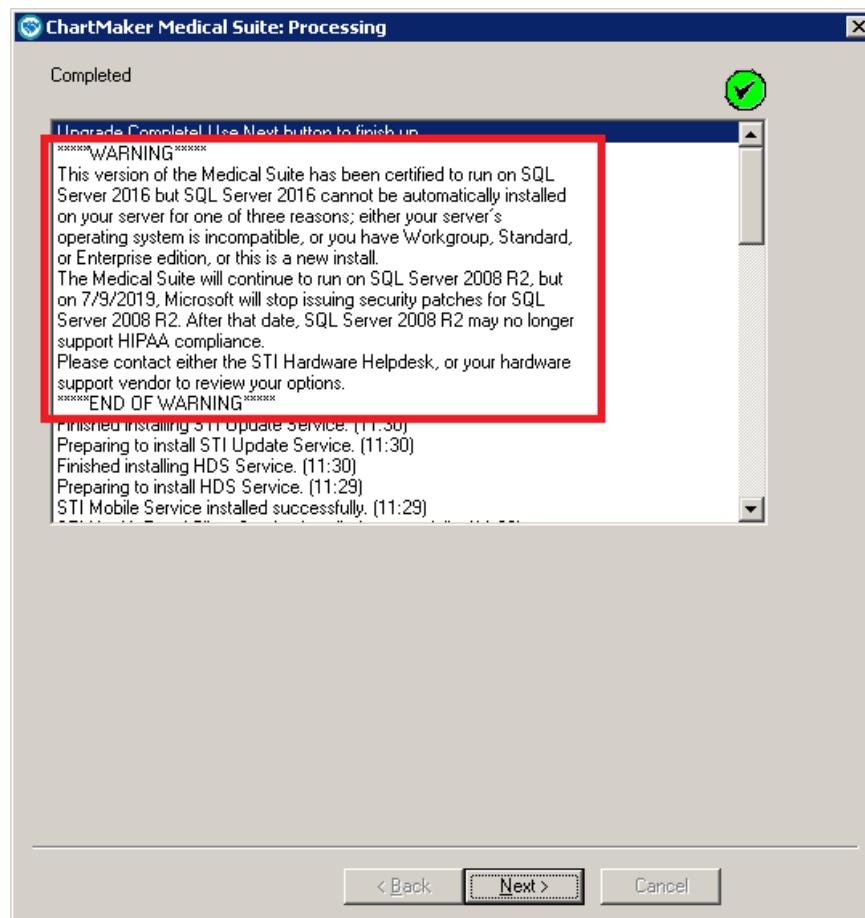


ChartMaker® Clinical Release Notes

ChartMaker® 2018.2 (fv6.5.5)

Important Notifications

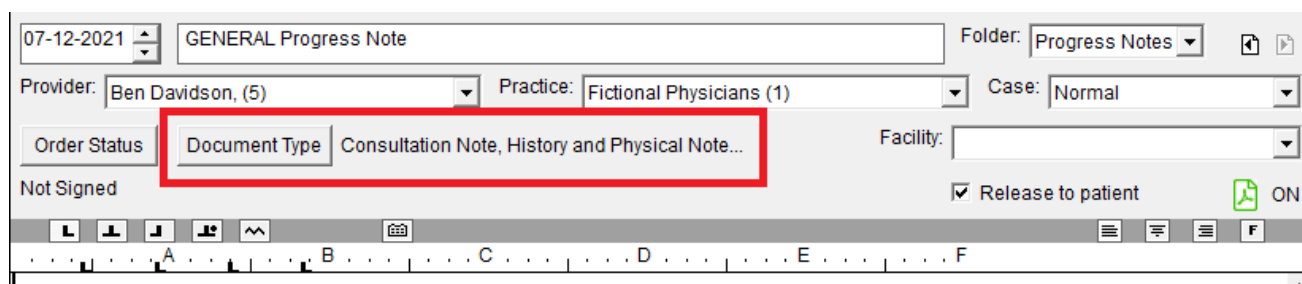
- **Upgrade from Microsoft Server 2008 and Windows 7** – Since January 2020, your Windows 7 workstations and Microsoft 2008 Servers are no longer supported. Even with security patches, [problems may still arise](#) if you choose not to upgrade. In addition, your workstations are not HIPAA compliant. To avoid these issues, contact our [Technical Services Department](#) today.
- **SQL Server 2016 & the ChartMaker 2018.2 (File Version 6.3.3) Upgrade** – Beginning with ChartMaker 2018.2 (File Version 6.3.3) Upgrade, a warning message will appear upon the completion of the upgrade regarding the transition of the ChartMaker Medical Suite to using SQL Server 2016, for those offices where an automated upgrade to SQL Server 2016 was not possible. See the figure below. If you are receiving this message, to avoid potential issues and to ensure your system remains HIPAA compliant, it is important to contact either STI Hardware Helpdesk, or your software vendor, to review your options.



ChartMaker Medical Suite SQL Server 2016 Warning

Added Features

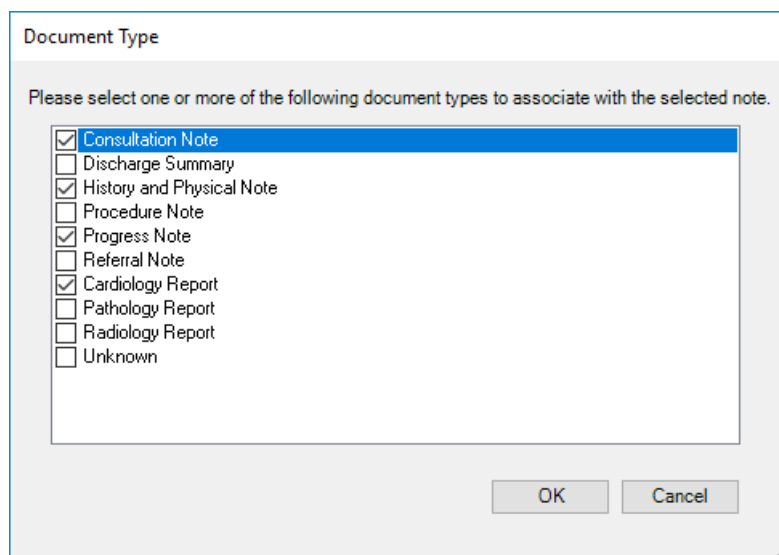
- **Export – Export Patient Data – Note PDF** – As part of the compliance with the requirements against Information Blocking as outlined in the 21st Century Cures Act (21CCA), the system has been updated to export PDF copies of chart notes that contain text-only information (e.g., inter-office messages, basic phone message templates, free-text notes, etc.) to the patient's ChartMaker® PatientPortal, when signing that note. In previous versions, a PDF copy of the chart note was only generated when database events were entered or modified in the chart note (medications, diagnoses, allergies, future appointments, etc.). Now, in addition to any notes that contain database events, any text-only notes, will be also be exported upon signing if the **Release to Patient** option is checked in the Note Header. However, PDF copies of chart notes will not be generated for auto-drug logs, auto In-House Orders, and batch signing of documents, although these documents can be manually exported by right-clicking and selecting the Send to Patient Access option, if desired.
- **The Note Tab – Note Header** – The Note Header has been updated with a new **Document Type** button that allows you to configure the document types for the chart note. See Figure 1. Up to two document types that are associated with the note will appear in the label to the right of the button, and if there are more than two document types, an ellipsis will follow. You can hover over the label and a tooltip will appear displaying all the document types associated with the note. When a new note is created, any document types configured for the note template will default. You can then modify the document types on a note-by-note basis, if needed.



The screenshot shows the 'Note Header' interface. At the top, there is a date field set to '07-12-2021' and a text field containing 'GENERAL Progress Note'. To the right is a 'Folder' dropdown menu set to 'Progress Notes'. Below these are fields for 'Provider' (Ben Davidson, (5)), 'Practice' (Fictional Physicians (1)), and 'Case' (Normal). A 'Facility' dropdown is also present. A 'Document Type' button is highlighted with a red rectangle; next to it is a label 'Consultation Note, History and Physical Note...'. To the left of the button is an 'Order Status' button. Below the button is a 'Not Signed' status. On the right, there is a 'Release to patient' checkbox which is checked, and a green 'ON' button. At the bottom, there is a timeline with markers A through F.

Figure 1 – Note Header – Document Type

Click the **Document Type** button to access the Document Type dialog to configure or modify the document types for chart note. See Figure 2. Do note, checking the **Unknown** option will clear all other selected choices.



The screenshot shows the 'Document Type' dialog box. It has a title bar 'Document Type' and a message: 'Please select one or more of the following document types to associate with the selected note.' Below the message is a list of document types with checkboxes: 'Consultation Note' (checked), 'Discharge Summary' (unchecked), 'History and Physical Note' (checked), 'Procedure Note' (unchecked), 'Progress Note' (checked), 'Referral Note' (unchecked), 'Cardiology Report' (checked), 'Pathology Report' (unchecked), 'Radiology Report' (unchecked), and 'Unknown' (unchecked). At the bottom right are 'OK' and 'Cancel' buttons.

Figure 2 – Document Type

Once a note is signed, or when manually sending a note to the PatientPortal/API by right-clicking in the note and selecting **Send note for Patient Access**, each document type associated with the note will be generated and sent to the patient's PatientPortal and/or API if the **Release to patient** option is checked. Additionally, a separate exclusion dialog will appear for each document type, if the preference is set, allowing you to exclude information for each type if needed. See Appendix below for details on the contents of each document type.

Added Features (continued)

- **The Note Tab – Order Procedure – Immunizations** – The program has been updated to ensure that the latest CVX codes and CVX mappings, MVX codes and MVX mappings, Manufacturers, and NDC codes, per the latest CDC guidelines, are used for immunization procedures.
- **The Note Tab – Screening – PHQ9 – Modified for Teenagers** – The Screening dialog has been updated with a **PHQ9-Modified for Teenagers** questionnaire that is accessed by clicking the corresponding button at the top of the dialog. See Figure 3. After the questionnaire is accessed, you can configure the answers for the various questions.

Clicking the **Instructions** link at the top of the questionnaire will provide additional instructions when you are performing the screening.

The first nine assessment questions have a measured **Total Score** based on the answered questions allowing you to quickly determine levels of depression. If you click the **Total Score** link, additional information is provided about how the scoring is conducted, and additional information when assessing the level of depression.

In addition, you can determine how this information is outputted to the note. You can choose only to output only the **Title**, to output the configured information in **List** format, to output the configured information in **Paragraph** format, or to output the **Title & Score**. When information is configured in the Screening dialog, the information will appear in the History tab for the patient and will be tracked in the Audit Trail.

The screenshot shows a software window titled "Screening" with a standard Windows-style title bar (minimize, maximize, close buttons). Inside the window, there is a tabbed interface with two tabs: "Quick Depression Assessment Panel (PHQ9)" and "PHQ9-Modified for Teenagers". The second tab is selected and highlighted. Below the tabs, there is a link labeled "Instructions". The main area contains a list of nine numbered questions, each followed by a dropdown menu for the answer. The questions are: 1. Feeling down, depressed, irritable or hopeless? (More than half the days), 2. Little interest or pleasure in doing things? (Nearly every day), 3. Trouble falling asleep, staying asleep, or sleeping too much? (Several days), 4. Poor appetite, weight loss, or overeating? (More than half the days), 5. Feeling tired, or having little energy? (Several days), 6. Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down? (Several days), 7. Trouble concentrating on things like school work, reading or watching TV? (Several days), 8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you were moving around a lot more than usual? (Several days), 9. Thoughts that you would be better off dead, or of hurting yourself in some way? (More than half the days). Below these questions, there is a "Total Score: 14" link. Further down, there are four more questions, each with a dropdown menu: "In the past year have you felt depressed or sad most days, even if you felt okay sometimes?", "If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?", "Has there been a time in the past month when you have had serious thoughts about ending your life?", and "Have you EVER in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?". At the bottom of the window, there is a "Note Output" section with a dropdown menu, and two buttons: "OK" and "Cancel".

Figure 3 – Screening – PHQ9-Modified for Teenagers

- **The Note Tab – Vitals** – The Vitals widget has been updated so that when an Oxygen Saturation value is deleted, the associated Oxygen Flow Rate and FOI2 fields are also automatically cleared.

Added Features (continued)

- Organizer – Document Type**– The Organizer has been updated with a **Document Type** column allowing you to easily see what document types are configured for the various chart notes. Likewise, whenever right clicking an item, or multiple items, the menu will contain an **Edit Document Type(s)** option allowing you to access the Document Type dialog to modify the document types for the selected notes. See Figure 4. When selecting multiple chart notes, those selected notes must have the same document types associated with them, or you will not be able to edit them, and an error will appear outlining the issue.

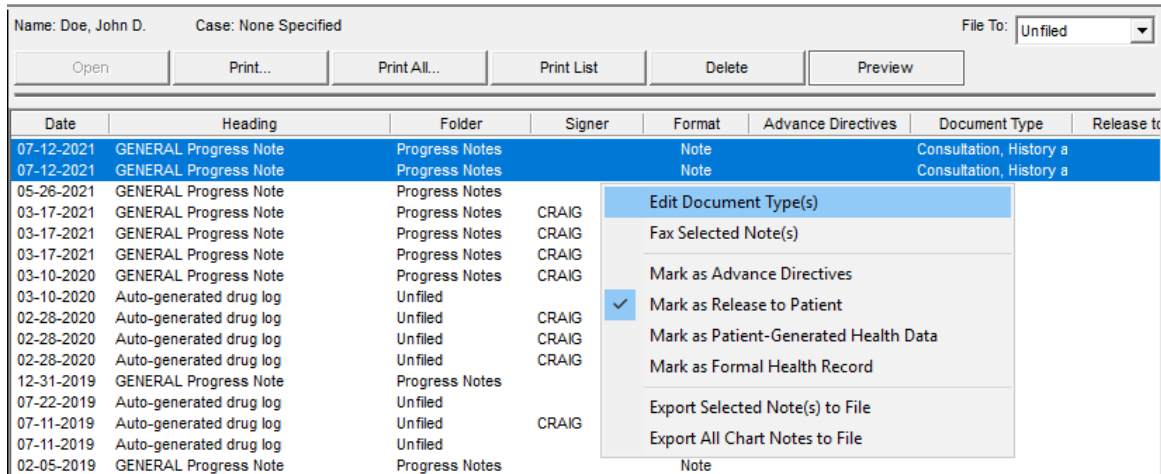


Figure 4 – The Organizer

After the Edit Document Type(s) option has been selected, the Document Type dialog will appear allowing you to add or modify the document types for chart notes selected. See Figure 5. Do note, checking the **Unknown** option will clear all other selected choices. Once a note is signed, or when manually sending a note to the PatientPortal/API by right-clicking in the note and selecting **Send note for Patient Access**, each document type associated with the note will be generated and sent to the patient's PatientPortal and/or API if the **Release to patient** option is enabled.

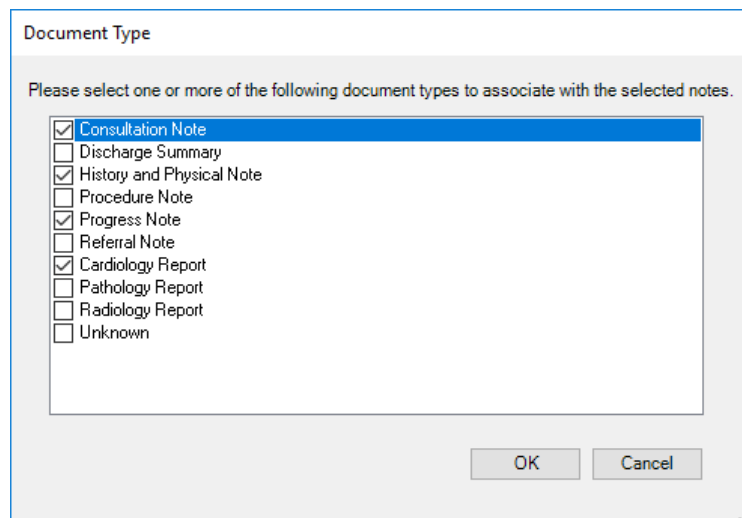


Figure 5 – Document Type

- Organizer – Release to Patient** – The Organizer has been updated with a **Release to Patient** column allowing you to easily see what notes are set to be released to the patient upon signing. Likewise, whenever right clicking an item, or multiple items, the menu will contain a **Mark as Release to Patient** option allowing you to modify whether the note should be released to the patient's PatientPortal/API upon signing. See Figure 4. When the Release to Patient option is disabled for a note, a **No** will appear in the Release to Patient column.

Added Features (continued)

- **System Update – SNOMED Codes**– The system has been updated to use the latest version (March 2021) of SNOMED codes, per the National Institutes of Health.
- **Template Editing – Screening** – The Screening Selection dialog (accessed via the Screening button), has been updated with a new **PHQ9-Modified for Teenagers** screening. See Figure 6. You can view each screening questionnaire, by highlighting the applicable screening, and then clicking the **Preview** button. Do note, that for any existing Screening buttons in chart templates, the new screenings will appear in the **Unused screenings** section, and will need to be activated for those buttons, as needed. Any new Screening button added to a chart template will have all screenings activated, and you can modify the position, as well as remove any screenings that are not needed for that button.

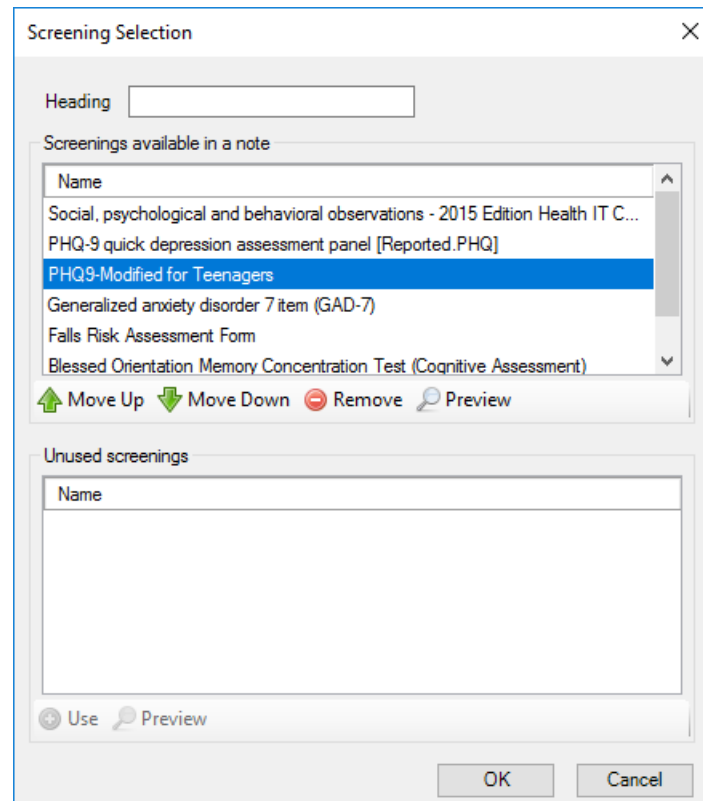


Figure 6 – Screening Selection

Added Features (continued)

- **Template Editing – Template List** – The Template List has been updated so that you can now tag templates with document types, which will then default when creating a new chart note using those templates. To tag a template, or multiple templates, highlight the applicable template(s), then right-click the template(s) and click **Edit Document Type**, or when the templates are highlighted, click the **Document Type** button at the bottom of the list. See Figure 7. Do note that when selecting multiple templates, those selected templates must have the same document types, or you will not be able to edit them, and an error will appear outlining the issue.

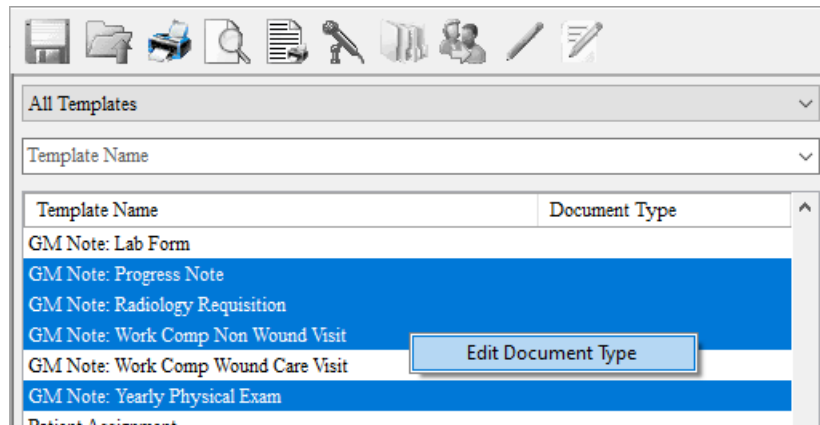


Figure 7 – Template List

A Document Type dialog will then appear allowing you to select the applicable document types for the highlighted templates. See Figure 8. Do note, checking the **Unknown** option will clear all other selected choices. After the document types have been selected for the template(s), click the **OK** button.

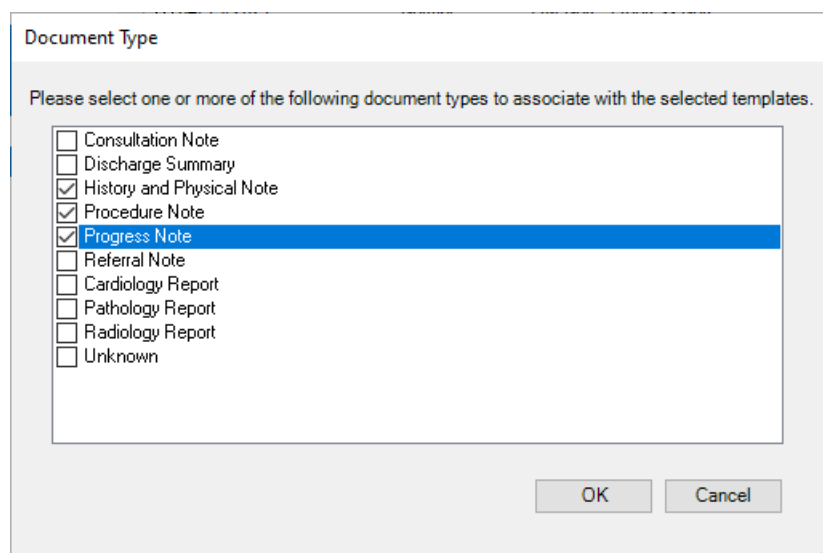


Figure 8 – Document Type

The document types configured for a template will appear in the Document Type column next to the corresponding Template Name. See Figure 9. When hovering over a template a tooltip will appear with the Template Name, followed, in parentheses, by any document types configured for the template. Also, a new **Document Type** option is also available in the Search Column drop-down list, allowing you to search for templates that are tagged with certain document types.

Template Editing – Template List (continued)

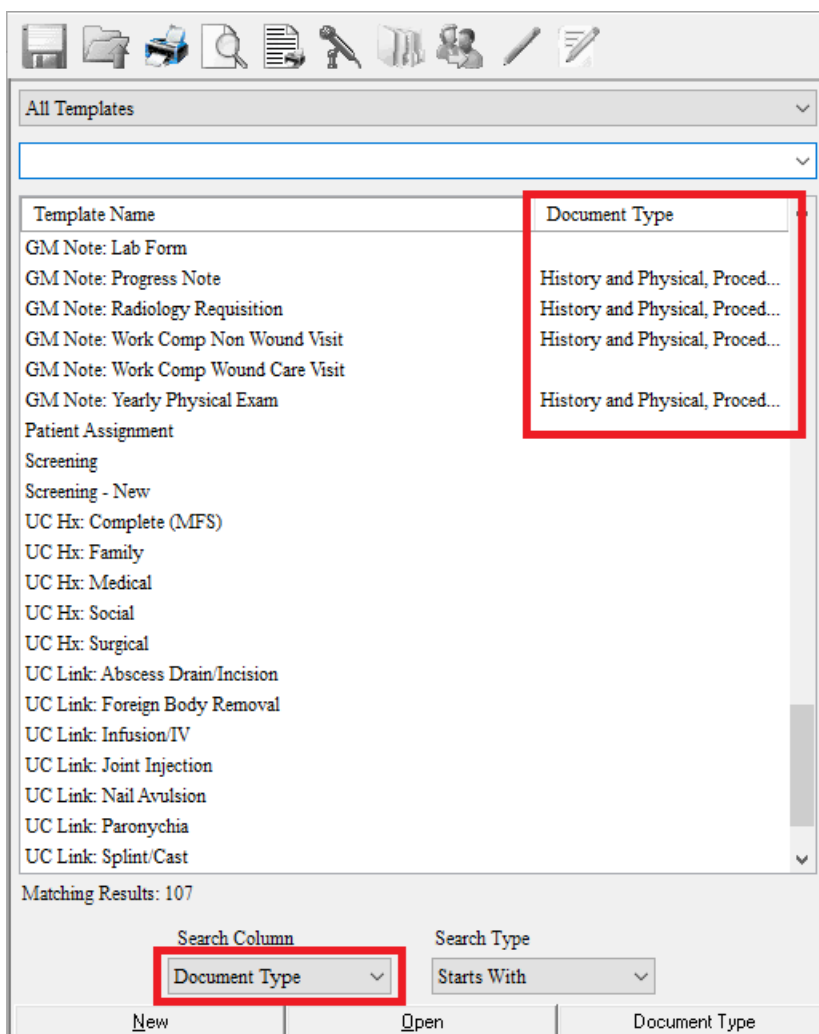


Figure 9 – Document Type

Appendix

CCDA Document Type Contents

The following lists the CCDA contents for the various Document Types that are can be manually exported via the Export Patient Data area or are generated and exported when a chart note is signed should the applicable type be selected in the Note Header.

Consultation Note

- Assessment
 - Checklist include as Assessment
 - Care plan widget - Impression
- Review of Systems
 - Checklist include as Review of Systems
- Chief Complaint
 - Chief Complaint Widget
- Reason for Visit
 - Appointment reason code, if appointment is for patient on note date for the practice and provider in note header if filled in. If multiple appointments for patient on same day as note, use the time on the note to get correct appointment
- History of Present Illness
 - Checklist include as HPI
- General Status
 - Checklist include as General Status
- Medications
 - Medication widget
- Plan of Treatment
 - Educational Materials
 - Checklist goals
 - Checklist instructions
 - Recalls
 - Future appointments
 - In house and out of house orders
 - Checklist Plan of Treatment
- Medical Equipment
 - Implantable Devices Widget (only verified implants)
 - Checklist include as Medical Equipment
- Nutrition
 - Checklist include as Nutrition
- Procedures
 - Procedure Widget
- Functional Status
 - Checklist include as Functional Status
- Mental Status
 - Checklist include as Cognitive Status
- Immunizations
 - Procedure Widget, use procedure marked as immunization
- Results
 - Numeric Widget with condition(i.e., Hba1c)
- Past Medical History
 - Checklist include as Past Medical History
- Vitals
 - Vitals Widget
- Problems
 - Diagnosis Widget
- Social History
 - Smoking History Widget
- Advance Directives
 - Advanced Directive button patient id tab
- Family History
 - Family History Widget
- Allergies
 - Allergy Widget

Discharge Summary Note

- Review of Systems
 - Checklist include as Review of Systems
- Chief Complaint
 - Chief Complaint Widget
- Reason for Visit
 - Appointment reason code, if appointment is for patient on note date for the practice and provider in note header if filled in. If multiple appointments for patient on same day as note, use the time on the note to get correct appointment
- History of Present Illness
 - Checklist include as HPI
- Hospital Course
 - Checklist include as Hospital Course
- Plan of Treatment
 - Educational Materials
 - Checklist goals
 - Checklist instructions
 - Recalls
 - Future appointments
 - In house and out of house orders
 - Checklist Plan of Treatment
- Nutrition
 - Checklist include as Nutrition
- Procedures
 - Procedure Widget
- Functional Status
 - Checklist include as Functional Status
- Immunizations
 - Procedure Widget, use procedure marked as immunization
- Hospital Discharge Diagnosis
 - Diagnosis Widget
- Past Medical History
 - Checklist include as Past Medical History
- Vitals
 - Vitals Widget
- Social History
 - Smoking History Widget
- Family History
 - Family History Widget
- Allergies
 - Allergy Widget

History and Physical Note

- Assessment
 - Checklist include as Assessment
 - Care plan widget - Impression
- Review of Systems
 - Checklist include as Review of Systems
- Chief Complaint
 - Chief Complaint Widget
- Reason for Visit
 - Appointment reason code, if appointment is for patient on note date for the practice and provider in note header if filled in. If multiple appointments for patient on same day as note, use the time on the note to get correct appointment
- History of Present Illness
 - Checklist include as HPI
- General Status
 - Checklist include as General Status
- Medications
 - Medication widget
- Plan of Treatment
 - Educational Materials
 - Checklist goals
 - Checklist clinical instructions
 - Recalls
 - Future appointments
 - In house and out of house orders
 - Checklist Plan of Treatment
- Procedures
 - Procedure Widget
- Immunizations
 - Procedure Widget
- Results
 - Numeric Widget with condition(i.e., Hba1c)
- History of Past Illness (Past Medical History)
 - Checklist include as Past Medical History
- Vitals
 - Vitals Widget
- Problems
 - Diagnosis Widget
- Physical Exam
 - Checklist include as Physical Exam
- Social History
 - Smoking History Widget
- Family History
 - Family History Widget
- Allergies
 - Allergy Widget

Procedure Note

- Assessment Section
 - Care Plan widget (impressions)
 - Checklist include as Assessment
- Review of Systems
 - Checklist include as Review of Systems
- Chief Complaint
 - Chief Complaint Widget
- Reason for Visit
 - Appointment reason code, if appointment is for patient on note date for the practice and provider in note header if filled in. If multiple appointments for patient on same day as note, use the time on the note to get correct appointment
- History of Present Illness
 - Checklist include as HPI
- Procedure Description
 - Checklist include as Procedure Description
- Medications
 - Medication widget
- Medications Administered - (Based on meds being tagged as administered during visit)
 - Medication widget
- Plan of Treatment
 - Educational Materials
 - Checklist goals
 - Checklist instructions
 - Recalls
 - Future appointments
 - In house and out of house orders
 - Checklist Plan of Treatment
- Procedure Indications
 - Checklist include as Procedure Indications
- Anesthesia
 - Checklist include as Anesthesia
- Procedures
 - Procedure widget
- Complications
 - Checklist include as Complications
- Past Medical History
 - Checklist include as Past Medical History
- Procedure Findings
 - Checklist include as Procedure Findings
- Post Procedure Diagnosis
 - Checklist include as Interventions
- Physical Exam
 - Checklist include as Physical Exam
- Social History
 - Smoking History Widget
- Family History
 - Family History Widget
- Allergies
 - Allergies Widget

Progress Note

- Assessment Section
 - Care Plan widget (impressions)
 - Checklist include as Assessment
- Review of Systems
 - Checklist include as Review of Systems
- Chief Complaint
 - Chief Complaint Widget
- Objective
 - Checklist include as Objective
- Subjective
 - Checklist include as Objective
- Medications Section
 - Medication widget
- Plan of Treatment
 - Educational Materials
 - Checklist goals
 - Checklist instructions
 - Recalls
 - Future appointments
 - In house and out of house orders
 - Checklist Plan of Treatment
- Nutrition
 - Checklist include as Nutrition
- Instructions
 - Checklist include as Clinical Instructions (include in plan of treatment)
- Results
 - Numeric Widget with condition(i.e., Hba1c)
- Vital Signs
 - Vitals Widget
- Problem Section
 - Diagnosis Widget
- Physical Exam
 - Checklist include as Physical Exam
- Interventions
 - Checklist include as Interventions
- Allergies
 - Allergy widget

Referral Note

- Assessment
 - Checklist include as Assessment
 - Care plan widget - Impression
- Review of Systems
 - Checklist include as Review of Systems
- History of Present Illness
 - Checklist include as History of Present Illness
- General Status
 - Checklist include as General Status
- Medications
 - Medication widget
- Plan of Treatment
 - Educational Materials
 - Checklist goals
 - Checklist instructions
 - Recalls
 - Future appointments
 - In house and out of house orders
 - Checklist Plan of Treatment
- Medical Equipment
 - Implantable Devices Widget
 - Checklist include as Medical Equipment
- Nutrition
 - Checklist include as Nutrition
- Procedures
 - Procedure Widget
- Functional Status
 - Checklist include as Functional Status
- Reason for Referral
 - Referral Widget
- Mental Status
 - Checklist include as Cognitive Status
- Immunizations
 - Procedure Widget, use procedure marked as immunization
- Results
 - Numeric Widget with condition(i.e Hba1c)
- Past Medical History
 - Checklist include as Past Medical History
- Vitals
 - Vitals Widget
- Problems
 - Diagnosis Widget
- Physical Exam
 - Checklist include as Physical Exam
- Social History
 - Smoking History Widget
- Advance Directives
 - Advanced Directive button patient id tab
- Family History
 - Family History Widget
- Allergies
 - Allergy Widget

Cardiology Report and Unknown

- Allergies
 - Allergy Widget
- Medications
 - Medication Widget
- Problems
 - Diagnosis Widget
- Chief Complaint
 - Chief Complaint Widget
- Procedures
 - Procedure Widget
- Vitals
 - Vitals Widget
- Immunizations
 - Procedure Widget
- Social History
 - Smoking History Widget
- Referrals
 - Referral Widget
- Functional Status
 - Checklist include as Functional Status
- Mental Status
 - Checklist include as Cognitive Status
- Medical Equipment
 - Implantable Devices Widget (only verified implants)
 - Checklist include as Medical Equipment
- Assessment
 - Checklist include as Assessment
 - Care plan widget - Impression
- Health Concerns
 - Care Plan Widget - Health Concerns
- Plan of Treatment
 - Educational Materials
 - Checklist goals
 - Checklist instructions
 - Recalls
 - Future appointments
 - In house and out of house orders
 - Checklist Plan of Treatment
- Encounters
 - Procedure Widget

Pathology Report

- Checklist tagged as Pathology Report Narrative

Imaging Narrative Report

- Checklist tagged as Imaging Narrative

Lab Report Narrative

- Checklist tagged as Lab Report Narrative

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