ChartMaker® Clinical Release Notes
ChartMaker® 2016 (fv6.2.8)

Added Features

- **Audit Trail –** The Audit Trail has been updated to track whenever patient data is exported (via Clinical Summary) to an API. When an audit event occurs the Event column will display **Export**; the Group column will display **Clinical Summary**; the Audit Trail Description will display **API Export**; and the **Account ID** will be listed in the Metadata column.

- **Audit Trail –** The Audit Trail has been updated to track whenever procedures are added through an Order Set. When an audit event occurs the Event column will display **Added**; the Group column will display **Lab/Test/Imaging**; the Audit Trail Description will display the From Order Set: **Procedure Description**; the New Value will contain the procedure details that were added; and the **Account ID**, **Note Heading**, **Note ID**, and **Visit Date/Time** will be listed in the Metadata column.

- **Audit Trail –** The Filters section of the Audit Trail has been updated with a **Group** field that allows you to select a specific group to filter the audit events. See Figure 1. When a group is selected, only audit events contained in that group will be displayed.
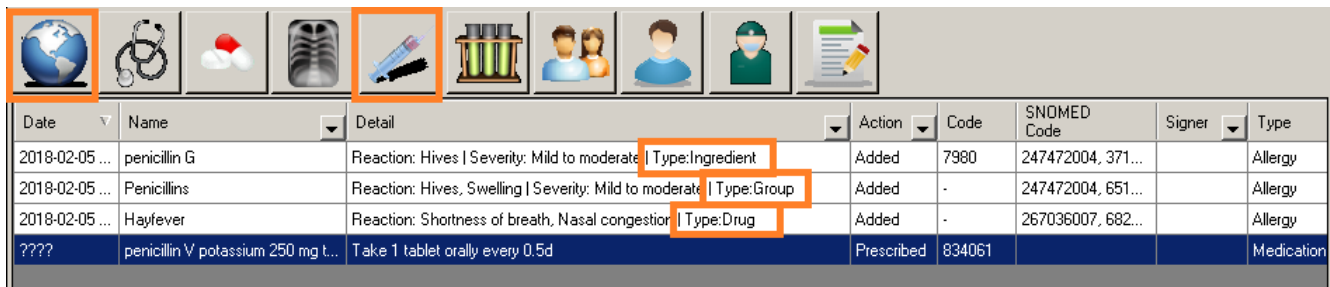

Figure 1 – Audit Trail
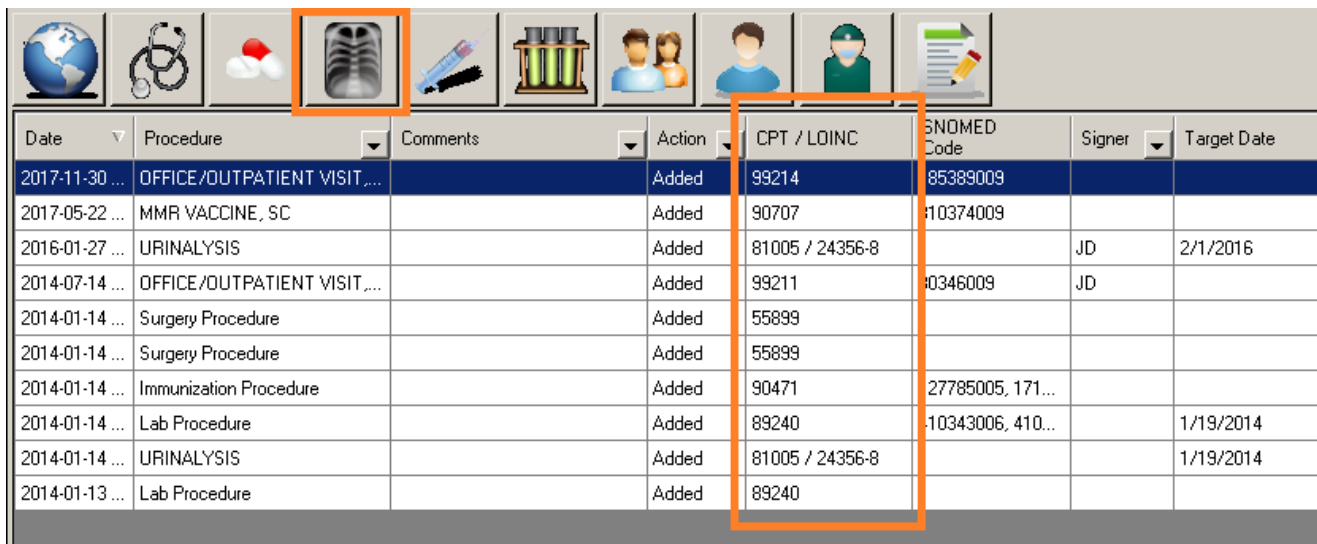
Added Features (continued)

- **History Tab –** The Global (**All**) and **Allergy** views of the History tab have been updated to display the allergy's **Type** (Drug, Group, or Ingredient) in the of Detail column after any Reaction and/or Severity that was configured for the allergy. See Figure 2.

Date	Name	Detail	Action	Code	SNOMED Code	Signer	Type
2018-02-05 ...	penicillin G	Reaction: Hives	Severity: Mild to moderate	Type:Ingredient	Added	7980	247472004, 371...		Allergy
2018-02-05 ...	Penicillins	Reaction: Hives, Swelling	Severity: Mild to moderate	Type:Group	Added	-	247472004, 651...		Allergy
2018-02-05 ...	Hayfever	Reaction: Shortness of breath, Nasal congestion	Type:Drug	Added	-	267036007, 682...		Allergy
????	penicillin V potassium 250 mg t...	Take 1 tablet orally every 0.5d	Prescribed	834061			Medication

Figure 2 – History Tab – Global (All) View

- **History Tab –** The **Procedure** view of the History tab has been updated to display any LOINC code that has been associated with a procedure in the CPT/LOINC column. See Figure 3. The CPT/LOINC column heading replaces the CPT Code heading in previous versions.

Date	Procedure	Comments	Action	CPT / LOINC	SNOMED Code	Signer	Target Date
2017-11-30 ...	OFFICE/OUTPATIENT VISIT,...		Added	99214	85389009		
2017-05-22 ...	MMR VACCINE, SC		Added	90707	10374009		
2016-01-27 ...	URINALYSIS		Added	81005 / 24356-8		JD	2/1/2016
2014-07-14 ...	OFFICE/OUTPATIENT VISIT,...		Added	99211	0346009	JD	
2014-01-14 ...	Surgery Procedure		Added	55899			
2014-01-14 ...	Surgery Procedure		Added	55899			
2014-01-14 ...	Immunization Procedure		Added	90471	27785005, 171...		
2014-01-14 ...	Lab Procedure		Added	89240	10343006, 410...		1/19/2014
2014-01-14 ...	URINALYSIS		Added	81005 / 24356-8			1/19/2014
2014-01-13 ...	Lab Procedure		Added	89240			

Figure 3 – History Tab – Procedures View

- **Medications – Prescription Layout Tool** – The Prescription Layout Editor has updated with a new patient phone (**PATPHN**) tag that allows you to include the patient's primary phone number on the printed prescription, if needed. For the phone number to be printed, it must be active and marked as primary. When the prescription contains a PATPHN tag, the Primary Home number will print if configured. If the primary home number is not configured, the Primary Cell number will print. If the primary home and primary cell are not configured, then the Primary Work number will print. If the primary home, cell, and work are not configured, then the primary user-defined phone number will print.

- **Medications – Process Change Request** – The system has been updated so that whenever a change request is denied, an auto drug log will be created in the patient's chart outlining the denial. The information in the drug log will include the patient's name, date of birth, sex, the denied medication information, the denied reason, any comments, and the user who denied the request.

Added Features (continued)

- **Medications – Process Refill Request** – The system has been updated so that whenever a refill request is denied, an auto drug log will be created in the patient's chart outlining the denial. The information in the drug log will include the patient's name, date of birth, sex, the denied medication information, the denied reason, any comments, the user who denied the request, as well as information from whom the refill request was received such as the pharmacy information, the patient information, medication information, and any comment sent to the pharmacy.

- **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.

- **Scan Management –** The Scan Management dialog has been updated so that when importing files in the **Docs** tab, the **Scan as Advance Directive**, **Scan as Educational Materials**, and **Scan as Patient-Generated Health Data** options will be enabled, allowing you to select these options for the imported documents, if applicable. See Figure 4. When the Scan as Advance Directive option is selected, the document will be tagged as an Advance Directive in the patient's chart, the system will then update the information in the Facesheet and in the Advanced Directives dialog for the patient, and when viewing the scan in the Organizer the Advance Directives column will contain Yes. When the Scan as Educational Materials option is selected, the document will be tagged as Educational Materials in the patient's chart. When the Scan as Patient-Generated Health Data option is selected, document will be tagged as Patient-Generated Health Data in the patient's chart, and when viewing the scan in the Organizer the Patient-Generated column will contain Yes.

- **Scan Management –** The Scan Management dialog has been updated with a **Provider** field that allows you to associate a specific provider with the scan or document being imported. See Figure 4.

Figure 4 – Scan Management

SureScripts® E-Prescribing Best Practice Guidelines

Below are best practices that have been developed to assist in the construction of complete, non-contradictory, and clear patient directions:

Ensure that Directions are complete and accurate

- All information in the Sig must be accurate, complete, and include all the required components written in the following order: action, dose, dose units, route, frequency, and finally auxiliary information.
    o The exception to this syntax is Sigs which simply state "Take/Use as Directed/Instructed as per manufacturer labeling."
- Information within the Sig must not conflict with itself

Example: Use "**Take 1 tablet by mouth** daily" instead of just "Daily."

Always qualify "...as Directed" with a source

- Statements such as "Take as directed" and "Use as instructed" should only be used when followed by a source that clearly dictates to the patient where or from whom they can obtain the specific directions.
- If a Sig builder tool is used, ensure that prescribers enter the specific source of the instruction after selecting the "Take/Use as directed/instructed" option before they can proceed with finalizing the e-prescription.

*Example: Use "Use as instructed **per instructions on package**" instead of "Use as instructed."*

Always qualify "PRN (as needed)" with an indication

- The use of "PRN" (i.e. "as needed") should only be used in conjunction with an indication.
- For all other non-PRN directions, inclusion of an indication is also recommended; alternatively, there is also a designated structured field for Diagnosis, in which ICD-10 codes may be used to communicate the appropriate diagnosis or indication relevant for the prescribed product
- If a Sig builder tool is used, ensure that the Sig builder tool requires prescribers to enter the specific indication or conditions for PRN use if the prescriber selects a "PRN" frequency

*Example: Use "Take 1 tablet by mouth every 4 hours as needed **for mild to moderate pain**" instead of "Take 1 tablet by mouth every 4 hours as needed."*

Always specify the Duration of Therapy for Acute Treatments

- Duration of therapy should **only** be specified for medications for acute treatments with a defined length of therapy, e.g., antibiotics.

Avoid Abbreviations, Acronyms or Symbols

- ISMP (Institute for Safe Medication Practices) provides the complete list of *Error-Prone Abbreviations, Symbols, and Dose Designations* that should never be used in a prescription
- If the use of Latin abbreviations is desired, the system should include the ability to expand Latin abbreviations into plain English text via keystroke accelerators. The expanded text form of the Sig should be displayed to the prescriber to ensure correct transition from abbreviations to full text

Example: Use "**Instill 1 drop into both eyes once daily**" instead of "1 gtt ou qd."

Never Truncate or Split Directions between multiple fields

- If the patient directions are being transmitted exceeds the 140-character limit, it should be communicated by other means, e.g. as a fax or printed handout
- Sig information should **not** be written into the Notes field if it exceeds the 140-character limit.

Send only Patient Directions (Sig) within the Directions field

- The Sig should not contain information for which another designated field exists in the SCRIPT standard (e.g. the Sig should never include the quantity, drug name, NDC or RxCUI values, or Notes to pharmacists, etc.)

*Example: Use "**Take 1 tablet by mouth once daily**" instead of "Take 1 tablet by mouth once daily. Dispense #30, 3 Refills, Thank you."*

Do not include Clinical or Prescription Information in the Notes field.

- The Notes field be used to contain information related to, but not part of the prescription. While clinical and prescription information should appear in the designated fields for these data elements, not in the Notes field.

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.
  - o 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.
  - o Abbreviations can lead to a misinterpretation of the prescriber's intent, which can result in medication errors.
  - o 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.
  - o Not doing so causes problems in pharmacies due to missing data components.
  - o 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.
  - o 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."
  - o This helps pharmacists to accurately choose the product to be dispensed when brand names are not used.
  - o 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.
  - o The strength in the drug description should match that in the drug strength field.
  - o 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.
  - o 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.
  - o 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).
  - o The apothecary and avoirdupois systems of weights and volumes are no longer considered appropriate in the world of pharmaceuticals.
  - o 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).
  - o Trailing zeros are particularly dangerous in that they can lead to ten-fold overdoses. Thus, trailing zeros should never be used.
  - o 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.
  - o Example: Use "Aspirin 325 mg" instead of "Aspirin V grains."
- Other specific abbreviation issues:
  - o 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."
  - o The word "unit" should be spelled out and never abbreviated as "U" or "u."
  - o "M" should not be used as an abbreviation for thousands (e.g., 5 M units), as it has been mistaken as meaning one million.
  - o Do not use commas when expressing thousands as they might be misinterpreted as periods.

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 <u>directions for use should not be split between the Sig and Notes fields.</u>
  - o 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.
  - o 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."
- <u>Information in the Sig field should not conflict with information in the Notes field.</u>
  - o 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.
  - o Inconsistent information in the Sig versus the Notes fields can result in incorrect directions being conveyed to patients.
  - o Example of improper use: Sig field—"1 cap orally 3 times a day", Notes field—"One capsule by mouth daily."
- <u>Care must be taken so that Sigs are not truncated because important information can be lost.</u>
  - o 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"
- <u>Sig information should be clinically correct.</u>
  - o Example: Use "Amoxicillin 500 mg Oral Capsules"—Sig "One capsule three times a day" instead of "500 caps 3 times a day."
- <u>Directions for use should be spelled out clearly in proper English.</u>
  - o 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.
  - o Example: Use "Take 1 tablet by mouth twice a day" instead of "1 T PO BID."
- <u>Information in the Sig field should be limited to the Sig.</u>
  - o 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."
  - o 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."
  - o 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."
  - o 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.)
- <u>Sigs should be complete, properly formatted, and not repeated.</u>
  - o Sig should be complete.
    - ▪ ☐ Example: Use "Apply topically to forearm three times a day" instead of "Topical each day."
  - o Sig should be properly formatted.
    - ▪ ☐ Example: Use "Take one capsule three times a day" instead of "1 3 times a day."
  - o Sig should not be repeated.
    - ▪ ☐ Example: Use "Take one capsule daily" instead of "1 PO QD – Take one tablet every day."
- <u>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.</u>
  - o Intended use can help patients to organize and better understand their medications and why they are taking them.
  - o 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.
  - o Other prescribers may find the indication helpful when a patient brings their medication bottles with them to office visits.
  - o Example: "Take according to instructions in dosepak for poison ivy rash."

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.
- Clinical information that has a designated, standardized data field should not be placed in the Notes field.
  - As with prescription information, the clinical information should appear in the designated fields 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:

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**

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

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

ChartMaker Mobile 6.2.8 Enhancements

Schedule

- **Schedule –** The Schedule screen has been updated to allow you to swipe left and right to move the schedule day forward and back respectively. Swiping right to left in the Schedule screen will advance the schedule a day, like tapping the **>** icon. Swiping left to right in the Schedule screen will move the schedule back a day, like tapping the **<** icon.

- **Schedule – Appointment List –** The Schedule screen has been updated so that the number of appointments for the selected day will be displayed below the provider's name next to a calendar icon. See Figure 1. In previous versions, the number of appointments was displayed above the ⚏ icon.
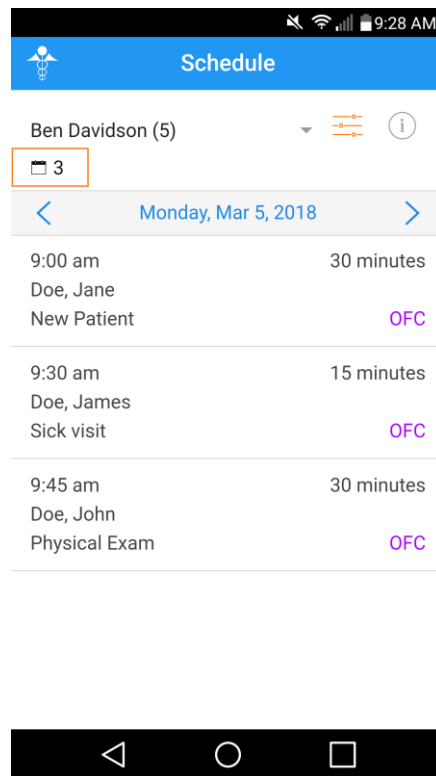
Figure 1 – Schedule – Appointment List

Charges

- **Charges –** The Charges functionality has been redesigned to offer a more streamlined experience that allows you to enter charges in an easy an efficient manner. The Charge Capture option in the home screen has been replaced with a **Charges** option. See Figure 2. Likewise, the Mobile menu, accessed by tapping the 🔷 icon, has also been updated so the new Charges option replaces the Charge Capture option in previous versions. See Figure 3.

  When you click the **Charges** option from either the Home screen or the Mobile menu, you are now taken to a new **Charges** screen that gives you the options to enter a **New Charge**, select a **Provider**, and will list any **Mobile Charges** that have been entered via ChartMaker Mobile for the selected provider. See Figure 4.

  From the **Mobile Charges** section, you can access the Charge Details screen for a patient charge by tapping the applicable charge in the list, copy a charge for a patient by tapping the corresponding ⬜ icon, or enter a new charge for a patient by tapping the corresponding ⊕ icon.

  When tapping the **New Charge** option at the top of the Charges screen, you will be taken to the Patient Search screen to locate the applicable patient, and then once the patient is located and selected, to the Charge Capture screen to enter the charge. When copying or entering a charge for a specific patient in the Mobile Charges section of the Charge screen, you will access the Charge Capture screen for that patient and are able to enter and/or modify charge information for the patient.
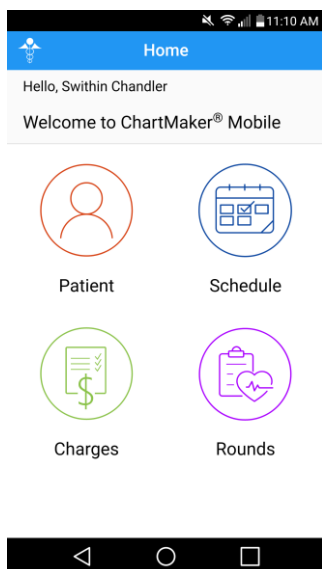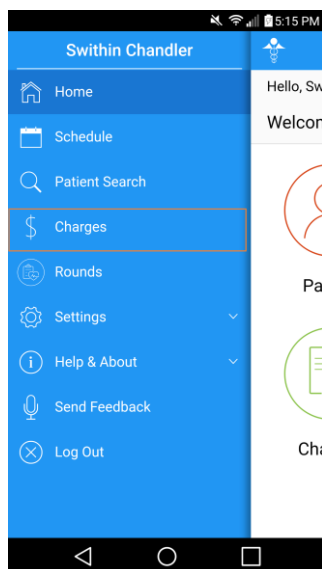
Figure 2 – Home	**Figure 3 – Mobile Menu**	**Figure 4 – Charges**
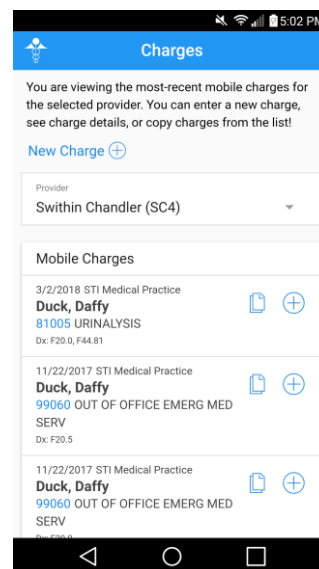
Charges (continued)

- **Charges – Charge Capture –** The Charges Capture screen has been redesigned to offer a more efficient method of entering and modifying charge information with significantly less scrolling. See Figure 5 and 6. When accessing the Charge Capture screen, the Additional Charge Details section will be expanded if there are more than one practice, otherwise it will appear collapsed. Likewise, the Procedure section has been updated to only display the CPT Code and Description; the IH Code for the procedure will no longer be displayed. The functionality for entering and modifying Provider, Facility, Procedure, Diagnosis, and Additional Charge Details is like previous versions.

Figure 5 – Charge Capture

Figure 6 – Charge Capture – Additional Charge Details

Rounds

- **Rounds – Discharged – –** The Discharged screen has been updated so that the number of patients in the discharged list, for the date range selected, will be displayed below the date range (From and To dates) next to a patient icon. See Figure 7. In previous versions, the number of appointments was displayed above the ⚏ icon.

- **Rounds – Discharged – –** The Discharged screen has been updated to let you to swipe right to left on a discharged patient to display a **Skip** and an **Undo Discharge** option, allowing you to easily select either of these options in the Discharged screen instead of having to access the Rounding Details screen to access these options for the patient. See Figure 8.
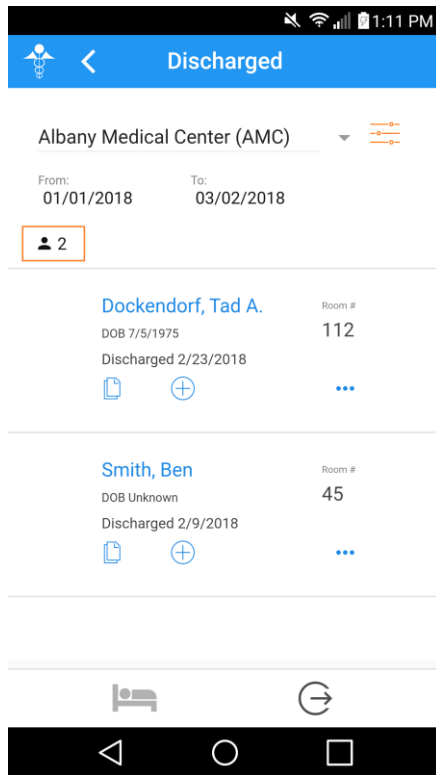

Figure 7 – Discharged — Patient Count
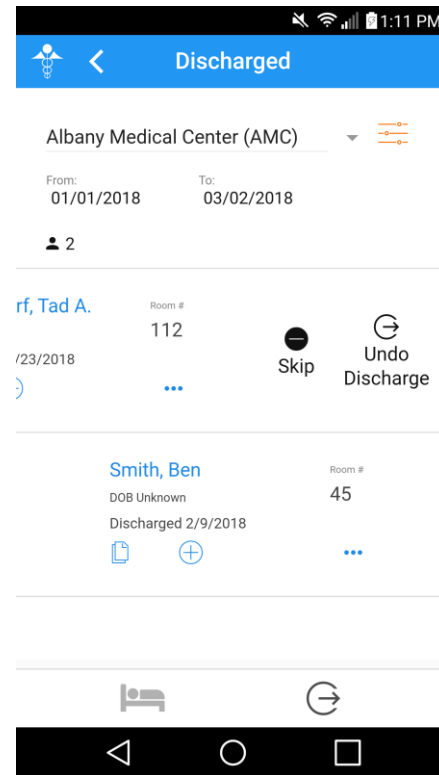
Figure 8 – Discharged – Swipe Functionality

Rounds (continued)

- **Rounds – Rounding List –** The Rounding List screen has been updated so that the number of patients in the rounding list, for the date range selected, will be displayed below the date range (From and To dates) next to a patient icon. See Figure 9. In previous versions, the number of patients was displayed above the ⚌ icon.

- **Rounds – Rounding List –** The Rounding List screen has been updated to let you to swipe right to left on a patient to display a **Skip** and an **Discharge** option, allowing you to easily select either of these options in the Rounding List screen instead of having to access the Rounding Details screen to access these options for the patient. See Figure 10.
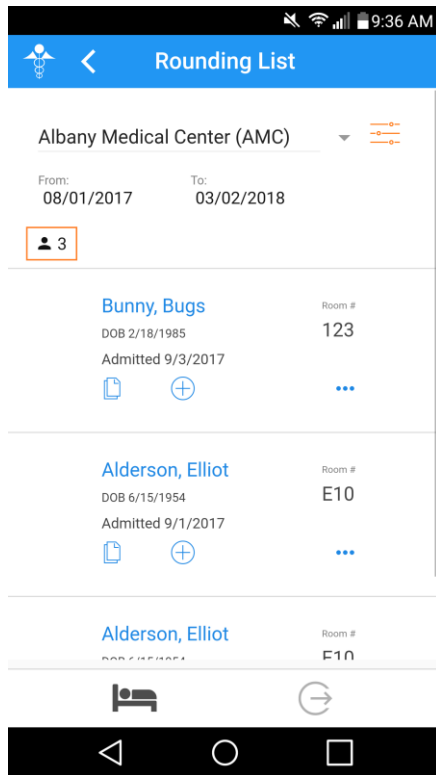
Figure 9 – Rounding List — Patient Count
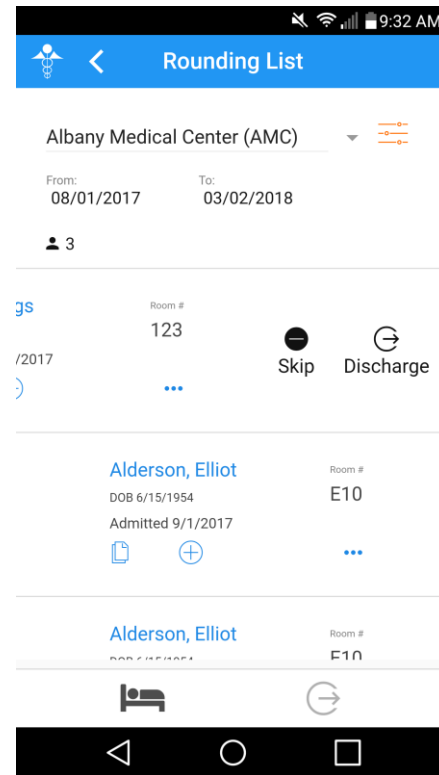
Figure 10 – Rounding List – Swipe Functionality

Administration

- **Administration – Utilities – Audit – Audit Trail –** The Filters section of the Audit Trail has been updated with a **Group** field that allows you to select a specific group to filter the audit events. See Figure 1. When a group is selected, only audit events contained in that group will be displayed.

Figure 1 – Audit Trail

Appointment

- **Appointment – Select Patient** – The Patient Portal button in previous versions of Practice Manager has been replaced with a new **Patient Access** button. See Figure 2.
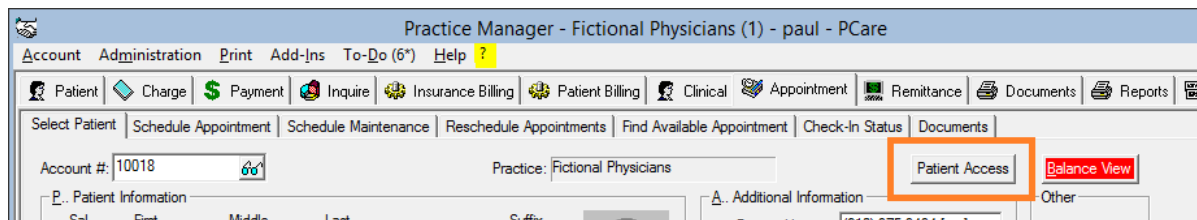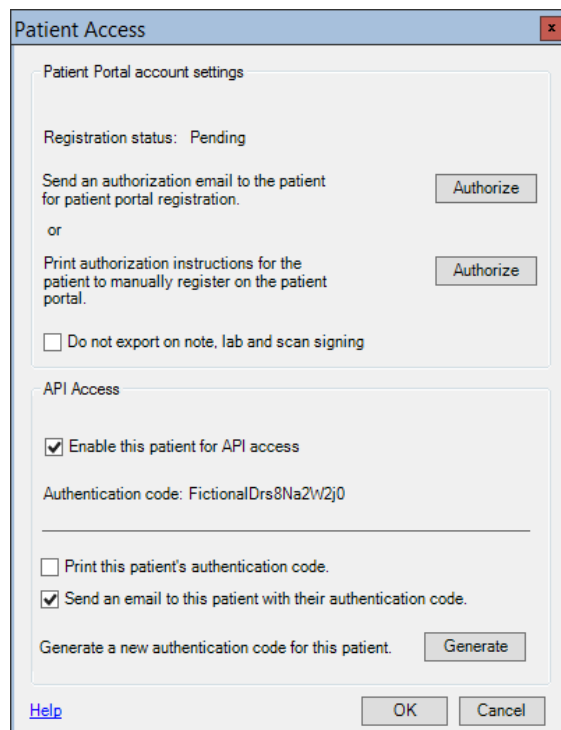

Figure 2 – Appointment – Select Patient

When the Patient Access button is clicked, a Patient Access dialog will appear, allowing you to authorize and maintain PatientPortal access, as well as enable and generate API access. See Figure 3. The options in the **Patient Portal account settings** section of the Patient Access dialog work in a similar manner as the functionality in the Patient Portal dialog in previous versions.

The new **API Access** section, in the Patient Access dialog, allows you to enable API access for the patient. Once the **Enable this patient for API Access** option is selected, the system will generate an authentication code for the patient. They can then use this code to view their healthcare information in conjunction with any participating third-party application. There are also options to print or send this authentication code, as well as the ability to generate a new authentication code via the **Generate** button.

Whenever the Patient Portal and API Access options are activated for a patient, they will be used in calculating the applicable performance measures for Meaningful Use, MIPS 2017, and MIPS 2018.

Figure 3 – Patient Access

Clinical

- **Clinical – Immunization** – 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.

Patient

- **Patient – Patient Access** – The Patient Portal button in previous versions of Practice Manager has been replaced with a new **Patient Access** button. See Figure 4.
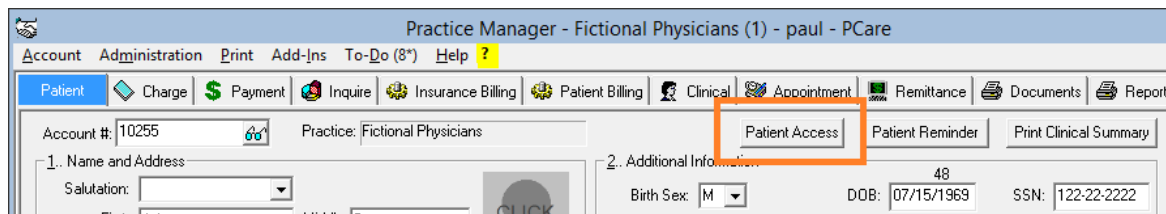

Figure 4 – Patient – Patient Access

When the Patient Access button is clicked, a Patient Access dialog will appear, allowing you to authorize and maintain PatientPortal access, as well as enable and generate API access. See Figure 5. The options in the **Patient Portal account settings** section of the Patient Access dialog work in a similar manner as the functionality in the Patient Portal dialog in previous versions.

The new **API Access** section, in the Patient Access dialog, allows you to enable API access for the patient. Once the **Enable this patient for API Access** option is selected, the system will generate an authentication code for the patient. They can then use this code to view their healthcare information in conjunction with any participating third-party application. There are also options to print or send this authentication code, as well as the ability to generate a new authentication code via the **Generate** button.

Whenever the Patient Portal and API Access options are activated for a patient, they will be used in calculating the applicable performance measures for Meaningful Use, MIPS 2017, and MIPS 2018.
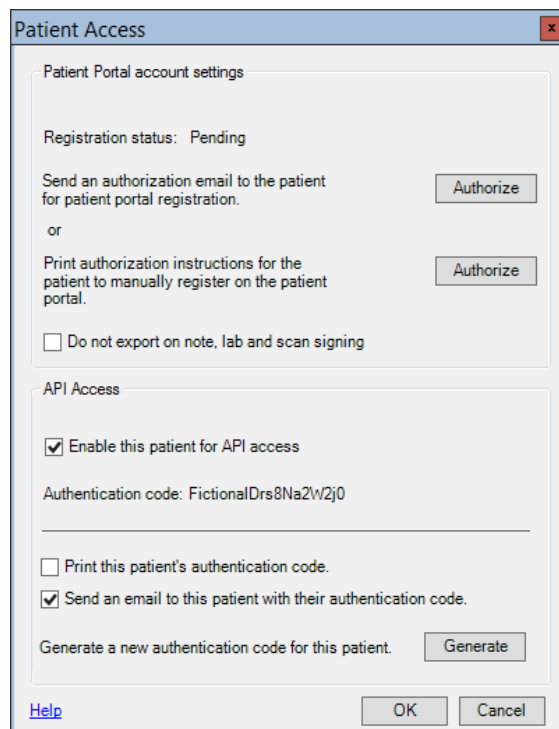

Figure 5 – Patient Access