Provide Enterprise
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Care Services

Provide Enterprise Web User Guide

Virginia Department of Health

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Table of Contents

Chapter One: Introduction & Background 2
Chapter Two: Finding Clients 3
Find – Find Client 3
View\PLWH Clients 3
Chapter Three: Case Management Summary 5
Assessments 5
Contacts & Services 6
Marking the Service Provided as “Completed” 7
Marking the Service Provided as “Not Provided” 7
Common Notes 7
Appointments 8
Test Result 9
Referral 10
Chapter 4: Medical Summary 13
Diagnosis 14
Medical Problem 15
Treatment Record 15
Care Action 16
Appointment 17
Drug 17
Allergy 18
Test Result 19
Vaccination 20
Referral 21
Chapter Five: Additional Records 23
Eligibility Assessment 23
Letter 23
Scan 25

Chapter One: Introduction & Background

The Virginia Department of Health will use Provide Enterprise (PE) to manage their Care Services programs. This user guide will walk through the input and management of services.

This guide assumes knowledge of Provide Enterprise Navigation, Client Registration, Client Profile, and Eligibility Assessments. Please refer to the following user guides for more information on these foundational topics.

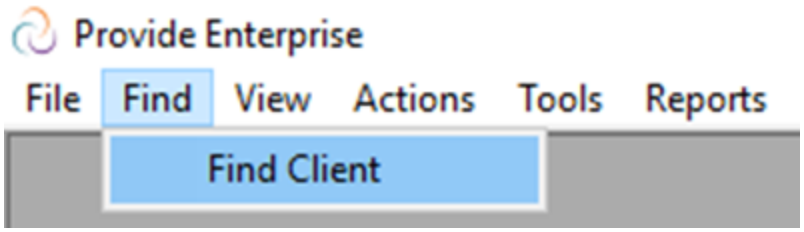
1. Navigating Provide Enterprise
2. Client Registration – Completing the Client Profile
3. Eligibility Assessment User Guide

Chapter Two: Finding Clients

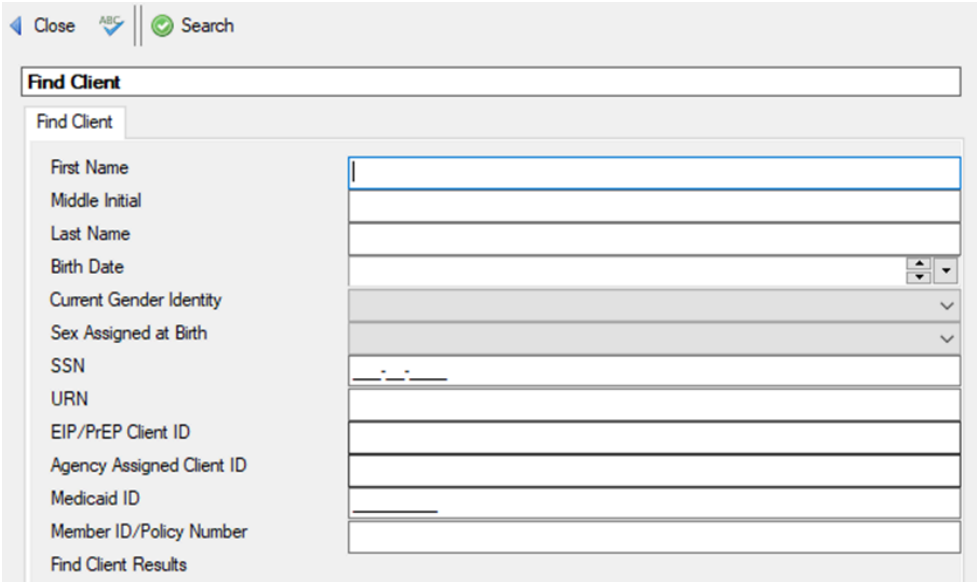
There are two ways to find PLWH clients in Provide, detailed below:

Find – Find Client

The first way to find a client is by clicking on **Find** and then **Find Client**.

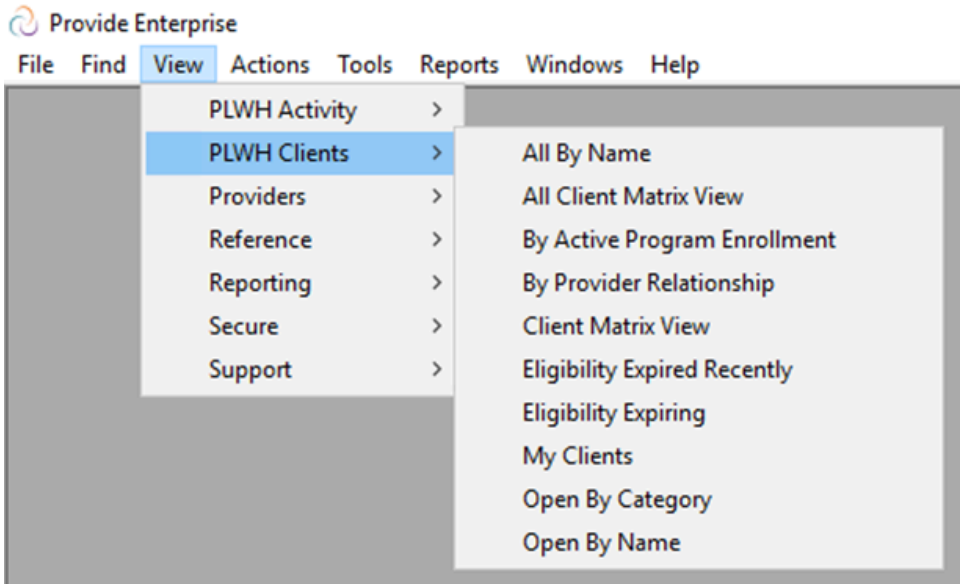


Here, you can search by client name, birth date, SSN, gender, etc.



View\PLWH Clients

The second way to find a PLWH client is by going to View\PLWH Clients.



From this view, you can search by name, provider relationship, clients that are assigned to you, clients that are open, etc.

Chapter Three: Case Management Summary

In the Client Profile, medical and non-medical case managers will often use the Case Management Summary view (see image below).

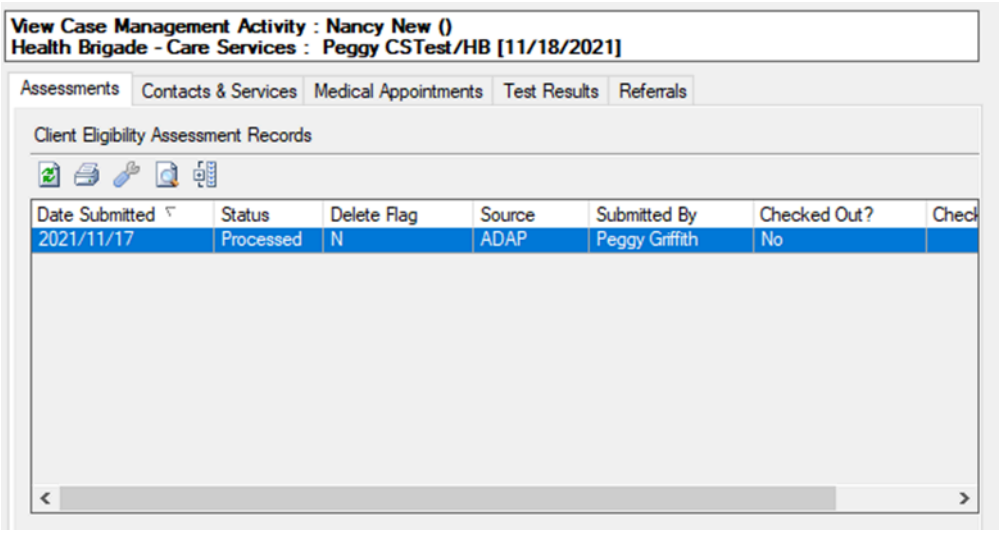
In the Case Management Summary view, a case manager can create or view a number of things including:

- Assessments
- Contacts and Services Provided
- Appointment
- Test Result
- Referrals

Many of these activities can also be created from the **Create** button within the Client Profile and/or within the Case Management Summary.

Assessments

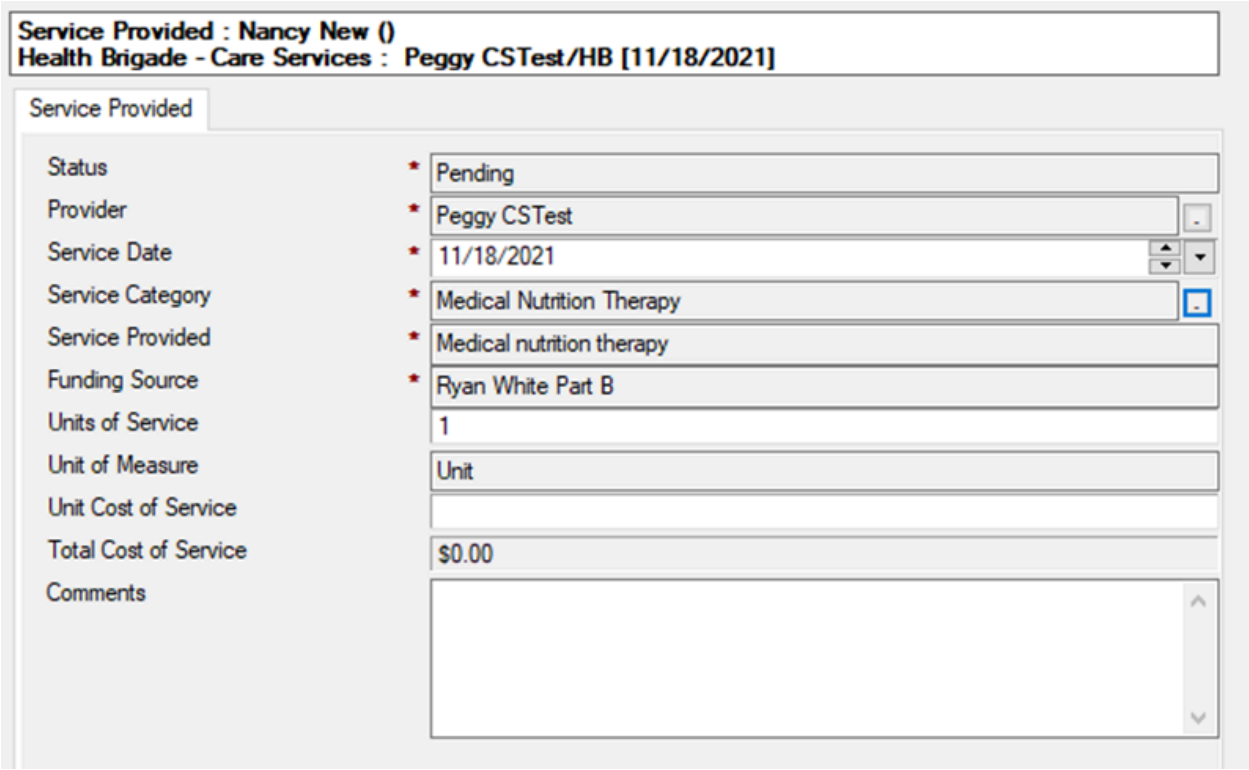
The Assessments tab shows a history of client Eligibility Assessments and status. Double-click on the Eligibility Assessment record to view it.



Contacts & Services

Services Provided are used to document a tangible service that you provided to the client. To create a Service Provided, follow the steps below:

- On the Contacts & Services Tab in the Case Management Summary view, click on the **Add Service Provided** button.



- Fill in the appropriate fields. Depending on the Service Provided, the data entry fields will vary.
- When finished, you can either mark the service as "Completed" or "Not Provided".
- If you do not have time to enter in all the required information in one sitting, you can save the Service Provided as "Pending" so you can come back to it later. To save it as "Pending", click on the **Close** button and then **Yes** to save your changes. When you want to come back and complete the Service Provided, double click into the "Pending" Service Provided and click on the **Edit** button.

PLEASE NOTE: It is important to complete each Service Provided. Services Provided that are not in a "Completed" status will not be included in your reports. You can see a list of all your "Pending" Services Provided at *View\PAHR Activity\Services Provided Records Pending*.

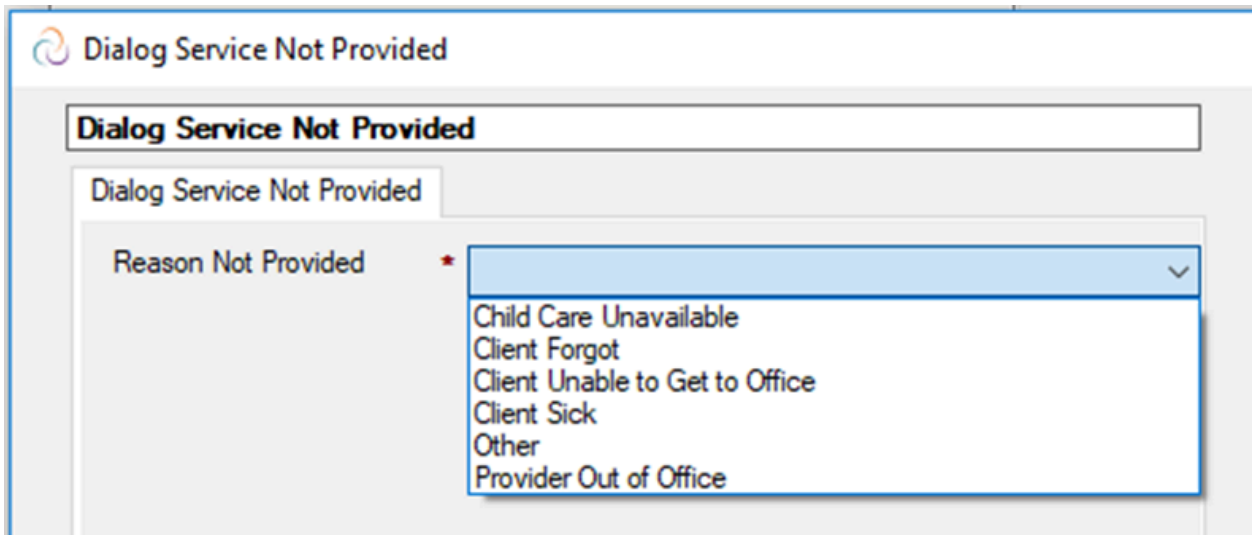
Marking the Service Provided as "Completed"

Click on the **Complete** button to save your changes. Once a Service Provided is marked as Complete, you cannot edit the Service Provided.

Marking the Service Provided as "Not Provided"

Marking the Service Provided as "Not Provided" allows you to document that you had planned to deliver a service but did not actually deliver the service.

Click on the **Not Provided** button to mark the Service Provided as "Not Provided".

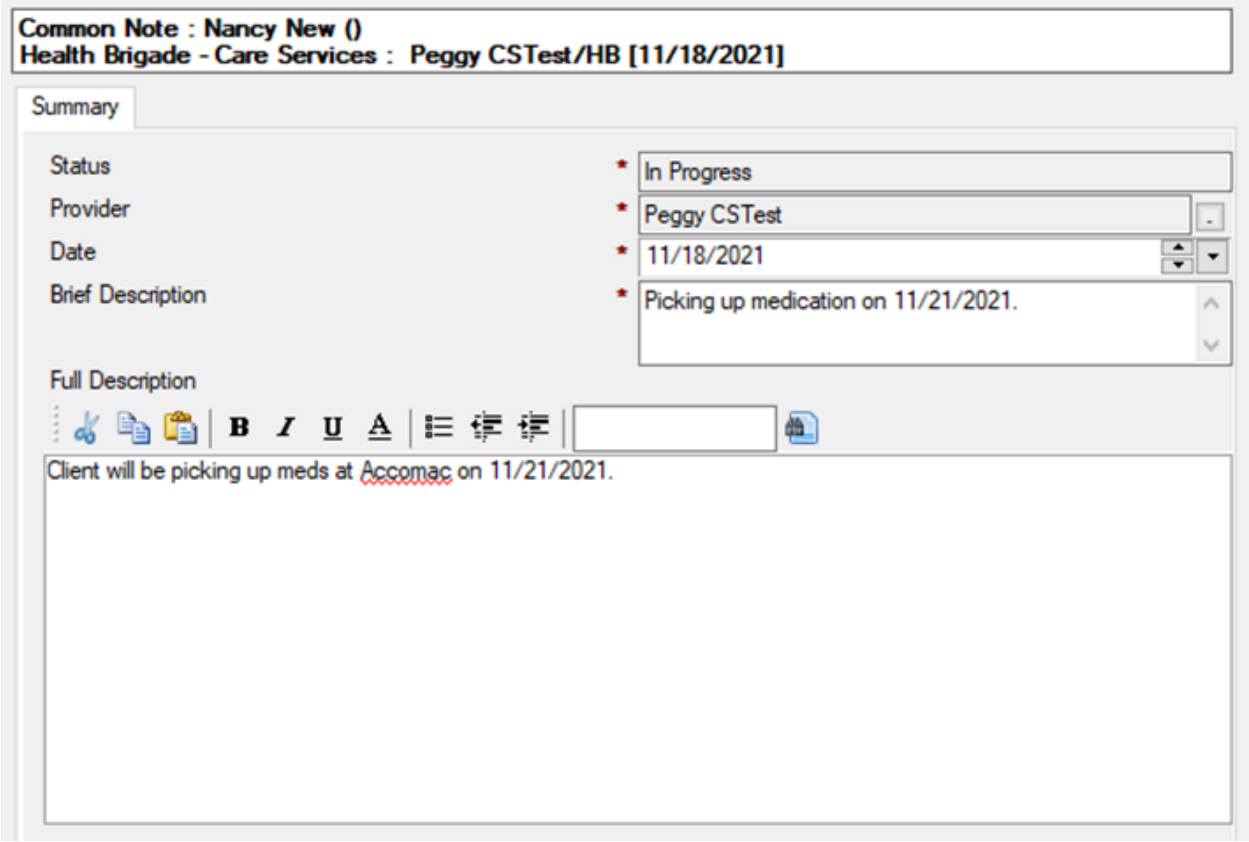


Select the reason you are marking the service as "Not Provided" and click **OK**.

Common Notes

Common Notes are used to capture any informational notes about the client that are not billable and can be seen by other care services staff. Common Notes are not progress logs, and should not contain sensitive medical case management information.

- On the Contacts & Services Tab in the Case Management Summary view, click on the **Add Common Notes** button.



When finished, you may mark the note as **Complete**.

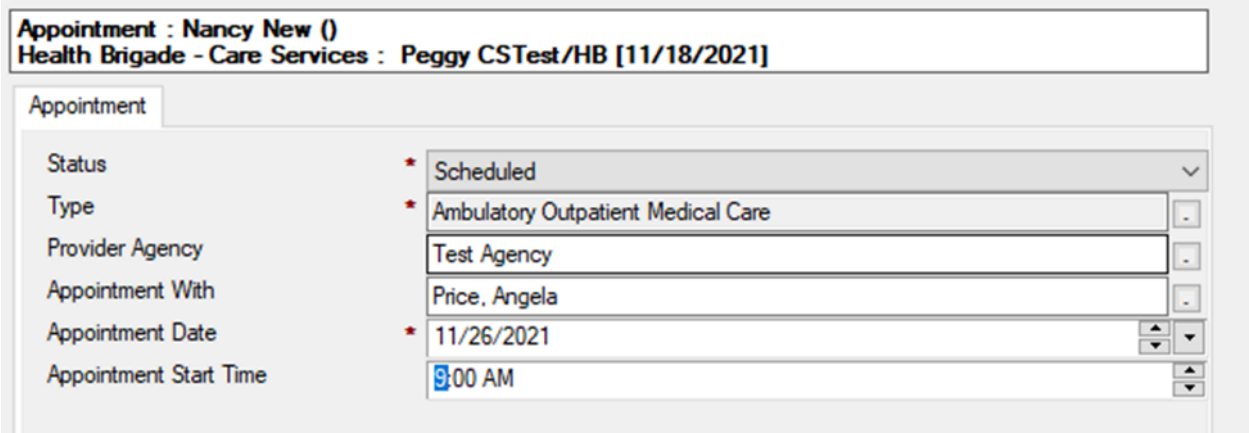
If you do not have time to enter in all the required information in one sitting, you can save the Note as "In Progress" so you can come back to it later. To save it as "In Progress", click on the **Close** button and then **Yes** to save your changes. When you want to come back and complete the Service Provided, double click into the "In Progress" Note and click on the **Edit** button.

Appointments

This form is used to document scheduled, kept and missed appointments. It is useful to record appointments of all status (scheduled, kept, missed, etc.).

To create an Appointment, follow the steps below:

- On the Medical Appointments Tab in the Case Management Summary view, click on the Add Appointment button.



- Fill in the appropriate fields.

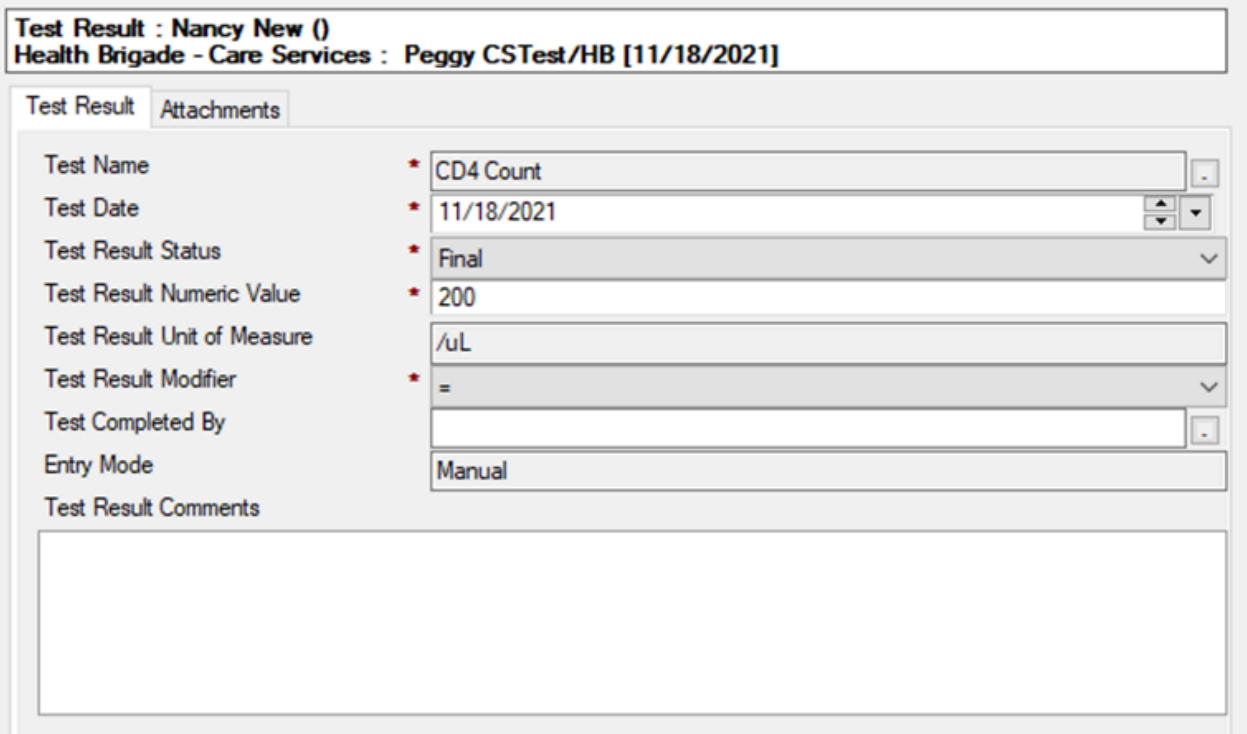
When finished, click on the Close button and then Yes to save your changes. You can come back into an appointment at any time and click on the Edit button to update the status of the appointment.

Test Result

This tab documents information related to specific medical tests a client has been given. At a minimum, each the following Tests need to be documented when a client has them performed:

- CD4 Count
- Viral Load
- Syphilis Screening
- Hepatitis B Screening
- Hepatitis C Screening
- PAP Smear
- Other STI Screenings

To create a Test Result, follow the steps below:
On the Test Results Tab in the Case Management Summary view, click on the Add Test Result button.

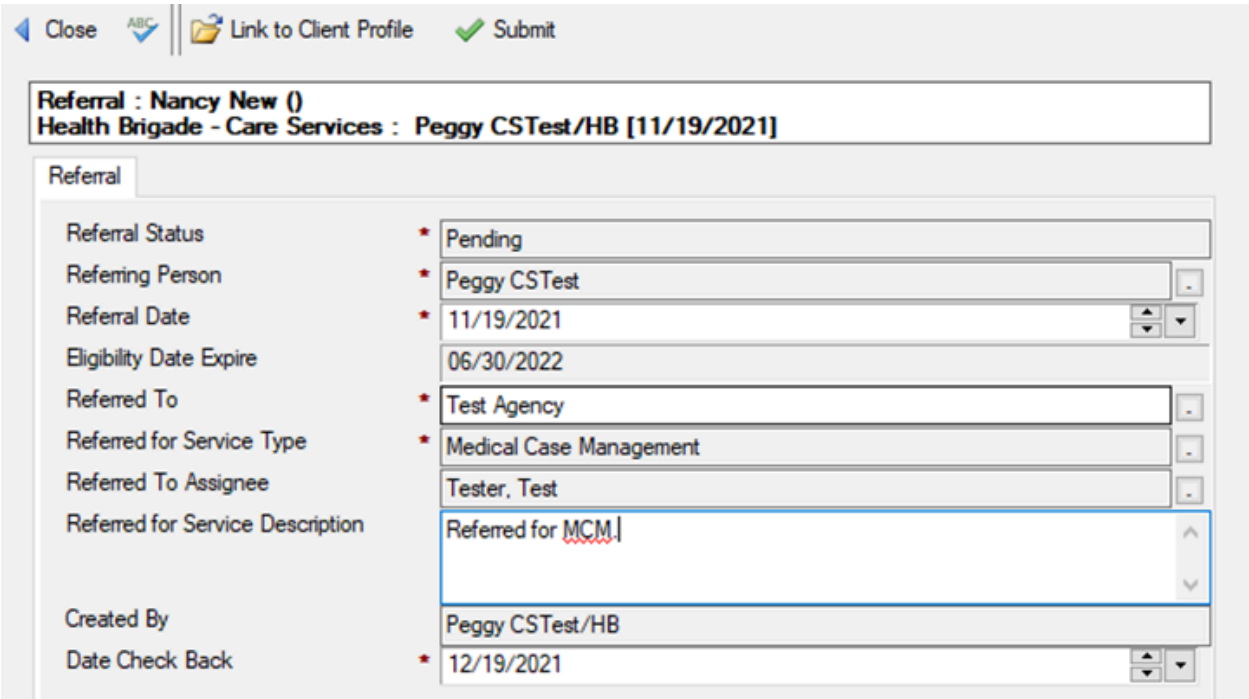


- Fill in the appropriate fields.
- Use the Attachments tab to attach any proof documents.
- When finished, click on the **Close** button and then **Yes** to save your changes.

Referral

To create a Referral, follow the steps below:

- On the Referrals Tab in the Case Management Summary view, click on the Add Referral button.

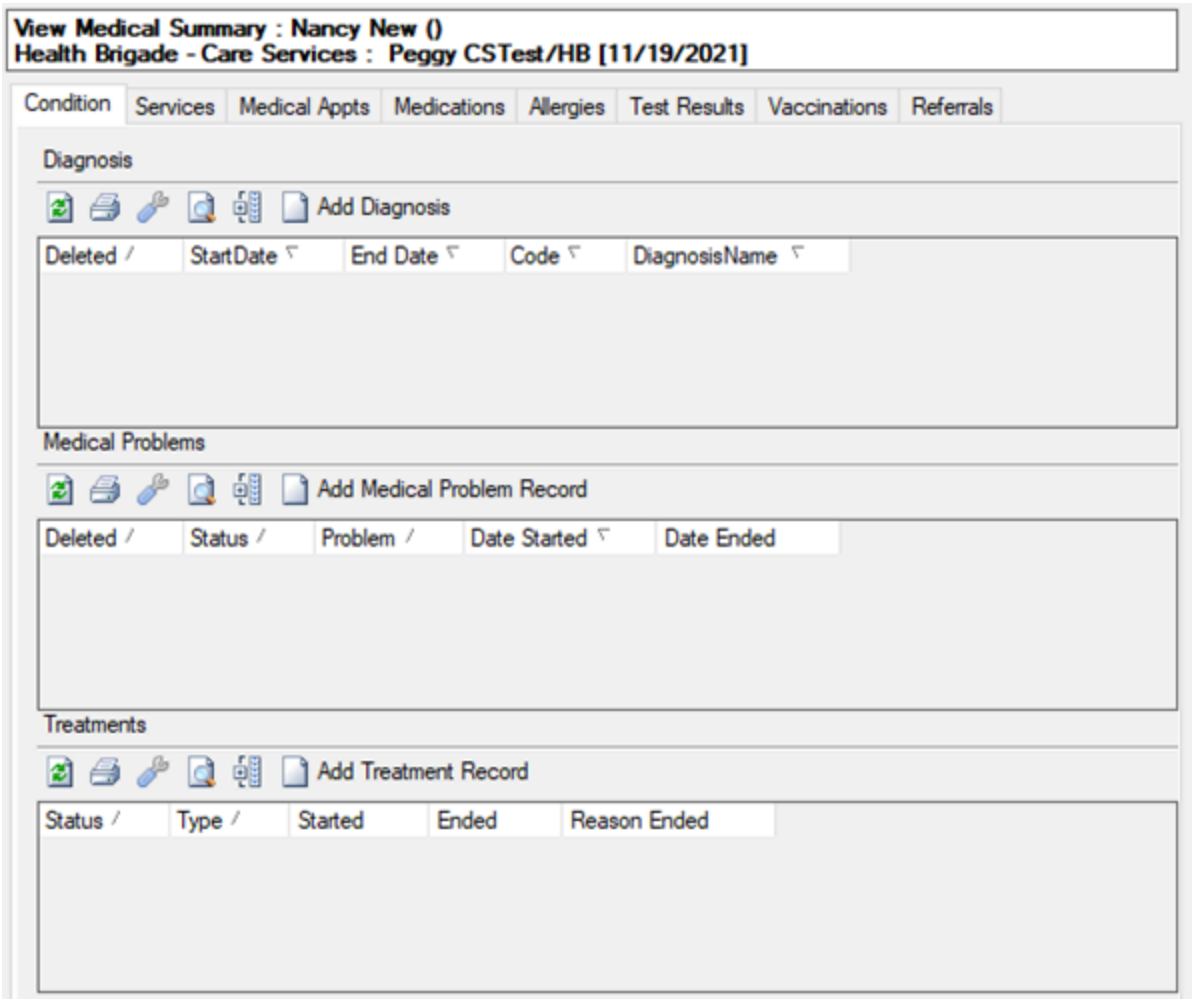


- Fill in the appropriate fields:
    - **Referring Person** – This will default to you, but you can select a different person
    - **Referred To** – Select the agency you are referring the client to
    - **Referred for Service Type** – Select the service type
    - **Referred to Assignee** – If there is a referred to assignee, select it here
    - **Referred for Service Description** – Enter the description of the referral service
    - **Date Check Back** – Enter the date to check back on the referral.
    - **Consent Required** – defaults to Yes
    - **Client Consent Obtained**? – Confirm that client has signed informed consent
    - When finished, click on the **Submit** button to save your changes and submit the referral. The referrals then can be "Acknowledged" by the receiving agency by clicking on the **Acknowledge** button. Acknowledging the referral will inform the referring provider that the referral has been received.

- When a referral is completed, the agency receiving the referral will be able to view the referral in any of the *View\PLWH Activity\Referrals* views.
- Once a referral is opened, it cannot be edited. However, you can come back to the referral at any time and click the **Close** button to close the referral.

Chapter 4: Medical Summary

Much of the data related to the client's Medical Care can be found in the Medical Summary view. From the Client Profile, click on View – Medical Summary.



The Medical Summary contains seven tabs, each containing different information:

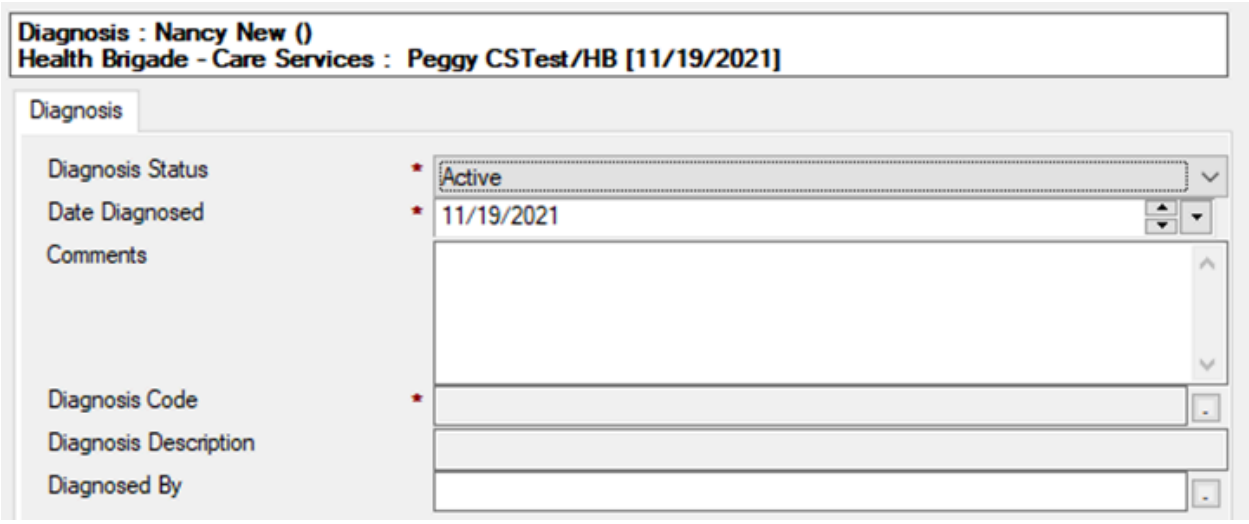
- **Condition:** Information on to the client's diagnosis, medical problems, and treatment records.
- **Services:** Information regarding services provided to the client. Includes Care Actions, Services Provided, and Procedure records. Care Actions and Services Provided can be created in this tab.

- **Medical Appointments:** Lists all medical appointments the client has in Provide. Appointments can be added in this tab.
- **Allergies:** Information on client's allergies to medications and other irritants.
- **Medications:** Information on the client's current drug protocol, prescriptions, and allergy records. Drugs, Prescriptions, and Allergy records can be created in this tab.
- **Test Results:** Displays all labs the client has had completed, including CD4s and Viral Loads. Test Results and Lab Panels can be created in this tab.
- **Vaccinations:** Information regarding the client's vaccinations for Hep A, Hep B, HPV, Influenza, and Pneumonia.
- **Referrals:** Displays any Referrals made for the client. Referral records can be created in this tab.

Diagnosis

Diagnosis records are used to track medical diagnoses a client may have received. To create a Diagnosis record, follow the steps below:

- On the Condition Tab in the Medical Summary view, click on the **Add Diagnosis** button.

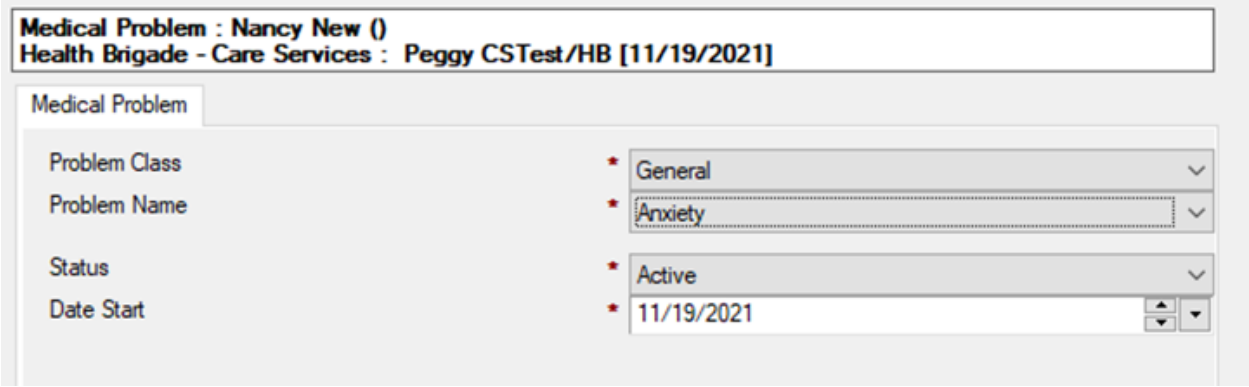


- Fill in the appropriate fields.
- When finished, click on the **Close** button and then **Yes** to save your changes.

Medical Problem

Medical problem records are used to track the client's medical problems using either generalized problem names or SNOMED problem list codes. To create a Medical Problem record, follow the steps below:

- On the Condition Tab in the Medical Summary, click on the **Add Medical Problem Record** button.

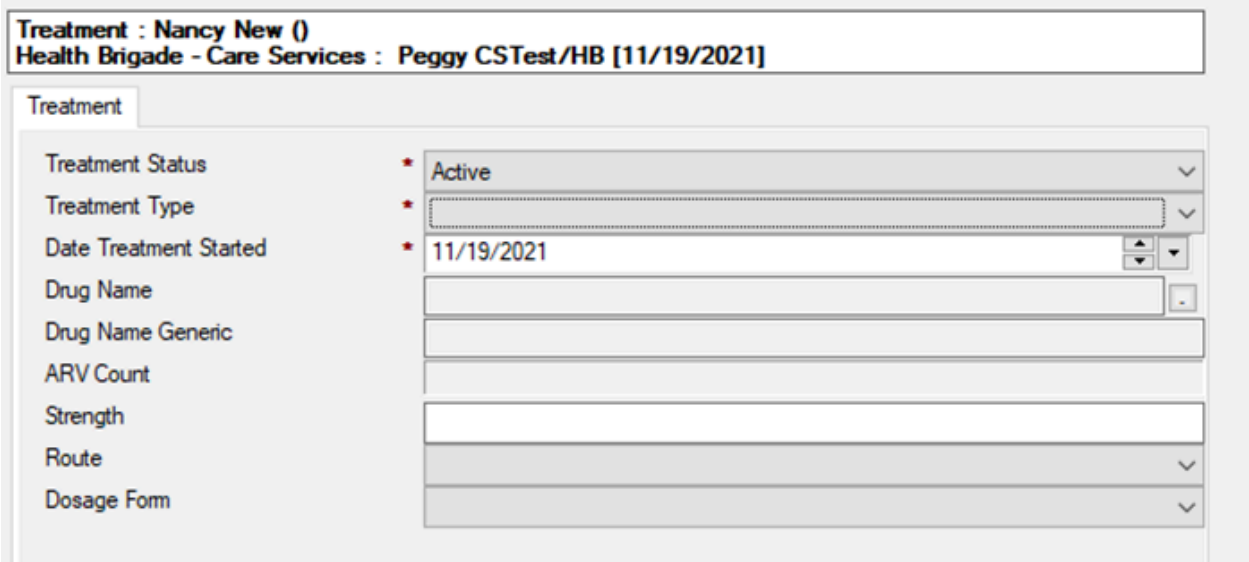


- Fill in the appropriate fields.
- When finished, click on the **Close** button and then **Yes** to save your changes.

Treatment Record

The Treatment Record is used to track when a client undergoes treatment for (or documents when it is determined that treatment is not clinically indicated) for key conditions that are monitored and reported on for HIV Care.
Conditions include Chlamydia, CMV, Gonorrhea, Hepatitis A, Hepatitis B, Hepatitis C, Herpes, HPV, PCP Prophylaxis, and Syphilis. Documentation of treatment for these conditions is done within the Treatment record. To create a Treatment record, follow the steps below:

- On the Condition Tab in the Medical Summary view, click on the **Add Treatment Record** button.



- Fill in the fields as appropriate.
- When finished, click on the **Close** button and then **Yes** to save your changes.

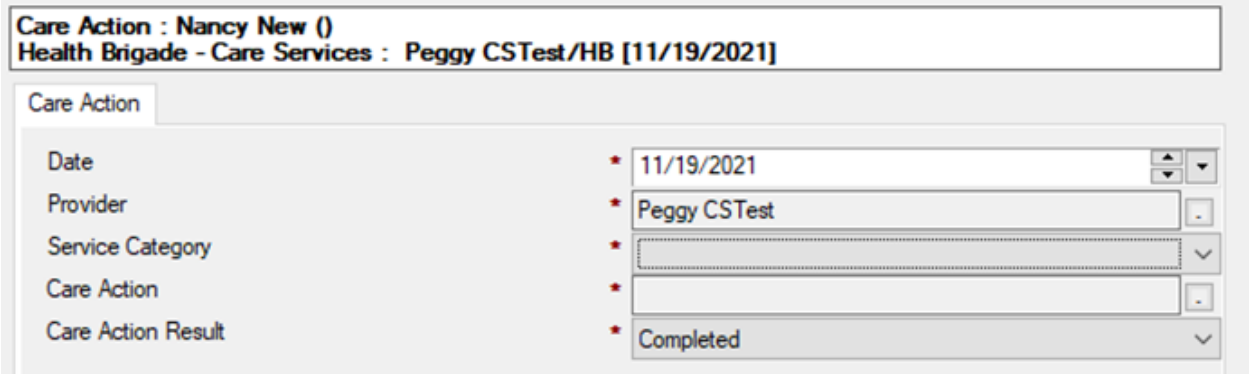
Care Action

This form is used to capture some specific clinical activities that are not typically captured as data points like in CPT4 encoded procedures. These interventions may or may not have been provided by your agency but should be documented when they occur. They include:

- Adherence Counseling
- HIV Alcohol Counseling
- HIV Risk Counseling
- Mental Health History
- Mental Health Evaluation
- Oral Health Exam
- Substance Abuse Evaluation
- Tobacco Cessation Counseling

To create a Care Action, follow the steps below:

- On the Services Tab in the Medical Summary view, click on the Add Care Action button.

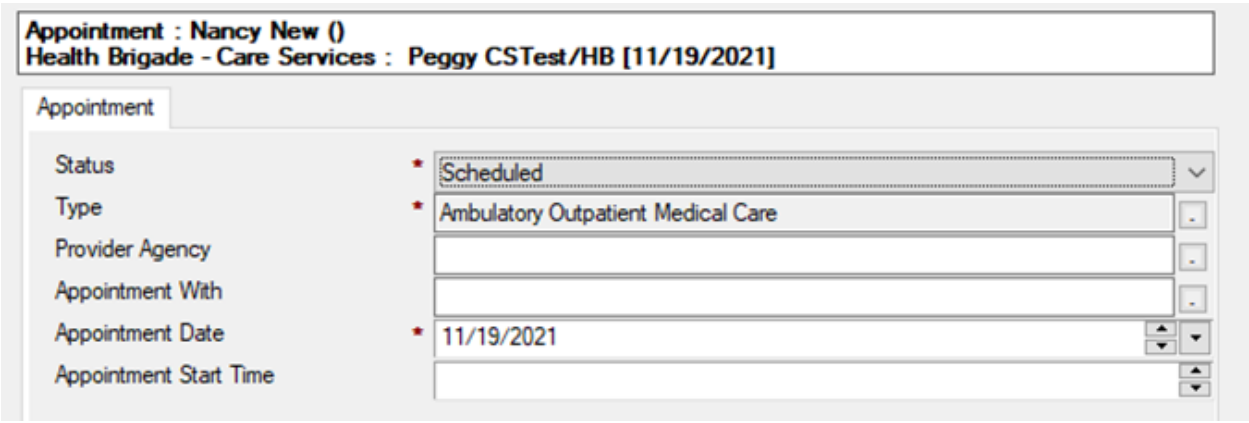


Appointment

This form is used to document scheduled, kept and missed appointments. It is useful to record appointments of all status (scheduled, kept, missed, etc.).

To create an Appointment, follow the steps below:

- On the Medical Appointments Tab in the Medical Summary, click on the Add Appointment button.



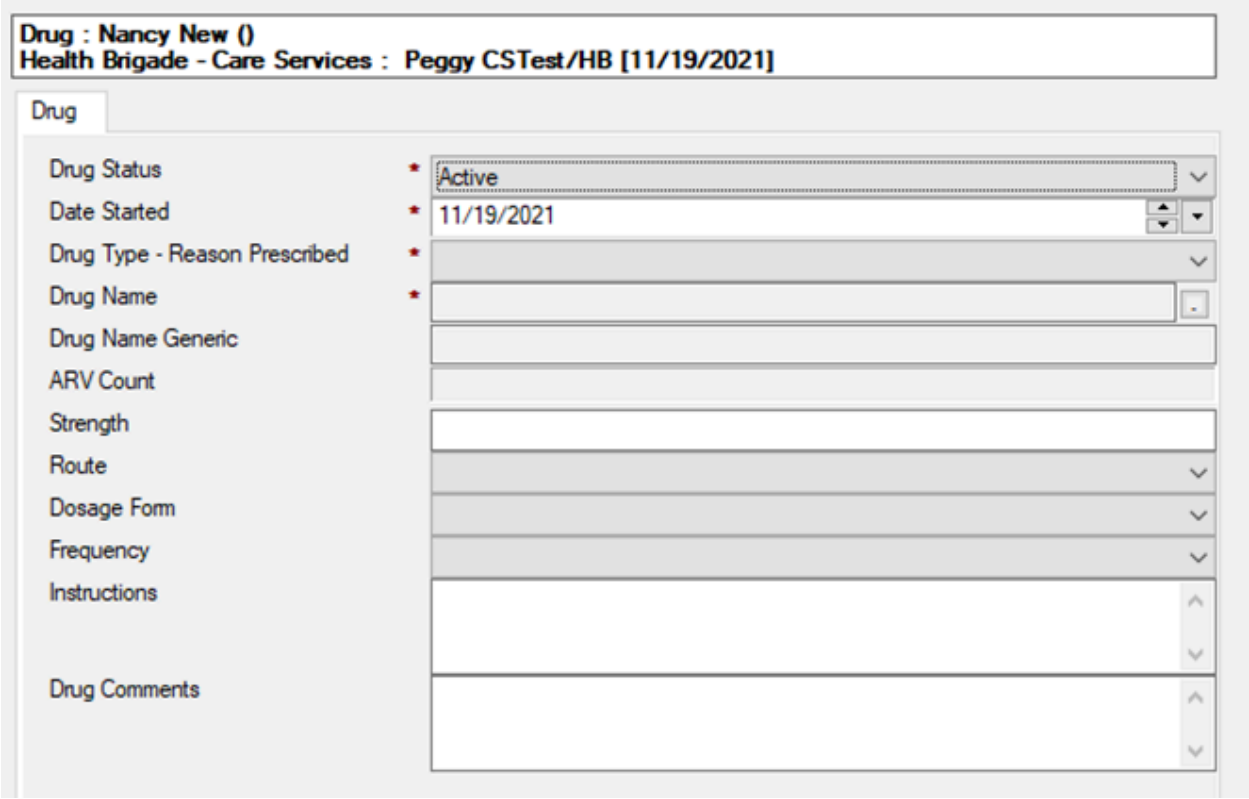
- Fill in the appropriate fields.
- When finished, click on the **Close** button and then **Yes** to save your changes. You can come back into an appointment at any time and click on the **Edit** button to update the status of the appointment.

Drug

Drug records are used to track a client's medication. It is not required to keep track of a client's medications, but it can be a helpful tool as a medical provider.

To create a Drug record, follow the steps below:

- On the Medications Tab in the Medical Summary view, click on the Add Drug button.



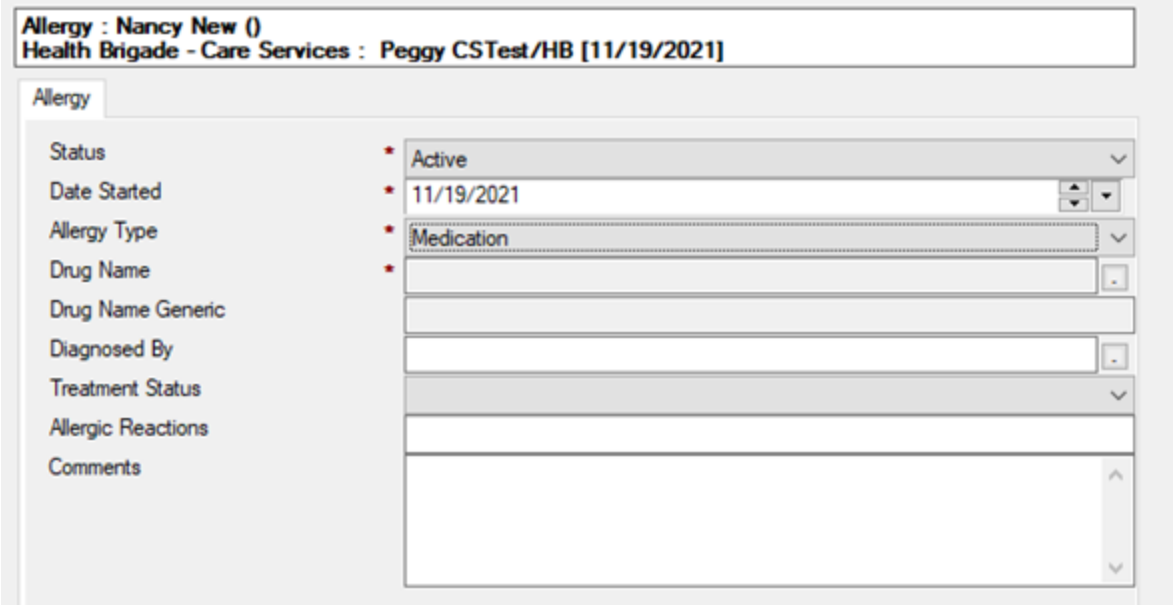
- Fill in the appropriate fields.
- When finished, click on the **Close** button and then **Yes** to save your changes.

Allergy

Allergy records are used to track a client's allergies. It is not required to keep track of a client's allergies, but it can be a helpful tool as a medical provider.

To create an Allergy record, follow the steps below:

- On the Medications Tab in the Medical Summary view, click on the Add Allergy Record button.

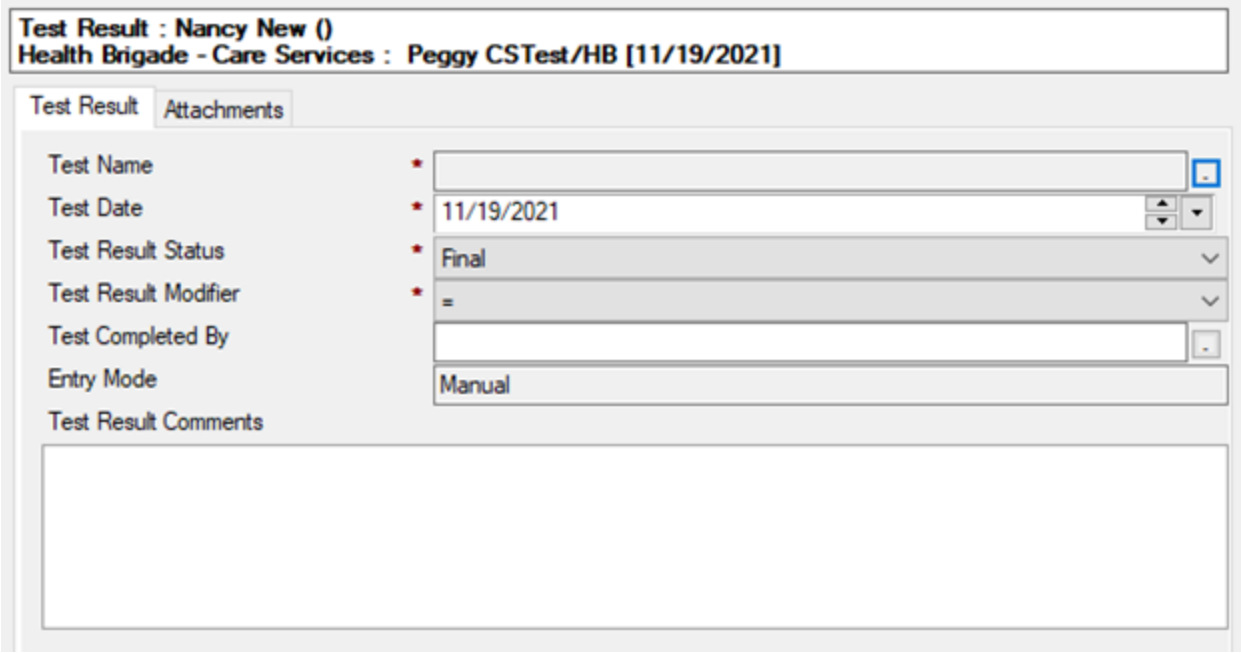


- Fill in the appropriate fields.
- When finished, click on the **Close** button and then **Yes** to save your changes.

Test Result

This tab documents information related to specific medical tests a client has been given. To create a Test Result, follow the steps below:

- On the Test Results Tab in the Medical Summary view, click on the Add Test Result button.

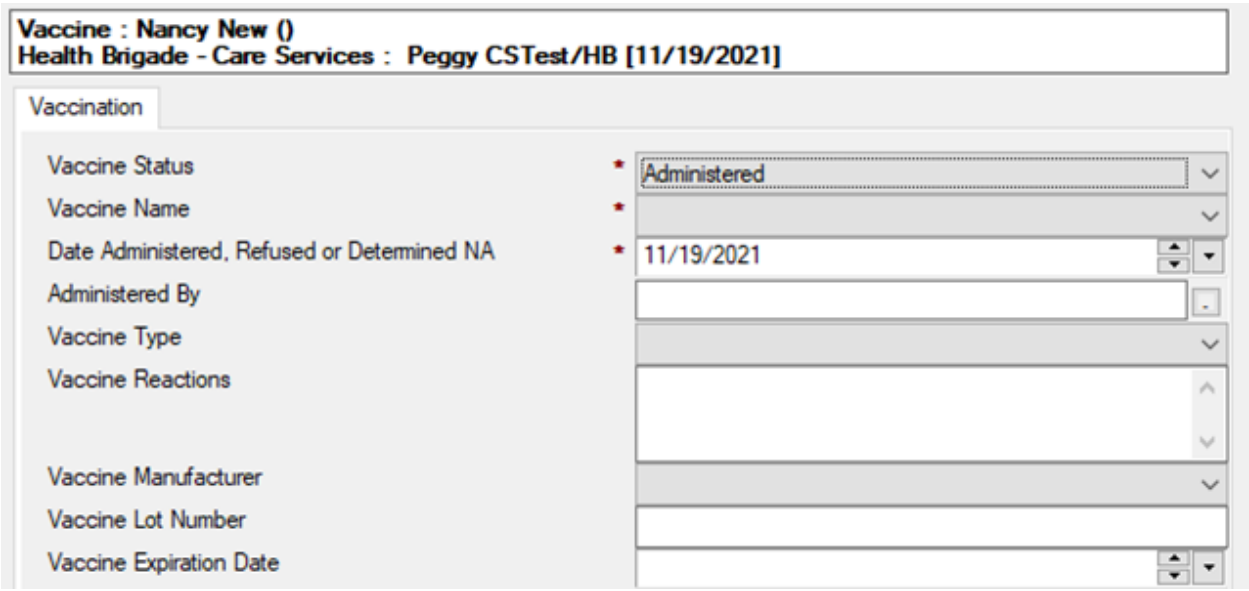


- Fill in the appropriate fields.
- When finished, click on the **Close** button and then **Yes** to save your changes.

Vaccination

To create a Vaccination, follow the steps below:

- On the Vaccinations Tab in the Medical Summary view, click on the Add Vaccination button.

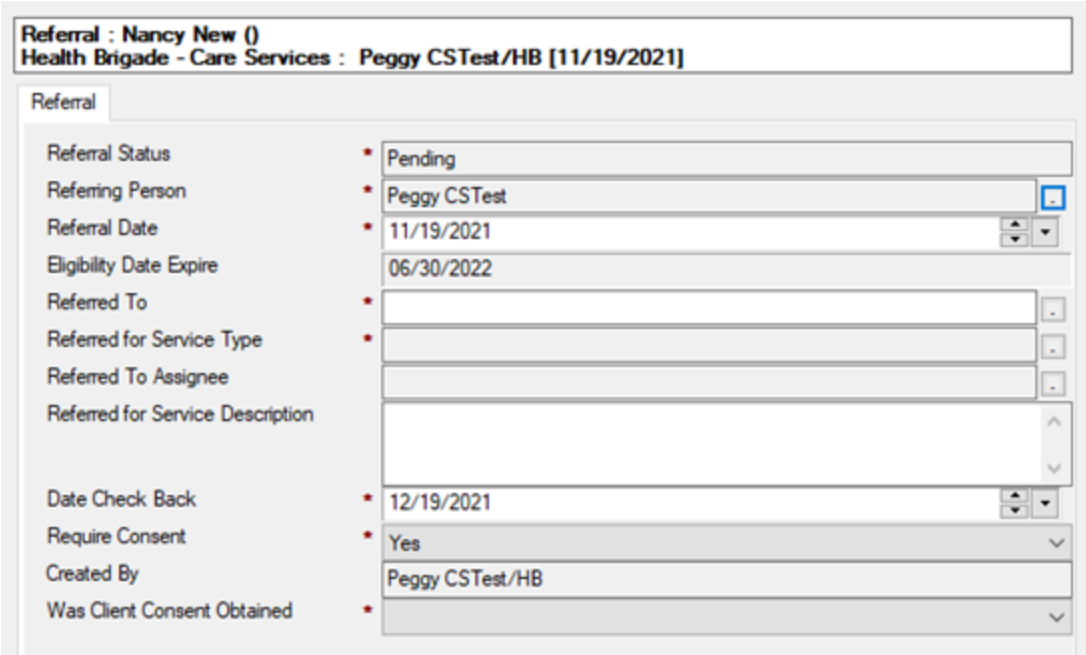


- Fill in the appropriate fields.
- When finished, click on the **Close** button and then **Yes** to save your changes.

Referral

To create a Referral, follow the steps below:

On the Referrals Tab in the Medical Summary view, click on the Add Referral Button.



- Fill in the appropriate fields:
    - **Referring Person** – This will default to you, but you can select a different person.
    - **Referred To** – Select the agency you are referring the client to.
    - **Referred for Service Type** – Select the service type.
    - **Referred to Assignee** – If there is a referred to assignee, select it here.
    - **Referred for Service Description** – Enter the description of the referral service.
    - **Date Check Back** – Enter the date to check back on the referral.
- When finished, click on the **Submit** button to save your changes and submit the referral. The referrals then can be "Acknowledged" by the receiving agency by clicking on the **Acknowledge** button. Acknowledging the referral will inform the referring provider that the referral has been received.

When a referral is completed, the agency receiving the referral will receive an email regarding the referral. Referrals can be viewed in any of the *View\PLWH Activity\Referrals* Views.

Once a referral is opened, it cannot be edited. However, you can come back to the referral at any time and click the **Close** button to close the referral.

Chapter Five: Additional Records

Many of the records discussed above can be created by clicking on **Create – Activity** or by going to one of the Case Management, Medical, or Oral Health Summary views. However, a few records can only be created by clicking on **Create – Activity** while in the Client Profile. These few records are detailed in this chapter.

Eligibility Assessment

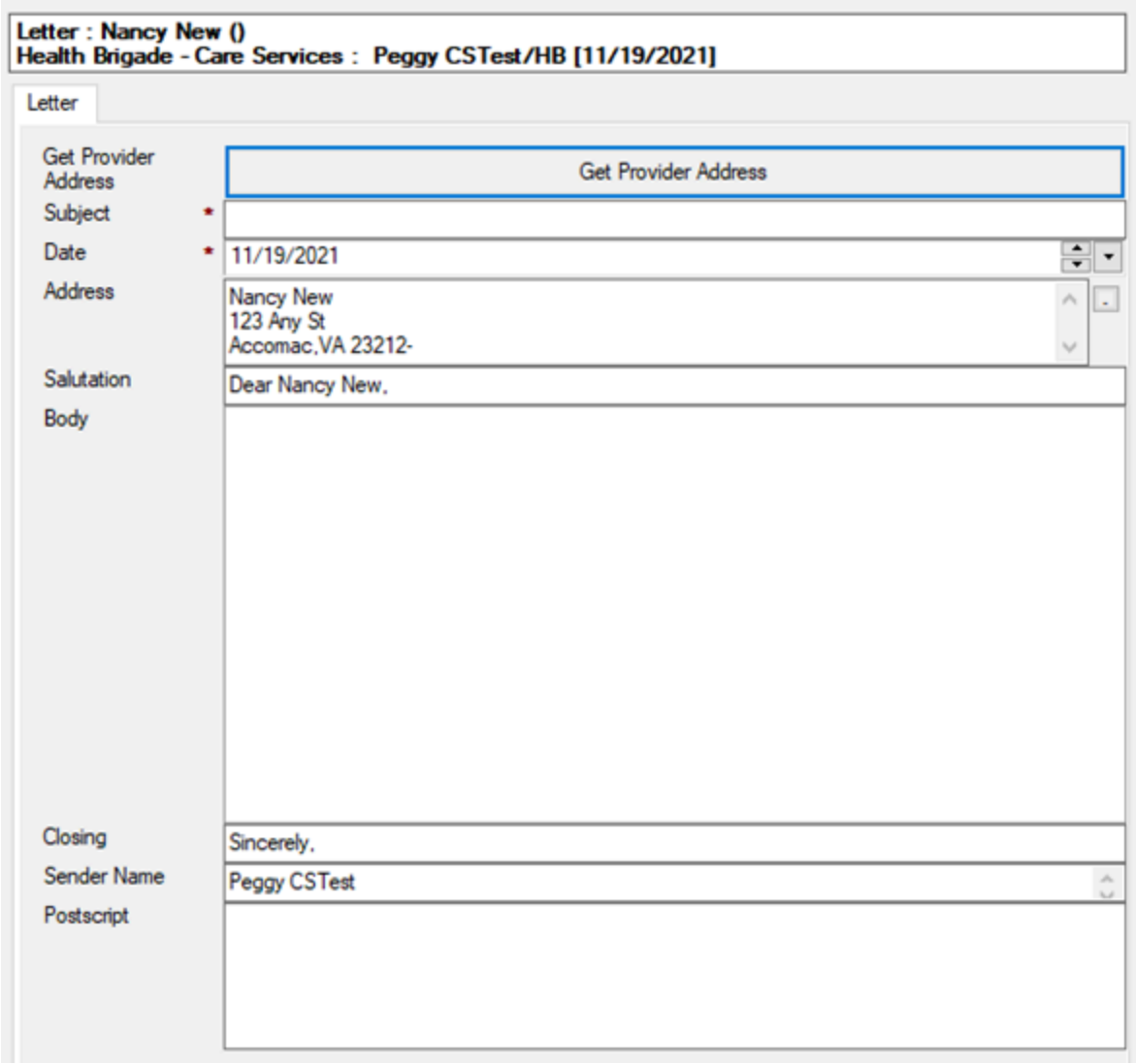
A client's eligibility must be updated every 12 months. For instructions on how to complete an Eligibility Assessment, please see the user guide titled "Eligibility Assessment".

Letter

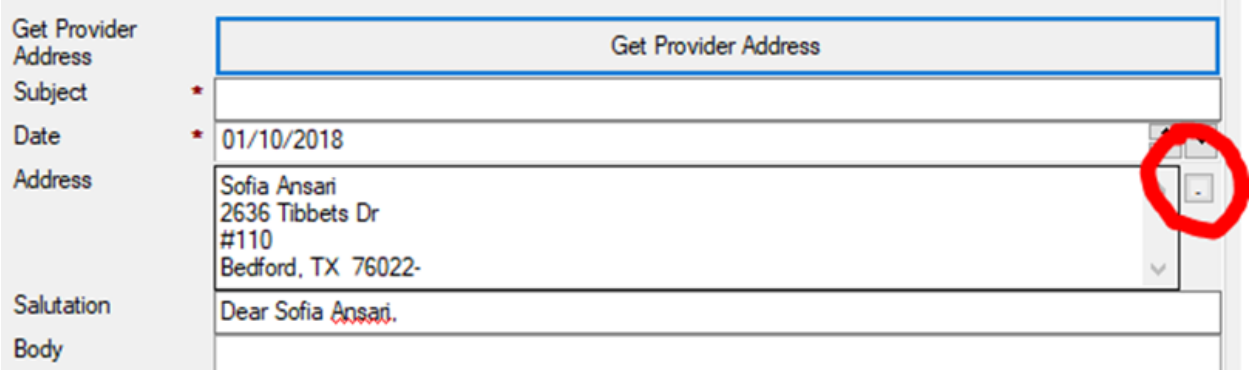
This form is designed to make it easy to write a Letter to a client or to one of their Providers.

To create a Letter:

- Navigate to the Client Profile
- Click on the **Create** button and then the **Letter** button.



- You can address the Letter to either a client or a provider.
- Use the **Get Provider Address** button to select the provider you wish to address the letter to.
- Use the small square button to the right of the “Address” field (circled in red in the image below) to populate the client’s mailing address from the Client Profile.



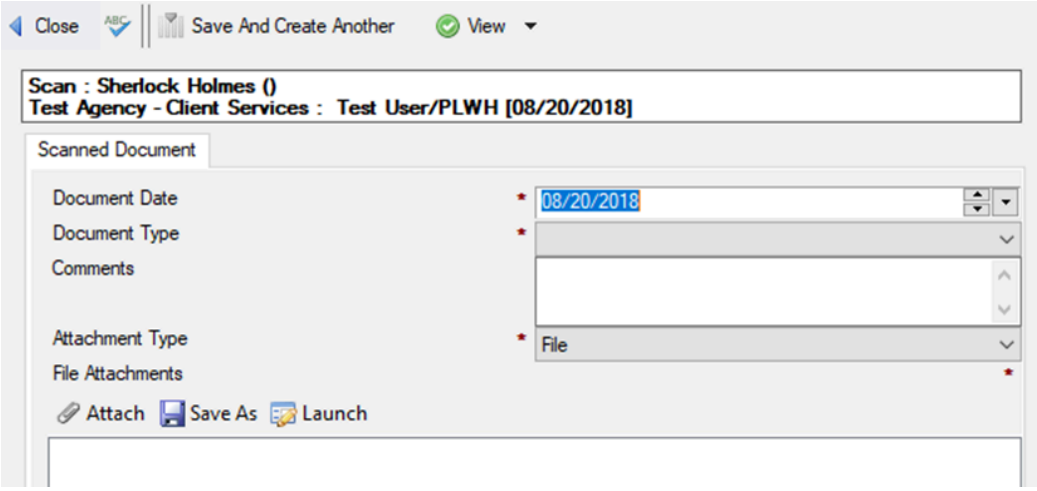
Please Note: The client's mailing address pulls from the Mail Tab in the Client Profile..

Both buttons populate the address and salutation fields. The body of the letter can be typed or it may be helpful to use sample text (described below).

Scan

To create a Scan:

- Navigate to the Client Profile
- Click on the **Create** button and then the **Scan** button.



- Fill in the appropriate fields.
- Click on the **Attach** button to attach a document that you saved on your computer.
- When finished, click on the **Close** button and then **Yes** to save your changes.