# THE MEDICARE ANNUAL WELLNESS VISIT: RECOMMENDED SCREENING TOOLS

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## **Disclosure Declaration**

• I have no actual or potential conflict of interest in relation to this program or presentation.



## GOALS OF PRESENTATION:

- To provide the clinician with easy-to-use, appropriate screening tools for assessing geriatric patients at the initial and annual Medicare wellness visits for:
  - DEPRESSION
  - FUNCTIONAL ABILITY
  - COGNITION



## OBJECTIVES

At the end of this presentation:

- 1. The student will be able to understand the difference in the Assessment components for the Initial and Annual Medicare Wellness Visits.
- 2. The student will be able to administer, score, and interpret the clinical significance of specific geriatric screening tools for:
  - Depression
  - Functional Ability
  - Cognition



## MEDICARE ANNUAL WELLNESS VISIT (AWV)

 "The purpose of the Annual Wellness Visit (AWV) is to help Medicare patients in maintaining health and preventing or slowing chronic disease processes along with encouraging healthy lifestyle habits."



## COMPONENTS OF THE AWV

• 3 components of the AWV:

- 1. History: PMH, PSH, medications and supplements, list of current providers, FH
- 2. Patient Assessment: Ht., Wt., BMI, BP, Cognitive evaluation, Depression screening, Functional ability
- 3. Orders or Counseling: Written recommended screening schedule, list of RF/conditions w/ interventions, personalized health advice, voluntary advance care planning.



## "Initial" AWV Requirements:

- Must have been enrolled in Medicare for >12 months
- Must NOT have had their "Welcome to Medicare Physical (IPPE)" service within the past 12 months
- History component must contain a completed Health Risk Assessment
- Complete medical history
- Complete list of medications and supplements
- Current list of all medical providers
- Family history



## "Initial" AWV cont.

- Patient Assessment:
  - Screening Tests for:
    - Depression
    - Functional Ability
      - IADLs
      - Home Safety
      - Fall Risk
    - Cognition
  - Blood Pressure, Height, Weight, BMI



## "Initial" AWV cont.

### Orders and counseling

- Personalized written schedule for covered health screening services and immunizations
- A written list of the conditions and risk factors for which treatment is being recommended to them
- Personalized health advice based on the patient's age and health status

### Voluntary Advanced Care Planning

 Written or verbal information about preparing an advance directive if the patient is receptive



## "Subsequent" AWV Requirements

- Must have already had an "initial" AWV and be 11 full months after a previous AWV
- Essentially updates all historical information obtained during the initial AWV or previous AWV:
  - Update the HRA
  - Update medical and family histories
  - Update medications and supplements
  - Update provider list



## "Subsequent" AWV cont.

- Patient Assessment:
  - Blood Pressure, Weight
  - Cognition
- Orders and counseling:
  - Update the written screening schedule from the prior AWV
  - Update the written list of conditions, risk factors, treatments, and recommended interventions
  - Personalized health advice as appropriate
- Voluntary Advanced Care Planning:
  - Review and update as per the patient's wishes



## Screening Tools for the AWV

 There is no particular screening instrument recognized by CMS for use in the AWV, so the provider may choose to use any screening tool as long as it is a nationally recognized instrument.



# **Specific Screening Tools**

### Depression Screening:

- PHQ 2
- PHQ 9
- Functional Ability:
  - Timed Up and Go (TUG)
  - IADLs
- Cognition:
  - MiniCog
  - Memory Impairment Screen (MIS)
  - General Practitioner Assessment of Cognition (GPCOG)



## **Depression Screening**

- The Patient Health Questionnaire-2: PHQ-2
   Overview
  - Used as an initial screen for depression
  - Inquires about the frequency of anhedonia and depressed mood over the past 2 weeks
  - Includes the first two items of the PHQ-9
  - A PHQ-2 score ranges from 0 6
  - A score of 3 is the optimal cut point for screening purposes and warrants further evaluation
  - A positive screen should be further evaluated with the PHQ-9 to determine whether the patient meets criteria for a depressive disorder

**PHQ - 2** 

Over the past two weeks, how often have you been bothered by any of the following problems?

- 1. Little interest or pleasure in doing things.
  - 0 = Not at all
  - 1 = Several days
  - 2 = More than half the days
  - 3 = Nearly every day
- 2. Feeling down, depressed, or hopeless.
  - 0 = Not at all
  - 1 = Several days
  - 2 = More than half the days
  - 3 = Nearly every day

Total point score: \_\_\_\_\_

Information from Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. Med Care 2003; 41:1284-92.

## **Depression Screening**

- The Patient Health Questionnaire-9: PHQ-9
   Overview
  - Administered to patients with a positive stage-one screen (PHQ-2)
  - An excellent questionnaire for confirming the diagnosis of major depressive episode
  - Two-stage screening with the point-scored PHQ-2 as the initial screening instrument and the PHQ-9 for confirmation of a major depressive episode yields accurate overall results (95.1%)
  - Can also be used to monitor the severity of depressive symptoms and assess response to treatment



## **PHQ - 9**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use """ to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3

## PHQ - 9 (cont.)

DAYS NEARLY EVERYDAY				
<ol> <li>Feeling bad about yourself — or that you are a failure or have let yourself or your family down</li> </ol>	0	1	2	3
<ol> <li>Trouble concentrating on things, such as reading the newspaper or watching television</li> </ol>	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
<ol> <li>Thoughts that you would be better off dead or of hurting yourself in some way</li> </ol>	0	1	2	3

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

## PHQ – 9 Interpretation

#### Interpretation of Total Score Total Score Depression Severity

1-4 Minimal depression5-9 Mild depression10-14 Moderate depression15-19 Moderately severe depression20-27 Severe depression

## **Functional Ability**

- Determines the ability of the older adult to remain independent
- Multi-factorial
- Often modifiable
- Annual screening is appropriate and helpful in older adults after the age of 65

## Screen for Falls and/or Fall Risk

- Key Falls Questions:
  - 1. Did you fall within the last year?
    - If "YES", ask: How many times?

Were you injured?

- 2. Do you feel unsteady when standing or walking?
- 3. Do you worry about falling?

If the patient answers YES to any key question, evaluate gait, strength, and balance.



## Timed Up and Go (TUG)

#### **Purpose:**

To assess mobility

#### Equipment:

A stopwatch

#### **Directions:**

Patients wear their regular footwear and can use a walking aid if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters or 10 feet away on the floor.

#### Instructions to the patient:

When I say "Go," I want you to:

Stand up from the chair

Walk to the line on the floor at your normal pace

Turn

Walk back to the chair at your normal pace

Sit down again

On the word "Go" begin timing. Stop timing after patient has sat back down and record.

Time in seconds \_\_\_\_\_



## **TUG: Interpretation**

An older adult who takes ≥12 seconds to complete the TUG is at high risk for falling.

Observe the patient's postural stability, gait, stride length, and sway.

**Circle all that apply:** Slow tentative pace / Loss of balance / Short strides / Little or no arm swing / Steadying self on walls / Shuffling / En bloc turning / Not using assistive device properly

www.cdc.gov/injury/STEADI

**STEADI:** Stopping Elderly Accidents, Deaths & Injuries



### Instrumental Activities of Daily Living: IADLs

Lawton, M.P., & Brody, E.M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. The Gerontologist, 9(3), 179-186.

		SCORE
Ability to use telephone	Are you able to operate a telephone on own initiative (look up and dial numbers, etc.) $OR$ dial a few well known numbers $OR$ answer the phone but not dial = 1	
	Do not use the phone at $all = 0$	
Shopping	Are you able to take care of all shopping needs independently = 1	
	Do you shop independently for small purchases $OR$ do you need to be accompanied on any shopping trip $OR$ are you completely unable to shop = 0	
Food Preparation	Are you able to plan, prepare and serve adequate meals independently $= 1$	
	Do you prepare adequate meals if supplied with ingredients $OR$ heat and serve prepared meals $OR$ prepare meals but does not maintain adequate diet OR need to have meals prepared and served = 0	

# IADLs (cont.)

Housekeeping	Are you able to maintain your home alone or with occasional assistance (ie: "heavy work-domestic help") $OR$ perform light daily tasks (ie: dishwashing or bed making) $OR$ performs light daily tasks but cannot maintain acceptable level of cleanliness $OR$ needs help with all home maintenance = 1 Do not participate in any housekeeping tasks = 0	
Laundry	Are you able to do all your personal laundry completely OR launder small	
	items (ie: rinse socks, stockings) = $1$	
	All laundry is done by others $= 0$	
Mode of	Are you able to travel independently on public transportation, drive your	
transportation	own car, arrange your own travel via taxi OR travel on public transportation	
	when assisted or accompanied by another $person = 1$	
	Do you travel via taxi and automobile with assistance of others or not travel	
	at all = 0	



# IADLs (cont.)

Responsibility for own medication	Are you able to be responsible for taking your medication in correct dosage at the correct time $= 1$	
	Do you take responsibility for your medication if the medication is prepared in advance in separate dosages $OR$ are you not capable of dispensing your own medications = 0	
Ability to handle finances	Are you able to manage financial matters independently (budget, write checks, pay bills), collect and keep track of income $OR$ manage day-to-day purchases but need assistance with major purchases = 1	
	Are you incapable of handling money =0	
	TOTAL IADL SCORE:	/8



## **AWV Cognitive Screen**

The AWV requires detection of cognitive impairment by:

• "....assessment of an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers, or others."



# Medicare Detection of Cognitive Impairment Workgroup

- Convened by the Alzheimer's Association
- Workgroup comprised of US experts with published works in detecting cognitive impairment
- Goal to develop recommendations for operationalizing the cognitive assessment component
- Deliberate focus on primary care



# **Guiding Principles:**

- 1. Detection of cognitive impairment is a stepwise, iterative process.
- 2. Informal observation alone by a physician is insufficient.
- Detection can be enhanced by asking specific questions (i.e. changes in memory, language problems, ability to complete routine tasks).
- 4. An initial structured assessment should provide either a baseline for cognitive surveillance or trigger for further evaluation.



## Guiding Principles: cont.

- Clinical staff can offer valuable observations of cognitive and functional changes in patients who are seen over time.
- 6. Counseling before and after cognitive assessment is an essential component of any cognitive evaluation.
- 7. Informants can provide valuable information about the presence of a change in cognition.



## Principles specific to the AWV:

- Careful review of the pts. Health Risk Assessment questionnaire, looking for any reported signs of possible dementia.
- 2. Tools should be brief, appropriately validated, easily administered, and available free of charge for use in a clinical setting.
- 3. If further evaluation is indicated, an appropriate follow-up visit should be scheduled.



## Workgroup review results

- 1. Memory Impairment Screen (MIS)
- 2. General Practitioner Assessment of Cognition (GPCOG)

3. Mini-Cog



## ATTRIBUTES OF THE TOOLS:

- 1. Requires 5 minutes or less to administer.
- 2. Is validated in a primary care or community setting
- 3. Is easily administered by medical staff members who are not physicians.
- 4. Has good to excellent psychometric properties.
- 5. Is relatively free from educational, language, and/or cultural bias.
- 6. Can be used by clinicians in a clinical setting without payment for copyrights.

## **Benefits**:

### • GPCOG:

Has patient and informant components that can be used alone or together to increase specificity and sensitivity.

### • MINI-COG:

Has been validated in population-based studies in community-dwelling older adults heterogeneous with respect to language, culture, and education.

#### • MIS:

Is a verbally administered word-recall task that tests encoding as well as retrieval and is an option for patients who have motor impairments that prevent use of paper and pencil.







# Mini-Cog

- Cognitive impairment screening test for primary care settings
- The tool can be administered in three minutes
- Does not require any special equipment
- Sensitivity reported from 76-99% with specificity from 89-93%
- Effectively used in multilingual populations with diverse socioeconomic status and education level

Borson S. et al. Int J of Geriatr Psychiat 2000; 15:1021-1027. Borson S et al. J Am Geriatr Soc 2003; 51:1451-1454. Borson S et al. J Am Geriatr Soc. 2005; 53:871-4. Scanlan JM, Borson S. Int J of Geriatr Psychiat. 2001; 16:216-222.

# Mini-Cog

- 1) Registration
- 2) Clock draw test
- 3) Three word recall

#### Registration

# Ask the patient to remember 3 words: APPLE, WATCH, PENNY

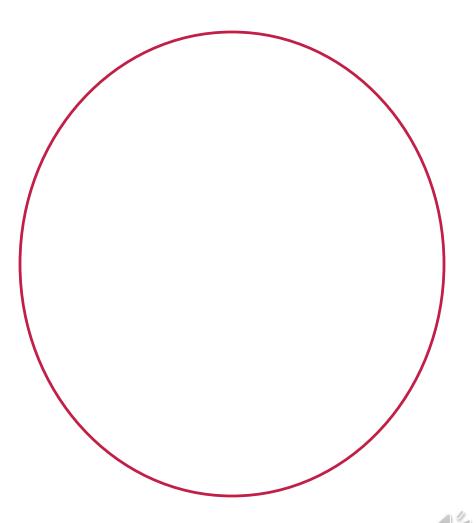
- Say each word with a one second pause between them
- If they can't repeat all 3 say them all again
  - Repeat them up to 5 times
  - The patient should not be given any help or cues to remember
- Then instruct the patient:

Remember these three words - I will ask you to repeat them later



# **Clock Draw**

- Give the patient a predrawn circle
- Ask them to place the numbers so they "look like the face of a clock"
- After the patient has completed placing the numbers, ask them to "draw the hands of the clock so it reads ten after eleven"



### Three Word Recall

Ask the patient to recall the three words
Do not give any hints or cues



# Scoring

#### Clock:

- All numbers present and in the right sequence
- Two hands joining in the center of the clock
- Long hand must point to the 2
- Short hand pointing to the 11

#### • Recall:

 Patient must remember all 3 words correctly



http://www.theagepage.co.uk/.a/6a00d83443d1b053ef0176166513f2970c-pi



#### Mini-Cog interpretation

#### Scoring

#### 3 recalled words 1-2 recalled words + normal CDT 1-2 recalled words + abnormal CDT 0 recalled words

Negative for cognitive impairment Negative for cognitive impairment Positive for cognitive impairment Positive for cognitive impairment

**1.** Borson S, Scanlan J, Brush M, Vitaliano P, Dokmak A. The mini-cog: a cognitive "vital signs" measure for dementia screening in multi-lingual elderly. Int J Geriatr Psychiatry. 2000;15(11):1021-1027.

**2.** Borson S, Scanlan JM, Chen P, Ganguli M. The Mini-Cog as a screen for dementia: validation in a population-based sample. J Am Geriatr Soc. 2003;51(10):1451-1454. **3.** McCarten JR, Anderson P Kuskowski MA et al. Finding dementia in primary care: the results of a clinical demonstration project. J Am Geritr Soc. 2012;60(2):210-217.

Mini-Cog<sup>™</sup> Copyright S Borson. Reprinted with permission of the author (soob@uw.edu). All rights reserved.



#### Mini-cog: detailed directions

ADMINISTRATION	SPECIAL INSTRUCTIONS			
<ol> <li>Get patient's attention and ask him or her to remember three unrelated words. Ask patient to repeat the words to ensure the learning was correct.</li> </ol>	<ul> <li>Allow patient three tries, then go to next item.</li> <li>The following word lists have been validated in a clinical study:<sup>1-3</sup></li> <li>Version 1 Version 3 Version 5         <ul> <li>Banana</li> <li>Village</li> <li>Captain</li> <li>Sunrise</li> <li>Kitchen</li> <li>Garden</li> <li>Chair</li> </ul> </li> </ul>			
	Version 2Version 4Version 6• Daughter• River• Leader• Heaven• Nation• Season• Mountain• Finger• Table			
<ol> <li>Ask patient to draw the face of a clock. After numbers are on the face, ask patient to draw hands to read 10 minutes after 11:00 (or 20 minutes after 8:00).</li> </ol>	<ul> <li>Either a blank piece of paper or a preprinted circle (other side) may be used.</li> <li>A correct response is all numbers placed in approximately the correct positions AND the hands pointing to the 11 and 2 (or the 4 and 8).</li> <li>These two specific times are more sensitive than others.</li> <li>A clock should not be visible to the patient during this task.</li> <li>Refusal to draw a clock is scored abnormal.</li> <li>Move to next step if clock not complete within three minutes.</li> </ul>			
3. Ask the patient to recall the three words from Step 1.	Ask the patient to recall the three words you stated in Step 1.			

# MIS: MEMORY IMPAIRMENT SCREEN



### MIS

- 1. Verbal memory test (no writing or drawing)
- 2. Little or no education bias
- Does not test executive function or visuospatial skills



## **MIS:** Instructions

- 1. Show patient a sheet of paper with the 4 items to be recalled in 24-point or greater uppercase letters, and ask patient to read the items aloud.
- 2. Tell patient that each item belongs to a different category. Give a category cue and ask patient to indicate which of the words belongs in the stated category (eg. "Which one is the game?"). Allow up to 5 attempts. Failure to complete this task indicates possible cognitive impairment.
- 3. When patient identifies all 4 words, remove the sheet of paper. Tell patient that he or she will be asked to remember the words in a few minutes.



# MIS: 4 items to be recalledCHECKERS

#### SAUCER

#### TELEGRAM

### RED CROSS

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# MIS: Instructions (cont.)

- 4. Engage patient in distractor activity for 2 to 3 minutes, such as counting to 20 and back, counting back from 100 by 7, spelling WORLD backwards.
- 5. FREE RECALL 2 points per word: Ask patient to state as many of the 4 words s/he can recall. Allow at least 5 seconds per item for free recall. Continue to step 6 if no more words have been recalled for 10 seconds.
- 6. CUED RECALL 1 point per word: Read the appropriate category cue for each word not recalled during free recall (eg. "What was the game?").



# **MIS: Scoring**

Word	Cue	Free recall (2 pts.)	Cued Recall (1 pts)
Checkers	Game		
Saucer	Dish		
Telegram	Message		
Red Cross	Organization		

# **MIS:** Interpretation

- The maximum score for the MIS is 8.
  - 5-8: No cognitive impairment
  - ≤ 4: Possible cognitive impairment

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# GPCOG: General Practitioner Assessment of Cognition



#### GPCOG

- 1. Developed for and validated in primary care
- 2. Informant component useful when initial complaint is informant-based
- 3. Little or no education bias
- 4. Multiple languages accessible at: <u>www.gpcog.com.au</u>
- Requires an informant score when pt. score is indeterminate range



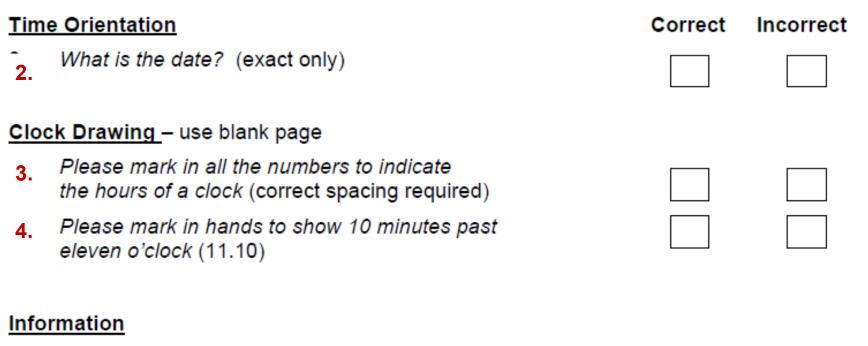
## GPCOG

- 1. Recall
- 2. Time orientation
- 3. Clock drawing/executive function
- 4. Information

#### **GPCOG Screening Test:** Step 1: Patient Examination

#### Name and Address for subsequent recall test

 "I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington." (Allow a maximum of 4 attempts).



5. Can you tell me something that happened in the news recently? (Recently = in the last week. If a general answer is given, eg "war", "lot of rain", ask for details. Only specific answer scores).

#### **Step 1: Patient Examination (cont.)**

#### <u>Recall</u>

6. What was the name and address I asked you to remember

John Brown 42 West (St)

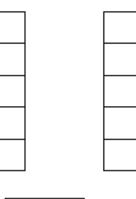
Kensington

(To get a total score, add the number of items answered correctly Total correct (score out of 9)

If patient scores 9, no significant cognitive impairment and further testing not necessary.

If patient scores 5-8, more information required. Proceed with Step 2, informant section.

If patient scores 0-4, cognitive impairment is indicated. Conduct standard investigations.



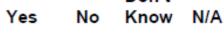
/9

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#### **Step 2: Informant Interview**

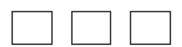
These six questions ask how the patient is compared to when s/he was well (5 -10 years)

- Does the patient have more trouble remembering things that have happened recently than s/he used to?
- Does he or she have more trouble recalling conversations a few days later?
- 3. When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often?
- 4. Is the patient less able to manage money and financial affairs (e.g. paying bills, budgeting)?



Don't









#### Step 2: Informant Interview (cont.)

These six questions ask how the patient is compared to when s/he was well (5-10 years)

- 5. Is the patient less able to manage his or her medication independently?
- 6. Does the patient need more assistance with transport (either private or public)? (If the patient has difficulties due only to physical problems, e.g bad leg, tick 'no')

#### Total score (out of 6)

(*To get a total score, add the number of items answered 'no', 'don't know' or 'N/A'*), If patient scores 0-3, cognitive impairment is indicated. Conduct standard investigations.

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Don't

No

Yes

Know N/A

## Annual Wellness Visit

- An excellent opportunity to provide healthcare and wellness care to our older adult patients
- Helpful for maintaining health and preventing disability in our aging population
- Serves as a revenue source for our practices
- Provides an opportunity to educate and inform our older adults through screening and prevention
- Simple screening tools are available for incorporation into the AWV and into day-to-day practice.



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Thank you!!

