

ChartMaker[®] Clinical

Added Features

- **The Audit Trail** – The Audit Trail has been updated to track whenever the order status for procedure order has been modified.
- **Doctor's Orders & Procedures – Order Status** – The chart header has been updated with an Order Status button that allows you to review and complete multiple orders for a patient. See Figure 1.

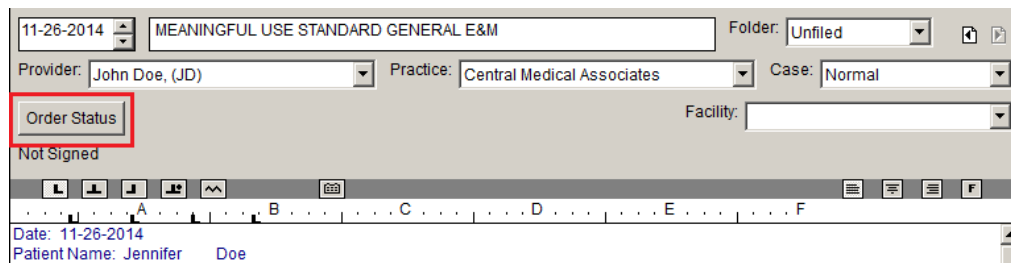


Figure 1 – Chart Header

Once the Order Status button is clicked an Order Status dialog will appear allowing you to select the applicable pending and completed orders to update the status (Pending, Completed, Reviewed, Completed with Image, or Reviewed with Image). Likewise, you can also update the status (Reviewed or Reviewed with Image) for any orders processed in the current note. See Figure 2.

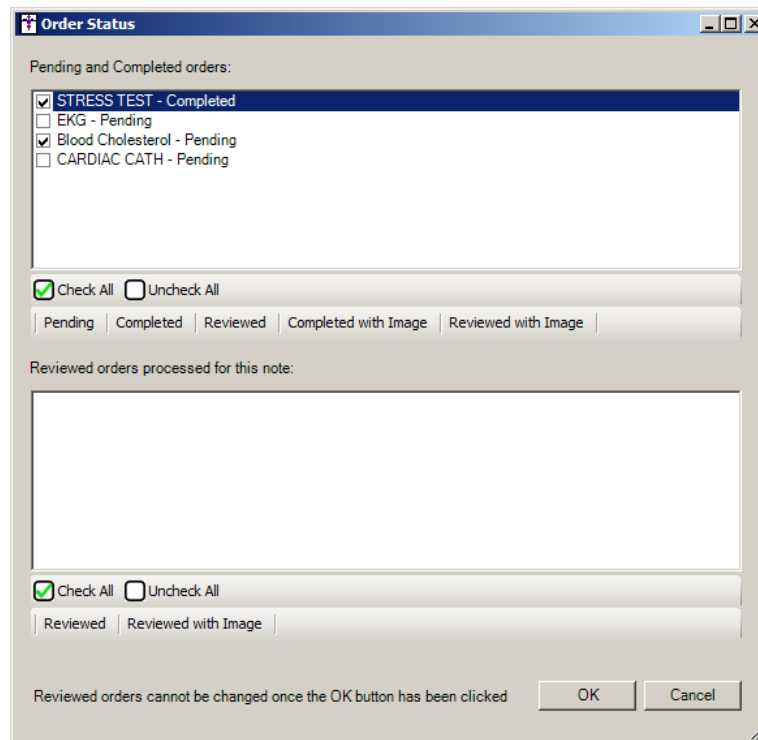


Figure 2 – Order Status

Added Features (continued)

- **Doctor's Orders & Procedures – Printing Orders** – The program has been updated so that when printing orders, if there is only one active insurance, in either Ins 1 or Ins 2 spot for the case the order was entered against, it will always printed in the Primary Insurance section of the printed order.
- **The Facesheet –Appointment List** – The Appointment List options for the facesheet (Today's Appointments; Today's Appointments, time filtered; Tomorrow's Appointments, and Yesterday's Appointments) have been updated to display standard time with an AM/PM designation, instead of military time. See Figure 3.

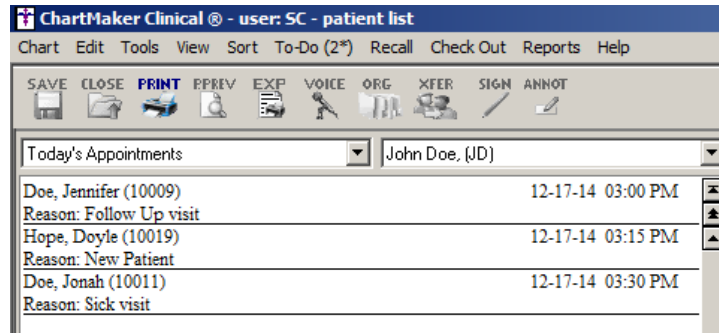


Figure 3 – Facesheet – Today's Appointments

- **The ID Tab – Patient Representative** – The Patient Representative dialog has been updated with Type field that allows you to specify the type of patient representative you are configuring for the patient (Emergency Contact, Health Care Proxy, Legal Guardian, Next of Kin, Primary Caregiver, Patient Portal Representative, etc.). See Figure 4. You have the ability to select multiple types for a patient representative when applicable. A Type needs to be selected before you are able to save the patient representative. You are able to add additional patient representative types by clicking the adjacent Edit button.

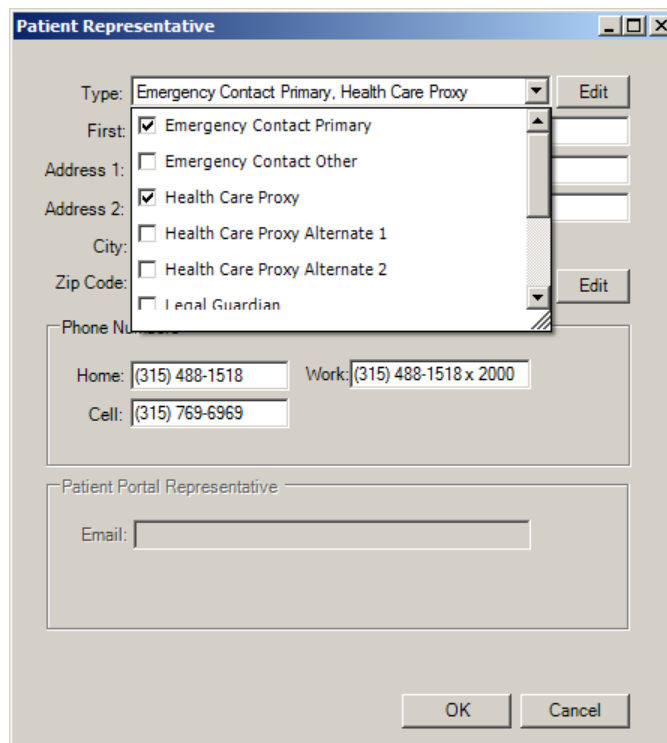


Figure 4 – Patient Representative

Added Features (continued)

- Meaningful Use – ALPHA Query Dashboard** – The system has been updated with an ALPHA Query Dashboard that allows you to run upcoming CQMs that are being created, but are not yet certified, thereby giving you the ability to set up applicable templates and adjust documentation workflows to be sure that you are capturing the correct data. See Figure 5. The ALPHA Query Dashboard works in a similar manner as the Meaningful Use Dashboard where you can configure data for an eligible provider for a specified date range, save configurations, run reconciliation reports, and print and export the results. However, these queries cannot be used for Meaningful Use Attestation, nor any other reporting requirements. This dashboard, is instead for testing upcoming clinical quality measures that are applicable to your practice to ensure data is configured properly within your system to meet the requirements of those measures.

ALPHA Query Dashboard

Currently Loaded Configuration: None

Eligible Provider (NPI): Doe, John (1212321313)

Stage: Alpha

Reporting Period: 11/17/2014 to 12/17/2014

These queries can not be used for Meaningful Use Attestation or any other reporting requirements. These queries are for customer testing only and can be used to be sure data is configured properly within the note.

Calculate Results

Configurations

Configuration Name

Select

Save

Save As...

Clear

Delete

Quality Measures

- NQF0022-Use of High-Risk Medications in the E...
- NQF0069-Appropriate Treatment for Children with...
- Care Coordination
- NQFTBD-Closing the referral loop: receipt of...
- Population / Public Health
- Clinical Process / Effectiveness
- NQF0028-Preventive Care and Screening: T...
- NQF0033-Chlamydia Screening for Women
- NQF0038-Childhood Immunization Status
- NQF0041-Preventive Care and Screening: Ir...
- NQF0421-Preventive Care and Screening: B...

Measure description	Result description	Numerator	Denominator	Result	Goal	Den. Exclusions	Exception
NQF0022-Use of High-Risk Medicatio...	At least one high ...				>= 0.0%		
NQF0022-Use of High-Risk Medicatio...	At least two differ...				>= 0.0%		
NQF0069-Appropriate Treatment for C...					>= 0.0%		
NQFTBD-Closing the referral loop: rec...					>= 0.0%		
NQF0056-Diabetes: Foot Exam					>= 0.0%		
NQF0060-Hemoglobin A1c Test for Pe...					>= 0.0%		
NQF0062-Diabetes: Urine Protein Scre...					>= 0.0%		
NQF0075-Ischemic Vascular Disease (...)	Complete lipid pro...				>= 0.0%		
NQF0075-Ischemic Vascular Disease (...)	most recent LDL-...				>= 0.0%		
NQF0081-Heart Failure (HF): Angioten...					>= 0.0%		
NQF0083-Heart Failure (HF): Beta-Blo...					>= 0.0%		
NQF0088-Diabetic Retinopathy: Docu...					>= 0.0%		
NQF0108-ADHD: Follow-Up Care for C...	Visit within 30 da...				>= 0.0%		
NQF0108-ADHD: Follow-Up Care for C...	Maintenance Ph...				>= 0.0%		
NQFTBD-Hypertension: Improvement i...					>= 0.0%		
NQF0028-Preventive Care and Screen...					>= 0.0%		

Clear Selections

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

Denominator Exclusions and Exceptions (CQM Only)

Generate Reconciliation Report

Save or print results

Export to text

Print

Close

Figure 5 – ALPHA Query Dashboard

Added Features (continued)

- **Meaningful Use Stage 1 2014/Stage 2 – Meaningful Use Dashboard** – To provide consistent and efficient usability, the Meaningful Use Dashboard has been updated so that the various measures are listed in the same order that CMS's order for attestation.
- **Meaningful Use Stage 1 2014 – Meaningful Use Dashboard – Clinical Lab Test Results** – To provide an accurate accounting of the percentage for the Incorporate clinical lab test results as structured data (2) menu set performance measure, the system has been updated so that tracked orders with a target date which falls outside the range of the reporting period will not be included in the calculation for this measure.
- **Meaningful Use Stage 2 – Meaningful Use Dashboard – Clinical Lab Test Results** – To provide an accurate accounting of the percentage for the Incorporate Clinical Lab Results (10) core performance measure, the system has been updated so that tracked orders with a target date which falls outside the range of the reporting period will not be included in the calculation for this measure.
- **Medication – Current Medications Documented** – The Medication button has been updated with a new Current Medications Documented option that allows you to easily document whether or not the current medications were reviewed and documented during the patient's visit. See Figure 6. This option will default to active and checked. If the patient's current medications were not reviewed, simply click this option and it will become unchecked and the chart note will be updated indicating that the patient's medications were not reviewed for this visit. Likewise, the system will record the applicable SNOMED code depending upon whether or not the Current Medications Documented option is checked, and the CQM NQF 0419 Documentation of Current Medications in the Medical Record query will be updated to accurately calculate this measure.

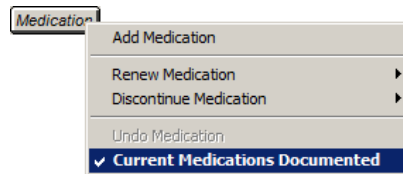


Figure 6 – Medication Button – Current Medications Documented

- **Medication – E-Prescribe** – The program has been updated so that all outgoing e-prescriptions will include the ISA13 number (the Eligibility Interchange Control Number), when available.

Added Features (continued)

- **Medication – Prescribe Medication** – To prevent conflicting information from appearing in SIG field and thereby in the electronic prescriptions being sent to pharmacies, a number of changes have been made to the Prescribe Medication dialog. The Notes to the Pharmacist field has been reduced and a watermark has been added that states “Do not include clinical information in this field.” Likewise, the Save Notes option for the Notes to the Pharmacist field has been removed so that previously entered notes do not default for future prescriptions. See Figure 7.

Prescribe Medication

(Schedule IV) Ativan 0.5 mg tablet (Rx, Brand)

lorazepam

Medication History Consent: Yes

Medication Eligibility

Medication History

Prescription

Route: oral

Ativan 0.5 mg tablet

Action: Take

Dose: 1 Dose Calculator

Dose Units: tablet

Frequency: Every day

Dispense: 30 Tablet

Add'l SIG: Edit...

Refills: 2 Substitution OK

Days Supply: 30 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
-----	Ativan	Unknown	N/A	N/A	

Drug Alternatives (* = Payer Specified)

Payer	Medication	Status	Coverage	Copay	Copay Info
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Payer: [Dropdown]

Transmission: E-Prescribe

Diagnosis: [Dropdown]

Sample Lot #: [Field]

Expiration Date: 12/10/2014

Administered during visit: [Checkbox]

Initial order created outside of Clinical: [Checkbox]

SIG: Take 1 tablet orally Every day

Started: 12/10/2014

Ended: 12/10/2014

Earliest Fill Date: 12/10/2014

Cancel Back Next

Figure 7 – Prescribe Medication

The system has also been updated to check the Days Supply field when the Next button is clicked, and to produce a subsequent Days Supply Mismatch warning message when the calculated Days Supply (based on the Dose, Frequency, and Dispense values) conflicts with the information entered in Days Supply field. See Figure 8. You can click the Yes button to continue with the mismatched days supply, or click No button to return to the Prescribe Medication dialog and update the applicable information.

Days Supply Mismatch

The entered Days Supply does not match the calculated Days Supply

Entered Days Supply: 98

Calculated Days Supply: 30

Do you want to continue?

Yes No

Figure 8 – Prescribe Medication

- **Medication – Refill Response – EPCS** – The program has been updated so that the DEA number for refill requests for controlled substances will automatically be selected based on the SPI number in the refill request header. The applicable DEA number will then be displayed in the DEA Number field as a static entry that cannot be edited, thereby reducing errors and incorrect information being sent with the refill.

Added Features (continued)

- **The Note Tab – Custom Forms** – Custom Forms that contain Emergency Contact information have been updated to pull the emergency contact data from the new emergency contact type information in the Patient Representative dialog
- **The Note Tab – Diagnosis** – The Diagnosis dialog has been updated so that the diagnoses appearing in the left pane (Encounter Diagnoses and Chart Diagnoses) are color coded to easily identify those codes missing an ICD code (red), those diagnoses that do not have a SNOMED code attached (orange), and those diagnoses that are part of an order set (green). Likewise, a Legend button has been added to outline the color scheme. See Figure 9.

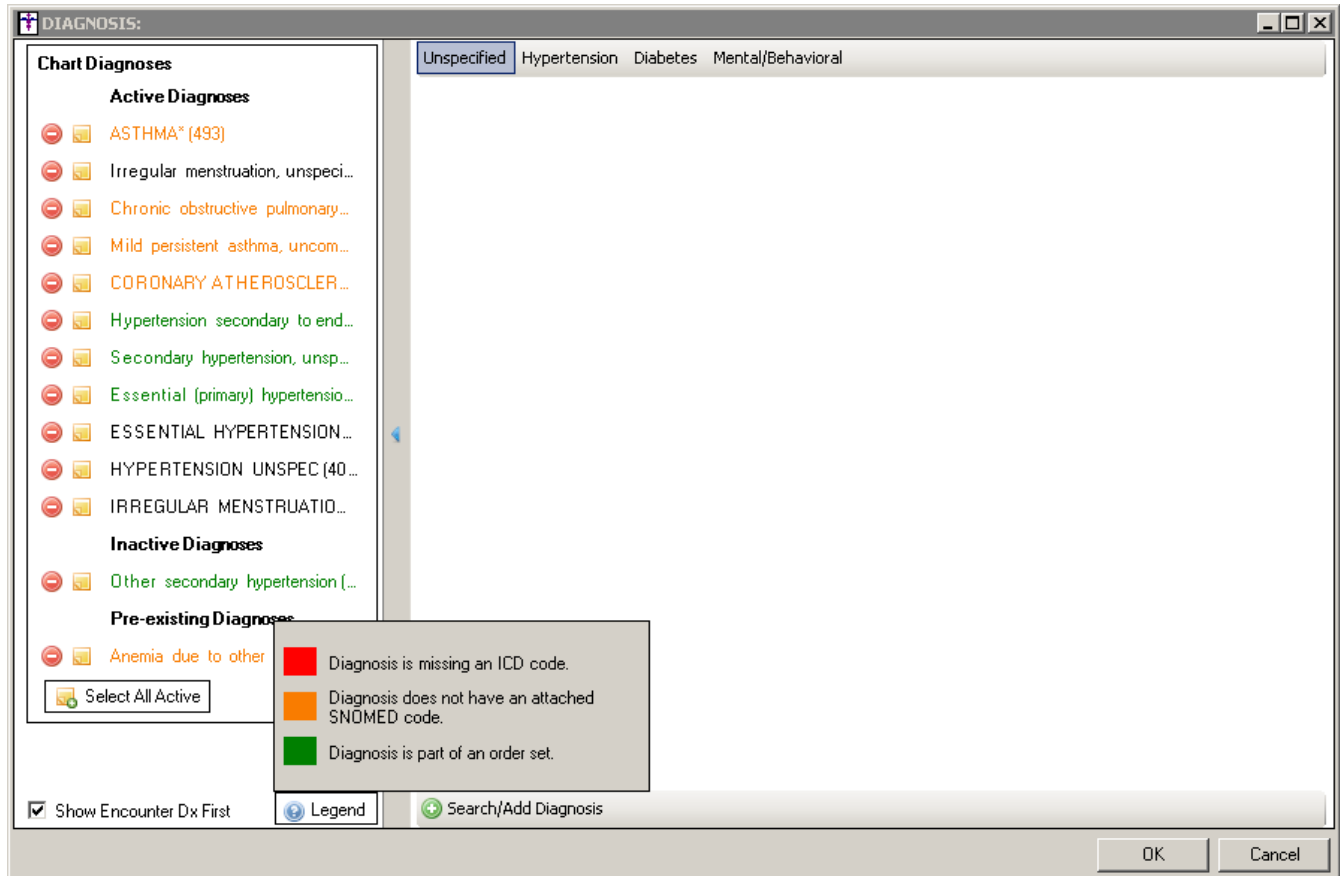


Figure 9 – Diagnosis

Added Features (continued)

- **The Note Tab – Diagnosis** – The Chart Diagnoses section of the Diagnosis dialog has been updated with a Select All Active button that allows you to select all active ongoing diagnoses in a chart note. See Figure 10.

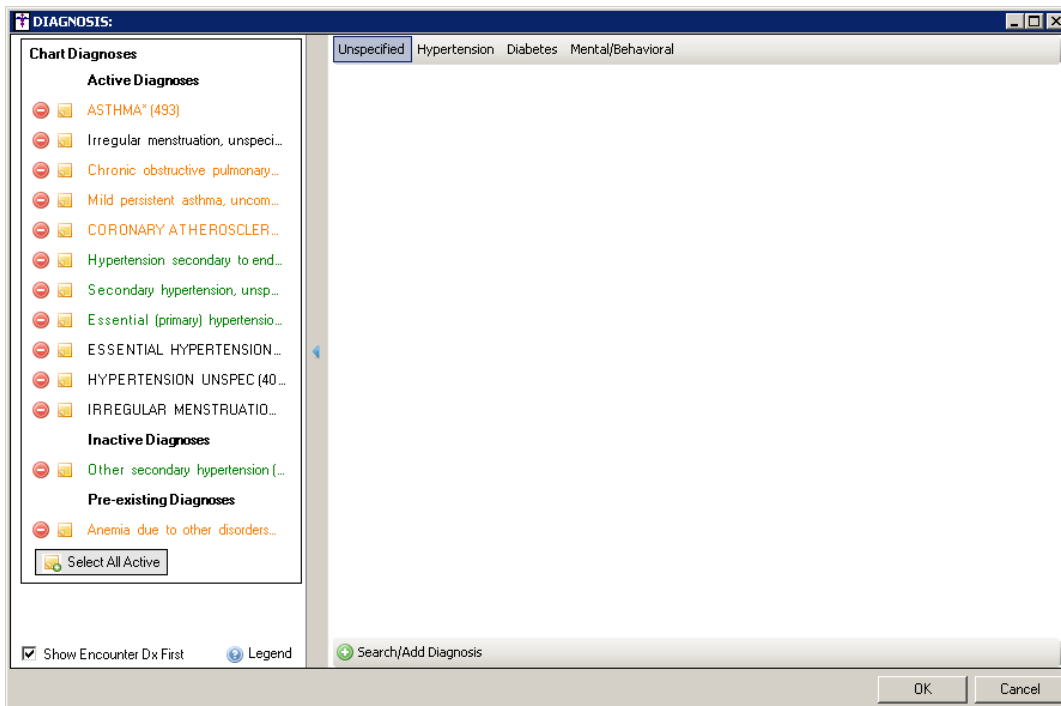


Figure 10 – Diagnosis – Quick Note

When the Select All Active button is clicked, all Active Diagnoses, with an ICD code attached, will become selected. Any Inactive and/or Pre-existing Diagnoses will not be automatically selected. Likewise, an Accept and Cancel button will then appear. See Figure 11. You can then select or deselect any applicable diagnoses, and then click the Accept button.

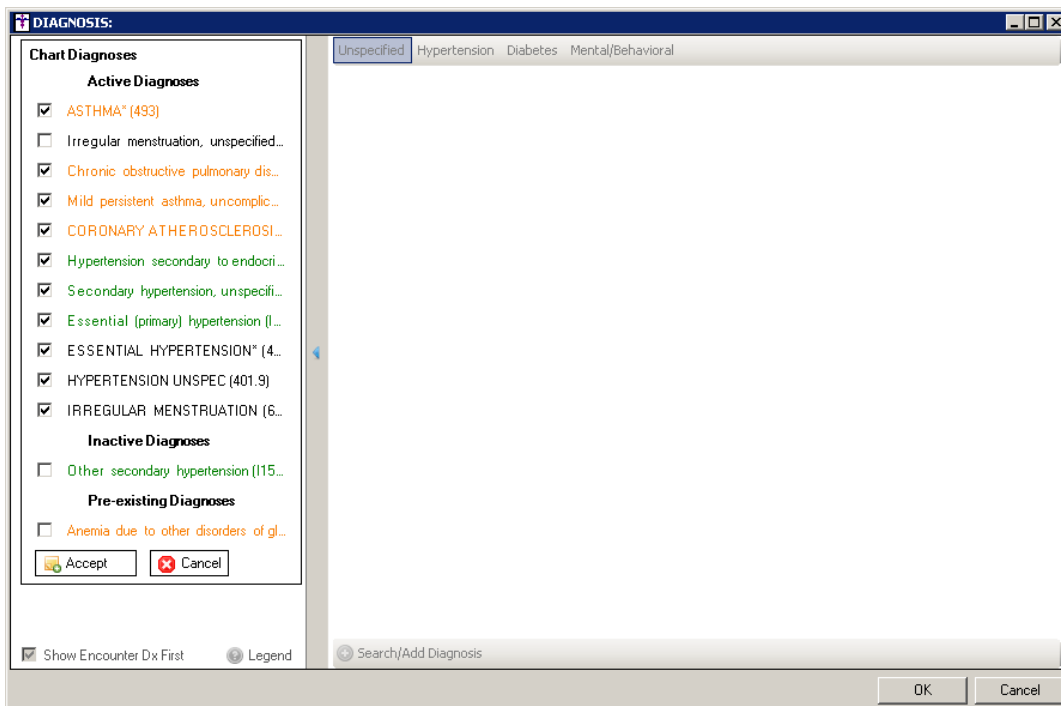


Figure 11 – Diagnosis – Selecting Select All Active Diagnoses

Added Features (continued)

The Note Tab – Diagnosis (continued)

Once accepted, all of the selected diagnoses will be moved to the Encounter Diagnoses section and each diagnosis will be noted with no additional information provided. See Figure 12. You can now edit each applicable diagnosis to add any additional information (comments or options) as needed. The updated information will be outputted to the chart note.

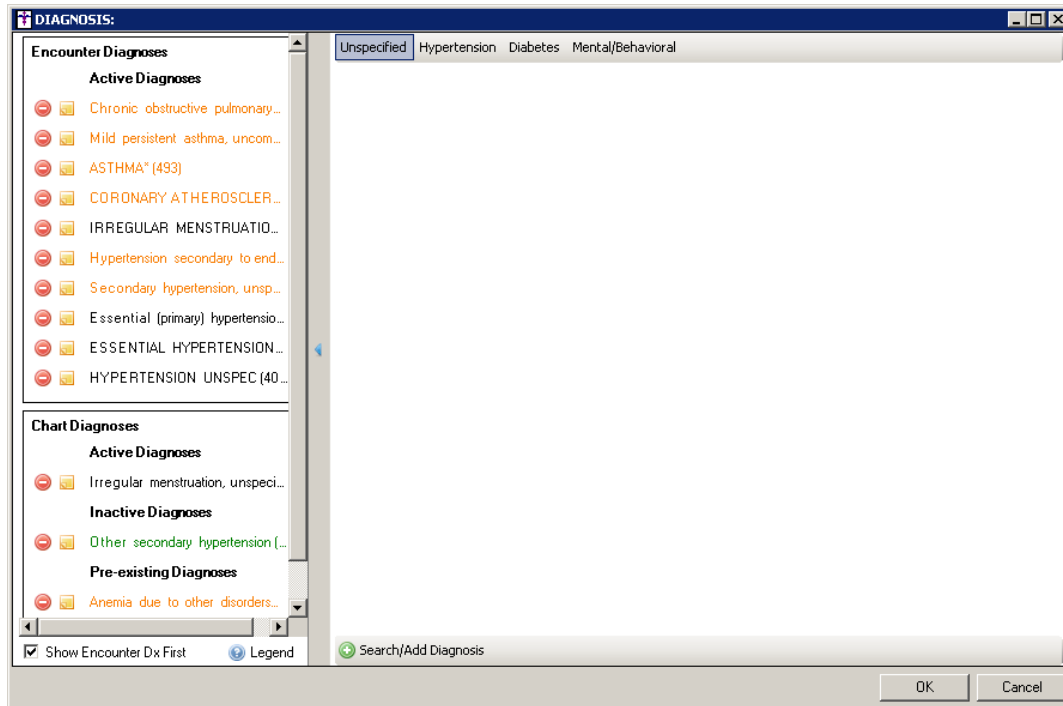


Figure 12 – Diagnosis

Added Features (continued)

- **The Note Tab – Diagnosis** – The program has been updated so whenever you are adding, editing, or noting a diagnosis, you have the ability to select any existing Order Set in the system to use for that diagnosis, regardless if that diagnosis is linked to that order set. See Figure 13. The order sets in the Use Order Set drop-down will be listed in alphabetical order, and any order set linked to the diagnosis will have an asterisk next to it.

Note Diagnosis

Diagnosis: Chronic obstructive pulmonary disease with (acute) exacerbation

CDC Status: None - Not a case per CDC

Action:

Observation Noted

Minor Stable/Improved Worsening None

Use Order Set: Another Order Set

Order Sets marked with (*) are linked to this Diagnosis

Diagnosis Status

Onset: 10/31/2014 11:11:53

Inactivate: ??/??/???? ??:??:??

Reactivate: ??/??/???? ??:??:??

Resolve: 12/17/2014 14:19:51

Apply Last Comment

Yes No

SNOMED Selection

Double click an item or Search to add a SNOMED code.

Item Description	Apply	SNOMED
Chronic obstructive pulmonary di...		

No mappings are available.

Disclaimer: Diagnosis to SNOMED mappings are provided by the National Library of Medicine.

User Defaults: Save, Restore

SNOMED: Search, Delete

Comments

OK, Cancel, Help

Figure 13 – Note Diagnosis

- **Order Sets – Referrals** – The system has been updated so that whenever a Referral is attached to an order set, and that order set is activated, then the referral information will be outputted to the Referral button in the chart note and to the Referrals section of the patient's facesheet.

Added Features (continued)

- **System Tables – Folder Management – Manage Folders** – The System Tables menu has been updated with a new Folder Management option that allows access to the Manage Folders dialog (Edit > System Tables > Folder Management > Manage Folders) allowing you to add and maintain custom folders. See Figure 14. This functionality has moved from the Manage Folders button in the Chart Header for patient charts, and from the Organizer in previous versions of the Clinical application.

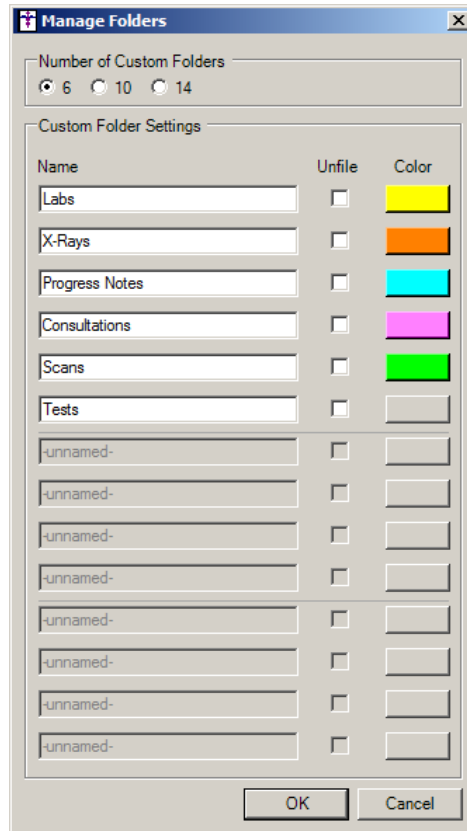


Figure 14 – Manage Folders

Added Features (continued)

- **System Tables – Folder Management – Default Folders** – The System Tables menu has been updated with a new Folder Management option that allows access to the new Default Folders dialog (Edit > System Tables > Folder Management > Default Folders) allowing you to map a particular destination folder for specific Labs, Notes, and Scans. See Figure 15. When a destination folder is mapped to a lab, note, or scan, the system will automatically transfer that applicable lab, note, or scan to that folder whenever they occur.

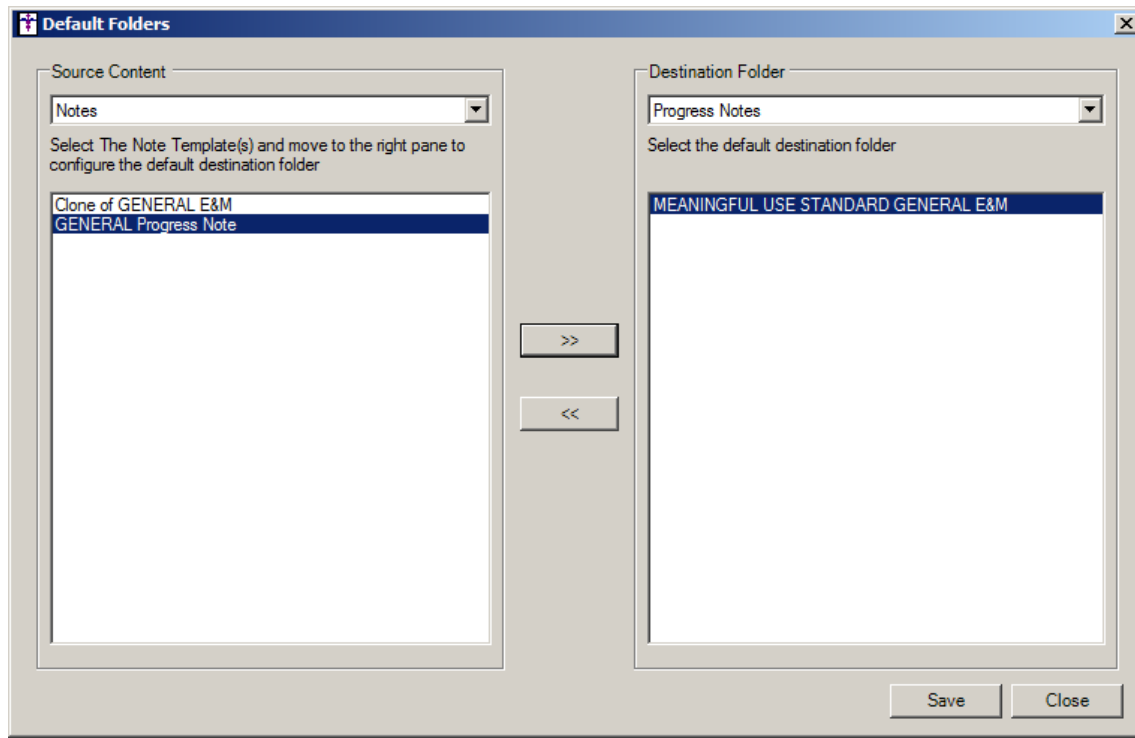


Figure 15 – Default Folders

- **Template Editing – Checklist – Finding Check List Properties** – The Include As field in the Finding Check List Properties dialog has been updated with a HPI category. See Figure 16. When the HPI category is selected, this checklist will be designated as a HPI checklist and will allow the data to be pulled into custom forms.

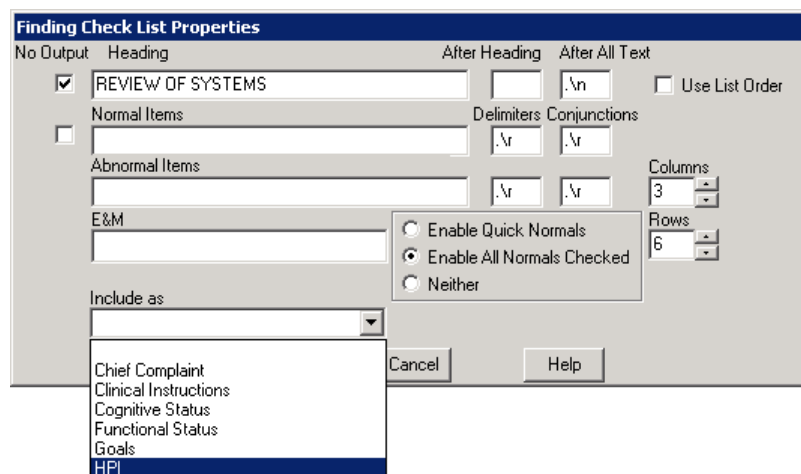


Figure 16 – Finding Check List Properties

Added Features (continued)

- **To-Do List – Transfer** – The To-Do List has been updated with a Transfer button that allows you to transfer unsigned note reminders to another user without having access the patient's chart. See Figure 17 and 18. To transfer unsigned note reminders to another user, simply highlight the applicable items, and then click the Transfer button. A User Selection dialog will then appear allowing you to select the user you want to transfer the note reminders to. See Figure 19.

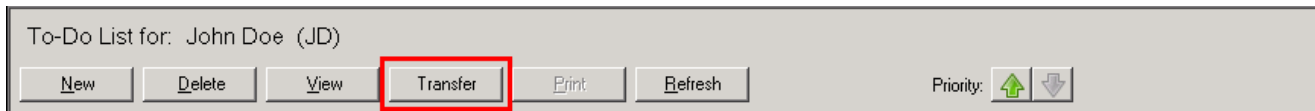


Figure 17 – To-Do List

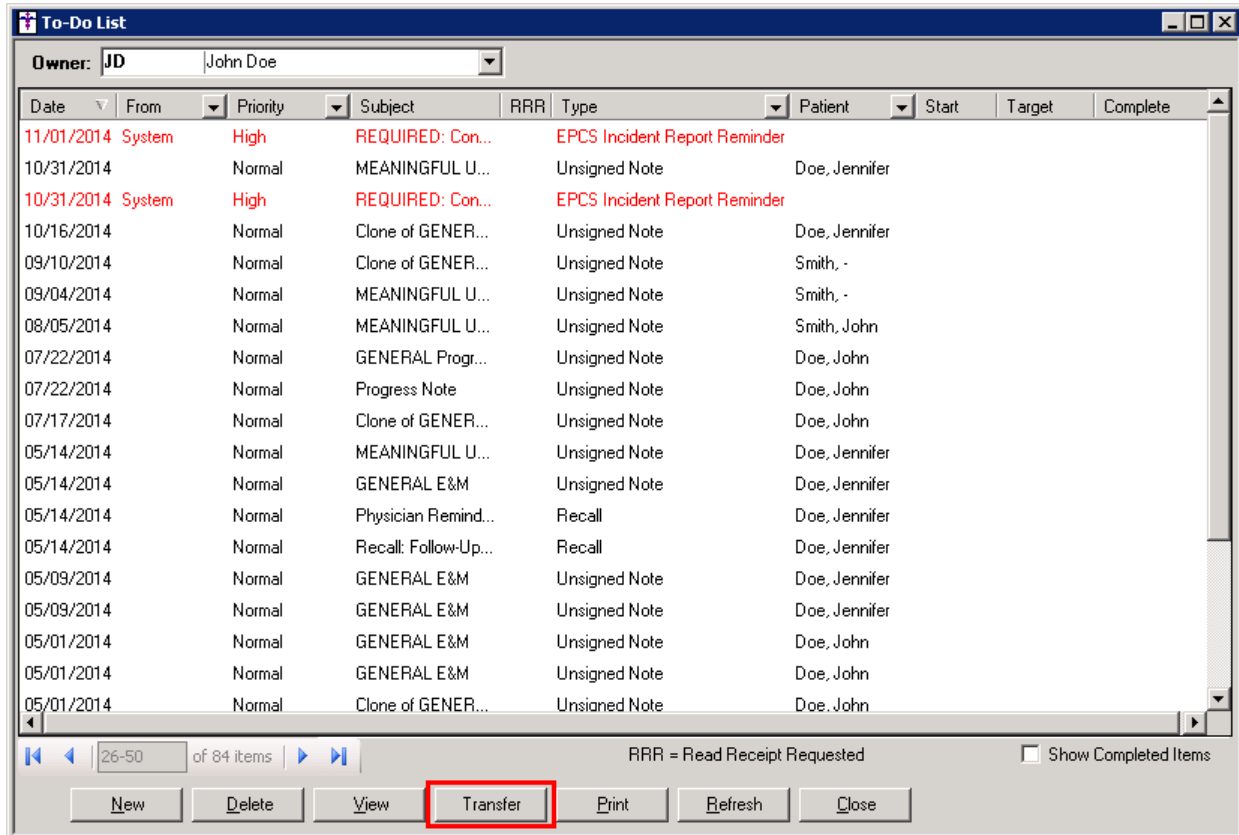


Figure 18 – To-Do List

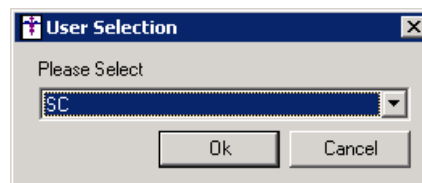


Figure 19 – To-Do List

Addendum

SureScripts® E-Prescribing Best Practice Guidelines

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 dosepak 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.
 - 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 Topical Ointment	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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