CMG COMMUNITY MEDICAL GROUP

THE ANNUAL PLANNED VISIT TOOLKIT

A Practice's Guide to Medicare's Initial Preventive Physical Exam and Annual Wellness Visit

3rd Edition | January 2023

Introduction to the Annual Planned Visit Toolkit

Dear Participating Provider,

Community Medical Group has compiled a number of resources designed to assist you and your practice in making the most of Medicare's yearly planned visits: the Initial Preventive Physical Examination (IPPE) and both initial and subsequent Annual Wellness Visits (AWV):

Initial Preventive Physical Examination (IPPE):

This visit is also known as the "Welcome to Medicare Preventive Visit," and its goals are health promotion, disease prevention, and detection. Medicare pays for one IPPE per lifetime, and it must occur within the first 12 months of Medicare coverage. You are expected to review the patient's medical and social history, potential risk factors for depression and other mood disorders, functional ability, and level of safety. A routine examination and, if the patient consents, end-of-life planning should also be part of this visit. Finally, patient education, counsel, and referrals to Medicare-covered screenings and other preventive services should conclude the visit.

Initial and Subsequent Annual Wellness Visits (AWV):

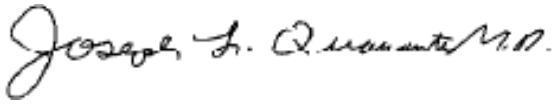
Similar to the IPPE, these visits also require you to create or update a personalized prevention plan for your patient. The goal is to help prevent illness based on the patient's current health and risk factors. The visit is only covered if the patient has had Medicare coverage for more than 12 months and has not received an IPPE or AWV in the past 12 months.

Within this toolkit, you will find valuable information and resources that address the following:

- A new section about screening for the **Social Determinants of Health (SDoH)**
- Required components for the **IPPE**, **initial AWV**, and **subsequent AWVs**
- Billing and coding the **IPPE**, **AWV**, and **additional preventive services**
- **Health risk assessment and screenings** (including large-print forms for the visually impaired and **translated versions for Spanish speakers**)
- Patient education on the **benefits of both visits**
- Questions frequently posed by **providers** and **patients**
- Ways to **keep track of preventive care needs and referrals**

Our hope is that some or all of these tools may become a valuable resource for your practice, and support you as you strive to provide the best care for your patients.

Sincerely,



Joseph L. Quaranta, MD

CMG President

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PREPARING FOR AND PERFORMING ANNUAL PLANNED VISITS

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Comparing Initial Preventive Physical Examinations (IPPEs) and Annual Wellness Visits (AWVs)

Required Components	IPPE	Initial AWV	Subsequent AWVs
Perform during first 12 months of Medicare coverage	✓		
Perform after first 12 months of Medicare coverage		✓	✓
Review medical and social history (including opioid use)	✓	✓	
Update medical and social history (review of opioid use is recommended, but not required)			✓
Administer Health Risk Assessment (HRA) before or during appointment		✓	✓
Establish/update list of current providers and suppliers		✓	✓
Review potential risk factors for depression and other mood disorders	✓	✓	✓
Review functional ability and level of safety	✓	✓	✓
EXAM: height, weight, BMI, BP, and other factors deemed appropriate based on medical/social history and current clinical standards	✓	✓	✓
EXAM: visual acuity screen	✓		
Detect any cognitive impairment the patient might have		✓	✓
End-of-life planning* with patient's consent	✓		
Provide education, counseling, and referrals**	✓	✓	✓
Provide brief written plan to patient to obtain appropriate screenings and Medicare-covered preventive services	✓		
Establish written screening schedule/checklist for next 5-10 years		✓	✓
Establish a list of risk factors and conditions for which the primary, secondary, or tertiary interventions are recommended or underway		✓	✓

***End-of-life planning is not a required component of the AWV, but it is recommended as an optional (billable) component.**

****Education, counseling, and referrals should be provided during all visits.** However, CMS specifies that referrals to "services or programs aimed at community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including: fall prevention, nutrition, physical activity, tobacco-use cessation, [and] weight loss" be provided during all AWVs. These specific recommendations are not stated for the IPPE.

This guide is based on the following resources provided by the CMS Medicare Learning Network: "The ABCs of the Initial Preventive Physical Examination (IPPE)" and "The ABCs of the Annual Welness Visit (AWV)," both published in April 2017.

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Annual Planned Visit Payer Coverage Guide

	Traditional Medicare Part B	Aetna Medicare	Anthem Medicare	CarePartners of CT	ConnectiCare Medicare	UnitedHealthcare Medicare	WellCare Medicare
INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE) Covered for all newly enrolled beneficiaries within the first 12 months after the effective date of their Medicare Part B coverage **Billing code:** G0402	✓	✓	✓	✓	✓	✓	✓
ELECTROCARDIOGRAM (ECG)* Routine ECG with 12 leads; performed as a screening for the IPPE **Billing codes:** **G0402** - With interpretation and report **G0404** - Tracing only without interpretation and report **G0505** - Interpretation and report only	✓	✓	✓	✓	✓	✓	✓
ANNUAL WELLNESS VISIT (AWV): Initial and Subsequent Visits Covered for beneficiaries who are no longer within 12 months after the effective date of their first Medicare Part B coverage and who have not received either an IPPE or an AWV providing Personalized Prevention Plan Services (PPPS) within the past 12 months. Medicare pays for only one first AWV per year thereafter. **Billing codes:** **G0438** - Initial **G0439** - Subsequent	✓	✓	✓	✓	✓	✓	✓
ANNUAL ROUTINE PHYSICAL Covered **Billing codes:** 99381-99387, 99391-99397		✓	✓	✓	✓	✓	✓

**Once per lifetime at the time of the IPPE; deductible and copayment apply.*

Initial Preventive Physical Examination (IPPE) Guide

This guide explains the components included in the IPPE. All components of the IPPE must be provided, or provided and referred, prior to submitting a claim for the IPPE.ded in the Initial AWV. All components of the Initial AWV must be provided, or provided and referred, prior to submitting a claim for the Initial AWV.

1. Before scheduling the appointment, confirm that the patient is eligible for coverage.

Medicare provides coverage of the IPPE for all newly enrolled beneficiaries who receive the IPPE within the first 12 months after the effective date of their Medicare Part B coverage. Please note that this is a one-time benefit per Medicare Part B enrollee.

2. Counsel your patient to prepare for their appointment.

Before the appointment, encourage patients to bring the following information with them:

- ✓ Medical records, including immunization records
- ✓ Family health history, in as much detail as possible
- ✓ Full list of medications and all OTC supplements, including calcium and vitamins – how often and how much of each is taken

3. Obtain a detailed medical and social history.

At a minimum, the following should be reviewed:

- ✓ Past medical/surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments)
- ✓ Current medications and supplements, including calcium and vitamins – how often and how much of each is taken
- ✓ Review of opioid use, including opioid use disorder (OUD)
- ✓ Family history (review of medical events in the family, including diseases that may be hereditary or place the patient at risk)
- ✓ History of alcohol, tobacco, and illicit drug use
- ✓ Diet
- ✓ Physical activities

4. Assess potential risk factors for depression and other mood disorders.

Use any appropriate screening instrument for persons without a current diagnosis of depression recognized by national professional medical organizations to obtain current or past experiences with depression or other mood disorders. CMG recommends that the **PHQ-9 be used to screen for depression**.

5. Assess patient's functional ability and level of safety.

Use any appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas:

- ✓ Hearing impairment
- ✓ Activities of daily living (ADLs)
- ✓ Home safety
- ✓ **Falls risk**

6. Begin examination.

Obtain the following:

- ✓ Height, weight, and blood pressure
- ✓ Visual acuity screen
- ✓ Body mass index (BMI) measurement
- ✓ Other factors deemed appropriate based on the patient's medical and social history and current clinical standards

7. Discuss end-of-life planning, with the patient's consent.

End-of-life planning is a required service, upon the patient's consent. End-of-life planning is verbal or written information provided to the patient regarding:

- ✓ The patient's ability to prepare an advance directive in the case that an injury or illness causes the patient to be unable to make health care decisions
- ✓ Whether the physician is willing to follow the patient's wishes as expressed in the advanced directive

8. Provide counsel to the patient based on your assessment.

Based on the results of the review and evaluation services, provide education and counseling to the patient.

9. Write a brief follow-up plan for the patient.

Complete a brief, written plan (such as a checklist) to be given to the patient for obtaining a screen electrocardiogram (EKG), as appropriate, and any other appropriate screenings/preventive services that are covered as separate Medicare Part B benefits.

Medicare Part B-Covered Preventive Services include:

- ✓ Annual Wellness Visit (AWV)[1]
- ✓ Abdominal Aortic Aneurysm Screening
- ✓ Alcohol Misuse Screening and Counseling
- ✓ Bone Mass Measurement (Bone Density Test)
- ✓ Cardiovascular Disease (Behavioral Therapy)
- ✓ Cardiovascular Screenings (Cholesterol/Lipids/Triglycerides)
- ✓ Colorectal Cancer Screenings
- ✓ Depression Screening
- ✓ Diabetes Screening
- ✓ Diabetes Self-Management Training
- ✓ Annual Flu Shot (Vaccine)
- ✓ Glaucoma Test
- ✓ Hepatitis B Shot (Vaccine)
- ✓ Hepatitis Screening
- ✓ HIV Screening
- ✓ Breast Cancer Screening (Mammogram)
- ✓ Medical Nutritional Therapy Services
- ✓ Obesity Screening and Counseling
- ✓ Pap Test and GYN Exam
- ✓ Pneumococcal Shot (Vaccine)
- ✓ Prostate Cancer Screening

- ✓ Sexually Transmitted Infection Screening and Counseling
- ✓ Shingles Shot (Vaccine)
- ✓ Tobacco Use Cessation (Counseling to Stop Smoking)

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1. For dates of service on or after January 1, 2011, the Affordable Care Act (ACA) allows for coverage of an Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS).
2. Effective for dates of service on or after August 25, 2010, Medicare provides coverage of counseling to prevent tobacco use.
3. A Medicare beneficiary with certain risk factors for AAAs may receive a referral for a one-time preventive ultrasound screening for early detection of AAAs. Eligible beneficiaries must receive a referral for an ultrasound for AAA as a result of an IPPE.

This guide is based on a resource provided by the CMS Medicare Learning Network, "The ABCs of the Initial Preventive Examination (IPPE)," published in April 2017.

Initial Annual Wellness Visit (AWV) Guide

This guide explains the components included in the Initial AWV. All components of the Initial AWV must be provided, or provided and referred, prior to submitting a claim for the Initial AWV.

1. Before scheduling the appointment, confirm that the patient is eligible for coverage.

Medicare will pay for an AWV for a beneficiary who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage and has not received either an IPPE or an AWV providing PPPS within the past 12 months. Medicare pays for only one initial AWV per beneficiary per lifetime, and pays for one subsequent AWV per year thereafter.

2. Counsel your patient to prepare for their appointment.

Before the appointment, encourage patients to bring the following information with them:

- ✓ Medical records, including immunization records
- ✓ Family health history, in as much detail as possible
- ✓ Full list of medications and OTC supplements, including calcium and vitamins – how often and how much of each is taken
- ✓ Full list of current providers and suppliers involved in providing care
- ✓ A completed **Health Risk Assessment (HRA)** – you or the patient can also complete the HRA during the appointment if preferred (see below)

3. Administer Health Risk Assessment (HRA).

The HRA collects self-reported information from the patient. You or the patient can complete the HRA before or during the AWV. The HRA must meet the following standards:

- ✓ Accounts for the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs, and is appropriately tailored to their needs
- ✓ Takes no more than 20 minutes to complete
- ✓ At a minimum, addresses the following topics:
  - Demographic data
  - Self-assessment of health status
  - Psychosocial risks
  - Behavioral risks
  - Activities of daily living (ADLs), including (but not limited to): dressing, bathing, and walking
  - Instrumental ADLs, including (but not limited to): shopping, housekeeping, managing own medications, and handling finances

4. Establish a list of current providers and suppliers.

This list should include all current providers and suppliers who are regularly involved in providing medical care to the patient.

5. Obtain a detailed medical and social history.

At a minimum, the following should be reviewed:

- ✓ Past medical/surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments)
- ✓ Use or exposure to medications and all OTC supplements, including calcium and vitamins – how often and how much of each is taken
- ✓ Review of opioid use, including opioid use disorder (OUD)
- ✓ Medical events in the patient's parents and any siblings and children, including diseases that may be hereditary or place the patient at increased risk

6. Assess potential risk factors for depression and other mood disorders.

Use any appropriate screening instrument for persons without a current diagnosis of depression recognized by national professional medical organizations to obtain current or past experiences with depression or other mood disorders. CMG recommends that the **PHQ-9 be used to screen for depression**.

7. Assess patient's functional ability and level of safety.

Use direct observation of the beneficiary, or any appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations to assess, at a minimum, the following topics:

- ✓ Hearing impairment
- ✓ Ability to successfully perform activities of daily living (ADLs)
- ✓ Home safety
- ✓ **Falls risk**

8. Begin examination.

Obtain the following:

- ✓ Height, weight, and blood pressure
- ✓ Body mass index (BMI) measurement (or waist circumference, if appropriate)
- ✓ Other routine measurements as deemed appropriate, based on medical and family history

9. Evaluate the patient's cognitive function.

Assess the patient's cognitive function by direct observation, with due consideration of information obtained by way of:

- ✓ Patient reports
- ✓ Concerns raised by family members, friends, caretakers, or others

10. Establish a written screening schedule for the patient as appropriate.

Write out a screening schedule, such as a checklist for the next 5-10 years, as appropriate. Base written screening schedule on:

- ✓ Age-appropriate preventive services Medicare covers
- ✓ Recommendations from the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP)
- ✓ The patient's HRA, health status, and screening history

Medicare Part B-Covered Preventive Services include:

- ✓ Annual Wellness Visit (AWV)[1]
- ✓ Abdominal Aortic Aneurysm Screening
- ✓ Alcohol Misuse Screening and Counseling
- ✓ Bone Mass Measurement (Bone Density Test)
- ✓ Cardiovascular Disease (Behavioral Therapy)
- ✓ Cardiovascular Screenings (Cholesterol/Lipids/Triglycerides)
- ✓ Colorectal Cancer Screenings
- ✓ Depression Screening
- ✓ Diabetes Screening
- ✓ Diabetes Self-Management Training
- ✓ Annual Flu Shot (Vaccine)
- ✓ Glaucoma Test
- ✓ Hepatitis B Shot (Vaccine)
- ✓ Hepatitis Screening
- ✓ HIV Screening
- ✓ Breast Cancer Screening (Mammogram)
- ✓ Medical Nutritional Therapy Services
- ✓ Obesity Screening and Counseling
- ✓ Pap Test and GYN Exam
- ✓ Pneumococcal Shot (Vaccine)
- ✓ Prostate Cancer Screening
- ✓ Sexually Transmitted Infection Screening and Counseling
- ✓ Shingles Shot (Vaccine)
- ✓ Tobacco Use Cessation (Counseling to Stop Smoking)

11. Establish a list of risk factors and conditions of which the primary, secondary, and tertiary interventions are recommended or underway for the patient.

Any of the following should be included in this list:

- ✓ Any mental health conditions or any such risk factors that have been identified through an IPPE
- ✓ A list of treatment options and their associated risks and benefits

12. Provide personalized health advice to the patient and a referral as appropriate to health education or prevention counseling services.

This may include referrals to programs aimed at:

- ✓ Community-based lifestyle interventions to reduce health risks and promote self-management and wellness
- ✓ Fall prevention

- ✓ Nutrition
- ✓ Physical activity
- ✓ Tobacco use cessation
- ✓ Fall prevention
- ✓ Weight loss

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1. For dates of service on or after January 1, 2011, the Affordable Care Act (ACA) allows for coverage of an Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS).
2. Effective for dates of service on or after August 25, 2010, Medicare provides coverage of counseling to prevent tobacco use.
3. A Medicare beneficiary with certain risk factors for AAAs may receive a referral for a one-time preventive ultrasound screening for early detection of AAAs. Eligible beneficiaries must receive a referral for an ultrasound for AAA as a result of an IPPE.

This guide is based on a resource provided by the CMS Medicare Learning Network, "The ABCs of the Annual Wellness Visit (AWV)," published in April 2017.

Subsequent Annual Wellness Visit (AWV) Guide

This guide explains the components included in Subsequent AWVs. All components of the Initial AWV must be provided, or provided and referred, prior to submitting a claim for the Subsequent AWV.

1. Before scheduling the appointment, confirm that the patient is eligible for coverage.

Medicare will pay for an AWV for a beneficiary who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage and has not received either an IPPE or an AWV providing PPPS within the past 12 months. Medicare pays for only one initial AWV per beneficiary per lifetime, and pays for one subsequent AWV per year thereafter.

2. Counsel your patient to prepare for their appointment.

Before the appointment, encourage patients to bring the following information with them:

- ✓ Medical records, including immunization records
- ✓ Family health history, in as much detail as possible
- ✓ Full list of medications and OTC supplements, including calcium and vitamins – how often and how much of each is taken
- ✓ Full list of current providers and suppliers involved in providing care
- ✓ A completed **Health Risk Assessment (HRA)** – you or the patient can also complete the HRA during the appointment if preferred (see below)

3. Complete an updated Health Risk Assessment (HRA).

The HRA collects self-reported information from the patient. You or the patient can complete the HRA before or during the AWV. The HRA must meet the following standards:

- ✓ Accounts for the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs, and is appropriately tailored to their needs
- ✓ Takes no more than 20 minutes to complete
- ✓ At a minimum, addresses the following topics:
  - Demographic data
  - Self-assessment of health status
  - Psychosocial risks
  - Behavioral risks
  - Activities of daily living (ADLs), including (but not limited to): dressing, bathing, and walking
  - Instrumental ADLs, including (but not limited to): shopping, housekeeping, managing own medications, and handling finances

4. Update the patient's previously established list of current providers and suppliers.

This list should include all current providers and suppliers who are regularly involved in providing medical care to the patient.

5. Obtain an update of the patient's medical and social history.

At a minimum, the following should be reviewed:

- ✓ Past medical/surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments)
- ✓ Use or exposure to medications and all OTC supplements, including calcium and vitamins – how often and how much of each is taken
- ✓ Review of opioid use, including opioid use disorder (OUD)
- ✓ Medical events in the patient's parents and any siblings and children, including diseases that may be hereditary or place the patient at increased risk

6. Begin examination.

Obtain the following:

- ✓ Weight (or waist circumference, if appropriate) and blood pressure
- ✓ Other routine measurements as deemed appropriate, based on medical and family history

7. Evaluate the patient's cognitive function.

Assess the patient's cognitive function by direct observation, with due consideration of information obtained by way of:

- ✓ Patient reports
- ✓ Concerns raised by family members, friends, caretakers, or others

10. Update previously established screening schedule for the patient as appropriate.

Review the patient's previously established screening schedule and adjust as necessary. Base written screening schedule on:

- ✓ Age-appropriate preventive services covered by Medicare (see below)
- ✓ Recommendations from the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP)
- ✓ The patient's health status and screening history

Medicare Part B-Covered Preventive Services include:

- ✓ Annual Wellness Visit (AWV)[1]
- ✓ Abdominal Aortic Aneurysm Screening
- ✓ Alcohol Misuse Screening and Counseling
- ✓ Bone Mass Measurement (Bone Density Test)
- ✓ Cardiovascular Disease (Behavioral Therapy)
- ✓ Cardiovascular Screenings (Cholesterol/Lipids/Triglycerides)
- ✓ Colorectal Cancer Screenings
- ✓ Depression Screening
- ✓ Diabetes Screening
- ✓ Diabetes Self-Management Training
- ✓ Annual Flu Shot (Vaccine)
- ✓ Glaucoma Test
- ✓ Hepatitis B Shot (Vaccine)
- ✓ Hepatitis Screening
- ✓ HIV Screening

- ✓ Breast Cancer Screening (Mammogram)
- ✓ Medical Nutritional Therapy Services
- ✓ Obesity Screening and Counseling
- ✓ Pap Test and GYN Exam
- ✓ Pneumococcal Shot (Vaccine)
- ✓ Prostate Cancer Screening
- ✓ Sexually Transmitted Infection Screening and Counseling
- ✓ Shingles Shot (Vaccine)
- ✓ Tobacco Use Cessation (Counseling to Stop Smoking)

11. Update the list of risk factors and conditions of which the primary, secondary, and tertiary interventions are recommended or underway for the patient.

Be sure to include any such risk factors or conditions that have been identified.

12. Provide personalized health advice to the patient and a referral as appropriate to health education or prevention counseling services.

This may include referrals to programs aimed at:

- ✓ Community-based lifestyle interventions to reduce health risks and promote self-management and wellness
- ✓ Fall prevention
- ✓ Nutrition
- ✓ Physical activity
- ✓ Tobacco use cessation
- ✓ Fall prevention
- ✓ Weight loss

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4. For dates of service on or after January 1, 2011, the Affordable Care Act (ACA) allows for coverage of an Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS).
5. Effective for dates of service on or after August 25, 2010, Medicare provides coverage of counseling to prevent tobacco use.
6. A Medicare beneficiary with certain risk factors for AAAs may receive a referral for a one-time preventive ultrasound screening for early detection of AAAs. Eligible beneficiaries must receive a referral for an ultrasound for AAA as a result of an IPPE.

This guide is based on a resource provided by the CMS Medicare Learning Network, "The ABCs of the Annual Wellness Visit (AWV)," published in April 2017.

Initial Preventive Physical Examination (IPPE), aka "Welcome to Medicare" Visit: Scheduler Call Script

Scheduler: Hello, Mr. /Mrs. /Ms. [patient's name]. This is [scheduler's name] from [clinician's name]'s office. We are contacting all of our patients who are new to Medicare to schedule your "Welcome to Medicare" visit. How are you doing today?

Patient: I am doing well. What is a "Welcome to Medicare" visit?

Scheduler: As you may already know, it is very important for you to see your primary care provider at least once a year. As a new Medicare member, you are allowed a comprehensive 'Welcome to Medicare' preventive visit within the first 12 months of your coverage.

This visit includes a brief examination with routine measurements (like height and weight), review of your medical and social history related to your health, and counseling about Medicare preventive services. Our goal is to help you reach your goals in getting or staying healthy. Your Medicare plan pays 100% of the cost for this exam with no out-of-pocket expense to you. However, if we need to address other medical concerns (like a sore knee or other medical conditions) at this visit, we want you to know you may have a deductible or copay.

Patient: Okay, I see. Sure, I'll come in.

Scheduler: What would be a good day to get your "Welcome to Medicare" visit scheduled for you?

Patient: I can come in anytime in the next few weeks.

Scheduler: We will schedule your appointment [date/time].

To prepare for this visit, please bring all medications, vitamins (including inhalers and injectable), supplements and topical creams you are taking so we can update your records. We look forward to seeing you soon.

Annual Wellness Visit (AWV), Initial or Subsequent:

Scheduler Call Script

Scheduler: Hello, Mr. /Mrs. /Ms. [patient's name]. This is [scheduler's name] from [clinician's name]'s office. We are contacting all of our Medicare patients to schedule your Annual Wellness Visit. How are you doing today?

Patient: I am doing well. What is an Annual Wellness Visit?

Scheduler: As you may already know, it is very important for you to see your primary care provider at least once a year. As a Medicare member, you are allowed a comprehensive Annual Wellness Visit every 12 months.

This visit includes a brief examination with routine measurements (like height and weight), review of your medical and social history related to your health, and counseling about Medicare preventive services. Our goal is to develop or update your personalized prevention health plan in order to prevent disease and disability based on your current health and risk factors. Your Medicare plan pays 100% of the cost for this exam with no out-of-pocket expense to you. However, if we need to address other medical concerns (like a sore knee or other medical conditions) at this visit, we want you to know you may have a deductible or copay.

Patient: Okay, I see. I would definitely like to come in.

Scheduler: What would be a good day to get your Annual Wellness Visit scheduled for you?

Patient: I can come in anytime in the next few weeks.

Scheduler: We will schedule your appointment [date/time].

To prepare for this visit, please bring all medications, vitamins (including inhalers and injectable), supplements and topical creams you are taking so we can update your records. When you arrive, we will ask that you complete a **Health Risk Assessment** form to assist us in developing your personalized prevention plan for you to stay healthy. If you like, we can also send this form to you to fill out before your appointment. We look forward to seeing you soon!

INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE)

Q: Who can perform an IPPE?

A: Medicare Part B covers an IPPE if it is furnished by a:

- ✓ Physician (doctor of medicine or osteopathic medicine), or
- ✓ Another qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist)

Q: When is a beneficiary eligible for the IPPE?

A: Medicare provides coverage of the IPPE for all beneficiaries who receive the IPPE within the first 12 months after the effective date of their first Medicare Part B coverage period. This is a one-time benefit per Medicare Part B enrollee. A summary of the information regarding Medicare coverage of the IPPE is available **on page 11**.

Q: Is there a way to find out whether a beneficiary previously had an IPPE and when these services were performed?

A: In order to verify whether the coverage requirements concerning time intervals between services have been met, you should contact the local Medicare contractor that has jurisdiction for the beneficiary. If the beneficiary has moved, you should contact the Medicare contractor where you believe the service may have been provided previously. The Review Contractor Directory Map can be found at this web address: **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/**

Q: What elements need to be included in the IPPE?

A: The IPPE, also commonly referred to as the "Welcome to Medicare" Preventive Visit, includes all of the elements (as defined in Medicare regulations) that can be found summarized on **page 13**.

Q: Is the IPPE required or mandated?

A: No. While CMS encourages healthcare providers to furnish the IPPE or Annual Wellness Visit (AWV) services to Medicare beneficiaries, they are not required to do so. Both IPPE and AWV are statutorily defined benefits.

Q: Does the supervising physician have to be in the same room with the patient to meet the requirements for Direct Supervision for the IPPE?

A: To meet the Direct Supervision requirement, the physician or non-physician practitioner who is billing Medicare for the service must be present in the office suite and immediately available to provide assistance and direction throughout the time the service is being provided, but they do not have to be in the room where the services are being furnished.

Q: Is an Advanced Beneficiary Notice (ABN) required for non-covered services?

A: The ABN is not required for services that are statutorily excluded from coverage, such as preventive exams. Practitioners should alert beneficiaries to financial liabilities and the voluntary ABN is *one* way of doing so.

Q: Do all Medicare Managed Care Plans cover the IPPE?

A: Yes, the IPPE and AWV *must* be covered by all Medicare Managed Care Plans following CMS coverage requirements and guidelines for these services. Medicare Advantage Organizations (MAOs) are required by statute and regulation to cover (by furnishing, arranging, or making payment for) all items and services covered under Medicare Parts A & B and that are available to Medicare beneficiaries in the plan's service area. In addition, the MAOs must comply with coverage requirements in the *Code of Federal Regulations*, CMS National Coverage Determinations, local coverage determinations from MACs with jurisdictions over the plan's service area, and general coverage guidelines and instructions in Medicare manuals, the *Federal Register* and other instructions, unless superseded by other Medicare Advantage specific requirements and instructions.

Q: What do I need to know about billing the IPPE?

A: You can read about billing and coding the IPPE on **page 33**.

ANNUAL WELLNESS VISIT (AWV)

Q: Who can perform an AWV?

A: Medicare Part B covers the AWV if it is furnished by a:

- ✓ Physician (doctor of medicine or osteopathic medicine)
- ✓ Physician assistant
- ✓ Nurse practitioner
- ✓ Clinical nurse specialist
- ✓ Medical professional (including a health educator, a registered dietitian, nutrition professional, or licensed practitioner) or a team of such medical professionals working under the direct supervision of a physician (doctor of medicine or osteopathy)

Q: When is a beneficiary eligible for the AWV?

A: Medicare provides coverage of an AWV for a beneficiary who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period and who has not received either an Initial Preventive Physical Examination (IPPE) or an AWV within the past 12 months. Medicare pays for only one first AWV per beneficiary per lifetime, and pays for one subsequent AWV per years thereafter. A brief summary of the information regarding Medicare coverage of the AWV is available on **page 11**.

Q: Is there a way to find out whether a beneficiary previously had an AWV and when these services were performed?

A: In order to verify whether the coverage requirements concerning time intervals between services have been met, you should contact the local Medicare contractor that has jurisdiction for the beneficiary. If the beneficiary has moved, you should contact the Medicare contractor where you believe the service may have been provided previously. The Review Contractor Directory Map is located at this address: **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/**

Q: What elements need to be included in the AWV?

A: The initial AWV and Subsequent AWVs should include all of the elements (as defined in Medicare regulations) that can be found summarized on **pages 17-21**.

Q: Where can I find more information on the Health Risk Assessment (HRA) for the AWV? Are there templates or examples I can use?

A: According to CMS, the standards outlined for the HRA are those that experts in the field of HRAs report as being scientifically valid and for which there is evidence of effectiveness. CMS believes it is important that health professionals have the flexibility to address additional topics, as appropriate, based on patient needs. Feel free to utilize the **HRA** included in this toolkit (**page 43; Spanish version on page 51**), but keep in mind that there are many kinds of HRAs that will meet the minimum requirements listed on the next page.

Minimum HRA requirements, as outlined by CMS:

- ✓ Accounts for the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs and is appropriately tailored to their needs
- ✓ Takes no more than 20 minutes to complete
- ✓ At a minimum, addresses the following topics:
  - Demographic data
  - Self-assessment of health status

- Psychosocial risks
- Behavioral risks
- Activities of daily living (ADLs), including, but not limited to: dressing, bathing, and walking
- Instrumental ADLs, including, but not limited to: shopping, housekeeping, managing own medications, and handling finances

Q: Is the AWV required or mandated?

A: No. While CMS encourages health care providers to furnish the Initial Preventive Physical Exam (IPPE) or AWV services to Medicare beneficiaries, they are not required to do so. Both IPPE and AWV are statutorily defined benefits.

Q: Do all Medicare Managed Care plans cover the AWV?

A: Yes, the IPPE and AWV *must* be covered by all Medicare Managed Care plans following CMS coverage requirements and guidelines for these services. Medicare Advantage Organizations (MAOs) are required by statute and regulation to cover (by furnishing, arranging, or making payment for) all items and services covered under Medicare Parts A & B and that are available to Medicare beneficiaries in the plan's service area. In addition, MAOs must comply with coverage requirements in the *Code of Federal Regulations*, CMS National Coverage Determinations, local coverage determinations from MACs with jurisdictions over the plan's service area, and general coverage guidelines and instructions in Medicare manuals, the *Federal Register* and other instructions, unless superseded by other Medicare Advantage specific requirements and instructions.

Q: Are clinical laboratory tests part of the AWV?

A: No, the AWV does not include any clinical laboratory tests, but the provider may want to make referrals for such tests as part of the AWV.

Q: Is the AWV the same as a beneficiary's yearly physical?

A: No, this visit is a preventive wellness visit and not a "routine physical checkup" that some seniors may receive every year or two from their physician and other qualified non-physician practitioner. Medicare does not provide coverage for routine physical exams.

Q: What do I need to know about billing the AWV?

A: You can read about billing and coding the AWV on **page 33**.

The information provided in this document is based on resources published by the Centers for Medicare & Medicaid Services.

Annual Planned Visits: Patient Q&A

Q: What is the "Welcome to Medicare" preventive visit? Why should I get it?

A: The "Welcome to Medicare" preventive visit puts you in control of your health and your Medicare from the start. Offered during the first year that you are enrolled in Medicare, this comprehensive visit is an easy way for you and your primary care provider to get an accurate reference point for your health now and for the future.

Q: How much does the preventive visit cost?

A: The "Welcome to Medicare" preventive visit is free for most people with Medicare.

Q: I have a Medicare Advantage Plan. Can I still get the "Welcome to Medicare" preventive visit?

A: Yes. The "Welcome to Medicare" preventive visit is available to people who are in Medicare Advantage Plans. Check with your plan to find out if your visit will be free for you.

Q: How can I get the "Welcome to Medicare" preventive visit?

A: It's easy to take advantage of the "Welcome to Medicare" preventive visit. If you currently have a primary care provider, just ask him/her about it, and schedule an appointment.

Q: If my primary care provider already knows my health history, what's the benefit of this preventive visit?

A: Enrollment in Medicare is an important step in your healthcare. At the start of this new stage, the "Welcome to Medicare" preventive visit is more comprehensive than a typical visit and allows for you and your primary care provider to discuss short-term and long-term steps to prevent disease, improve your health, and stay well. It is also the time to make sure that your healthcare wishes are carried out in the future.

Q: How long do I have to get the 'Welcome to Medicare" preventive visit after I enroll in Medicare?

A: The "Welcome to Medicare" preventive visit is offered during the first 12 months that you are enrolled in Medicare. Once you enroll, it's important to schedule your "Welcome to Medicare" preventive visit.

Q: What if I have been enrolled in Medicare longer than 12 months? Can I still get the "Welcome to Medicare" preventive visit?

A: No. After the 12-month period has passed, you will need to schedule your visit as an Annual Wellness Visit as opposed to the "Welcome to Medicare" preventive visit.

Q: What is the Annual Wellness Visit?

A: This is a visit to develop or update a prevention plan just for you, based on your current health and risk factors. You'll pay nothing for this benefit if your primary care provider participates in the Medicare program.

Q: Should I do anything to prepare for these preventive visits?

A: To make the most of your visit, you should bring the following things with you when you go to your "Welcome to Medicare" preventive visit:

- ✓ Medical records, including immunization records (if you are seeing a new doctor for the first time)
- ✓ Family health history – in advance of your appointment, try to learn as much as you can about your family's health history before your appointment; any information you can give your doctor can help you determine if you are at risk for certain diseases
- ✓ A list of prescription drugs and over-the-counter medications that you currently take, how often you take them, and why

Q: Where can I get more information on the "Welcome to Medicare" preventive visit?

A: Get more information about the "Welcome to Medicare" preventive visit at **https://www.medicare.gov/coverage/welcome-to-medicare-preventive-visit** or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

The information provided in this document is based on resources published by the Centers for Medicare & Medicaid Services.

COMMUNITY MEDICAL GROUP

BILLING & CODING ANNUAL PLANNED VISITS

CMG COMMUNITY MEDICAL GROUP

Billing & Coding: Other Preventive Services

CPT Description	CPT/ HCPC	Diagnosis Code	Coding Tips	Commonly Used Modifiers	Cost Share, Deductible, & Coinsurance	Average Reimbursement Range◆
Advance care planning; including the explanation and discussion of advance directives, such as standard forms (with completion of such forms, when performed), by the physician or after QHCP; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	99497	Use diagnosis for the condition you are counseling for.	When ACP is provided outside of the AWV, notify the patient that cost share applies. There are no limits on the number of times you can report ACP in a given time period. Document the change in the patient's health status and/or wishes regarding their care.	33*	When billed with the AWV, coinsurance and deductible are waived; with an E/M, deductible and coinsurance will be applied.	$60-98
Advance care planning; each additional 30 minutes. List separately in addition to code for primary procedure.	99498	N/A	N/A	N/A	N/A	$30-85
Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention (SBI) services, 5-14 minutes	G2011	Z13.39	If the provider performs the screening and decides the patient does not require an intervention, include the screening in the selection of the E/M or preventive service code.	N/A	Deductible and coinsurance are waived.	$17-29
Annual alcohol misuse screening (e.g., AUDIT-C); 5-15 minutes	G0442	Z13.39	G0442 must be billed first in order for subsequent claims for G0443 to be covered. Medicare covers G0442 annually. Both screening and counseling can be covered on same date of service.**	N/A	Deductible and coinsurance are waved.	$9-23
Annual depression screening; 5-15 minutes	G0444	Z13.31	For Medicare & Medicare Advantage plans, G0444 cannot be billed in conjunction with an IPPE or initial AWV as it is considered inclusive. Covered only once a year.	33* and 59	Deductible and coinsurance are waived.	$9-23

CPT Description	CPT/ HCPC	Diagnosis Code	Coding Tips	Commonly Used Modifiers	Cost Share, Deductible, & Coinsurance	Average Reimbursement Range◆
Annual, face-to-face intensive behavioral therapy for cardiovascular disease; individual, 15 minutes	G0446	Cardio disease – ICD-10 "I" codes series	Covered only once a year	59	Deductible and coinsurance are waved.	$24-33
Brief emotional/behavioral assessment with scoring and documentation, per standardized instrument (e.g., PHQ-9, ASRS)	96127	For simple emotional and behavioral screenings, use Z13.89.	You can bill up to 4 screenings per patient, per visit. Essentially, these are brief measures used to assess for depression, anxiety, suicide risk, substance abuse, ADHD, eating disorders – such as the GAD-7.	24, 25, 33*, and 59	Cost share may apply.	$5-9
Brief face-to-face alcohol counseling for alcohol misuse; for those who screen positive; 4 times per year; 15 minutes	G0443	E24.4, F10.10, F10.120, F10.121, F10.129, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.21, O99.310 - O99.315, T51.8X2A, T51.8X3A, T51.8X4A, T51.92XA, T51.93XA, T51.94XA, Z02.83, Z63.72, Z71.41, Z71.42, and Z81.1	Covered for those who screen positive for alcohol misuse, but not alcohol dependence; covered 4 times per year.**	N/A	Deductible and coinsurance are waived.	$12-20
Cervical or vaginal cancer screening; pelvic or clinical breast examination	G0101	Z11.51, Z12.39, Z12.4, Z12.72	N/A	N/A	Deductible and coinsurance are waved.	$29-51

CPT Description	CPT/ HCPC	Diagnosis Code	Coding Tips	Commonly Used Modifiers	Cost Share, Deductible, & Coinsurance	Average Reimbursement Range◆
Face-to-face behavioral counseling for obesity; 15 minutes **Criteria:** ✓ BMI greater than 30 ✓ Patient competent, alert ✓ 1st month: 1 visit per week ✓ Months 2-6: 1 visit every other week ✓ Months 7-12: 1 visit per month ✓ 6 month assessment is done to determine improvement and a minimum of 3 kg weight reduction.	G0447	Code BMI: Z68.30 through Z68.39, Z68.40 through Z68.45.	Medicare has indicated that you should not bill G0447 with any other visit code.	59	Deductible and coinsurance are waved.	$24-33
Face-to-face behavioral counseling for obesity; group (2-10), 30 minutes **Criteria**: ✓ BMI greater than 30 ✓ Patient competent, alert ✓ 1st month: 1 visit per week ✓ Months 2-6: 1 visit every other week ✓ Months 7-12: 1 visit per month ✓ 6 month assessment is done to determine improvement and a minimum of 3 kg weight reduction.	G0473	Code Obesity and BMI: E66.XX, Z68.30-Z68.39, Z68.40-Z68.45.	Group counseling – note that same criteria applies (see G0447).	N/A	Deductible and coinsurance are waived.	$12-15
High intensity behavioral counseling to prevent sexually transmitted infections; face-to-face, individual; includes education, skills-training and guidance on how to change sexual behavior; preferred semiannually, 30 minutes	G0445	Z11.3 Z11.59 Z34.03 Z34.80-83 Z34.90-93 O09.90-93	HCPCS G0445 used by Medicare plans. Refer to Preventative Medicine Counseling CPT codes 99401-99404, 99411-99412 for commercial carriers.	25	Deductible and coinsurance waived.	$28

CPT Description	CPT/ HCPC	Diagnosis Code	Coding Tips	Commonly Used Modifiers	Cost Share, Deductible, & Coinsurance	Average Reimbursement Range◆
Preventive medicine - counseling for domestic violence; individual counseling	99401-99404	Z69.11	Not covered by Medicare Part B as a preventive service Service usually not covered when billed with another preventative service on the same day	25	Deductible and coinsurance waived by most commercial carriers	$29-181
Preventive medicine - counseling for domestic violence; group counseling	99411-99412	Z69.11	Not covered by Medicare Part B as a preventive service Service usually not covered when billed with another preventative service on the same day	25	Deductible and coinsurance waived by most commercial carriers	$29-181
Prolonged preventive service(s) beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for the preventive service)	G0513	Use code for condition(s) being addressed or applicable screening code (ZXX.XX).	N/A	24, 25, and 33*	Deductible and coinsurance are waved.	$53-175
Prolonged preventive service(s) beyond the typical service time of the primary procedure, in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)	G0514	Use code for condition(s) being addressed or applicable screening code (ZXX.XX).	N/A	24, 25, and 33*	Deductible and coinsurance are waived.	$65-82

CPT Description	CPT/ HCPC	Diagnosis Code	Coding Tips	Commonly Used Modifiers	Cost Share, Deductible, & Coinsurance	Average Reimbursement Range◆
Screening pap smear; obtaining, preparing, or conveyance of cervical or vaginal smear to laboratories	Q0091	**High Risk:** Z72.51, Z72.52, Z72.53, Z77.53, Z77.29, Z77.9, Z91.89, Z92.89 **Low Risk:** Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, Z12.89	If using CPT preventive medicine services, and also performing a screening pap smear, report acode in 99381-99397 series and Q0091. If using E/M codes for a symptom or condition and practitioner also obtains a pap smear, report only the E/M service. Do not report Q0091 because it is for obtaining a screening test.	N/A	Deductible and coinsurance are waived.	$19-47
Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	99406	F17.210, F17.211, F17.213, F17.218, F17.219, F17.220, F17.221, F17.223, F17.228, F17.229, F17.290, F17.291, F17.293, F17.298, F17.299, T65.211A, T65.212A, T65.213A, T65.214A, T65.221A, T65.222A, T65.223A, T65.224A, T65.291A, T65.292A, T65.293A, T65.294A, Z87.891	Counseling (99406-99407) can be reported with E/M (99201-99215) on the same day – append Modifier 25 to E/M to indicate separate identifiable service.**	24, 25 and 33*	Deductible and coinsurance are waived.	$12-24
Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	99407					$26-49

***Tips for Billing CPT Modifier 33:** The modifier 33 was created to aid compliance with the Affordable Care Act (ACA) which prohibits member cost sharing for defined preventive services for non-grandfathered health plans. The appropriate use of modifier 33 reduces claim adjustments related to preventive services and your corresponding refunds to members. Modifier 33 is applicable to CPT codes representing preventive care services. CPT codes not appended with modifier 33 will process under the member's medical or preventive benefits, based on the diagnosis and CPT codes submitted. Modifier 33 should be appended to codes represented for services described in the US Preventive Services Task Force (USPSTF) A

and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by the Health Resources and Services Administration (HRSA) Guidelines. The CPT 2016 Professional Edition Manual shares the following information regarding the billing of modifier 33, "When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used."

****Not all carriers may cover all services listed – check with individual carriers.** You should also check with carriers regarding frequency limitations for each service. Under Section 2713 of the ACA, private health plans must provide coverage for a range of preventive services and may not impose cost-sharing (such as copayments, deductibles, or co-insurance) on patients receiving these services. Any E/M services reported on the same day must be distinct and reported with modifier 25, and time spent providing these services may not be used as a basis for the E/M code selection.

◆**Average reimbursement range up-to-date as of January 2023.** Check fee schedules for most updated information.

CMG COMMUNITY MEDICAL GROUP

ADDITIONAL TOOLS FOR YOUR PRACTICE

CMG COMMUNITY MEDICAL GROUP

Health Risk Assessment Form

PATIENT INFORMATION

Today's Date:	
First Name:	
Last Name, Suffix:	
Date of Birth:	
Sex:	

GENERAL QUESTIONS

1. **What is your height?**
   _____ feet _____ inches

2. **What is your weight?**
   - ☐ Under 100 pounds
   - ☐ 100-125 pounds
   - ☐ 126-150 pounds
   - ☐ 151-175 pounds
   - ☐ 176-200 pounds
   - ☐ 201-225 pounds
   - ☐ Over 226 pounds

3. **In general, how would you rate your health?**
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

4. **Have you had your flu shot this year or are you planning to receive one this year?**
   - ☐ Yes
   - ☐ No

5. **When is the last time you had a pneumonia vaccine?**
   - ☐ In the last year
   - ☐ In the last 2-4 years
   - ☐ In the last 5 years
   - ☐ In the last 10 years
   - ☐ Never
   - ☐ Not applicable

6. **When is the last time you had a breast cancer screening (mammogram)?**
   - ☐ In the last year
   - ☐ In the last 2-4 years
   - ☐ In the last 5 years
   - ☐ In the last 10 years
   - ☐ Never
   - ☐ Not applicable

7. **When is the last time you had a colorectal cancer screening?**
   - ☐ In the last year
   - ☐ In the last 2-4 years
   - ☐ In the last 5 years
   - ☐ In the last 10 years
   - ☐ Never
   - ☐ Not applicable

YOUR HEALTH

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

- ☐ Asthma
- ☐ Bipolar disorder
- ☐ Cancer
- ☐ COPD or emphysema
- ☐ Coronary artery disease
- ☐ Dementia
- ☐ Diabetes
- ☐ Hearing problems
- ☐ Heart failure
- ☐ Hypertension
- ☐ Organ transplant
- ☐ Renal/kidney failure
- ☐ Stroke
- ☐ Vision problems
- ☐ Other medical conditions: _____ _____
- ☐ No medical conditions

9. How many medications do you take?

- ☐ No medications
- ☐ 1-3 medications
- ☐ 4-5 medications
- ☐ 6-7 medications
- ☐ 8 or more medications

10. Do you find that you sometimes have to choose between buying groceries or medications?

- ☐ Yes
- ☐ No

11. Have you fallen or had issues with walking or balance in the past 6 months? (A fall is when your body goes to the ground without being pushed.)

- ☐ Yes
- ☐ No

12. In the past 6 months, have you experienced leaking of urine?

- ☐ Yes, and it made me change my daily activities and interfered with my sleep
- ☐ Yes, but it did not make me change my daily activities or interfere with my sleep
- ☐ No

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

- ☐ 0 times
- ☐ 1 time
- ☐ 2 times
- ☐ 3 or more times

14. In the past 3 months, how many times have you had unplanned overnight stays as a patient in a hospital?

- ☐ 0 times
- ☐ 1 time
- ☐ 2 times
- ☐ 3 or more times

15. How often do you exercise or engage in physical activity?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Always
- ☐ Often

16. Has your healthcare provider recently told you that you need to lose weight?

- ☐ Yes
- ☐ No

17. Are you on a special diet recommended by your healthcare provider?

- ☐ Yes
- ☐ No

18. How many times per week do you eat red meat?

- ☐ 0-1 times per week
- ☐ 2-3 times per week
- ☐ 4-5 times per week
- ☐ 5 or more times per week

19. How many times per week do you eat vegetables?

- ☐ 0-1 times per week
- ☐ 2-3 times per week
- ☐ 4-5 times per week
- ☐ 5 or more times per week

20. How many times per week do you eat prepared meals (frozen pizza or TV dinners like Lean Cuisine, Healthy Choice, Stouffer's, etc.)?

- ☐ 0-1 times per week
- ☐ 2-3 times per week
- ☐ 4-5 times per week
- ☐ 5 or more times per week

21. How many times per week do you cook your own meals from scratch?

- ☐ 0-1 times per week
- ☐ 2-3 times per week
- ☐ 4-5 times per week
- ☐ 5 or more times per week

22. How many times per week do you eat out at a restaurant?

- ☐ 0-1 times per week
- ☐ 2-3 times per week
- ☐ 4-5 times per week
- ☐ 5 or more times per week

23. When was the last time you smoked or used any tobacco products, including cigarettes, chew, snuff, pipes, cigars, and/or vapor cigarettes?

- ☐ Today
- ☐ Last week
- ☐ Last month
- ☐ Last 3 months
- ☐ Last year
- ☐ A year to 5 years ago
- ☐ Longer than 5 years ago
- ☐ Never

24. Are you interested in quitting tobacco use?

- ☐ Yes
- ☐ No
- ☐ Not applicable

25. In the past 2 weeks, have you felt stressed or anxious?

- ☐ Yes
- ☐ No

26. In the past 2 weeks, have you had little interest or pleasure in doing things that you normally like to do?

- ☐ Yes
- ☐ No

27. In the past 2 weeks, have you been feeling downhearted, depressed, or "blue" more than usual?

- ☐ Yes
- ☐ No

28. Are you using any street drugs or abusing medications?

- ☐ Yes
- ☐ No

29. Do you drink alcohol?

- ☐ Yes
- ☐ No

30. Have you ever thought you should cut down your drug or alcohol use?

- ☐ Yes
- ☐ No
- ☐ Not applicable

31. Have you ever felt annoyed when people have commented on your drug or alcohol use?

- ☐ Yes
- ☐ No
- ☐ Not applicable

32. Have you ever felt guilty or badly about your drug or alcohol use?

- ☐ Yes
- ☐ No
- ☐ Not applicable

33. Have you ever used drugs to ease withdrawal symptoms, or to avoid feeling low after using drugs or alcohol?

- ☐ Yes
- ☐ No
- ☐ Not applicable

34. Have you ever been treated for drug or alcohol abuse?

- ☐ Yes
- ☐ No
- ☐ Not applicable

35. In the past 4 weeks, how much body pain have you had?

- ☐ None
- ☐ Very mild
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Very severe

36. During the past 4 weeks, how much did pain interfere with your normal activities?

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

37. During the past 4 weeks, how has your health impacted your ability to work or caused you to be absent from activities you enjoy?

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

38. Which of the following (if any) do you need help doing?

- ☐ Standing up from a sitting position
- ☐ Walking in the house
- ☐ Walking outside of the house
- ☐ Preparing a meal
- ☐ Eating a meal
- ☐ Getting dressed
- ☐ Bathing
- ☐ Using the toilet
- ☐ Organizing your day
- ☐ Driving or getting to places

39. If you need help doing any of the above activities, do you have someone who can assist you?

- ☐ Yes
- ☐ No

40. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your health care provider or pharmacy?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Never

41. 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

42. Do you have a Medical Power of Attorney? (Medical Power of Attorney = someone to make medical decisions for you in the event you are unable to.)

- ☐ Yes
- ☐ No
- ☐ I do not know or remember

43. Do you have a living will or advance directive? (These are documents that make your healthcare wishes known.)

- ☐ Yes
- ☐ No
- ☐ I do not know or remember

44. Is a copy of your advance directive on file at your health care provider's office?

- ☐ Yes
- ☐ No
- ☐ I do not know or remember

ABOUT YOU AND YOUR HEALTH CARE

45. Please indicate how strongly you agree or disagree with the following statements:

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
My health is important to me.	☐	☐	☐	☐
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 take care of myself.	☐	☐	☐	☐
I am confident I can talk to my health care provider about my health concerns even when he or she does not ask.	☐	☐	☐	☐
I am confident I can follow through on medical treatments I may need to do at home.	☐	☐	☐	☐
It is easy for me to get timely appointments with my health care providers, including specialists.	☐	☐	☐	☐
It is easy for me to get timely care, tests, and treatment when I need them.	☐	☐	☐	☐
I am able to access urgent care as soon as I need it.	☐	☐	☐	☐
My health care providers communicate, collaborate and manage my care/services to my satisfaction.	☐	☐	☐	☐
My health care providers follow up promptly on test results.	☐	☐	☐	☐
My health care providers talk to me about all the medications I am taking.	☐	☐	☐	☐
I am satisfied with my overall healthcare.	☐	☐	☐	☐
I am satisfied with the care I receive from my primary health care provider.	☐	☐	☐	☐
I am satisfied with the care I receive from my primary specialist (the specialist I see most often).	☐	☐	☐	☐

46. Who completed this Health Risk Assessment form?

- ☐ Myself
- ☐ Relative of mine
- ☐ Friend of mine
- ☐ Professional caregiver of mine

47. Whom do you live with?

- ☐ I live alone.
- ☐ I live with my spouse or significant other.
- ☐ I live with a family member.
- ☐ I live with someone who is not related to me.
- ☐ I live in a nursing home or assisted living facility.

48. What is your primary language?

- ☐ English
- ☐ Spanish
- ☐ Other language: _____

49. What is the highest grade or level of school that you completed?

- ☐ 8th grade or less
- ☐ Some high school, but I did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year college degree
- ☐ 4-year college degree
- ☐ More than a 4-year college degree

50. What is your ethnicity?

- ☐ African-American
- ☐ Native American
- ☐ Hispanic
- ☐ Native Hawaiians
- ☐ Indian
- ☐ Asian
- ☐ Caucasian
- ☐ Pacific Islander
- ☐ Other

51. Do you ever choose not to seek medical care because of religious or personal beliefs?

- ☐ Yes
- ☐ No
- ☐ No answer

NOTE: This HRA was created with guidance from a template designed by Cigna HealthSpring. The HRA questions outlined above are provided as examples. They represent one HRA model; use of this model is not a requirement for the Medicare Annual Wellness Visit HRA, as a variety of HRA instruments will meet the Medicare HRA definition. Clinician discretion will guide the implementation and use of HRAs. HRAs are not intended to be prescriptive, and clinician judgment will identify appropriate interventions for individual patients.

CMG COMMUNITY MEDICAL GROUP

Forma de evaluación de riesgo de salud

Información de paciente

Fecha de hoy:	
Primer nombre:	
Apellido:	
Fecha de nacimiento:	
Sexo:	

Preguntas generales

1. **¿Cuál es su estatura?**
   _____ pies _____ pulgadas

2. **¿Cuál es su peso?**
   - ☐ Menos de 100 libras
   - ☐ 100-125 libras
   - ☐ 126-150 libras
   - ☐ 151-175 libras
   - ☐ 176-200 libras
   - ☐ 201-225 libras
   - ☐ Sobre 226 libras

3. **¿En general, como usted considera su salud?**
   - ☐ Excelente
   - ☐ Muy buena
   - ☐ Buena
   - ☐ Aceptable
   - ☐ Pobre

4. **¿Ha tenido su vacuna de influenza este año, o está planeando recibirla este año?**
   - ☐ Sí
   - ☐ No

5. **¿Cuándo fue la última vez que tuvo la vacuna de neumonía?**
   - ☐ En el último año
   - ☐ En los últimos 2-4 años
   - ☐ En los últimos 5 años
   - ☐ En los últimos 10 años
   - ☐ Nunca
   - ☐ No aplica

6. **¿Cuándo fue la última vez que tuvo un examen para cáncer de senos (mamograma)?**
   - ☐ En el último año
   - ☐ En los últimos 2-4 años
   - ☐ En los últimos 5 años
   - ☐ En los últimos 10 años
   - ☐ Nunca
   - ☐ No aplica

7. **¿Cuándo fue la última vez que tuvo un examen de cáncer colorrectal (colonoscopía)?**
   - ☐ En el último año
   - ☐ En los últimos 2-4 años
   - ☐ En los últimos 5 años
   - ☐ En los últimos 10 años
   - ☐ Nunca
   - ☐ No aplica

Su salud

8. ¿Qué condiciones médicas tiene o ha tenido en el pasado?

- ☐ Asma
- ☐ Cáncer
- ☐ COPD/enfisema
- ☐ Demencia
- ☐ Derrame cerebral
- ☐ Desorden de bipolar
- ☐ Diabetes
- ☐ Enfermedad de arteria coronaria
- ☐ Fallo renal
- ☐ Hipertensión
- ☐ Problema de audición
- ☐ Problema de corazón
- ☐ Problemas de visión
- ☐ Trasplante de órgano
- ☐ Otras condiciones médicas: _____ _____
- ☐ Sin condiciones médicas

9. ¿Cuántos medicamentos usted toma?

- ☐ No medicamentos
- ☐ 1-3 medicamentos
- ☐ 4-5 medicamentos
- ☐ 6-7 medicamentos
- ☐ 8 o más medicamentos

10. ¿Usted siente que a veces tienes que escoger entre comprar alimentos o medicamentos?

- ☐ Sí
- ☐ No

11. ¿Se ha caído o ha tenido problemas de caminar o mantener el equilibrio en los últimos 6 meses? (Una caída es cuando su cuerpo cae al piso sin ser empujado.)

- ☐ Sí
- ☐ No

12. En los últimos 6 meses, ¿ha experimentado pérdidas de orina?

- ☐ Sí, y me hizo cambiar mis actividades diarias e interfirió con mi sueño
- ☐ Sí, pero no me hizo cambiar mis actividades diarias ni interfirió con mi sueño

13. ¿En los últimos 3 meses, cuantas veces fue a la sala de emergencia?

- ☐ 0 veces
- ☐ 1 vez
- ☐ 2 veces
- ☐ 3 o más veces

14. ¿En los últimos 3 meses, cuantas veces ha tenido hospitalizaciones no planeadas en el hospital?

- ☐ 0 veces
- ☐ 1 vez
- ☐ 2 veces
- ☐ 3 o más veces

15. ¿Le ha dicho su proveedor de salud recientemente que tiene que bajar de peso?

- ☐ Sí
- ☐ No

16. ¿Está usted en una dieta especial recomendada por su proveedor de salud?

- ☐ Sí
- ☐ No

17. ¿Cuántas veces a la semana usted come carnes rojas?

- ☐ 0-1 vez por semana
- ☐ 2-3 veces por semana
- ☐ 4-5 veces por semana
- ☐ 5 o más veces por semana

18. ¿Cuántas veces a la semana usted come vegetales?

- 0-1 vez por semana
- 2-3 veces por semana
- 4-5 veces por semana
- 5 o más veces por semana

19. ¿Cuántas veces a la semana usted come comidas preparadas (pizza congelada o comidas congeladas, como Lean Cuisine, Healthy Choice, Stouffer's, etc.)?

- 0-1 vez por semana
- 2-3 veces por semana
- 4-5 veces por semana
- 5 o más veces por semana

20. ¿Cuántas veces a la semana usted cocina su propia comida?

- 0-1 vez por semana
- 2-3 veces por semana
- 4-5 veces por semana
- 5 o más veces por semana

21. ¿Cuantas veces a la semana usted come fuera en un restaurante?

- 0-1 vez por semana
- 2-3 veces por semana
- 4-5 veces por semana
- 5 o más veces por semana

22. ¿Cuándo fue la última vez que usted fumó o usó algún producto con tabaco, incluyendo cigarrillos, masticado, inhalado, pipas, cigarro, o cigarrillos de vapor?

- Hoy
- La semana pasada
- El mes pasado
- Los últimos 3 meses
- El año pasado
- Hace 1-5 años
- Más de 5 años
- Nunca

23. ¿Está interesado en dejar de fumar o usar tabaco?

- Sí
- No
- No aplica

24. ¿En las pasadas dos semanas, se ha sentido estresado o ansioso?

- Sí
- No

25. ¿En las pasadas dos semanas, ha sentido poco interés o placer en hacerlas cosas que normalmente hace?

- Sí
- No

26. ¿En las pasadas dos semanas, se ha sentido desanimado o deprimido más de los usual?

- Sí
- No

27. ¿Está usando algunas drogas ilícitas o abusando medicamentos?

- Sí
- No

28. ¿Usted toma alcohol?

- Sí
- No

29. ¿Ha pensado usted que debería disminuir su uso de drogas o alcohol?
- Sí
- No
- No aplica

30. ¿Se ha sentido alguna vez molesto cuando alguna persona ha comentado acerca de su uso de droga o alcohol?
- Sí
- No
- No aplica

31. ¿Se ha sentido alguna vez culpable o mal sobre su uso de drogas o alcohol?
- Sí
- No
- No aplica

32. ¿Alguna vez ha usado drogas para ayudar con alivio de síntomas de abstinencia o para evitar sentirse desanimado después de usar drogas o alcohol?
- Sí
- No
- No aplica

33. ¿Ha sido tratado para el abuso de drogas o alcohol?
- Sí
- No
- No aplica

34. Durante las pasadas 4 semanas, ¿cuánto dolor de cuerpo ha tenido?
- Nada
- Muy poco
- Poco
- Moderado
- Severo
- Muy severo

35. ¿Durante las pasadas 4 semanas, cuanto interfirió el dolor con sus actividades normales?
- Para nada
- Un poco
- Moderadamente
- Bastante
- Extremadamente

36. ¿Durante las pasadas 4 semanas, cuanto su salud ha afectado su capacidad de trabajo o ha causado que se ausente de las actividades que disfruta?
- Para nada
- Un poco
- Moderadamente
- Bastante
- Extremadamente

37. ¿Con cuál de las siguientes (si alguna) usted necesita ayuda para hacer?

- Parándose de una posición sentada
- Caminando en la casa
- Caminando afuera de la casa
- Preparando alimentos
- Comiendo alimentos
- Vestirse
- Bañarse
- Usando el inodoro
- Organizando su día
- Manejando o llegando a lugares

38. ¿Si usted necesita ayuda haciendo algunas de las actividades antes mencionadas, tiene alguien que lo ayude?
- Sí
- No

39. ¿Qué tan seguido necesita alguien que lo ayude a leer instrucciones, panfletos, o algún otro material escrito de su proveedor de salud o farmacia?

- ☐ Siempre
- ☐ Usualmente
- ☐ Algunas veces
- ☐ Nunca

40. ¿En las pasadas 2 semanas, ha experimentado usted algún cambio significativo en la cantidad de tiempo que usted duerme normalmente, ya sea problemas para poder dormir o durmiendo mucho?

- ☐ Sí
- ☐ No

Planificación de cuidado avanzado

41. ¿Usted tiene un Poder Legal Médico (Poder Legal Médico = alguien que puede tomar decisiones médicas en caso de que usted no pueda)?

- ☐ Sí
- ☐ No
- ☐ No sé o no recuerdo

42. ¿Usted tiene un testamento o directiva médica anticipada? (Estos son documentos para que se conozcan sus deseos de cuidado de salud.)

- ☐ Sí
- ☐ No
- ☐ No sé o no recuerdo

43. ¿Hay una copia de su directiva médica anticipada en su record en la oficina de su proveedor primario?

- ☐ Sí
- ☐ No
- ☐ No sé o no recuerdo

Sobre usted y su atención médica

44. ¿Por favor indique cuán fuertemente usted está de acuerdo o desacuerdo con las siguientes declaraciones?

	TOTALMENTE DESACUERDO	DESACUERDO	DE ACUERDO	TOTALMENTE DE ACUERDO
Mi salud es importante para mí.	☐	☐	☐	☐
Es importante para mi tomar un rol activo en mi cuidado de salud.	☐	☐	☐	☐
Estoy confiado que me puedo provenir o reducir problemas asociados con mi salud.	☐	☐	☐	☐
Estoy confiado de que sé cuándo necesito buscar cuidado médico y cuando puedo cuidarme yo mismo.	☐	☐	☐	☐
Estoy confiado de que puedo hablar con mi proveedor de salud sobre mis preocupaciones de salud aun cuando él o ella no pregunten.	☐	☐	☐	☐
Estoy confiado de que puedo continuar tratamientos médicos que yo necesito hacer en la casa.	☐	☐	☐	☐
Es fácil para mí obtener citas oportunas con mis proveedores de atención médica, incluidos los especialistas.	☐	☐	☐	☐
Es fácil para mí obtener atención, pruebas y tratamiento oportunos cuando los necesito.	☐	☐	☐	☐
Puedo acceder a la atención de urgencia tan pronto como la necesito.	☐	☐	☐	☐
Mis proveedores de atención médica se comunican, colaboran y administran mi atención/servicios a mi entera satisfacción.	☐	☐	☐	☐
Mis proveedores de atención médica realizan un seguimiento inmediato de los resultados de las pruebas.	☐	☐	☐	☐
Mis proveedores de atención médica me hablan sobre todos los medicamentos que estoy tomando.	☐	☐	☐	☐
Estoy satisfecho con mi atención médica en general.	☐	☐	☐	☐
Estoy satisfecho con la atención que recibo de mi proveedor de atención médica primaria.	☐	☐	☐	☐
Estoy satisfecho con la atención que recibo de mis especialistas primarios (los especialistas que veo con más frecuencia).	☐	☐	☐	☐

45. ¿Quién completó esta evaluación de riesgo de salud?

- ☐ Yo mismo
- ☐ Un familiar
- ☐ Un amigo
- ☐ Mi cuidador profesional

46. ¿Con quién vive?

- Yo vivo solo.
- Yo vivo con mi esposo o pareja.
- Yo vivo con un familiar.
- Yo vivo con alguien que no está relacionado conmigo.
- Yo vivo en un asilo de ancianos o en una facilidad de vivienda asistida.

47. ¿Cuál es su idioma principal?

- Ingles
- Español
- Otro idioma

48. ¿Cuál es el grado o nivel más alto que usted alcanzó en la escuela?

- 8 grado o menos
- Parte de escuela superior, pero no me gradué
- Escuela superior o GED
- Parte de colegio o título universitario de 2 años
- Título universitario de 4 años
- Más de 4 años

49. ¿Cuál es su etnicidad?

- Afroamericano
- Nativo americano
- Hispano
- Hawaiano nativo
- Indio
- Asiático
- Blanco
- Isleño del Pacífico
- Otro

50. ¿Ha usted escogido alguna vez no buscar atención médica basado en sus creencias religiosas o personales?

- Sí
- No
- No respuesta

Gracias por tomar de su tiempo para completar esta evaluación de riesgo de salud.

NOTA: Esta evaluación de riesgo de salud fue diseñada basada en una forma provista por Cigna HealthSpring. Las preguntas mencionadas anteriormente están provistas como ejemplos. Estas representan un modelo de evaluación de riesgo de salud. El uso de este modelo no es requerido para visita de bienestar anual de Medicare, pues hay una variedad de instrumentos de evaluación de riesgo de salud que cumple con los requisitos de la definición provista por Medicare. Discreción clínica guiara la implementación y uso de la evaluación de riesgo de salud. Esto no está destinado a ser prescriptivo y juicio clínico identificara las intervenciones apropiadas para cada paciente individualmente.

CMG COMMUNITY MEDICAL GROUP

Fall Risk Assessment

PATIENT INFORMATION	
Today's Date:	
Patient's Name:	
Date of Birth:	
Sex:	

FALL RISK ASSESSMENT		
Questions	**Yes**	**No**
1. Are you over the age of 65?	**1**	**0**
2. ***For the healthcare provider:*** Does the patient have 3 or more co-existing medical diagnoses?	**1**	**0**
3. Have you fallen once in the last three months?	**1**	**0**
4. If you answered "Yes" to the previous question, were you injured? a. If yes, please describe injury: _____	**1**	**0**
5. Do you have any inability to make it to the bathroom or commode in a timely manner? (This includes frequency, urgency, and/or nocturia.)	**1**	**0**
6. Do you have any visual impairment? (Examples: macular degeneration, diabetic retinopathies, visual field loss, age-related changes, decline in visual acuity, glare intolerance, depth perception, or night vision.)	**1**	**0**
7. Do you have any gait (walking) problems? (Examples: arthritis, pain, fear of falling, foot problems, impaired sensation, or impaired coordination.)	**1**	**0**
8. Are there any environmental hazards at home, such as poor lighting, equipment tubing, inappropriate footwear, pets, uneven floor surfaces, or clutter in the doorways?	**1**	**0**
9. Are you taking at least 4 or more prescriptions of ANY type? (Drugs associated with fall risk, include narcotics, anti-depressants, cardiac medications, anti-anxiety drugs.)	**1**	**0**
10. Do you have pain severe enough to affect your ability to move or pain severe enough to be a factor in maintaining your safety?	**1**	**0**
11. ***For the healthcare provider:*** Does the patient suffer from dementia or Alzheimer's disease? Have they suffered a stroke? Do they have decreased comprehension or memory deficits?	**1**	**0**
Total Score: A total score of 4 or more is considered at risk for falling**.**		

This Fall Risk Assessment form was created with guidance from the Johns Hopkins Fall Risk Assessment Tool.

_____

Healthcare Provider – Sign Above

CMG COMMUNITY MEDICAL GROUP

Forma de evaluación de riesgo de caída

Información de paciente	
Fecha de hoy:	
Primer nombre y apellido:	
Fecha de nacimiento:	
Sexo:	

Evaluación de riesgo de caída		
Preguntas	**Sí**	**No**
1. ¿Tiene más de 65 años?	**1**	**0**
2. ***For the healthcare provider:*** Does the patient have 3 or more co-existing medical diagnoses?	**1**	**0**
3. ¿Se ha caído una vez en los últimos tres meses?	**1**	**0**
4. Si respondió "Sí" a la pregunta anterior, ¿estuvo lesionado? a. En caso afirmativo, describa la lesión: _____	**1**	**0**
5. ¿Es incapaz de llegar al baño o al baño portátil a tiempo? (Esto incluye frecuencia urinaria, urgencia y/o necesidad de levantarse a orinar en la noche.)	**1**	**0**
6. ¿Tienes algún impedimento visual? (Ejemplos: degeneración macular, retinopatía diabética, pérdida del campo visual, cambios relacionados con la edad, disminución de la agudeza visual, intolerancia al resplandor, percepción de la profundidad o visión nocturna.)	**1**	**0**
7. ¿Tienes algún problema para caminar? (Ejemplos: artritis, dolor, miedo a caerse, problemas en los pies, problemas de la sensibilidad o problemas de coordinación.)	**1**	**0**
8. ¿Hay algún riesgo ambiental en el hogar, como iluminación deficiente, tubos de equipo, calzado inadecuado, mascotas, superficies irregulares del piso o desorden que bloquea las puertas?	**1**	**0**
9. ¿Está tomando por lo menos 4 o más medicamentos de cualquier tipo? (Los medicamentos asociados con el riesgo de caída incluyen narcóticos, antidepresivos, medicamentos cardíacos y medicamentos contra la ansiedad).	**1**	**0**
10. ¿Tiene un dolor lo suficientemente severo como para afectar su capacidad para moverse o un dolor lo suficientemente severo como para ser un factor en mantener su seguridad?	**1**	**0**
11. ***For the healthcare provider:*** Does the patient suffer from dementia or Alzheimer's disease? Have they suffered a stroke? Do they have decreased comprehension or memory deficits?	**1**	**0**
Total Score: A total score of 4 or more is considered at risk for falling**.**		

This Fall Risk Assessment form was created with guidance from the Johns Hopkins Fall Risk Assessment Tool.

_____

Healthcare Provider – Sign Above

CMG COMMUNITY MEDICAL GROUP

Patient Health Questionnaire (PHQ-9)

PATIENT INFORMATION	
Today's Date:	
Patient's Name:	
Date of Birth:	
Sex:	

QUESTIONNAIRE				
Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.	**Not at all**	**Several days**	**More than half the days**	**Nearly everyday**
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 badly about yourself – or feeling that you are a failure and 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 fidgety and 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 in some way	**0**	**1**	**2**	**3**
Healthcare providers, please calculate totals for each column and combine for Total Score:	**0**			
TOTAL SCORE:				

If you checked off any of the problems above, 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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CMG COMMUNITY MEDICAL GROUP

Cuestionario sobre la salud del paciente (PHQ-9)

Información de paciente	
Fecha de hoy:	
Primer nombre y apellido:	
Fecha de nacimiento:	
Sexo:	

Cuestionario

Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? Por favor circule sus respuestas.	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Poco interés o placer en hacer cosas	**0**	**1**	**2**	**3**
2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas	**0**	**1**	**2**	**3**
3. Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado	**0**	**1**	**2**	**3**
4. Se ha sentido cansado(a) o con poca energía	**0**	**1**	**2**	**3**
5. Sin apetito o ha comido en exceso	**0**	**1**	**2**	**3**
6. Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	**0**	**1**	**2**	**3**
7. Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión	**0**	**1**	**2**	**3**
8. ¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal	**0**	**1**	**2**	**3**
9. Ha tenido pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera	**0**	**1**	**2**	**3**
Healthcare providers, please calculate totals for each column and combine for Total Score:	**0**			
TOTAL SCORE:				

Si marcó cualquiera de los problemas, ¿qué tanta dificultad le han dado estos problemas para hacer su trabajo, encargarse de las tareas del hogar, o llevarse bien con otras personas?

- ☐ No ha sido difícil
- ☐ Un poco difícil
- ☐ Muy difícil
- ☐ Extremadamente

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CMG COMMUNITY MEDICAL GROUP

Patient Questionnaire (GAD-7)*

PATIENT INFORMATION	
Today's Date:	
Patient's Name:	
Date of Birth:	
Sex:	

QUESTIONNAIRE				
Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.	**Not at all**	**Several days**	**More than half the days**	**Nearly everyday**
1. Feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
2. Not being able to stop or control worrying	**0**	**1**	**2**	**3**
3. Worrying too much about different things	**0**	**1**	**2**	**3**
4. Trouble relaxing	**0**	**1**	**2**	**3**
5. Being so restless that it is hard to sit still	**0**	**1**	**2**	**3**
6. Becoming easily annoyed or irritable	**0**	**1**	**2**	**3**
7. Feeling afraid, as if something awful might happen	**0**	**1**	**2**	**3**
Healthcare providers, please calculate totals for each column and combine for Total Score:	**0**			
TOTAL SCORE:				

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*Please, note that providers are not required to administer the GAD-7 during the IPPE or any AWVs. This screening form is included as an optional resource for your practice to use.

CMG COMMUNITY MEDICAL GROUP

Cuestionario sobre la salud (GAD-7)*

Información de paciente	
Fecha de hoy:	
Primer nombre y apellido:	
Fecha de nacimiento:	
Sexo:	

Cuestionario				
Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? Por favor circule sus respuestas.	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta	**0**	**1**	**2**	**3**
2. No ha sido capaz de parar o controlar su preocupación	**0**	**1**	**2**	**3**
3. Se ha preocupado demasiado por motivos diferentes	**0**	**1**	**2**	**3**
4. Ha tenido dificultad para relajarse	**0**	**1**	**2**	**3**
5. Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)	**0**	**1**	**2**	**3**
6. Se ha molestado o irritado fácilmente	**0**	**1**	**2**	**3**
7. Ha tenido miedo de que algo terrible fuera a pasar	**0**	**1**	**2**	**3**
Healthcare providers, please calculate totals for each column and combine for Total Score:	**0**			
TOTAL SCORE:				

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*Please note that providers are not required to administer the GAD-7 during the IPPE or any AWVs. This screening form is included as an optional resource for your practice to use.

CMG COMMUNITY MEDICAL GROUP

Patient Questionnaire (AUDIT-C)

PATIENT INFORMATION	
Today's Date:	
Patient's Name:	
Date of Birth:	
Sex:	

QUESTIONNAIRE

1. **How often do you have a drink containing alcohol?**
   - ☐ Never
   - ☐ Monthly or less
   - ☐ 2-4 times a month
   - ☐ 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ 1 or 2
   - ☐ 3 or 4
   - ☐ 5 or 6
   - ☐ 7 to 9
   - ☐ 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - ☐ Never
   - ☐ Less than monthly
   - ☐ Monthly
   - ☐ Weekly
   - ☐ Daily or almost daily

This form was created with guidance from the U.S. Department of Veterans Affairs website. The AUDIT-C Test is a publication of the World Health Organization.

CMG COMMUNITY MEDICAL GROUP

Cuestionario sobre la salud (AUDIT-C)

Información de paciente	
Fecha de hoy:	
Primer nombre y apellido:	
Fecha de nacimiento:	
Sexo:	

Cuestionario

1. **¿Con qué frecuencia consume alguna bebida alcohólica?**
   - ☐ Nunca
   - ☐ Una o menos veces al mes
   - ☐ De 2 a 4 veces
   - ☐ De 2 a 3 veces a la semana
   - ☐ 4 o más veces a la semana

2. **¿Cuantas bebidas alcohólicas suele consumir en un día de consumo normal?**
   - ☐ 1 or 2
   - ☐ 3 or 4
   - ☐ 5 or 6
   - ☐ 7, 8, o 9
   - ☐ 10 o más

3. **¿Con qué frecuencia toma 6 o más bebidas alcohólicas en un sólo día?**
   - ☐ Nunca
   - ☐ Menos de una vez al mes
   - ☐ Mensualmente
   - ☐ Semanalmente
   - ☐ A diario o casi a diario

This form was created with guidance from the U.S. Department of Veterans Affairs website. The AUDIT-C Test is a publication of the World Health Organization.

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Six Item Cognitive Impairment Test (6CIT)

PATIENT INFORMATION	
Today's Date:	
Patient's Name:	
Date of Birth:	
Sex:	

TEST		
Questions	**Possible Points**	**Points**
1. "What year is it?"	**Correct =** 0 points **Incorrect =** 4 points	
2. "What month is it?"	**Correct =** 0 points **Incorrect =** 3 points	
3. "About what time is it?"	**Correct =** 0 points **Incorrect =** 3 points	
4. "Count backwards from 20 to 1."	**Correct =** 0 points **1 error** = 2 points **More than 1 error =** 4 points	
Before proceeding to the next item, tell the patient, "Remember these four words: book, car, eagle, and phone." (You can also tell the patient to memorize any 5-item street address.)		
5. "Say the months of the year in reverse."	**Correct =** 0 points **1 error =** 2 points **More than 1 error =** 4 points	
6. "Repeat the four words."	**Correct =** 0 points **1 error =** 2 points **2 errors =** 4 points **3 errors =** 6 points **4 errors =** 8 points **All wrong =** 10 points	
Scoring Guide: 0-7 = Normal 8-9 = Mild Cognitive Impairment 10-28 = Significant Cognitive Impairment	**6CIT Score:**	_____ **points** **28 possible points**

This form was created with guidance from OPTUM's Cognitive-Function Screening Form.

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6 artículo prueba de deterioro cognitivo (6CIT)

Información de paciente	
Fecha de hoy:	
Primer nombre y apellido	
Fecha de nacimiento:	
Sexo:	

6 artículo prueba de deterioro cognitivo

Questions	Possible Points	Points
1. "¿Que año es?"	**Correct =** 0 points **Incorrect =** 4 points	
2. "¿Qué mes es?"	**Correct =** 0 points **Incorrect =** 3 points	
3. "¿Aproximadamente, qué hora es?"	**Correct =** 0 points **Incorrect =** 3 points	
4. "Cuente hacia atrás de 20 a 1."	**Correct =** 0 points **1 error** = 2 points **More than 1 error =** 4 points	
Before proceeding to the next item, tell the patient, "Recuerda estas cuatro palabras: libro, automóvil, águila y teléfono."		
5. "Diga los meses del año al revés."	**Correct =** 0 points **1 error =** 2 points **More than 1 error =** 4 points	
6. "Repite las cuatro palabras."	**Correct =** 0 points **1 error =** 2 points **2 errors =** 4 points **3 errors =** 6 points **4 errors =** 8 points **All wrong =** 10 points	
Scoring Guide: 0-7 = Normal 8-9 = Mild Cognitive Impairment 10-28 = Significant Cognitive Impairment	**6CIT Score:**	_____ **points** **28 possible points**

This form was created with guidance from OPTUM's Cognitive-Function Screening Form.

Screening Results Interpretation Guide

The following section briefly describes how to interpret results from the screenings included in this toolkit. For more detailed instructions, please visit: www.phqscreeners.com and/or www.mdcalc.com.

Six Item Cognitive Impairment Test (6CIT) *Dementia screening*	
Patient scored between 0-7:	**Normal** – Referral to specialist not necessary at present time
Patient scored between 8-9:	**Mild cognitive impairment** – Probably refer the patient to specialist
Patient scored between 10-28:	**Significant cognitive impairment** – Refer the patient to a specialist
Audit-C for Alcohol Use *Identifies at-risk drinkers (i.e., binge drinking) who may be alcohol dependent*	
Men:	**A score of 4 or more is considered positive** – optimal for identifying hazardous drinking or active alcohol use disorders
Women:	**A score of 3 or more is considered positive** – optimal for identifying hazardous drinking or active alcohol use disorders
Exceptions:	**When the points are all from question #1 alone (#2 and #3 are zero),** it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy. Generally, the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.
GAD-7 *Measures severity of anxiety*	
Patient scored between 5-9:	**Mild symptom severity** – Monitor the patient
Patient scored between 10-14:	**Moderate symptom severity** – Possible clinically significant condition
Patient scored 15 or above:	**Severe symptom severity** – Active treatment is probably warranted
PHQ-9 *Objectifies degree of depression severity*	
Patient scored between 0-4:	**Minimal or no depression** – Monitor; may not require treatment
Patient scored between 5-9:	**Mild depression** – Use clinical judgment (symptom duration, functional impairment) to determine necessity of treatment
Patient scored between 10-14:	**Moderate depression** – Use clinical judgment (symptom duration, functional impairment) to determine necessity of treatment
Patient scored between 15-19:	**Moderately severe depression** – Warrants active treatment with psychotherapy, medications, or combination
Patient scored between 20-27:	**Severe depression** – Warrants active treatment with psychotherapy, medications, or combination

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Preventive Services Checklist

✓	PREVENTIVE SERVICES	DATE
	One-time 'Welcome to Medicare" Preventive Visit – This visit occurs within the first 12 months you have Medicare Part B.	
	Yearly Annual Wellness Visits – The first visit occurs 12 months after your one-time "Welcome to Medicare" preventive visit; subsequent visits occur every 12 months.	
	Abdominal Aortic Aneurysm Screening	
	Alcohol Misuse Screening and Counseling	
	Bone Mass Measurement (Bone Density Test)	
	Cardiovascular Disease (Behavioral Therapy)	
	Cardiovascular Screenings (Cholesterol/Lipids/Triglycerides)	
	Colorectal Cancer Screenings	
	Depression Screening	
	Diabetes Screening	
	Diabetes Self-Management Training	
	Annual Flu Shot (Vaccine)	
	Glaucoma Test	
	Hepatitis B Shot (Vaccine)	
	Hepatitis Screening	
	HIV Screening	
	Breast Cancer Screening (Mammogram)	
	Medical Nutritional Therapy Services	
	Obesity Screening and Counseling	
	Pap Test and GYN Exam	
	Pneumococcal Shot (Vaccine)	
	Prostate Cancer Screening	
	Sexually Transmitted Infection Screening and Counseling	
	Shingles Shot (Vaccine)	
	Tobacco Use Cessation (Counseling to Stop Smoking)	

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Lista de servicios preventivos

(Preventive Services Checklist)

✓	Servicios preventivos	Fecha
	Visita preventiva "Bienvenido a Medicare" por única vez: esta visita se realiza dentro de los primeros 12 meses que tiene Medicare Parte B.	
	Visita de bienestar anual: esta primera visita se realiza 12 meses después de su visita preventiva de "Bienvenida a Medicare"; las visitas posteriores ocurren cada 12 meses.	
	Detección de aneurisma aórtico abdominal	
	Detección y asesoramiento de abuso de alcohol	
	Medición de masa ósea (prueba de densidad ósea)	
	Enfermedad cardiovascular (terapia conductual)	
	Exámenes cardiovasculares (colesterol / lípidos / triglicéridos)	
	Exámenes de detección de cáncer colorrectal	
	Detección de depresión	
	Detección de diabetes	
	Entrenamiento para el autocontrol de la diabetes	
	Vacuna antigripal anual	
	Prueba de glaucoma	
	Vacuna contra la hepatitis B	
	Detección de hepatitis	
	Prueba de detección del VIH	
	Examen de detección de cáncer de mama (mamografía)	
	Servicios de terapia de nutrición médica	
	Examen de obesidad y consejería	
	Prueba de Papanicolaou y examen GYN	
	Vacuna antineumocócica	
	Pruebas de cáncer de próstata	
	Detección y asesoramiento de infecciones de transmisión sexual	
	Vacuna contra la culebrilla	
	Cese de uso de tabaco (asesoramiento para dejar de fumar)	

YOUR PRACTICE LOGO HERE

Note: *Contact CMG for an electronic, customizable form for your practice.*

ANNUAL PHYSICAL EXAM
Follow-Up Recommendations

RECOMMENDED SCREENINGS AND PREVENTIVE CARE

- ☐ **Bloodwork:** A prescription for bloodwork will be electronically submitted to Quest or printed for you. The bloodwork should be completed while fasting. You should not eat for 8-10 hours prior to completing the bloodwork. However, you may drink water or black coffee, and take your morning medications.
- ☐ **Screening Colonoscopy:** A screening colonoscopy is recommended at age 45, or sooner if you have any concerning symptoms. Repeat screening is recommended based on findings from your initial colonoscopy (to be determined by your GI doctor). A referral will be sent to your GI doctor. Please contact your preferred provider to schedule an appointment.
- ☐ **Ophthalmology:** An annual eye exam is encouraged. Please contact your preferred provider to schedule an appointment.
- ☐ **Dental Exam:** You are encouraged to see your dentist every 6 months for cleaning and oral cancer screening. Please contact your preferred provider to schedule an appointment.
- ☐ **Mammography/Bone Density Test:** You are due for your mammogram and/or bone density test; a prescription was provided to you at your appointment. Please call your preferred radiology facility to book your appointment.
- ☐ **Gynecology Exam:** You are due for your routine gynecology exam. Please call your preferred provider to schedule an appointment.

RECOMMENDED VACCINATIONS

- ☐ **Tetanus Vaccine:** This vaccine is recommended once every 10 years.
- ☐ **Influenza Vaccine:** This vaccine is recommended annually, and can be administered at our office.
- ☐ **Pneumonia Vaccine (Pneumovax/Prevnar):** This vaccine is recommended at age 65, unless you have other risk factors. It can be administered at our office.
- ☐ **Shingles Vaccine (Shingrix):** This vaccine is recommended at age 50 or older, and can be obtained at your local pharmacy.
- ☐ **HPV Vaccine (Gardasil):** This vaccine is recommended for women up to age 46.
- ☐ **COVID-19 Vaccine**

RECOMMENDED PROVIDERS

We recommend that you always contact your insurance company regarding participating providers and covered services.

DENTAL
Dr. Dental (takes Husky) - (203) 850-7900
New Haven Dental Group - (475) 256-5546
Long Wharf Dental Group - (203) 764-2386

OB/GYN
List your preferred referral sources here.
List your preferred referral sources here.
List your preferred referral sources here.

OPHTHALMOLOGY
List your preferred referral sources here.
List your preferred referral sources here.
List your preferred referral sources here.

RADIOLOGY/MAMMOGRAPHY/DEXA
List your preferred referral sources here.
List your preferred referral sources here.
List your preferred referral sources here.

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Mini-Cog™
Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, **"Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now."** If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: **"Next, I want you to draw a clock for me. First, put in all of the numbers where they go."** When that is completed, say: **"Now, set the hands to 10 past 11."**

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: **"What were the three words I asked you to remember?"** Record the word list version number and the person's answers below.

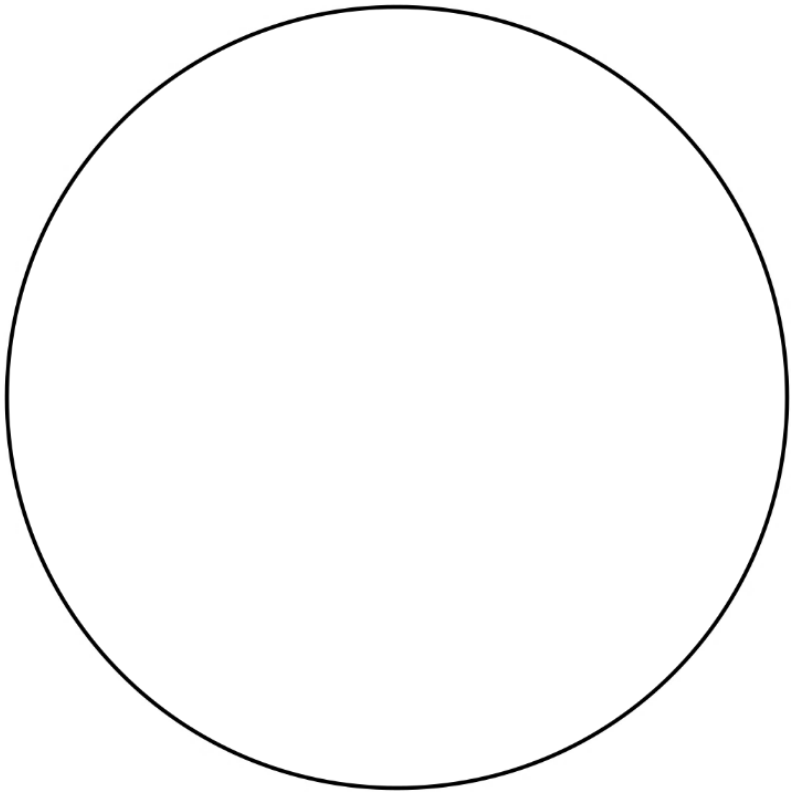
Word List Version: ____ Person's Answers: _____ _____ _____

Scoring

Word Recall:	____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw:	____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6, and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score:	____ (0-5 points)	Total score = Word Recall score + Clock Draw score A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Mini-Cog™ Clock Drawing

ID: _____ Date: _____



References

1. Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population-based sample. J Am Geriatr Soc 2003;51:1451-1454.
2. Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006;21:349-355.
3. Lessig M, Scanlan J et al. Time that tells: Critical clock-drawing errors for dementia screening. Int Psychogeriatr. 2008 June; 20(3): 459-470.
4. Tsoi K, Chan J et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015; E1-E9.
5. McCarten J, Anderson P et al. Screening for cognitive impairment in elderly veteran population: Acceptability and results using different versions of the Mini-Cog. J Am Geriatr Soc 2011; 59: 309-213.
6. McCarten J, Anderson P et al. Finding dementia in primary care: The results of a clinical demonstration project. J Am Geriatr Soc 2012; 60: 210-217.
7. Scanlan J & Borson S. The Mini-Cog: Receiver operating characteristics with the expert and naïve raters. Int Geriatr Psychiatry 2001; 16: 216-222.

Mini-Cog™ Spanish Version
Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, **"Le voy a decir tres palabras que quiero que usted recuerde ahora y mas tarde. Las palabras son [select list of words from the versions below]."** If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Plátano	Líder	Pueblo	Río	Capitán	Hija
Amanecer	Temporada	Cocina	Nación	Jardín	Cielo
Silla	Mesa	Bebé	Dedo	Imagen	Montaña

Step 2: Clock Drawing

Say: **"Por favor, dibuje un reloj en este espacio. Comience dibujando un círculo grande. Coloque todos los números en el círculo."** When that is completed, say: **"Ahora coloque las manecillas del reloj para que marquen las 11 y 10."**

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: **"¿Cuáles fueron las tres palabras que le pedí que recordara?"** Record the word list version number and the person's answers below.

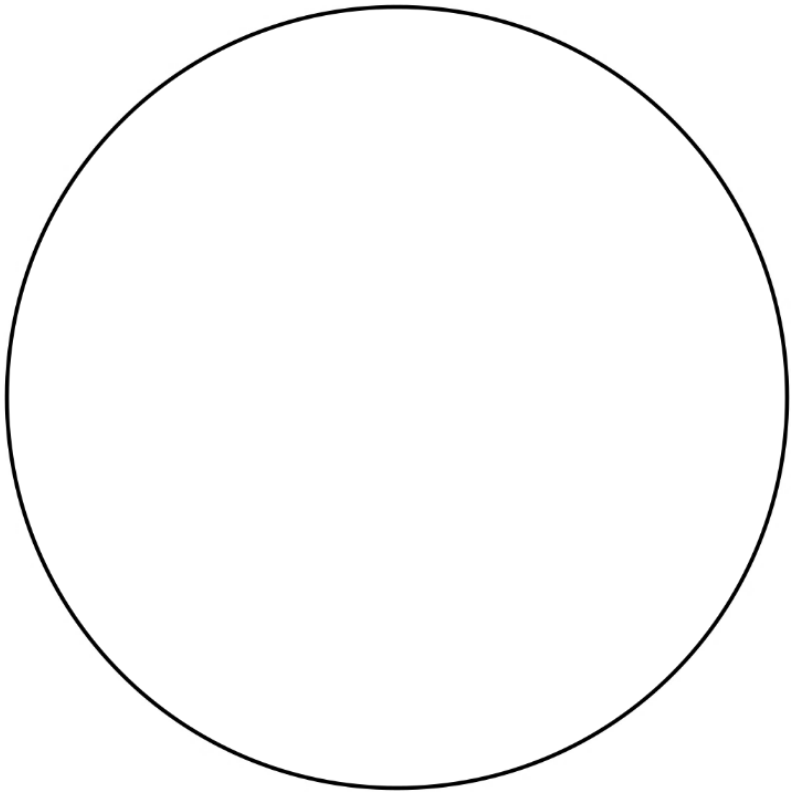
Word List Version: _____ Person's Answers: _____ _____ _____

Scoring

Word Recall:	_____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw:	_____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6, and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score:	_____ (0-5 points)	Total score = Word Recall score + Clock Draw score A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Mini-Cog™ Clock Drawing

ID: _____ Date: _____



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8. Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population-based sample. J Am Geriatr Soc 2003;51:1451-1454.
9. Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006;21:349-355.
10. Lessig M, Scanlan J et al. Time that tells: Critical clock-drawing errors for dementia screening. Int Psychogeriatr. 2008 June; 20(3): 459-470.
11. Tsoi K, Chan J et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015; E1-E9.
12. McCarten J, Anderson P et al. Screening for cognitive impairment in elderly veteran population: Acceptability and results using different versions of the Mini-Cog. J Am Geriatr Soc 2011; 59: 309-213.
13. McCarten J, Anderson P et al. Finding dementia in primary care: The results of a clinical demonstration project. J Am Geriatr Soc 2012; 60: 210-217.
14. Scanlan J & Borson S. The Mini-Cog: Receiver operating characteristics with the expert and naïve raters. Int Geriatr Psychiatry 2001; 16: 216-222.

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SOCIAL DETERMINANTS OF HEALTH (SDOH) RESOURCES

Social Determinants of Health (SDoH)

SDoH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The SDoH can be grouped into five domains:

1. **Financial and Economic Stability**
2. **Educational Quality and Access**
3. **Access to Quality Healthcare**
4. **Neighborhood and Living Environment**
5. **Social and Community Resources and Support**

The SDoH have a significant effect on our patients' health outcomes. As healthcare practitioners, it is imperative that we strive to address the needs of our patients that extend beyond the examination room. SDoH have become increasingly recognized by the payers as a key indicator of health outcomes.

Practitioners should strive to assess their patients' SDoH needs at least once per year and Annual Planned Visits provide the perfect opportunity to perform this assessment. Practices should use their clinical judgment in selecting a standardized assessment tool.

Several standardized assessment tools are hyperlinked below for your reference. In addition, we have provided several resources for patients with identified social needs.

Standardized SDoH Assessment Tools

- HealthBegins Upstream Risks Screening Tool & Guide
  https://www.aamc.org/media/25736/download
- The AHC Health-Related Social Needs Screening Tool
  https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
- The EveryONE Project
  https://www.aafp.org/family-physician/patient-care/the-everyone-project.html
- PRAPARE Tool
  http://www.nachc.org/research-and-data/prapare/prapare_one_pager_sept_2016-2/
- HealthLeads Social Needs Screening Toolkit
  https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

Resources for Patients with Identified Social Needs

- Neighborhood Navigator
  https://familydoctor.org/neighborhood-navigator/
- Aunt Bertha
  https://hpp.auntbertha.com/
- 211 Website
  https://www.211.org/
- CMG Care Management Team

Note About Billing & Coding

SDoH assessment is not a separate, billable service; however, identified SDoH needs can increase visit complexity and medical decisionmaking (MDM). Consult the American Medical Association's Level of MDM table: https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf.

ACCOUNTABLE HEALTH COMMUNITIES (AHC)
Health-Related Social Needs (HRSN) Screening Tool

AHC HRSN Screening Tool Core Questions
If someone chooses the underlined answers, they might have an unmet health-related social need.

LIVING SITUATION

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, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY.**
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

FOOD
Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. **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?**
   - ☐ Yes
   - ☐ No

UTILITIES

6. **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?**
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

SAFETY

Because violence and abuse happen to a lot of people and affects their health, we are asking the following questions.

7. **How often does anyone, including family and friends, physically hurt you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

8. **How often does anyone, including family and friends, insult or talk down to you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

9. **How often does anyone, including family and friends, threaten you with harm?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

10. **How often does anyone, including family and friends, scream or curse at you?**
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

A score of 11 or more when the numerical values for answers to questions 7-10 are added shows that the person might not be safe.

NOTE: Supplemental questions concerning financial strain, employment, family and community support, education, physical activity, substance use, mental health, and disabilities can be found at the following URL: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf.

ACCOUNTABLE HEALTH COMMUNITIES (AHC)
Health-Related Social Needs (HRSN) Screening Tool
Spanish Version

AHC HRSN Screening Tool Core Questions
If someone chooses the underlined answers, they might have an unmet health-related social need.

LA VIVIENDA [LIVING SITUATION]

1. **¿Cuál es su situación de vivir hoy?**
   - ☐ Tengo un lugar estable donde vivir
   - ☐ Tengo un lugar para vivir hoy, pero me preocupa perderlo en el futuro
   - ☐ No tengo un lugar fijo para vivir (estoy viviendo temporalmente con otras personas, en un hotel, en un refugio, viviendo afuera en la calle, en una playa, en un automóvil, edificio abandonado, estación de autobús o tren, o en un parque)

2. **Piensa en el lugar donde vives. ¿Tienes problemas con alguno de los siguientes? ELIJA TODO LO QUE CORRESPONDA.**
   - ☐ Plagas como insectos, hormigas o ratones
   - ☐ Moho
   - ☐ Pintura o tuberías con plomo
   - ☐ Falta de calor
   - ☐ El horno o la estufa no funcionan
   - ☐ Detectores de humo faltantes o no funcionan
   - ☐ Fugas de agua
   - ☐ Ninguna de las anteriores

LA COMIDA [FOOD]
Algunas personas han hecho las siguientes afirmaciones sobre su situación alimentaria. Responda si las afirmaciones fueron A MENUDO, A VECES o NUNCA verdaderas para usted y su hogar en los últimos 12 meses.

3. **En los últimos 12 meses, le preocupaba que se le acabara la comida antes de tener dinero para comprar más.**
   - ☐ A menudo cierto
   - ☐ A veces cierto
   - ☐ Nunca cierto

4. **En los últimos 12 meses, la comida que compró simplemente no duró y no tuvo dinero para comprar más.**
   - ☐ A menudo cierto
   - ☐ A veces cierto
   - ☐ Nunca cierto

EL TRANSPORTE [TRANSPORTATION]

5. **En los últimos 12 meses, ¿la falta de transporte confiable le ha impedido acudir a citas médicas, reuniones, trabajar o conseguir las cosas necesarias para la vida diaria?**
   - ☐ Si
   - ☐ No

LAS UTILIDADES [UTILITIES]

6. **En los últimos 12 meses, ¿la compañía de electricidad, gas, petróleo o agua amenazó con cortar los servicios en su hogar?**
   - ☐ Si
   - ☐ No
   - ☐ Ya apagado

LA SEGURIDAD [SAFETY]

Debido a que la violencia y el abuso le suceden a muchas personas y afectan su salud, hacemos las siguientes preguntas.

7. **¿Con qué frecuencia alguien, incluidos familiares y amigos, lo lastima físicamente?**
   - ☐ Nunca (1)
   - ☐ Raremente (2)
   - ☐ A veces (3)
   - ☐ Con bastante frecuencia (4)
   - ☐ Frecuentemente (5)

8. **¿Con qué frecuencia alguien, incluidos familiares y amigos, lo insulta o lo desprecia?**
   - ☐ Nunca (1)
   - ☐ Raremente (2)
   - ☐ A veces (3)
   - ☐ Con bastante frecuencia (4)
   - ☐ Frecuentemente (5)

9. **¿Con qué frecuencia alguien, incluidos familiares y amigos, lo amenaza con hacerle daño?**
   - ☐ Nunca (1)
   - ☐ Raremente (2)
   - ☐ A veces (3)
   - ☐ Con bastante frecuencia (4)
   - ☐ Frecuentemente (5)

10. **¿Con qué frecuencia alguien, incluidos familiares y amigos, le grita o le maldice?**
    - ☐ Nunca (1)
    - ☐ Raremente (2)
    - ☐ A veces (3)
    - ☐ Con bastante frecuencia (4)
    - ☐ Frecuentemente (5)

A score of 11 or more when the numerical values for answers to questions 7-10 are added shows that the person might not be safe.

NOTE: Supplemental questions concerning financial strain, employment, family and community support, education, physical activity, substance use, mental health, and disabilities can be found at the following URL: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf.

To inform continuous improvements to screening and follow-up processes, internally track the percentage of all patients with at least one office or telemedicine visit who completed at least one SDoH assessment (i.e., G9919 or G9920) within the past year. Because patients may only complete some sections of the SDoH assessments, a "completed" screen can be defined as an assessment with at least one of the domains completed.

Code	Description
Z13.9	Encounter for screening, unspecified
G9919	Screening performed and positive
G9920	Screening performed and negative

LIVING SITUATION

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, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY.**
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Code	Description
Z58.81*	Basic services unavailable in physical environment
Z58.89*	Other problem related to physical environment
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.10*	Inadequate housing, unspecified
Z59.11*	Inadequate housing, environmental temperature
Z59.12*	Inadequate housing, utilities
Z59.19*	Other inadequate housing
Z59.2	Discord with neighbors, lodgers and landlord
Z59.3	Problems related to living in a residential institution
Z59.81	Housing instability, housed
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z50.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified

FOOD

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

Code	Description
Z59.41	Food insecurity
Z59.42	Other specified lack of adequate food
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support

TRANSPORTATION

5. **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?**
   - ☐ Yes
   - ☐ No

Code	Description
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support

UTILITIES

6. **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?**
   - ☐ Yes
   - ☐ No+
   - ☐ Already shut off

Code	Description
Z58.81*	Basic services unavailable in physical environment
Z58.89*	Other problem related to physical environment
Z59.10*	Inadequate housing, unspecified
Z59.11*	Inadequate housing, environmental temperature
Z59.12*	Inadequate housing, utilities
Z59.19*	Other inadequate housing
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified

SAFETY

7. **How often does anyone, including family and friends, physically hurt you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

8. **How often does anyone, including family and friends, insult or talk down to you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

9. **How often does anyone, including family and friends, threaten you with harm?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

10. **How often does anyone, including family and friends, scream or curse at you?**
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

Code	Description
Z62.814*	Personal history of child financial abuse
Z62.815*	Personal history of intimate partner abuse in childhood
Z91.4	Personal history of psychological trauma
Z91.41	Personal history of adult abuse
Z91.410	Personal history of adult physical and sexual abuse
Z91.411	Personal history of adult psychological abuse
Z91.412	Personal history of adult neglect
Z91.419	Personal history of unspecified adult abuse

**Indicates new codes that will go into effect on 4/1/2023*

COMMUNITY MEDICAL GROUP

ADVANCE CARE PLANNING RESOURCES

ADVANCE CARE PLANNING

UPDATES

We revised this product with the following content updates:

- Added Information – You can offer ACP services during Medicare Wellness Visits (MWVs) (which covers both the Annual Wellness Visit [AWV] and the Initial Preventive Physical Examination [IPPE]).

VOLUNTARY ADVANCE CARE PLANNING (ACP)

Voluntary ACP is a face-to-face service between a Medicare physician (or other qualified health care professional) and a patient to discuss the patient's health care wishes if they become unable to make decisions about their care.

As part of this discussion, you may talk about advance directives (ADs) with or without completing legal forms. An AD appoints an agent and/or records the person's wishes about their medical treatment based on their values and preferences. You can generally find ADs on your State attorney generals' office website. Examples of ADs include:

- Living wills
- Instruction directives
- Health care proxy
- Health care power of attorney

Medicare pays for ACP as either:

- An optional element of a patient's MWV
- A separate Medicare Part B medically necessary service

BILLING & PAYMENT

If you bill this service more than once, document the change in the patient's health status and/or wishes about their end-of-life care. There's no **limit** on the number of times you can report ACP for a patient.

You can offer ACP services in **facility and non-facility settings**.

When a patient gets ACP services outside the MWVs, we **encourage** you to tell the patient Part B cost sharing applies as it does for other physicians' services.

DIAGNOSIS

Report the condition you counsel the patient about using an International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code. This code shows an administrative examination, or a well exam diagnosis when part of the MWVs. You don't need to report a specific diagnosis to bill ACP.

CODING

Hospitals, physicians or non-physician practitioners (NPP) may bill ACP services if the practice scope and Medicare benefit category include the services described below.

CPT Codes & Descriptors

CPT Codes	Billing Code Descriptors
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

NOTE: There are no limits on the number of times you can report ACP for a given patient in a given time period.

BILLING

Medicare waives the ACP coinsurance and the Part B deductible when the ACP is:

- Delivered on the same day as a covered MWV (HCPCS codes G0438 or G0439)
- Offered by the same provider as a covered MWV
- Billed with modifier –33 (Preventive Services)

If Medicare denies the MWV for exceeding the once-per-year limit, Medicare can still make the ACP payment as a separate Medicare Part B medically necessary service.

In that case, Medicare applies the deductible and coinsurance to the ACP service.

NOTE: Critical Access Hospitals (CAHs) may bill ACP services using type of bill 85X with revenue codes 96X, 97X, and 98X. Medicare bases the CAH Method II payment on the lesser of the actual charge or the facility-specific Medicare PFS.

RESOURCES

- 42 Code of Federal Regulations, Part 489, Subpart I (Advance Directives policy)
- 2016 Hospital Outpatient Prospective Payment Systems Final Rule (OPPS policy for ACP services) Pages 70469–70470
- 2016 Medicare Physician Fee Schedule Final Rule (Medicare PFS policy for ACP services) Pages 70955–70959
- Advance Care Planning (information for Medicare patients)
- Medicare Benefit Policy Manual Chapter 15, Covered Medical and Other Health Services, Section 280.5.1
- Medicare Claims Processing Manual Chapter 18, Preventive and Screening Services, Section 140.8
- MWV
- National Hospice and Palliative Care Organization (download your state's advance directives)

Table 2. ACP Resources (cont.)

Resource	Website
Medicare Benefit Policy Manual Chapter 15, Covered Medical and Other Health Services	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
Medicare Claims Processing Manual Chapter 18, Preventive and Screening Services	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf
National Hospice and Palliative Care Organization Download Your State's Advance Directives	CaringInfo.org/i4a/pages/index.cfm?pageid=3289
National Institute on Aging Advance Care Planning	NIA.NIH.gov/Health/Caregiving/Advance-Care-Planning

Table 3. Hyperlink Table

Embedded Hyperlink	Complete URL
Annual Wellness Visit	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246474.html
Evaluation and Management	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243514.html
International Classification of Disease, Tenth Revision, Clinical Modification	https://www.cms.gov/Medicare/Coding/ICD10
Part B	https://www.medicare.gov/what-medicare-covers/part-b/what-medicare-part-b-covers.html

Note to Community Medical Physicians about Advance Care Planning Process

A Yale New Haven Health System committee has been working on processes to ensure that, when patients come to emergency rooms, hospitals, or to specialist physicians, they receive the intensity of care that they desire. The best way for patients to take control of their health care planning, and control this intensity, is to appoint a health care representative and to document their goals of care as explicitly as possible.

The System has developed an "advance care planning navigator" in the Epic electronic medical record. Hospital physicians can access this navigator easily by clicking on "advance care plan" on the header of each patient's chart. This navigator brings the clinician to a site which displays all advance care plans, living wills, and appointment of health care representative forms. This navigator also outlines all "code" discussions that have occurred during prior hospital admissions. Emergency room physicians, hospitalists, and resident physicians are enthusiastic about using this navigator to assist them with goals of care discussions with patients.

This navigator will be helpful only if clinicians work with their patients to help them outline their goals of care and to appoint health care representatives. To this end, the Health System has been working to make this process as simple and efficient as possible. The System has acquired and developed a number of brochures and documents, including the "Conversation Starter", "Advance Directives: Living Wills and Health Care Representatives", and "How to Choose a Health Care Proxy". Specific documents include a treatment preference/living will form and an appointment of health care representative form.

We recommend the following process:

- Brochures be given to patients and their families about the advance care planning process.
- A visit should be scheduled to discuss advance care planning. This can be part of the regular annual wellness visit. Medicare will pay for this advance care discussion. The CPT code for a 30 minute discussion is 99497. An additional 30 minutes can be charged by using CPT code 99498.
- The clinician should discuss the patient's goals of care and wishes about future care at that visit.
- The patient should be encouraged to appoint a health care representative. Once the patient appoints that representative, he or she should fill out the health care representative form, have it witnessed by two people, and return it to the physician's office. That form should then be faxed to the Health System Medical Records Department at (203) 688-1251. The forms should be accompanied by a "fax-to-scan cover sheet" which includes pertinent demographic information and instructions for the medical records staff.

- If the patient wishes to fill out a treatment preference/living will document, that document should be provided to the patient. Once the patient fills out the form and has it witnessed by two individuals, the physician's office staff can then fax the form to the Yale New Haven Medical Records Department at (203) 688-1251, using the process outlined above.

We believe that we now have the systems in place to ensure that patients' wishes are followed when they are hospitalized. These efforts will be effective only if clinicians ensure that patients' goals of care and health care representatives are clearly outlined in the Epic electronic medical record.

Yale
NewHaven
Health

Advance Directives

Advance Directives

Living Wills and Healthcare Representatives

What are Advance Directives?

Advance Directives are forms you can fill out before you get sick or go to the hospital to let your doctors and loved ones know about your healthcare wishes if you ever become too ill to make decisions or speak for yourself. In certain situations, hospitals are required by federal law to give you information about Advance Directives.

Connecticut has two main types of Advance Directives forms:

- Living Will or Healthcare Instructions
- Appointment of Healthcare Representative

In Rhode Island, Advance Directives are referred to as a Durable Power of Attorney for Healthcare and includes Healthcare Instructions and the appointment of a Healthcare Representative.

Living Will (also called Treatment Preferences or Healthcare Instructions) form

A Living Will is a form that tells your doctors about what medical care you want, especially if you are in the final stages of a terminal illness or are permanently unconscious. For example, do you want to be fed through a tube, have a machine breathe for you (mechanical ventilation), or have your heart and lungs restarted if they stop (cardiopulmonary resuscitation or CPR)?

Appointment of Healthcare Representative form

A Healthcare Representative is someone you choose to make medical decisions for you if you can't make them all yourself. It can be an adult relative or friend you trust, but not your doctor. Your Healthcare Representative can even make decisions about stopping life support machines. This person should follow the instructions in your Living Will, if you have one.

Combined Living Will and Healthcare Representative form

A combined or consolidated form lets you make a Living Will, designate a conservator if you need one in the future and appoint a Healthcare Representative in a single form. It lets you decide if you would like to make an "anatomical gift" – this is, donate all or any part of your body (organs) after you die for research, transplant, therapy, medical or dental education or the advancement of medical or dental sciences.

Frequently Asked Questions

Who can fill out Advance Directives forms?

You can fill out the forms if you're 18 years or older and of sound mind. You don't need a lawyer to fill out the forms, but you must have two people witness and sign the form so that it is legal. Your Healthcare Representative can't be one of your witnesses. Rhode Island has different requirements for witnesses. Visit http://www.health.state.ri.us/.

Who should have a copy of my Advance Directive forms?

Give a copy to your doctor and to your Healthcare Representative. You might also want to have copies for your family, clergy or anyone else you think might be asked about your wishes. If you know ahead of time that you're going to a hospital, bring a copy with you.

Can the hospital keep my Advance Directives forms in my medical record?

Yes, if you bring your Advance Directives forms to the hospital when you come for an admission or procedure, it can be scanned into your record.

What if I change my mind?

You can change or revoke your Living Will at any time and in any way – orally or in writing. But if you want to change or revoke your Healthcare Representative, you must do it in writing and have it witnessed by two people. Remember that when you change or revoke Advance Directives, you need to let your doctor and anyone who has a copy know about the changes.

Do I have to fill out Advance Directives forms?

No, you don't have to fill out the forms if you don't want to. You can just talk with your doctors and ask them to write down what you've said in your medical chart. And you can talk with your family. But filling out the forms makes it easier for your doctors and loved ones to understand and respect your wishes.

Can I still get treated if I don't have Advance Directives forms?

Yes. You don't have to have a Living Will or a Healthcare Representative to be admitted to a hospital or other healthcare setting and receive treatment.

How does my Healthcare Representative know what I want?

After you choose your representative, tell that person what you want. Give them a copy of your Living Will, where you can write down when you would or wouldn't want certain types of medical treatments.

What happens if I'm too sick to make decisions?

If you're too sick to make decisions, your Healthcare Representative will make them for you. If you haven't chosen a Healthcare Representative, your doctor will usually ask your closest relative or friend (including a domestic and/or same sex partner) to help decide what you would want or what's best for you. But sometimes relatives or friends disagree about what to do. Filling out Advance Directive forms ahead of time saves your loved ones a lot of worry.

Where can I get Advance Directives forms?

- When you are admitted to the hospital, you can ask an admitting staff person for the Advance Directives forms.
- If you're already in the hospital, you can get Advance Directives forms from your doctor, nurse or a social worker.
- You also can get them by calling:
  - Bridgeport Hospital: 203-384-3211 (Spiritual Care), 203-384-3186 (Social Work) or 203-384-3704 (Patient Relations, 8 am - 5 pm M - F only)
  - Greenwich Hospital: 203-863-4746 (Patient & Guest Relations) or 203-863-3146 (Spiritual Care)
  - Yale New Haven Hospital: 203-688-2151 at York Street; 203-789-3245 at Saint Raphael Campus (Spiritual Care)
  - Lawrence + Memorial Hospital: 860-442-2614 (Social Work) or 860-442-2305 (Spiritual Care)
  - Westerly Hospital: 401-348-3979 (Spiritual Care)
  - Northeast Medical Group: 203-502-6527
- Your primary care physician or your lawyer can help you get Advance Directives forms and help you fill them out. A lawyer is not required.
- YNHHS refers to the forms as "Appointment of Health Care Representative" (F8311) and "Treatment Preferences and Living Will" (F8485). Different states may use other titles.
- You can also get information and state forms for advance directives on state health department websites and type "Advance Directives" in the search bar:
  - In Connecticut, visit http://portal.ct.gov/
  - In Rhode Island, visit http://www.health.state.ri.us/

Discrimination is against the law

Yale New Haven Health complies with applicable civil rights laws and does not discriminate against, exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex.

Yale New Haven Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Patient Relations, 203-688-3430.

If you believe that Yale New Haven Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Patient Relations, Yale New Haven Health, 20 York Street, New Haven, CT 06510; 203-688-3430; Fax 203-688-1667; patientrelations@ynhh.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Patient Relations can help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Patient Rights and Responsibilities

Yale New Haven Health System (YNHHS) respects, protects and supports patient rights, recognizing that each patient is an individual with unique needs. We strive to provide considerate, respectful care to every patient. YNHHS does not restrict, limit or deny care or visitation based on race, color, religion, ancestry or national origin, age, sexual orientation, gender identity and expression, marital status, physical or mental disability, citizenship status or any other basis protected by law. YNHHS provides emergency medical care to all patients regardless of insurance status or ability to pay.

As a patient, you have the right to:

1. Understand your rights and responsibilities.
2. Patient and family-centered care that is safe, considerate and high-quality.
3. Clear information about your health status, treatment and care, benefits, risk and caregivers.
4. Take part in decisions about your care, treatment, services and discharge.
5. Have help making an advance directive and have your wishes as expressed in your advance directive honored.
6. Confidentiality and privacy in all matters, including visitor restriction, on request.
7. Safety and security in an environment that offers dignity, including freedom from neglect or mistreatment.
8. Assessment and management of pain.
9. Receive information in a language you understand, free of charge.
    a. If English is not your primary language, YNHHS will provide language assistance services through interpreters or written information.
    b. If you are deaf or hard of hearing, YNHHS will provide sign language interpreters or other aids and services.
10. Prompt response to concern, complaints or request for help, without fear of reprisal.
    a. If you are not happy with how your complaint was handled by staff, you can contact Bridgeport Hospital Patient Relations at 203-384-3704 or BHPatientRelations@bpthosp.org; Greenwich Hospital Patient and Guest Relations at 203-863-4746 or GHPatientRelations@ynhh.org; Yale New Haven Hospital Patient Relations 203-688-3430 or patientrelations@ynhh.org; Northeast Medical Group Patient Experience at 203-502-6527 or NEMGPatientExperience@ynhh.org; Lawrence + Memorial Hospital or Westerly Hospital Patient Relations at 860-442-0711 x 5032 or patientrelations@lmhosp.org / patientrelations@westerlyhospital.org.

b. If your complaint was not resolved to your satisfaction by the hospital, you have the right to contact the Connecticut Department of Public Health, 410 Capitol Avenue, Hartford, CT 06134, 860-509-8000. For Westerly Hospital complaints, you can contact Rhode Island Department of Health Office of Facilities Regulation, 3 Capitol Hill, Providence, RI 02908, (401) 222-2566, TTY: 711.

c. You have the right to contact the Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181, 630-792-5000.

d. If you feel you were discriminated against you can file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20204; 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://hhs.gov/ocr/office/file/index.html.

As a patient, you have responsibility to:

1. Give staff full, accurate information, including medical history, medications, symptoms and changes in your condition. Tell us if you have any reactions or allergies to medicine or anesthesia.
2. Ask questions about your care and treatment, especially if information is not clear.
3. Take an active role in both your care and discharge planning.
4. Let staff know if you do or do not want family or others involved in your care or decision-making.
5. Tell us if you have an advance directive. If not, ask about making an advance directive (you can choose someone who knows your wishes and can speak for you if you are unable).
6. Ask about managing pain and discuss pain relief with your doctor or nurse.
7. Respect others by following YNHHS rules and policies. Show consideration for other patients and staff.
8. Leave valuables at home.
9. Do not use tobacco, vapor products or electronic nicotine delivery systems in YNHHS buildings or on the property.
10. Provide us with your insurance information and ask about financial help.
11. Tell staff if you cannot keep a scheduled appointment.

Language assistance

Language services are available at no charge. Patients and families should be asked to point to their language and request help from staff.

American Sign Language: 

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Tregoni me gisht gjuhën tuaj dhe kërkoni ndihmë nga stafi.

Arabic:
إنتبه : إذا كنت تتحدث العربية، خدمات مساعدة اللغة
متوفرة مجانا . أشر إلى لغتك واطلب المساعدة من العاملين

Chinese (Simplified)
注意：如果您使用繁体中文，您可以免费获得语言援助服务。请指导您的语言，并要求工作人员协助。

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Point to your language and ask staff for help.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Indiquez votre langue et demandez au personnel de l'aide.

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Montre lang-ou avèk dwèt-la e mande yon anplwaye pou èd.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Zeigen Sie auf Ihre Sprache und bitten einen Mitarbeiter um Hilfe.

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Δείξτε τη γλώσσα σας και ζητήστε να σας εξυπηρετήσει το προσωπικό.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। अपनी भाषा की ओर इशारा करें और स्टॉफ से मदद मांगे

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Indichi la sua lingua e chieda al personale aiuto.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。言語を指さしてスタッフに支援を求めてください

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Yale
NewHaven
Health

Instrucciones anticipadas para decisiones médicas

F7387 13551 (02/19)

Instrucciones anticipadas para decisiones médicas

Testamentos vitales y representantes para el cuidado de la Salud

¿Qué son las Instrucciones anticipadas para decisiones médicas *(Advance Directives)*?

Son formularios que usted puede llenar antes de enfermarse o ser hospitalizado para dar a conocer a sus médicos y seres queridos sus preferencias de atención médica en caso de que su salud se deteriore hasta el punto que usted no sea capaz de tomar decisiones o hablar por sí mismo(a). En algunas situaciones la ley federal le exige a los hospitales que le den información sobre las Instrucciones anticipadas para decisiones médicas.

En Connecticut hay dos tipos de Instrucciones anticipadas para decisiones médicas:

- El Testamento vital o Instrucciones para cuidados de la salud
- La Designación de un representante para el cuidado de la salud

En Rhode Island, las Instrucciones Anticipadas para Decisiones Médicas se llaman Poder Legal Permanente para Asuntos Médicos. Este incluye instrucciones para la atención médica y la designación de un representante para el cuidado de la salud.

Formulario de Testamento Vital (*también se le conoce como Preferencias de tratamiento o Instrucciones para cuidados de la salud – Treatment Preferences or Healthcare Instructions*)

Un Testamento vital es un formulario que le indica a sus médicos la atención médica que usted desea, especialmente si usted está en las etapas finales de una enfermedad terminal o se encuentra en un estado de inconsciencia permanente. Por ejemplo: ¿Desearía que le alimentaran por un tubo, que una máquina respirara por usted (ventilador mecánico) o que le hicieran reanimación cardiopulmonar si su corazón o sus pulmones dejaran de funcionar?

Designación de un Representante para el cuidado de la salud *(Appointment of Healthcare Representative)*

Un Representante para el cuidado de la salud es alguien a quien usted designa para que tome decisiones médicas por usted cuando usted no puede hacerlo por sí mismo. Puede ser un familiar o amigo adulto de confianza, pero no su médico. Su representante puede, incluso, decidir detener el uso de máquinas de soporte vital. Esta persona debe seguir las instrucciones establecidas en el Testamento vital, si es que usted tiene uno.

Formulario combinado de testamento vital y representante para el cuidado de la salud

El formulario conjunto o combinado le permite hacer un Testamento vital, designar a un representante *(conservator)* en caso que necesite uno, designar un Representante para el cuidado de la salud en un solo formulario y decidir si desea realizar una "donación anatómica" – esto es, la donación de todo o de una parte de su cuerpo (órganos) para después de su fallecimiento con fines de investigación, trasplante, terapia, educación médica o dental; o para el progreso de la ciencia médica o dental.

Preguntas Frecuentes

¿Quién puede llenar los formularios de Instrucciones anticipadas para decisiones médicas?

Usted puede hacerlo si tiene por lo menos 18 años de edad y está en su sano juicio. No necesita que un abogado llene el formulario. Sin embargo, para que los formularios tengan validez jurídica se requieren dos testigos y que estos firmen el documento. El Representante para el cuidado de la salud no puede ser uno de los testigos. Rhode Island exige requisitos diferentes para los testigos. Visite el sitio http://www.health.state.ri.us/.

¿Quién debe tener una copia de mis Instrucciones anticipadas para decisiones médicas?

Entregue una copia a su médico y otra a la persona que nombró como su representante para el cuidado de la salud. También podría entregarles copias adicionales a los miembros de su familia, clérigo o cualquier otra persona a quien usted crea que el personal del hospital podría preguntarle sobre sus deseos. Si sabe con anticipación que va a ir a un hospital lleve una copia con usted.

¿Puede el hospital guardar mis Instrucciones anticipadas para decisiones médicas en mi archivo médico?

Sí, si usted trae los documentos al hospital cuando venga para una hospitalización o procedimiento. Se pueden escanear y guardar en su archivo.

¿Qué pasa si cambio de parecer?

Usted puede cambiar o revocar su Testamento vital en cualquier momento y de cualquier forma – verbalmente o por escrito. Si desea cambiar o revocar a su Representante para el cuidado de la salud, tiene que hacerlo por escrito y frente a dos testigos. Recuerde que cuando usted cambia o revoca sus Directivas para provisiones futuras del cuidado de la salud, debe informar de los cambios a su médico y a cualquier persona que tenga una copia del documento.

¿Es obligatorio llenar el formulario de Instrucciones anticipadas para decisiones médicas?

No, no tiene que llenar los formularios si no quiere. Puede simplemente hablar con sus médicos y pedirles que escriban lo que les dijo en su expediente médico. También puede hablar con su familia; sin embargo, si usted llena los formularios les resultará más fácil a sus seres queridos y a sus médicos entender y respetar sus deseos.

¿Me darán tratamiento si no tengo las Instrucciones anticipadas para decisiones médicas?

Sí. Usted no necesita tener un Testamento vital o un representante para el cuidado de la salud para que le admitan en un hospital u otra institución de atención de la salud y recibir tratamiento.

¿Cómo sabe mi Representante para el Cuidado de la Salud lo que yo deseo?

Después de elegir a su representante, dígale lo que usted desea. Entréguele una copia desu Testamento vital. En éste debe indicar en qué casos desea o no ciertos tipos de tratamiento médico.

¿Qué pasa si estoy demasiado enfermo(a) para tomar decisiones?

Si usted está demasiado enfermo como para tomar decisiones, su representante para el cuidado de la salud las tomará por usted. Si no ha designado a un representante, su médico, generalmente, le pedirá a su pariente o amigo más cercano (incluso las parejas de hecho y/o las parejas del mismo sexo) que ayuden a decidir lo que usted querría o lo que es mejor para usted. Sin embargo, en ocasiones, los parientes o amigos están en desacuerdo en cuanto a qué hacer.

Si llena con anticipación los formularios de las Instrucciones anticipadas para decisiones médicas le evitará muchas preocupaciones a sus seres queridos.

¿Dónde puedo obtener los formularios para Instrucciones anticipadas para decisiones médicas?

- Cuando lo ingresan al hospital, puede pedir al personal de admisiones una copia de los formularios de las Instrucciones anticipadas para decisiones médicas.
- Si ya está hospitalizado, los formularios están disponibles a través de su médico, enfermera o trabajador social.
- También los puede obtener llamando a:
  - Bridgeport Hospital: 203-384-3211 (Spiritual Care), 203-384-3186 (Social Work) o al 203-384-3704 (Patient Relations, de 8 am a 5 pm de lunes a viernes solamente)
  - Greenwich Hospital: 203-863-4746 (Patient & Guest Relations) o al 203-863-3146 (Spiritual Care)
  - Lawrence + Memorial Hospital: 860-442-2614 (Social Work) o 860-442-2305 (Spiritual Care)
  - Yale New Haven Hospital: 203-688-2151 en York Street; 203-789-3245 en Saint Raphael Campus (Spiritual Care)
  - Westerly Hospital: 401-348-3979 (Spiritual Care)
  - Northeast Medical Group: 203-502-6527
- Su médico de cabecera o su abogado pueden ayudarle a conseguir y llenar los formularios. No se requiere un abogado.
- YNHHS se refiere a estos formularios como “Designación de un representante para el cuidado de la salud” (F8311) y “Preferencias de tratamiento y testamento vital” (F8485). Otros Estados pueden utilizar nombres diferentes.
- Usted también puede obtener información y formularios del Estado para sus instrucciones anticipadas al ingresar a los sitios de internet de los departamentos de salud estatales y escribir Advanced Directives en la barra de búsqueda:
  - En Connecticut, visite el sitio http://portal.ct.gov/
  - En Rhode Island, visite el sitio http://www.health.state.ri.us/

La discriminación es contraria a la ley

Yale New Haven Health cumple con las leyes sobre derechos civiles aplicables y no discrimina, excluye, ni trata a las personas de manera diferente por motivos de raza, color, nacionalidad de origen, edad, discapacidad o sexo.

Yale New Haven Health:

- Provee de forma gratuita ayuda y servicios a las personas que tengan discapacidades para comunicarse efectivamente con nosotros, tales como:
  - Intérpretes de lenguaje de señas calificados
  - Información escrita en otros formatos (letras grandes, audio, formatos electrónicos accesibles, otros formatos)
- Provee gratuitamente servicios en otros idiomas a las personas cuyo idioma primario no es el inglés, tales como:
  - Intérpretes calificados
  - Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con Patient Relations, al 203-688-3430.

Si usted cree que Yale New Haven Health no le proporcionó estos servicios o discriminó de otra manera por motivo de raza, color, nacionalidad de origen, edad, discapacidad o sexo, usted puede presentar una queja ante el: Patient Relations, Yale New Haven Health, 20 York Street, New Haven, CT 06510: 203-688-3430; Fax 203-688-1667; patientrelations@ynhh.org. Usted puede presentar una queja en persona, por correo postal, fax o correo electrónico. Si necesita ayuda para presentar la queja, Patient Relations puede ayudarle.

También puede presentar una queja formal sobre derechos civiles ante el U.S. Department of Health and Human Services, Office for Civil Rights, de forma electrónica a través del portal de Office for Civil Rights Complaint, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf o por correo postal o teléfono al:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Los formularios para las quejas están disponibles en www.hhs.gov/ocr/office/file/index.html.

Derechos y responsabilidades del paciente

Yale New Haven Health System (YNHHS) respeta, protege y apoya los derechos de los pacientes, al reconocer que cada uno es un individuo con necesidades únicas. Nos esforzamos para ofrecer una atención considerada y respetuosa a todos los pacientes. YNHHS no restringe, limita ni deniega atención o visitas por motivos de raza, color, religión, ascendencia o nacionalidad de origen, edad, orientación sexual, identidad o expresión de género, estado civil, discapacidad física o mental, situación migratoria o cualquier otra condición protegida por la ley. YNHHS proporciona atención médica de emergencia a todos los pacientes, sin importar la situación de estos con respecto al seguro o capacidad de pago.

Como paciente usted tiene derecho a:

1. Entender sus derechos y responsabilidades.
2. Cuidado centrado en el paciente y la familia, que sea seguro, considerado y de alta calidad.
3. Información clara sobre su estado de salud, tratamiento y cuidado, beneficios, riesgos y sobre aquellos que lo atienden.
4. Participar en las decisiones sobre su cuidado, tratamiento, servicios y alta.
5. Tener ayuda para hacer un documento de Instrucciones Médicas Anticipadas (Advance Directives) y a que se respeten los deseos que usted estableció en ellas.
6. Confidencialidad y privacidad en todos los asuntos, lo que incluye visitas restringidas si lo solicita.
7. Seguridad y protección en un entorno que ofrezca dignidad, lo cual incluye estar libre de negligencia o maltrato.
8. Evaluación y control del dolor.
9. Recibir la información en un idioma que usted entienda y de forma gratuita.
   a. Si el inglés no es su idioma primario, YNHHS le ayudará con el idioma a través de los servicios de intérpretes o información escrita.
   b. Si usted es sordo o tiene dificultad para oír, YNHHS le proporcionará intérpretes de lenguaje de señas u otros dispositivos de ayuda.
10. Que se responda con prontitud a sus inquietudes, reclamo o solicitudes de ayuda, sin miedo a represalia.
    a. Si no está contento con la forma en que el personal atendió su reclamo, usted puede comunicarse con: Patient Relations de Bridgeport Hospital al 203-384-3704 o BHPatientRelations@bpthosp.org; Patient and Guest Relations de Greenwich Hospital al 203-863-4746 o GHPatientRelations@ynhh.org; Patient Relations de Yale New Haven Hospital 203-688-3430 o patientrelations@ynhh.org; Patient Experience de Northeast Medical Group al 203-502-6527 o NEMGPatientExperience@ynhh.org; Patient Relations de Lawrence + Memorial Hospital o Westerly Hospital Patient Relations al 860-442-0711 ions@westerlyhospital.org.

b. Si el hospital no resolvió su reclamo a su entera satisfacción, tiene el derecho de comunicarse con el Connecticut Department of Public Health, 410 Capitol Avenue, Hartford, CT 06134, 860-509-8000. En el caso de reclamos relacionados con Westerly Hospital puede comunicarse con Rhode Island Department of Health Office of Facilities Regulation, 3 Capitol Hill, Providence, RI 02908, 401-222-2566, TTY: 711.

c. Tiene derecho a comunicarse con la Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181. 630-792-5000.

d. Si usted cree que lo discriminaron, puede presentar una queja ante el U.S. Department of Health and Human Services, Office of Civil Rights, de forma electrónica a través del portal de Office for Civil Rights Complaint Portal, https://ocrportal.hhs.gov/ocr/portal/lobby.jsf o por correo postal o teléfono al: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019, 800-537-7697 (TDD). Los formularios están disponibles en http://hhs.gov/ocr/office/file/index.html.

Como paciente usted tiene la responsabilidad de:

1. Proporcionar al personal información completa y exacta lo que incluye a su historia médica, medicamentos, síntomas y cambios en su condición. Decirnos si tiene reacciones o alergias a medicamentos o anestesia.
2. Hacer preguntas sobre su atención y tratamiento, especialmente si la información no es clara.
3. Desempeñar un papel activo en su cuidado y en la planificación del alta.
4. Informarle al personal si usted quiere o no que su familia u otros participen en su atención o en la toma de decisiones.
5. Decirnos si tiene un documento de Instrucciones Médicas Anticipadas. Si no lo tiene, preguntar sobre cómo preparar uno (puede elegir a alguien que conozca sus deseos y que pueda hablar por usted si no está en capacidad de hacerlo).
6. Preguntar sobre el control del dolor y analizar las formas de aliviar el dolor con su médico o enfermera.
7. Respetar a los demás al cumplir las reglas y políticas de YNHHS. Mostrar consideración por otros pacientes y el personal.
8. Dejar los objetos de valor en casa.
9. No usar tabaco, productos vaporizados ni sistemas electrónicos de administración de nicotina en los edificios de YNHHS ni en ningún sitio que forme parte de sus instalaciones.
10. Proporcionarnos información sobre su seguro y preguntar sobre la ayuda financiera.
11. Informar al personal si no puede ir a una cita que tenga programada.

Language assistance

Language services are available at no charge. Patients and families should be asked to point to their language and request help from staff.

American Sign Language: 

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Tregoni me gisht gjuhën tuaj dhe kërkoni ndihmë nga stafi.

Arabic:
إنتبه : إذا كنت تتحدث العربية ،خدمات مساعدة اللغة
متوفرة مجانا . أشر إلى لغتك واطلب المساعدة من العاملين

Chinese (Simplified)
注意：如果您使用繁体中文，您可以免费获得语言援助服务。请指导您的语言，并要求工作人员协助。

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Point to your language and ask staff for help.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Indiquez votre langue et demandez au personnel de l'aide.

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Montre lang-ou avèk dwèt-la e mande yon anplwaye pou èd.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Zeigen Sie auf Ihre Sprache und bitten einen Mitarbeiter um Hilfe.

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Δείξτε τη γλώσσα σας και ζητήστε να σας εξυπηρετήσει το προσωπικό.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। अपनी भाषा की ओर इशारा करें और स्टॉफ से मदद मांगे

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Indichi la sua lingua e chieda al personale aiuto.

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MEDICAL RECORD NUMBER:

NAME

BIRTH DATE:

DELIVERY NETWORK:

CMG COMMUNITY MEDICAL GROUP

Yale NewHaven Health Northeast Medical Group

Yale Medicine

Treatment Preferences and Living Will

I am providing the information below to help my physicians and care team understand my care choices, particularly to help them understand my wishes relating to end-of-life care.

☐ I already have a Living will or Advance Directive that I wish to be read in conjunction with this document.

☐ I do not already have a Living Will or other Advance Directive, and would like Part 2 of this document to serve as my Living Will, and be read in conjunction with this document.

****

Part 1. Information About My Treatment Preferences

If I am no longer able to make my own health decisions, the information I have provided below outlines my goals and preferences for care at the end of life.

Future health situations:

- When you think about your health and health situations you may experience in the future, how do you feel?
  - ☐ Life is always worth living no matter what type of serious illness, disability, or pain I may be experiencing.
  - ☐ There may be some health situations that would make my life not worth living.
- How do you balance quality of life with medical care? If you had serious illness, what would be important to you?
  - ☐ I want medical treatments to try to live as long as possible. I would not want to stop treatment even if I were in pain, could not feed or care for myself, or needed machines to live.
  - ☐ I want to try treatments for a period of time, but I don't want to suffer. If after a period of time the treatments do not help or I am suffering, I want to stop.
  - ☐ I want to focus on my quality of life and being comfortable, even if it means having a shorter life.

In the event of serious illness:

- If I am terminally ill or so ill that I am unlikely to get better
  - ☐ I would not want to receive treatment to try to keep me alive
  - ☐ I would want to receive treatment to try to keep me alive
- If my doctors decide that I am likely to die within a short period of time, and life support treatment would only delay the moment of my death:
  - ☐ I would not want to receive treatment to try to keep me alive
  - ☐ I would want to receive treatment to try to keep me alive
- If my doctors decide that I am in a coma from which I am not expected to wake up or recover, and life support treatment will only delay the moment of my death:
  - ☐ I would not want to receive treatment to try to keep me alive
  - ☐ I would want to receive treatment to try to keep me alive
- If my doctors decide that I have permanent and severe brain damage, and I am not expected to get better, and life support treatment would only delay the moment of my death:
  - ☐ I would not want to receive treatment to try to keep me alive
  - ☐ I would want to receive treatment to try to keep me alive

Part 2. Living Will

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

As the author of this document, I request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, that the treatment options outlined below be followed. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Treatment Options at the end of life

If I have a terminal illness and am close to death or am unconscious and not likely to wake up, I want the following care:

- If my heart stops:
  - ☐ I would want cardio pulmonary resuscitation done to try to restart my heart
  - ☐ I would not want cardio pulmonary resuscitation done to try to restart my heart; if I have an implanted automatic defibrillator in place, I want to have the defibrillator turned off.

- If I'm unable to breathe on my own:
  - ☐ I would want a breathing machine
  - ☐ I would not want a breathing machine for any length of time

- If I am terminally ill or so ill that I am unlikely to get better, and I am unable to swallow enough food and water to stay alive:
  - ☐ I would want a feeding tube
  - ☐ I would not want a feeding tube

****

This request is made, after careful reflection, while I am of sound mind.

Patient's Printed Name	Patient's Signature	Date

****

Part 3 – Witnesses' Statements

WITNESSES' STATEMENTS

This document was signed in our presence by the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

First Witness

Witness Printed Name	Witness Signature	Date

Address	City	State	Zip Code

Second Witness

Witness Printed Name	Witness Signature	Date

Address	City	State	Zip Code

(Note – this form requires two witnesses, but does not require a notary, to be valid)

INSTRUCTIONS FOR SCANNING INTO EPIC

1. Scan into Media Manager
2. For document type, select "Living Will"

MEDICAL RECORD NUMBER:

NAME

BIRTH DATE:

DELIVERY NETWORK:

CMG COMMUNITY MEDICAL GROUP

Yale NewHaven Health Northeast Medical Group

Yale Medicine

Preferencias de tratamiento y testamento vital
(Treatment Preferences and Living Will)

Con el propósito de ayudar a que mis médicos y el equipo de atención entiendan mis decisiones de cuidados de salud, especialmente para ayudarles a entender mis deseos sobre el cuidado terminal, proporciono la información que aparece a continuación.

- ☐ Ya tengo un testamento vital o documento con instrucciones anticipadas para decisiones médicas que deseo que se lea junto con este documento.
- ☐ Todavía no tengo un testamento vital ni un documento con instrucciones anticipadas para decisiones médicas y quiero que la parte 2 que aparece aquí sirva como mi testamento vital y que se lea junto con este documento.

****

Parte 1. Información sobre mis preferencias de tratamiento

Si ya no estoy en condiciones de tomar decisiones médicas por mí mismo(a), la información que proporciono a continuación describe mis objetivos y preferencias de cuidado terminal.

Situaciones futuras concernientes a la salud:

- Cuando piensa en su salud y las situaciones concernientes a esta que pudiera experimentar en el futuro, ¿cómo se siente?
  - ☐ Siempre vale la pena seguir viviendo sin importar el tipo de enfermedad grave, discapacidad o dolor que pudiera estar sintiendo.
  - ☐ Podría haber algunas situaciones relacionadas con la salud que pudieran hacer que no valiera la pena seguir viviendo.
- ¿Cómo mide la calidad de vida en relación con la atención médica? Si tuviera una enfermedad grave, ¿qué sería importante para usted?
  - ☐ Quiero tratamientos médicos para intentar seguir viviendo tanto como sea posible. No deseo que cese el tratamiento aunque tenga dolor, no pueda comer ni atenderme a mí mismo(a) o necesite máquinas para mantenerme vivo(a).
  - ☐ Quiero intentar tratamientos por un tiempo, pero no quiero sufrir. Si después de un tiempo, los tratamientos no me ayudan o estoy sufriendo, quiero que se detengan.
  - ☐ Quiero enfocarme en mi calidad de vida y estar a gusto, aunque eso signifique una vida más corta.

En caso de tener una enfermedad grave:

- Si estoy en etapa terminal o demasiado enfermo(a) hasta tal punto que sea muy poco probable que mejore:
  - ☐ No quisiera recibir tratamiento para intentar seguir viviendo
  - ☐ Quisiera recibir tratamiento para intentar seguir viviendo
- Si mis médicos deciden que lo más probable es que muera dentro de poco tiempo y el tratamiento de soporte vital solamente retrasará el momento de mi muerte:
  - ☐ No quisiera recibir tratamiento para intentar seguir viviendo
  - ☐ Quisiera recibir tratamiento para intentar seguir viviendo
- Si mis médicos deciden que estoy en un estado de coma del cual no se espera que despierte o me recupere y el tratamiento de soporte vital solamente retrasará el momento de mi muerte:
  - ☐ No quisiera recibir tratamiento para intentar seguir viviendo
  - ☐ Quisiera recibir tratamiento para intentar seguir viviendo
- Si mis médicos deciden que tengo daño cerebral permanente y severo y no se espera que mejore y el tratamiento de soporte vital solamente retrasará el momento de mi muerte:
  - ☐ No quisiera recibir tratamiento para intentar seguir viviendo
  - ☐ Quisiera recibir tratamiento para intentar seguir viviendo

Parte 2. Testamento vital

Si llego a estar incapacitado(a) a tal punto que no pueda participar activamente en la toma de decisiones sobre mi propia vida y no pueda dar instrucciones a mis médicos con respecto al cuidado de mi atención médica, deseo que esta declaración se considere la declaración de mis deseos.

Como autor de este documento, solicito que si se considera que mi condición es terminal o si se determina que yo estaré inconsciente permanentemente, se sigan las opciones de tratamiento que se describen a continuación. Al decir *condición médica terminal*, me refiero a una condición incurable o irreversible que, sin el uso de sistemas de soporte vital, según la opinión del médico a cargo de mi cuidado, resultará en mi muerte dentro de un periodo relativamente corto. Al decir inconsciente permanentemente, me refiero a que estoy en coma o estado vegetativo permanente, que es una condición irreversible en la que yo en ningún momento estoy consciente de mí mismo(a) o mi entorno y no muestro ningún comportamiento en respuesta al entorno.

Opciones de tratamiento terminal

Si tengo una enfermedad terminal y estoy cerca de la muerte o estoy inconsciente y no es probable que despierte, quiero la siguiente atención médica:

- Si mi corazón deja de latir:
  - ☐ Quiero que me hagan reanimación cardiopulmonar para intentar hacer que el corazón vuelva a funcionar
  - ☐ No quiero que me hagan reanimación cardiopulmonar para intentar hacer que el corazón vuelva a funcionar; si tengo implantado un desfibrilador automático, quiero que lo apaguen.
- Si no puedo respirar por mí mismo(a):
  - ☐ Quiero que me conecten a un respirador
  - ☐ No quiero que me conecten a un respirador durante ningún período de tiempo
- Si estoy en estado terminal o tan enfermo(a) que no es posible que mejore y no puedo ingerir suficiente comida ni agua para mantenerme con vida:
  - ☐ Quisiera que me coloquen una sonda alimentaria
  - ☐ No quisiera que me coloquen una sonda alimentaria

****

Esta solicitud se elaboró, después de una reflexión cuidadosa, mientras gozo de un estado de lucidez mental.

_____	_____	_____
Nombre del paciente en letra de imprenta	Firma del paciente	Fecha

****

Parte 3 – Declaraciones de los testigos
DECLARACIONES DE LOS TESTIGOS

Este documento lo firmó en nuestra presencia el autor del mismo, quien parece tener dieciocho años o más, estar en su cabal juicio y con la capacidad de entender las características y consecuencias de las decisiones sobre el cuidado médico al momento de firmar este documento. El autor no parecía estar bajo ninguna influencia inapropiada. Firmamos este documento en presencia del autor y a petición del mismo y en la presencia de cada uno de nosotros.

Primer testigo

_____	_____	_____
Nombre del testigo en letra de imprenta	Firma del testigo	Fecha

_____	_____	_____	_____
Dirección	Ciudad	Estado	Código postal

Segundo testigo

_____	_____	_____
Nombre del testigo en letra de imprenta	Firma del testigo	Fecha

_____	_____	_____	_____
Dirección	Ciudad	Estado	Código postal

(Nota – Este formulario requiere de dos testigos, pero no requiere de un Notario (Notary Public) para ser válido)

INSTRUCTIONS FOR SCANNING INTO EPIC

1. *Scan into Media Manager*
2. *For document type, select "Living Will"*

MEDICAL RECORD NUMBER:

NAME:

BIRTH DATE:

DELIVERY NETWORK:

CMG COMMUNITY MEDICAL GROUP

Yale NewHaven Health Northeast Medical Group

Yale Medicine

Appointment of Health Care Representative/Agent

I _____ understand that, as a competent adult, I have the right to make decisions about my health care. However, there may come a time when I am unable to make my own health care decisions due to illness or incapacity. In these circumstances, those caring for me will need direction from someone who knows my values and health care wishes. By signing this appointment of health care representative/agent, I give the person named below legal authority to make health care decisions on my behalf in such case or at such time.

I appoint – Name _____

Address _____

Phone number _____

Cell phone number _____

to be my health care representative/agent. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment, **my health care representative/agent is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, (2) make the decision to provide, withhold or withdraw life support systems and (3) to receive any health care information about me that might be necessary to make these decisions, including information related to my mental health or HIV status.**

I direct my health care representative/agent to make decisions on my behalf in accordance with my wishes as stated in my living will, or as otherwise known to my health care representative/agent. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative/agent may make a decision in my best interests, based upon what is known of my wishes.

If this person is unwilling or unable to serve as my health care representative/agent, I appoint:

Name _____

Address _____

Phone number _____

Cell phone number _____

to be my alternative health care representative/agent.

This request is made, after careful reflection, while I am of sound mind and will remain in effect unless and until it is revoked in accordance with state law.

Date | Patient's Printed Name | Patient's Signature

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

First Witness

Date	Witness Printed Name	Witness Signature

Address	City	State	Zip Code

Second Witness

Date	Witness Printed Name	Witness Signature

Address	City	State	Zip Code

INSTRUCTIONS FOR SCANNING INTO EPIC

1. Scan into Media Manager
2. For document type, select "Healthcare Representative/POA"

MEDICAL RECORD NUMBER:

NAME:

BIRTH DATE:

DELIVERY NETWORK:

CMG COMMUNITY MEDICAL GROUP

Yale NewHaven Health Northeast Medical Group

Yale Medicine

Designación de un representante/apoderado para el cuidado de la salud
Appointment of a Health Care Representative/Agent

Yo, _____, entiendo que al ser un adulto competente, tengo el derecho de tomar decisiones relacionadas con mi salud. Sin embargo, puede que en algún momento yo no esté en condiciones de tomar mis propias decisiones médicas debido a enfermedad o incapacidad. Bajo tales circunstancias, aquellos que me atienden necesitarán las instrucciones de alguien que conozca mis valores morales y mis deseos sobre el cuidado médico. Al firmar esta designación de un representante/apoderado para el cuidado de la salud, le otorgo a la persona que se nombra a continuación la autoridad legal para que tome las decisiones médicas en mi nombre, dado el caso o en ese momento.

Designo a – Nombre _____

Dirección _____

Número telefónico _____

Número de celular _____

para que sea el representante/apoderado que tome decisiones médicas por mí. Si el médico jefe encargado de mi cuidado determina que yo no puedo entender ni apreciar las características y consecuencias de las decisiones sobre el cuidado médico ni puedo tomar o comunicar una decisión informada relacionada con el tratamiento, **mi representante/apoderado para el cuidado médico está autorizado para: (1) aceptar o rechazar cualquier tratamiento, servicio o procedimiento utilizado para el diagnóstico o tratamiento de mi condición física o mental, excepto cuando la ley especifique lo contrario, (2) decidir si se proporcionan, niegan o retiran los sistemas de soporte vital y (3) recibir cualquier información médica sobre mí que sea necesaria para tomar tales decisiones, incluso información relacionada con mi salud mental o estado de VIH.**

Doy instrucciones a mi representante/apoderado para el cuidado de la salud para que tome decisiones en mi nombre, de acuerdo con los deseos mencionados en mi testamento vital, o según el representante/apoderado sepa. En caso de que mis deseos no sean claros o si surge una situación que yo no anticipé, mi representante/apoderado para el cuidado de la salud puede tomar la decisión que considere ser la mejor para mí, en función de mis deseos.

Si esta persona no está dispuesta o no puede ser mi representante/apoderado para el cuidado de la salud, designo a:

Nombre _____

Dirección _____

Número telefónico _____

Número de celular _____

para que sea mi representante/apoderado para el cuidado de la salud alternativo.

Esta solicitud se elaboró después de una reflexión cuidadosa, mientras gozo de un estado de lucidez mental y continuará siendo válida a menos o hasta que sea revocada de acuerdo con las leyes estatales.

Fecha _____ Nombre del paciente en letra de imprenta _____ Firma del paciente _____

DECLARACIONES DE LOS TESTIGOS

Este documento lo firmó en nuestra presencia _____, autor del mismo, quien parece tener dieciocho años de edad o más, estar en su cabal juicio y con la capacidad de entender las características y consecuencias de las decisiones médicas, al momento en el que se firma este documento. El autor no parece estar bajo ninguna influencia inapropiada. Firmamos este documento en presencia del autor y a petición del mismo y en presencia de cada uno de nosotros.

Primer Testigo

Fecha	Nombre del testigo en letra de imprenta	Firma del testigo

Dirección	Ciudad	Estado	Código postal

Segundo Testigo

Fecha	Nombre del testigo en letra de imprenta	Firma del testigo

Dirección	Ciudad	Estado	Código postal

INSTRUCTIONS FOR SCANNING INTO EPIC

1. *Scan into Media Manager*
2. *For document type, select "Healthcare Representative/POA"*







Your Conversation Starter Guide

How to talk about what matters to you and have a say in your health care.

Institute *for* Healthcare Improvement

the **conversation** project

We can't plan for everything. But we can talk about what is most important — in our life, and in our health care — with those who matter most.

Talking with the important people in our life can bring us closer together. It also helps us create the foundation of a care plan that's right for us — a plan that will be available when the need arises.

The Conversation Project wants to help everyone talk about their wishes for care through the end of life, so those wishes can be understood and respected. We created this guide to help you start a conversation (and keep talking) so you can have a say in your health care — today and tomorrow.

It's also important to choose what's known as a health care proxy, or health care advocate — someone who would make health care decisions on your behalf if you became unable to voice those decisions yourself. Visit our Guide to Choosing a Health Care Proxy for guidance on picking a proxy.

> If you are completing this document on a computer, first save it to your desktop with a name you can easily find again. Then open your saved document and type in your answers. (Otherwise, what you type will not be saved.) Completing it on your computer will create a digital document that you can easily share with others.

We'll help you take it step by step.

You can take your time! There's no need to say everything that matters in one conversation — you can start talking, then keep talking. It's all about what works best for you.

This document does not seek to provide legal advice.

STEP 1

Think About What Matters to You

To get ready to talk about what matters to you and your wishes for care through the end of life, it's helpful to gather your thoughts as a first step. You don't need to have the conversation just yet. Here are some helpful ways to think about what matters to you and prepare for your conversation.

- What does a good day look like for you?

SOME IDEAS Is it time with family or friends? Enjoying favorite everyday activities? What do you need to enjoy a good life — through the end of life?

- What or who supports you during difficult times?

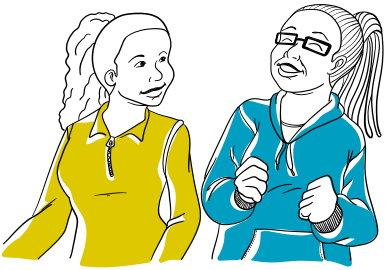
SOME IDEAS Your faith, culture, family, friends, pets

- Try finishing this sentence:
  What matters to me through the end of my life is...

SOME IDEAS Being able to recognize my children; being independent; being able to spend time with the ones I love

That's your "what matters to me" statement.

Sharing it with people you trust could be a big help if they need to communicate with your health care team one day. They may need to share what's important to you and what you need to be able to have a good day. They also may need to decide what type of treatment you'd want to receive. Completing this guide will help you refine what you want them to know about what matters to you.



STEP 2

Plan Your Talk

Having a say in your health care is more likely if you share how you feel about certain situations that could arise now, in the future, and toward the end of life.

For each statement below, mark the place on the line that is closest to what you think or believe about each statement now. There are no "right" or "wrong" choices — your answers are about what works for you.

› As a patient, I'd like to know…

Only the basics about my condition and my treatment

All the details about my condition and my treatment

› When there is a medical decision to be made, I would like…

My health care team to do what they think is best

To have a say in every health care decision

› What are your concerns about medical treatments?

I worry that I won't get enough care

I worry that I'll get too much care

› If I am diagnosed with a serious illness that could shorten my life, I would prefer to…

Not know how quickly it is progressing or my doctor's best estimation for how long I have to live

Understand how quickly it is progressing and my doctor's best estimation for how long I have to live

› Any other notes you want to add?

› If you were seriously ill or near the end of your life, how much medical treatment would you feel was right for you?

I would want to try every available treatment to extend my life, even if it's uncomfortable

I would not want to try treatments that impact my quality of life in order to extend my life

› Where do you prefer to be toward the end of life?

I strongly prefer to spend my last days in a health care facility (hospital, assisted living, or nursing facility)

I strongly prefer to spend my last days at home

Now, look at your previous answers. What do you notice about the kind of health care you said is right for you?

If you weren't able to speak for yourself, would you want people to follow all your wishes or do what they think is best in the moment?

I want the people I trust to do exactly what I've said, even if it makes them uncomfortable

I want the people I trust to do what brings them peace, even if it's different from what I've said

When it comes to sharing information about my health with others…

I don't want those close to me to know all the details about my health

I am comfortable with those close to me knowing all the details about my health

When I die…

I want to be alone

I want to be with other people

- What specific information would you want (or not want) shared with certain trusted people?

- Look at your previous answers. What are the most important things for your friends, family, and health care team to understand about what matters most to you through the end of life?

STEP 3

Start Talking

How much do the people who matter to you know about what matters most to you? There may be some things they already know, and other things that you need to tell them. Sometimes we might think others know how we feel, but they don't. Conversations help make what we think and how we feel as clear as possible.

› Who needs to know what matters to you in your health care?

Check all that apply:

- ◯ Parent(s)
- ◯ Spouse/partner(s)
- ◯ Chosen family member(s)
- ◯ Adult child/children
- ◯ Faith leader (minister, priest, rabbi, imam, etc.)
- ◯ Trusted friend(s)
- ◯ Doctor(s)
- ◯ Nurse practitioner/nurse(s)
- ◯ Social worker
- ◯ Other: _____

› Where would you feel comfortable talking?

- ◯ At the kitchen table
- ◯ At a favorite restaurant
- ◯ In the car
- ◯ On a walk
- ◯ Video chat or phone call
- ◯ At my place of worship
- ◯ Other: _____

› The Conversation Project uses the saying, "It always seems too soon, until it's too late."

When will you start this conversation?

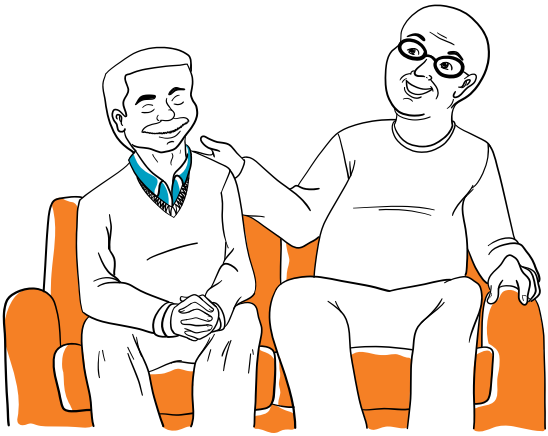
You've gathered your thoughts, written down your ideas, and picked your trusted people. Now, how do you begin a conversation?

This list doesn't cover everything, but here are some things you can say to start talking.

- "I need your help with something."
- "Can you and I have a conversation about _____?"
- "I was thinking about what happened to _____, and it made me realize _____."
- "Even though I'm OK right now, I'm worried that _____, and I want to be prepared. Can we talk about some things that matter to me?"
- "Will you help me think about my future?"
- "I heard about the Conversation Project and answered some of their questions about things that matter to me when it comes to my care through the end of life. I'd like to talk to you about it."
- "When _____ died, do you think their wishes and priorities were respected toward the end of their life?"

Here is a list of some other things you may want to cover when you talk.

- Do you have any worries about your health?
- What do you need to address to feel more prepared (examples: finances, property, legal documents, relationships, health care situations)?
- Do you have any fears, concerns, or mistrust about where or how you receive health care?
- Who do you want (or not want) to be involved in your health care?
- When you look ahead to the future, are there important events or dates you hope you're there for?
- Are there kinds of treatment you would want or not want (examples: resuscitation attempts, ventilation, feeding tube)?
- If your health condition changed, when would it be OK with you to shift from trying to cure an illness to trying to enjoy the end of life as much as possible?



Tips for your talk

Imagine the conversation in your mind first. You can even write a letter that explains your values about the kind of care that works for you to figure out words that feel comfortable for you to use.

- You can also consider having a practice conversation, so you feel as prepared as possible to have a "real" conversation.
- You don't have to talk about everything or talk to everyone in the first conversation. In fact, we suggest you keep talking over time!
- Be patient. Some people are nervous or may need time to get ready to talk. Every time you start a conversation, it helps you come closer to making your wishes fully known. Keep trying.
- You don't have to lead the whole conversation; it's important to also listen to what the other person says so you can build trust.
- Nothing you say is permanent. You can always change your mind as things change in the future.
- You may find out during these conversations that you and your trusted people disagree. That's OK (no judgment!). The important thing is that you're talking now and to keep talking — so you're prepared in case your health changes.
- You can share this guide, with or without your thoughts included, with your trusted people.

STEP 4

Keep Talking

Now that you've started the conversation, keep going! Talk to more people who may have a say in your health care. The more you talk, the more people you are close to will know what matters to you. And that makes it more likely that you'll get the kind of health care you want — now and through the end of life. Here are some things you can think about to keep the conversation going.

- When would be a good time to talk again?

SOME IDEAS It's a good idea to have another conversation when life changes happen, such as the birth of a baby, when family and friends are together for a holiday or visit, before a trip, or when a health issue is getting harder to manage.

- What might you want to repeat or explain again, so you're sure your trusted people understand what's important to you?

- Who do you want to talk to next time? Are there people (such as family members who may disagree) who should hear things from you at the same time?

- What do you want to make sure to ask or talk about next time?

What to do next

Now, it's a good idea to record your conversation with an important legal document to be sure your choices are followed. This is called an advance directive. It has two parts.

1. Your Health Care Proxy

This is the part of the advance directive where you name the person you have chosen to make health care decisions on your behalf, if needed, as well as an alternate if your first choice is unavailable. As explained in this guide, be sure to have a conversation — and keep talking — with these people to be sure they understand what matters to you. You can find more information and suggestions in our Guide to Choosing a Health Care Proxy.

2. Your Living Will

This is the part of the advance directive where you describe your preferences and wishes for your health care if you cannot speak for yourself. These are many of the same things that you have thought about and discussed throughout this guide.

Every state and most countries have their own advance directive forms. In the United States, the NHPCO (National Hospice and Palliative Care Organization) can help you find the right forms in your state (nhpco.org/advancedirective).

It's important to share your advance directive with more than your proxy alone. For example, if you pick an adult child to be your proxy and have other children, they should all be aware of what matters to you in your health care and know who you have chosen as your proxy. Talk to anyone who can help you have a say in your care through the end of life and provide copies of your advance directive to anyone who may need them. If you want tips on talking about what matters to you with your health care team, visit our Guide for Talking with a Health Care Team.

Learn more and share

VISIT US
theconversationproject.org

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conversationproject@ihi.org

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Institute for Healthcare Improvement

the **conversation** project







Guía para iniciar la conversación

Cómo hablar sobre lo que le importa y tomar decisiones de atención médica.

Institute *for* Healthcare Improvement

the **conversation** project

No podemos planearlo todo. Pero podemos hablar sobre lo que más nos importa (en nuestra vida y en nuestra atención médica) con quienes más nos importan.

Hablar con las personas importantes en nuestra vida puede acercarnos. También ayuda a crear las bases de un plan de atención adecuado para nosotros, un plan que estará disponible para cuando llegue el momento.

El proyecto Conversation Project desea ayudar a que todas las personas hablen sobre sus deseos respecto a la atención médica que quieren recibir mientras vivan, para que esos deseos puedan ser entendidos y respetados. Creamos esta guía para ayudarlo a empezar una conversación (y seguir hablando sobre este tema) para que pueda tener voz y voto con respecto a su atención médica, tanto en la actualidad como en el futuro.

Es importante que elija un "representante de atención médica" o "apoderado de salud", que es la persona que tomará las decisiones de atención médica en su nombre en el caso de que usted se vuelva incapaz de tomarlas de forma personal. Consulte la Guía para elegir un representante de atención médica para orientarse sobre cómo elegir a la persona indicada.

> Si completa este documento en la computadora, primero guarde el archivo con un nombre que pueda volver a encontrar fácilmente. Luego, abra el documento guardado y escriba sus respuestas (de otro modo, no se guardará lo que escriba). Al completar el documento en la computadora, se creará un archivo digital que podrá compartir con otras personas fácilmente.

Lo ayudaremos a hacerlo paso a paso.

¡Puede tomarse el tiempo que necesite! No hay necesidad de decir todo lo que le importa en una sola conversación. Puede empezar a hablar y luego seguir hablando. Se trata de lo que más le sirva a usted.

Este documento no busca brindar asesoramiento legal.

PASO 1.

Piense en lo que más le importa

Para comenzar a hablar sobre lo que le importa y sobre sus deseos respecto de la atención médica que desea recibir hacia el final de la vida, es útil que comience por ordenar sus pensamientos. No es necesario que hable sobre el tema en este momento. A continuación encontrará algunas sugerencias para que piense en lo que le importa y se prepare para tener la conversación.

› ¿Cómo es un buen día para usted?

ALGUNAS IDEAS ¿Es pasar tiempo con su familia o con amigos? ¿Hacer las actividades diarias que le gustan? ¿Qué necesitaría para disfrutar de una buena vida... hasta el final de la vida?

› ¿Qué o quién lo acompaña en momentos difíciles?

ALGUNAS IDEAS La fe, la cultura, la familia, los amigos, las mascotas...

› Complete la siguiente oración:
Lo que me importa hacia el final de la vida es...

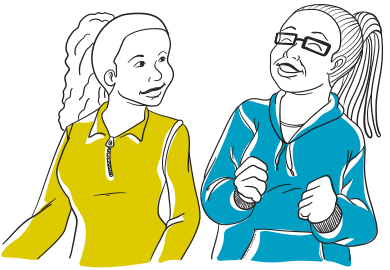
ALGUNAS IDEAS Ser capaz de reconocer a mis hijos, ser independiente, ser capaz de pasar tiempo con las personas que amo.

Esa es su declaración sobre lo que más le importa.

Compartirlo con sus personas de confianza podría ser de gran ayuda si en algún momento necesitan comunicárselo al equipo de atención médica. Es posible que algún día tengan que compartir lo que le importa a usted y lo que necesita para tener un buen día. También podrían tener que decidir qué tipo de tratamiento le gustaría recibir. Completar esta guía lo ayudará a definir qué quiere que sepan sus personas de confianza sobre lo que es importante para usted.

PASO 2.

Planee la conversación



Es más probable que su opinión tenga más peso en su atención médica si comparte cómo se siente acerca de ciertas situaciones que podrían surgir ahora, en el futuro y hacia el final de la vida.

Para cada una de las siguientes declaraciones, marque el círculo en la línea que más se acerque a lo que usted piensa o cree actualmente con respecto a la declaración. No hay opciones "correctas" ni "incorrectas". Sus respuestas corresponden a lo que le sirve a usted.

› Como paciente, me gustaría saber…

Solo la información básica sobre mi enfermedad y mi tratamiento — Todos los detalles sobre mi enfermedad y mi tratamiento

› Cuando se deba tomar una decisión médica, me gustaría...

Que mi equipo de atención médica haga lo que considere mejor — Opinar sobre cada decisión de atención médica, en tanto me sea posible

› ¿Cuáles son sus preocupaciones sobre los tratamientos médicos?

Me preocupa no recibir la atención suficiente — Me preocupa recibir demasiada atención

Si me diagnostican una enfermedad grave que podría acortar mi vida, preferiría…

No saber cuán rápido está progresando ni cuánto tiempo de vida el doctor estima que me queda

Saber cuán rápido está progresando y cuánto tiempo de vida el doctor estima que me queda

Cualquier otro tipo de comentario que desee agregar:

Si tuviera una enfermedad grave o estuviera cerca del final de la vida, ¿cuánto tratamiento médico creería adecuado recibir?

Me gustaría probar cualquier tratamiento disponible, para alargar mi vida incluso si es incómodo

No me gustaría pasar por ningún tratamiento que afecte mi calidad de vida para extenderla

¿Dónde prefiere estar hacia el final de la vida?

Prefiero pasar mis últimos días en un centro médico (hospital, hogar de ancianos, asilo)

Prefiero considerablemente pasar mis últimos días en mi casa

› Ahora, observe sus respuestas anteriores. ¿Qué observa respecto del tipo de atención médica que dijo ser el adecuado para usted?

› Si no pudiera hablar, ¿quisiera que otras personas cumpliesen sus deseos o hicieran lo que consideren mejor en el momento?

Quiero que mis personas de confianza respeten mi voluntad, incluso si les genera incomodidad

Quiero que mis personas de confianza hagan lo que les dé tranquilidad, incluso si difiere de mi voluntad

› Cuando se trata de compartir información sobre mi salud con otras personas...

No quiero que mis personas cercanas sepan todos los detalles sobre mi salud

Estoy a gusto con la idea de que mis personas cercanas conozcan todos los detalles sobre mi salud

› Cuando muera...

Prefiero estar solo

Quiero estar con otras personas

› ¿Qué información específica le gustaría compartir (o no) con sus personas de confianza?

› Sobre la base de su respuesta anterior, ¿qué es aquello fundamental que deben entender sus amigos, su familia y su equipo de atención médica respecto de lo que más le importa hacia el final de su vida?

PASO 3.

Empiece a hablar

¿Cuánto saben las personas que le importan sobre qué es importante para usted? Existen cosas que ya saben, y otras que necesita contarles. A veces pensamos que las demás personas saben cómo nos sentimos, pero pueden no saberlo. Las conversaciones ayudan a aclarar lo más posible qué pensamos y cómo nos sentimos.

› ¿Quién tiene que saber lo que es importante para usted respecto de su atención médica?

Marque todas las opciones que correspondan:

- ◯ Padres
- ◯ Cónyuge o pareja
- ◯ Familiares específicos
- ◯ Hijos pequeños o adultos
- ◯ Líder de fe (ministro, cura, rabino, imán, etc.)
- ◯ Amigos de confianza
- ◯ Doctores
- ◯ Practicantes de enfermería o enfermeros
- ◯ Trabajador social
- ◯ Otro: _____

› ¿Dónde se sentiría cómodo hablando?

- ◯ En la mesa de la cocina
- ◯ En un restaurante favorito
- ◯ En el auto
- ◯ En una caminata
- ◯ En una charla por video o llamada telefónica
- ◯ En mi lugar de oración
- ◯ Otro: _____

› El proyecto Conversation Project toma como referencia el dicho de que “Siempre parece muy pronto, hasta que es demasiado tarde”.

¿Cuándo comenzará usted a hablar sobre este tema?

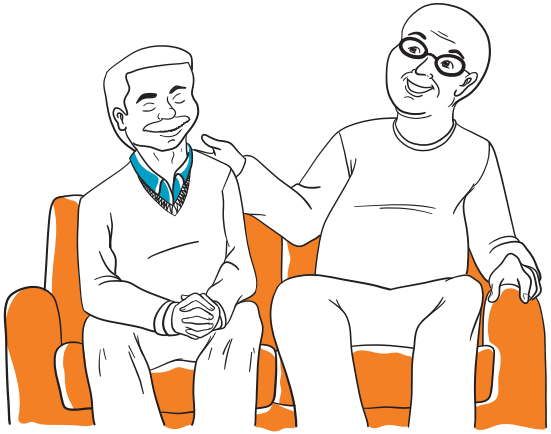
Ha ordenado sus pensamientos, plasmado sus ideas y elegido a sus personas de confianza. Ahora... ¿cómo puede comenzar la conversación?

Esta lista no enumera todo, pero incluye algunas cosas que puede decir para empezar a hablar sobre el tema.

- "Necesito ayuda con algo".
- "¿Podemos conversar sobre _____?"
- "Estaba pensando en lo que le sucedió a _____, y me hizo dar cuenta de que _____".
- "Si bien ahora me siento bien, me preocupa que _____, y quiero estar listo". "¿Podemos hablar sobre alguno de los temas que me importan?"
- "¿Me ayudaría a pensar en mi futuro?"
- "Me enteré del proyecto Conversation Project y respondí algunas de las preguntas sobre lo que me importa respecto de mi atención médica hacia el final de la vida. Quisiera que hablemos al respecto".
- "Cuando falleció _____, ¿cree que sus deseos y prioridades fueron respetados hacia el final de su vida?"

Estas son otras cuestiones sobre las que puede querer hablar cuando tenga la conversación.

- ¿Tiene alguna preocupación con respecto a su salud?
- ¿Qué temas necesita abordar para sentirse más preparado (ejemplos: finanzas, propiedad, documentos legales, relaciones, situaciones de atención médica)?
- ¿Tiene miedos, preocupaciones o inseguridades sobre el lugar donde recibe atención médica o la manera de recibirla?
- ¿Quién quiere (o no quiere) que se involucre en su atención médica?
- Cuando piensa en el futuro, ¿hay eventos o fechas importantes en las que le gustaría estar presente?
- ¿Existen tipos de tratamientos que querría recibir o no (ejemplos: intentos de resucitación, ventilación, sonda nasogástrica)?
- Si cambiara su estado de salud, ¿cuándo sería correcto dejar de intentar curar una enfermedad y pasar a intentar disfrutar el final de la vida tanto como sea posible?



CONSEJOS PARA LA CONVERSACIÓN

Primero imagine cómo será la conversación. Incluso puede escribir una carta que explique sus deseos sobre el tipo de atención médica que prefiere, para encontrar las palabras para expresarlo de la manera más cómoda para usted.

- También puede considerar tener una conversación de práctica, para sentirse lo más preparado posible cuando tenga la conversación real.
- No tiene que hablar de todo ni con todas las personas en la primera conversación. De hecho, le sugerimos que siga hablando sobre el tema a lo largo del tiempo.
- Sea paciente. Algunas personas se ponen nerviosas o pueden necesitar tiempo para estar listas para hablar. Cada vez que tiene una conversación sobre este tema, poco a poco logra que las otras personas conozcan sus deseos por completo. Siga intentándolo.
- No tiene que conducir toda la conversación; también es importante escuchar lo que dice la otra persona para generar confianza.
- Nada de lo que diga es definitivo. A medida que las cosas cambian, usted también puede cambiar de opinión.
- Durante estas conversaciones, podría descubrir que usted y sus personas de confianza no están de acuerdo en ciertas cuestiones. Está bien... No las juzgue. Lo importante es que están hablando sobre esas cuestiones ahora. Siga hablando al respecto para estar preparado en caso de que cambie su salud.
- Puede compartir esta guía (con o sin sus ideas incluidas) con sus personas de confianza.

PASO 4.

Siga hablando

El Proyecto de Conversación quiere ayudar a todos para que puedan hablar sobre sus deseos de atención médica hasta el final de la vida, para que esos deseos se puedan entender y respetar. Creamos esta guía para ayudarlo a iniciar una conversación (y seguir hablando) para que pueda opinar sobre su atención médica tanto en la actualidad como en el futuro.

› ¿Cuándo podríamos volver a hablar?

ALGUNAS IDEAS

Es buena idea tener otra conversación cuando suceden cambios en la vida, como el nacimiento de un bebé, cuando la familia o los amigos se van juntos de vacaciones, antes de un viaje o cuando un problema de salud comienza a volverse más difícil de manejar.

› ¿Qué quisiera volver a repetir o explicar para asegurarse de que sus personas de confianza entiendan lo que es importante para usted?

› ¿Con quién quiere hablar la próxima vez? ¿Existen personas (como los familiares con quienes pueda tener diferencias) que deberían escuchar lo que usted tiene para decir en esa misma conversación?

› ¿De qué quiere asegurarse o sobre qué quiere hablar la próxima vez?

Qué hacer después

Es buena idea registrar la conversación en un documento legal importante, para asegurarse de que se respeten sus decisiones. Es el documento de "Instrucciones anticipadas". Consta de dos partes.

1. Su representante de atención médica

Esta es la parte de las Instrucciones anticipadas donde usted nombra a la persona que ha elegido para que tome las decisiones de atención médica en su nombre, de ser necesario, y una persona alternativa en el caso de que su primera opción no se encuentre disponible. Como se explica en esta guía, asegúrese de hablar (y de seguir hablando) con estas personas para garantizar que entiendan qué es lo que a usted le importa. Puede encontrar más información y sugerencias al respecto en la Guía para elegir un representante de atención médica.

2. Su instrucciones anticipadas

Esta es la parte de las Instrucciones anticipadas en la que describe cuáles son sus preferencias y deseos con respecto a su atención médica llegado el caso de que no pueda expresarlas por sí mismo. Son muchas de las cuestiones sobre las que ha pensado y hablado a lo largo de esta guía.

Cada estado y la mayoría de los países tienen sus propios formularios de Instrucciones anticipadas. En los Estados Unidos, la Organización Nacional de Hospicios y Cuidados Paliativos (National Hospice and Palliative Care Organization, NHPCO) puede ayudarlo a encontrar los formularios correspondientes a su estado (nhpco.org/advancedirective).

Es importante que comparta su documento de Instrucciones anticipadas con otras personas además de su representante.
Por ejemplo, si elige que un hijo adulto sea su representante y tiene otros hijos, todos ellos deberían estar al tanto de lo que le importa a usted respecto de la atención médica, y deberían saber a quién ha elegido como representante. Háblelo con quien pueda ayudarlo a tener voz y voto en su atención hacia el final de la vida, y ofrezca una copia de las Instrucciones anticipadas a cualquier persona que pueda necesitarla. Si desea obtener consejos para hablar sobre lo que le importa con su equipo de atención médica, consulte la Guía para hablar con el equipo de atención médica.

Obtenga más información y comparta.

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FIVE WISHES®
FOR PHYSICIAN PRACTICES

Five Wishes is a perfect resource for supporting clinical excellence and positive patient experiences.

Advance care planning has become a popular service provided through physician practices. Why? Because research consistently demonstrates that advance care planning improves patient and family satisfaction with care, reduces unnecessary hospitalizations, and increases timely enrollment in hospice and palliative care.[1] In addition, advance care planning conversations foster meaningful communication between patients and providers, a major component in measures of patient experience.

Five Wishes is America's most popular advance care planning tool because it's written in clear, everyday language, and because it goes further than traditional advance directives – addressing the emotional, spiritual, and personal aspects of care. *Five Wishes* fosters and supports values-based conversations and communication about what matters to most to patients.

Five Wishes is the only advance directive that invites people to consider and identify what brings them comfort, how they want to be treated, and what they want their loved ones and others to know.

Hundreds of physician networks use *Five Wishes* because it helps address areas that are critical in shaping the patient experience.

Communication About What Matters

Communication is one of the most important elements of excellent patient care, and it is central to patient perceptions of their healthcare provider. *Five Wishes* fosters and supports values-based conversations and communication between physicians, patients, and families about what matters to most to patients at the end of their lives. It goes further than traditional advance directives, addressing the emotional, spiritual, and personal aspects of care.

Values-Based Care Decisions

Values such as dignity and comfort are individual. What matters most to one patient may not be important to another. *Five Wishes* provides a structure for values-based care conversations, and allows patients to define for themselves what dignity and comfort mean to them. Your patients using *Five Wishes* are empowered to identify their specific, personal preferences for what brings them comfort, how they wish to be treated, and what they want loved ones to know.

Help Starting the Conversation

Starting conversations about end-of-life care is difficult. *Five Wishes* makes beginning and documenting the conversation easier. It opens the dialogue about preferences for comfort, communication and care. With its clear instructions and step-by-step guidance, *Five Wishes* guides physicians through starting the conversation, and it is easy for patients and families to understand and complete. It is written at a 7th grade reading level and is available in 29 different languages, so it's useful for all your patients.

Reimbursement for Conversations

Physicians can now bill Medicare and many private insurance carriers for advance care planning conversations. Physician practices using *Five Wishes* can easily pursue these new reimbursement opportunities. Because the document itself provides clear guidance, you can begin having advance care planning conversations without having to develop complicated protocols. *Five Wishes* works for having one conversation or a series of conversations over time, during annual wellness visits, or any time there is a change in your patient's health, condition, or medical setting.

For more information about how your physician practice can use *Five Wishes* resources and training, contact Aging with Dignity.

1. Coalition for Compassionate Care of California. (2015). Value Snapshot: Advance Care Planning.

FIVE WISHES®

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The *Five Wishes* Physician Toolkit

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The *Five Wishes* Physician Toolkit is a comprehensive, turnkey resource for starting or improving an advance care planning initiative using *Five Wishes*. The Toolkit includes:

- ***Five Wishes* Conversation Guide for Clinicians**
  Step -by-step guidance for clinicians about conducting advance care planning conversations with patients and families using the Five Wishes conversation framework. This guide can also be purchased separately.
- ***Five Wishes* Patient Guide to Advance Care Planning**
  Patient education tool that explains the benefits of advance care planning and provides information about FIVE WISHES. Great for waiting rooms and exam areas.
- **Five Steps to Billing Medicare for Advance Care Planning Conversations**
  Quick reference guide to the requirements that must be met to bill Medicare for advance care planning conversations.
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  Thorough implementation guide for physician practices that covers how to use all the resources in the Toolkit.
- ***Five Wishes* Advance Directive**
  The easy-to-use advance directive document, appropriate for all adults regardless of age or health status. Five Wishes can also be purchased separately and customized in large quantities for your organization or practice.