Added Features

- **Face Sheet – Medication List –** The Facesheet has been updated so that when viewing medication information by clicking the * (asterisk) button, the Days Supply (the number of days for which the patient will have an adequate supply of the medication prescribed) will be displayed. See Figure 1.

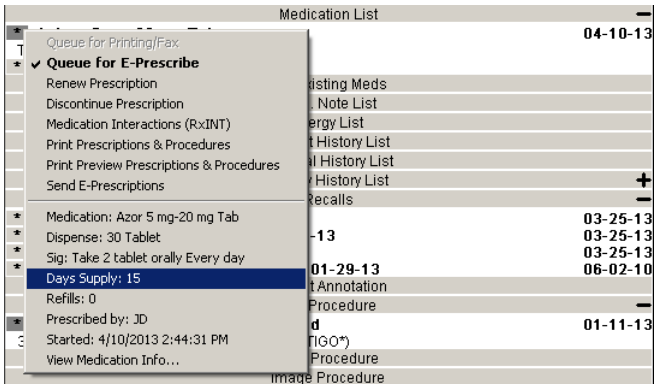
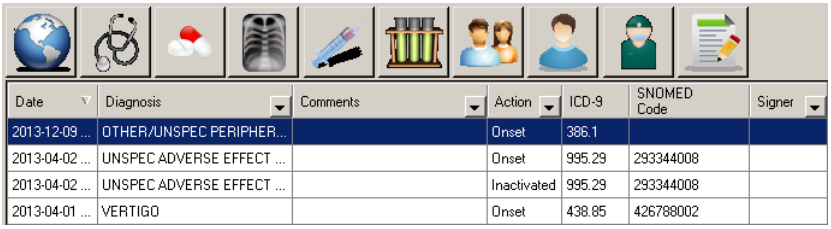


Figure 1 – Facesheet – Medication List

- **The Health Portal –** To maintain efficient and effective system performance the Health Portal has been updated to purge old Medication Eligibility and Drug History requests after they are no longer valid.

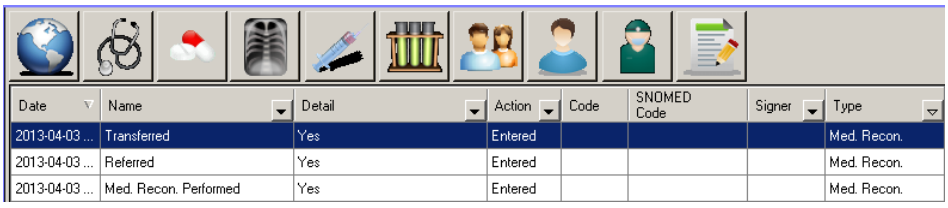
- **The History Tab – Diagnosis –** The History tab has been updated with a SNOMED Code column that will display the SNOMED Code for the applicable diagnosis code in the Global and Diagnosis view. See Figure 2.



Date	Diagnosis	Comments	Action	ICD-9	SNOMED Code	Signer
2013-12-09 ...	OTHER/UNSPEC PERIPHER...		Onset	386.1		
2013-04-02 ...	UNSPEC ADVERSE EFFECT ...		Onset	995.29	293344008	
2013-04-02 ...	UNSPEC ADVERSE EFFECT ...		Inactivated	995.29	293344008	
2013-04-01 ...	VERTIGO		Onset	438.85	426788002	

Figure 2 – History Tab – Diagnosis

- **The History Tab – Medication Reconciliation –** The History tab has been updated to display Medication Reconciliation information whenever a Medication Reconciliation is added or modified. See Figure 3.

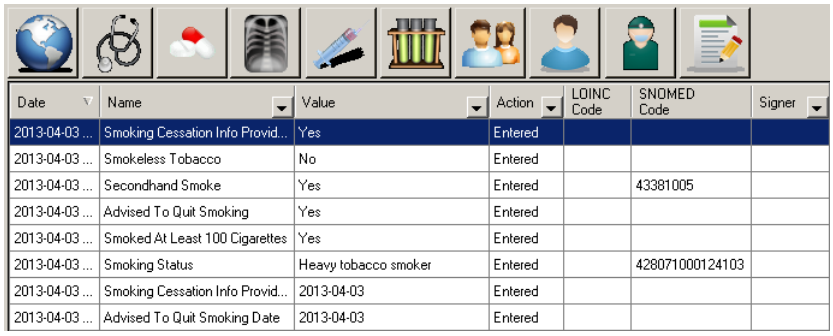


Date	Name	Detail	Action	Code	SNOMED Code	Signer	Type
2013-04-03 ...	Transferred	Yes	Entered				Med. Recon.
2013-04-03 ...	Referred	Yes	Entered				Med. Recon.
2013-04-03 ...	Med. Recon. Performed	Yes	Entered				Med. Recon.

Figure 3 – History Tab – Medication Reconciliations

Added Features (continued)

- **The History Tab – Smoking History –** The History tab has been updated with a SNOMED Code column that will display the SNOMED Code for the applicable smoking status in the Global and Results view. See Figure 4.



Date	Name	Value	Action	LOINC Code	SNOMED Code	Signer
2013-04-03 ...	Smoking Cessation Info Provid...	Yes	Entered			
2013-04-03 ...	Smokeless Tobacco	No	Entered			
2013-04-03 ...	Secondhand Smoke	Yes	Entered		43381005	
2013-04-03 ...	Advised To Quit Smoking	Yes	Entered			
2013-04-03 ...	Smoked At Least 100 Cigarettes	Yes	Entered			
2013-04-03 ...	Smoking Status	Heavy tobacco smoker	Entered		428071000124103	
2013-04-03 ...	Smoking Cessation Info Provid...	2013-04-03	Entered			
2013-04-03 ...	Advised To Quit Smoking Date	2013-04-03	Entered			

Figure 4 – History Tab – Smoking History

- **Meaningful Use – Meaningful Use Dashboard –** The Meaningful Use Dashboard has been updated with a ChartMaker Medical Suite Unique Patient Count option that will display the total number of encounters (based on charges in Practice Manager) versus the total number of Meaningful Use encounters (in Clinical) and the calculated percentage. This allows you to determine if 80% of the unique patients seen during the reporting period have an electronic medical record, and thereby whether or not you can successfully attest for Meaningful Use. See Figure 5. Do note, that this calculation will only reflect results based on charges entered in Practice Manager and chart notes being entered into the Clinical application. If this is not the case, this will not provide an accurate percentage.

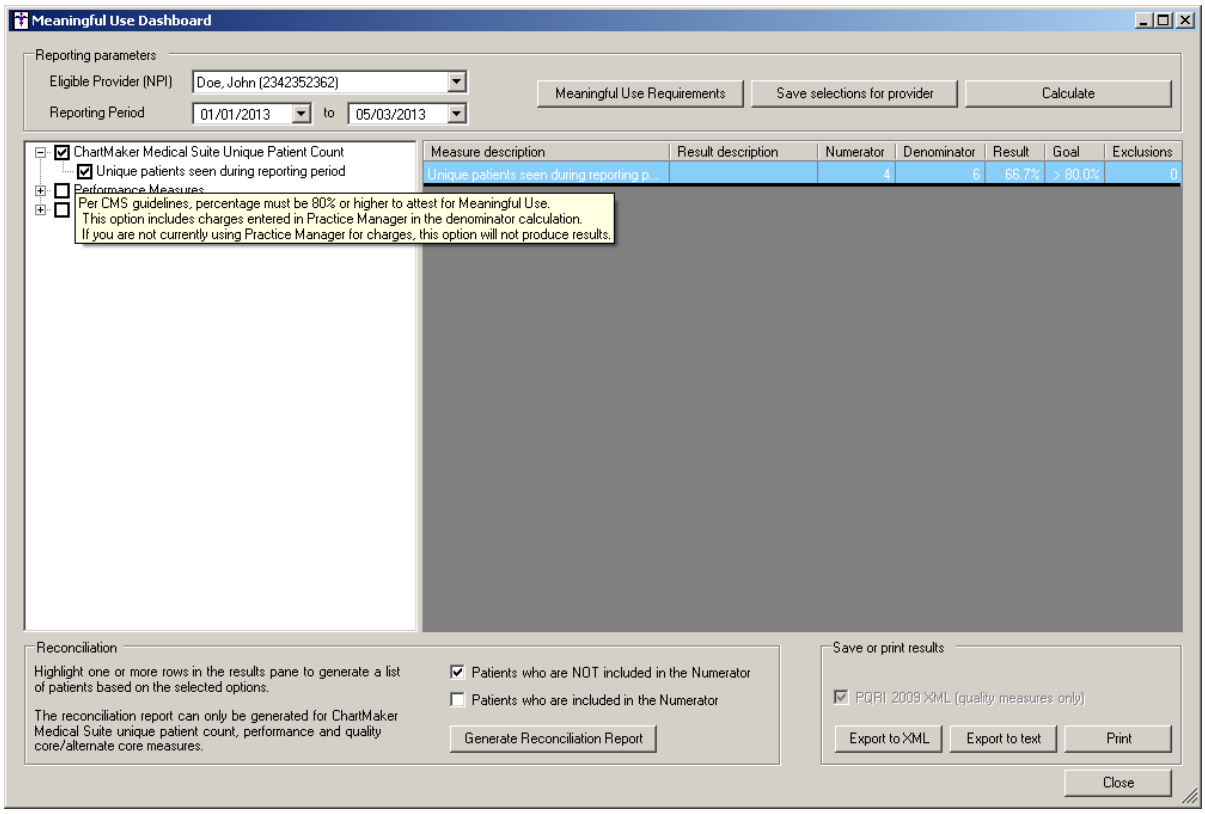


Figure 5 – Meaningful Use Dashboard

Added Features (continued)

- **Meaningful Use – Meaningful Use Dashboard –** The Reconciliation section of the Meaningful Use Dashboard has been updated with two new options: Patients who are NOT included in the Numerator, and Patients who are included in the Numerator. This allows you to determine the patients you want to see in the reconciliation report for the selected measure. See Figure 6.

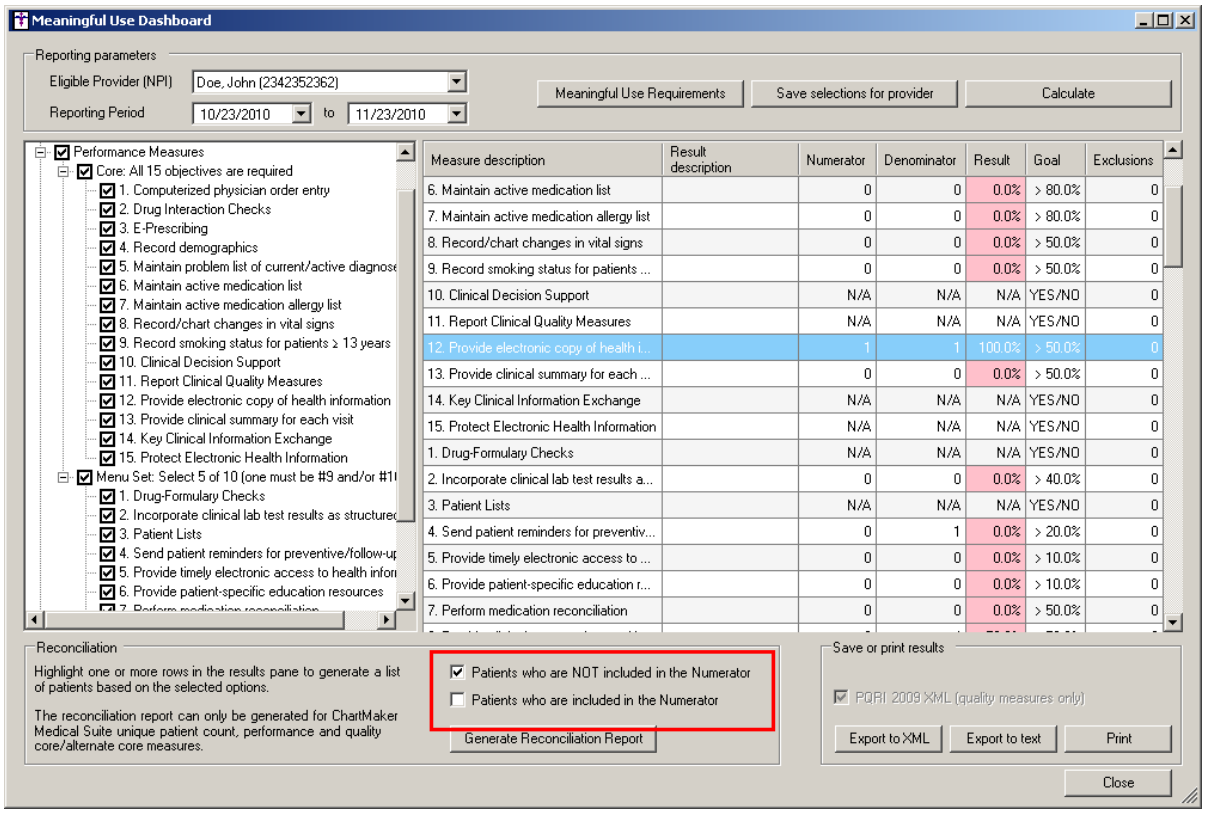


Figure 6 – Meaningful Use Dashboard

- **Meaningful Use – Stage 2 – SNOMED CT –** SNOMED CT (**S**ystematized **No**menclature of **Med**icine **C**linical **T**erms) is a terminology used to describe the care and treatment of patients. This terminology uses numeric codes to represent medical concepts (including symptoms, diseases, procedures, devices, and medicines), thereby eliminating the confusion that may result from the use of informal or local terms or phrases. The use of SNOMED CT codes to record clinical data is one of the certification criteria for Meaningful Use Stage 2, and allows for a consistent recording of clinical data with the aim of improving patient care.

  The Clinical application has been updated to map applicable procedure, diagnosis, family history relationships, diseases, and other applicable status codes throughout the system to appropriate SNOMED CT code per Meaningful Use Stage 2 requirements.

- **The Note Tab – Diagnosis –** The Add to Problem List, Note Diagnosis, and End Diagnosis dialogs have been updated with a SNOMED section that allows you to map the diagnosis code to the applicable SNOMED CT code. See Figure 7. When mapping diagnosis codes to SNOMED CT codes, there are three types of mapping that can take place: mapped, multiple mappings are available, and no mappings are available.

  When a diagnosis code is mapped directly to a SNOMED CT code, the applicable code will appear in the corresponding field with a disclaimer below, and the various buttons in the SNOMED section will be grayed out.

  When a diagnosis code has multiple SNOMED CT codes that it can be mapped to, you have the ability to click the Select button and search the applicable SNOMED codes to find the appropriate code. See Figure 7. Once that code is selected it will appear in the corresponding field with a disclaimer below and will remain attached to that patient's diagnosis until the diagnosis is resolved, or until it is either cleared or modified. You have the ability to remove an attached SNOMED code by clicking the Clear button. Likewise, you have the ability to set a SNOMED code as a default for that diagnosis by clicking the Set as Default button.

  When a diagnosis code has no mappings available, you have the ability to click the Search button and search for the applicable SNOMED code. Once that code is selected it will appear in the corresponding field and will remain attached to that patient's diagnosis until the diagnosis is resolved or until it is either cleared or modified. You have the ability to remove an attached SNOMED code by clicking the Clear button. Likewise, you have the ability to set a SNOMED code as a default for that diagnosis by clicking the Set as Default button.

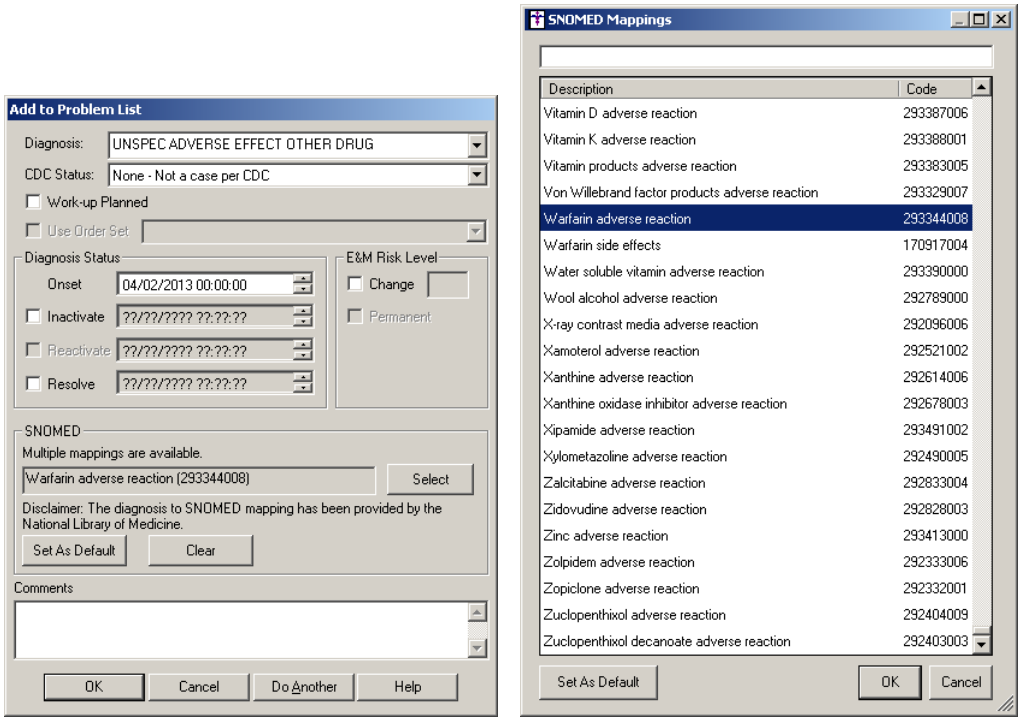


Figure 7 – Add to Problem List/SNOMED Mappings

- **The Note Tab – Medication Reconciliation –** The program has been updated with the ability to enter and capture medication reconciliation information for incoming transition of care patients via the Medication Reconciliation button. See Figure 8.

Figure 8 – Medication Reconciliation Button

Once the Medication Reconciliation button has been clicked the Medication Reconciliations dialog will appear allowing you to answer three questions regarding the patient's transition of care and whether a Medication Reconciliation has been performed. See Figure 9. To edit medication reconciliation information, you must access the chart in which the original note was entered. All medication reconciliation entry and modifications are tracked in the History tab.

When Medication Reconciliation information is entered in the chart note you have the ability to determine if that will information will appear in list or paragraph format in the note. The Medication Reconciliation entry will also be counted toward any applicable Meaningful Use Stage1/Stage 2 objectives or measures.

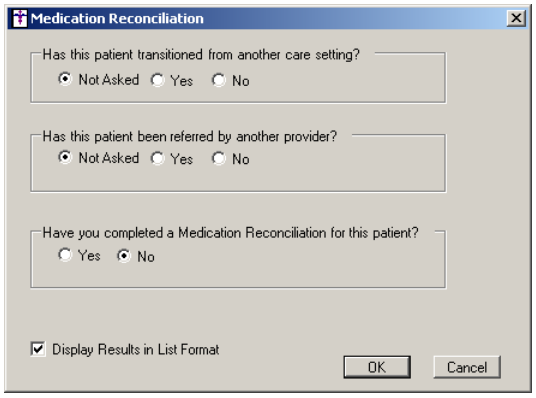


Figure 9 – Medication Reconciliations

- **The Note Tab – Recall/Physician Reminders –** The New/Edit Recall dialog has been updated with the ability to select a recall date for +1, +3, +6, and +12 months into the future by clicking the corresponding button, while also allowing you to advance a specified number of days, weeks, months, or years into the future using the Advance fields. See Figure 10. The recall date will advance based on the date currently in the Recall Date field. If entering a new recall and this field is blank, then the recall date will advance from today's date.

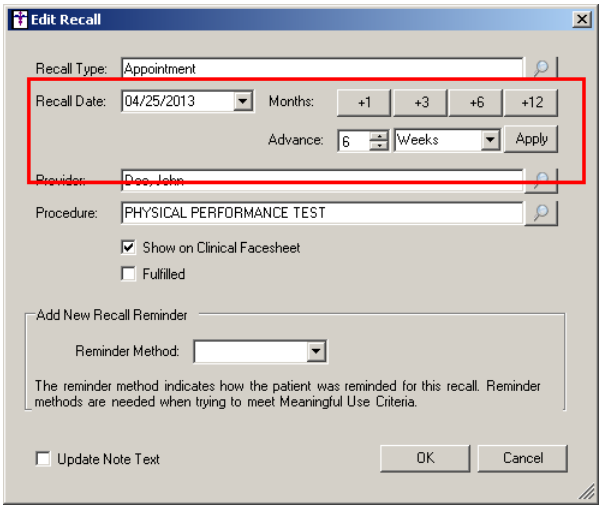


Figure 10 – New/Edit Recall

- **The Note Tab – Smoking History –** The Smoking/Tobacco Use dialog has been updated with two new Smoking Status options: Heavy tobacco smoker and Light tobacco smoker. See Figure 11. The new Smoking Status options will become available when Smoking History question, Have you smoked at least 100 cigarettes in your entire life, is tagged as Yes.

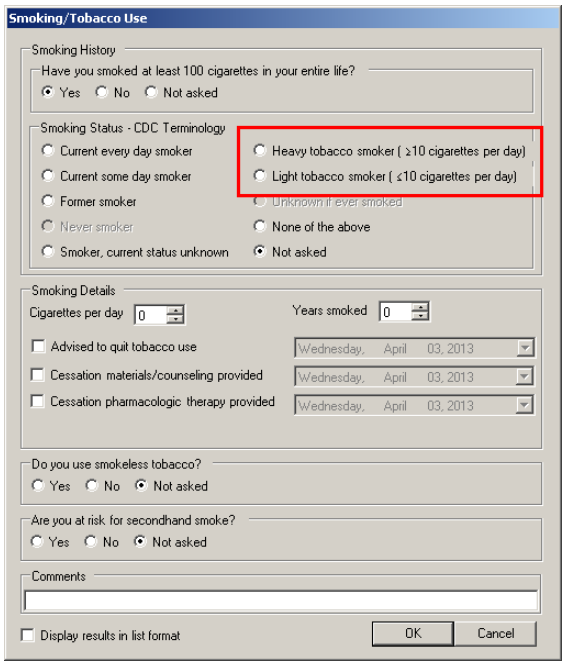


Figure 11 – Smoking/Tobacco Use

- **Prescribe – Find a Medication –** The Find a Medication dialog has been updated so it no longer displays an F before those medications from the First Data Bank medication list. An M prior to a medication, however, still indicates that that medication was manually entered.

- **Prescribe – Prescribe Medication –** The Prescribe Medication dialog has been updated with a Days Supply field that allows you to enter the number of days for which the patient will have an adequate supply of the medication prescribed. See Figure 12. For example, in the figure below, the SIG is 2 tablet everyday and the Dispense quantity is 30, therefore, the Days Supply would be 15 (30/2 = 15).

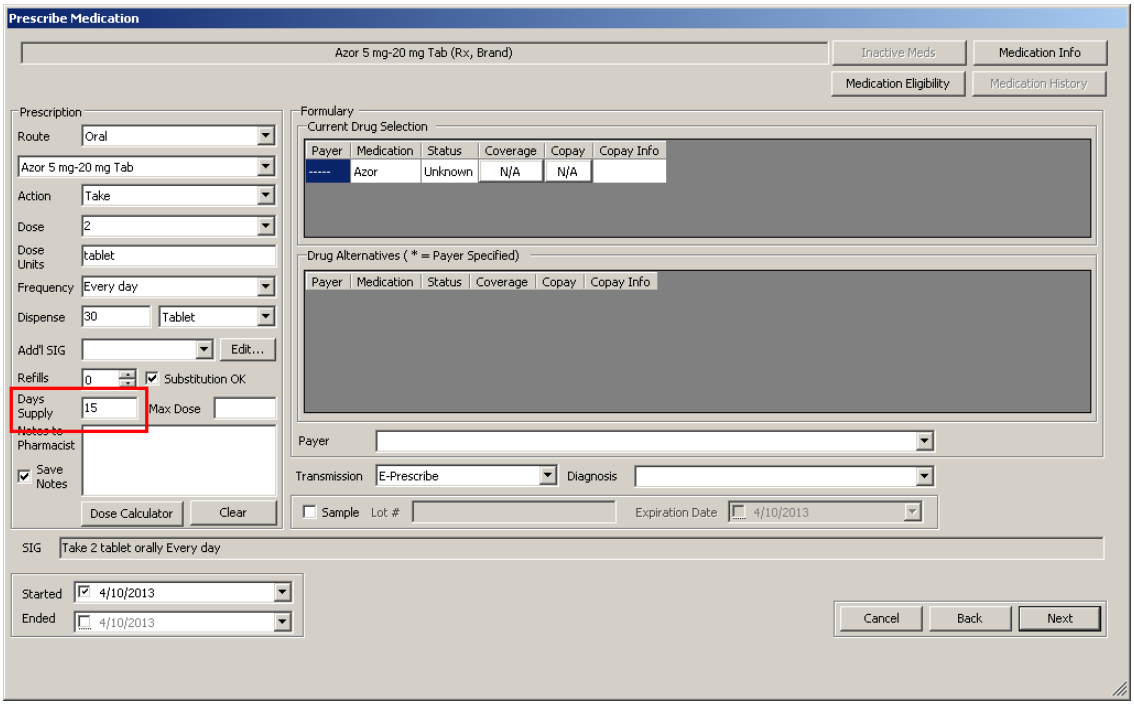


Figure 12 – Prescribe Medication

- **Prescribe – Confirm Prescription –** The Confirm Prescription dialog has been updated with a Days Supply field that will display the number of days for which the patient will have an adequate supply of the medication prescribed. See Figure 13.

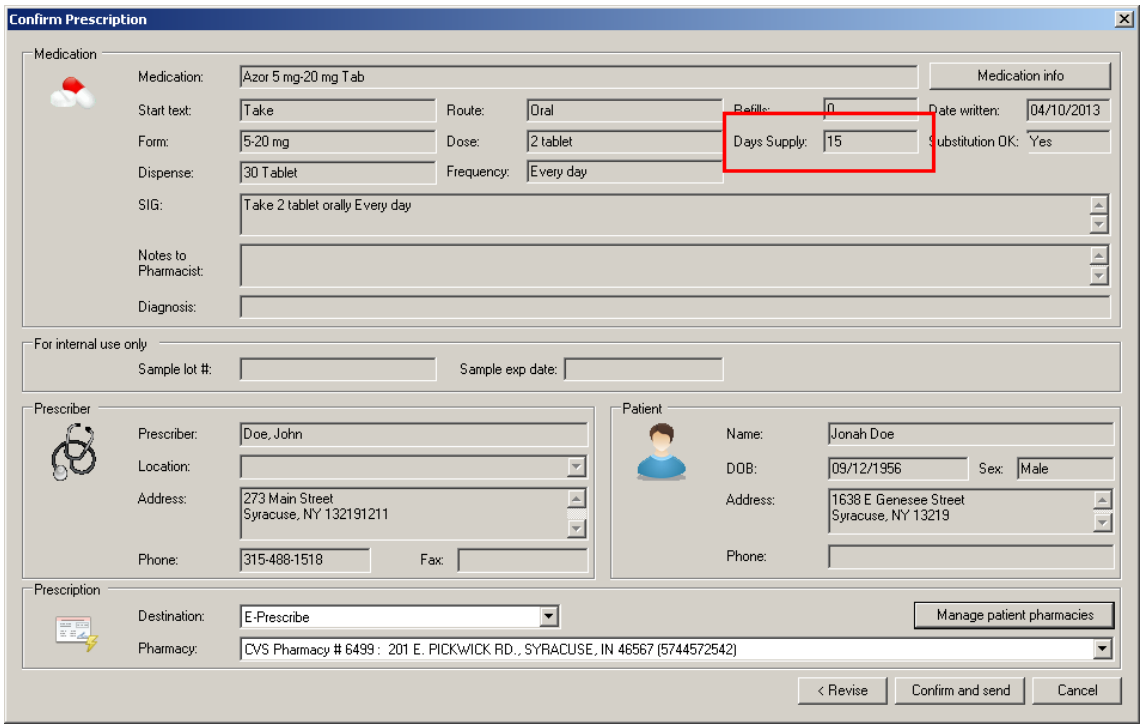


Figure 13 – Confirm Prescription

- **Prescribe – E-Prescriptions – Prescription Details –** The Prescription Details dialog accessed via the Medication Details button in the E-Prescriptions dialog has been updated with a Days Supply field that will display the number of days for which the patient will have an adequate supply of the medication prescribed. See Figure 14.

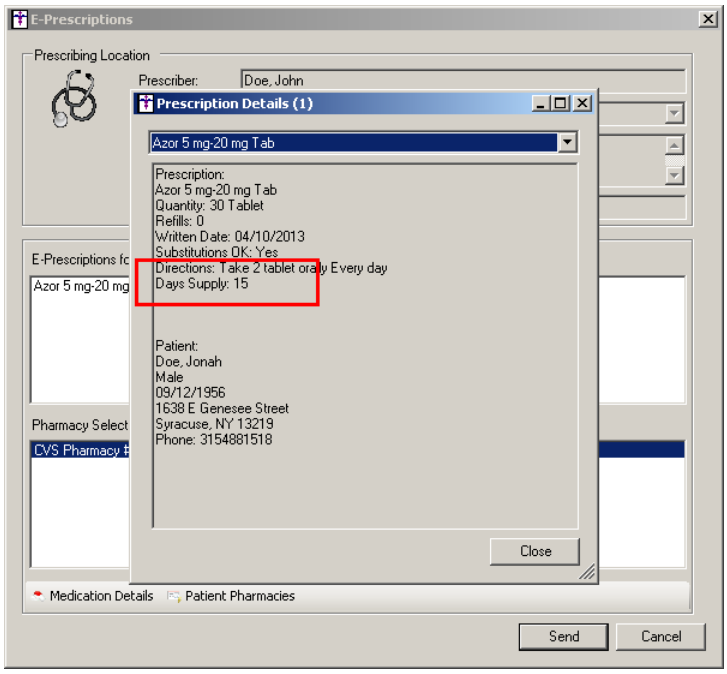


Figure 14 – E-Prescriptions – Prescription Details

- **Reports –** The Reports module has been updated so that whenever a report query is run a date and time stamp will appear on the printed, previewed, saved report.

Added Features (continued)

- **System Change – First and Last Name Fields –** The program has been updated so that First and Last Name fields allow you to enter and view up to 35 and 60 characters respectively per ANSI 5010 A1 and Scripts 10.6 requirements.

- **System Change – Sante DICOM Viewer CDR –** The system has been updated to use the Sante DICOM Viewer CDR instead of the Sante DICOM Viewer FREE when viewing DICOM images. This allows you to view DICOM images as before, but without the hassle of having to purchase a license from Sante to fully utilize the viewer.

- **Template Editing – Checklist – Findings –** The system has been updated to allow you to Tag a checklist Finding with a procedure.

- **Template Editing – Medication Reconciliation –** The Template Editor has been updated with the ability to add a Medication Reconciliation button to a template. The Medication Reconciliation button allows you to track medication reconciliation information for incoming transition of care patients.

- **Template Editing – Pick List –** The system has been updated to allow you to Tag a Pick List with a procedure.