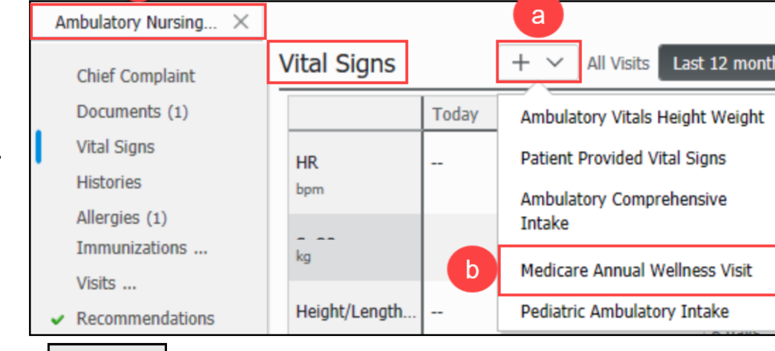
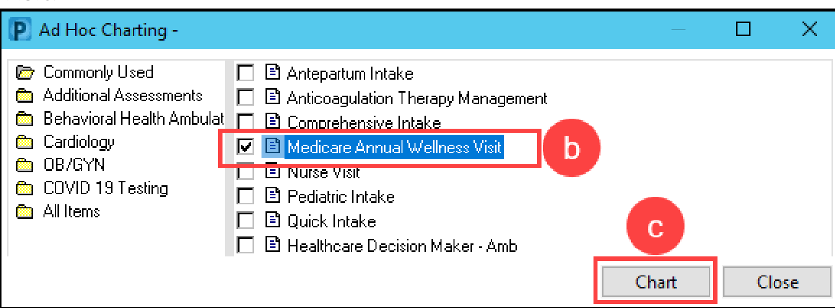
Medicare Annual Wellness Visit PowerForm for Clinical Staff

Medicare Annual Wellness Visit PowerForm

The Medicare Annual Wellness Visit PowerForm is completed as part of a patient's annual wellness visit clinical intake. The Medicare Annual Wellness Visit PowerForm can be accessed from the Ambulatory Nursing Workflow page or from AdHoc.



1. Ambulatory Nursing Workflow:
   a. Click the drop-down arrow in the Vital Signs component.
   b. Select Medicare Annual Wellness Visit.
2. AdHoc:
   a. Click AdHoc on the PowerChart toolbar.
   b. Select Medicare Annual Wellness Visit.
   c. Click Chart.



PowerForm Navigation

- PowerForms are divided into pages on the left.
- Blue highlight indicates the current page that is open.
- Indicates there is a required field on a page that must be answered before signing the PowerForm.

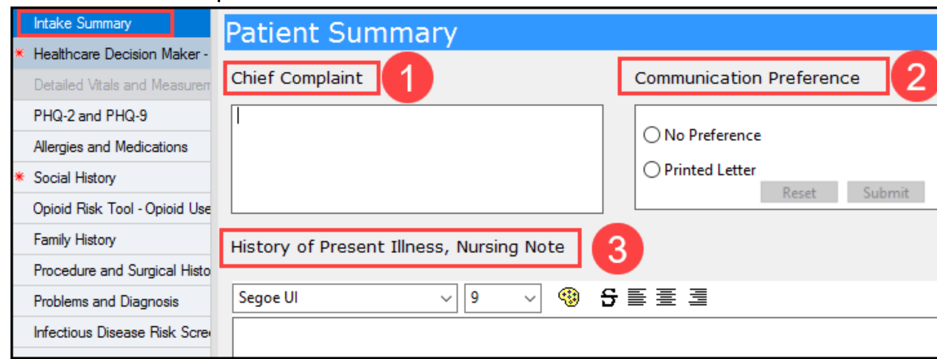
- Required fields will display as yellow.
- Light grey indicates a page that is available to document on and is unopened.
- Light blue indicates a page that has been opened.
- Dark grey indicates a page that is not available to document on. (It may become available based on responses entered in other areas of the PowerForm.)
- To complete and sign a PowerForm.
- Cancels documentation of the PowerForm. The form will close without saving any entered information.
- Saves the information entered on the PowerForm without completing. This is not recommended for use.
- Clears all information on the current page of the PowerForm.
- Navigate through the pages of the PowerForm.
- Clinical calculator offers clinical formulas and conversions.

Intake Summary

Patient Summary

The following are **optional** for documentation:

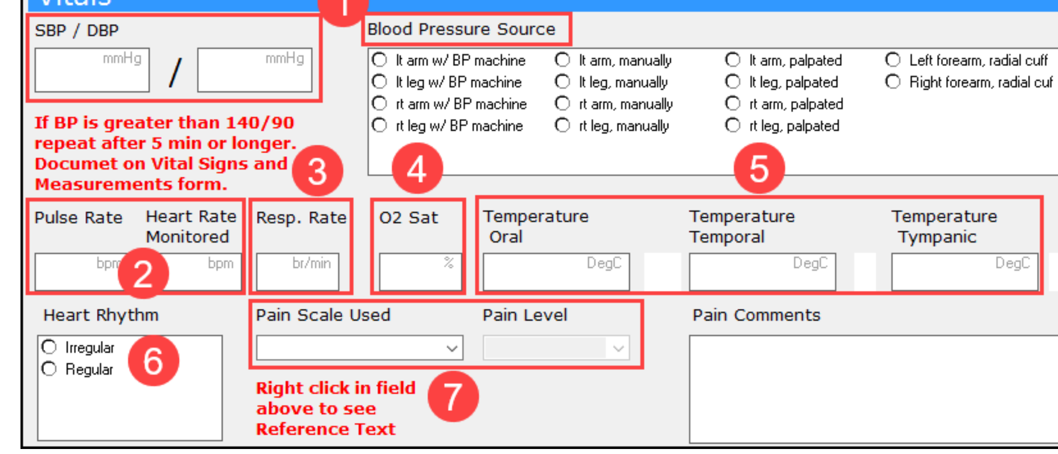
1. Chief Complaint: Enter the patient stated chief complaint.
2. Communication Preference: Select or update as needed. This must be selected to use patient invitations.
3. History of Present Illness Nursing Note: HPI is optional and should be used only as directed by the practice.



Vitals

All the following fields are **mandatory** for documentation, except Heart Rhythm.

1. Blood Pressure
2. Pulse Rate: Document beats per minutes when auscultated or palpated. Document as Heart Rate Monitored: when a machine is used to record beats per minute. Either method satisfies the mandatory requirement.
3. Respiratory Rate
4. O2 Sat
5. Temperature: Documentation is in Degree Celsius and can be done as oral, temporal, or tympanic. One method satisfies the mandatory requirement.
6. Heart Rhythm (optional)
7. Pain Scale: Select the Pain Scale Used and document the Pain Level. Pain Comments is available to enter additional comments.



Measurements

It is **mandatory** to enter a **measured** Height and Weight. **Both** Height **and** Weight need to be measured to calculate a Measured Body Mass Index (BMI). An accurate BMI is needed for ordering a correct BMI code.

Measurements

DISPLAY ONLY
Field below displays the last Height Measured for the last 364 days

Height/Length Measured: 182.88 cm (03/13/23 10:09:00)

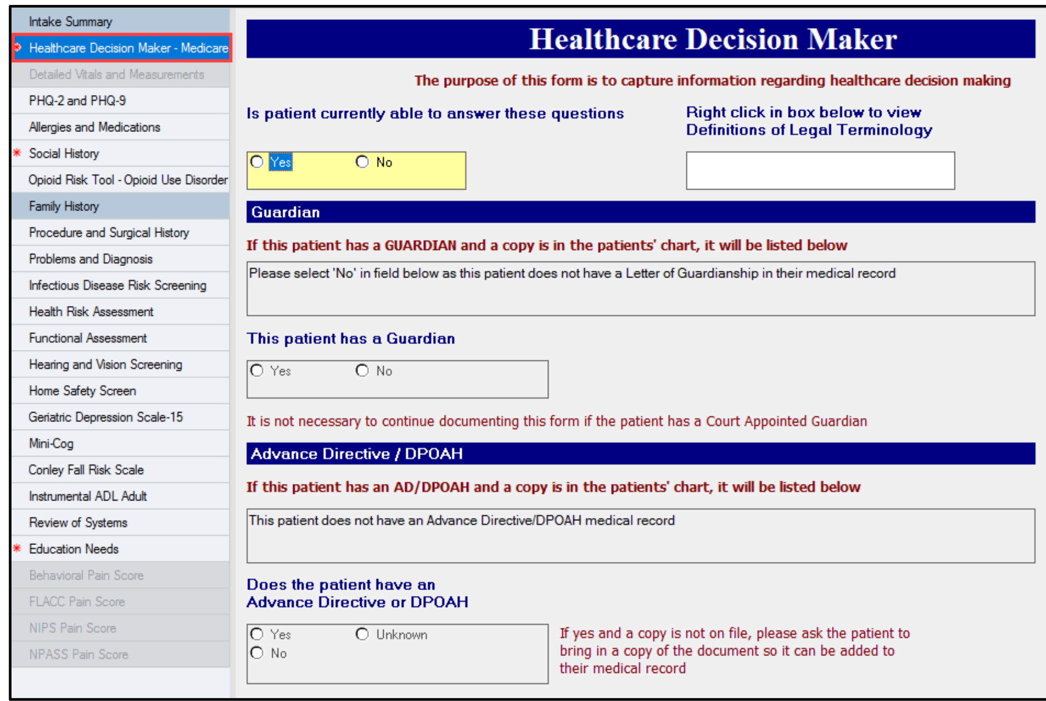
Weight Measured (kg) | Height/Length Measured (cm) | BMI Measured | Waist Circumference (cm)

Weight Non Measured (kg) | Height/Length Non Measured (cm) | BMI Non Measured | Pre-Pregnancy Weight (kg) | Calculated Cumulative Weight Gain (kg)

Reason Measurements Not Obtained | Measurements Comments

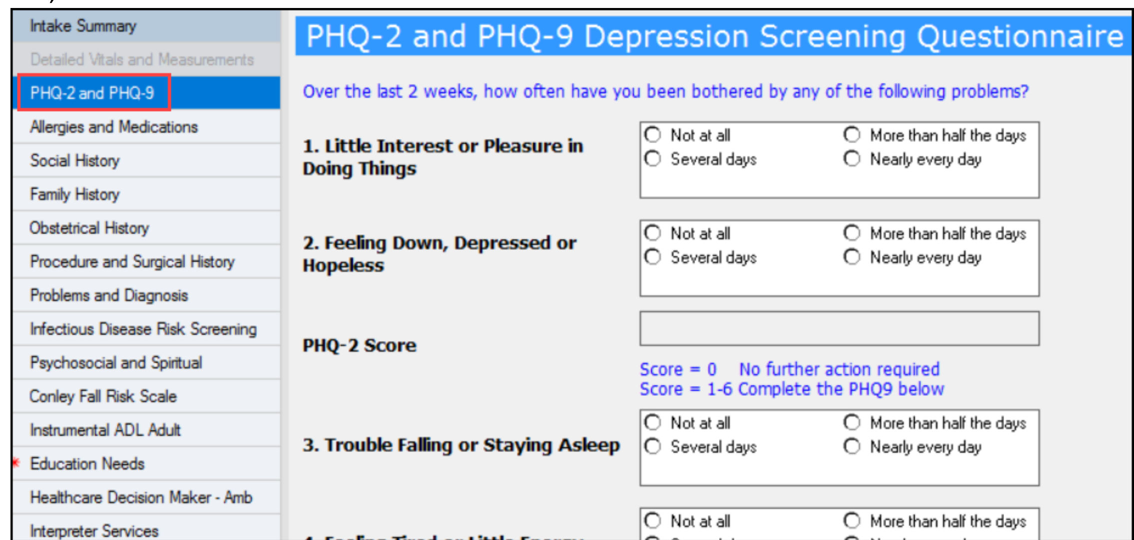
Healthcare Decision Maker

Healthcare Decision Maker is **required** to complete and/or update. Healthcare Decision Maker is used to capture information regarding healthcare decision making, Guardian, and Advance Directive/DPOAH for the patient. Follow practice guidelines for documentation requirements.



Depression Screening

PHQ-2 and PHQ-9 depression screening is **mandatory** to document. Document **both** PHQ-2 and PHQ-9 questionnaire, regardless of the PHQ-2 score, for the Medicare Annual Wellness Visit.



Allergies and Medications

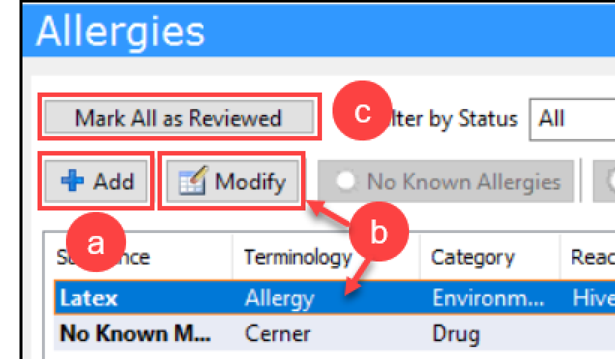
Review of allergies and medications is **required** at every patient visit. The review can be done from the Ambulatory Nursing Workflow or Medicare Annual Wellness Visit PowerForm.

Allergies:

a. Click the Add button to add an allergy to the list.

b. Select a current allergy on the list, then click the Modify button to Modify an existing allergy.

c. When the allergy review is complete, click the Mark All as Reviewed button.



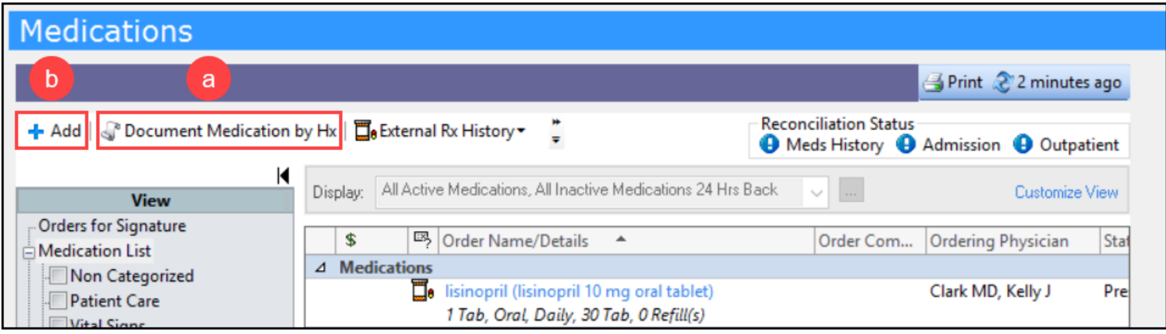
- Complete steps for Allergy Reconciliation can be found on Clinical EHR Education website.

Note: If the allergy review is done on the Intake form, the Complete Reconciliation button in the Allergies component on the Ambulatory Nursing Workflow will still need to be clicked for meaningful use credit.

Medications:

a. Click Document Medication by Hx to begin the medication review. Medication compliance is required when reviewing medications. This should include all prescribed and over the counter medications/supplements.

b. Clicking Add will add a medication order.



c. Send a message to the rendering or primary care provider regarding any medications that the patient reports taking incorrectly or not compliant.

d. When the medication history is completed, the Meds History Reconciliation Status will display a green check mark. Reconciliation Status Meds History

- Complete steps for Documenting medications by history can be found on the Clinical EHR Education website.

Social History

Social History is **required** to be reviewed at every patient visit. Documentation should include, at a minimum, **Tobacco status, Alcohol, and Substance Use**.

- Psychosocial/Spiritual is required for documentation only one time and will be carried across encounters for review.
- Abuse/Neglect screening is required once every year for all patients and must be completed at the patient's Wellness Visit if required.

- Follow practice guidelines for additional Social History documentation.
- See Instructions for making changes to Social History for steps on modifying and adding documentation.

Medicare Annual Wellness Visit - AMBCERNED, ERNEST

*Performed on: 03/10/2023 1312 EST

- Intake Summary
- * Healthcare Decision Maker - Medicare
- Detailed Vitals and Measurements
- PHQ-2 and PHQ-9
- Allergies and Medications
- Social History
- Opioid Risk Tool - Opioid Use Disorder
- Family History
- Procedure and Surgical History
- Problems and Diagnosis
- Infectious Disease Risk Screening
- Health Risk Assessment
- Functional Assessment
- Hearing and Vision Screening
- Home Safety Screen
- Geriatric Depression Scale-15
- Mini-Cog
- Conley Fall Risk Scale
- Instrumental ADL Adult
- Review of Systems
- * Education Needs
- Behavioral Pain Score

Social History

Instructions for making changes to Social History documentation

If no documentation present, right click and Add

If documentation present, and no error message, right click and modify

If documentation present, and error message present, right click Add, then right click and remove old documentation

Mark all as Reviewed button is no longer active

Mark all as Reviewed

Social

Add Modify Display: Active

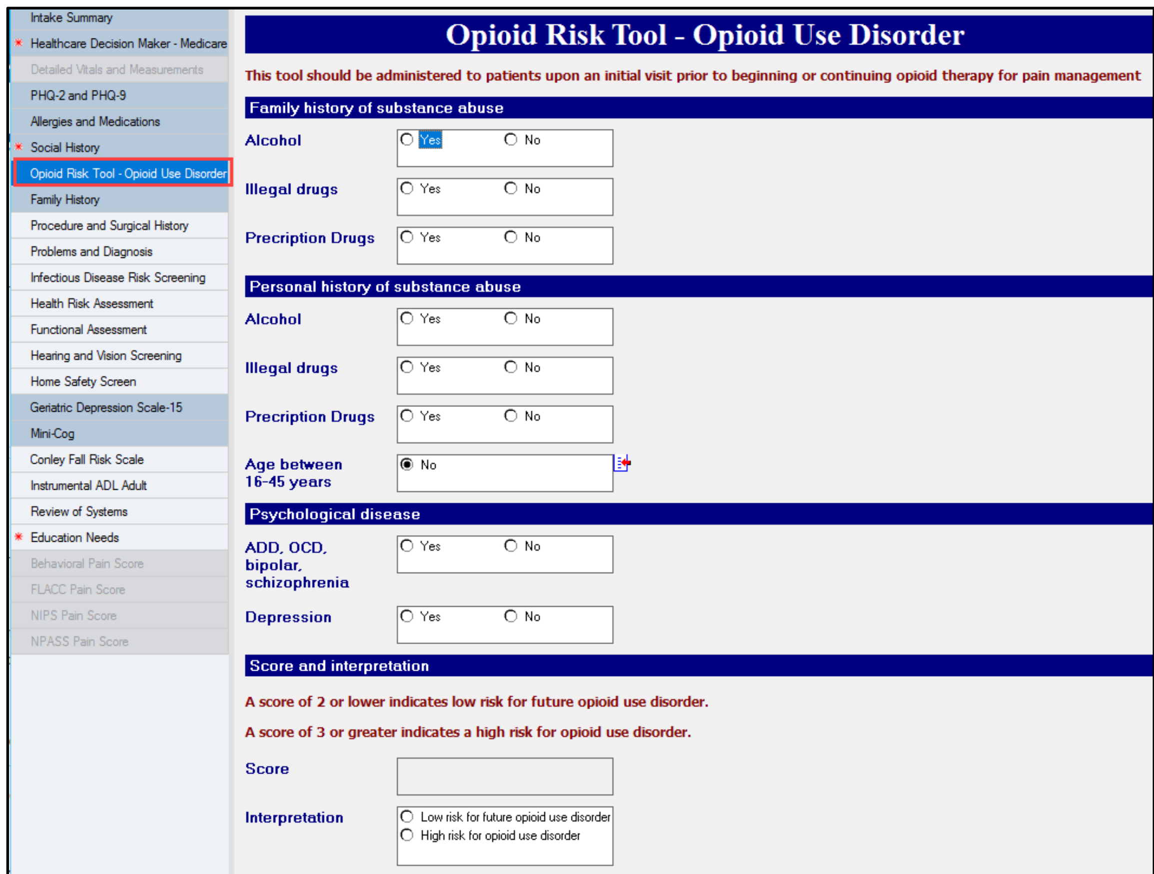
Category	Details	Last Updated	Last Updated By
Tobacco	Smoking Status: Never (less than 100 in lifetime).	10/10/2022 11:59...	Ambrnlpn, 20
Electronic Cigarette/Va...			
Alcohol	None	10/10/2022 11:59...	Ambrnlpn, 20
Substance Use			
Nutrition			
Exercise			
Sexual			
Home/Environment			
Employment/School			
Psychosocial/Spiritual	No Spiritual/cultural preferences:.	10/10/2022 11:59...	Ambrnlpn, 20
* Abuse/Neglect	Question not asked	10/10/2022 11:59...	Ambrnlpn, 20

Reference Policy for Interventions if Abuse/Neglect is suspected

If Current or Quit within 12 months, Smoking Cessation Counseling Provided	◯ Yes	◯ No
Patient asked, during any previous encounter in the past 24 months, about the use of Tobacco	◯ Yes	◯ No

Opioid Risk Tool – Opioid Use Disorder

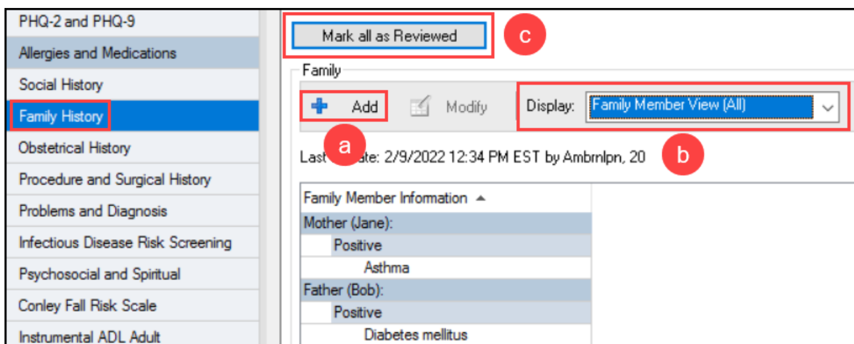
The Opioid Risk Tool is **mandatory** to be administered to all patients.



Family History

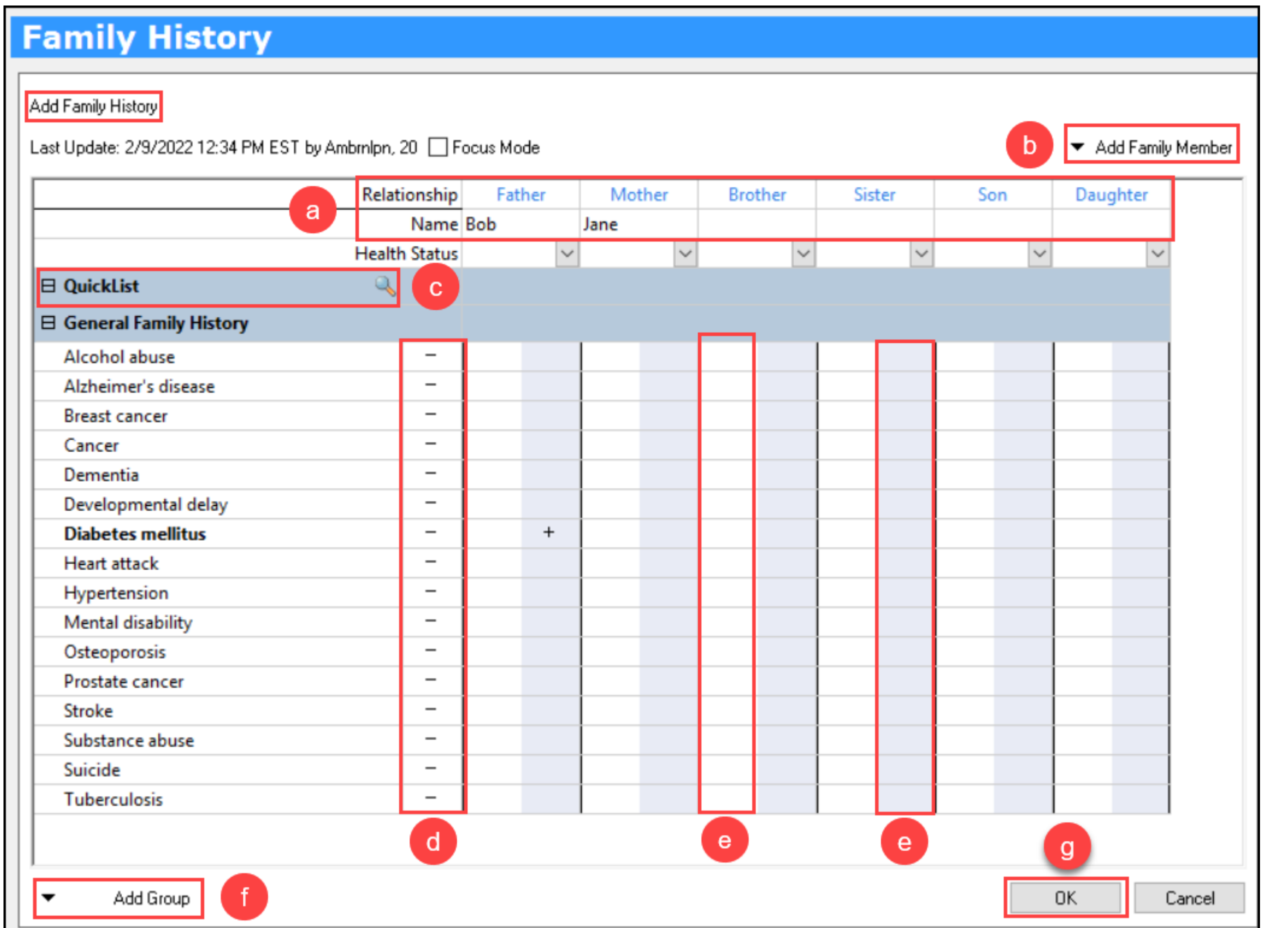
Family History is **mandatory** to be reviewed and/or updated at every patient visit. Family history review includes first degree relatives: parents, siblings, and offspring. Pertinent positive **and** negative information should be documented.

a. Click **Add** button to add and/or modify any health history for a family member. Refer to step 2 for more information.
b. The Display drop-down allows for different viewing options.
c. Once the Family History review is complete, click Mark all as Reviewed.



2. If the [Add] button is clicked, the Add Family History screen will appear.

    a. Family members will be listed at the top from left to right. Names and demographics can be entered by left clicking on the relationship. Family members that do not exist should be removed by right clicking on the relationship.
    b. Family relationships can be added by clicking the drop-down Add Family Member.
    c. Click the QuickList magnifying glass to search for and create a list of histories not found in the General Family History list.
    d. Selecting negative here will document a negative history for the selected condition for all family relationships listed.
    e. Click in the white or blue column under each family member to document a negative or positive history.
    f. Click on Add Group to add additional groups of histories for review.
    g. Once complete, click OK.

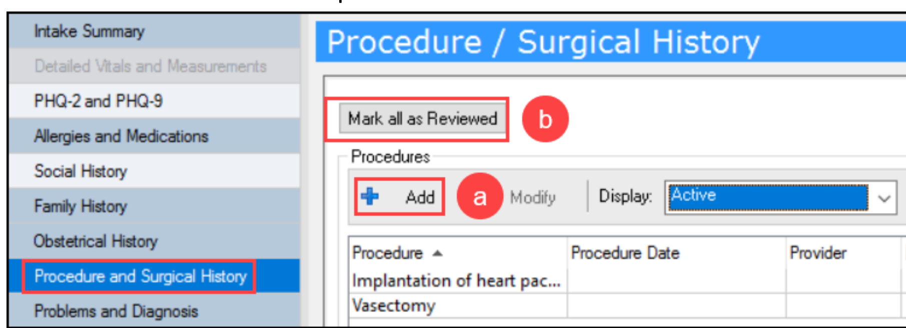


Procedure and Surgical History

Procedure and Surgical History is **mandatory** to be documented and/or updated at every Medicare Annual Wellness Visit.

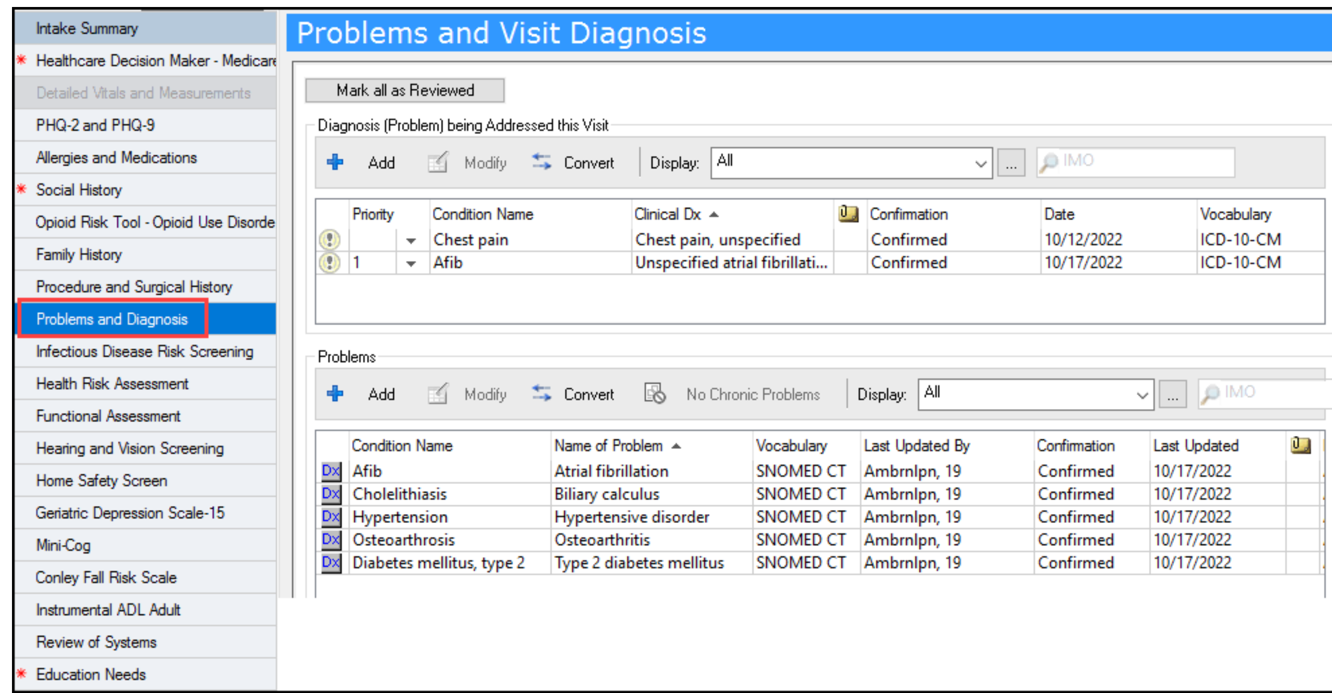
a. Click the Add button to add a procedure/surgery to the history list.
b. Click the Mark all as Reviewed button when the review is complete.

Note: Complete steps for adding and documenting Procedure/Surgical History can be found on the Clinical EHR Education website.



Problems and Diagnosis

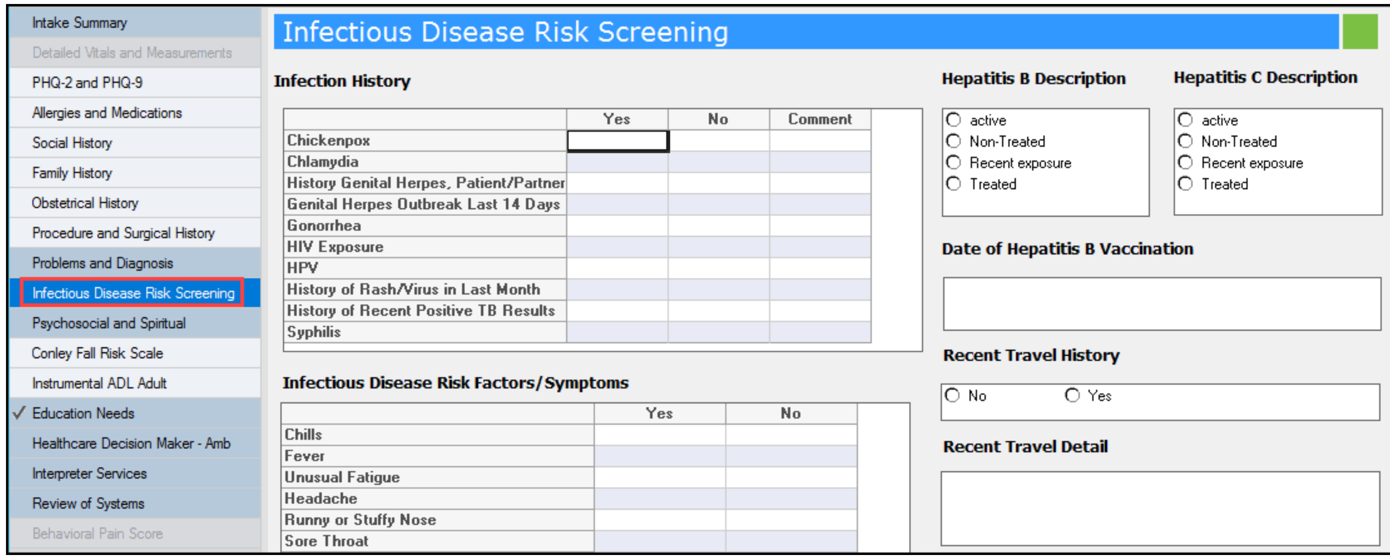
Problems and Diagnosis allows viewing of problems and diagnoses in the same window. This should be reviewed and/or updated on the Ambulatory Nursing Workflow page. It is **required** to document patient stated medical problems at every visit.



Note: Complete steps for adding and documenting Problems and Diagnosis History can be found on the Clinical EHR Education website.

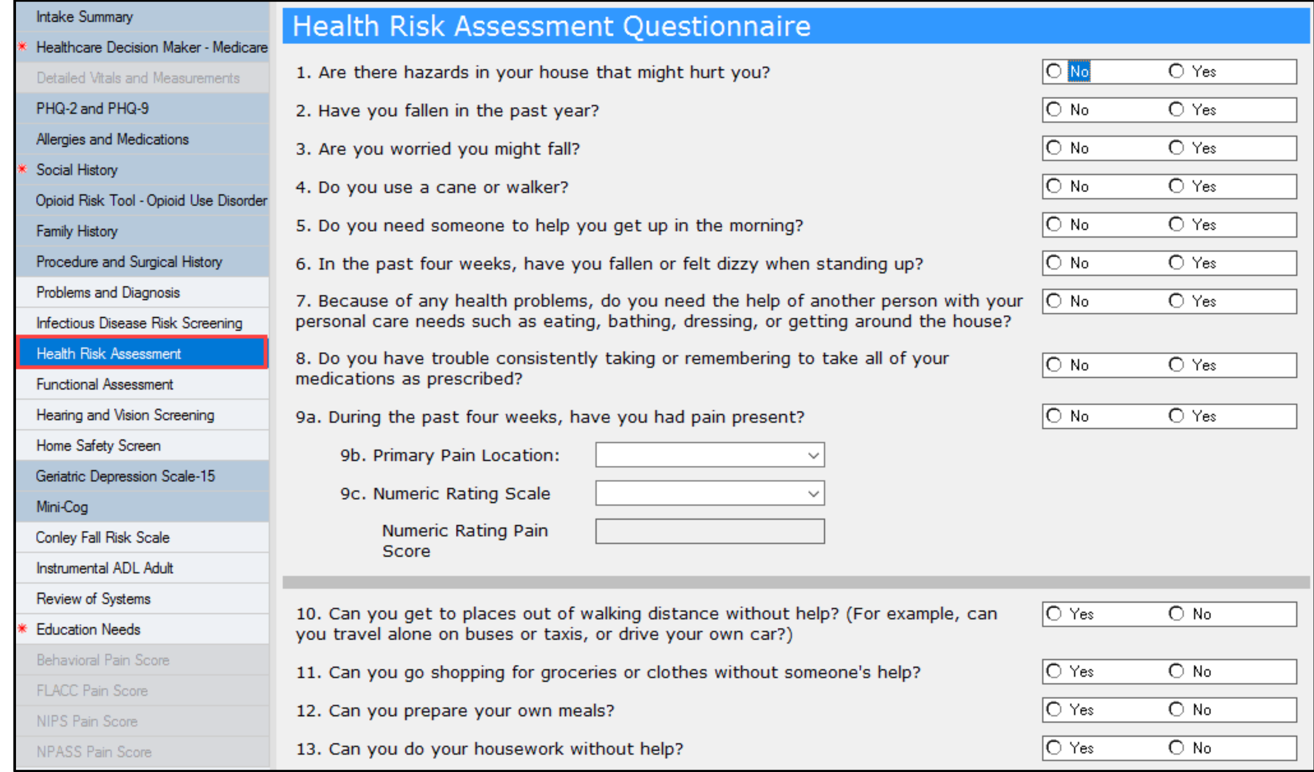
Infectious Disease Risk Screening

Infectious Disease Risk Screening page is **optional** for documentation of Infection History, Infectious Disease Risk Factors/Symptoms, Tuberculosis Risk Factors/Symptoms, and several other family member and travel history information. Follow practice guidelines for documentation requirements.



Health Risk Assessment

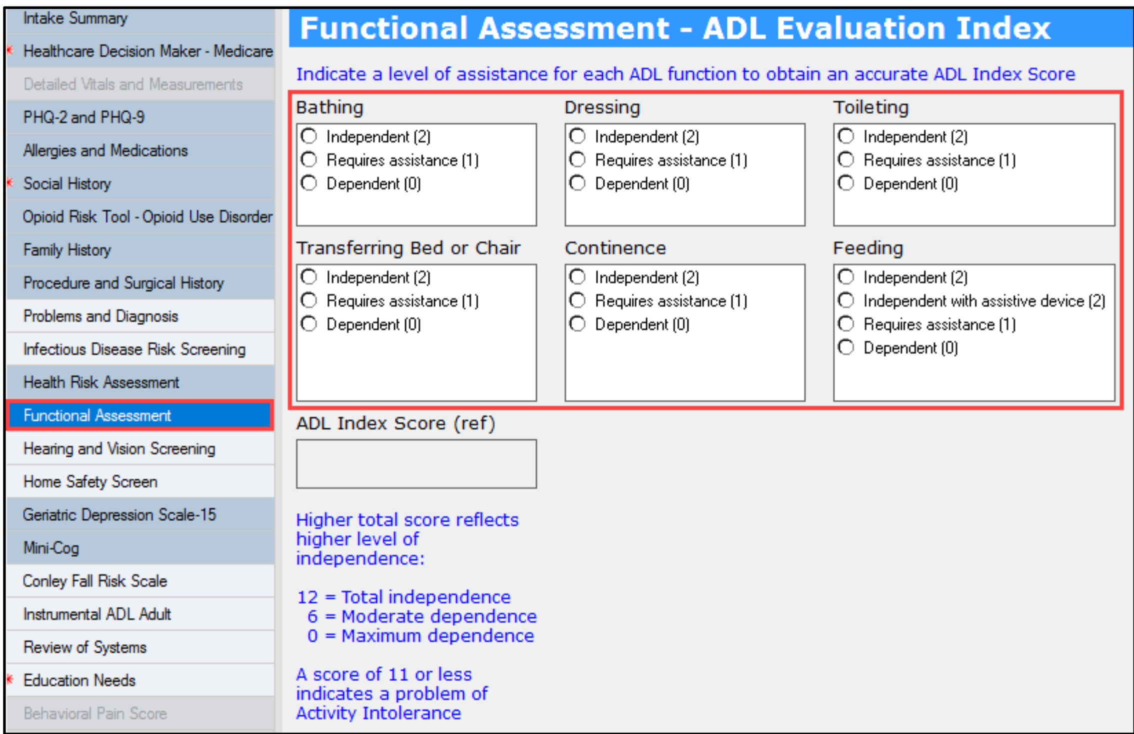
The Health Risk Assessment Questionnaire is **mandatory.** Complete **all** 25 questions for documentation.



Functional Assessment

Functional Assessment – ADL Evaluation Index is used to assess the level of assistance needed for each ADL function and get an accurate ADL Index Score. It is **mandatory** to complete **all** six ADL categories.

- A score of 11 or less indicates a problem of Activity Intolerance.

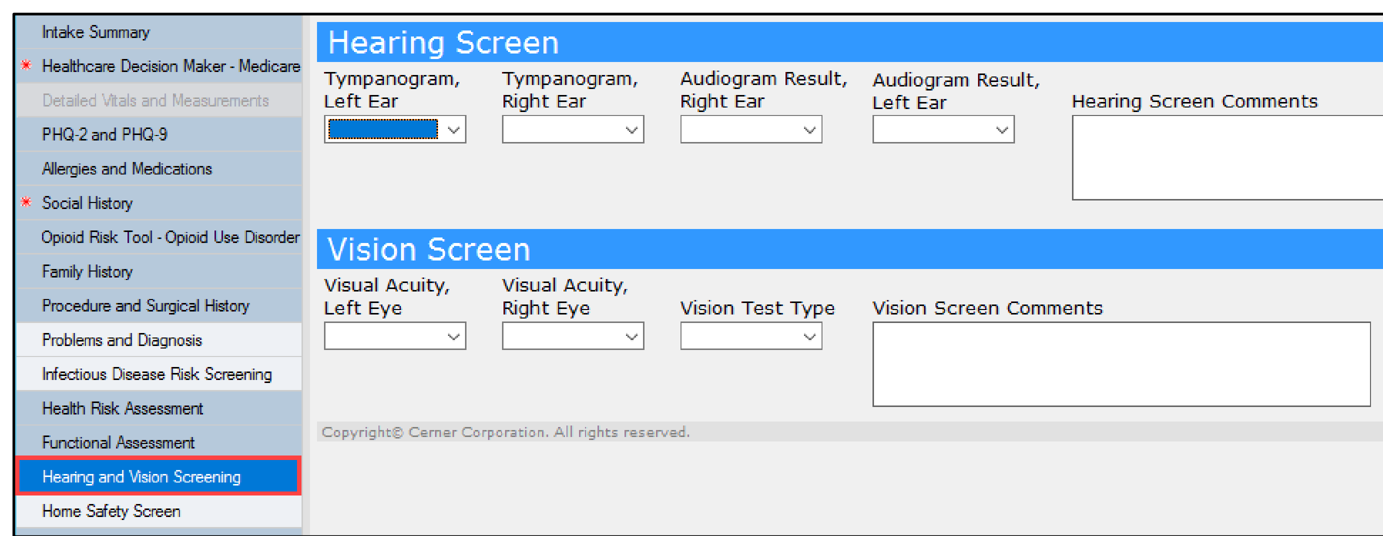


Hearing and Vision Screening

Hearing and Vision Screening Comments are **mandatory**. Document Hearing and Vision concerns using the Comments fields.

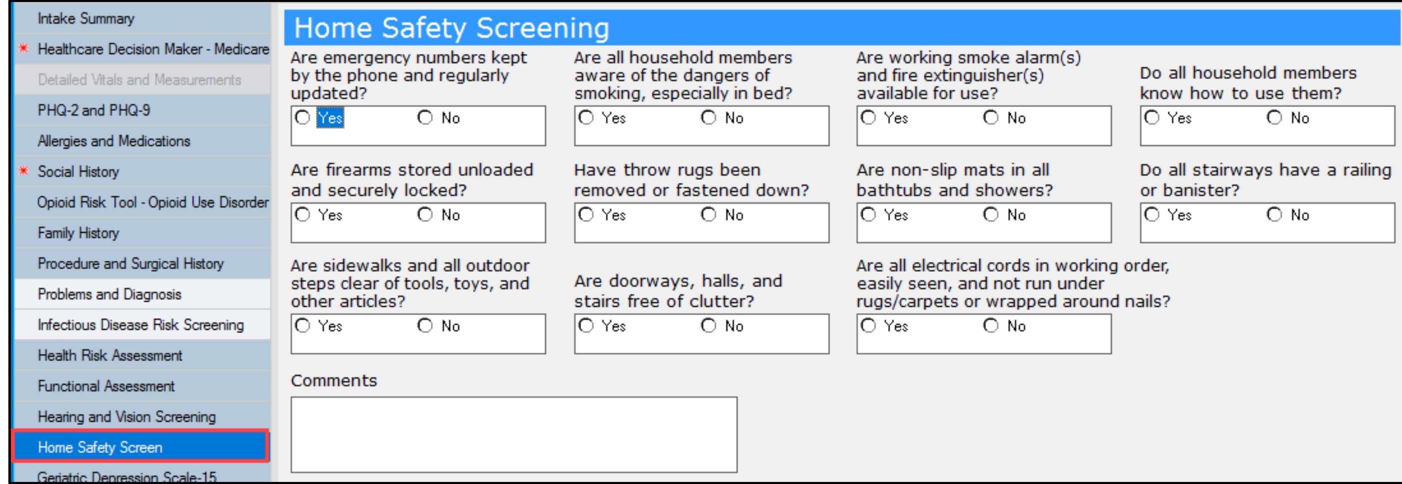
Type any patient reported concerns in the appropriate Comments field(s), for example: patient uses hearing aids.

If the patient has no concerns, type "No concerns" in the Comments field(s).



Home Safety Screening

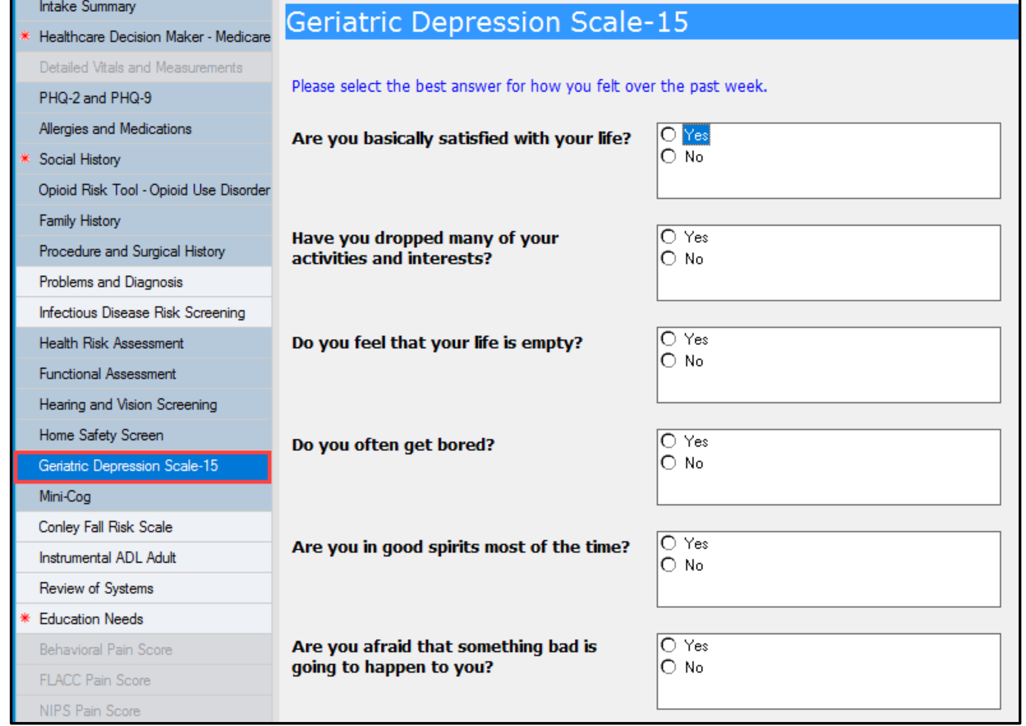
Home Safety Screening is **mandatory.** Document as many of the screening questions as possible.



Geriatric Depression Scale-15

Geriatric Depression Scale-15 page is available, but **not required** for depression screening for geriatric patients. (The PHQ-2 and PHQ-9 depression screening is used).

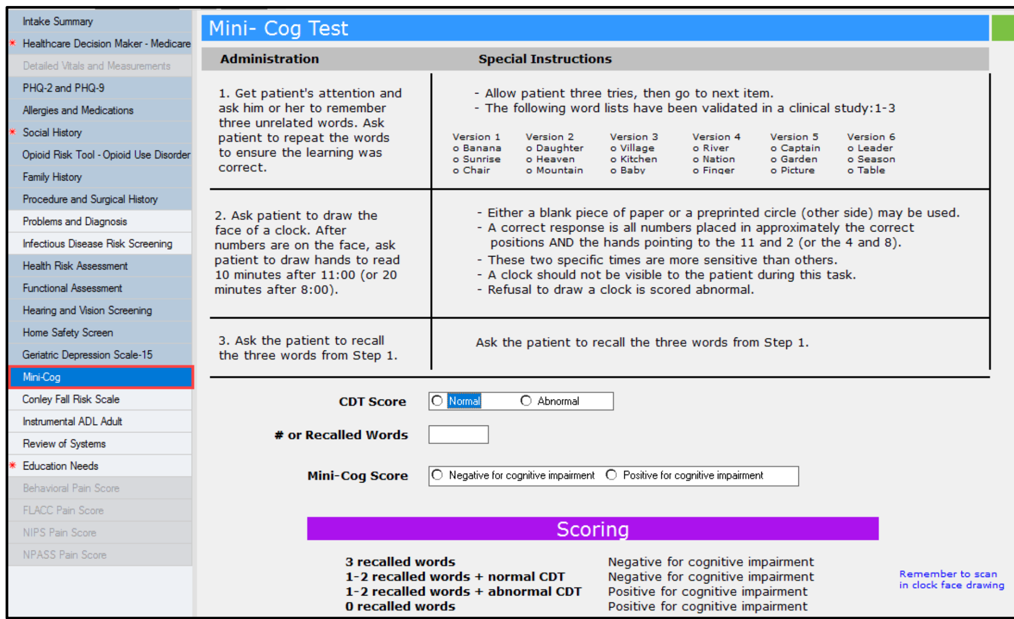
A total score will be automatically calculated to grade the degree of depression. Follow practice guidelines for documentation requirements and follow up.



Mini-Cog

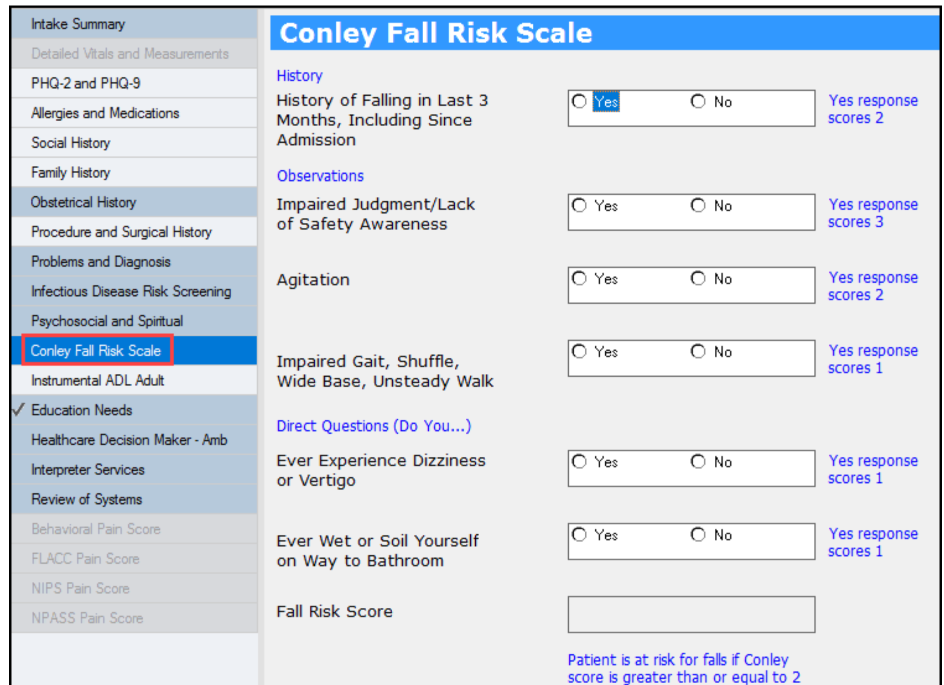
Mini-Cog Test is a **mandatory** test used to evaluate the patient for cognitive impairment.

- Patients scoring negative for cognitive impairment will require no further action.
- However, patients scoring **positive** for cognitive impairment **must** complete the St. Louis Mental Exam (SLUMS) paper form. Follow practice guidelines for any additional documentation requirements.



Conley Fall Risk Scale

The Conley Fall Risk Scale is used to score patient's fall risk. A full assessment is **mandatory** for documentation.

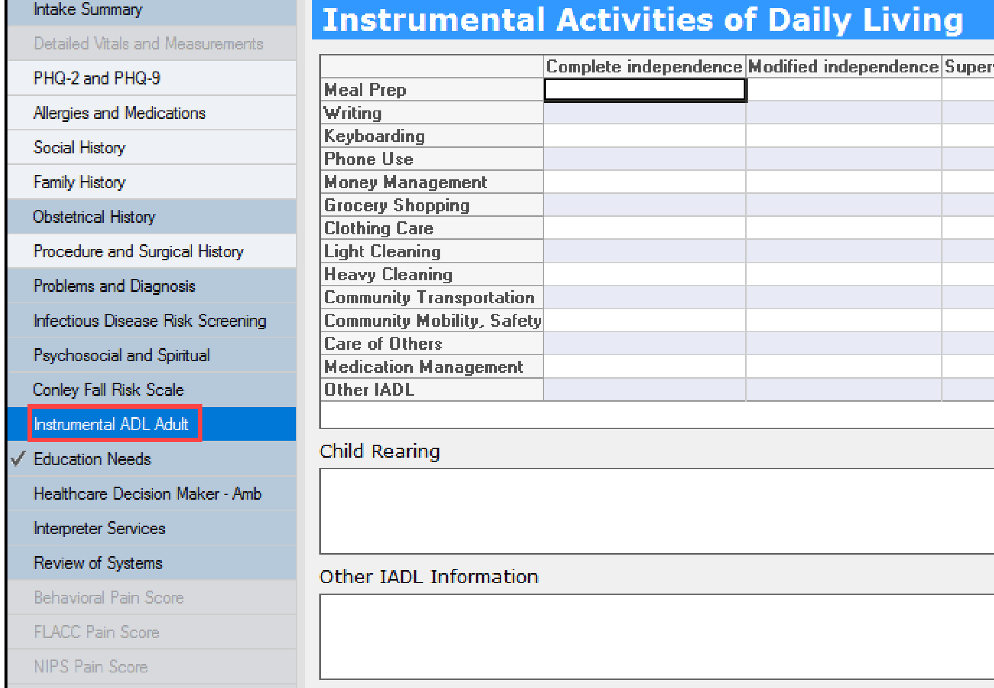


Instrumental ADL Adult

Instrumental Activities of Daily Living is **mandatory** to complete. Document levels of independence for as many categories as possible.

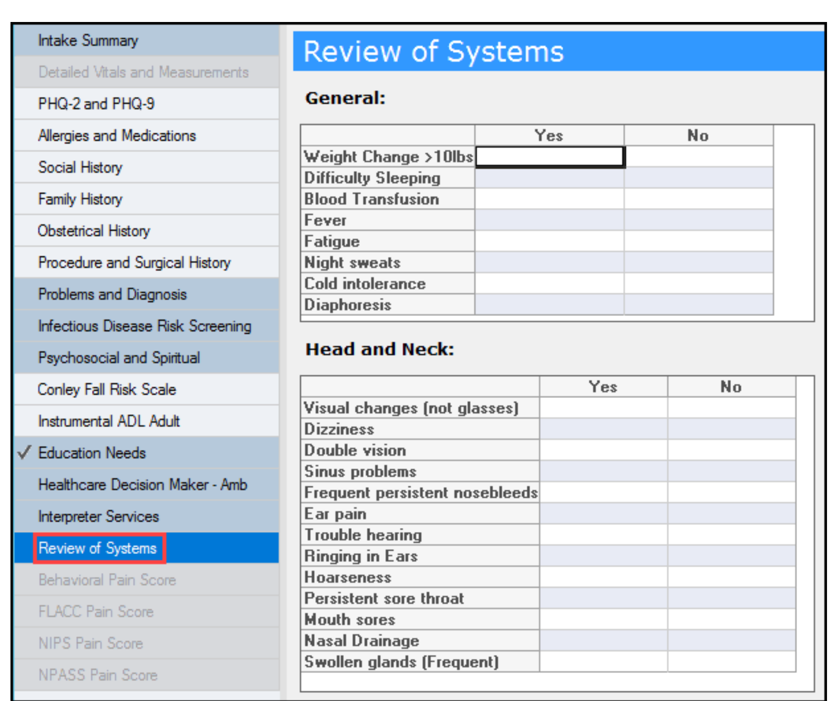
Use the following three levels of assistance for documentation to accurately track changes:

- Complete independence
- Modified independence
- Total assistance



Review of Systems

Review of Systems page is available, but **not required** for documentation. Follow practice guidelines for documentation requirements.



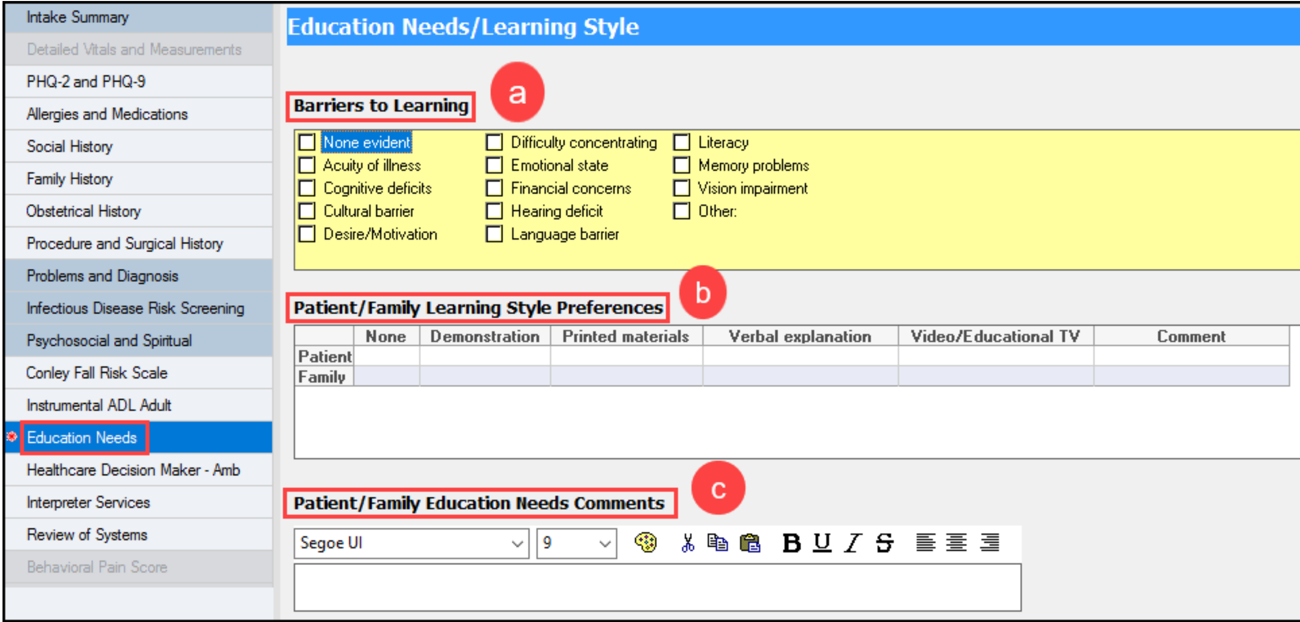
Education Needs

Educational Needs is **required** to be completed.

a. Barriers to Learning is **required** to be documented at every visit.

b. Patient/Family Learning Style Preferences for the patient and family may be documented. Multiple learning styles can be selected by clicking inside the boxes. These preferences will be saved across visits.

c. Patient/Family Education Needs Comments is a free text box for any additional comments.



Signing the Form

When documentation is complete, click the green check on the top of the PowerForm to sign and complete the Medicare Annual Wellness Visit PowerForm.