



ChartMaker® Clinical Release Notes

ChartMaker® 2018.2 (fv6.3.2)

Added Features

- **Audit Trail** – The Audit Trail has been updated to track whenever a hospitalization record is added or modified in Rounding List of ChartMaker® Mobile. When an audit event occurs, the Event column will display **Modified**; the Group column will display **Case**; the Audit Trail Description will display the **Added hospitalization** or **Modified hospitalization**; the Old Value and New Value columns will display the **Room #, Provider, and Facility** as applicable; and the patient's **Account #, Case Name; and Practice ID** will be listed in the Metadata column.
- **Audit Trail** – The Audit Trail has been updated to track whenever a PDMP report request is sent. When an audit event occurs, the Event column will display **Sent**; the Group column will display **PHI**; the Audit Trail Description will display the **Patient request sent to PDMP (Appriss)**; and the patient's **Account #** will be listed in the Metadata column.
- **Audit Trail** – The Audit Trail has been updated to track whenever a PDMP report is viewed. When an audit event occurs, the Event column will display **Viewed**; the Group column will display **PHI**; the Audit Trail Description will display the **PDMP report viewed**; and the patient's **Account #** will be listed in the Metadata column.
- **Export – All Notes to File** – The export all functionality has been updated when using the export all notes to file options (**Chart > Export > All Notes to File**, or **Chart > Export All Notes to File**, depending upon where you are in the patient's chart; or in the Organizer, by selecting the desired notes, if applicable, then right-clicking and selecting **Export Selected Notes to File** or **Export All Chart Notes to File**).

All multi-page chart notes will now be exported as a single PDF file, while external files added to the chart will be exported as is and will maintain their file extensions. Likewise, a Table of Contents document will also be included that will outline all the notes included in the export, as well as those notes that were selected, but were unable to be exported (e.g., Midmark notes, and unfinalized forms).

Also, the subfolder directory for each patient has been updated with the patient's date of birth to easily distinguish patients with the same names. The new subfolder format is:

\\Output... \PatientLastName_PatientFirstName_DOB_Chart#.

In addition, the Note Export dialog has been updated with a new **Display note heading first in filename** option below the Output Folder field, that allows users to select if they want the note heading to appear first in the file naming schema. The default file name schema for exported notes is YYYY-MM-DD_NoteHeading_NoteID. If the **Display note heading first in filename** option is selected the file name schema will be NoteHeading_YYYY-MM-DD_NoteID.

Added Features (continued)

- **Facesheet – Patient Access** – The Facesheet has been updated so the Patient Access button replaces the Patient Portal button in legacy versions of Clinical. See Figure 1. Likewise, the Patient Access status color-scheme has also been updated to reflect the patient’s status for both PatientPortal and API Access, thereby easily alerting you in case there is an issue of access for the patient.



Figure 1 – Facesheet – Buttons

When you click the Patient Access button, the Patient Access dialog will appear. See Figure 2. The Patient Access dialog replaces the Patient Portal dialog in legacy versions of Clinical. Like previous versions, you cannot authorize Patient Portal access, or API access, from the Patient Access dialog in Clinical, these need to be done in Practice Manager. You can however, suspend the export of patient data, by clicking the Do not export on note, lab and scan signing option. Likewise, the Status Legend will appear at the bottom of the dialog.

Patient Access

Patient Portal account settings

Registration status:

Send an authorization email to the patient for patient portal registration.

or

Print authorization instructions for the patient to manually register on the patient portal.

API Access

Enable this patient for API access

Authentication code: FictionalDrsz5MXGdN1

Print this patient's authentication code.

Send an email to this patient with their authentication code.

Generate a new authentication code for this patient.

Do not export on note, lab and scan signing

Status Legend

- Patient Portal and API are not enabled
- Patient Portal enabled and API is not enabled or Patient Portal not enabled and API is enabled
- Patient Portal pending and API not enabled
- Patient Portal is pending and API is enabled
- PatientPortal and API are enabled
- PatientPortal and API have note data not being sent (suspended)

[Help](#)

Figure 2 – Patient Access

Added Features (continued)

- **Immunization Registry – PhilaVax** – The system has been updated so that the Philadelphia Immunization Information System (PhilaVax), in conjunction with the ChartMaker® Medical Suite, utilizes 2.5.1 HL7 bidirectional messaging and exchange of vaccine (immunization) information. Once the system is set up, and you are enrolled with PhilaVax, immunization records will be automatically sent to the PhilaVax when the immunization record is saved (via the **Next Account** button) in the Immunization sub-tab of Clinical tab in Practice Manager, or when a chart note is saved or closed in the Clinical application.
- **Meaningful Use Dashboard – CQM Reporting** – The CQM Reporting dialog, accessed by clicking the **CQM Reporting** button in the Meaningful Use Dashboard dialog, has been updated with a **Select Patient** button that allows you to generate the file for a single patient, if applicable. See Figure 3. When the Select Patient button is clicked, a Patient Selection dialog will appear, allowing you to search for and select a specific patient. See Figure 4. When a patient is selected, the file will be created using the applicable data for that specific patient.

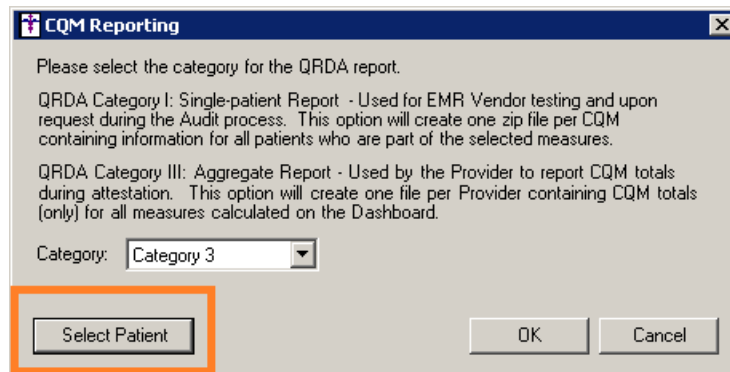


Figure 3 – CQM Reporting

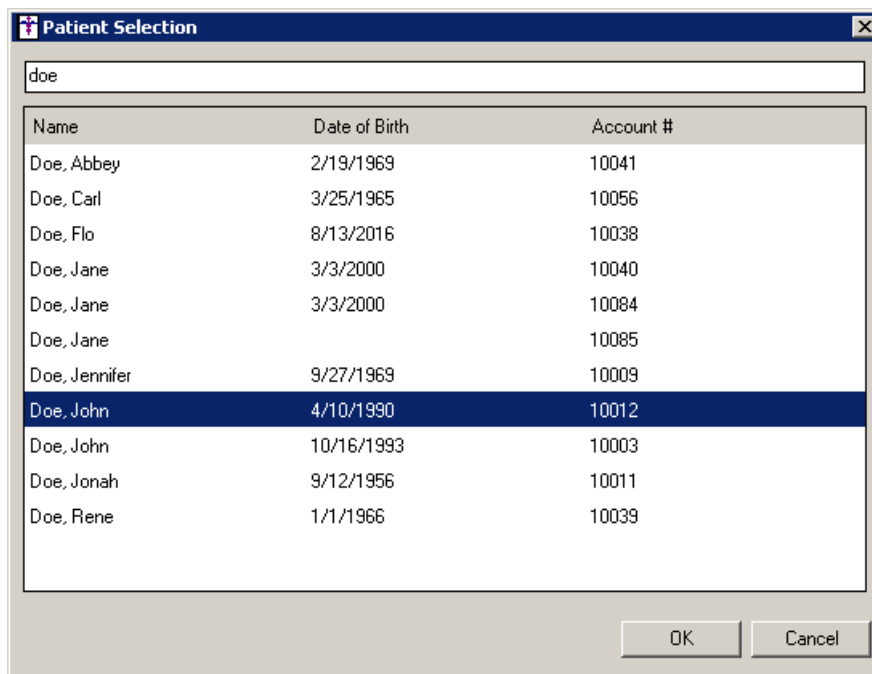


Figure 4 – Patient Selection

Added Features (continued)

- **Medication – Prescribe Medication – PDMP Report** – The Prescribe Medication dialog has been updated with a **PDMP Report** button that allows access to PDMP Report dialog which will display any applicable prescription history data for the patient, thereby allowing you to make more informed decisions when prescribing medications (specifically controlled substances) for that patient. See Figure 5. The PDMP (Prescription Drug Monitoring Program) Report can also be accessed, when in the patient's chart, via **Chart > PDMP Report**. The PDMP Report data is only accessible for those practices and physicians that have been enabled for PDMP (see the **System Tables – Prescribing – PDMP Setup** entry below for further details).

NOTE

Prior to using these new features in Clinical, you must first complete the Appriss Health EHR Integration Sign-Up to integrate with your state PDMP. You will then need to submit an enrollment via our website to activate this feature in the ChartMaker® Medical Suite. See the Prescription Drug Monitoring Program (PDMP) Enrollment page on our website for further details on enrolling for PDMP: <http://sticomputer.com/pdmp-enrollment/>.

Once activated and enabled, when the PDMP Report dialog is accessed, either via the **PDMP Report** button or **Chart > PDMP Report**, the applicable report will be displayed, or any messages or warnings that prevented the report in part, or in whole, from displaying, or both messages and the report.

Prescribe Medication

(Schedule II) oxyCODONE-acetaminophen 5 mg-325 mg tablet (Rx, Generic)

PDMP Report Medication History Consent: Yes Medication Eligibility MedicationHistory

Prescription

Route oral

oxyCODONE-acetaminophen 5 mg-325 mg tz

Action Take

Dose 2 Dose Calculator

Dose Units tablet

Frequency As Needed

Dispense 90 Tablet

Add'l SIG Edit...

Refills 0 Substitution OK

Days Supply 45 Max Dose

Notes to Pharmacist Do not include clinical information in this field

Clear

Formulary

Current Drug Selection

Payer	Medication	Status	Coverage	Copay	Copay Info
-----	oxycodone-acetaminophen	Unknown	N/A	N/A	

Drug Alternatives (* = Payer Specified)

Payer	Medication	Status	Coverage	Copay	Copay Info
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Payer

Transmission E-Prescribe Diagnosis

Administered during visit

Print patient prescription savings materials

Initial order created outside of Clinical

ePA status pending... Override?

Cancel Back Next

SIG Take 2 tablet orally As Needed

Started 8/24/2018

Ended 8/24/2018

Earliest Fill Date 8/24/2018

Figure 5 – Prescribe Medication

Added Features (continued)

- **MIPS Dashboard – Quality** – The Generate File for Submission dialog, accessed by clicking the **Generate File for Submission** button in the Quality Measures dialog, has been updated with a **Select Patient** button that allows you to generate the file for a single patient, if applicable. See Figure 6. When the Select Patient button is clicked, a Patient Selection dialog will appear, allowing you to search for and select a specific patient. See Figure 7. When a patient is selected, the file will be created using the applicable data for that specific patient.

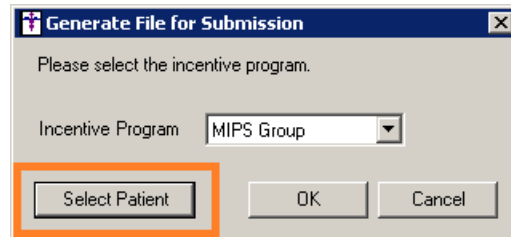


Figure 6 – Generate File for Submission

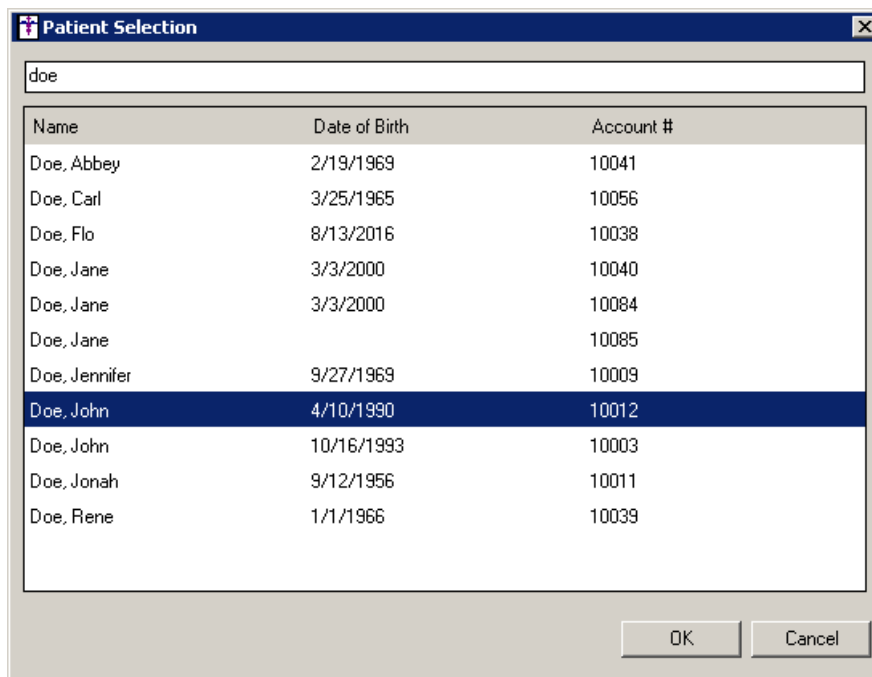
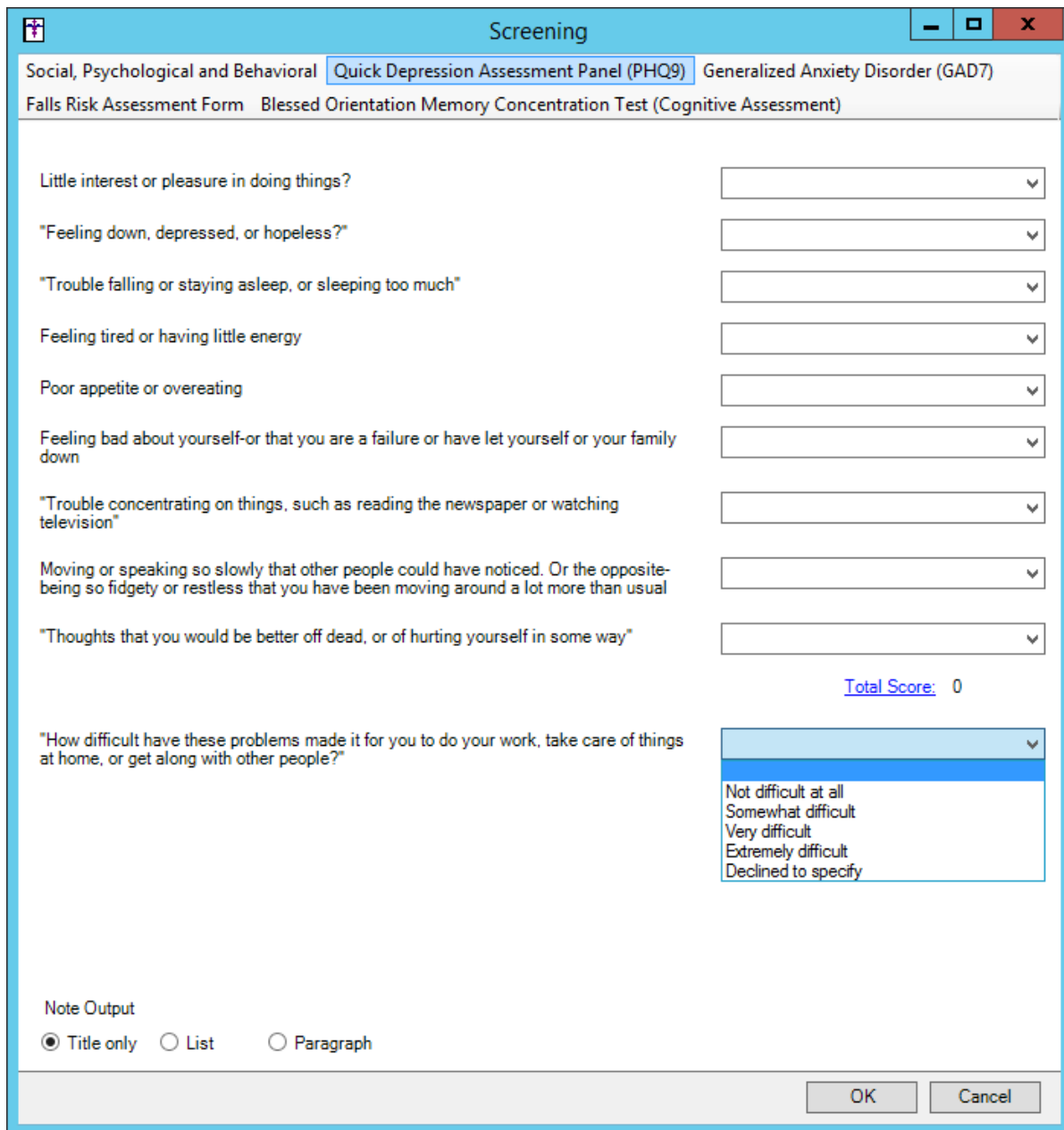


Figure 7 – Patient Selection

- **The Note Tab – Diagnosis** – The **ICD10 Code Set** field, in the ICD10 Search and Crosswalk areas of the Diagnosis Search dialog, has been updated with an **October 1, 2018 – Sept 30, 2019** code set when searching for diagnosis codes or using the crosswalk functionality. You can toggle between the Oct 1, 2014 – Sept 30, 2016 code set, the Oct 1, 2016 – Sept 30, 2017 code set, the Oct 1, 2017 – Sept 30, 2018 code set, and All ICD10 Codes, in addition to this new code set. This allows you to easily search for the applicable ICD10 codes that are active, as outlined by the CDC, for the applicable date ranges. When accessing the Diagnosis Search dialog when adding or editing a diagnosis in the chart note, the system will default to the code set based on the **Note Date** to ensure that the proper ICD codes for that date are selected.

Added Features (continued)

- **The Note Tab – Screening – Quick Depression Assessment Panel (PHQ9)** – The options in the drop-down for the last question in the Quick Depression Assessment Panel (PHQ9) screening, “How difficult have these problems made it for you to...”, have been updated to reflect the latest options for this screening: **Not difficult at all**, **Somewhat difficult**, **Very difficult**, **Extremely difficult**, and **Declined to specify**. See Figure 8.



The screenshot shows a software window titled "Screening" with a tab for "Quick Depression Assessment Panel (PHQ9)". The window contains a list of nine screening questions, each with a corresponding dropdown menu. The questions are:

- Little interest or pleasure in doing things?
- "Feeling down, depressed, or hopeless?"
- "Trouble falling or staying asleep, or sleeping too much"
- Feeling tired or having little energy
- Poor appetite or overeating
- Feeling bad about yourself-or that you are a failure or have let yourself or your family down
- "Trouble concentrating on things, such as reading the newspaper or watching television"
- Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual
- "Thoughts that you would be better off dead, or of hurting yourself in some way"

Below the questions, the "Total Score" is displayed as 0. The final question, "How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?", has its dropdown menu open, showing the following options:

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult
- Declined to specify

At the bottom of the window, there are radio buttons for "Note Output" with options: Title only, List, and Paragraph. "OK" and "Cancel" buttons are also present.

Figure 8 – Screening – Quick Depression Assessment Panel (PHQ9)

- **System Tables – Diagnosis Search** – The **ICD10 Code Set** field, in the ICD10 Search and Crosswalk areas of the Diagnosis Search dialog, has been updated with an **October 1, 2018 – Sept 30, 2019** code set when searching for diagnosis codes or using the crosswalk functionality. You can toggle between the Oct 1, 2014 – Sept 30, 2016 code set, the Oct 1, 2016 – Sept 30, 2017 code set, the Oct 1, 2017 – Sept 30, 2018 code set, and All ICD10 Codes, in addition to this new code set. This allows you to easily search for the applicable ICD10 codes that are active, as outlined by the CDC, for the applicable date ranges. When accessing the Diagnosis Search dialog via the **Edit > System Tables** menu, the system will default to the code set based on the current day's date.

Added Features (continued)

- **System Tables – Mobile – Mobile Administration** – The **Audit** tab, in the Mobile Administration dialog, has been updated to track when hospitalization record is added or modified in the Rounding List of ChartMaker® Mobile. See Figure 9. When an audit event occurs, the Activity Type column will display **Modify Patient**, and the Additional Info column will display **Hospitalization added from rounding list screen...**

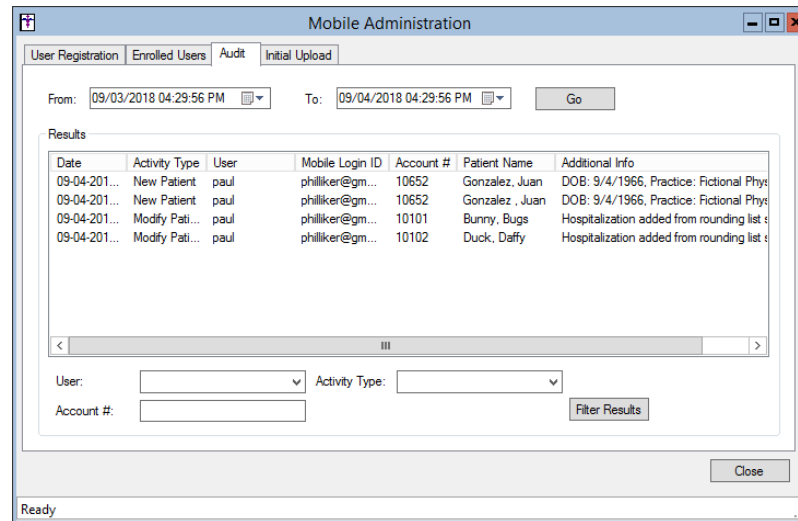


Figure 9 – Mobile Administration – Audit

- **System Tables – Prescribing – PDMP Setup** – The **Prescribing** submenu (**Edit > System Tables > Prescribing**) has been updated with a **PDMP Setup** option that allows access to the PDMP Setup dialog where you can enter, edit, and remove credentials for practices to enable or disable them for PDMP; as well as configure applicable roles for providers within those practices. Each applicable practice and provider will need this information configured in the PDMP Setup dialog, prior to accessing PDMP reports. See Figure 10.

NOTE

Prior to using these new features in Clinical, you must first complete the Appriss Health EHR Integration Sign-Up to integrate with your state PDMP. You will then need to submit an enrollment via our website to activate this feature in the ChartMaker® Medical Suite. See the Prescription Drug Monitoring Program (PDMP) Enrollment page on our website for further details on enrolling for PDMP: <http://sticomputer.com/pdmp-enrollment/>.

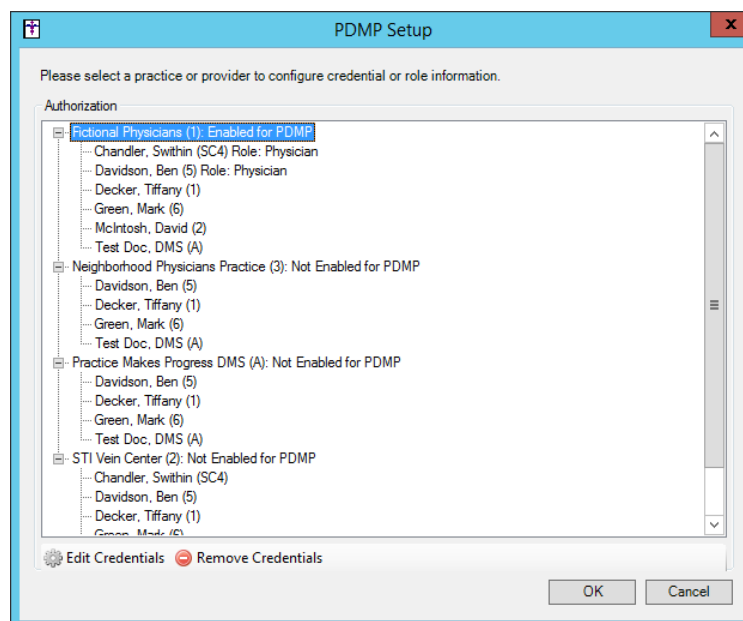
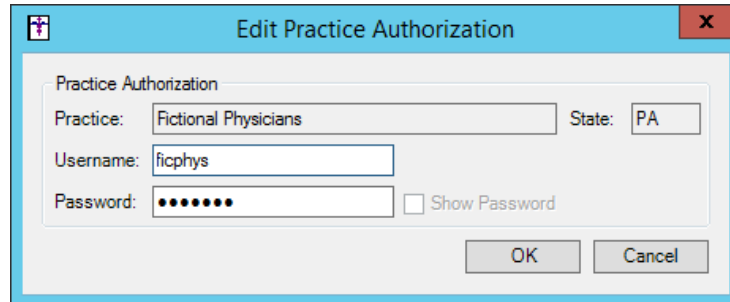


Figure 10 – PDMP Setup

Added Features (continued)

System Tables – Prescribing – PDMP Setup (continued)

To edit the credentials for a practice, simply highlight the applicable practice in the Authorization list, and then click the **Edit Credentials** button. In the Edit Practice Authorization dialog, you enter the applicable **Username** and **Password** in the corresponding fields, and then click the **OK** button. See Figure 11. Credentials can be removed for a practice by highlighting the applicable practice in the PDMP Setup dialog, and then clicking the **Remove Credentials** button.

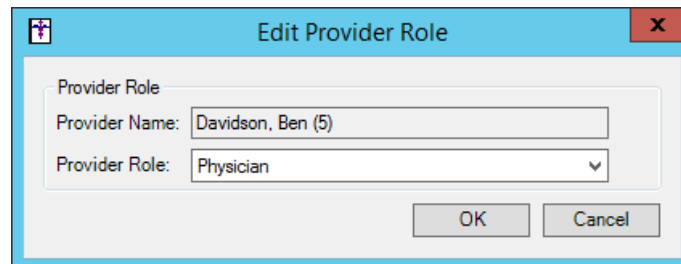


The screenshot shows a dialog box titled "Edit Practice Authorization". It contains the following fields and controls:

- Practice:** Fictional Physicians
- State:** PA
- Username:** ficphys
- Password:** A field with seven dots, followed by a checkbox labeled "Show Password".
- Buttons:** OK and Cancel.

Figure 11 – Edit Practice Authorization

After the credentials have been entered for a practice, you can assign roles to the various providers within that practice by highlighting the applicable provider, and then clicking the **Edit Role** button. In the Edit Provider Role dialog, you can select the applicable **Provider Role** in the corresponding drop-down list, and then click the **OK** button. See Figure 12. Roles can be removed for a provider by highlighting the applicable provider in the PDMP Setup dialog, and then clicking the **Remove Role** button.



The screenshot shows a dialog box titled "Edit Provider Role". It contains the following fields and controls:

- Provider Name:** Davidson, Ben (5)
- Provider Role:** A drop-down menu currently showing "Physician".
- Buttons:** OK and Cancel.

Figure 12 – Edit Provider Role

Addendum

SureScripts® E-Prescribing Best Practice Guidelines

Below are best practices that have been developed to assist in the construction of complete, non-contradictory, and clear patient directions:

Ensure that Directions are complete and accurate

- All information in the Sig must be accurate, complete, and include all the required components written in the following order: action, dose, dose units, route, frequency, and finally auxiliary information.
 - The exception to this syntax is Sigs which simply state "Take/Use as Directed/Instructed as per manufacturer labeling."
- Information within the Sig must not conflict with itself

Example: Use **"Take 1 tablet by mouth daily"** instead of just **"Daily."**

Always qualify "...as Directed" with a source

- Statements such as "Take as directed" and "Use as instructed" should only be used when followed by a source that clearly dictates to the patient where or from whom they can obtain the specific directions.
- If a Sig builder tool is used, ensure that prescribers enter the specific source of the instruction after selecting the "Take/Use as directed/instructed" option before they can proceed with finalizing the e-prescription.

Example: Use **"Use as instructed per instructions on package"** instead of **"Use as instructed."**

Always qualify "PRN (as needed)" with an indication

- The use of "PRN" (i.e. "as needed") should only be used in conjunction with an indication.
- For all other non-PRN directions, inclusion of an indication is also recommended; alternatively, there is also a designated structured field for Diagnosis, in which ICD-10 codes may be used to communicate the appropriate diagnosis or indication relevant for the prescribed product
- If a Sig builder tool is used, ensure that the Sig builder tool requires prescribers to enter the specific indication or conditions for PRN use if the prescriber selects a "PRN" frequency

Example: Use **"Take 1 tablet by mouth every 4 hours as needed for mild to moderate pain"** instead of **"Take 1 tablet by mouth every 4 hours as needed."**

Always specify the Duration of Therapy for Acute Treatments

- Duration of therapy should **only** be specified for medications for acute treatments with a defined length of therapy, e.g., antibiotics.

Avoid Abbreviations, Acronyms or Symbols

- ISMP (Institute for Safe Medication Practices) provides the complete list of *Error-Prone Abbreviations, Symbols, and Dose Designations* that should never be used in a prescription
- If the use of Latin abbreviations is desired, the system should include the ability to expand Latin abbreviations into plain English text via keystroke accelerators. The expanded text form of the Sig should be displayed to the prescriber to ensure correct transition from abbreviations to full text

Example: Use **"Instill 1 drop into both eyes once daily"** instead of **"1 gtt ou qd."**

Never Truncate or Split Directions between multiple fields

- If the patient directions are being transmitted exceeds the 140-character limit, it should be communicated by other means, e.g. as a fax or printed handout
- Sig information should **not** be written into the Notes field if it exceeds the 140-character limit.

Send only Patient Directions (Sig) within the Directions field

- The Sig should not contain information for which another designated field exists in the SCRIPT standard (e.g. the Sig should never include the quantity, drug name, NDC or RxCUI values, or Notes to pharmacists, etc.)

Example: Use **"Take 1 tablet by mouth once daily"** instead of **"Take 1 tablet by mouth once daily. Dispense #30, 3 Refills, Thank you."**

Do not include Clinical or Prescription Information in the Notes field.

- The Notes field be used to contain information related to, but not part of the prescription. While clinical and prescription information should appear in the designated fields for these data elements, not in the Notes field.

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category II—Prescription Data Elements Requiring Extra Care and Attention When Input.

- (1) Guidelines that apply to name, strength, dosage form, and quantity of drug prescribed as well as the directions for use (the "Sig")
- Drug names should be spelled out in full, avoiding the use of abbreviations.
 - While it might be possible to make the case that abbreviations save time in the world of paper prescriptions, no such time savings accrue in the electronic world in which the prescriber simply picks a medication from a drug database.
 - Abbreviations can lead to a misinterpretation of the prescriber's intent, which can result in medication errors.
 - Examples:
 - Use "Hydrochlorothiazide 50 mg" instead of "HCTZ 50 mg."
 - Use "Zidovudine 300 mg" instead of "AZT 300 mg."
 - Drug descriptions should include complete name, strength, strength units and dosage form information (if applicable) in the same exact order, and all should appear in one drug description field.
 - Not doing so causes problems in pharmacies due to missing data components.
 - It is preferred that either the generic or the brand name be used in the drug description, but not both. Using both unnecessarily complicates the information in the drug description field.
 - Examples:
 - Use "Doxycycline Monohydrate 50 mg oral capsule" instead of "Doxycycline caps."
 - Use "Ciprofloxacin 500 mg tablet" instead of "Ciprofloxacin tablet 500 mg."
 - Use "Atorvastatin calcium 20 mg tablet" or "Lipitor 20 mg tablet" instead of "Lipitor (Atorvastatin calcium) 20 mg tablet."
 - Drug descriptions for generic products should use the naming conventions found in the Food and Drug Administration's "Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations."
 - This helps pharmacists to accurately choose the product to be dispensed when brand names are not used.
 - Examples:
 - Use "Glipizide 10mg tablets, extended release" instead of "Glipizide TAB OSM 24 10mg."
 - Drug strength information should be consistent across all fields in which it appears.
 - The strength in the drug description should match that in the drug strength field.
 - Drug strength units in the drug description should match those in the drug strength units field. Drug strength units should not be sent in the drug strength field.
 - Example of improper use: The drug description is "Amoxicillin 500 mg oral capsule" and the drug strength field contains the value of "250."
 - Dosage form codes should match the forms sent in drug description fields.
 - Example of improper use: The drug description is Amoxicillin 500 mg capsule and the dosage form code field contains "10," which is the NCPDP code that stands for tablet.
 - All orders should be written using metric measurements of weight (e.g., mg, gm and kg) and volume (e.g., ml).
 - The apothecary and avoirdupois systems of weights and volumes are no longer considered appropriate in the world of pharmaceuticals.
 - Example: Use "Aspirin 81 mg" instead of "Aspirin 1 ¼ grains."
 - A zero should be used before a decimal (use 0.X mg instead of .X mg), but not after (use X mg instead of X.0 mg).
 - Trailing zeros are particularly dangerous in that they can lead to ten-fold overdoses. Thus, trailing zeros should never be used.
 - Examples:
 - Use "Digoxin 0.25 mg" instead of "Digoxin .25 mg."
 - Use "Haloperidol 5 mg" instead of "Haloperidol 5.0 mg."
 - Arabic (decimal) numerals are preferable to Roman numerals, and in some instances it is preferable for numbers to be spelled out.
 - Example: Use "Aspirin 325 mg" instead of "Aspirin V grains."
 - Other specific abbreviation issues:
 - The term "microgram" can be abbreviated as "mcg," but it should not be abbreviated as "ug," which can easily be mistaken for the abbreviation for "mg," standing for "milligram."
 - The word "unit" should be spelled out and never abbreviated as "U" or "u."
 - "M" should not be used as an abbreviation for thousands (e.g., 5 M units), as it has been mistaken as meaning one million.
 - Do not use commas when expressing thousands as they might be misinterpreted as periods.

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category II—Prescription Data Elements Requiring Extra Care and Attention When Input. (Continued)

(2) Issues related specifically to the Sig field or directions for use.

- The directions for use should not be split between the Sig and Notes fields.
 - Depending upon the design of the pharmacy system and/or the effectiveness of the training of pharmacy personnel, splitting directions between the Sig and Notes fields can result in part of the directions being missed, thereby preventing complete directions from being conveyed to patients. Patients may experience significant negative therapeutic outcomes when this occurs.
 - Examples of improper use:
 - Sig field—"Take one tablet daily," Notes field—"Take only on Monday, Wednesday and Friday." NOTE: This is an actual example from a warfarin e-prescription, which if not taken according to the complete directions, could possibly result in serious patient harm.
 - Sig field—"Dissolve one tablet under the tongue every 10 minutes for chest pain," Notes field—"Call physician immediately if relief is not obtained after three doses."
 - Sig field—"Apply and rub well into affected area twice a day," Notes field—"Discontinue use and call physician if rash worsens."
 - Sig field—"One drop to eye having surgery three times daily," Notes field—"Start two days prior to surgery."
- Information in the Sig field should not conflict with information in the Notes field.
 - Conflicting information in these fields usually requires pharmacists to contact prescribers to ascertain their actual intent with respect to the directions, which compromises the efficiencies related to e-prescribing.
 - Inconsistent information in the Sig versus the Notes fields can result in incorrect directions being conveyed to patients.
 - Example of improper use: Sig field—"1 cap orally 3 times a day", Notes field—"One capsule by mouth daily."
- Care must be taken so that Sigs are not truncated because important information can be lost.
 - Example of improper use: "Take 1 tablet once a month in the am 1 hr before eating or drinking, with 1 C water. Remain upright x 1 hour and nothing by mouth, then resu"
- Sig information should be clinically correct.
 - Example: Use "Amoxicillin 500 mg Oral Capsules"—Sig "One capsule three times a day" instead of "500 caps 3 times a day."
- Directions for use should be spelled out clearly in proper English.
 - Since the pharmacist must interpret—and nearly always writes—the label in English, the use of abbreviations (particularly Latin) or symbols is unnecessary and discouraged because it can lead to medication errors.
 - Example: Use "Take 1 tablet by mouth twice a day" instead of "1 T PO BID."
- Information in the Sig field should be limited to the Sig.
 - Quantity to be dispensed should not be placed in the Sig field.
 - Example: Use "One capsule by mouth three times daily" instead of "One capsule by mouth three times daily – Disp # 30."
 - Duration of therapy should not be placed in the Sig field.
 - Example: Use "One capsule by mouth four times daily" instead of "One four times daily – Disp 10 day supply."
 - Drug description should not be placed in Sig field.
 - Example: Use "One capsule by mouth at bedtime" instead of "One by mouth at bedtime– Paxil CR 20 mg."
 - Example of improper use:
 - "One drop to eye having surgery three times daily. Start two days prior to surgery. May substitute Acular LS, Xibrom, or Voltaren if less expensive." (i.e., the indication of alternative approved drugs "May substitute Acular LS, Xibrom, or Voltaren if less expensive" should be placed in the Notes field.)
- Sigs should be complete, properly formatted, and not repeated.
 - Sig should be complete.
 - Example: Use "Apply topically to forearm three times a day" instead of "Topical each day."
 - Sig should be properly formatted.
 - Example: Use "Take one capsule three times a day" instead of "1 3 times a day."
 - Sig should not be repeated.
 - Example: Use "Take one capsule daily" instead of "1 PO QD – Take one tablet every day."
- The inclusion of the intended use or the indication for the medication in the directions for use is helpful to patients, pharmacists and other prescribers, and is strongly encouraged.
 - Intended use can help patients to organize and better understand their medications and why they are taking them.
 - Including the indication in the Sig field can help prevent dispensing errors, and it provides pharmacists with a foundation for patient counseling and medication therapy management.
 - Other prescribers may find the indication helpful when a patient brings their medication bottles with them to office visits.
 - Example: "Take according to instructions in dosepack for poison ivy rash."

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category II—Prescription Data Elements Requiring Extra Care and Attention When Input. (Continued)

- The instruction “take as directed” is rarely appropriate and should be avoided by prescribers.
 - Such an instruction assumes an understanding on the part of the patient that may not exist, and even if it does, will very likely be short lived.
 - Using the term “take as directed” provides little information upon which the pharmacist can base their counseling of the patient.

(3) Proper use of the Notes field (referred to as “free text” in the NCPDP SCRIPT Standard).

- Prescription information that has a designated, standardized data field should not be placed in the Notes field.
 - For example, neither the drug name, strength nor quantity should be placed in the Notes field because there are specific fields in the NCPDP SCRIPT Standard for these data elements. This is important because if this information isn’t placed in the fields in which pharmacy personnel are trained to look for it, it might be missed.
- Clinical information that has a designated, standardized data field should not be placed in the Notes field.
 - As with prescription information, the clinical information should appear in the designated fields for these data elements. This is important because if this information isn’t placed in the fields in which pharmacy personnel are trained to look for it, it might be missed.
- Reserve use of the Notes field for information related to, but not part of, the prescription.
 - For example, a comment such as: “Please have the patient call the office when they have finished taking this prescription” would be an appropriate use of the Notes field.
- To reiterate, as mentioned above, the directions for use should not be split between the Sig and Notes fields nor should the information in the Sig field conflict with information in the Notes Field.
 - The former can lead to critical information being missed by pharmacy personnel and possibly not being transmitted to the patient, and the latter normally requires pharmacists to contact the prescriber to clarify their intent, thereby compromising the potential efficiencies of e-prescribing.

(4) Refills authorized, if any

- Although allowed both by convention and NCPDP SCRIPT, the indication of “PRN” (refill as needed) is not considered to be good practice and should be discouraged.
 - Example: Use “Refill 11 times” instead of “Refill PRN.”

(5) Other items unique to electronic prescribing.

- Representative NDC number requirements.
 - Representative NDC numbers, which contain 11 digits, must be correct, as incorrect representative NDC numbers may cause drug identification problems in the receiving pharmacies.
 - Representative NDC numbers must be current and included in e-prescription messages unless the items do not have assigned NDCs.
- Quantity Qualifiers must be correctly associated with drug descriptions.
 - Correct mapping procedures are available in the Units of Measure table, which can be found in the NCPDP External Code List and the Surescripts Implementation Guides.
 - Where possible, quantities should reflect the actual metric quantity to be dispensed.
 - Example: Use “Amoxicillin 250mg/5ml, 150 ml” instead of “Amoxicillin 250mg/5ml, 1 bottle.”
 - The use of “ZZ”, “EA” and “00” should be limited to instances in which none of the available qualifiers in the Units of Measure table can be applied.
 - Examples of improper use: Drug description—Amoxicillin 500 mg Oral Capsule, Quantity 30 and Quantity Qualifier sent “ZZ”—mutually defined, “EA”—each or “00”—unspecified instead of “AV”—capsules.

Category III—Prescription Common Mistakes

Even though providers using the ChartMaker Medical Suite strive to be accurate in entering information for E-prescription, there are common mistakes made that can easily be corrected. Please read through the examples below in order to understand E-prescription best practices.

(1) Incorrect or incorrectly formatted SIG

This occurs when the appropriate dose is entered incorrectly. The following examples demonstrate typical errors:

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category III—Prescription Common Mistakes (continued)

Drug Description	SIG	Notes	Nomenclature Description	Comment
Combivent Respimat 20 mcg-100 mcg/actuation Aerosol Inhaler	Spray 1 aerosol with adapter (gram) puff(s) 4 times a day		Incorrect or incorrectly formatted SIG	"1 aerosol" is not an appropriate dose for Combivent
Advair HFA 115 mcg-21 mcg/actuation Aerosol Inhaler	Take 2 aerosol with adapter (gram) puff(s) twice a day		Incorrect or incorrectly formatted SIG	"2 aerosol" is not an appropriate dose for Advair HFA
ProAir HFA 90 mcg/actuation Aerosol Inhaler	Take 2 puffs puff(s) q 4-6 hrs prn cough or wheeze or before exercise		Incorrect or incorrectly formatted SIG	Part of the patient instructions are duplicated
Proctosol HC 2.5 % Rectal Cream	Apply 1 cream (gram) rectally 4 times a day		Incorrect or incorrectly formatted SIG	"1 cream" is not an appropriate dose for Proctosol
dicyclomine 10 mg capsule	Take 1 capsule (hard, soft, etc.) orally Three times a day	prn as directed	Incorrect or incorrectly formatted SIG	SIG should be free of all extraneous characters All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
Lotrel 5 mg-10 mg capsule	Take 1 capsule (hard, soft, etc.) orally Daily	Name Brand Medically Nec.	Incorrect or incorrectly formatted SIG; Conflicting or Supplementary Drug Substitution information in the Notes	SIG should be free of all extraneous characters All Drug Substitution information should be sent in its designated field; No parts of the Drug Substitution information should be in the Notes
Suprax 400 mg capsule	Take 1 capsule (hard, soft, etc.) orally qd		Incorrect or incorrectly formatted SIG; Incorrect, Missing or Incomplete Dosage Form sent in Drug Description	SIG should be free of all extraneous characters - Suprax 400mg is not available in capsule form; Appropriate dosage form: Oral Tablet

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category III—Prescription Common Mistakes (continued)

(2) Incomplete SIG

The following examples indicate incomplete SIG:

Drug Description	SIG	Comment
Suprep 17.5 gram-3.13 gram-1.6 gram Oral Solution	Take 1 solution, reconstituted, oral orally As Needed	SIG should include the dose, route and frequency of the prescribed medication
Coumadin 4 mg tablet	Take 2 tablet orally as directed	SIG should include the dose, route and frequency of the prescribed medication
Zithromax Z-Pak 250 mg tablet	Take 1 tablet orally As Directed	SIG should include the dose, route and frequency of the prescribed medication

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category III—Prescription Common Mistakes (continued)

(3) Conflicting or Supplementary SIG information included in the Notes

Drug Description	SIG	Notes	Comment
nystatin 100,000 unit/gram Ointment Topical	Apply 1 ointment (gram) topically Twice a day	FOR CORNER OF LIP	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
metformin 500 mg tablet	Take 1 TABLET orally bid	*take 1 tablet daily for 1 month, then increase to 1 tablet twice a day	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
Augmentin 875 mg-125 mg tablet	Take 1 tablet orally Every 12 hours	x 5 days	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
Mobic 7.5 mg tablet	Take 1 tablet orally twice a day	as needed	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes

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ChartMaker® Mobile Release Notes

ChartMaker® 2018 (fv6.3.2 R1) (Deployed 08/30/2018)

ChartMaker Mobile 6.3.2 R1 Enhancements

Patient

- **New Patient** – The New Patient screen (accessed by tapping  in the Patient Search screen) has been updated with a **Hospitalization** section, that allows you to enter a hospitalization record for the new patient, if needed. See Figure 1 and 2. When entering a new patient in the New Patient screen accessed via the **Patient > Patient Search** screen, the hospitalization section will default closed and is optional, but the Admission Date and Facility will toggle to become required if any information is entered in any of the fields in the Hospitalization section. Likewise, when any hospitalization information is entered, it will appear with the new patient summary that allows you to confirm or cancel the new patient information.

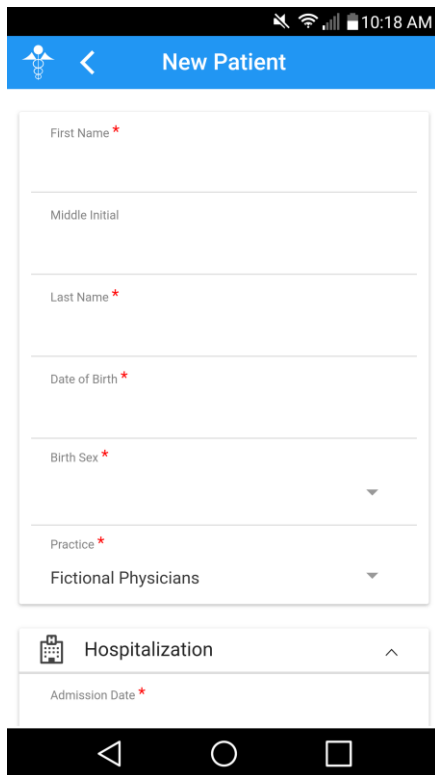


Figure 1 – Patient – Patient Search – New Patient

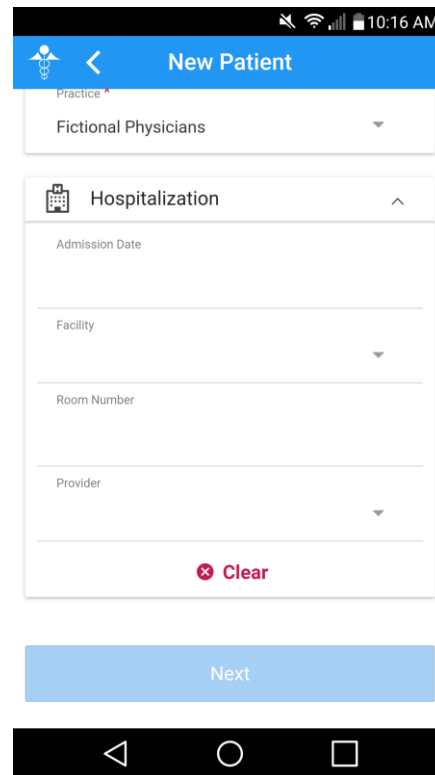




Figure 2 – Patient – Patient Search – New Patient

Rounds

- Rounding List – Add Hospitalization Record** – The Rounding List screen has been updated with a  icon in upper-right of the title bar, that allows you access to the Patient Search screen so you can add a new hospitalization record for an existing patient, or add a hospitalization record for a new patient via the by tapping  button. See Figure 3 and 4.

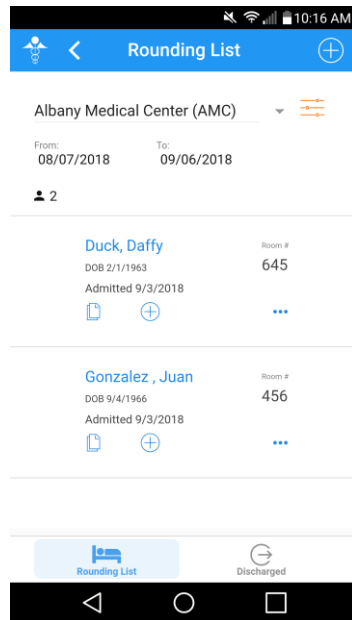


Figure 3 – Rounding List

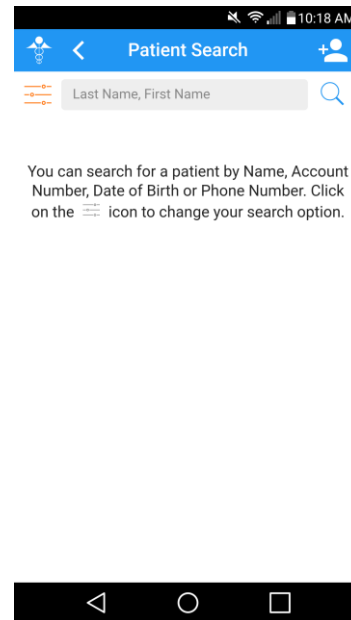


Figure 4 – Patient Search


To add a hospitalization record for an existing patient, enter the applicable name search criteria in the corresponding field, and then tap the  icon. Once the applicable patient is located, tap that patient to access the Hospitalization screen. See Figure 5 and 6. In the Hospitalization screen, you can enter or select the applicable **Practice, Case, Admission Date, Facility, Room Number, and Provider**, and then tap the **Save** button. The Practice, Case, Admission Date, and Facility are required before you can save the hospitalization record. If the patient is only in one practice, that practice will default, and if the patient has only one case, that case will default. After the applicable information has been configured and saved, the patient will appear in the Rounding List.



Figure 5 – Patient Search

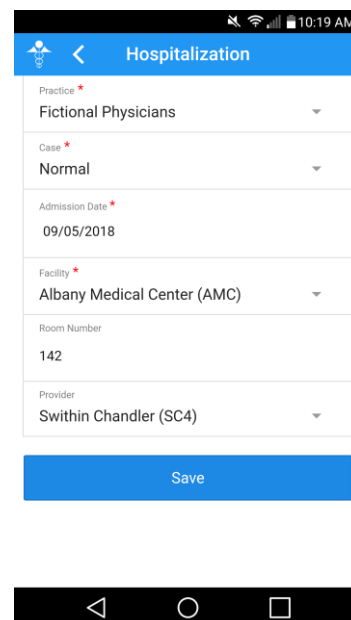

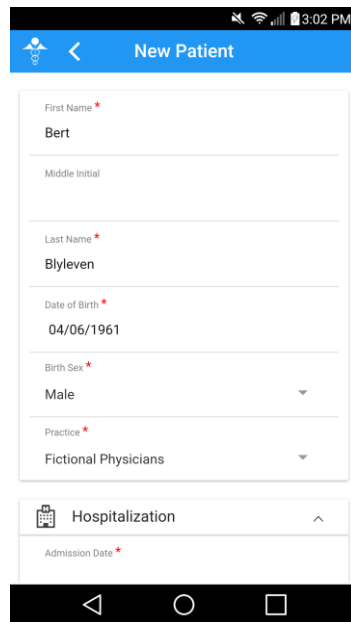


Figure 6 – Hospitalization

Rounds (continued)

Rounding List – Add Hospitalization Record (continued)

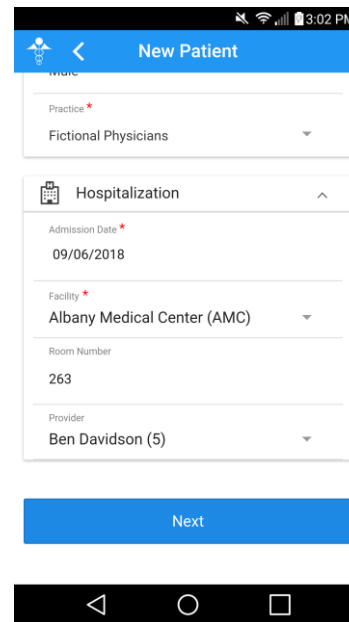
To add a hospitalization record for a new patient, when in the Patient Search screen, tap . See Figure 4. In the New Patient screen, you can enter or select the applicable First Name, Middle Initial, Last Name, Date of Birth, Birth Sex, and Practice; and then in the Hospitalization section, you can enter or select the applicable **Practice, Case, Admission Date, Facility, Room Number, and Provider**, and then tap the **Next** button. See Figure 7 and 8. The First Name, Last Name, Date of Birth, Birth Sex, Practice, Admission Date, and Facility are required before you can continue.



The screenshot shows the 'New Patient' form with the following fields and values:

- First Name: Bert
- Middle Initial: (empty)
- Last Name: Blyleven
- Date of Birth: 04/06/1961
- Birth Sex: Male
- Practice: Fictional Physicians
- Hospitalization section: Admission Date (empty)

Figure 7 – New Patient

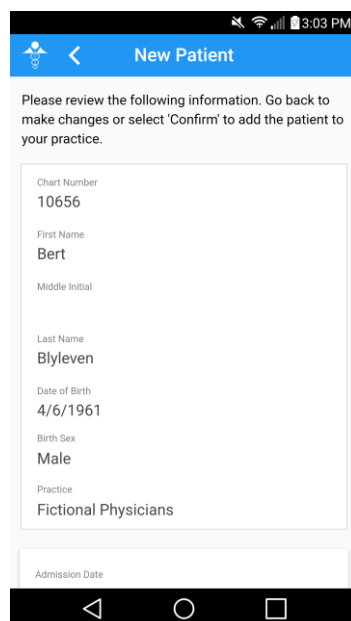


The screenshot shows the 'New Patient' form with the following fields and values:

- Practice: Fictional Physicians
- Hospitalization section:
 - Admission Date: 09/06/2018
 - Facility: Albany Medical Center (AMC)
 - Room Number: 263
 - Provider: Ben Davidson (5)
- Next button: (blue)

Figure 8 – New Patient – Hospitalization

The New Patient screen will provide a summary of the new patient information for you to review and confirm. See Figure 9 and 10. Tap the **Confirm** button to add the new patient and accompanying hospitalization record. After the applicable information has been confirmed, the patient will appear in the Rounding List.

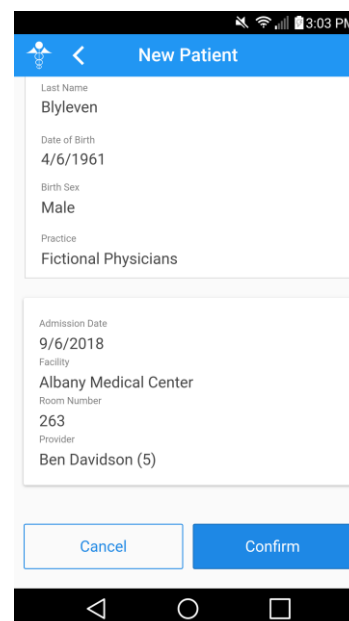


The screenshot shows the 'New Patient' confirm screen with the following information:

Please review the following information. Go back to make changes or select 'Confirm' to add the patient to your practice.

- Chart Number: 10656
- First Name: Bert
- Middle Initial: (empty)
- Last Name: Blyleven
- Date of Birth: 4/6/1961
- Birth Sex: Male
- Practice: Fictional Physicians
- Admission Date: (empty)

Figure 9 – New Patient (Confirm)



The screenshot shows the 'New Patient' confirm screen with the following information:

- Last Name: Blyleven
- Date of Birth: 4/6/1961
- Birth Sex: Male
- Practice: Fictional Physicians
- Admission Date: 9/6/2018
- Facility: Albany Medical Center
- Room Number: 263
- Provider: Ben Davidson (5)
- Buttons: Cancel (blue), Confirm (blue)

Figure 10 – New Patient – Confirm

Rounds (continued)

- **Rounding List – Edit Hospitalization Record** – The Rounding List screen has been updated to allow you to edit a hospitalization record for a patient, thereby offering the ability to maintain their hospital record during their hospitalization through the ChartMaker® Mobile. To edit a hospitalization record for a patient, swipe left to right on the patient you want to edit, and then select **Edit**. See Figure 11. In the Hospitalization screen, you can then add and/or modify the **Admission Date**, **Facility**, **Room Number**, and **Provider** as needed, and when finished, tap the **Save** button. See Figure 12. You will return to the Rounding List and the applicable hospitalization information will be updated for the patient.

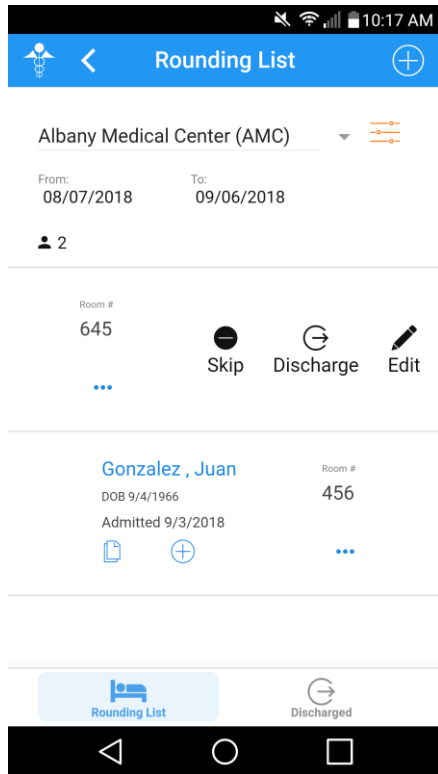


Figure 11 – Rounding List

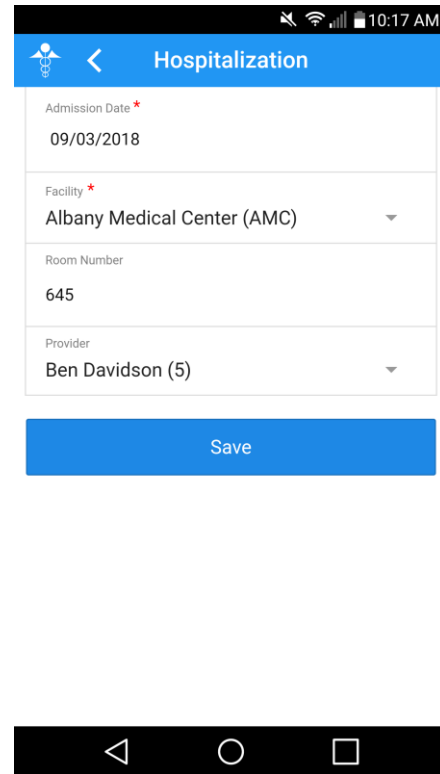


Figure 12 – Hospitalization

ChartMaker® Medical Suite Enhancements for ChartMaker® Mobile 6.3.2

Clinical

- **Audit Trail** – The Audit Trail has been updated to track whenever a hospitalization record is added or modified in Rounding List of ChartMaker® Mobile. When an audit event occurs, the Event column will display **Modified**; the Group column will display **Case**; the Audit Trail Description will display the **Added hospitalization** or **Modified hospitalization**; the Old Value and New Value columns will display the **Room #, Provider, and Facility** as applicable; and the patient’s **Account #, Case Name**; and **Practice ID** will be listed in the Metadata column.
- **System Tables – Mobile – Mobile Administration** – The **Audit** tab, in the Mobile Administration dialog, has been updated to track when hospitalization record is added or modified in the Rounding List of ChartMaker® Mobile See Figure 13. When an audit event occurs, the Activity Type column will display **Modify Patient**, and the Additional Info column will display **Hospitalization added from rounding list screen...**

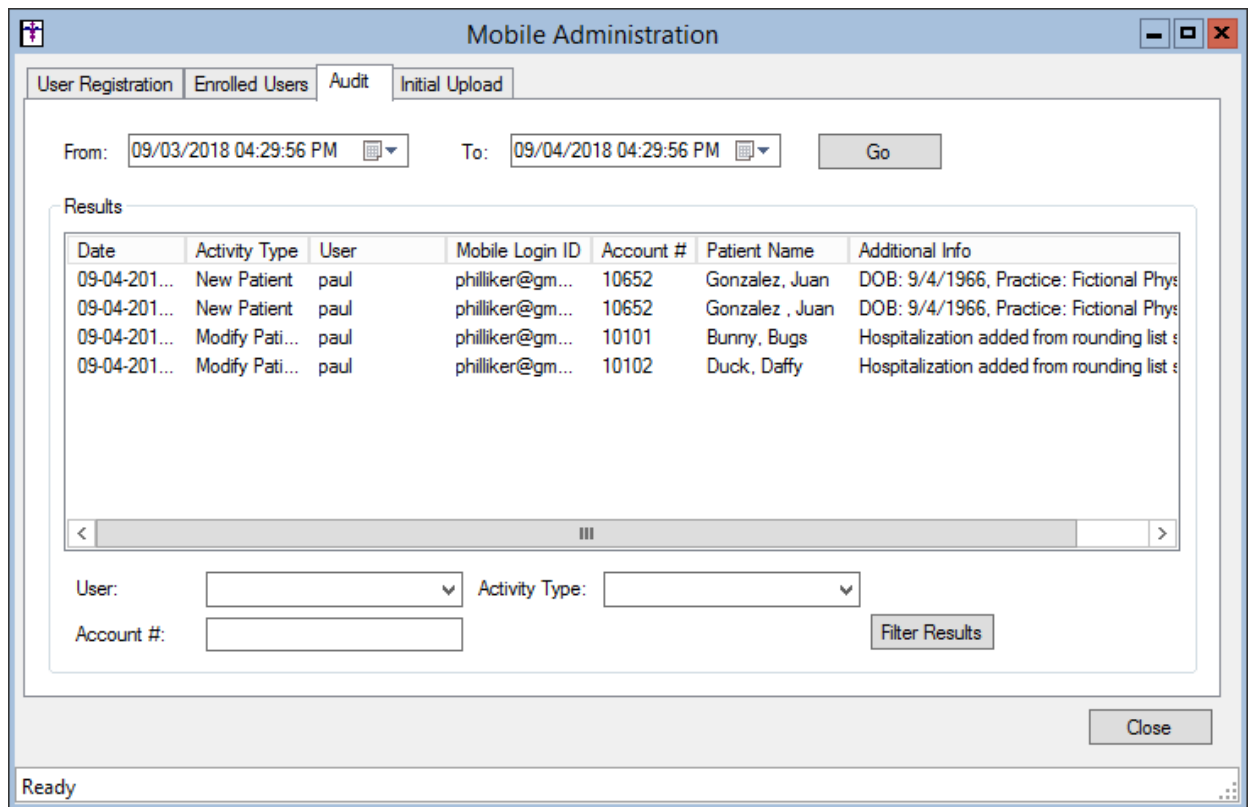


Figure 13 – Mobile Administration – Audit

Practice Manager

- Administration – Mobile – Mobile Administration – Audit** – The **Audit** tab, in the Mobile Administration dialog, has been updated to track when hospitalization record is added or modified in the Rounding List of ChartMaker Mobile. See Figure 14. When an audit event occurs, the Activity Type column will display **Modify Patient**, and the Additional Info column will display **Hospitalization added from rounding list screen...**

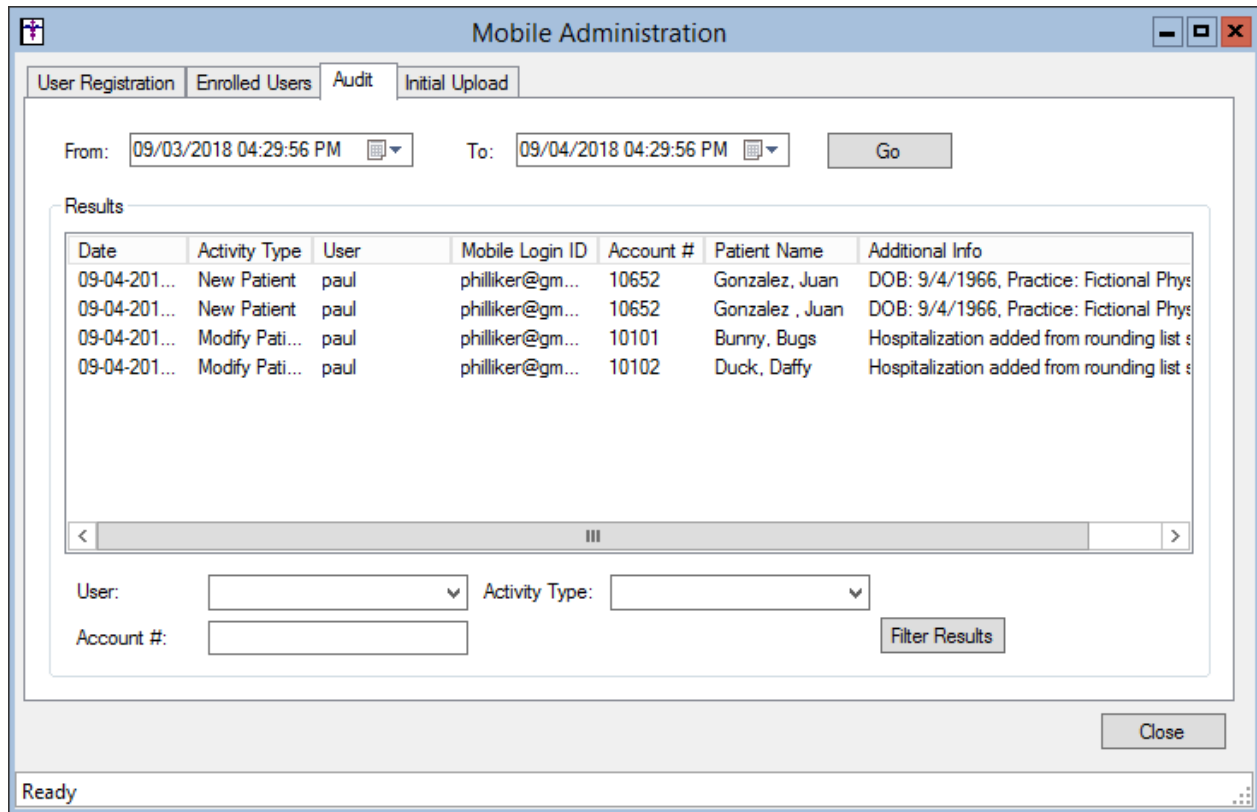


Figure 14 – Mobile Administration – Audit

- Administration – Utilities – Audit – Audit Trail** – The Audit Trail has been updated to track whenever a hospitalization record is added or modified in Rounding List of ChartMaker® Mobile. When an audit event occurs, the Event column will display **Modified**; the Group column will display **Case**; the Audit Trail Description will display the **Added hospitalization** or **Modified hospitalization**; the Old Value and New Value columns will display the **Room #, Provider, and Facility** as applicable; and the patient's **Account #, Case Name**; and **Practice ID** will be listed in the Metadata column.



ChartMaker® Practice Manager Release Notes

ChartMaker® 2018.2 (fv6.3.2)

Administration

- **Administration – Diagnosis Search** – The **ICD10 Code Set** field, in the ICD10 Search and Crosswalk areas of the Diagnosis Search dialog, has been updated with an **October 1, 2018 – Sept 30, 2019** code set when searching for diagnosis codes or using the crosswalk functionality. You can toggle between the Oct 1, 2014 – Sept 30, 2016 code set, the Oct 1, 2016 – Sept 30, 2017 code set, the Oct 1, 2017 – Sept 30, 2018 code set, and All ICD10 Codes, in addition to this new code set. This allows you to easily search for the applicable ICD10 codes that are active, as outlined by the CDC, for the applicable date ranges. When accessing the Diagnosis Search dialog via the **Administration** menu, the system will default to the code set based on the current day's date.
- **Administration – Mobile – Mobile Administration** – The **Audit** tab, in the Mobile Administration dialog, has been updated to track when hospitalization record is added or modified in the Rounding List of ChartMaker Mobile. See Figure 1. When an audit event occurs, the Activity Type column will display **Modify Patient**, and the Additional Info column will display **Hospitalization added from rounding list screen...**

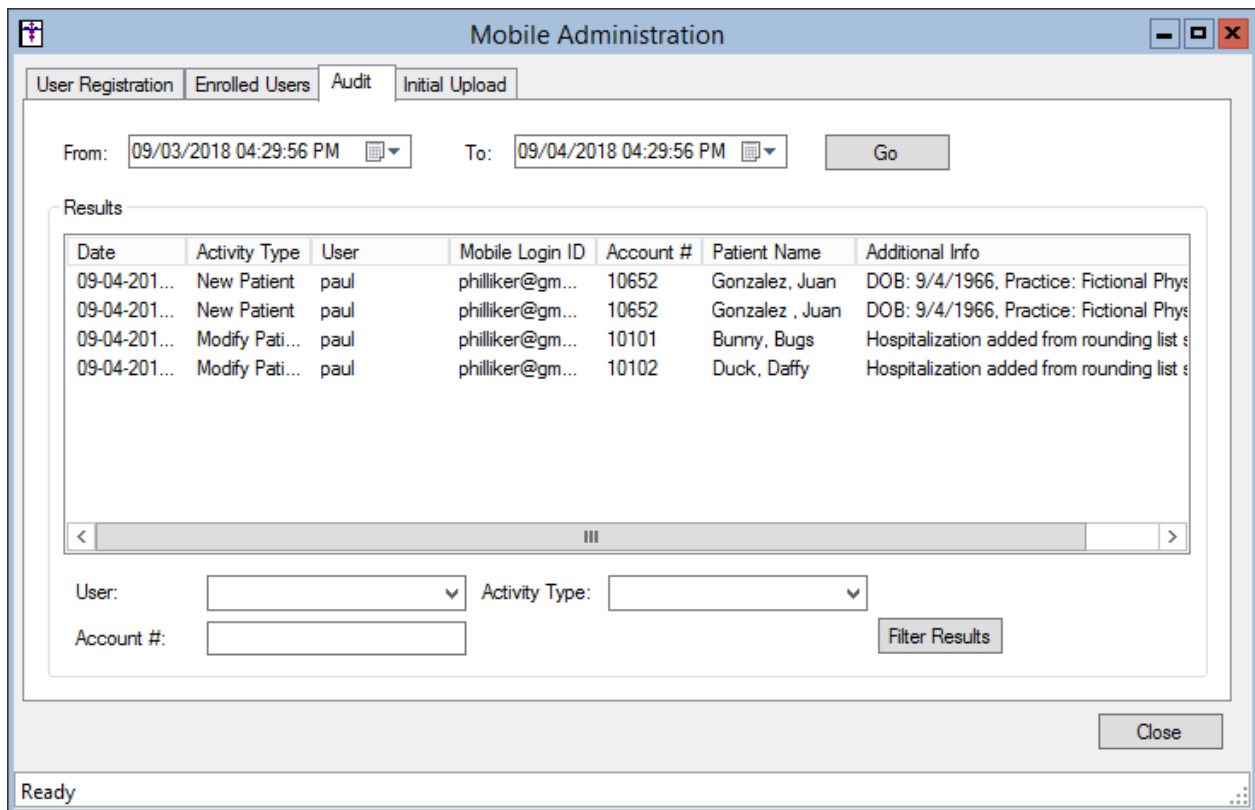


Figure 1 – Mobile Administration – Audit

- **Administration – Utilities – Audit – Audit Trail** – The Audit Trail has been updated to track whenever a hospitalization record is added or modified in Rounding List of ChartMaker® Mobile. When an audit event occurs, the Event column will display **Modified**; the Group column will display **Case**; the Audit Trail Description will display the **Added hospitalization** or **Modified hospitalization**; the Old Value and New Value columns will display the **Room #, Provider, and Facility** as applicable; and the patient's **Account #, Case Name**; and **Practice ID** will be listed in the Metadata column.

Appointment

- **Appointment – Select Patient – Patient Access** – The Patient Access button has been updated to reflect the patient’s status for both PatientPortal and API Access, thereby easily alerting you in case there is an issue of access for the patient. Likewise, the Patient Access dialog has been updated with a Status Legend section outlining the color-scheme for the access status. See Figure 2.

Patient Access

Patient Portal account settings

Registration status:

Send an authorization email to the patient for patient portal registration.

or

Print authorization instructions for the patient to manually register on the patient portal.

API Access

Enable this patient for API access

Authentication code: FictionalDrsz5MXGdN1

Print this patient's authentication code.

Send an email to this patient with their authentication code.

Generate a new authentication code for this patient.

Do not export on note, lab and scan signing

Status Legend

- Patient Portal and API are not enabled
- Patient Portal enabled and API is not enabled or Patient Portal not enabled and API is enabled
- Patient Portal pending and API not enabled
- Patient Portal is pending and API is enabled
- PatientPortal and API are enabled
- PatientPortal and API have note data not being sent (suspended)

[Help](#)

Figure 2 – Patient Access

Charge

- **Charge – Enter a Charge – Quick Pay** – The system has been updated with a new validation warning that is triggered when trying to save the quick pay when a copay credit is checked in the Copay Credits section of the Charge List – Quick Pay dialog but has not applied to charge by clicking the **Apply** button. See Figure 3.

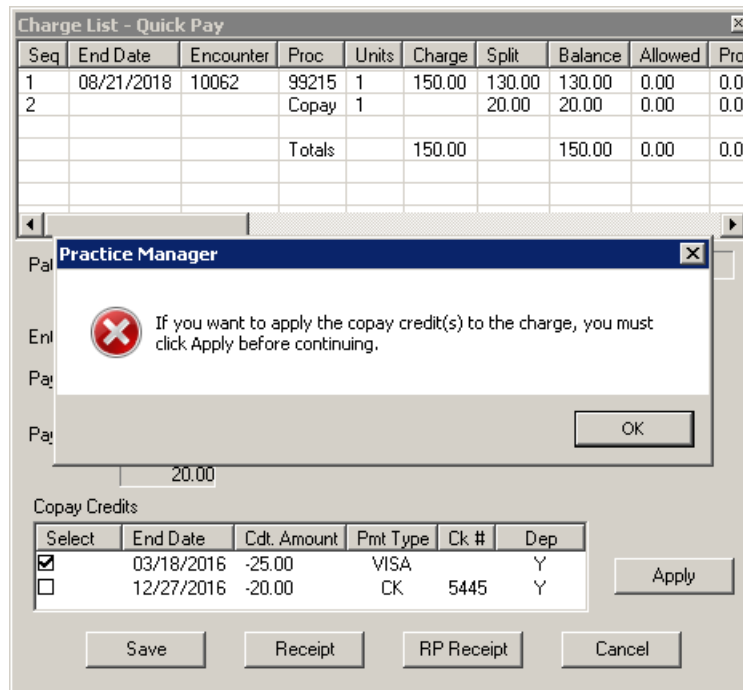


Figure 3 – Charge List – Quick Pay – Copay Credits Warning

- **Charge – Enter a Charge** – The **ICD10 Code Set** field, in the ICD10 Search and Crosswalk areas of the Diagnosis Search dialog, has been updated with an **October 1, 2018 – Sept 30, 2019** code set when searching for diagnosis codes or using the crosswalk functionality. You can toggle between the Oct 1, 2014 – Sept 30, 2016 code set, the Oct 1, 2016 – Sept 30, 2017 code set, the Oct 1, 2017 – Sept 30, 2018 code set, and All ICD10 Codes, in addition to this new code set. This allows you to easily search for the applicable ICD10 codes that are active, as outlined by the CDC, for the applicable date ranges. When accessing the Diagnosis Search dialog when entering charges, the system will default to the code set based on the service **Start Date** to ensure that the proper ICD codes for that date are selected.
- **Charge – Enter a Charge – Forms – NY Worker’s Compensation** – The Additional Forms dialog, accessed via the **Forms** button, has been updated with new **C-4 AUTH 2018 ~ Request for Authorization, MG-1 2018 ~ Request for Optional Prior Approval, and MG-2 2018 ~ Request for Approval of Variance** forms that are required for use by 10/6/2018. Legacy forms will remain in case they are currently in use.
- **Charge – Edit a Charge** – The **ICD10 Code Set** field, in the ICD10 Search and Crosswalk areas of the Diagnosis Search dialog, has been updated with an **October 1, 2018 – Sept 30, 2019** code set when searching for diagnosis codes or using the crosswalk functionality. You can toggle between the Oct 1, 2014 – Sept 30, 2016 code set, the Oct 1, 2016 – Sept 30, 2017 code set, the Oct 1, 2017 – Sept 30, 2018 code set, and All ICD10 Codes, in addition to this new code set. This allows you to easily search for the applicable ICD10 codes that are active, as outlined by the CDC, for the applicable date ranges. When accessing the Diagnosis Search dialog when editing charges, the system will default to the code set based on the service **Start Date** to ensure that the proper ICD codes for that date are selected.
- **Charge – Edit a Charge – Forms – NY Worker’s Compensation** – The Additional Forms dialog, accessed via the **Forms** button, has been updated with new **C-4 AUTH 2018 ~ Request for Authorization, MG-1 2018 ~ Request for Optional Prior Approval, and MG-2 2018 ~ Request for Approval of Variance** forms that are required for use by 10/6/2018. Legacy forms will remain in case they are currently in use.

Clinical

- **Clinical – Immunization – Immunization Registry – PhilaVax** – The system has been updated so that the Philadelphia Immunization Information System (PhilaVax), in conjunction with the ChartMarker® Medical Suite, utilizes 2.5.1 HL7 bidirectional messaging and exchange of vaccine (immunization) information. Once the system is set up, and you are enrolled with PhilaVax, immunization records will be automatically sent to the PhilaVax when the immunization record is saved (via the **Next Account** button) in the Immunization sub-tab of Clinical tab in Practice Manager, or when a chart note is saved or closed in the Clinical application.

Insurance

- **Insurance Billing – SPARCS Summary Report** – The SPARCS Summary Report has been updated so that claims that have errors will be displayed first. In addition, the Payer ID and Source of Payment will be displayed for secondary and tertiary insurances. Also, the Procedure Code and Rev Code will be displayed for all charge items.

Patient

- **Patient – Case – Diagnosis** – The **ICD10 Code Set** field, in the ICD10 Search and Crosswalk areas of the Diagnosis Search dialog, has been updated with an **October 1, 2018 – Sept 30, 2019** code set when searching for diagnosis codes or using the crosswalk functionality. You can toggle between the Oct 1, 2014 – Sept 30, 2016 code set, the Oct 1, 2016 – Sept 30, 2017 code set, the Oct 1, 2017 – Sept 30, 2018 code set, and All ICD10 Codes, in addition to this new code set. This allows you to easily search for the applicable ICD10 codes that are active, as outlined by the CDC, for the applicable date ranges. When accessing the Diagnosis Search dialog when entering or editing patient information, the system will default to the code set based on the current day's date.
- **Patient – Case – Hospitalization** – The system has been updated so that the Patient Hospitalization dialog will be updated with any additions or modifications to the hospital records for a patient made in ChartMaker® Mobile. Just as any changes made within the Patient Hospitalization dialog in Practice Manager will be reflected in the Rounding List of ChartMaker Mobile, now any changes made in the Rounding List will be reflected in Patient Hospitalization dialog.

Patient (continued)

- **Patient – Patient Access** – The Patient Access button has been updated to reflect the patient’s status for both PatientPortal and API Access, thereby easily alerting you in case there is an issue of access for the patient. Likewise, the Patient Access dialog has been updated with a Status Legend section outlining the color-scheme for the access status. See Figure 4.

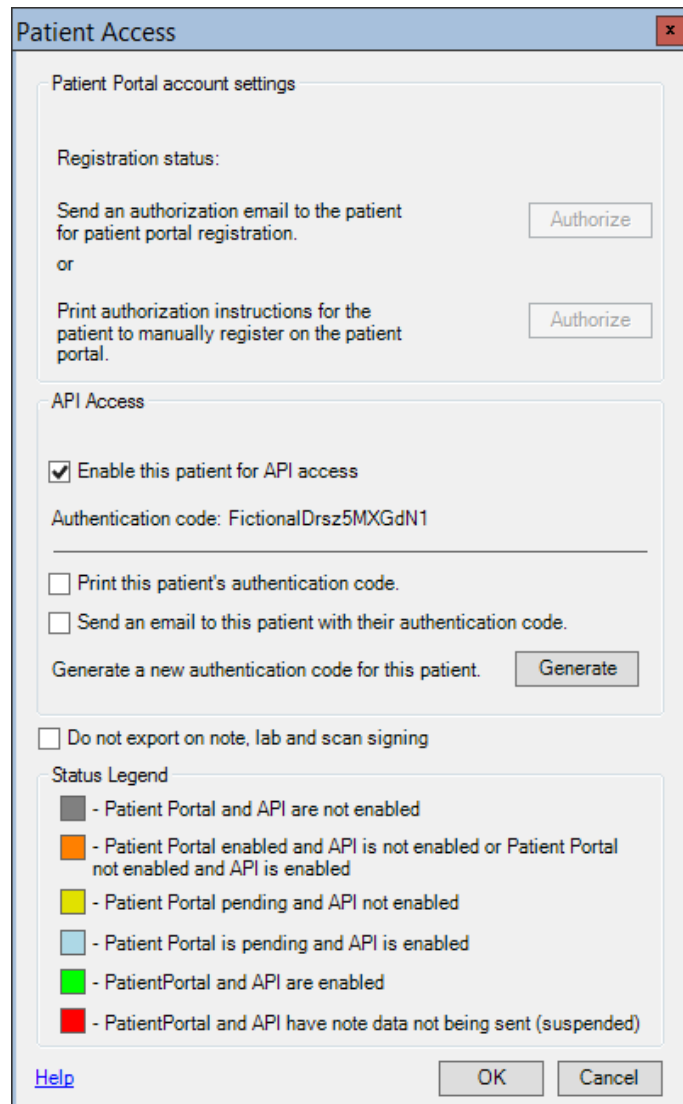


Figure 4 – Patient Access

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