

ChartMaker[®] Clinical

Added Features

- **The Audit Trail** – The Audit Trail has been updated to track whenever the Advance Directives have been added or modified via the Advance Directives dialog, the Organizer, or the Scan Management dialog.
- **Direct Messaging** – The To field in the New Direct Message dialog has been updated so the last 25 recipients will appear in the drop-down list. Likewise, when typing an address into the To field, the system will attempt to autocomplete the address for you based on the last 25 recipients.
- **Export Patient Document – Office Visit Clinical Summary** – The Office Visit Clinical Summary document has been updated to include Tall Man lettering when displaying medication names.
- **Export Patient Document – Transition of Care** – The Transition of Care Summary document has been updated to include Tall Man lettering when displaying medication names.
- **The Facesheet – Advance Directives** – The Facesheet has been updated with an Advance Directives section that will list whether or not there are any Advance Directives configured for the patient, as well as if a note or notes have been marked as Advance Directives. See Figure 1. If you click the asterisk next to the Has Advance Directives item, a menu will appear summarizing what directives are configured for the patient.

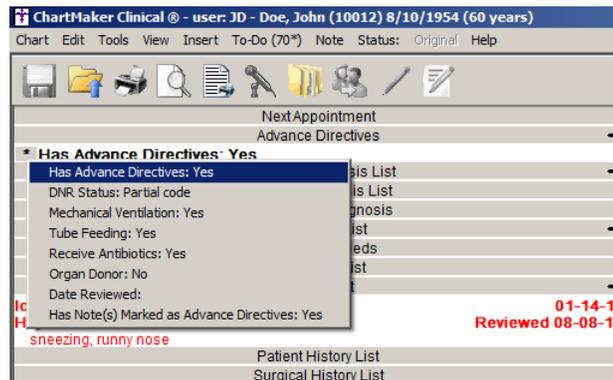


Figure 1 – Facesheet – Today's Appointments

- **The Facesheet – Allergies** – The Allergies section of the Facesheet has been updated so that all allergies will appear with a red boldfaced font to allow the user to easier identify these items. See Figure 2.

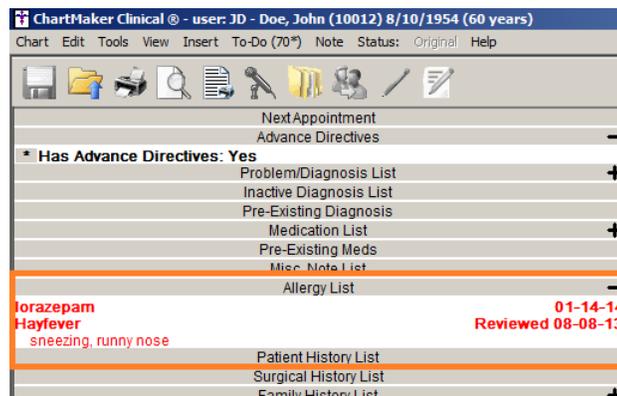


Figure 2 – Facesheet – Today's Appointments

Added Features (continued)

- **The Facesheet – Image Procedures** – The program has been updated so that when there are multiple Image Procedures queued for printing, each Image Procedure will be printed on an individual page.
- **The Facesheet – Test Procedures** – The program has been updated so that when there are multiple Test Procedures queued for printing, each Test Procedure will be printed on an individual page.
- **The ID Tab – Advance Directives** – The Patient section of the ID tab has been updated with an Advance Directives button that allows access to the Advance Directives dialog to configure any applicable advance directives for the patient. See Figure 3.

Once the Advance Directives dialog has been accessed, you will see a lists of questions regarding the various advance directives that the patient may have (DNR status, mechanical ventilation, feeding tube, antibiotics, and organ donor information). See Figure 4. Only the first question (Does the patient have Advance Directives?), will be active when initially entering this dialog. This question defaults to Not Asked, and you can change this as needed to No, Yes, or Declined to Provide. The subsequent advance directive questions will only activate if Yes is selected for this initial question. You can then configure the rest of the advance directives as applicable.

In addition, any configured Health Care Proxies, as well as any Notes that have been marked as Advanced Directive in ChartMaker® Clinical will be displayed in the corresponding fields. Likewise, you can access a Note tagged as Advance Directive by selecting the applicable note, and then clicking the Open Note button. You also have the ability to indicate that these directives were Reviewed, and configure the date on which these were reviewed.

All information added and modified in the Advance Directives dialog is tracked in the Audit Trail.

The screenshot shows the 'Patient' section of the ID tab. The 'Advance Directives' button is highlighted with a red box. The patient information includes: Chart # 10012, Salutation, First Name John, Middle, Last Name Doe, Suffix, Mailing Address 23 Main Street, City Syracuse, State NY, ZIP 13219, Social Security 212-32-1312, Status Active, Gender Male, Birth Date 08/10/1954, Time 12:00 AM, Age 60 years, and a photo of a man. The 'Advance Directives' button is located in the bottom left area of the patient information section.

Figure 3 – ID Tab – Patient – Advance Directives

The screenshot shows the 'Advance Directives' dialog box. It contains several sections: 'Advance Directives' with a dropdown for 'Does the patient have Advance Directives?' (set to 'Yes'), 'What is the patient's DNR status?' (set to 'Partial code'), 'Does the patient wish to have mechanical ventilation?' (set to 'Yes'), 'Does the patient wish to be provided nutrition or hydration via feeding tube?' (set to 'Yes'), 'Does the patient wish to receive antibiotics?' (set to 'Yes'), 'Is the patient an organ donor?' (set to 'Yes'), 'Health Care Proxies' table, 'Note marked as Advance Directive in ChartMaker® Clinical' (set to 'GENERAL Progress Note (04-23-2015)'), and 'Date Reviewed' (set to '4/24/2015'). The 'Health Care Proxies' table is as follows:

Name	Address	Phone
Joanna Doe	57 West Ave Syracuse, ...	(315) 488-1518

Buttons for 'Open Note' and 'Reviewed' are present. The dialog has 'OK' and 'Cancel' buttons at the bottom.

Figure 4 – Advance Directives

Added Features (continued)

- **Meaningful Use Stage 1 & 2 2014 – CQM Reporting** – The Quality Reporting Document Architecture (QRDA) dialog has been updated with a Use 2015 standard for QRDA checkbox that allows you to use the latest QRDA specifications when generating a QRDA file to be submitted to CMS during attestation. See Figure 5. When this option is unchecked, you will be using the old QRDA specifications.

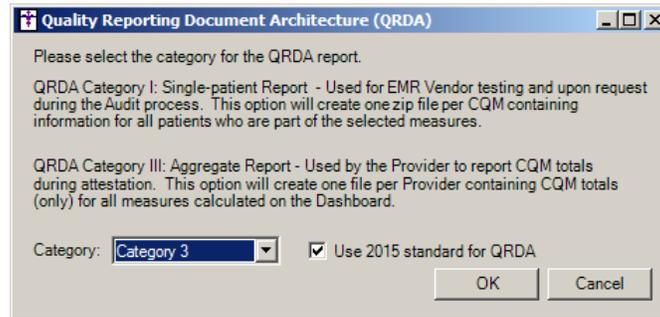


Figure 5 – Quality Reporting Document Architecture (QRDA)

- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0022 - Use of High-Risk Medications in the Elderly** quality measure that measures the percentage of patients 66 years of age and older who were ordered high-risk medications.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0060 Hemoglobin A1c Test for Pediatric Patients** quality measure that measures the percentage of patients 5-17 years of age with diabetes with an HbA1c test during the measurement period.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0069 Appropriate Treatment for Children with Upper Respiratory Infection (URI)** quality measure that measures the percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0108 ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication** quality measure that measures the percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQFTBD Hypertension: Improvement in Blood Pressure** quality measure that measures the percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention** quality measure that measures the percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0041 Preventive Care and Screening: Influenza Immunization** quality measure that measures the percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0056 Diabetes: Foot Exam** quality measure that measures the percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period.

Added Features (continued)

- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0062 Diabetes: Urine Protein Screening** quality measure that measures the percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0081 Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)** quality measure that measures the percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at each hospital discharge.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0083 Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)** quality measure that measures the percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0088 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy** quality measure that measures the percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0421 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan** quality measure that measures the percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQFTBD Closing the referral loop: receipt of specialist report** quality measure that measures the percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0033 Chlamydia Screening for Women** quality measure that measures the percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.
- **Meaningful Use Stage 1 & 2 2014 – Quality Measures** – The Meaningful Use Dashboard (Stage 1 & 2 2014) has been updated with the **NQF0075 Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control** quality measure that measures the percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL).
- **Medication** – Tall Man lettering (the term given to an alternate casing of a drug name, where portions of the name appear in all capital letters to visually distinguish it from a drug with a very similar name) has been implemented throughout the system to help distinguish those medications having a high probability of being mistaken for other drugs because of similarities in either their pronunciation or drug name description. For example, the Tall Man lettering of acetazolamide is acetaZOLAMIDE, which distinguishes it from the drug acetohexamide. In turn, Tall Man lettering for acetohexamide is acetoHEXAMIDE.

Added Features (continued)

- **Medication – Add Medication Not Ordered** – The Medication button has been updated with an Add Medication Not Ordered option that allows you to properly document specific medications that are not being ordered for a patient along with the reasons and applicable SNOMED codes. See Figure 6.

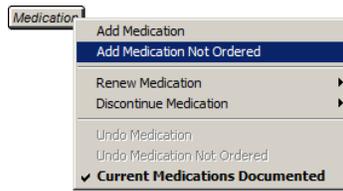


Figure 6– Medication – Add Medication Not Ordered

When the Add Medication Not Ordered option is selected, a Search For Medication Not Ordered dialog will appear allowing you to search for the specific medication that is not being ordered. See Figure 7. Once that medication is found and selected, you can indicate the Reason (Medical, Patient, or System), and then further define the reason in the SNOMED Selection section with the specific reason along with the applicable SNOMED code. The reasons and the SNOMED codes can be added by clicking the **Search** button. Multiple codes can be added if needed. Likewise, you have the ability to remove any codes by highlighting the specific reason and then clicking the **Delete** button, if needed.

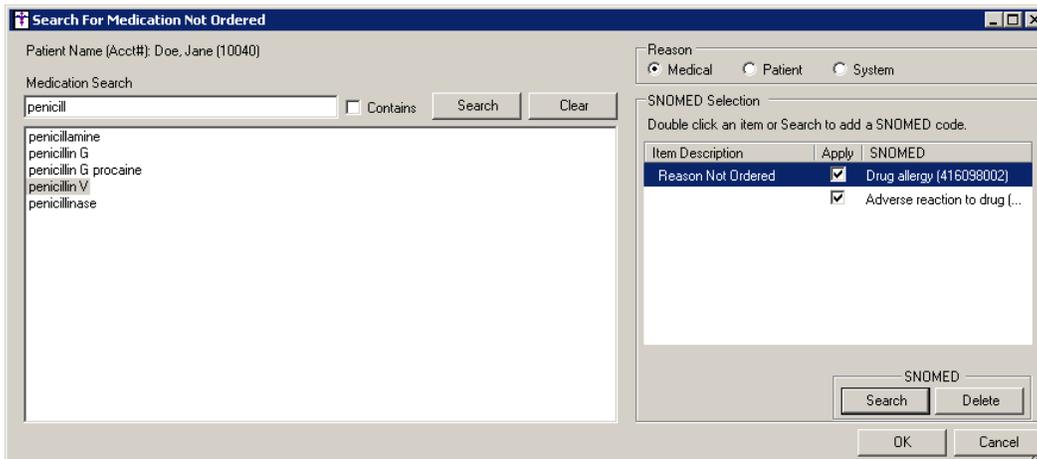


Figure 7 – Search For Medication Not Ordered

After the applicable medication and associated reason has been configured, you can click the OK button to add this to the patient's note. The medication not ordered will then appear next in the Medications Not Ordered: section next to the Medication button. See Figure 8. Likewise, this information will be tracked in the History tab and will be used for any applicable Meaningful Use Quality Measures.



Figure 8 – Medication Button

After a medication not ordered has been added to a note, you have the ability to undo that medication not ordered in the note which that medication was added. See Figure 9.

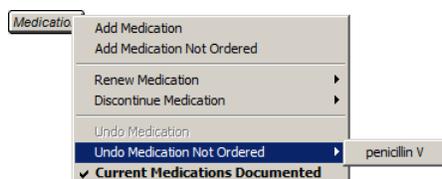


Figure 9 – Medication – Undo Medication Not Ordered

Added Features (continued)

- **Medication – EPCS** – The system has been updated to prevent providers from e-prescribing controlled substances to and from Missouri.
- **Medication – EPCS** – The system has been updated to allow providers to e-prescribe controlled substances to and from Kansas.
- **Medication – EPCS Audit Trail** – The system has been updated to prevent data tampering of EPCS related data tables. Likewise, the EPCS database triggers have been encrypted to provide an additional level of security. Whenever there are any data modifications or deletions, the system will display this information in the EPCS Audit Trail.
- **Medication – EPCS Audit Trail** – The system has been updated to log all EPCS audit trail actions performed by a system user on the Daily Incident Report.
- **Medication – EPCS Audit Trail** – The system has been updated to log all instances in which a user either cancels out of the Token Logon dialog, or enters an incorrect password in the Token Logon dialog, on the Daily Incident Report.
- **Medication – Confirm Prescription – EPCS** – The system has been updated with additional checks to ensure that the proper token is being used during the signing process when sending controlled substances.
- **Medication – Confirm Prescription – EPCS** – The system has been updated so any time the Ready to Sign option is unchecked when prescribing a controlled substance, an audit event will be created in the EPCS Audit Trail.
- **Medication – Prescribe Medication** – The system has been updated so that when prescribing topical drugs (i.e., Bactroban topical cream) the action field will default to Apply, and the Dose and Dose Units fields are no longer required to complete the prescription.
- **Medication – Prescribe Medication** – The Dispense field in the Prescribe Medication dialog has been updated so that the Unspecified unit is no longer an available option. Likewise, the system will also not allow you to continue with the prescription if you do not select a specific dispense unit. A warning message will appear indicating that a dispense unit must be selected. See Figure 10.



Figure 10 – Invalid Data – Dispense

- **Medication – Prescribe Medication – EPCS** – The Prescribe Medication screen has been updated so that whenever you are prescribing a Schedule II Controlled Substance, a warning will be issued and you will not be able to continue if the Days Supply, either entered manually or calculated by the system, is greater than 90 days. See Figure 11. Likewise, a similar warning will appear if the Days Supply field contains a zero.

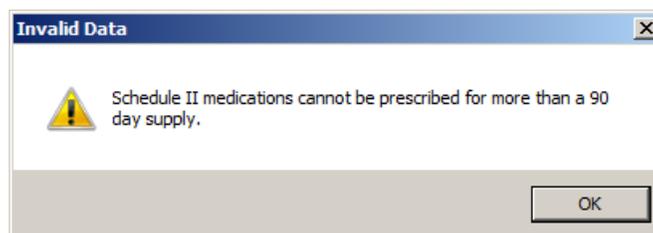


Figure 11 – Invalid Data – Days Supply

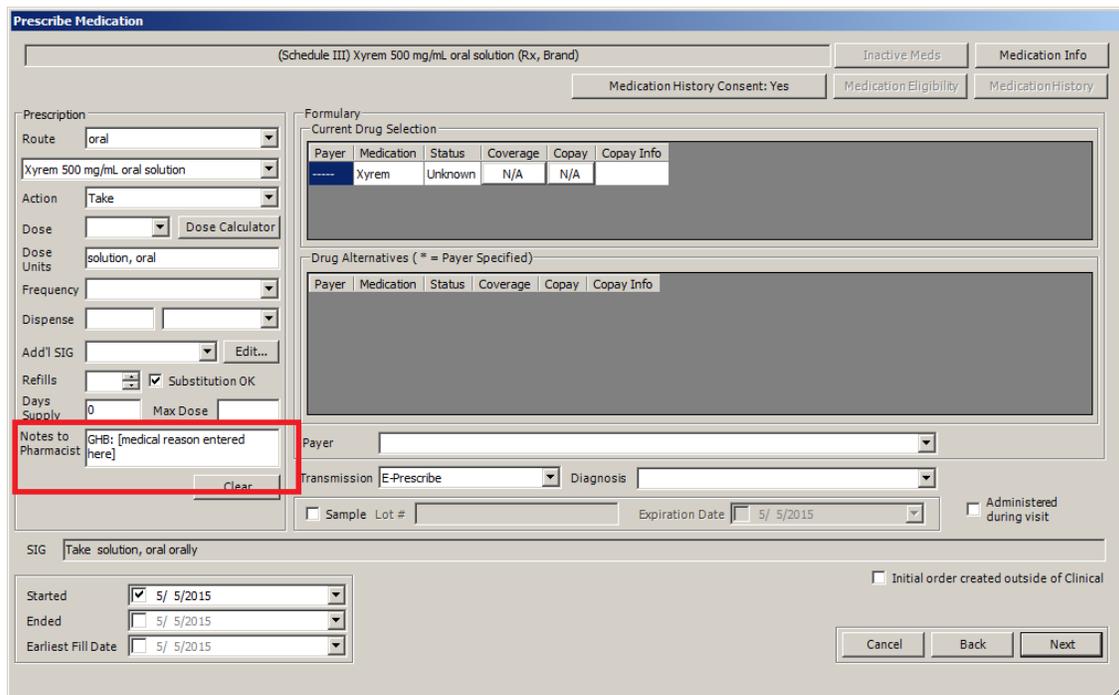
Added Features (continued)

- **Medication – Prescribe Medication – EPCS** – The Prescribe Medication screen has been updated so that whenever you are prescribing a Schedule III or Schedule IV Controlled Substance, a warning will be issued and you will not be able to continue if the Earliest Fill Date is greater than six months from today. See Figure 12.



Figure 12 – Invalid Data – Earliest Fill Date

- **Medication – Prescribe Medication – EPCS** – The Prescribe Medication screen has been updated so that whenever you are prescribing GHB (Xyrem), the system will enter "GHB:" in the Notes to Pharmacist field, and you will need to append this with a medical reason for prescribing this drug. See Figure 13. If a reason is not entered, you will not be able to continue prescribing the drug.



The "Prescribe Medication" screen for "(Schedule III) Xyrem 500 mg/mL oral solution (Rx, Brand)". The "Notes to Pharmacist" field is highlighted with a red box and contains the text "GHB: [medical reason entered here]".

Payer	Medication	Status	Coverage	Copay	Copay Info
-----	Xyrem	Unknown	N/A	N/A	

Payer	Medication	Status	Coverage	Copay	Copay Info
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Started: 5/ 5/2015
Ended: 5/ 5/2015
Earliest Fill Date: 5/ 5/2015

Figure 13 – Prescribe Medication – GHB

Added Features (continued)

- **Medication – Prescribe Medication – EPCS** – The Prescribe Medication screen has been updated so that whenever you are prescribing a drug for detoxification treatment (Suboxone, Zubsolv, etc.), the system will enter "NADEAN:" in the Notes to Pharmacist field, and you will need to append this with an applicable NADEAN number. See Figure 14. If a NADEAN number is not entered, you will not be able to continue prescribing the drug.

The screenshot shows the 'Prescribe Medication' window for '(Schedule III) Zubsolv 1.4 mg-0.36 mg sublingual tablet (Rx, Brand)'. The 'Notes to Pharmacist' field is highlighted with a red box and contains the text 'NADEAN: 1234334'. Other fields include Route (SL), Dose (tablets), Frequency, Dispense (Tablet), and a 'Clear' button. The 'Formulary' section shows a table with columns for Payer, Medication, Status, Coverage, Copay, and Copay Info. The 'Drug Alternatives' section is also visible.

Figure 14– Prescribe Medication – NADEAN #

- **Medication – Refill Response – EPCS** – The Refill Response dialog has been updated so that you are not allowed to approve a refill request for a Schedule II controlled substance. When the provider selects Ready to Sign option in the Refill Response dialog, a warning message will appear indicating that they are not allowed to process a refill request for a Schedule II medication. The provider will only be allowed to **Deny** or **Deny but new Rx will follow**. This is logged in audit trail with reason why they cannot proceed.
- **Medication – Refill Response – EPCS** – The Refill Response dialog has been updated so that you are not allowed to approve a refill request for a Schedule III or Schedule IV controlled substance that is for a prescription that was last prescribed in a patient's chart more than six (6) months ago. When provider selects the Ready to Sign checkbox in the Refill Response dialog, a warning message will appear indicating that the refill cannot be processed because the originating prescription is more than six months old. Do note, that the written date of the prescription will be compared to today's date when the provider is trying to process it, not the refill request date, to determine the six months.
- **Medication – Refill Response – EPCS** – The system has been updated so any time the Ready to Sign option is unchecked when prescribing a controlled substance, an audit event will be created in the EPCS Audit Trail.

Added Features (continued)

- Medication – Send E-Prescriptions** – The Send E-Prescriptions dialog has been updated to display all patient information (Name, Gender, Date of Birth, Address, and Phone) on the main Send E-Prescriptions screen. See Figure 15.

Figure 15– Send E-Prescriptions

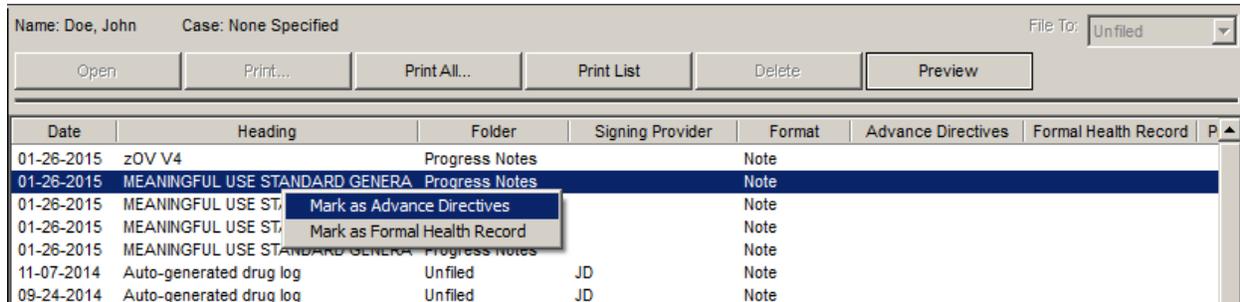
- Medication – Send E-Prescriptions – EPCS** – The system has been updated with additional checks to ensure that the proper token is being used during the signing process when sending controlled substances.
- Medication – Send E-Prescriptions – EPCS** – The system has been updated so any time the Ready to Sign option is unchecked when prescribing a controlled substance, an audit event will be created in the EPCS Audit Trail.
- The Note Tab – Diagnosis** – The Comments field in the Add to Problem List, Note Diagnosis, and End Diagnosis dialogs have been updated so that it can contain up to 1020 characters of text.
- The Note Tab – Lab Results** – The system has been updated to display previous lab results in the chart note for those templates that have the new Lab Results widget configured. See Figure 16. The configured Lab Results widget will display up to the last three results for a result. Those results that fall below or above the configured warning threshold will be displayed in red, with an [H] indicating higher or above the warning threshold, and a [L] indicating lower or below the warning threshold.

Prior Lab Results		
CO2		
03/15/15	28.111	mmol/L [H]
05/12/14	28.9	mmol/L [H]
06/22/12	28.9	mmol/L [H]
Potassium		
03/15/15	2.33333	mmol/L [L]
05/12/14	6	mmol/L [H]
06/22/12	6.1	mmol/L [H]
CHLORIDE		
03/15/15	107.2222	mmol/L
05/12/14	96	mmol/L
06/22/12	121	mmol/L [H]
SODIUM		
03/15/15	100.00111	mmol/L [L]
05/12/14	1000	mmol/L [H]
06/22/12	129	mmol/L [L]

Figure 16 – Note – Prior Lab Results

Added Features (continued)

- **The Organizer – Advance Directives** – The Organizer has been updated with an Advance Directives column as well as the ability to mark a chart note as Advance Directives. See Figure 17. To mark a note as Advance Directives, right-click the applicable note in the Organizer, and then click **Mark as Advance Directives**. Once a note has been tagged as Advance Directives a **Yes** will appear in the Advance Directives column. You can deselect a note that has been marked as Advance Directives in a similar manner, and once this is performed the Yes in the Advance Directives column will be removed. All information added and modified for Advance Directives in the Organizer is tracked in the Audit Trail.



The screenshot shows a software window titled "Name: Doe, John Case: None Specified" with a "File To:" dropdown set to "Unfiled". Below the title bar are buttons for "Open", "Print...", "Print All...", "Print List", "Delete", and "Preview". The main area is a table with columns: "Date", "Heading", "Folder", "Signing Provider", "Format", "Advance Directives", and "Formal Health Record". A context menu is open over the row dated "01-26-2015" with heading "MEANINGFUL USE STANDARD GENERAL". The menu options are "Mark as Advance Directives" and "Mark as Formal Health Record".

Date	Heading	Folder	Signing Provider	Format	Advance Directives	Formal Health Record
01-26-2015	zOV V4	Progress Notes		Note		
01-26-2015	MEANINGFUL USE STANDARD GENERAL	Progress Notes		Note		
01-26-2015	MEANINGFUL USE ST...			Note		
01-26-2015	MEANINGFUL USE ST...			Note		
01-26-2015	MEANINGFUL USE STANDARD GENERAL	Progress Notes		Note		
11-07-2014	Auto-generated drug log	Unfiled	JD	Note		
09-24-2014	Auto-generated drug log	Unfiled	JD	Note		

Figure 17 – The Organizer – Advance Directives

- **ChartMaker® PatientPortal** – The PatientPortal Practice Admin console has been updated allowing you to suspend patient accounts. A Suspend button has been added to the patient list for practice administrators. Likewise, practice administrators now have the ability to view a list of suspended patients which has a reactivate link for those patients. The patient will receive an email when the patient is suspended or reactivated.

When a patient's account is suspended, the patient and any patient representative accounts will not be able to log in to the PatientPortal. All data transfer for that patient will be stopped, and the PatientPortal button in ChartMaker Medical Suite (Clinical and Practice Manager) will appear red.

Added Features (continued)

- Reports – Clinical Notes Reconciliation** – The system has been updated with a Clinical Notes Reconciliation dialog, that is accessed via the Reports menu (Reports > Clinical Notes Reconciliation), that allows you to reconcile appointment visits with whether a chart note was entered for the corresponding appointment. See Figure 18. In the Select Date Range section, you have the ability to set a date range for the appointment visits, or you can select a preset value (Today, Yesterday, This Week, Last Week, This Month, or Last Month). In the Filter By section, you are able to filter the appointment visits by all practices or a specific practice, all providers or a specific provider, or by a specific account number. Likewise, in the Additional Filters section, you have the ability to narrow the list to some common problem cases. The Mismatch Practice option will show all rows that have a disagreement between the appointment practice and the note practice; the Mismatch Providers option will show all rows that have a disagreement between the appointment provider and the note provider; and the Unsigned or Missing Note option will show all rows that have either an unsigned or no note paired with the appointment. Once the applicable date range and filter items have been selected you click Run Report and the results will be displayed.

When the results are displayed the Note Status, Note Provider, Note Practice, and Note Case highlighted in red to provide a visual cue for any mismatched visits. You have the ability to double-click a visit in the list and the applicable patient's chart will then open in Clinical. Likewise, you can also print the Clinical Notes Reconciliation report if needed. Do note, you have the ability to minimize and keep the Clinical Note Reconciliation report open while working in Clinical.

Appt. Date/Time	Account #	Patient Name	Appt. Status	Note Status	Appt. Reason	Note Heading	Appt. Provider	Note Provider	Appt. Practice	Note Practice	Appt. Case	Note Case	Facility
3/18/2015 2:15 PM	10009	Doe, Jennifer	S	No Note	Follow U...		Doe, John		Central M...		10016		
3/18/2015 4:00 PM	10009	Doe, Jennifer	C	Not Re...	Follow U...		Doe, John		Central M...		10016		
3/18/2015 2:30 PM	10038	Doe, Flo	S	No Note	Sick visit		Doe, John		Central M...		10021		
3/18/2015 2:45 PM	10040	Doe, Jane	S	No Note	New Pati...		Doe, John		Central M...		10023		
3/18/2015 3:15 PM	10012	Doe, John	S	No Note	Follow U...		Doe, John		Central M...		10012		
3/18/2015 3:30 PM	10011	Doe, Jonah	S	No Note	Follow U...		Doe, John		Central M...		10015		
3/18/2015 3:45 PM	10039	Doe, Rene	S	No Note	Sick visit		Doe, John		Central M...		10022		

Only appointments scheduled in Practice Manager will appear on this report

Appointment Status: (I) - Checked In (O) - Checked Out (S) - Scheduled (C) - Cancelled (N) - No Show

Print

Figure 18 – Clinical Notes Reconciliation

Added Features (continued)

- **Reports – Reports** – The Reports dialog has been updated with Rx Date fields that allow you to query patient charts to display a list of patients that were taking the selected medication within the configured date range. See Figure 19. Patients will be considered taking the medication if: the Patient was prescribed or renewed a drug within the date range; the Patient was prescribed/renewed the drug before the date range, but it was discontinued within the date range; or the Patient was prescribed/renewed the drug before the date range, but it was discontinued after the date range, or it has not yet been discontinued.

The screenshot shows the 'Reports' dialog box with the following configuration:

- Create a list of: Patients Encounters
- with the following restrictions:
 - Active View Exempt Patients
 - Inactive Suppress Identity
 - Deceased Top 100 Only
- Birth date from: 05/05/2015 to 05/05/2015
- With Rx: B-12 Plus 5,000 mcg-100 mcg sublingual tablet
- Rx Date: 1/ 1/2015 to 5/ 5/2015 (highlighted in red)

Patient Name	Phone Num (H)	Phone Num (W)	Birth Date	Age	B-12 Plus 5,000 mcg-100 mcg sublingual tablet
👤 Doe, Jennifer	(315)4881518		09-27-1969	45 yr	YES
👤 Doe, Jonah	(315)4881518		09-12-1956	58 yr	YES

Figure 19 – Reports

Added Features (continued)

- **Scan Management** – The Scan Management dialog has been updated with a **Scan as an Advance Directive** checkbox that allows you to mark a scan as an advanced directive. See Figure 20. When this option is selected and the scan is saved, the system will then update the information in the Facesheet and the Advanced Directives dialog for the patient, and when viewing the scan in the Organizer the Advance Directives column will contain Yes. Likewise, the information will be tracked via the Audit Trail.

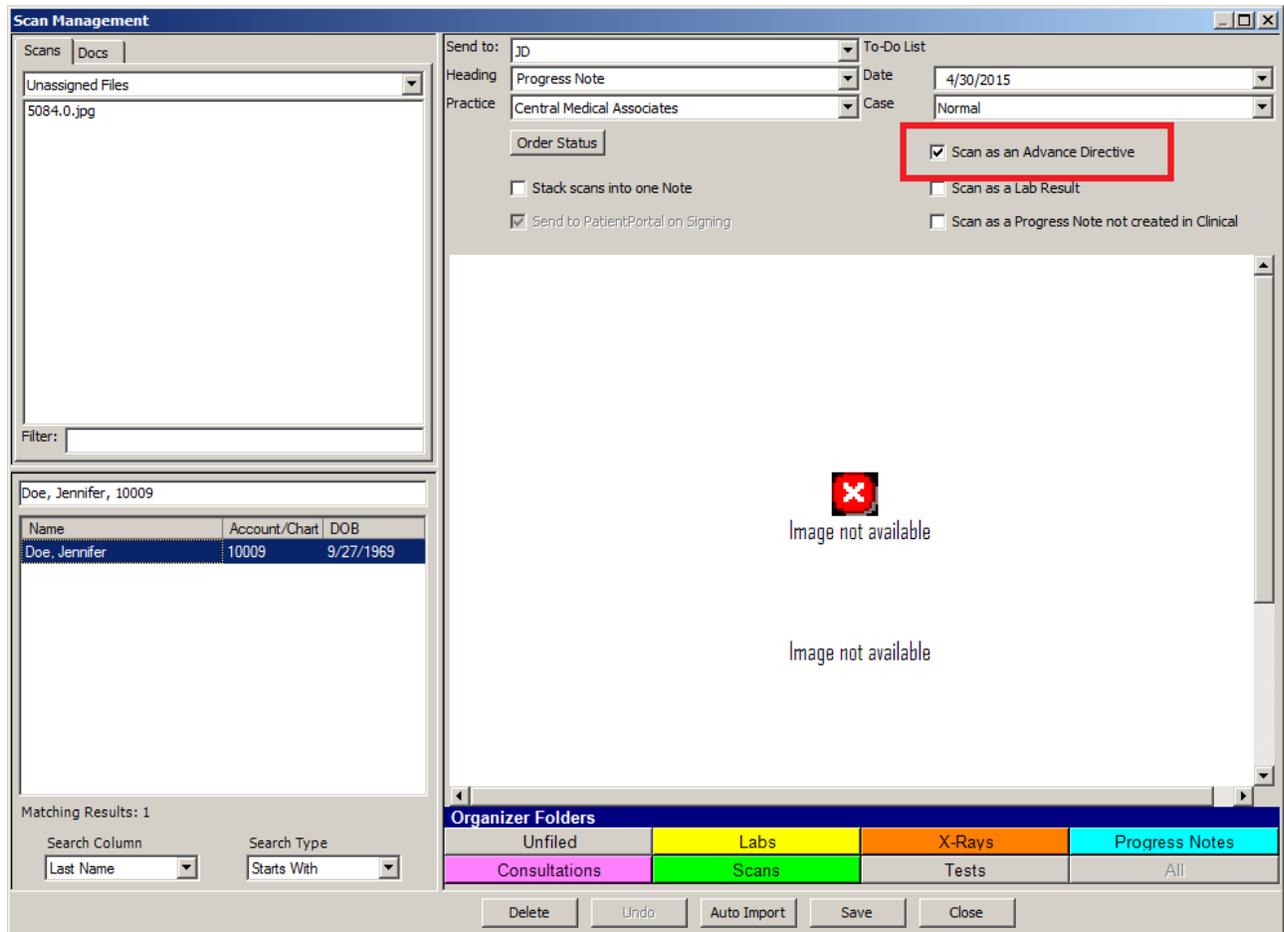


Figure 20 – Scan Management

Added Features (continued)

- **System Tables – Condition Groups** – The system has been updated with a new Condition Groups dialog that allows you to map individual procedures and results to a specific group, thereby offering you the ability to combine procedures and/or results that are duplicates, or have different descriptions or naming conventions, but represent the same procedure, result, or test, into a single group. See Figure 21. In the Procedure and Results section, you have the ability to search for specific procedures, results, or procedures and results to select and move into an existing or new group. The procedures and results will display any Unit of Measure or LOINC Code that were configured for the condition, and will also show the last modified Date for that condition. Do note, once a procedure or result has been added to a group it will no longer be displayed in the Procedure and Results list. Also, a condition can only belong to one group. In the Condition Group section you can search for a specific group, as well as add, edit, and delete groups as needed. Once groups have been created and conditions are mapped to them, they can be used throughout the system, specifically when importing lab information.

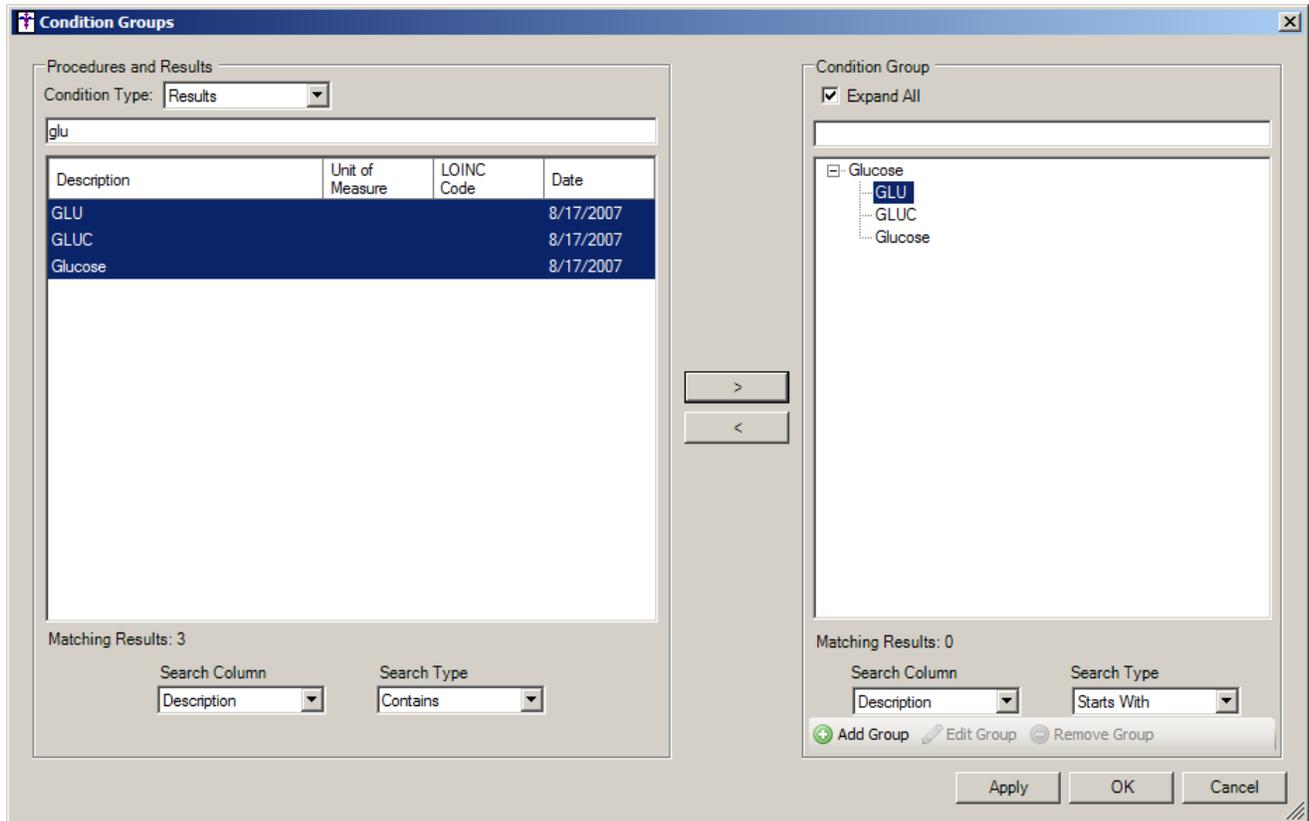


Figure 21 – Condition Groups

Added Features (continued)

- **System Tables – Database Backup** – The system has been updated with a new Backup Configuration dialog that allows you to configure multiple databases for backup snapshot monitoring. See Figure 22. You have the ability to Add and Delete databases as needed.

When a database is configured, a warning will appear when logging into Clinical if the any of the backup snapshots are older than 3 days old. Databases that were configured in previous versions will be migrated to the Backup Configuration dialog, however, additional databases that were not previously configured, or if there are multiple databases, these databases will need to be manually configured in this dialog.

All activity within the Backup Configuration dialog is tracked in the Audit System, allowing you to track any changes to this area.

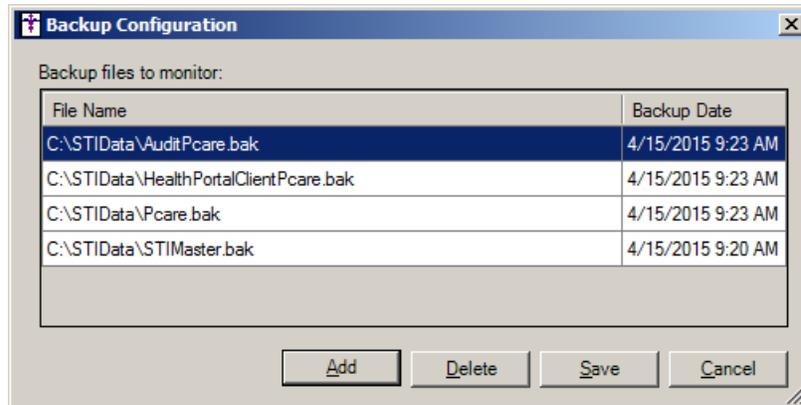


Figure 22 – Backup Configuration

If no databases are configured in the Backup Configuration dialog, a warning message will appear prior to logging into Clinical alerting you to this new feature and prompting you to configure this information. See Figure 23.

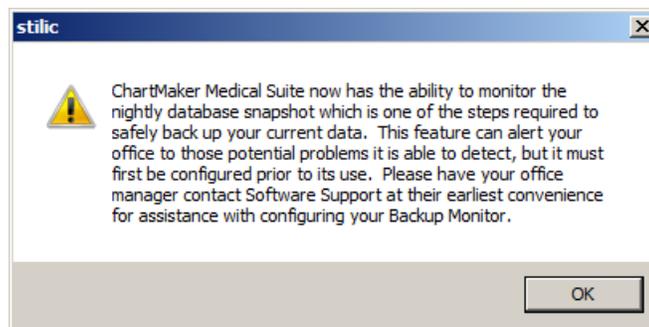


Figure 23 – stiliic – Backup Monitor Warning

Added Features (continued)

- **System Tables – Decision Support – DSS Rule Builder – Data Points** – The Data Points tab of the Rule Builder dialog has been updated with four new data points (Advance Directives Declined to Provide, Advance Directives No, Advance Directives Not Asked, and Advance Directives Yes) that allow you to configure rules so you are alerted when patients do or do not have advance directives documented. See Figure 24.

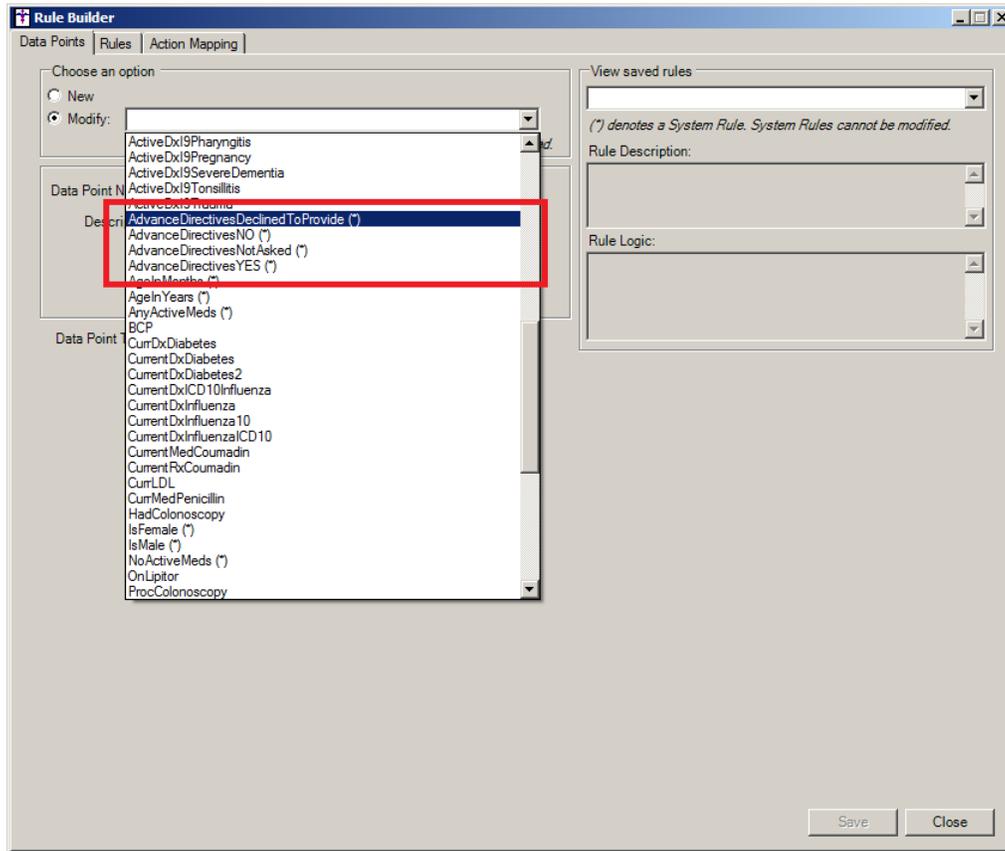


Figure 24 – Rule Builder – Data Points

Added Features (continued)

- **System Tables – Electronic Prescribing – EPCS Prescriber Authorization** – To assist in ensuring that the correct provider/prescriber is authorized with the correct token, the EPCS Prescriber Authorization dialog has been updated with a Token Information column that will display the linked token information for the prescriber listed in the row. See Figure 25.

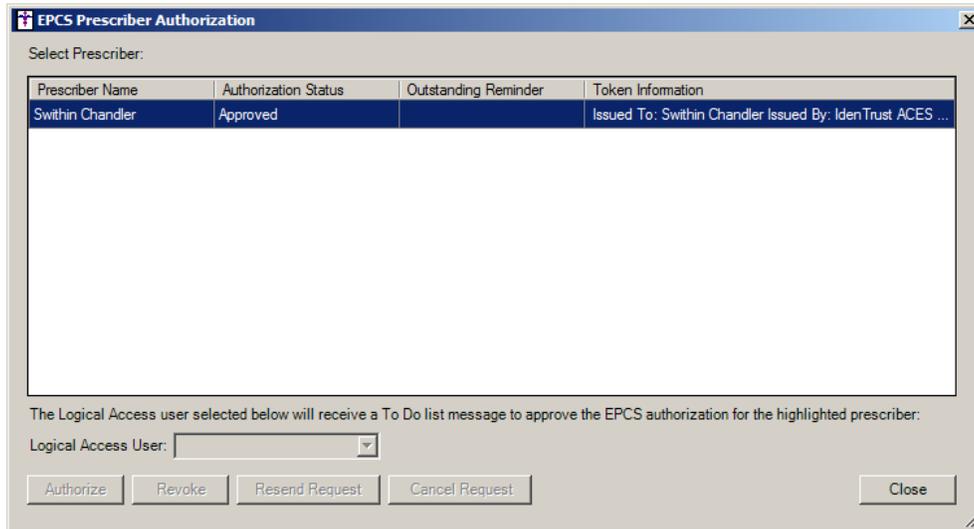


Figure 25 – EPCS Prescriber Authorization

Likewise, to further assist in ensuring that the provider/prescriber and token are linked and approved correctly, the EPCS Prescriber Request Approval dialog has been updated with more precise language regarding the approval and revocation process as well as listing Token Information for the provider/prescriber that is being asked to be approved or revoked. See Figure 26.

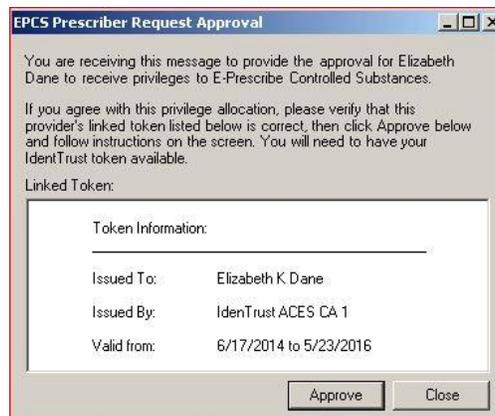


Figure 26 – EPCS Prescriber Request Approval

Added Features (continued)

- **System Tables – Office Hours** – The system has been updated with a new Office Hours dialog that allows you to configure standard office hours for your practice. See Figure 27. When office hours are configured, they will be used to determine when potentially unauthorized activity occurs with the EPCS module and any activity outside of the configured office hours will be displayed in the Daily Incident Report for EPCS. All changes that are made in the Office Hours dialog are tracked in the Audit Trail.

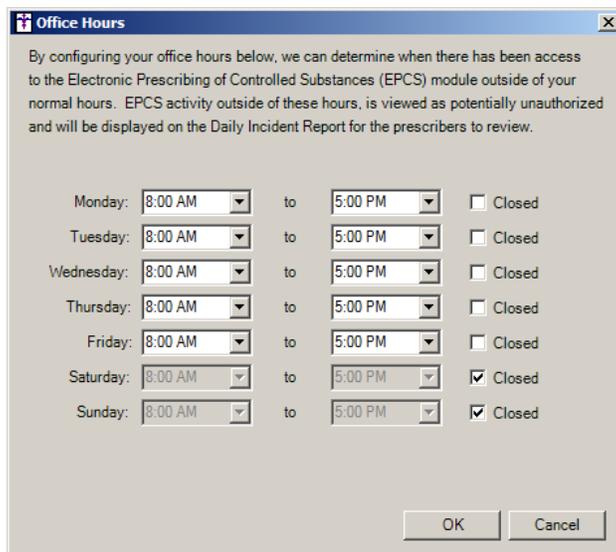


Figure 27 – Office Hours

- **System Update – ChartMaker Medical Suite Update** – The ChartMaker Medical Suite Update Status dialog has been updated to display the file size of the update, the current amount that has been downloaded, as well as the amount of time remaining for the download. See Figure 28.

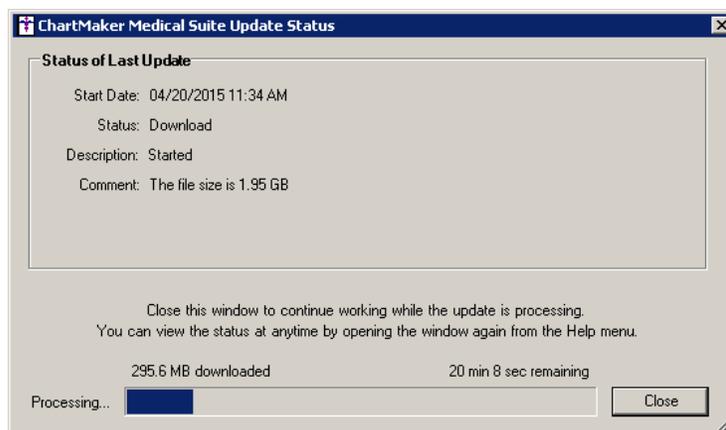


Figure 28 – ChartMaker Medical Suite Update Status

- **System Update – Install Runner** – The Install Runner has been updated so that whenever the Install Runner is executing an update to the ChartMaker Medical Suite, any user that attempts to login while the update is still running will be denied access and a warning message will appear alerting the user that the update is running and they will need to wait until it is finished before logging in. See Figure 29.

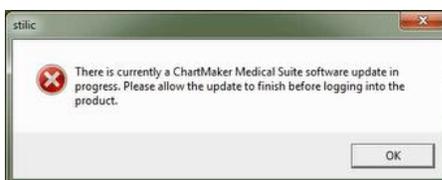


Figure 29 – stilic – Login Warning

Added Features (continued)

- **Template Editing – Lab Results** – The Template Editor has been updated with the ability to add a Lab Result widget to a template that will display prior lab results for a patient. See Figure 30.

Prior Lab Results

Figure 30 – Lab Results Widget

When the Lab Result widget is added to the template you have the ability to edit the properties of the widget where you can add and remove the results you want displayed via the widget, choose whether to display the last three results for a result, as well as to configure a warning threshold range (Warn Below and Warn Above) for a result. See Figure 31.

Description	Last 3	Warn Below	Warn Above
Glucose	<input checked="" type="checkbox"/>	70	150
GLU	<input checked="" type="checkbox"/>		
Glucose	<input checked="" type="checkbox"/>		

Figure 31 – Lab Results Properties

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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