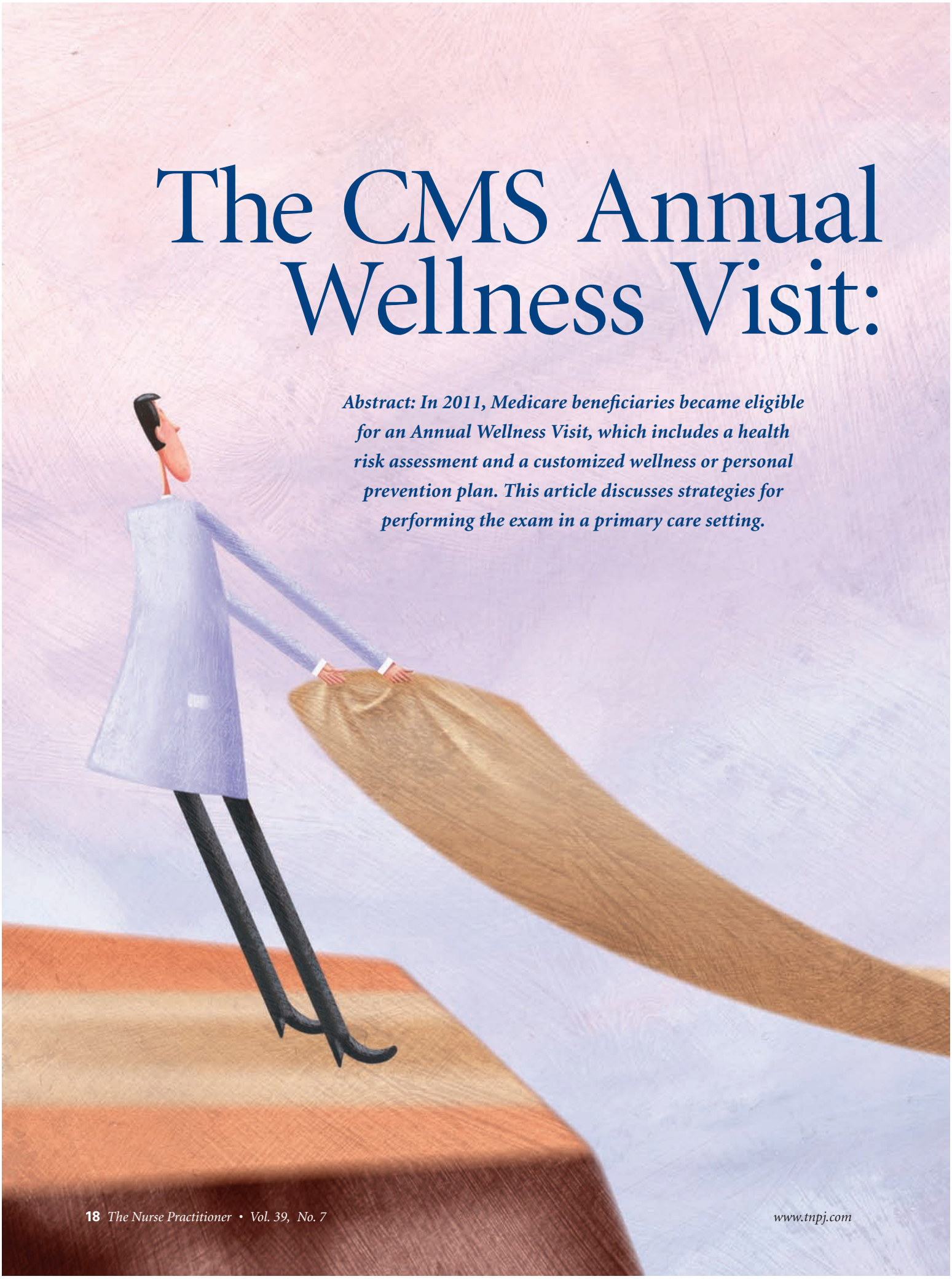
The CMS Annual Wellness Visit:

***Abstract:** In 2011, Medicare beneficiaries became eligible for an Annual Wellness Visit, which includes a health risk assessment and a customized wellness or personal prevention plan. This article discusses strategies for performing the exam in a primary care setting.*



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bridging the gap

By Debra J. Hain, PhD, APRN, ANP-BC, GNP-BC

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The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) includes many provisions aimed at improving the health of Americans and preventing the onset of chronic conditions. The Annual Wellness Visit (AWV) is a part of the Affordable Care Act specifically targeting older adults (age 65 and older). In 2011, Medicare beneficiaries became eligible for an AWV, which includes a health risk assessment (HRA) and a customized wellness or personal prevention plan (not subject to deductible or copay). This AWV supplements the "welcome to Medicare" preventive visit, which is a one-time, comprehensive health assessment offered to beneficiaries within the first 12 months of enrolling in Medicare.[1]

Medicare pays for one first AWV per beneficiary and subsequent visits on an annual basis (see *Subsequent AWVs*). The AWV can be provided by a physician, nurse practitioner (NP), clinical nurse specialist, or physician assistant and should include, at the very least, a history and physical, preventive screening, and personalized health planning. The law specifies that HRA guidelines will identify chronic disease(s), injury risks, modifiable risk factors, and urgent health needs of an individual; may be delivered through an interactive telephone or web-based program; may be offered during the encounter with a healthcare professional or through community-based prevention programs; or may be provided through any other means that assure accessibility and ease of use by beneficiaries (privacy must be considered).

The HRA includes collecting self-reported information and, at minimum, addresses the following: demographic data, including age, gender, race, and ethnicity; self-assessment of health status evaluation of frailty and physical functioning; psychosocial risks, including cognitive function, depression/life satisfaction, loneliness/social isolation, pain, and fatigue;

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behavioral risks, including tobacco use, physical activity, nutrition, oral health, alcohol consumption, sexual health, motor vehicle safety, and home safety; activities of daily living (ADLs), including dressing, feeding, toileting, ambulation (balance/risk of falls); and instrumental activities of daily living (IADLs), including shopping, food preparation, using the telephone, the ability to use or arrange for a mode of transportation (such as a car or taxi) managing finances, and medication management.

Subsequent AWVs[1,2]

Medicare provides annual coverage for an AWV for beneficiaries:

- Who are no longer within the 12 months of the effective date of their first Medicare Part B coverage period
- Who have not had either an Initial Preventive Physical Examination (IPPE) or an AWV within the last 12 months (there must be at least 11 full months after the IPPE or most recent AWV).

The elements included in the first and subsequent AWVs are different. For the purposes of this article, only the elements of the subsequent AWVs will be presented.

Elements for subsequent AWVs include:

- HRA
- Medical/family history
- Current medical providers and suppliers
- Screening schedule that was developed during the first AWV providing Personalized Prevention Plan of Services (PPPS) or subsequent AWV providing PPPS
- List of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway

Assessment:

- Weight (or waist circumference, if appropriate)
- BP
- Other routine measurements as deemed appropriate (based on the patient's medical and family history)

Detection of cognitive impairment

- Direct observation
- Patient self-report or concerns expressed by family members, friends, caregivers, or others

Personalized health advice and appropriate referral to health education or preventive counseling services or programs

HCPCS codes for the AWV

Codes	Code descriptor
G0438	Annual wellness visit; includes PPPS, initial visit
G0439	Annual wellness visit, includes a PPPS, subsequent

It is important to efficiently perform assessments that yield reliable results in a busy primary care practice with time limitations.[2] Valid and reliable instruments along with the individuals' clinical presentation can provide beneficial information for healthcare providers (HCPs) as they strive to meet the requirements of the AWV. This article will discuss strategies for the assessment and available tools that may be helpful for practitioners as they try to determine the need for further interventions, such as additional diagnostic testing and/or referrals to other healthcare professionals and services.

Assessment of older adults

A comprehensive assessment of older adults involves taking an interprofessional and multifactorial approach. It requires integration of physical, psychological, and socioeconomic factors in addition to how these influence health and functional status. Functional status refers to older adults' ability to perform tasks that are required for everyday living. Evaluation of functional status is critical in older adults because it can assist the clinician in determining overall health, well-being, and need for additional interventions.[3] The assessment begins with a good history and an environment that considers possible difficulties in hearing and vision.

It is important to use a well-lit room, avoid backlighting, minimize extraneous noise and interruptions, and speak slowly and in deep tones while facing the person. There are many reasons why older adults may underreport symptoms, such as cultural, educational background, and perception that illness may be a normal part of aging. Taking time to investigate by asking specific questions when appropriate, including family and others in the health history, and using instruments to help identify potential or real problems is essential. Keeping in mind that the goal of a comprehensive assessment of the older adult is to promote wellness and independence can help the clinician focus on essential components, such as functional, nutritional status, and socioeconomic factors.

Functional assessment

Knowing the functional status of an older adult is central to achieving optimal health outcomes. The use of standardized instruments may be beneficial in some circumstances; however, if tools are used, they should be in conjunction with self-report from patient/family and clinician evaluation and judgment.

Physical function. Global performance relates to the level of dependency. How much assistance does the person need for ambulation and performance of ADLs? The initial aspect of assessing ADLs is the person's appearance, which

is followed by evaluating the need for assistance with bathing, dressing, grooming, feeding, transferring, and mobility. The assessment of IADLs can be more challenging because some older adults may think they are performing adequately, when in reality, they may be experiencing some difficulties. Medication management evaluation is a crucial aspect of the assessment; however, it can be problematic to determine the most reliable way to assess one's ability to successfully self-manage medications.

Self-report of medication management is often not a strong indicator of a person's true ability. Medication management can be a complex task that requires HCPs to take an individualized approach to assessment. Collaborating with the individual's support system (family/caregiver) to determine if they are experiencing difficulty safely completing this task can be helpful. Inviting people to describe how they administer medications to determine if they have established a formal system (for example, divided container and regular schedule) of medication management rather than asking dichotomous questions may provide valuable information. In addition, inquiring about missed doses and/or problems with obtaining medications (for example, financial issues and transportation difficulties) is essential.

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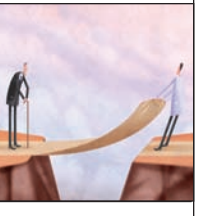

Evaluating the individual's cognitive ability to understand, comprehend, and follow the medication regimen is a fundamental aspect of the assessment. Reviewing the refill history and periodically having the patient bring prescribed and over-the-counter medications to the office for a review can be beneficial in determining if there is a problem.[3] It is important to discuss strategies for successful self-administration of medications and to know when to recommend supervision of this task.[4] Several strategies have been used to improve adherence in this population, such as once-daily dosing when appropriate, time doses in conjunction with daily routine, the use of aids (pill boxes and calendars), and keeping medication records.[3]

Older adults often have more than one HCP who may prescribe medications. Poor communication among prescribers and patients often creates an unclear picture of all the medications that the individual is taking.[3] This may lead to polypharmacy, which can be defined as use of more medications than are medically necessary.[5] Polypharmacy increases the risk of poor health outcomes, such as hospitalization, cognitive impairment, falls, functional decline, and medication nonadherence.[5] Having older adults carry an updated list of medications, incorporating medication lists into electronic medical records, and considering if the medication is necessary (determining risk versus benefit) may help reduce the risk of polypharmacy.[3]

Financial ability is another important aspect of the IADL assessment. Can the individual successfully pay bills and engage in financial transactions? Examples of other IADLs to consider include food preparation, use of telephone, taking medications, doing laundry, doing housework, shopping, and managing transportation. In most circumstances, the HCP can identify potential problems by observing the individual's performance of simple tasks, such as writing a sentence. For a quick screening, the HPC could ask, "Because of health or physical problems, do you need help with shopping, taking care of the house, bathing, or managing your finances?" For more in-depth evaluation, the Lawton Instrumental Activities of Daily Living Scale can be used to assess IADLs. The Lawton Instrumental Activities of Daily Living scale measures the function of community-dwelling older adults function at the present time, and repeated measures (during future AWVs) can help identify areas of improvement or deterioration.[6] The tool and a description of the tool can be found at: consultgerirn.org/uploads/File/trythis/try_this_23.pdf.

Falls are common among adults age 65 and older and are a major contributor to increased mortality, morbidity, and use of healthcare services in this population.[7] Older adults have a high risk for falls that can be due to intrinsic and extrinsic modifiable and nonmodifiable factors.[8] (See *Modifiable and nonmodifiable risk for falls*.) It is important that fall risk assessment is part of the AWV. During the AWV, the HCP should evaluate fall risk by first asking older adults if they have fallen in the last year. However, it is also important to define what constitutes a fall. There are many key aspects in obtaining an adequate history and physical exam when assessing for fall risk (see *Key aspects to consider when assessing fall risk*). Taking an interprofessional approach to address fall risk and prevention is imperative.

Referral to physical therapy, occupational therapy, ophthalmology, podiatry, and other HCPs is dependent upon the results of the evaluation. Referral to an occupational therapist for a home safety evaluation can be extremely beneficial and is a billable service. The American Geriatrics Society has developed evidence-based practice guidelines

that can be used in practice settings.[9] The Timed Get Up and Go Test is a quick and easy screening tool that can be used in a busy clinical practice setting.

Cognitive impairment

Psychological. Even though assessment to detect cognitive impairment is part of the AWV, CMS does not recommend a specific assessment tool, which may be due to the lack of universally accepted screening instruments. In an effort to provide some guidance for primary care practitioners, the Alzheimer's Association convened a Medicare Detection of Cognitive Impairment Workgroup to develop assessment recommendations.[10] The following principles derived from the workgroup should be considered when assessing for cognitive impairment: taking an interprofessional approach, which includes direct care personnel; observation by the HCP alone is not sufficient; no single tool has been identified as the "gold standard"; asking specific questions related to memory, language, and the ability to complete routine tasks; informants (family member, caregivers, or others) can provide valuable information; initial assessment should serve as a baseline; and counseling before and after the assessment is essential.[10]

Active listening to what patients and their family members are saying is central in detecting cognitive impairment and the need for further evaluation. In an NP-managed memory disorder center housed within a college of nursing, the NPs often receive referrals from HCPs because an older adult forgot an appointment, was not taking medications as prescribed, or the HCP recognized changes in the person's language ability and/or difficulties with IADLs. The majority of the older adults who underwent a comprehensive evaluation of their cognitive status met criteria for mild cognitive impairment or Alzheimer's disease, which supported the appropriateness of the referrals.[11]

Comprehensive evaluation of cognitive status is not within the scope of the AWV; however, if cognitive impairment is suspected, it is recommended that the HCP refer the person to a specialist, such as a geriatrician, geriatric psychologist, or NP, neurologist, and/or a memory disorder clinic.[10] A comprehensive evaluation includes a complete medical history (assessment of multiple cognitive domains), neurologic evaluation, physical function (gait, ADLs, and IADLs), standard lab tests (CBC, TSH, B12, folate, CMP), and for those at risk for neurocognitive changes associated with sexually transmitted infections (STIs), an MRI, or CT of the brain may be appropriate. Questions regarding cognitive status, self-report of problems with cognitive function, clinician observation, and reports for family members and/or caregivers should be included in the AWV (see *Questions related to cognitive assessment to consider for HRA*). If there are signs and symptoms of cognitive impairment,

Modifiable and nonmodifiable risk for falls[8,9,30]

	Intrinsic	Extrinsic
Nonmodifiable	• Age (older adults) • Gender (female) • Cognitive impairment • Chronic medical conditions (such as Parkinson disease, diabetes mellitus, arthritis, stroke)	• History of falls within last 3 months • Fear of falling
Modifiable	• Unrelieved pain • Dehydration/volume depletion • Postural hypotension • Depression/anxiety • Sleep disturbance • Visual field loss and/or convergence insufficiency • Sensory impairment • Weight loss related to nutritional deficit • Urinary incontinence • Slow walking speed • Gait and balance abnormalities • Muscle weakness of lower extremities • Functional limitations • Unsteadiness/dizziness	• Medications: sedatives, psychotropic agents, diuretics, opioids, anticholinergic, antidepressants, cardiovascular agents, anticoagulants, bowel preparations • Polypharmacy (four or more medications) • Alcohol intake • Foot wear or foot problems • Use of walking aid (assistive device) • Environmental hazards in the home and outside the home: uneven sidewalk, wet or slippery areas, uneven floor, or scatter rugs • Unfamiliarly with new environment

HCPs should then conduct a brief, structured assessment using a valid and reliable tool.

The Mini-Cog is a valid and reliable tool that is simple to administer in primary care practice.[12,13] It is important to note that use of this tool can help identify a potential problem but is not diagnostic of a cognitive impairment. Older adults with higher education and mild cognitive impairment may perform well on cognitive tests. Therefore, it is essential that clinical presentation also be considered when making decisions for further evaluation. The Mini-Cog is available at: www.alz.org/documents_custom/minicog.pdf.

Depression

Depression is not a normal part of aging and is often reversible if identified and treated early. There are many factors that predispose older adults to depression, including chronic medical conditions, loss of physical function, memory loss, some medications, loss of family and friends, isolation, loss of income, and relocation to long-term care facilities.[3] Older adults may not endorse symptoms of depression but rather present with changes in cognitive function, somatic complaints, and/or loss of interest or pleasure.[14] In addition, people may experience alterations in appetite (more often loss of appetite), insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness, and difficulty concentrating.[3]

Asking people if they often feel sad or depressed and if they have lost pleasure in doing things over the past few months is the first step in screening for depression. Screening for depression should be considered in anyone who presents with changes in cognitive function and/or sleep disturbances and is a crucial component of the AWV. There are valid and reliable screening tools that can be used to help identify depression (see *Depression screening instruments*); however, the 15-item Geriatric Depression Scale (GDS), a brief and easy to administer tool, is often used to assess older adults and is available at: http://consultgerirn.org/uploads/File/trythis/try_this_4.pdf.[15]

Psychosocial risks

Frailty and loneliness are two psychosocial issues that should be considered during the AWV because there are strong links between these and poor health outcomes. Frailty, "which is caused by age-related physiological decline and/or a combination of disease states, has been defined as a diminishing capacity to manage stress with subsequent risk of negative outcomes in terms of physical health and function."[3] HCPs should assess for signs and symptoms of frailty (see *Signs and symptoms of frailty*). A systematic review indicated there is a dearth of valid and reliable tools for use in primary care settings[16]; however, the SHARE-FI instrument has shown promising results.[17] This instrument was developed for screening frailty in primary care settings, but more research is needed. In the meantime, until there are valid and reliable instruments for use in the primary care setting, it is recommended that HCPs consider clinical presentation findings as a need for further evaluation. It is important to note that many older adults, in their attempt to remain independent and avoid institutionalization, may underreport symptoms. Therefore, if the HCP suspects frailty or risk of physical functional decline, they should be referred to a physical therapist and/or other appropriate

Key aspects to consider when assessing fall risk[8,9]

Key aspects of history

- History of previous falls
- Medications
- Fear of falling
- Cause of fall: person aware of impending fall, was it unexpected, did person trip or slip
- Describe where the fall happened, time of the day, witnessed or not, relationship to fall (such as position change, after a meal), activities, alone or with someone
- Symptoms before the fall, such as lightheadedness, palpitations, chest pain, shortness of breath, sudden neurologic symptoms, loss of consciousness

Key aspects of physical exam

- Vital signs, lying, sitting, and standing
- Eyes, visual acuity, accommodation
- Cardiovascular
- Extremities, degenerative joint disease, deformities, podiatric problems
- Neurologic, mental status, focal signs, muscle weakness, muscle rigidity, and tremors
- Assistive device

Questions related to cognitive assessment to consider for HRA[1]

- During the last 12 months, have you experienced confusion or memory loss that is happening more often or is getting worse?
- During the last 7 days, did you need help from others to perform everyday activities, such as eating, getting dressed, grooming, bathing, walking, or using the toilet?
- During the last 7 days, did you need help from others to take care of things, such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

healthcare professionals/services for further evaluation and intervention.

Loneliness and social isolation can lead to distress, suffering, and impaired quality of life in older adults. A relationship exists between loneliness and functional decline and increased risk for mortality as compared with those who are not lonely.[18] The problem has been associated with a lack of standardized instruments to measure loneliness in primary care; the Revised UCLA Loneliness Scale is 20-item tool and has been used in research but currently has not been used in the clinical setting.[19,20] Since there is a lack of available screening instruments, HCPs may consider asking these questions, which have been adapted from this scale[19,20]: do you feel isolated; do you feel left out; and do you lack companionship? If the individual answers yes to any of these questions, or if the clinical presentation is consistent with loneliness/social isolation, referral for further evaluation and possible counseling with a geriatric social worker or psychologist may be appropriate.

Depression screening instruments

Tool	Available at
Geriatric Depression Scale (30-item and 15-item)	http://www.stanford.edu/~yesavage/GDS.html
The Center for Epidemiologic Studies Depression Scale Revised	http://cesd-r.com/
Beck Depression Inventory	http://www.fpnotebook.com/Psych/Exam/BckDprsnInvntry.htm
Cornell Scale for Depression in Dementia	http://grnweb.dads.State.tx.US.Depression/CSDD.htm

Signs and symptoms of frailty[3]

- Decreased appetite
- Weight loss greater than 5% loss of body weight in the last year; unintentional weight loss of 10 lb or more in last 6 months; loose-fitting clothing
- Weakness, not able to perform usual activities; decline in grip strength as compared with prior testing; gait speed decreased
- Fatigue
- Pain; rate pain on a pain intensity scale of 0 to 10 (0 indicates no pain and 10 indicates the worst pain), determine if the pain affects normal activity
- Depression
- Falls

Alcohol misuse

Behavioral Risk. The scope of problems with drinking among older adults is not clearly known, which may be because alcohol misuse is often not identified. Although older adults tend to consume less alcohol than younger adults, the risks can be higher, especially when the person has chronic disease. According to the Office of Applied Studies, Substance Abuse & Mental Health Services Administration, about 45% of adults 50 years and older drink alcohol[21]; 12% binge drink (five or more drinks on the same occasion on at least 1 day in last 30 days), and 3.2% are considered heavy drinkers (five or more drinks on same occasion on each of 5 days or more in last 30 days). Many older adults have one or more chronic disease that may be affected by excessive alcohol intake, so assessment of alcohol use is an important aspect of the AWV. HCPs should consider alcohol misuse as a possible contributing factor to poorly controlled chronic disease (for example, hypertension or diabetes).

The U.S. Preventive Services Task Force recommends that all adults be screened for alcohol misuse and referral for counseling as necessary. That being said, it can be difficult to identify alcohol misuse among retired persons because there are fewer chances that they will have problems affecting work or community performance.[22] The CAGE questionnaire is a common tool that is used to assess for alcohol misuse.[23] This practical instrument asks four questions: Have you ever thought about **C**utting down; felt **A**nnoyed when others criticize your drinking; felt **G**uilty about drinking; or used alcohol as an **E**ye opener? This can easily be administered in primary care settings. This tool, along with other recommendations for screening for alcohol misuse, can be found on the National Institute on Alcohol Abuse and Alcoholism website: pubs.niaaa.nih.gov/publications/arh28-2/78-79.htm.

Sleep

Although sleep problems are not a normal aspect of aging, this common complaint may be a sign of other health problems. Factors that may contribute to sleep disturbances include depression, anxiety, obstructive sleep apnea (OSA), cardiovascular disease, restless legs syndrome, and gastroesophageal reflux disease. Obtaining a sleep history includes questioning initiation and maintenance of sleep, excessive sleepiness, daytime sleepiness, insomnia, and hypersomnia. Certain medications, uncontrolled pain, daytime naps, and increased time in bed can influence sleep and should be considered in the AWV.[3] Evaluating current medications taken for sleep may provide clues to sleep disturbances that require further assessment. The Epworth Sleepiness Scale is a tool that can be used for self-report of daytime sleepiness (available at the official website: http://epworthsleep

inessscale.com/about-epworth-sleepiness/).[24-26] The tools are a component of the assessment; the HCP should also ask older adults questions that can identify sleep problems, such as OSA. Polysomnography is considered the "gold standard" to assess for OSA; however, not all people will report sleep disturbances, so it is important to question risks for OSA and to take into account that depression might be a reason for sleep disturbance (see *Questions for assessing risk for sleep apnea*).

Questions for assessing risk for sleep apnea[3]

- Do you snore or have you been told that you snore?
- Have you been told that you appear to hold your breath while asleep?
- Do you experience awakenings from sleep with a snort, cough, choking, or shortness of breath?
- Do you wake up more often when you are sleeping on your back?
- Do you have difficulty concentrating or staying awake during the day?
- Do you feel tired during the day?
- Do you wake up three or more times during the night?
- Do you have heartburn, reflux, or acid/sour taste in your mouth?
- Are you overweight?
- Do you have high BP? Heart disease?

Sexual behavior

Many older adults are sexually active well into their later years, and some have had or have more than one sexual partner. Lack of concerns regarding the risk of pregnancy and lack of knowledge about risk for STIs decrease the chances that older adults will use protection, such as condoms, or ask to be screened for STIs. The CDC recommends screening for adults who are sexually active by first asking about sex partners and the use of condoms.[27] Appropriate tests can be determined by responses to questions regarding sexual activity. CDC recommendations are as follows: all adults should be tested at least once for HIV; all sexually active women with risk factors such as new or multiple sex partners should be screened for chlamydia and gonorrhea (gonorrhea if the women lives in an area where there is high disease burden); women with HIV should be screened annually for trichomoniasis; and screening once a year for syphilis, chlamydia, gonorrhea, and HIV for all sexually active gay men, bisexual men, and other men who have sex with men.[27]

Nutrition

There are several reasons older adults are at risk for poor nutrition, but malnutrition is most likely related to health status and poverty rather than aging itself.[3] Poor nutrition increases the risk of mortality and morbidity; therefore, nutritional status should be evaluated during the AWV. The patient assessment should include height, weight, and body mass index. Serial weights are used to identify weight loss; weight loss is considered clinically significant if there is 2% or more decrease in baseline body weight in 1 month; 5% or more decrease in 3 months; or 10% or more in 6 months.[28] Several screening tools are available, but the Mini-Nutritional Assessment Short Form has been used to assess nutrition in older adults and is practical for primary care settings. This tool can be found at: consultgerirn.org/uploads/File/trythis/try_this_9.pdf. The Simplified Nutrition Assessment Questionnaire (SNAQ) can be used to identify risk for weight loss and the "Meals on Wheels" mnemonic for treatable causes of weight loss.[29]

Improving health outcomes

AWV provides an opportunity for HCPs to screen for common problems older adults may face. This article provides an overview of assessment strategies that HCPs can take. Although it may seem overwhelming to consider all these components of the AWV, it is important to note some of the instruments presented are subjective and can be completed by the Medicare beneficiary. HCPs may consider having older adults or family members fill out the forms prior to the visit, thus reducing the time it takes to complete the AWV. The AWV is a billable service that can help HCPs provide quality care and yields better health outcomes, and ultimately, reduces healthcare costs.

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Debra J. Hain is an assistant professor at Florida Atlantic University, Christine E Lynn College of Nursing, Boca Raton, Fla.

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