____

Marlene Cereceres PA-C_____ Grace Andrade PA-C_____

Roxana Nieto PA-C_____

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HEALTH RISK ASSESSMENT

*(it is **very** important that you complete this **PRIOR** to the nurse taking you into the examination room for your Medicare Annual Wellness Visit. You may NOT be seeing the doctor during this visit as Medicare does not expect the doctor to see the patient during this Medicare required visit**. If you wish to see the doctor – you will be given a SEPARATE appointment for that visit**)*

BEHAVIORAL RISK FACTORS

PHYSICAL INACTIVITY/LACK OF EXERCISE

How many days a week do you usually exercise? _____days per week

On days when you exercise, for how long do you usually exercise (in minutes):

_____ Minutes per day [ ] Does not apply

How intense is your typical exercise? [ ] I am currently not exercising

[ ] Light (like stretching or slow walking) [ ] Moderate (like brisk walking)

[ ] Heavy (like jogging or swimming) [ ] Very heavy (like running or stairs)

SMOKING/TOBACCO USE

Do you currently smoke or use other types of tobacco? [ ] Yes [ ] No

Are you a former smoker? [ ] Yes [ ] No, I've never smoked

If you quit smoking, how long ago did you quit smoking cigarettes?

[ ] Less than 6 months ago [ ] 6–11 months ago [ ] 1–5 years ago [ ] 6–10 years ago

[ ] More than 10 years ago [ ] Does not apply

Indicate below if you currently use any of these other tobacco products:

[ ] Cigars [ ] Pipes [ ] Chewing tobacco/snuff

[ ] Nicotine Patch [ ] I use none of these

ALCOHOL USE

In a typical week, how many days do you drink alcohol? _____ days per week

When you drink alcohol, how many drinks do you consume? ___ drinks per day

In a typical week, how often do you have 5 or more alcoholic drinks at a time?

[ ] Never [ ] Once a week

[ ] 2–3 times per week [ ] More than 3 times per week

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NUTRITION

- □ *On a typical day, how many servings of fruits and/or vegetables do you eat? (1 serving = 1 cup of fresh vegetables, 1/2 cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.)* **_____ Servings per day**
- □ *On a typical day, how many servings of high fiber or whole grain foods do you eat? (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, 1/2 cup of cooked cereal such as oatmeal, or 1/2 cup of cooked brown rice or whole wheat pasta.)* **_____ Servings per day**
- □ *On a typical day, how many servings of fried or high-fat foods do you eat? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)* **_____ Servings per day**

Do you routinely add salt to your food? [ ] Yes [ ] No

MEMORY QUESTIONS

Has anyone in your family said you have memory problems? [ ] Yes [ ] No

Do you believe you have short term memory problems? [ ] Yes [ ] No

Do you believe you have long term memory problems? [ ] Yes [ ] No

Do you have more confusion at night time than day time? [ ] Yes [ ] No

MOTOR VEHICLE SAFETY

Do you always fasten your seat belt when you are in the car? [ ] Yes [ ] No

Do you ever drive after drinking, or ride with one who has? [ ] Yes [ ] No

Do you have changes in your vision or a problem driving? [ ] Yes [ ] No

If yes, please specify: _____

SUN EXPOSURE

Do you protect yourself from the sun when you are outdoors? [ ] Yes [ ] No

BIOMETRIC MEASURES—SELF-REPORTED

What was your most recent blood pressure?

[ ] Don't know/not sure

[ ] Low or normal (at or below 120/80)

[ ] Borderline high (120/80 to 139/89) [ ] High (140/90 or higher)

CHOLESTEROL

If your cholesterol was checked within the past year, what was your total cholesterol when it was last checked?

[ ] Desirable (Below 200) [ ] Borderline high (200-239)

[ ] High (240 or higher) [ ] Do not know/not sure

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BLOOD GLUCOSE

If your glucose was checked within the past year, what was your fasting blood glucose (blood sugar) level the last time it was checked?

[ ] Desirable (Below 100) [ ] Borderline high (100–125)

[ ] High (126 or higher) [ ] Don't know/not sure

Have you ever been told by a doctor or a health professional that you have diabetes or high blood sugar?

[ ] Yes [ ] No (skip to next section)

If you have had your hemoglobin A-1C level checked within the past year, what was it the last time you had it checked?

[ ] Desirable (6 or lower) [ ] Borderline high (7)

[ ] High (8 or higher) [ ] Don't know/not sure

OVERWEIGHT/OBESITY

What is your approximate height Feet _____ Inches _____

What is your approximate weight? Weight in pounds _____

Have you had a dramatic change in weight in past year? [ ] Yes [ ] No

PSYCHOSOCIAL RISK FACTORS/ DEPRESSION

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

[ ] Almost all of the time [ ] Most of the time

[ ] Some of the time [ ] Almost never [ ] Never

Over the past 2 weeks, how often have you felt little interest in doing things?

[ ] Almost all of the time [ ] Most of the time [ ] Some of the time

[ ] Almost never [ ] Never

Have your feelings caused you distress or interfered with your ability to interact socially with friends?

[ ] Yes [ ] No

During the past 6 months, how often have you felt sad or depression

[ ] Almost all of the time [ ] Most of the time [ ] Some of the time [ ] Almost never

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In general, how satisfied are you with your life?

[ ] Very satisfied [ ] Satisfied [ ] Dissatisfied [ ] Very dissatisfied

How often is stress a problem for you?

[ ] Never/rarely [ ] Sometimes [ ]Often [ ] Always

How well do you handle the stress in your life?

[ ] I'm usually able to cope effectively [ ] At times I have problems coping

[ ] I often have problems coping

GENERAL WELL-BEING ***In general, would you say your health is***

[ ] Excellent [ ] Very good [ ] Good

[ ] Fair [ ] Poor

SOCIAL/EMOTIONAL SUPPORT ***How often do you get the social and emotional support you need:***

[ ] Always [ ] Usually [ ] Sometimes [ ] Rarely [ ] Never

GENERAL LIFE SATISFACTION

In general, how satisfied are you with your life:

[ ] Very satisfied [ ] Satisfied [ ] Dissatisfied [ ]Very dissatisfied

SLEEP

How many hours of sleep do you usually get each night? _____

[ ] Do you have problems falling to sleep at night?

[ ] Do you wake in the middle of the night often?

[ ] Do you consider your sleep [ ] Restful [ ] Restless [ ] Adequate

DAILY ASPIRIN USE

Have you discussed taking a daily aspirin with your doctor? [ ] Yes [ ] No

Do you take a daily aspirin? [ ] Yes [ ] No

Dr. Suresh Prasad_____Dr. Kalpana Prasad_____

Marlene Cereceres PA-C_____ Grace Andrade PA-C_____

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OFFICE USE ONLY

The 6 CIT Dementia Test

How the test works

Question	Score range	Weighting	Weighted score
What Year is it	Correct = 0	Incorrect = 4	
What month is it	Correct = 0	Incorrect = 3	
Remember the following address *John Smith* *42 West Street, Bedford*			
About what time is it (within 60 minutes)	Correct = 0	Incorrect = 3	
Count back from 20-1	Correct = 0	1 Error =2 More than 1 Err = 4	
Say months in reverse	Correct = 0	1 Error = 2 More than 1 Err = 4	
Repeat the memory phrase	Correct = 0 2 Errors = 4 4 Errors = 6	1 Error = 2 3 Errors = 6 All incorrect = 10	
Total score for 6CIT	0-28		

0-7 = normal - referral not necessary at present
8- 9 = mild cognitive impairment - **probably refer**
10-28 = significant cognitive impairment - refer

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The PHQ-9 Test for Depression

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly every day
		0	**1**	**2**	**3**
a.	Little interest or pleasure in doing things	☐	☐	☐	☐
b.	Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c.	Trouble falling/staying asleep, sleeping too much.	☐	☐	☐	☐
d.	Feeling tired or having little energy.	☐	☐	☐	☐
e.	Poor appetite or overeating.	☐	☐	☐	☐
f.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
g.	Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h.	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.	☐	☐	☐	☐
i.	Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, 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
☐	☐	☐	☐

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression