Medicare AWV User Quick Start Guide

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Overview

The **Welcome to Medicare Visit** and **Annual Wellness Visit (AWV)** are to review the patient’s wellness and develop a plan to keep the patient healthy. A focused physical exam – not a comprehensive “head-to-toe” physical exam – is included.

**Visit Includes:**

- A health risk assessment (questions you answer about your health)
- A review of your medical and family history
- Developing or updating a list of your current providers and prescriptions
- Documenting your height, weight, blood pressure and other routine measurements
- Looking for signs of memory loss or dementia
- Personalized health advice just for you
- A list of risk factors and treatment options for you
- A screening schedule (like a checklist) for the preventive services recommended for you

The Annual Wellness Visit is an excellent time to screen for and to act on clinical needs identified with the Age-Friendly Health System 4M’s framework in primary care. The EPIC template for the AWV supports care teams in assessing and providing age friendly care so that it is integrated and not “just one more thing to do”. This also helps teams to find ways to ensure that we take into account What Matters to each individual patient and develop a unique plan of care based on that particular patient’s goals.

In an **Age-Friendly Health System (AFHS)**, value is optimized for all — patients, families, caregivers, health care providers, and the overall system. Age-Friendly Health Systems use a set of four evidence-based elements to organize the care of older adults, known as the **“4Ms”: What Matters, Medication, Mentation, and Mobility**. The 4Ms are essential elements of high-quality care for older adults. When implemented together, they are expected to result in significant improvement in the care of these individuals. The 4M’s can be applied to the inpatient and outpatient setting with different focus that is most relevant for the setting.

**AFHS icon is used throughout the guide to indicate essential met.**

![Age-Friendly Health Systems Icon](image)

**What Matters**

Know and align care with each older adult’s specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

**Medication**

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult. Mobility, or Mentation across settings of care.

**Mentation**

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

**Mobility**

Ensure that older adults move safely every day in order to maintain function and do What Matters.

[Click Here for Tip Sheet on What Matters](#)
## Comparison of Medicare Wellness Visits

<table>
<thead>
<tr>
<th>VISIT</th>
<th>Welcome to Medicare (Initial Preventive Physical Examination or IPPE)</th>
<th>Annual Wellness Visit (AWV)</th>
<th>Traditional Annual Physical Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHEN</td>
<td>Within the first 12 months of enrollment in Medicare Part B.</td>
<td>After the first 12 months enrollment in Medicare Part B and at least 1 year + 1 day after the IPPE (if provided).</td>
<td>Provided at patient’s request.</td>
</tr>
<tr>
<td>HOW OFTEN</td>
<td>Covered only once in a lifetime</td>
<td>Subsequent AWVs may be provided annually if more than 1 year + 1 day after the last Wellness Visit to review and update the wellness plan.</td>
<td>Every 1-2 years</td>
</tr>
<tr>
<td>COVERAGE</td>
<td>Medicare pays 100%.</td>
<td>Medicare pays 100%.</td>
<td>Not covered by Medicare</td>
</tr>
<tr>
<td>REQUIRED For both IPPE &amp; AWV</td>
<td>Medical/surgical history including: current meds and supplements, diet, physical activities sexual health and history of alcohol, tobacco and illicit drug use including opioid use disorders or at risk</td>
<td></td>
<td>A comprehensive, &quot;head-to-toe&quot; physical exam.</td>
</tr>
<tr>
<td></td>
<td>Family history</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of potential psychosocial risk factors for depression, life satisfaction, social isolation, stress, pain, and fatigue etc., including current or past experiences with depression or other mood disorders and any appropriate screening instrument (PHQ9).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of functional ability and level of safety (ADL/fall risk/hearing impairment, home safety)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exam: HT/WT/BMI/SP, other factors deemed appropriate based on history/clinical standards.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Educate, counsel and refer based (based on results)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establishment of a written screening schedule for a minimum of 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In addition to above for IPPE</td>
<td>In addition to above for AWV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Visual acuity screen</td>
<td>Review of a completed Health Risk Assessment (HRA)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>End-of-life planning</td>
<td>List of medical providers and suppliers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Screening EKG, as appropriate-once in lifetime</td>
<td>Detection of cognitive impairments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other screening such as AAA ultrasound (family hx or male 65-75 yo with smoking hx); covered only with referral from IPPE.</td>
<td>ACP discussion at patient’s discretion</td>
<td>Establish list of patient risk factors and conditions if any</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Give personalized health advice/appropriate referrals to health education/preventive counseling services</td>
<td></td>
</tr>
<tr>
<td>CODES</td>
<td>IPPE - G0402</td>
<td>Initial Annual Wellness Visit - G0438</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subsequent Wellness Visit - G0439</td>
<td>99387 – Estab pt, 65 &amp; &gt;, PE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>99387 – New patient, 65 &amp; &gt;, PE</td>
</tr>
</tbody>
</table>
Scheduling Protocols

Patient Service Representative (PSR) – Call Center

- Use scripts to clarify patient needs and expectations when a patient calls for appointments

- Educate patients and schedule appropriately
  - For patients signed up for MyChart, documents will be sent 2 weeks prior to the scheduled visit for patients to complete. If patient does not have an active MyChart account, ask if they would like to sign up for one.
  - Mail a Patient Packet for Annual Wellness Visit to the patient if they do not use MyChart.
  - Provide a HRA packet to the patient if scheduled during check out in the office.
  - Use the Medicare Wellness Visit Type during scheduling.

<table>
<thead>
<tr>
<th>MyChart Patient Packet for Medicare Wellness includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update current medical providers and equipment suppliers</td>
</tr>
<tr>
<td>List of all prescribed and OTC medications</td>
</tr>
<tr>
<td>Health Risk Assessment (HRA) Questionnaire (updates, see appendix)</td>
</tr>
<tr>
<td>SDOH MyChart Questionnaire (new tool with actions, see appendix)</td>
</tr>
<tr>
<td>PHQ9</td>
</tr>
</tbody>
</table>

- Proactively schedule patients by extending upcoming appointments
Pre-Visit Planning (As Applicable)

Update Care Team
Update the Care Team with names of consultants by reviewing the media and encounters tab for consult reports.

Other Patient Care Team Members List

<table>
<thead>
<tr>
<th>Role</th>
<th>List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending physician or resident physician <em>not</em> serving as the patient’s primary care provider.</td>
<td>Relationship = “Consulting Physician” Surgeons may optionally select a relationship of “Surgeon”</td>
</tr>
<tr>
<td>Nurse Practitioner <em>not</em> serving as the patient’s primary care provider.</td>
<td>Relationship = “Nurse Practitioner”</td>
</tr>
<tr>
<td>Physician Assistant <em>not</em> serving as the patient’s primary care provider.</td>
<td>Relationship = “Physician Assistant”</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>Relationship = “Registered Nurse”</td>
</tr>
<tr>
<td>Dietitian</td>
<td>Relationship = “Dietitian”</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Relationship = “Social Worker”</td>
</tr>
<tr>
<td>Care Manager</td>
<td>Relationship = “Care Manager”</td>
</tr>
<tr>
<td>Anticoagulation Manager – if applicable</td>
<td>Relationship= “Anticoagulation Manager”</td>
</tr>
</tbody>
</table>

Identify Health Maintenance Items
Identify the Health Maintenance (HM) items that the patient will be due for and make a note in the pre-visit planning tool.

Check Advance Directive Documentation
Check the banner for Advance Directives documentation. If none, make a note in the pre-visit planning tool that the patient needs the Advanced Care Planning booklet.
Identify Visit Type

Identify if the visit is a Welcome to Medicare (enrolled <12 months), initial Annual Wellness Visit (AWV) or Subsequent AWV or a Combination Wellness Visit (initial or subsequent) **WITH** an Annual for patients with a Medicare Advantage plan. Indicate the visit type in the Appointment Note and enter this as the Reason for Visit (RFV).

Add the annual physical as an additional RFV if appropriate. See Page 3 for a complete explanation of the different visit types.

If the patient is scheduled for a Medicare Wellness visit and the patient has a Medicare Advantage Plan, the visit can be turned into a combination AWV + Annual visit

Review any Special Instructions

Ask provider for any special instructions (e.g. ECG if needed for IPPE)
Patient Check-In

Health Risk Assessment Questionnaire

- Confirm that the patient has brought the Patient Packet for Medicare Wellness. If not, provide a packet for the patient to complete in the waiting room

Update Care Team

If the patient is actively seeing other specialists, you can verify and update the care team with names of consultants by reviewing the media and encounters tab for consult reports (as applicable).
Patient Rooming

Update Care Team
If the patient is actively seeing other specialists, you can verify and update the care team with names of consultants by reviewing the media and encounters tab for consult reports (as applicable).

Enter Chief Complaint/Reason for Visit
Enter Chief Complaint/RFV (if not already done), by choosing the appropriate Medicare visit.

- Welcome to Medicare Visit (also known as Initial Preventive Physical Examination, IPPE)
- Medicare Annual Wellness Visit Initial
- Medicare Annual Wellness Visit Subsequent
- Additional RFV if applicable

Refer to p. 3 for more information on Medicare Wellness Visit types.

Pull in results from MyChart

Enter Vital Signs
Enter Vital signs (Height, Weight, BP, Pulse) and document Pain Score.

Update Allergies
Review and update allergies.

Perform Medication Reconciliation

1. Perform Medication Reconciliation including over the counter medications and supplements.

Update Social History

1. Update the Tobacco and Alcohol history in the Social History section, including an assessment of smokeless tobacco use. If positive and not completed in MyChart, patient completes DAST and AUDIT screener.
2. Review SDOH for care gaps (Storyboard) and update assessment.
Complete Screenings

Complete the following items within the **Screenings** tab:

1. **Patient Health Questionnaire (PHQ)**
2. **Fall Risk**

   - Under the **Hearing/Vision** section:
     - Document Visual Acuity (required if visit is Welcome to Medicare Exam, aka IPPE)
3. **Cognitive/Functional** (includes visual and hearing questions).

   - Minicog will cascade regardless, complete when appropriate.
Enter Health Risk Assessment Questionnaire Responses

1. Enter the HRA questionnaire responses in the HRA section of the Screenings activity, if not already completed by the patient via MyChart. This must be entered before the provider portion of the visit. SDOH questions are now aligned with Epic foundation and questions about caregiver stress have been added.
2. If clinical staff need to make edits, they click on the **date/time** and update the entries.

If the Medicare HRA section does not appear, confirm that 1 of the 3 Medicare Reason For Visit (RFVs) have been entered and then press F5.

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**Enter Billing Codes (As Applicable)**

**Go to the Visit Taskbar**

1. Enter TC code(s) as applicable.
Physican and APP

Important Notes for Providers

1. Medicare Annual Wellness Visit (AWV) documentation will be generated by the AWV SmartSet. It is required that the patient receive a personal screening plan at the end of the visit. This will appear on the patient’s After Visit Summary (AVS), automatically with the use of the SmartSet.

2. All visits to be provided and documented the same regardless of visit type. NOTE: Welcome to Medicare requires visual screening to be performed by support staff.

3. All other documentation, e.g., the Annual physical, additional Evaluation and Management (E&M) services for acute or unstable conditions, and the patient’s Hierarchical Condition Category (HCC) can be completed in a separate note within the same encounter.

   If the visit is an AWV/PE combination, create a separate note. It is recommended to use your template that you normally use with annual physicals for the annual component. Similarly, you can use your usual visit templates for the E&M component. The AWV documentation will be generated separately by the SmartSet tools described below.

   Refer to p. 3 for more information on Medicare Wellness Visit types.

4. Sign the SmartSet prior to the patient checking out.

   The SmartSet needs to be signed prior to the patient checking out as it inserts necessary information into the After Visit Summary (AVS) and communicates follow-up instructions to check-out staff.
Before Opening the SmartSet

1. Open the Rooming activity to review and update the following sections:
   a) Home Medications
      • Discontinue medications that have been flagged for removal, if applicable.
   b) Vital Signs
   c) Safety Questions
   d) PHQ
   e) Fall Risk
   f) Cognitive/Functional
   g) Health Risk Assessment (HRA) questionnaire
      • To edit responses on the HRA questionnaire, click on the blue date hyperlink at the top of the response column. Clicking the hyperlink will open the response field to edit.

To view the questionnaires most effectively do not open the sections or responses individually. Instead, Click the Blue Arrow or scroll through the individual sections. With the HRA sections closed, abnormal responses appear in red text.

2. Open the History Section to review and update the following information:
   a) Medical History
   b) Surgical History
   c) Family History

3. Review and Update Health Maintenance

4. Review and Update Problem List
   a) Assess diagnosis coding for highest level of specificity (HCC Score)
   b) Update goals, as applicable
Opening the SmartSet

1. Within the Plan Activity navigate to the SmartSet section where you will find the suggested Medicare Annual Wellness Visit (AWV) SmartSet.

2. Open the Medicare AWV SmartSet

   - Based upon the responses to the Health Risk Assessment (HRA) questionnaire, relevant sections will be available. For instance, if the patient reports that they do not exercise, appropriate text will be added to the AVS to increase activity.
   - The check box to select which health risks were discussed has been replaced with a SmartList. Opioid Management has now been added to the list.

   ![Image of SmartList]

   - Positive screening measures will present options for interventions.
   - The SmartSet will automatically add the appropriate Wellness visit diagnosis. The Level of Service (LOS) needs to be selected within the SmartSet.
   - The SmartSet will automatically add the Health Maintenance list to the After Visit Summary (AVS).
   - New education materials (AVS attachments).

3. When finished placing orders, **Sign** the orders.

4. **Sign** the SmartSet

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**Note:** Smartset completes prevention plan including, **personalized health advice just for you**, **risk factors and treatment options for you**, and **screening for the preventive services recommended for you.**
The SmartSet needs to be signed prior to the patient checking out as it inserts the necessary information into the AVS.

- The minicog questions should be completed in the HRA, and they will now display in the progress note.
After Signing the SmartSet

1. Go to the Notes Activity
   - Edit additional notes including the AWV note and assessment of the HCC diagnosis.
   - While editing the AWV note, click the button at the top of the note and fill out the ACP SmartForm to document information about the patient’s ACP. There is now a text box available for documentation of any Advance Care Planning discussion.

   ![Image of NoteWriter](image)

   - ACP Notes box is now available for use in all contexts.

   ![Image of ACP Notes](image)

   - When writing your note, bring in the following SmartPhrases as appropriate. The SmartPhrase will include the AUDIT or DAST Score, a table with recommended interventions based on screening scores, and the intervention that you selected with the patient.
### AUDIT Score and Interventions

**Consumption Score Total: 16**

<table>
<thead>
<tr>
<th>Score</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7</td>
<td>Provide feedback and education. Rescreen in 1 year. Offer follow up visit as clinically indicated.</td>
</tr>
<tr>
<td>8-15</td>
<td>Provide brief intervention and offer follow up visit as clinically indicated.</td>
</tr>
<tr>
<td>16-18</td>
<td>Provide brief intervention and offer warm handoff to integrated behavioral health clinician. Offer follow up visit as clinically indicated. Screen for withdrawal risk.*</td>
</tr>
<tr>
<td>20 or more</td>
<td>Provide brief intervention and offer referral to specialty treatment provider. Offer follow up visit as clinically indicated. Screen for withdrawal risk.*</td>
</tr>
</tbody>
</table>

Note: *Discuss risk of alcohol withdrawal with patient. Offer local options for acute detox.*

**Brief Intervention: Brief intervention done**
**Referral to Treatment: Referral to Integrated Behavioral Health Clinician**

### DAST Score and Interventions

**DAST Score: 6**

<table>
<thead>
<tr>
<th>Score</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>Provide brief intervention and offer follow up visit as clinically indicated.</td>
</tr>
<tr>
<td>3-5</td>
<td>Provide brief intervention and offer warm handoff to integrated behavioral health clinician. Offer follow up visit as clinically indicated.</td>
</tr>
<tr>
<td>6-9</td>
<td>Provide brief intervention and offer warm handoff to integrated behavioral health clinician or referral to specialty treatment provider. Offer follow up visit as clinically indicated. Screen for withdrawal risk.*</td>
</tr>
<tr>
<td>9-10</td>
<td>Provide brief intervention and offer referral to specialty treatment provider. Offer follow up visit as clinically indicated. Screen for withdrawal risk.*</td>
</tr>
</tbody>
</table>

Note: *Assess willingness to treat opioid use disorder, if applicable. Refer to local ED or IJAT provider.*

**Brief Intervention: Brief intervention done**
**Referral to Treatment: Referral to Integrated Behavioral Health Clinician**

- Action buttons are listed below the AUDIT and DAST screeners in the screening section of the patient’s chart. It is important to select at least one of these to document the intervention taken with your patient. These recommendations will show up in the flowsheets and in your SmartPhrase.
2. Review and select the visit diagnosis from the problem list for assessment documentation.

3. Go to the Wrap-Up activity
   - Enter any additional billing codes such as 99397, or the additional E&M code, if appropriate, in the Additional E/M Codes of the LOS Activity. The appropriate Wellness Visit codes are added with the signing of the SmartSet.

The SmartSet defaults to a 1 year follow-up for the next AWV. This can be edited as needed.
## Health Risk Assessment Questionnaire

The following Health Risk Assessment questionnaire is aligned with the HRA in Epic for efficient entry of patient responses when completed in advance. (need updated copy/screenshot of form with question 5 removed.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had 2 or more falls in the last year?</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>Have you had a fall with injury in the last year?</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>Do you have difficulty with walking or balance?</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>Are you deaf or do you have serious difficulty hearing?</td>
<td>No, Yes</td>
</tr>
<tr>
<td>Have you noticed any changes in your memory lately?</td>
<td>No, Yes</td>
</tr>
<tr>
<td>In the past 2 weeks, how often have you felt nervous, anxious, or on edge?</td>
<td>Almost never, Some of the time, Most of the time, Almost all of the time</td>
</tr>
<tr>
<td>In the past 2 weeks, how often were you not able to stop worrying or control your worrying?</td>
<td>Almost never, Some of the time, Most of the time, Almost all of the time</td>
</tr>
<tr>
<td>In general, would you say your health is?</td>
<td>Excellent, Good, Fair, Poor</td>
</tr>
<tr>
<td>How confident are you that you can manage most of your health problems?</td>
<td>Very confident, Somewhat confident, Not very confident, I do not have any health problems</td>
</tr>
<tr>
<td>During the past 12 months, have you helped out a relative or friend with health and/or life tasks, even just a little bit?</td>
<td>No, Yes</td>
</tr>
<tr>
<td>Do you feel stressed by these caregiving/helping responsibilities?</td>
<td>No, Yes</td>
</tr>
<tr>
<td>In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking or using the toilet?</td>
<td>No, Yes</td>
</tr>
<tr>
<td>In the past 7 days, did you need help from others to take care of things such as laundry, housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your own medicine?</td>
<td>No, Yes</td>
</tr>
<tr>
<td>How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?</td>
<td>Never, Rarely, Sometimes, Often, Always</td>
</tr>
<tr>
<td>Here are the SDH questions - if it belongs here, which responses to which questions should drive its display?</td>
<td>On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?</td>
</tr>
</tbody>
</table>
# SDOH Questionnaire

## Social Factors

Attached to a message from Mary received 7/29/2021

On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?

- 0 days
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days
- Decline

On average, how many minutes do you engage in exercise at this level?

- 0 min
- 10 min
- 20 min
- 30 min
- 40 min
- 50 min
- 60 min
- 70 min
- 80 min
- 90 min
- 100 min

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

- Not at all
- Not very hard
- Somewhat hard
- Hard
- Very hard
- Decline

In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?

- Yes
- No
- Decline

In the last 12 months, how many places have you lived?

- Decline

In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (excluding now)?

- Yes
- No
- Decline

In the last 12 months, has lack of transportation kept you from medical appointments or from getting medications?

- Yes
- No
- Decline

In the last 12 months, has lack of transportation kept you from work, school, or from getting things needed for daily living?

- Yes
- No
- Decline

Within the past 12 months, you worried that your food would run out before you got the money to buy more.

- Never true
- Sometimes true
- Often true
- Decline

Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more.

- Never true
- Sometimes true
- Often true
- Decline

Do you feel stress—tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time—those days?

- Not at all
- Only a little
- To some extent
- Rather much
- Very much
- Decline

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?

- Never
- Once a week
- Twice a week
- Three times a week
- More than three times a week
- Decline

How often do you get together with friends or relatives?

- Never
- Once a week
- Twice a week
- Three times a week
- More than three times a week
- Decline

How often do you attend church or religious services?

- Never
- 1 to 3 times per year
- More than 4 times per year
- Decline

How often do you attend meetings of the clubs or organizations you belong to?

- Never
- 1 to 4 times per year
- More than 4 times per year
- Decline

Are you married, widowed, divorced, separated, never married, or living with a partner?

- Married
- Widowed
- Divorced
- Separated
- Never married
- Living with partner
- Decline

Within the last year, have you been afraid of your partner or ex-partner?

- Yes
- No
- Decline

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?

- Yes
- No
- Decline

Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?

- Yes
- No
- Decline

Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?

- Yes
- No
- Decline

How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2-4 times a month
- 2-5 times a week
- 2-4 times a week
- Decline

How many drinks containing alcohol do you have on a typical day when you are drinking?

- 1 or 2
- 3 or 4
- 5, 6, 7, 8
- 9 or more
- Decline

How often do you have six or more drinks in one occasion?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily
- Decline

We have care team members with special knowledge of assistance programs and community resources. Help is free and confidential. What kind of help would you like?

- We would like help.
- We would like information about help.
- I already have help.
- I do not need help.

If you would like help in the future, please let a member of your care team know. Or, use this link to search for resources in your community: [MaineHealth Community Resources](#)

Thank you.