eCW Updates

Effective: June 1, 2021

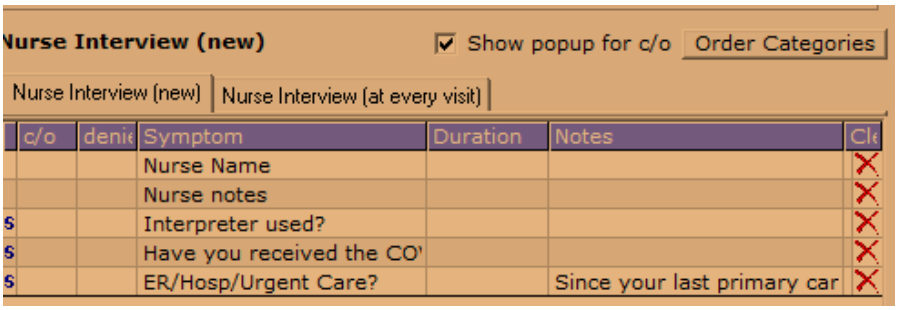
1. Documentation Goals

1. Enhance connection between nurse and patient. Less time checking boxes, more eye contact and relational connection.
2. Give nurses more freedom to use their judgment to determine what histories are needed for the patient's visit that day.
3. Improve efficiency so that more can be served, and so that those served are done so with respect for their time constraints
4. Standardize documentation technique across clinics, nursing personnel, etc.

2. Nurse Interview

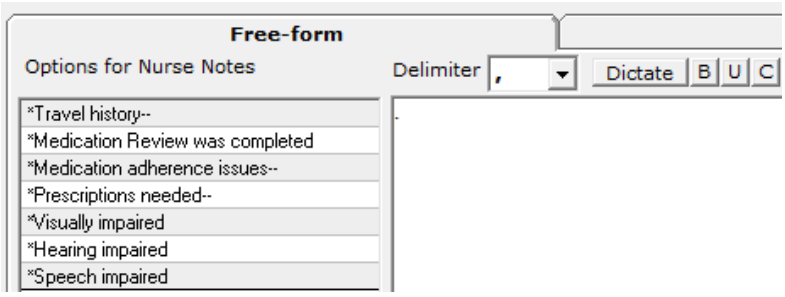
Will only consist of the following questions:

- Nurse Name
- Nurse Notes
- Interpreter used?
- Have you received the Covid vaccine?
  - Document vaccine given outside of CO
- ER/Hosp/Urgent Care?



The nurse will use his/her judgment to determine if any of the following statements from the "pick list" should be discussed/documented. Click the pertinent statement and it will be moved into the NI.

- Travel history
- Medication adherence issues…
- Prescriptions needed…
- Visually Impaired
- Hearing Impaired
- Speech Impaired

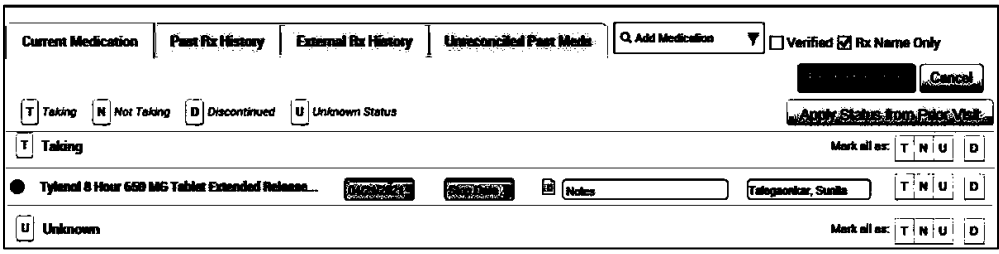


3. Medications

- Review and check 'Verified' box at each visit. Nurse to use judgement for certain pt visits…

The "notes" field for each medication is only for notes you want attached permanently (i.e. "prescribed by outside psychiatrist"). Put all other notes about medications in the 'nurses notes' section of the nurse interview (i.e. "Lisinopril refill needed" or "Patient doesn't consistently take HCTZ" or "Having nausea when she takes this".

Reminder:
T= Patient currently takes the medicine (scheduled and prn)
N= Pt is not taking the med but should be (failed to refill, stopped taking due to side effects, they don't feel they need it)
D= Only used when a medication was discontinued by a clinician.
U= Pt is unsure if they are taking the medicine
- sign = Removes medicine from the record permanently. Only use if you typed an incorrect medicine of if there is a duplicate medicine.



4. Medical History and Surgical Hx

- Check "Verified' box when Completed at New Patient Visits and prn.
  Reminder: List medical conditions and diagnoses in the Medical Hx
  Symptoms are documented in Nurses Notes.

5. Allergies

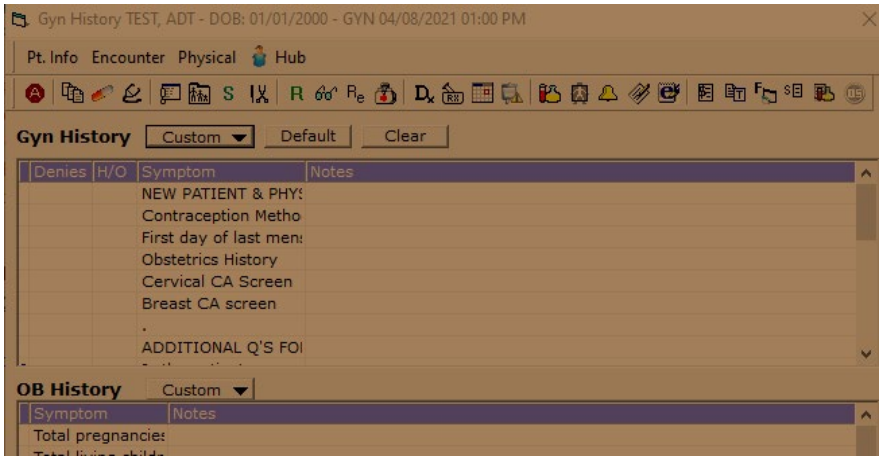
- Review allergies and check 'Verified' box at each visit.

6. GYN History

Divided into 2 sets of questions: New Patient and Physical Visit questions and Additional Questions for GYN visits.

New Patient and Physical Visit:

Contraception Method
First day of LMP
OB Hx
Cervical CA Screen
Breast CA Screen



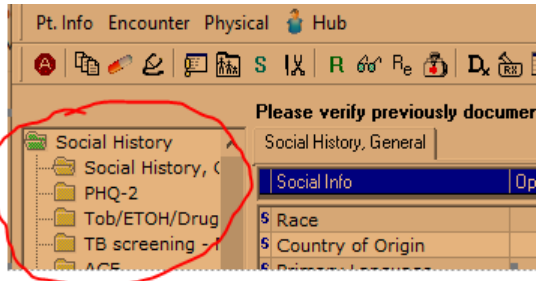
Additional Questions for GYN Visit:

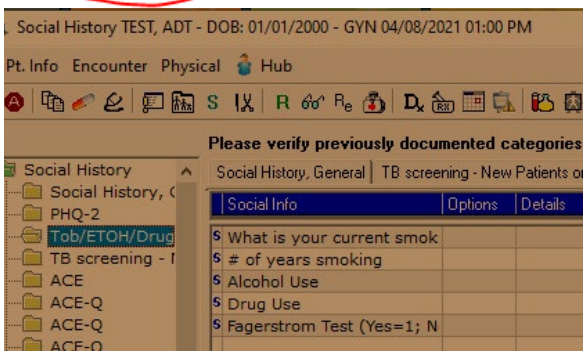
Is the patient menopausal?
Vaginal Discharge?
Pelvic Pain?
Frequency of menses?
Etc

7. Social History

The Social Hx has been separated into different folders (i.e. TB)

- **New Patient Visits- Social Worker will have completed** the Social Hx (including Domestic and Sexual Abuse) and PHQ2. Nurse will click on the folder to verify it has been completed and so that it appears in the note.
- **Established Patients at Annual Physicals- The nurse will:**
  - Briefly review Social hx for changes
  - Administer PHQ2. Also done *prn* based on patient's symptoms.
- **New Patient Visits & Annual Physicals- Nurse will complete/review**: Tob/ETOH/Drug and TB Screening
  - The "pack years" question will be changed to "number of years smoking"`

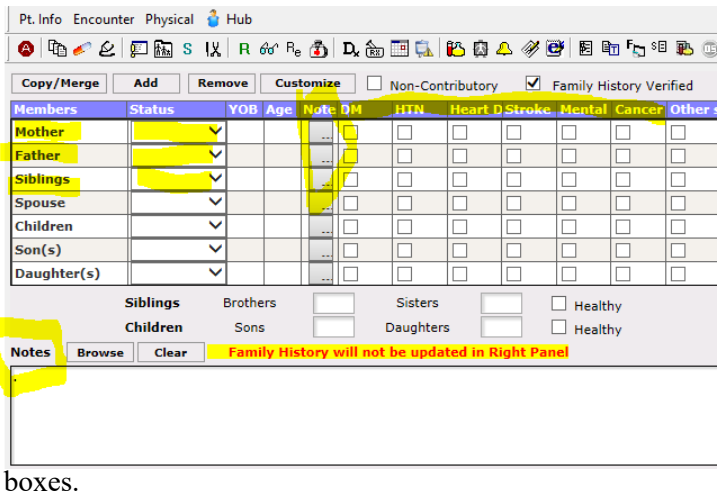




TB Screening questions have been revised:
Has the patient ever been diagnosed with active or latent TB? *Yes*
If yes, TB type: (active / latent / unknown)
Date and treatment details-
When was the last screening test for TB completed?
Have you ever worked or resided in one of the following institutions?
Has the patient lived in any of the following countries for longer than 3 months in the past 5 years? (check-box list)
Has the patient had an illness causing chronic immunosuppression or removal of part of the stomach?
Has the patient ever received the BCG vaccine? *Yes/no/ unknown*

8. Family History : New Pt Visits & Annual Physicals

- Only 1st degree relatives (mother, father, siblings). Clinicians do not need age or year of birth.
- Use the checkboxes under the columns for DM, HTN, Heart disease, etc.
- **"Notes" column** can be used for medical information not in checkboxes (Lupus).
- **"Notes" section** can be used for:
  - Pertinent medical information for multiple siblings or children.
  - Important information about 2nd degree relatives.
  - Other information such as: "Ms. Smith was adopted and her parents' health history is unknown"



- Nurse does not need to complete "Siblings" and "Children" boxes.