

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the Health Portal has been updated to purge old Medication Eligibility and Drug History requests after they are no longer valid.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.

Meaningful Use Dashboard

Reporting parameters

Eligible Provider (NPI): Doe, John (2342352362)

Reporting Period: 01/01/2013 to 05/03/2013

Buttons: Meaningful Use Requirements, Save selections for provider, Calculate

Measure description	Result description	Numerator	Denominator	Result	Goal	Exclusions
<input checked="" type="checkbox"/> ChartMaker Medical Suite Unique Patient Count <input checked="" type="checkbox"/> Unique patients seen during reporting period <input type="checkbox"/> Performance Measures <input type="checkbox"/> Per CMS guidelines, percentage must be 80% or higher to attest for Meaningful Use. This option includes charges entered in Practice Manager in the denominator calculation. If you are not currently using Practice Manager for charges, this option will not produce results.	Unique patients seen during reporting p...	4	6	66.7%	> 80.0%	0

Reconciliation

Highlight one or more rows in the results pane to generate a list of patients based on the selected options.

The reconciliation report can only be generated for ChartMaker Medical Suite unique patient count, performance and quality core/alternate core measures.

Patients who are NOT included in the Numerator
 Patients who are included in the Numerator

Generate Reconciliation Report

Save or print results

PQRI 2009 XML (quality measures only)

Export to XML, Export to text, Print

Close

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.

Reporting parameters

Eligible Provider (NPI)

Reporting Period to

Measure description	Result description	Numerator	Denominator	Result	Goal	Exclusions
6. Maintain active medication list		0	0	0.0%	> 80.0%	0
7. Maintain active medication allergy list		0	0	0.0%	> 80.0%	0
8. Record/chart changes in vital signs		0	0	0.0%	> 50.0%	0
9. Record smoking status for patients ...		0	0	0.0%	> 50.0%	0
10. Clinical Decision Support		N/A	N/A	N/A	YES/NO	0
11. Report Clinical Quality Measures		N/A	N/A	N/A	YES/NO	0
12. Provide electronic copy of health i...		1	1	100.0%	> 50.0%	0
13. Provide clinical summary for each ...		0	0	0.0%	> 50.0%	0
14. Key Clinical Information Exchange		N/A	N/A	N/A	YES/NO	0
15. Protect Electronic Health Information		N/A	N/A	N/A	YES/NO	0
1. Drug-Formulary Checks		N/A	N/A	N/A	YES/NO	0
2. Incorporate clinical lab test results a...		0	0	0.0%	> 40.0%	0
3. Patient Lists		N/A	N/A	N/A	YES/NO	0
4. Send patient reminders for preventiv...		0	1	0.0%	> 20.0%	0
5. Provide timely electronic access to ...		0	0	0.0%	> 10.0%	0
6. Provide patient-specific education r...		0	0	0.0%	> 10.0%	0
7. Perform medication reconciliation		0	0	0.0%	> 50.0%	0

Reconciliation

Highlight one or more rows in the results pane to generate a list of patients based on the selected options.

The reconciliation report can only be generated for ChartMaker Medical Suite unique patient count, performance and quality core/alternate core measures.

Patients who are NOT included in the Numerator
 Patients who are included in the Numerator

Save or print results

PQRI 2009 XML (quality measures only)

Figure 6 – Meaningful Use Dashboard

- Meaningful Use – Stage 2 – SNOMED CT** – SNOMED CT (Systematized Nomenclature of Medicine Clinical Terms) 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.

Added Features (continued)

- **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.

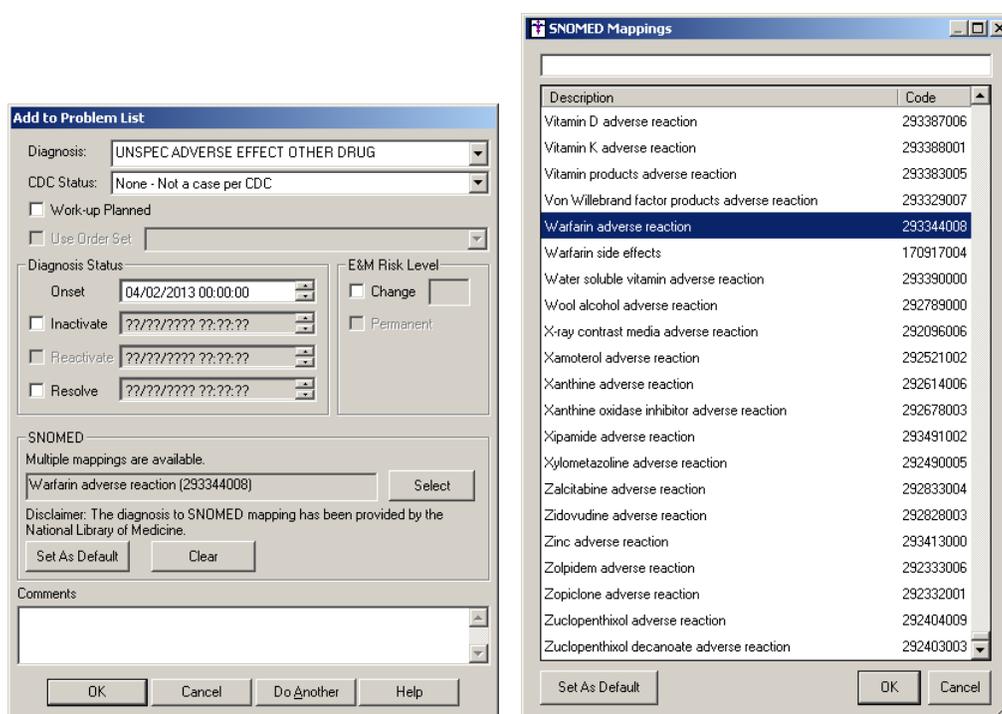


Figure 7 – Add to Problem List/SNOMED Mappings

Added Features (continued)

- **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.

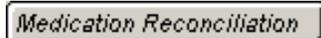
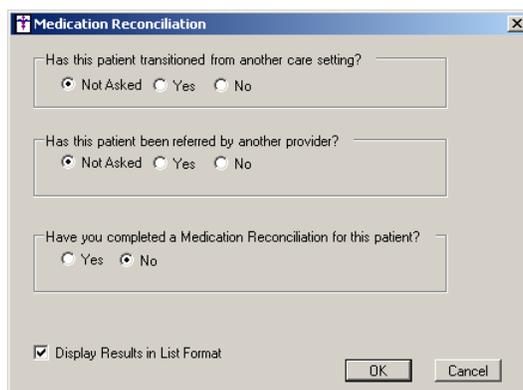


Figure 8 – Medication Reconciliation Button

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.

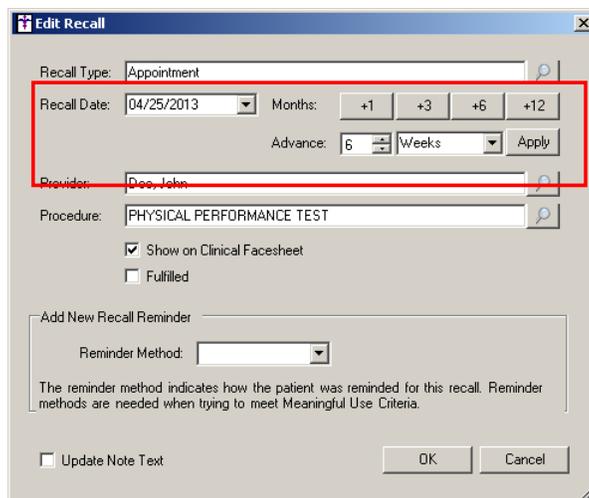
When Medication Reconciliation information is entered in the chart note you have the ability to determine if that will information will appear in list or paragraph format in the note. The Medication Reconciliation entry will also be counted toward any applicable Meaningful Use Stage1/Stage 2 objectives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



The dialog box titled "Medication Reconciliation" contains three sections of radio button questions. The first section asks "Has this patient transitioned from another care setting?" with options "Not Asked", "Yes", and "No". The second section asks "Has this patient been referred by another provider?" with options "Not Asked", "Yes", and "No". The third section asks "Have you completed a Medication Reconciliation for this patient?" with options "Yes" and "No". At the bottom, there is a checked checkbox for "Display Results in List Format" and "OK" and "Cancel" buttons.

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.

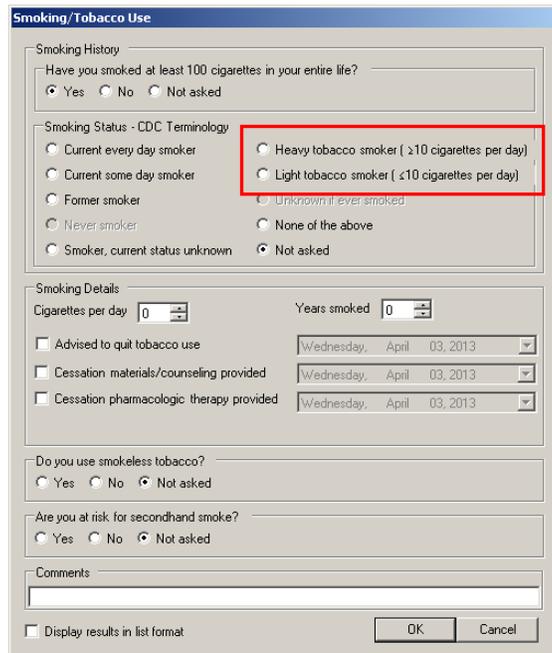


The "Edit Recall" dialog box shows a "Recall Type" of "Appointment" and a "Recall Date" of "04/25/2013". A red box highlights the "Recall Date" field, the "Months" buttons (+1, +3, +6, +12), the "Advance" field (set to 6), the "Weeks" dropdown, and the "Apply" button. Below this, the "Provider" is "Doc, John" and the "Procedure" is "PHYSICAL PERFORMANCE TEST". There are checkboxes for "Show on Clinical Facesheet" (checked) and "Fulfilled" (unchecked). At the bottom, there is an "Add New Recall Reminder" section with a "Reminder Method" dropdown, a note about reminder methods, and an "Update Note Text" checkbox. "OK" and "Cancel" buttons are at the bottom right.

Figure 10 – New/Edit Recall

Added Features (continued)

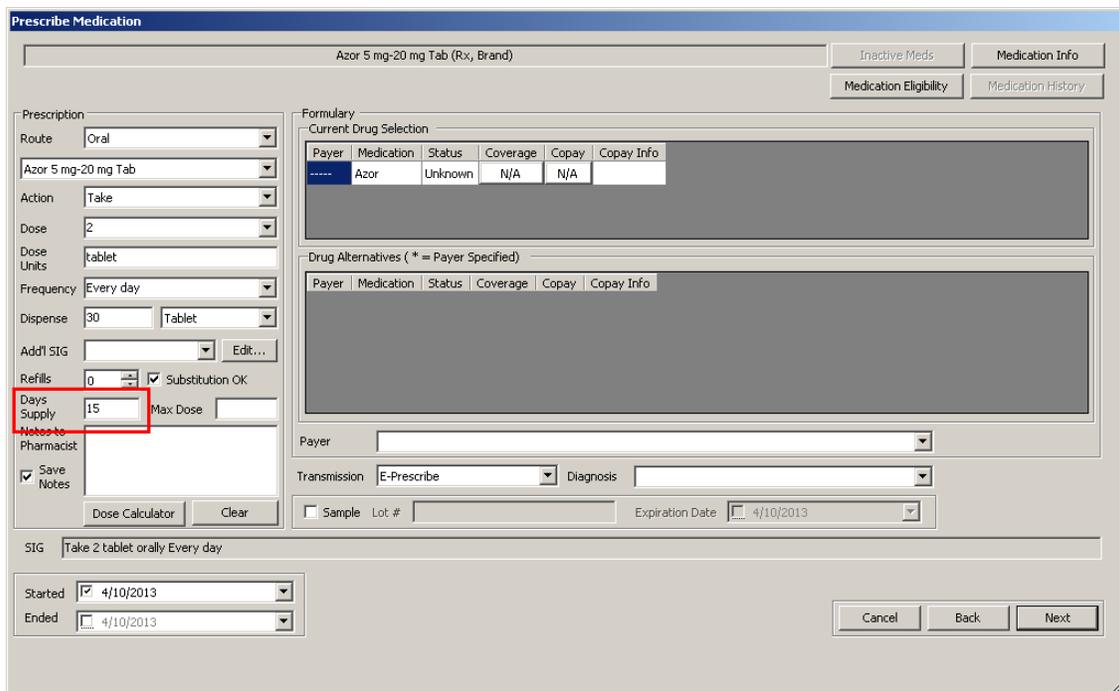
- **The Note Tab – Smoking History** – The Smoking/Tobacco Use dialog has been updated with two new Smoking Status options: Heavy tobacco smoker and Light tobacco smoker. See Figure 11. The new Smoking Status options will become available when Smoking History question, Have you smoked at least 100 cigarettes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



The image shows a software dialog box titled "Smoking/Tobacco Use". It contains several sections: "Smoking History" with radio buttons for "Yes", "No", and "Not asked"; "Smoking Status - CDC Terminology" with radio buttons for "Current every day smoker", "Current some day smoker", "Former smoker", "Never smoker", "Smoker, current status unknown", "Heavy tobacco smoker (>10 cigarettes per day)", "Light tobacco smoker (<10 cigarettes per day)", "Unknown if ever smoked", "None of the above", and "Not asked"; "Smoking Details" with spinners for "Cigarettes per day" and "Years smoked", and checkboxes for "Advised to quit tobacco use", "Cessation materials/counseling provided", and "Cessation pharmacologic therapy provided" with date pickers; "Do you use smokeless tobacco?" with radio buttons for "Yes", "No", and "Not asked"; "Are you at risk for secondhand smoke?" with radio buttons for "Yes", "No", and "Not asked"; a "Comments" text area; and a "Display results in list format" checkbox. "OK" and "Cancel" buttons are at the bottom right.

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 ($30/2 = 15$).



The image shows a software dialog box titled "Prescribe Medication" for "Azor 5 mg-20 mg Tab (Rx, Brand)". It includes buttons for "Inactive Meds", "Medication Info", "Medication Eligibility", and "Medication History". The "Prescription" section has dropdowns for "Route" (Oral), "Medication" (Azor 5 mg-20 mg Tab), "Action" (Take), "Dose" (2), "Dose Units" (tablet), "Frequency" (Every day), "Dispense" (30 Tablet), "Add'l SIG", "Refills" (0), and "Substitution OK" (checked). A "Days Supply" field is highlighted with a red box and contains the value "15". There is a "Notes to Pharmacist" section with a "Save Notes" checkbox. The "Formulary" section shows a table with columns: Payer, Medication, Status, Coverage, Copay, Copay Info. Below it is a "Drug Alternatives" section with a similar table. At the bottom, there are fields for "Payer", "Transmission" (E-Prescribe), "Diagnosis", "Sample", "Lot #", and "Expiration Date" (4/10/2013). The "SIG" field contains "Take 2 tablet orally Every day". "Started" and "Ended" date pickers are at the bottom left. "Cancel", "Back", and "Next" buttons are at the bottom right.

Figure 12 – Prescribe Medication

Added Features (continued)

- **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.

The screenshot shows the 'Confirm Prescription' dialog box. The 'Medication' section includes fields for Medication (Azor 5 mg-20 mg Tab), Start text (Take), Route (Oral), Refills (0), Date written (04/10/2013), Form (5-20 mg), Dose (2 tablet), Days Supply (15), Dispense (30 Tablet), Frequency (Every day), and Substitution OK (Yes). The 'SIG' field contains 'Take 2 tablet orally Every day'. The 'For internal use only' section has fields for Sample lot # and Sample exp date. The 'Prescriber' section includes fields for Prescriber (Doe, John), Location, Address (273 Main Street, Syracuse, NY 13219211), Phone (315-488-1518), and Fax. The 'Patient' section includes fields for Name (Jonah Doe), DOB (09/12/1966), Sex (Male), Address (1638 E Genesee Street, Syracuse, NY 13219), and Phone. The 'Prescription' section has a Destination dropdown (E-Prescribe) and a Pharmacy dropdown (CVS Pharmacy # 6499 : 201 E. PICKWICK RD., SYRACUSE, IN 46567 (5744572542)). Buttons for '< Revise', 'Confirm and send', and 'Cancel' are at the bottom.

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.

The screenshot shows the 'E-Prescriptions' dialog box with the 'Prescription Details (1)' dialog open. The 'Prescription Details' dialog displays the following information: Medication (Azor 5 mg-20 mg Tab), Prescription (Azor 5 mg-20 mg Tab), Quantity (30 Tablet), Refills (0), Written Date (04/10/2013), Substitutions OK (Yes), Directions (Take 2 Tablet orally Every day), and Days Supply (15). The 'Patient' section includes Name (Doe, Jonah), Sex (Male), DOB (09/12/1966), Address (1638 E Genesee Street, Syracuse, NY 13219), and Phone (3154881518). The 'E-Prescriptions for' section shows 'Azor 5 mg-20 mg'. The 'Pharmacy Select' section shows 'CVS Pharmacy #'. Buttons for 'Close', 'Send', and 'Cancel' are at the bottom.

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.

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