Comtron Corp. 2012 Medgen EHR
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Medgen EHR

A complete step by step guide on how

to achieve Meaningful Use Core Set Measures in Medgen EHR.

Contents

Important information regarding Meaningful Use

- You need to register yourself as a provider on the CMS website. For more information regarding how to register contact us through the **Support** tab in Medgen and we will send you the complete registration guide from the CMS website.
- EPs (eligible providers) must report on the following:

All 15 of the core measures and 5 out of 10 of the menu measures with one menu measure being a public health measure (Menu measure 9: Immunization Registry Submission or Menu measure 10: Syndromic Surveillance). **Note:** One of the required core measures is that EPs report clinical quality measures (CQMs).

- A sum total of up to 9 CQMs; 3 cores, up to 3 alternate core, and 3 additional CQMs. If an EP reports a denominator of 0 for any of the 3 core measures then the EP must record for an alternate core CQM to supplement the core measure. Therefore, an EP may report a minimum of 6 and a maximum of 9 CQMs depending on the resulting values in the denominators for the core measures as reported from their certified EHR.

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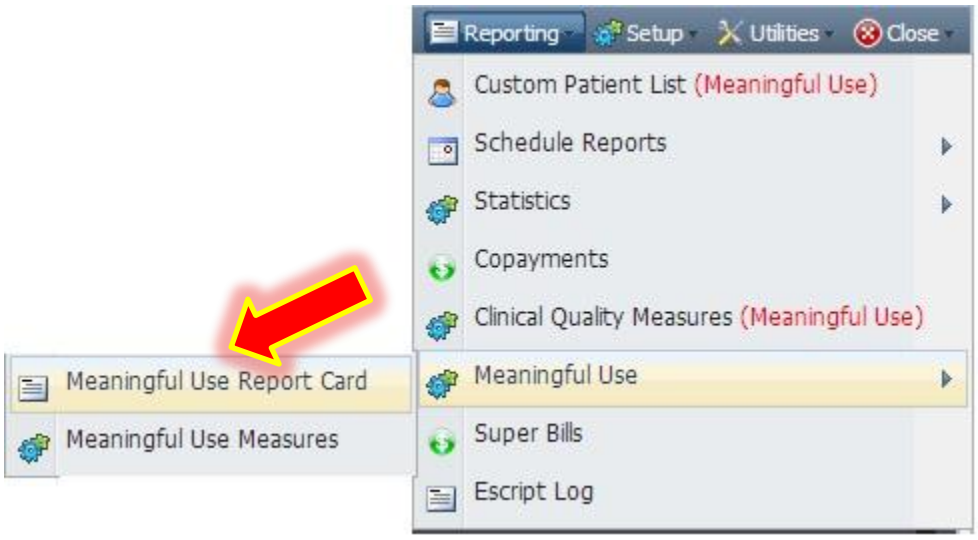
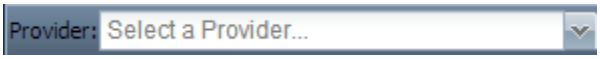
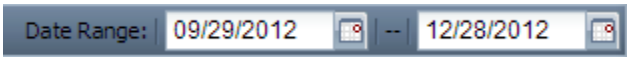
How to generate your measure report card

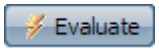
Your measure report card will show whether you are passing or failing a specific measure.

Go to: 



Then select a provider in the drop down window 

, specify the date range 

and click 

on the bottom left of the screen.

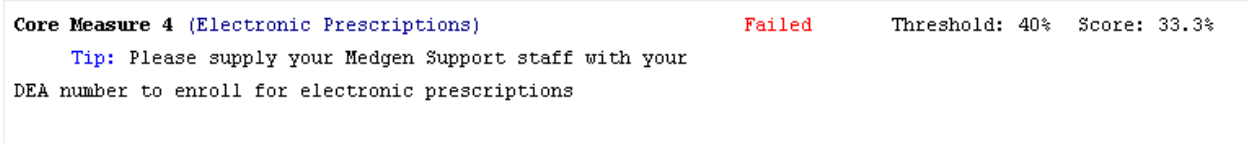
Note: Generating the meaningful use report care may take several minutes.

Core Measure 1 (CPOE for Medication) Tip: All patient medications should be entered from the Medications Section of the patient's chart	Passed	Threshold: 30%	Score: 100%
Core Measure 2 (Drug-Drug Interaction) Tip: Drug-Drug interaction checking is prebuilt into the system and is automatically checked when medications are ordered	Passed		
Core Measure 3 (Maintain Problem List) Tip: All patient problems should be recorded as valid diagnosis codes.	Passed	Threshold: 80%	Score: 85.7%
Core Measure 4 (Electronic Prescriptions) Tip: Please supply your Medgen Support staff with your DEA number to enroll for electronic prescriptions	Failed	Threshold: 40%	Score: 33.3%
Core Measure 5 (Maintain Medication List) Tip: Medications should be entered for all patients. Patients that have no medications taken please mark that from the patient Medications Section	Failed	Threshold: 80%	Score: 71.4%
Core Measure 6 (Maintain Allergy List)	Failed	Threshold: 80%	Score: 42.9%

The system will pull up the list of core and menu measures and will state whether the provider has passed or failed the measure. If the measure has a percentage threshold you must meet the system will provide this percentage along with the provider's current score.

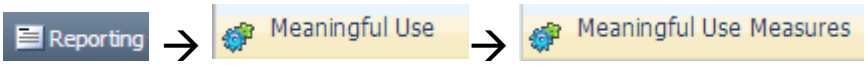
After reviewing your report you can also check the system for the patients you have created an encounter form for, but haven't completed the information necessary to comply with meaningful use.

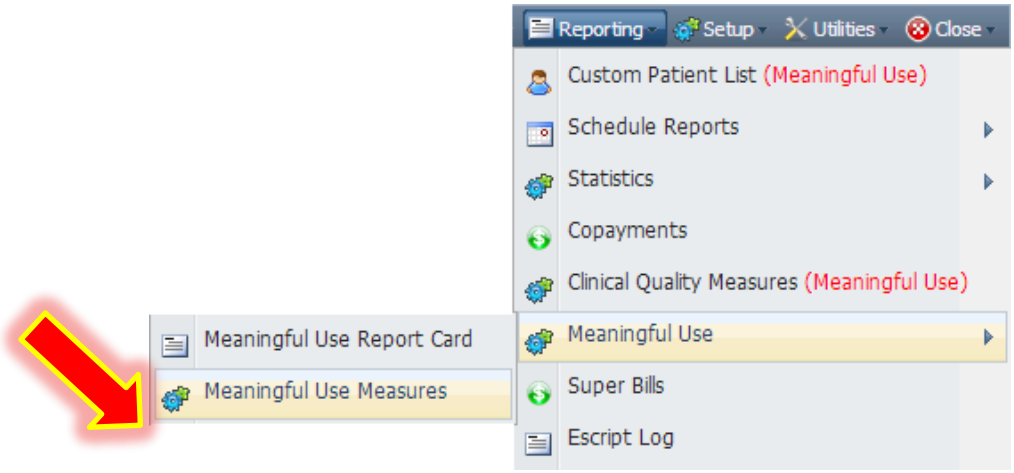
E.g.: As you can see above, our provider Jane Doe is failing Core Measure number 4 electronic prescriptions as her report card says:



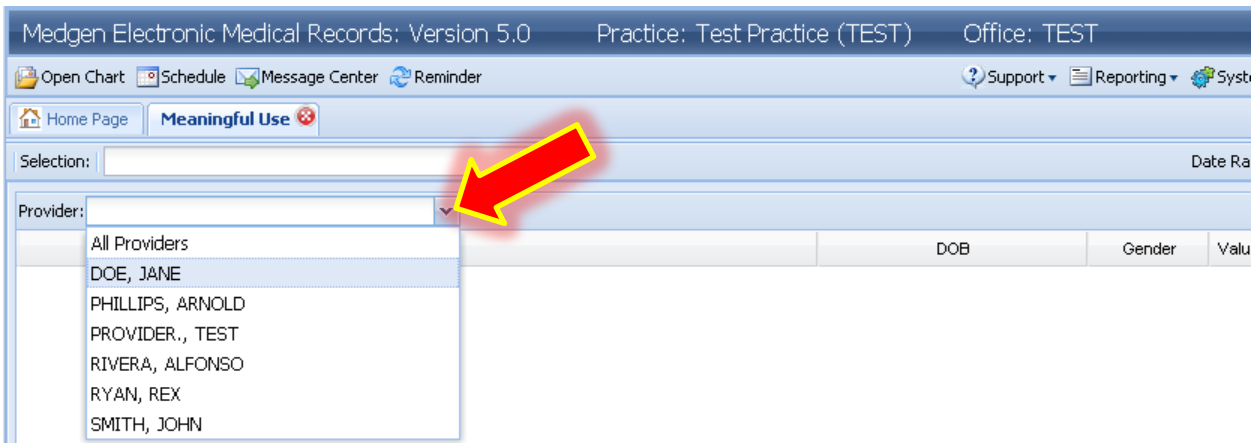
Core Measure 4 (Electronic Prescriptions) Tip: Please supply your Medgen Support staff with your DEA number to enroll for electronic prescriptions	Failed	Threshold: 40%	Score: 33.3%

Provider Jane Doe can check the patients that she has meet the measure for and the patients she has not met it for by going to

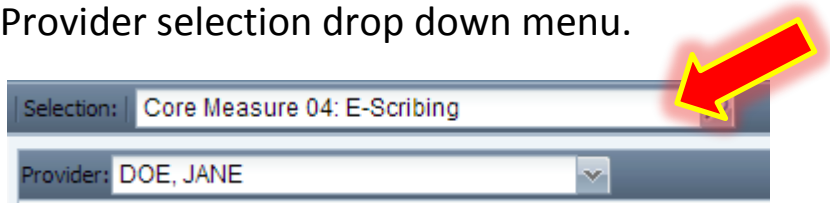




The same reporting window from before will open, but instead of evaluating her report card, she should select her name in the provider window. This is located at the top of the screen:



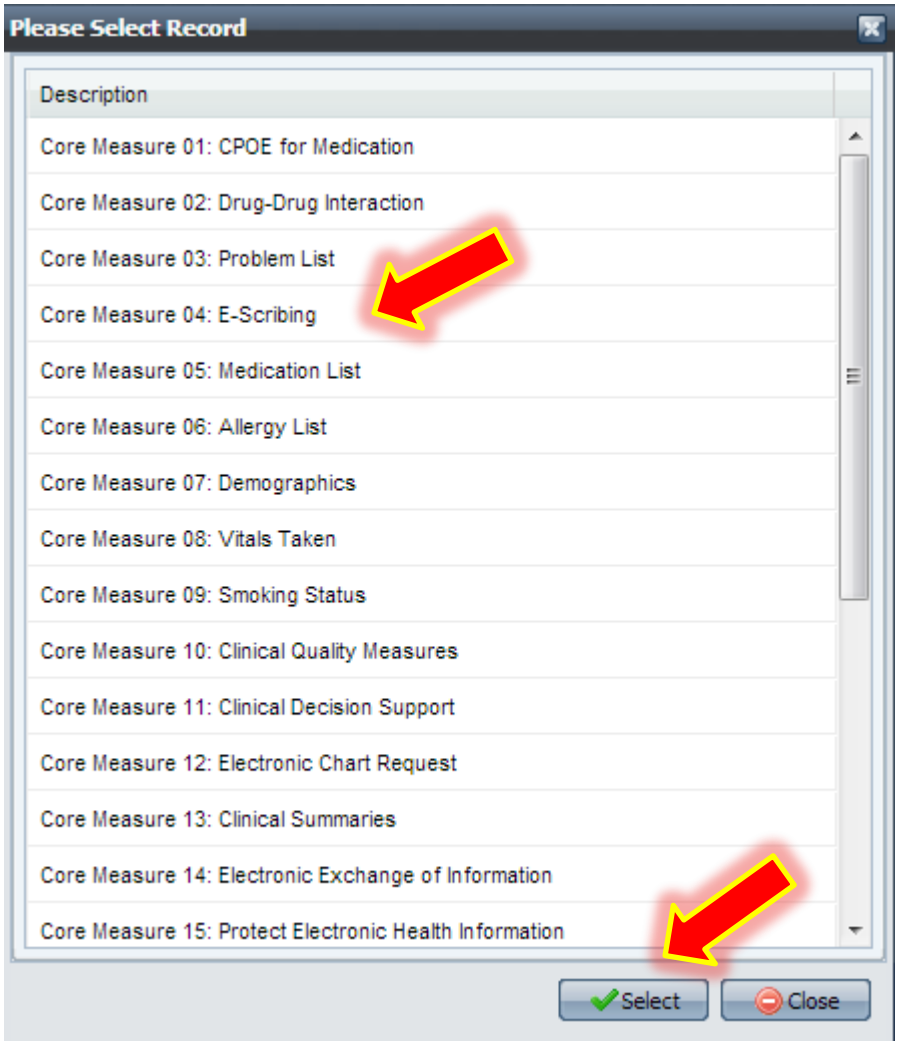
After selecting a provider click on the “Selection” magnifying glass up on top of the Provider selection drop down menu.



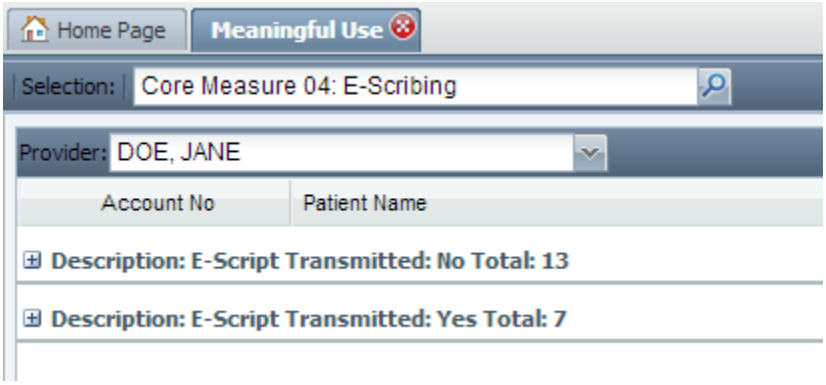
Another window will open showing you all of the Meaningful Use Core and Menu Measures. From that window you will need to select the ones you are failing; the patients you have created an encounter for, but have not yet filled in the correct information.

After selecting a Measure (you can scroll up and down to look for the one you want), click select on the bottom right of that window.

In this example we will choose core measure number four which is the one our provider Jane Doe is failing.



The above window will close and you will see this window:

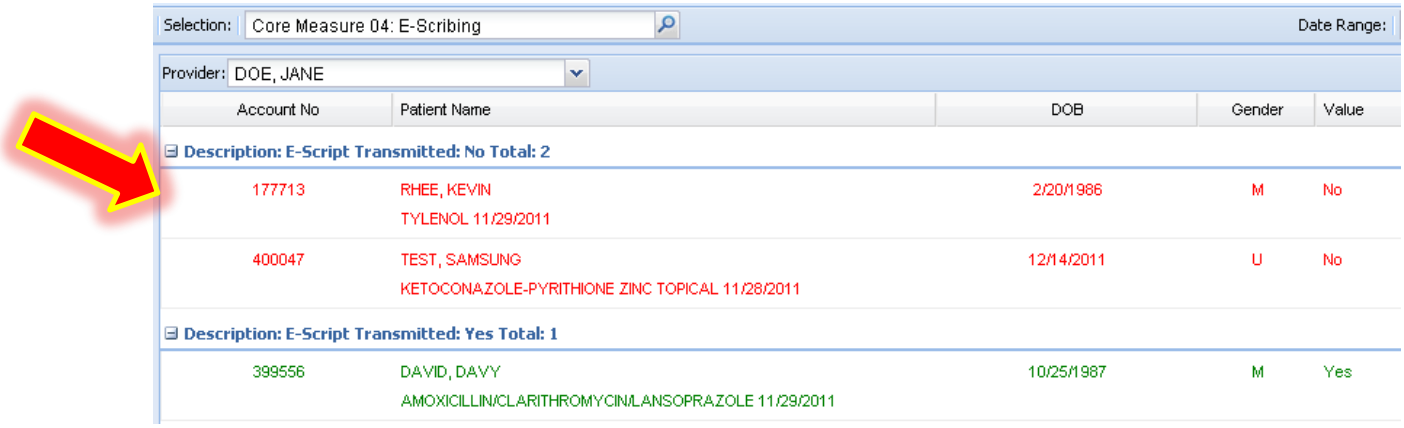


In here you see two descriptions. As you can see, the top one is showing you the patients that you haven't e prescribed for. It reads: **DESCRIPTION: E –SCRIPT TRANSMITTED: NO TOTAL: 13**, this means that you have 13 patients that you have prescribed a medication for but you haven't e prescribed.

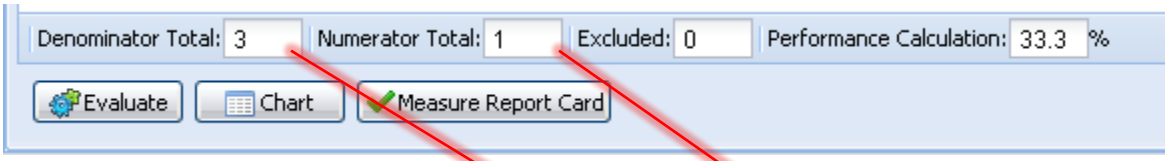
The other description reads:

DESCRIPTION: E – SCRIPT TRANSMITTED: YES TOTAL: 7, this means you have a total of 7 patients that you have prescribed a medication, and also e prescribed that medication for that patient.

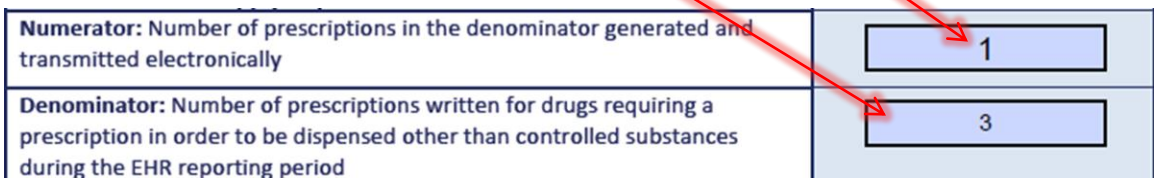
To see which patients each description is talking about click on the (+) located at the left of the word "Description" to expand the field.



NOTE: At the bottom of this screen you will see the numerator and denominator for this measure, which are the numbers that you need to fill in at the EP attestation worksheet in the CMS website.



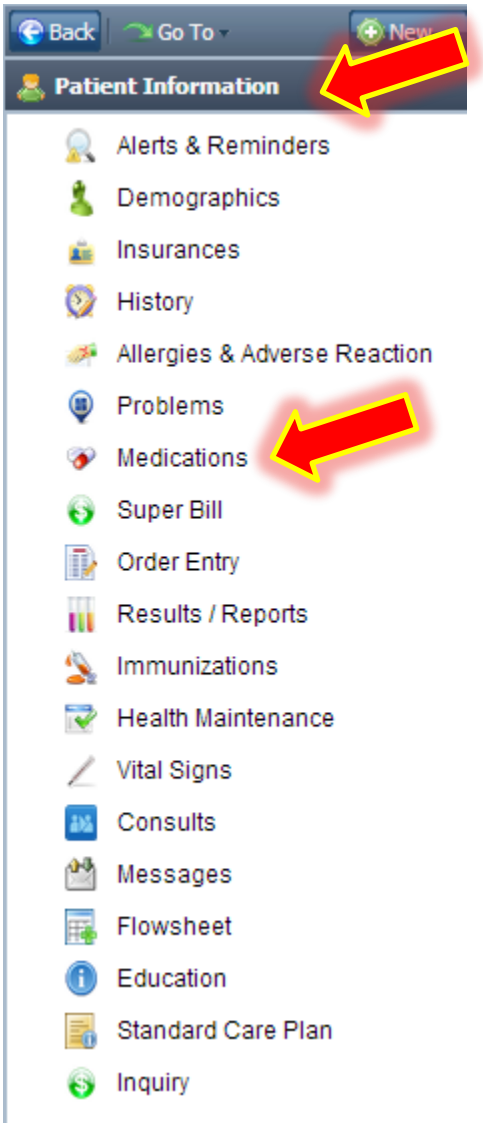
Example of what your EP attestation worksheet would look like for this measure and how you would fill it out in this case:



CORE MEASURE 1: (Computerized Provider Order Entry for Medication)

Core Measure 1 (CPOE for Medication)
Tip: All patient medications should be entered from the Medications Section of the patient's chart

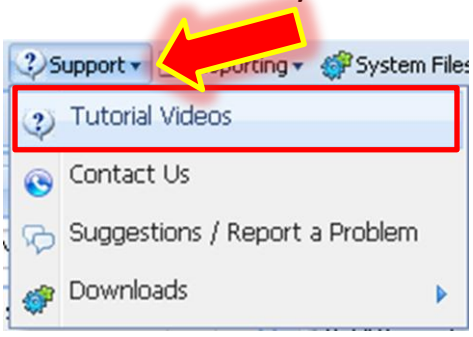
To achieve this measure you must enter your patient's medications from the patient information tab in their chart or from the Medication tab in the encounter form:

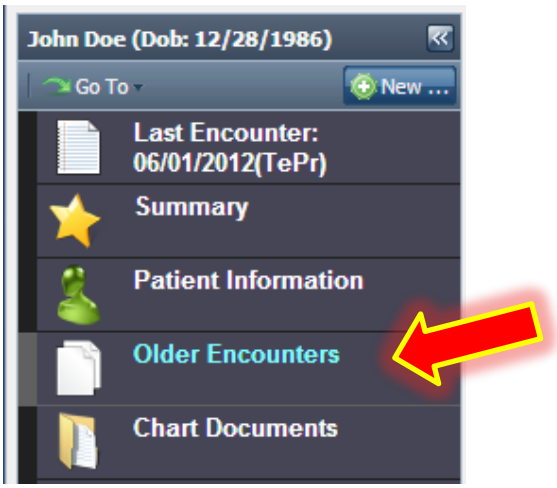


This is the patient information section in a patient's chart. To achieve meaningful use you must enter the patient's medication through the Medication tab situated here.

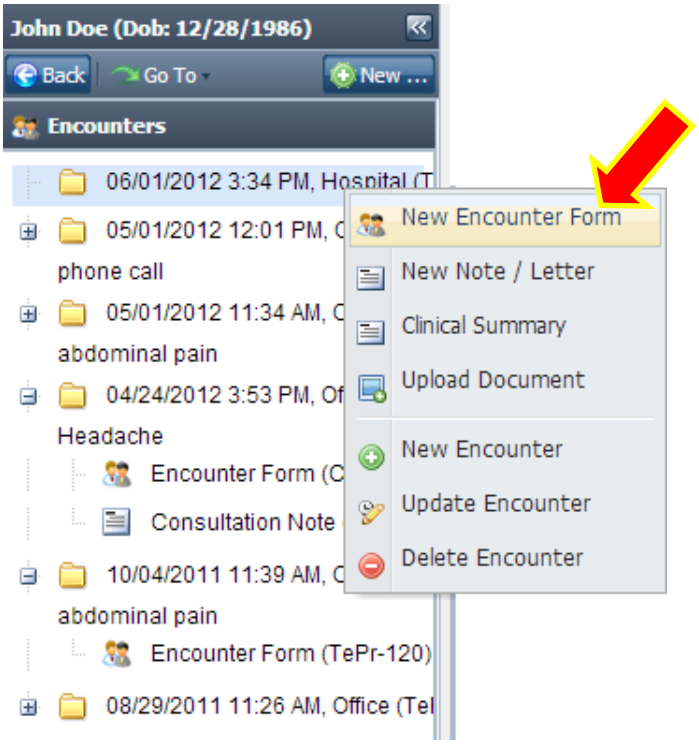
Once you select Medications from this menu another window will open where you select 

to add a new medication. If you would like more information on how to add a medication, please refer to the tutorial video 'Medication Entry'.

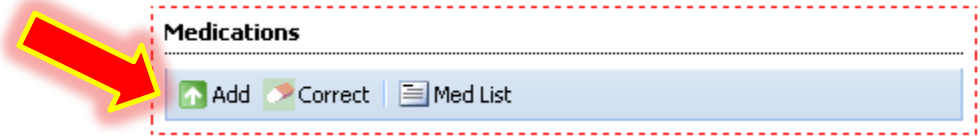




Another way of adding a patient's medication is located under the encounter section of the patient's chart. To open an encounter form, go to the encounter section in the patient's chart and create a new encounter for that patient. (An encounter is a folder in the patient's chart with the date and time the patient was in your office) After creating an encounter, a menu will appear asking if you want to create a new encounter form.



Once you open the new encounter form, go to the medication panel in the encounter Form. Please refer to the Medgen tutorial video 'Medication Entry' to add a Medication from the Encounter Form.



Note: Exclusion for this measure- Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement.

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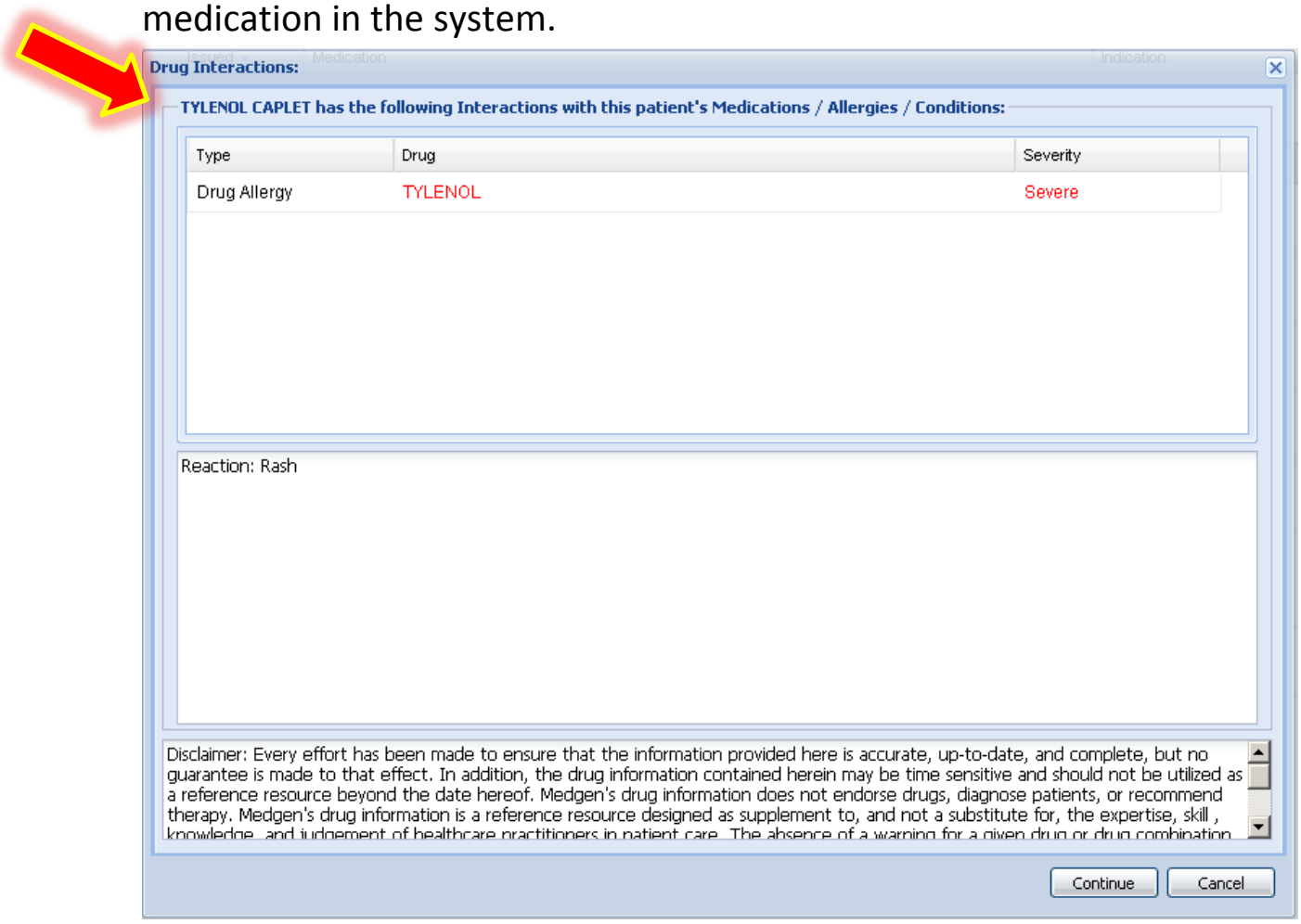
CORE MEASURE 2: (Drug to Drug Interaction)

Core Measure 2 (Drug-Drug Interaction)

Tip: Drug-Drug interaction checking is prebuilt into the system and is automatically checked when medications are ordered

Medgen has a prebuilt drug-drug and drug to allergy interaction module that automatically checks possible drug interactions between medications in a patient's medication list as well as check the interactions between the medications and the allergies entered in a patients chart. No additional step is needed by users for this measure the system will run this check and notify you every time you prescribe a medication in the system.



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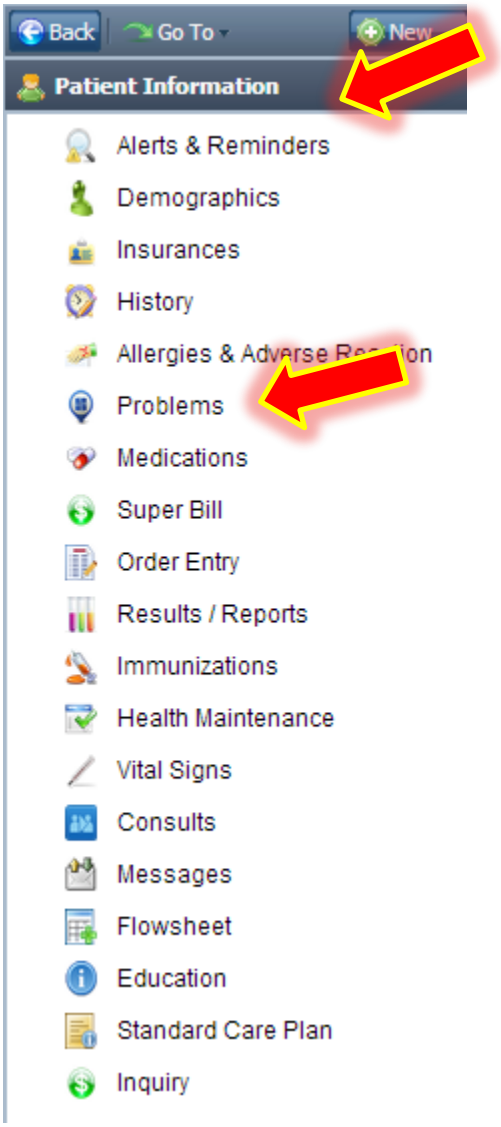
CORE MEASURE 3: (Maintain Problem List)

Core Measure 3 (Maintain Problem List)

Tip: All patient problems should be recorded as valid diagnosis codes.

In order to achieve this meaningful use measure you must to enter your patient's problems as diagnosis codes or ICD-9 codes. You can enter your patient's problems in two different locations:

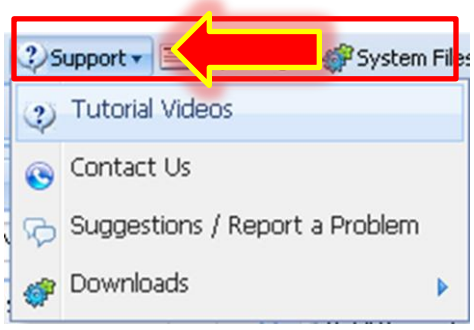
One is from the patient information section of a patient's chart:

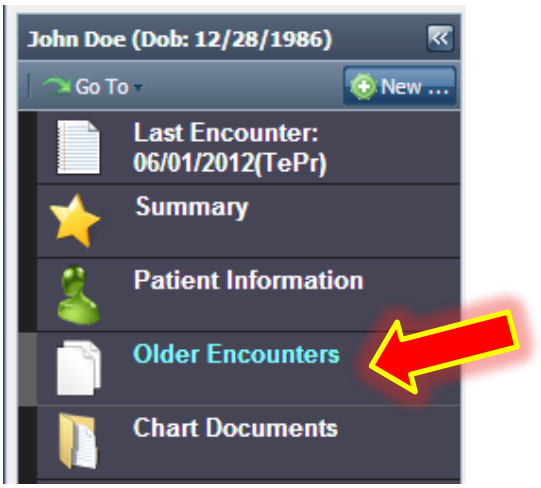


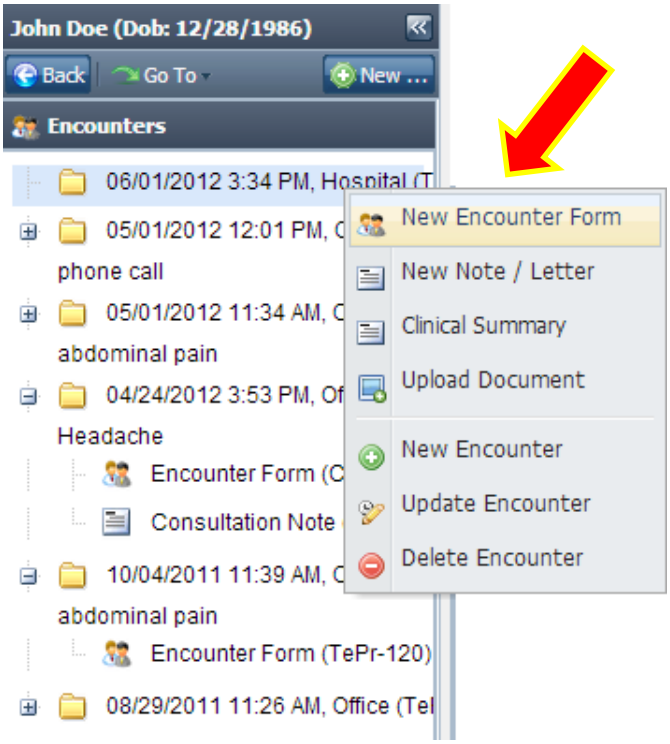
This is the patient information section in a patient's chart, to achieve meaningful use you will have to enter the patient's problems as valid diagnosis codes through the "Problems" tab situated here.

Once you select Problems from this menu another window will open where you have to select 

to add a new problem. If you would like more information on how to add a problem as a valid diagnosis code in Medgen please refer to the tutorial video 'Patient Problems'



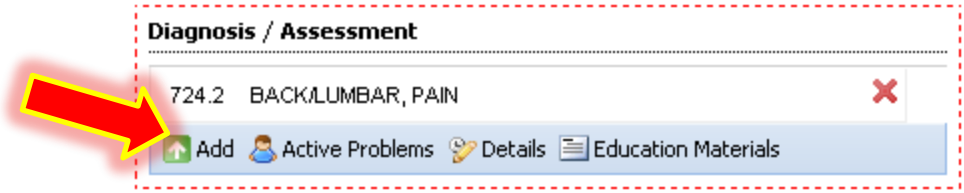




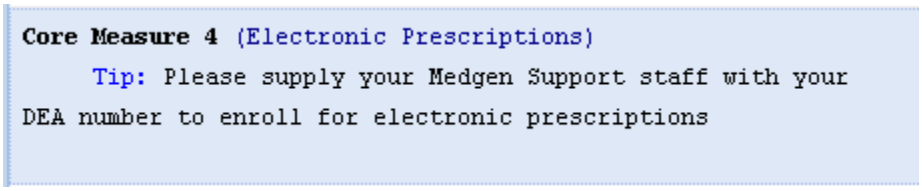
Another way of adding a patient's active problem is under the encounter section of the patient's chart. To open an encounter form; go to the encounter section in the patient's chart, and create a new encounter for that patient.

After creating an encounter, a menu will appear asking if you would like to create a new encounter form.

Note: Once a code is added to the Diagnosis/Assessment panel on the Encounter form it will auto populate into the patient's list of Active Problems for the future.



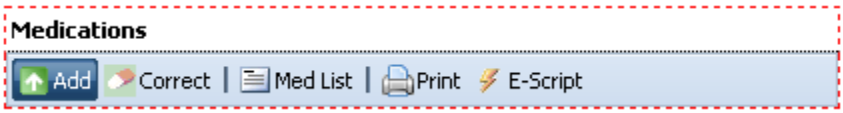
CORE MEASURE 4: (Electronic Prescriptions)



NOTE: Providers are not automatically enrolled to send electronic prescriptions from Medgen EHR. The provider must be enrolled by a Medgen representative. Please call Medgen Support with the provider's DEA to get enrolled in this service. This information is necessary for us to register you with Surescripts. If you are already enrolled to send electronic prescriptions with another EHR and would like to start sending them from Medgen EHR as well as receive refill request from pharmacies into Medgen EHR please inform the Medgen representative so the proper steps can be taken when enrolling the provider.

Add medications into the patient's chart using one of the ways below:

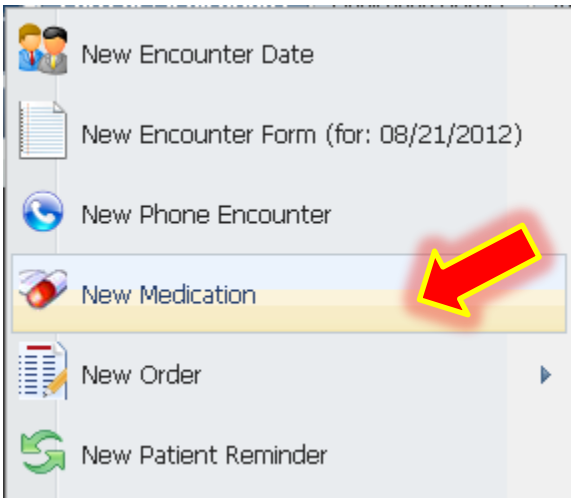
1) In the Encounter Form

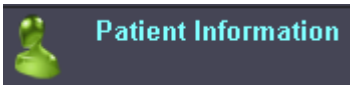


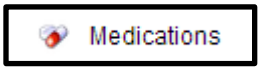
2) Using the Quick Menu in the patient's chart. When you open a patient's chart using 

click 

and the option to quickly add a medication into the patient's chart will appear.

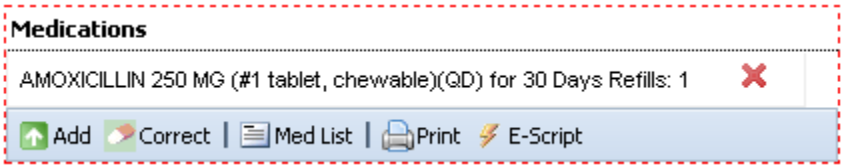


3) From the 

tab => 

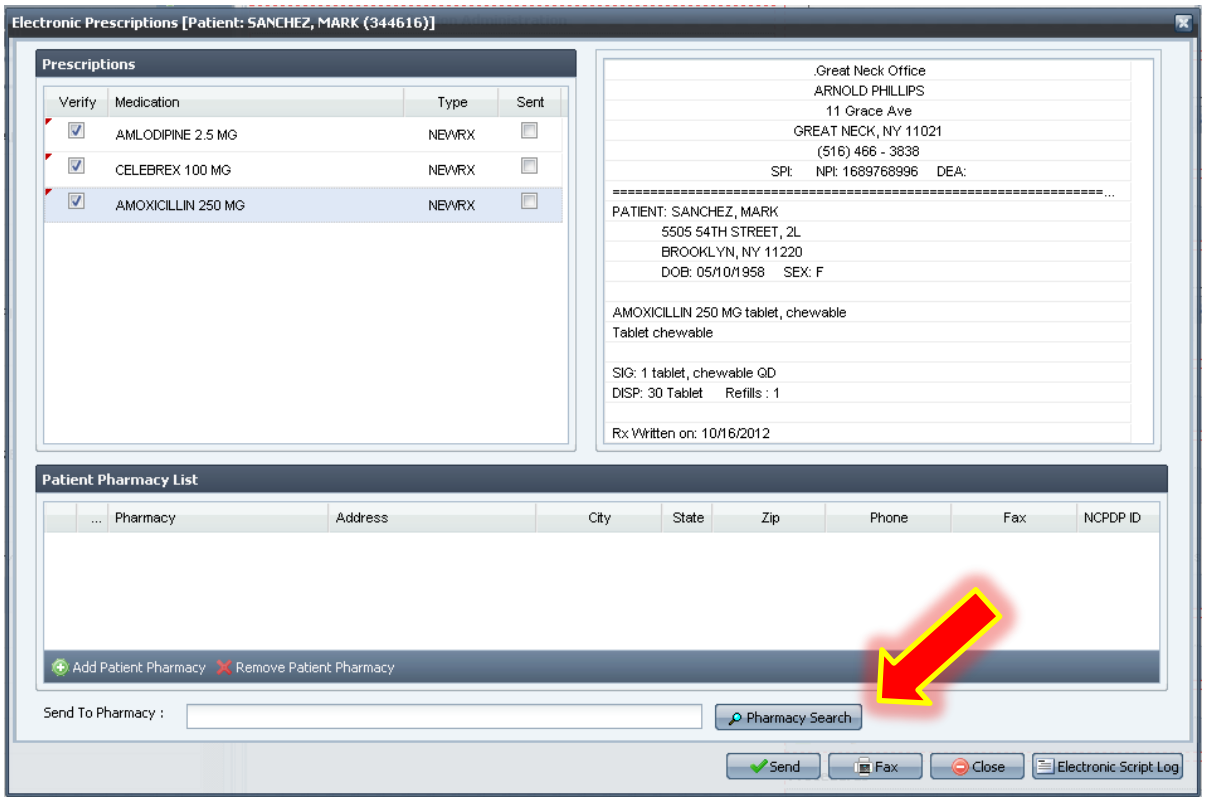
To send electronic prescriptions from the encounter form click 

and a new window will appear (Electronic Prescriptions).



Check off the Verify box next to each medication you wish to electronically prescribe after reviewing the script on the right panel.

Note: This is mandatory to send electronic prescriptions.



The lower window will contain the patient pharmacy list. If no pharmacy exists in this list it means that no patient pharmacy has been entered for this specific patient. If this is the case or, the patient will be going to a different location that the one you have on file click 

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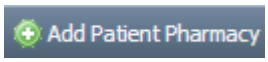
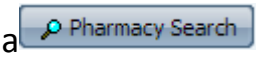
You may click 

or do a 

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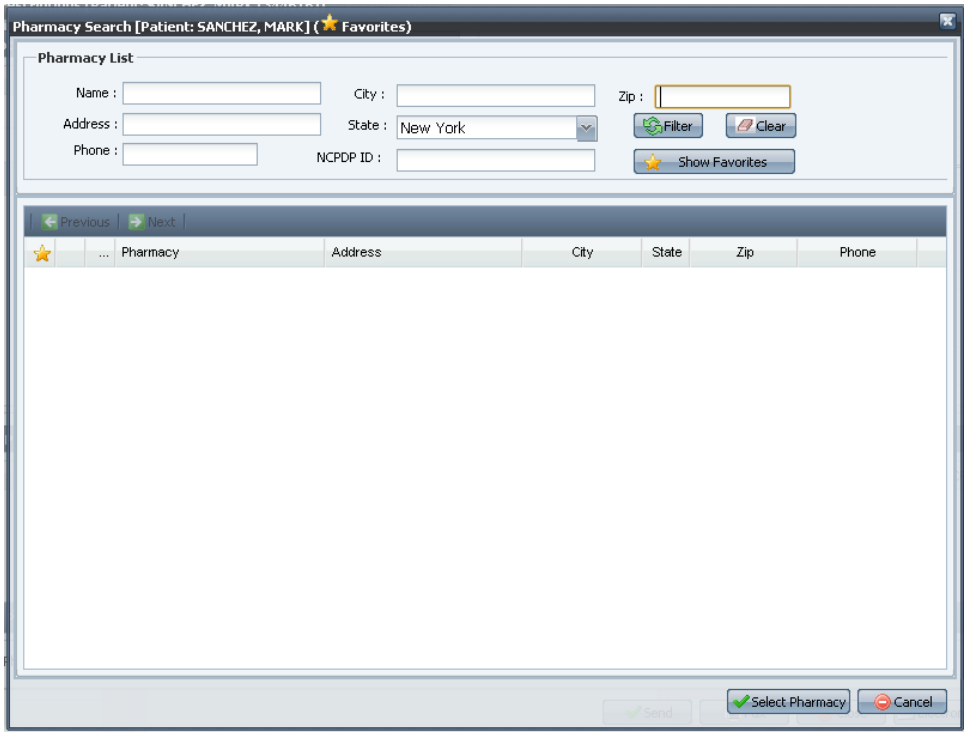
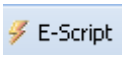
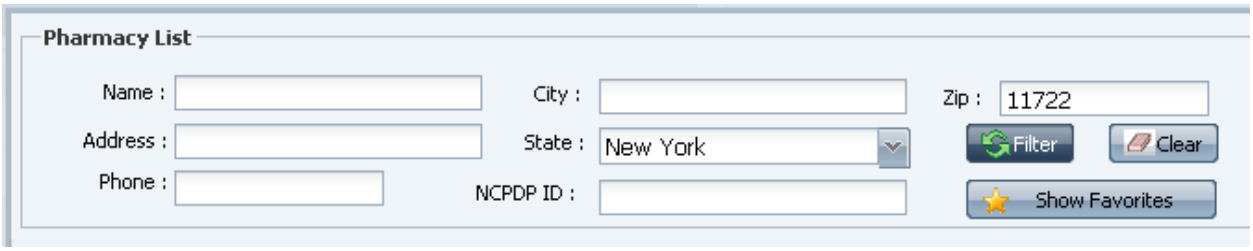
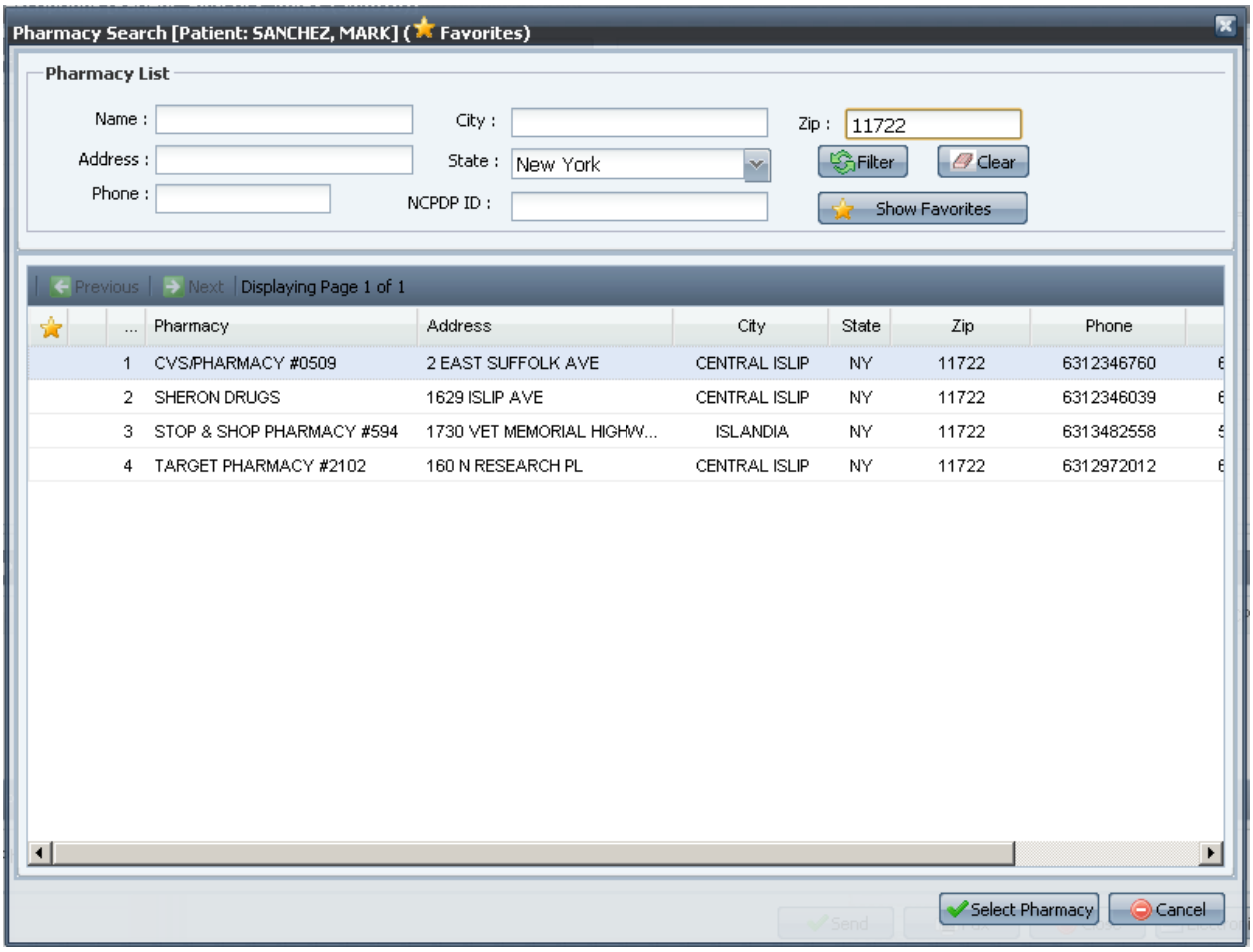


Click on the medication name to highlight it, and then click 

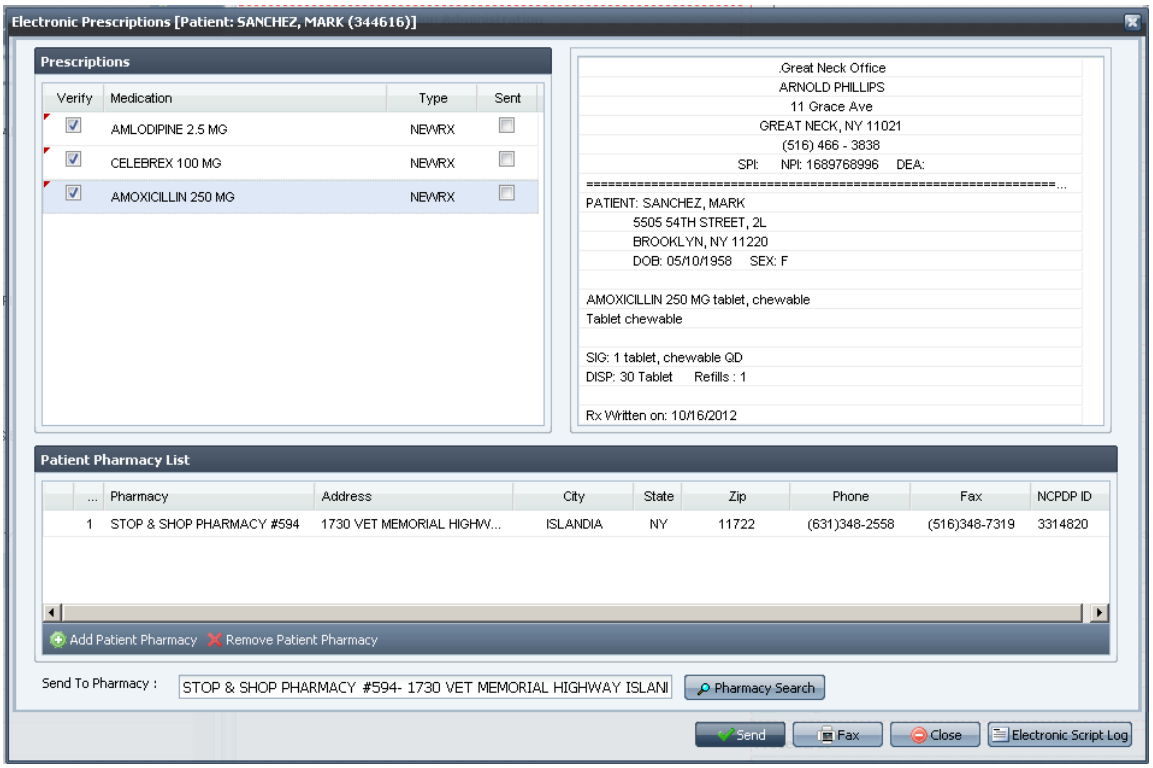
Search for the pharmacy with any information you have about the pharmacy. Then click 

or press the ENTER key on your keyboard to prompt the system to filter the pharmacy database.





All of the possible matches for your search will appear in the lower window. To select a pharmacy you just need to click on it. Selecting the pharmacy will add it to the list of the specific patient's pharmacy list.



1) Select the pharmacy that you desire to send the e-script to from the patient pharmacy list.
2) Then click Send to electronically prescribe the medications you have verified on the top left panel to the pharmacy that you have selected.

A new window will pop up once you Send the electronic prescriptions, which will contain a notice that the transaction was either successful or rejected.

Note: If the transaction is rejected please contact a Medgen Support Representative or create a ticket with the patient account number and medication name so we may investigate the issue for you.

- **Note: Exclusion- Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement.**

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CORE MEASURE 5 (Maintain Medication List)

Core Measure 5 (Maintain Medication List)

Tip: Medications should be entered for all patients.
Patients that have no medications taken please
mark that from the patient Medications Section

This measure can be achieved through the same steps as core measure 1 so please refer to the guide for **Core measure 1**. As you start entering medications in your patient's chart as instructed to achieve core measure 1, you will end up creating a medication list with all of your patient's medications. As you create this list, you will be complying with this measure; maintaining a medication list.

IMPORTANT TIP:

Make sure you click 

if the specific patient is currently not taking any medications and you will not be prescribing any medications. DO NOT leave the medication tab blank. Click on the 

tab to alert the system that you have reviewed the patient's medication history. Otherwise this patient **will not count towards meaningful use**.

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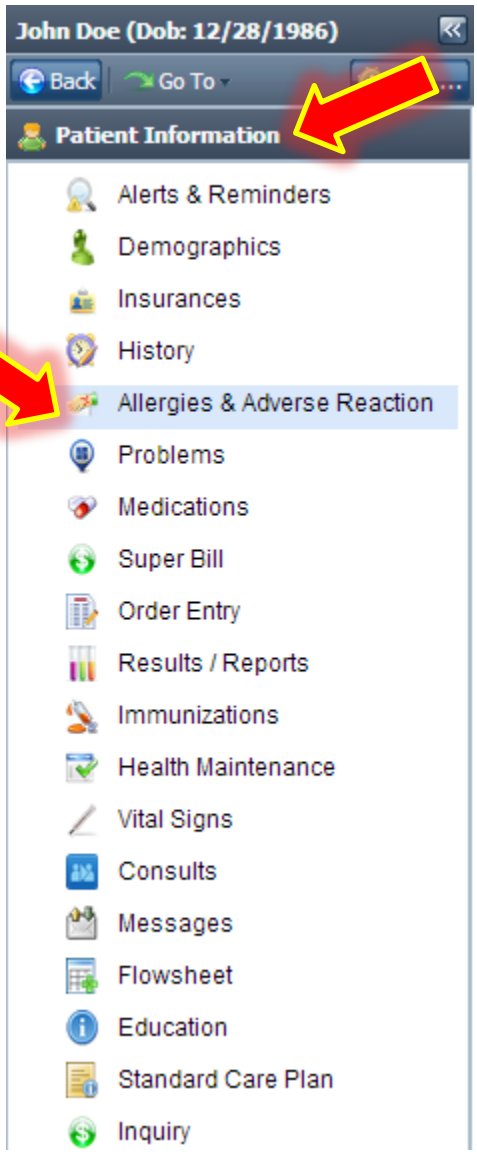
CORE MEASURE 6 (Maintain Allergy List)

Core Measure 6 (Maintain Allergy List)

Tip: Allergies should be entered for all patients.
Patients that have no known allergies please
mark that from the patient Allergies Section

To comply with this measure, you must enter ALLERGIES FOR ALL YOUR PATIENTS. This information can be entered in two locations, from the Patient Information section or the encounter form.



This is the patient information section in a patient's chart, to achieve meaningful use you will have to enter the patient's allergies from this section. To add a new allergy you will have to click on the tab:

situated on the bottom right of your screen and another window will open:

You may search for that allergy by substance medicine or Immunization allergy. You may also enter the type of allergy, the severity of it and the patient's reaction. After you are done, SAVE it and it will show under the allergy tab of the patient's chart.

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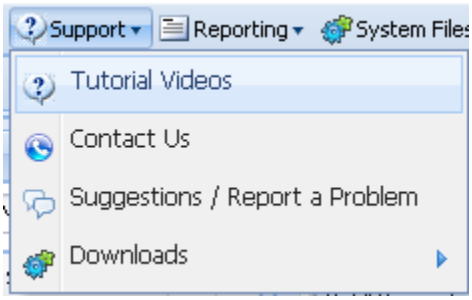
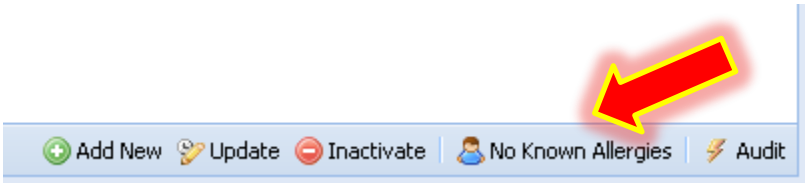


If you would like more information on how to add your patients' allergies in Medgen please refer to the appropriate tutorial video under our Support tab.

IMPORTANT TIP:

1) If the patient does not have any allergies, you must click 

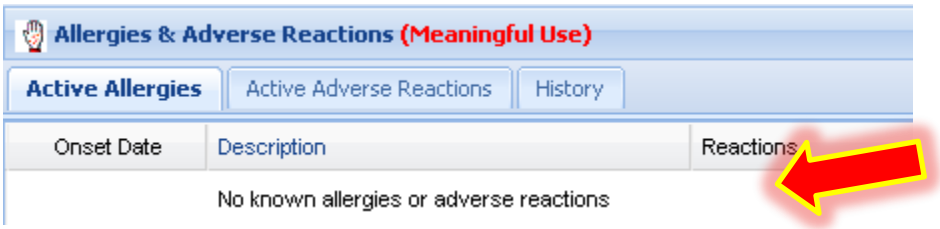
at the bottom right of your screen so the system will count it towards the meaningful use.
2) If you free-text the patient's allergy instead of finding it in our dictionary; the drug to allergy interaction in our system will NOT work.

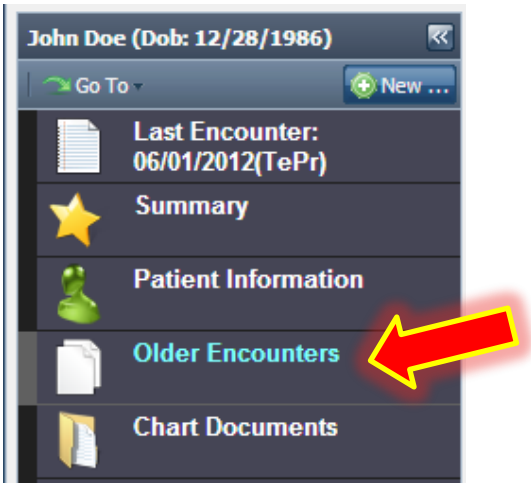


If you do not click the above tab and have not entered any allergies for a patient you will see the message below:

Once you have clicked on 

, the message should change to

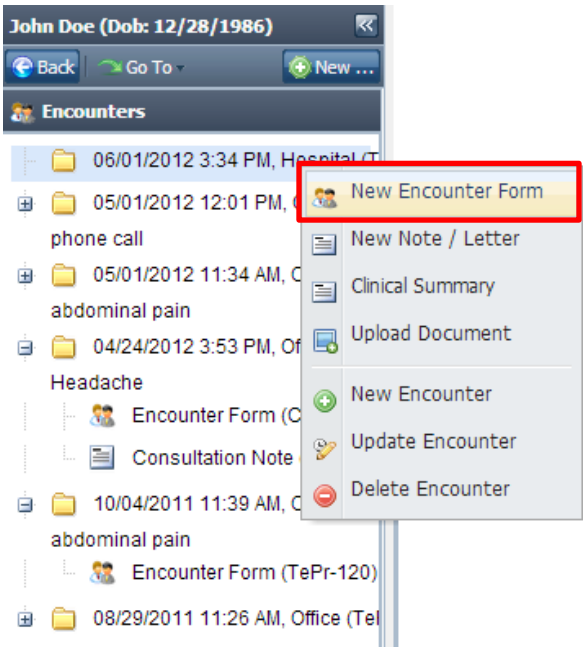




If you would like to add your patient's allergies from the encounter form, you will have to first open an encounter from.

To open an encounter form you will have to go to the encounter section in the patient's chart and create a new encounter for that patient.

After creating an encounter, a menu will appear asking if you would like to create a new encounter form. Once the encounter form is open you may enter allergies into the 'Current Allergies' panel.



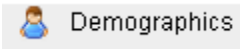
CORE MEASURE 7 (Maintain Patient Demographics)

Core Measure 7 (Maintain Patient Demographics)

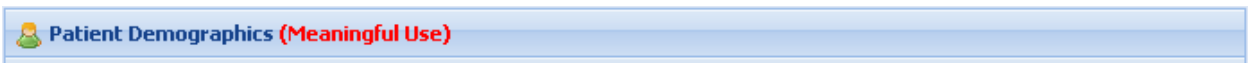
Tip: Patient Gender, DOB, Ethnicity, Race and Language must be present to meet this measure. Advise your staff to enter this information upon registration of the patient. This can also be entered during the check in / check out process

To successfully meet this measure requirement (and core measure 9) you would have to enter the following demographic information for all of your patients:

- Patient Gender
- Date of Birth
- Ethnicity (Medgen has a drop down menu with several options for your convenience)
- Race (Medgen has a drop down menu with several options for your convenience)
- Language (Medgen has a drop down menu with several options for your convenience)

In Medgen there are several locations to enter/edit this information for your patients. After the patient chart is open you will need to go to the patient information section under that patient's chart and select the 

menu.



As you can see in the pictures below, Medgen has (Meaningful Use) markers under the fields that should be filled out to remind you of the specific fields.

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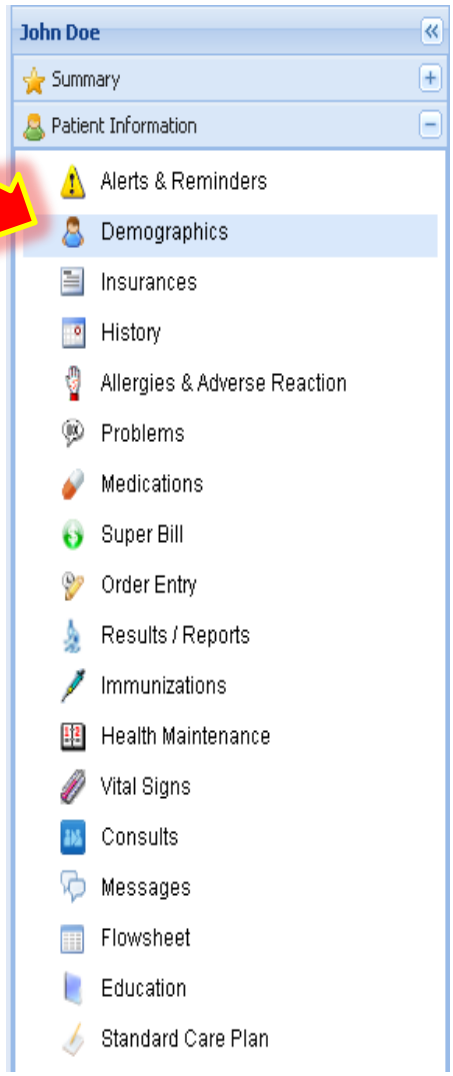
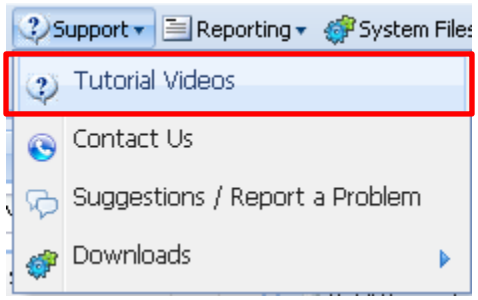


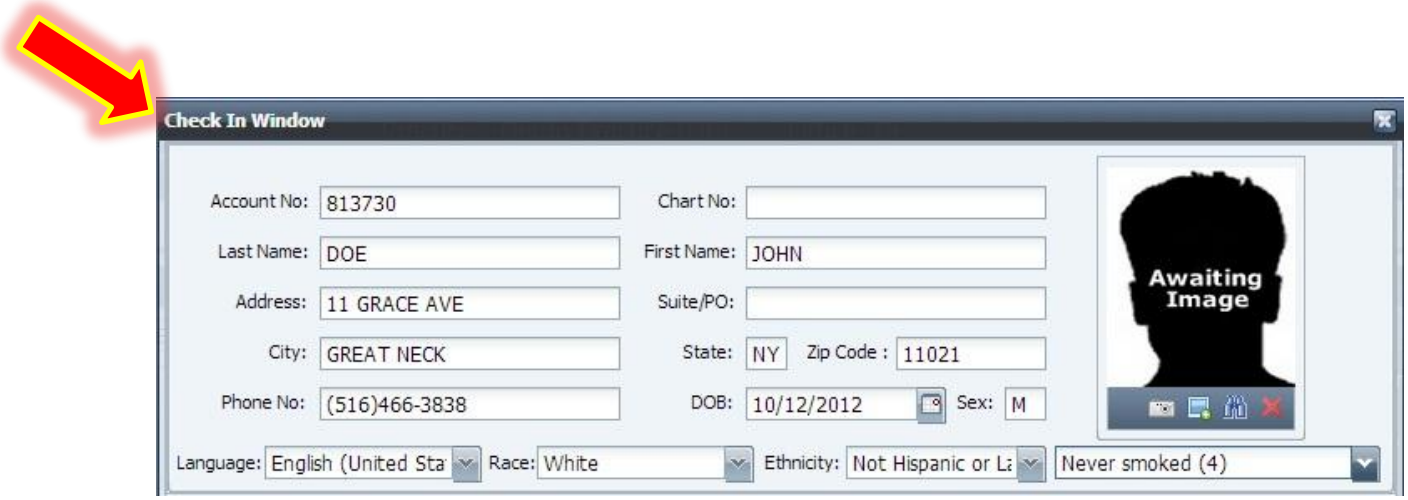
- Sex: M **Patient Gender**
- DOB: 05/05/1944 **Patient date of birth**
- Ethnicity: Not Hispanic or Latino (Meaningful Use) **Patient Ethnicity**
- Race: White (Meaningful Use) **Patient Race**
- Language: English (United States) (Meaningful Use) **Patient Language**
- Smoking Status: Unknown if ever smoked (9) (Meaningful Use) **Patient Smoking Status**

N o t e : Recording Smoking Status is necessary to meet core measure 9

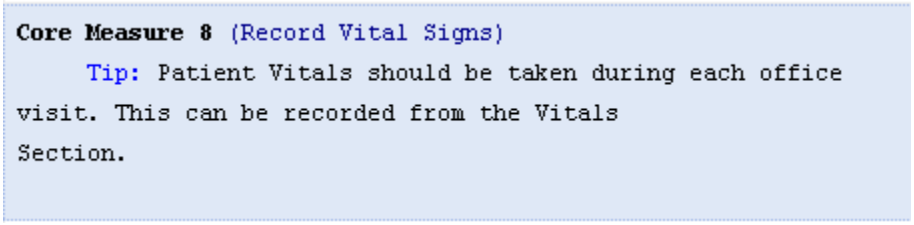


Another location that you can enter this information is in the check-in and the check-out window. Please refer to the Medgen tutorial videos for more information in how to check-in and check-out a patient.

Check-In/ Check-Out window:



CORE MEASURE 8 (Record Vital Signs)



Exclusion 1: Any EP who does not see patients 2 years or older would be excluded from this requirement.

Exclusion 2: Any EP who believes that all three vital signs of height, weight and blood pressure have no relevance to their scope of practice would be excluded from this requirement.

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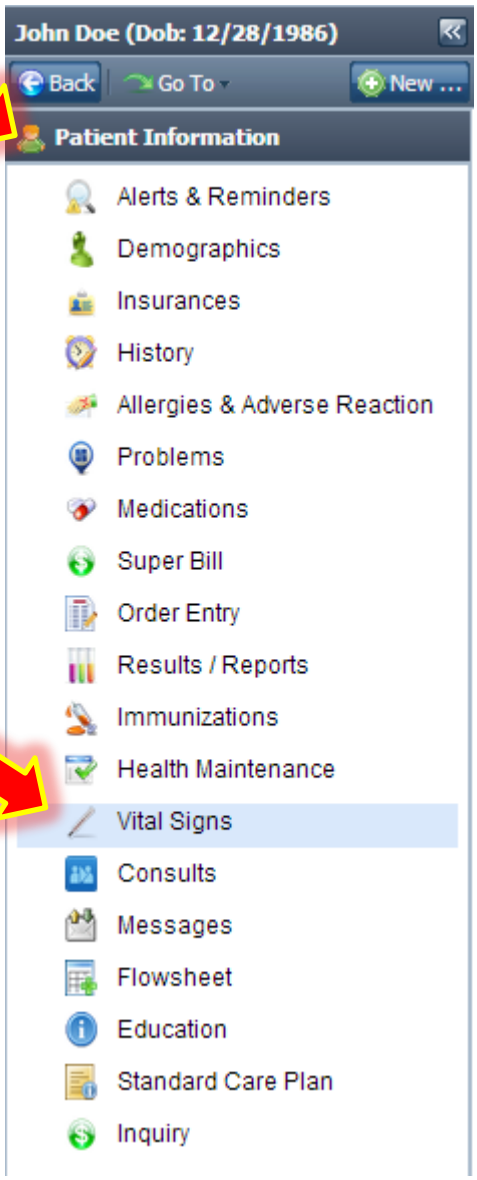
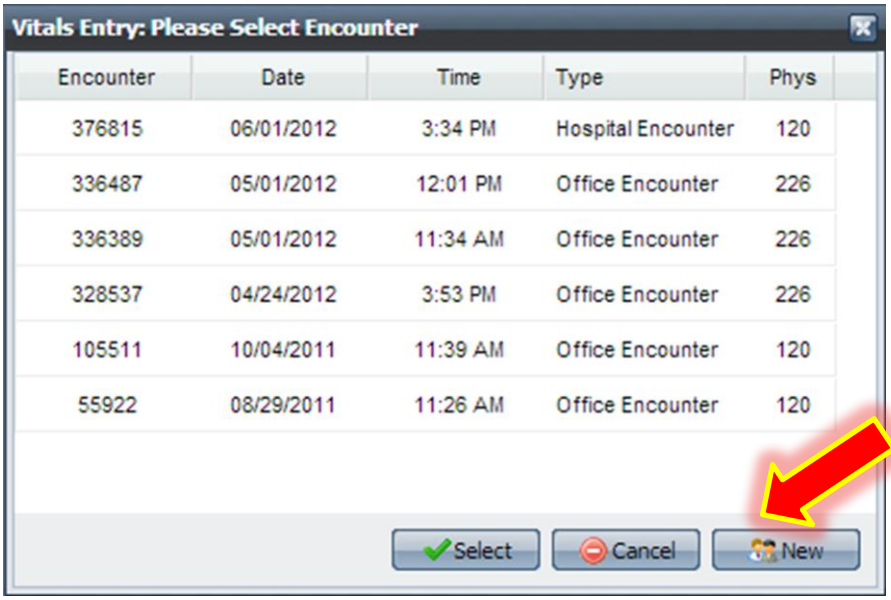
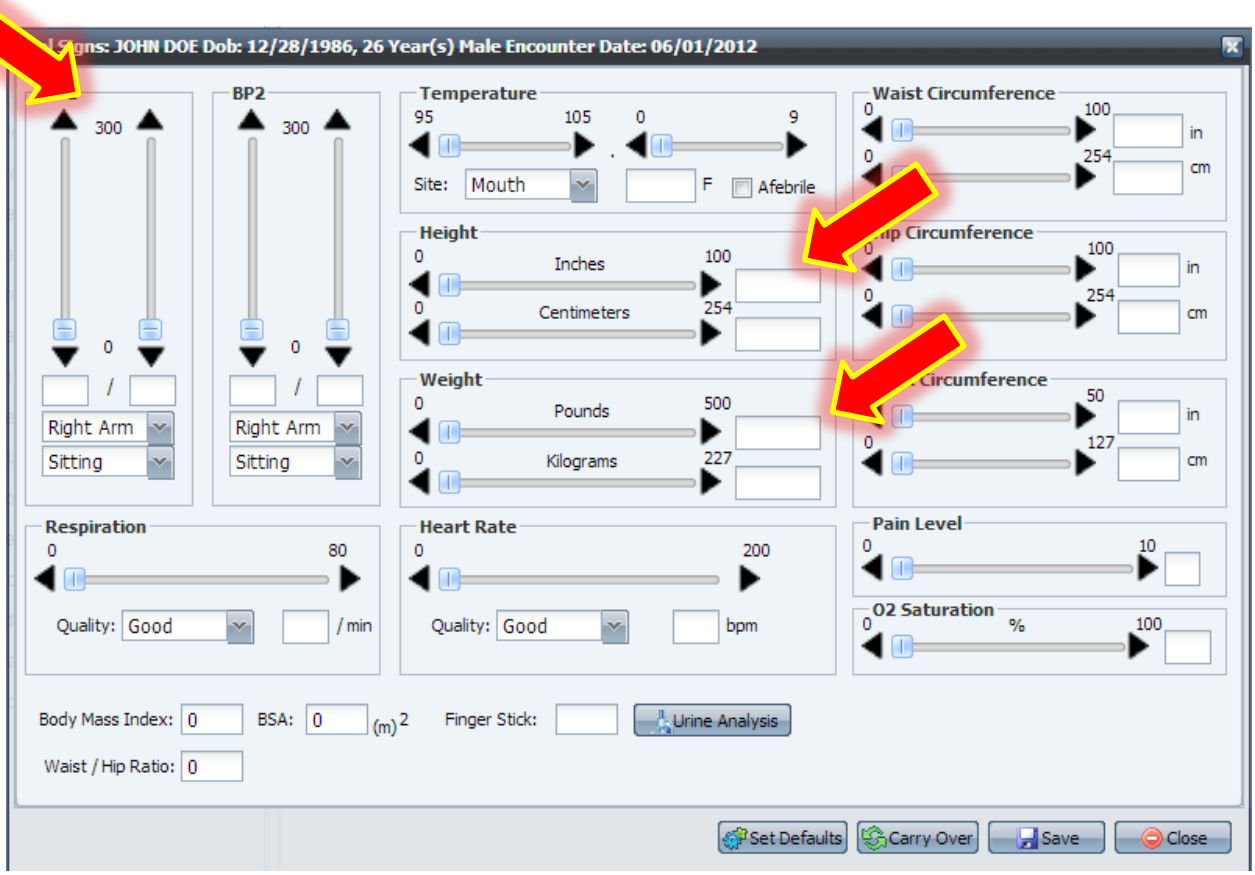


To achieve meaningful use, you will have to enter the patient's vital signs into the patient's chart. To add a new vital you will have to click on the tab 

at the bottom left of your screen within the tab 'Vital Signs'; a window will open asking you which encounter you took these vitals on. If no encounter was created for the patient for the specific visit, then you can create an encounter by selecting 





N o t e : You will need to enter you patient's height and weight in order for the system to calculate the BMI (Body Mass Index) automatically for you. After you complete the vitals window you simply save it and close it.

Once you have entered the vitals from the patient information section in the chart, they will appear at the top of the encounter form that you open for that day like this:

Vitals: BP: 120/114; BP2: 145/127; Pulse: 80 /min; Resp: 16 bpm; Temp: 98.60F; Weight: 169lb 8oz; Height: 55in; BMI: 39.40 kg/m2;

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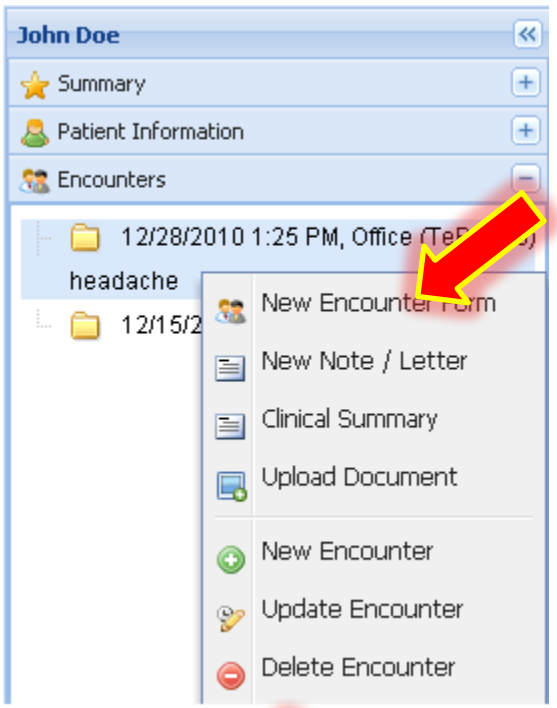
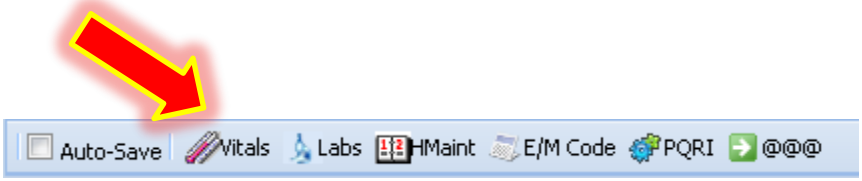
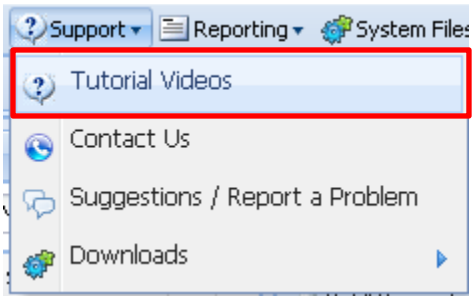
If you would like to add your patient's vitals from the encounter form, you will first need to open the encounter form.



To open an encounter form you will have to go to the encounter section in the patient's chart, and create a new encounter for that patient. After creating an encounter, a menu will appear asking if you would like to create a new encounter form. Once the encounter form is open you can enter vitals by click on the 'Vitals' tab on the bottom of the screen or the 'Vitals' tab in the panel named **Physical Exam**.





Please refer to the Medgen tutorial videos for more information about how to perform this task.

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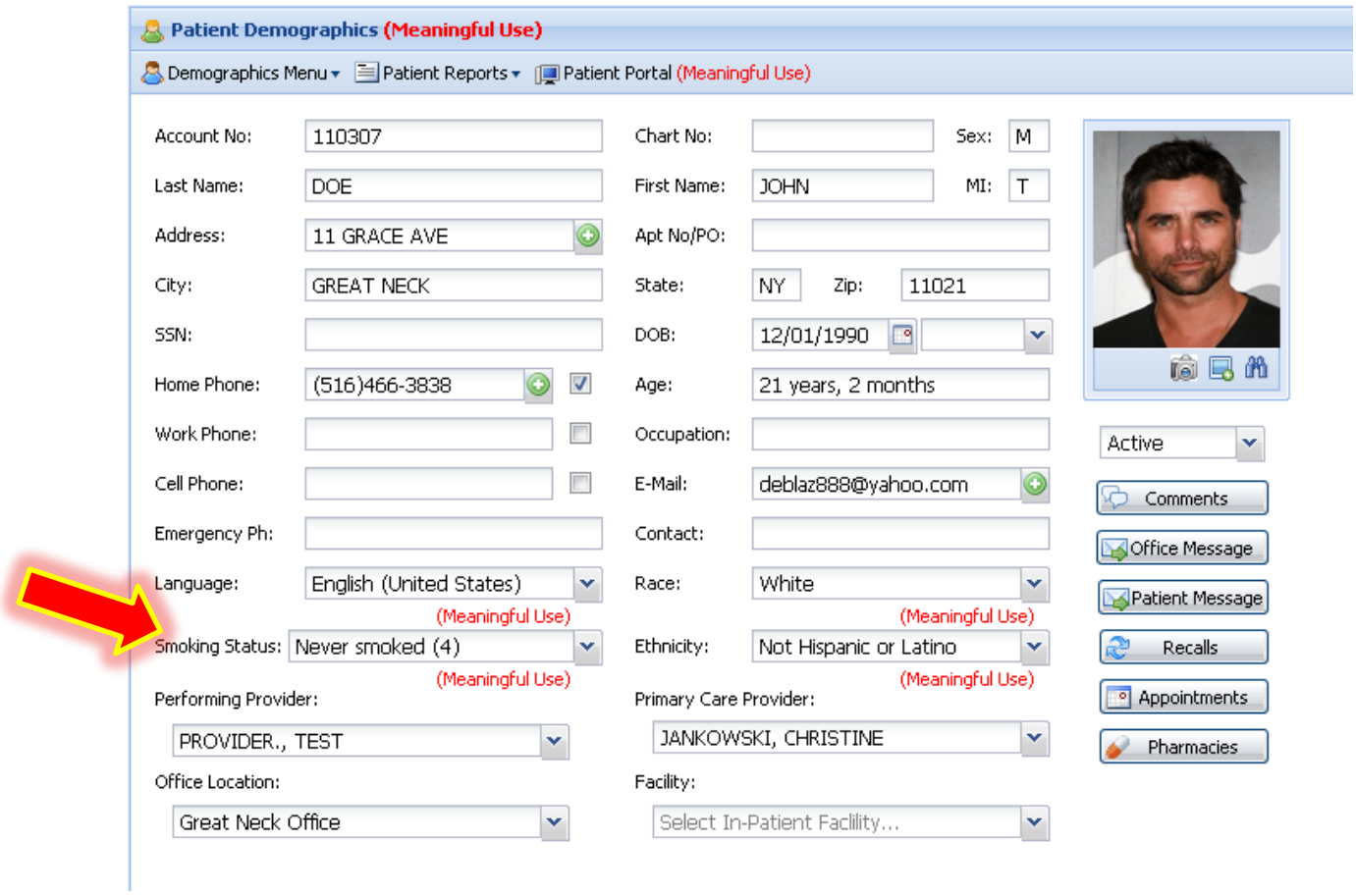
CORE MEASURE 9 (Record Smoking Status)

Core Measure 9 (Record Smoking Status)

Tip: Patient Smoking Status must be present to meet this measure. Advise your staff to enter this information upon registration of the patient. This can also be entered during the check in / check out process

For this measure please read: **CORE MEASURE 7** (Maintain patient demographics) to see where to enter this information. **NOTE:** This measure also pertains to ALL of your patients 13 years old or older.



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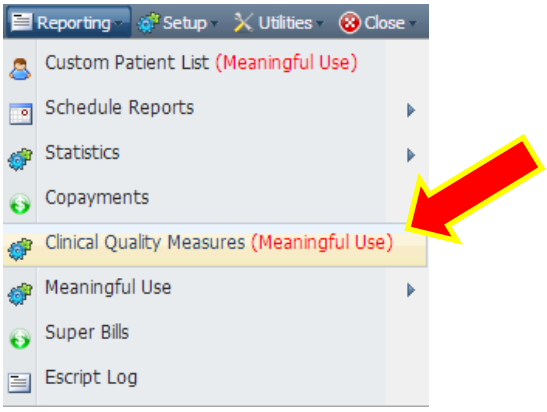
CORE MEASURE 10 (Report Clinical Quality Measures)

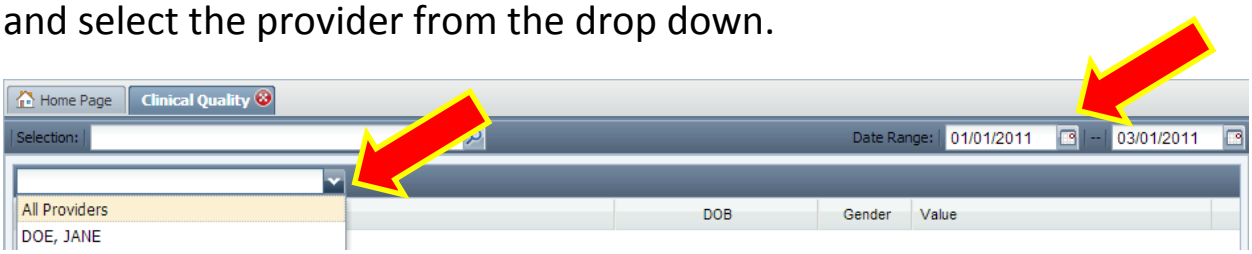
Core Measure 10 (Report Clinical Quality Measures)	Must	Core/Alt Core	3 Additional
Tip: For clinical quality measures you have to report on 3 Core / Alt Core Measures and 3 Additional Measures. You have to record the numerator and denominator values of each measure which can be obtained from the Clinical Quality Measures section of our Reporting Module.	Report	NQF0013 NQF0028 NQF0421	NQF0001,NQF00… NQF0024,NQF00… NQF0031,NQF00… NQF0034,NQF00… NQF0041,NQF00… NQF0047,NQF00… NQF0056,NQF00… NQF0061,NQF00… NQF0064,NQF00… NQF0070,NQF00… NQF00575

To accomplish core measure number 10 you need to report 3 core CQM, which are: NQF0013; NQF0028 and NQF0421 and 3 other alternatives (A sum total of up to 9 CQMs; 3 cores, up to 3 alternate core, and 3 additional CQMs. If an EP (eligible provider) reports a denominator of 0 for any of the 3 core measures, the EP must record for an alternate core CQM to supplement the core measure. Therefore, an EP may report a minimum of 6 and a maximum of 9 CQMs depending on the resulting values in the denominators for the core measures as reported from their certified EHR.)

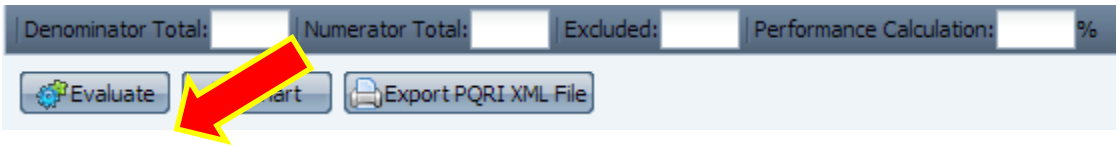
The values to report for this measure can be found by going under Reporting.



In the new tab that opens up (Clinical Quality), Specify the date range and select the provider from the drop down.



Click on the magnifying glass to select the CQM and then click Evaluate.



Doing so will pull up the denominator total, numerator total, # of patients excluded from the measure as well as the performance calculation.

Please contact Medgen Support to help you find the 3 additional Clinical Quality Measures that best suits your practice specialty.

NQF0013: Hypertension: Blood Pressure Measurement

NQF0028a: Preventive Care Tobacco Use

NQF0028b: Preventive Care Tobacco Cessation

NQF0421a: Adult Weight Screening and Follow Up 18-65

NQF0421b: Adult Weight Screening and Follow Up >65

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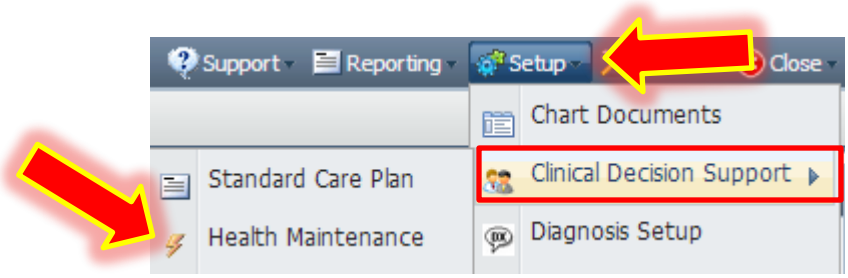
CORE MEASURE 11 (Clinical Decision Support)

Core Measure 11 (Clinical Decision Support)

Tip: Clinical Decision Support is prebuilt into the system and is automatically used when you Open a Chart with Health Maintenance

Medgen has prebuilt Health Maintenance systems that will remind you of different tests/exams that should be done for your patients, taking into consideration your patient's age, sex and medical condition(s). This prebuilt feature allows you to fulfill this measure automatically by using Medgen EHR.

If you would like to add/customize these tests with certain conditions of your own you may do so by going to Setup => Clinical Decision Support => Health Maintenance.



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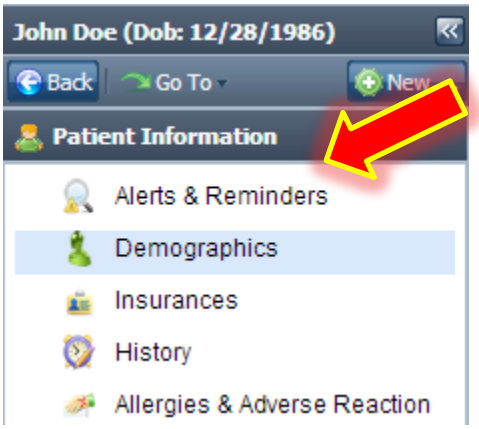
CORE MEASURE 12 (Electronic Chart Request)

Core Measure 12 (Electronic Chart Request)

Tip: If you have a valid chart request then you can mark that in the patients chart under Patient Information -> Demographics -> Patient Reports -> Flag Patient Chart Requested. To produce the report go to Patient Information -> Demographics -> Patient Reports -> Electronic Copy of Health Information. Any provider that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period is exempt from this measure

If you have a valid request from a patient for a copy of his/her health information, you need to follow a TWO step process:

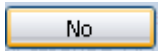
STEP ONE: Open patient chart and go to the demographics under patient information menu of the chart.



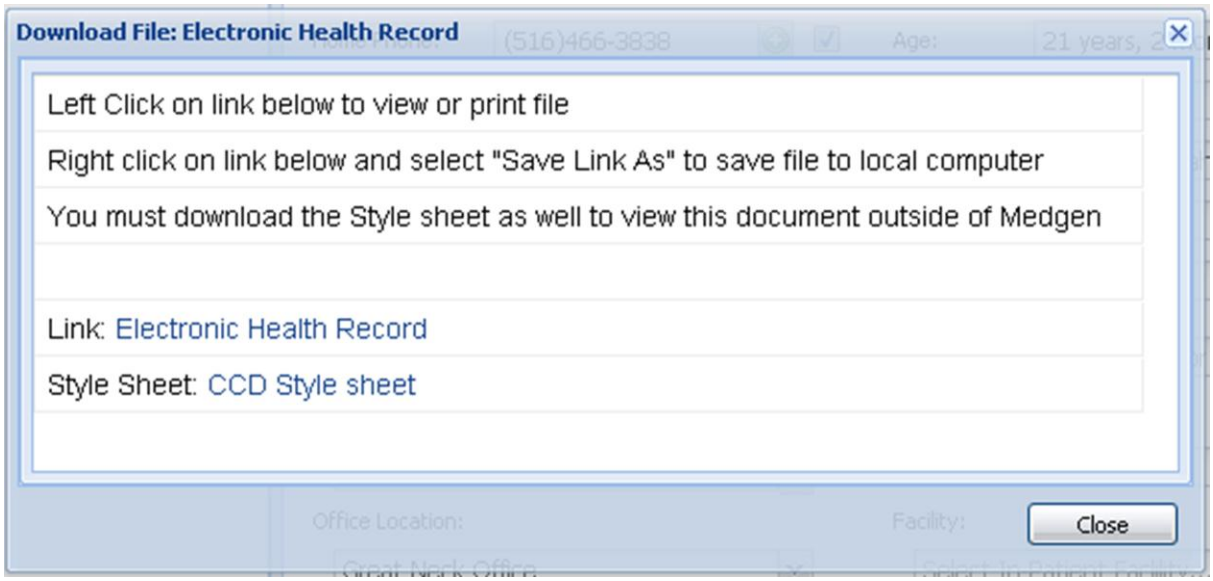
When you are on the patient demographics section of the chart you need to go to Patient Reports, and then Flag Patient Chart Request. After you do that you need to complete **STEP NUMBER 2.**

STEP TWO: To produce a summary of the chart open the patient chart and go to the demographics under patient information menu of the chart. Under Patient reports, click:

The system will ask you, whether you would like to encrypt the file or not. Since you are only producing the summary of the chart for printing purposes and not to actually sending the information you may select "No" to encrypt the file. If you select "Yes", the resulting report would be unreadable.

After you click 

this window will appear, with instructions on how to print the chart summary.



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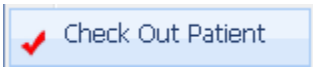
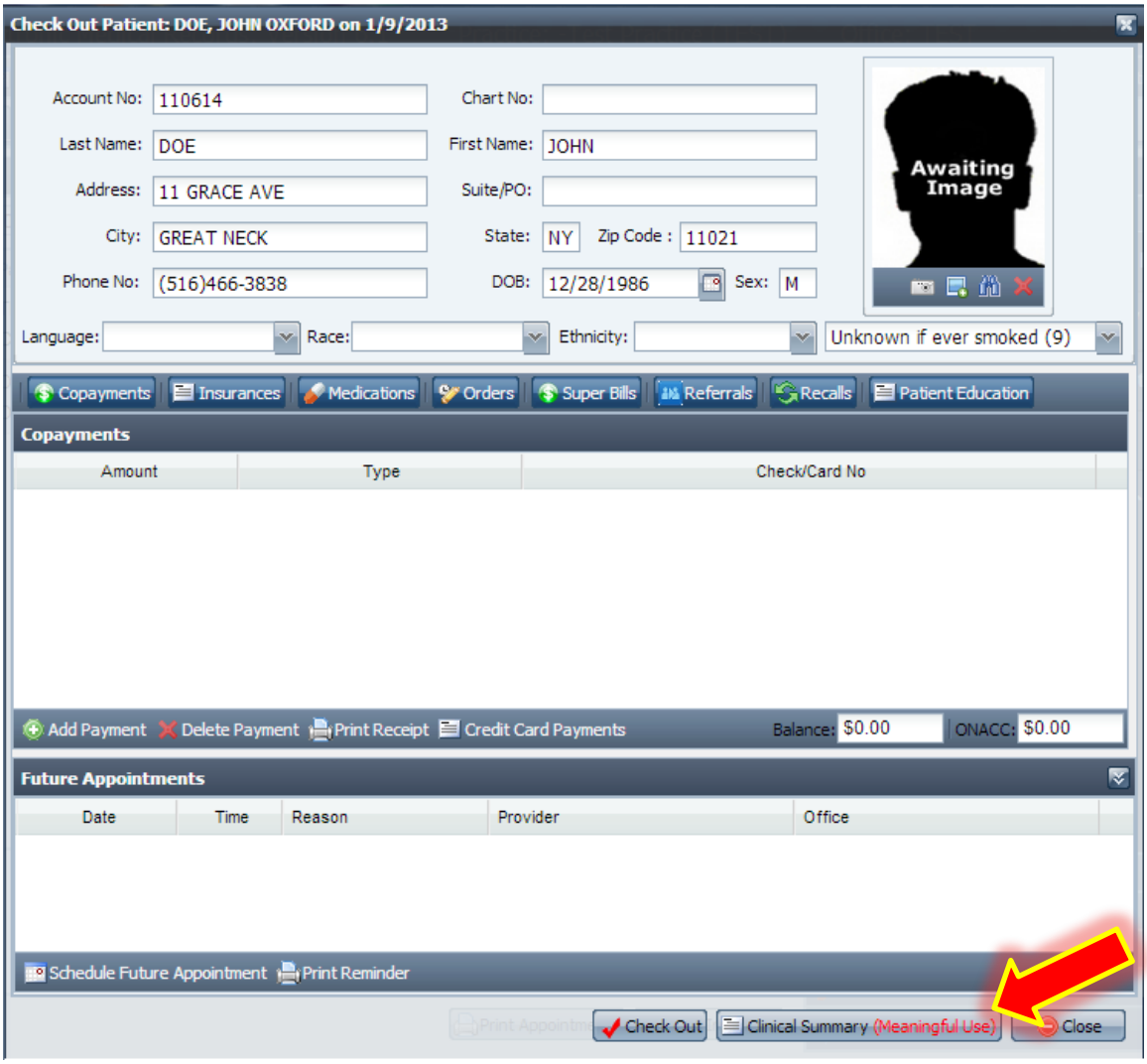
CORE MEASURE 13 (Produce Clinical Summaries)

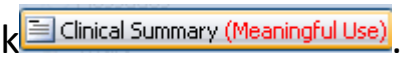
Core Measure 13 (Produce Clinical Summaries)

Tip: This document may be produced from a patient's encounter tree or during check out. Get your front end staff into the habit of printing the clinical summary document during the check out process.

The clinical summary is the summary of the patient's visit for the given day. One way to print your patient clinical summary is from the 

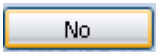
window at the end of the visit. When your staff performs the check out for that patient the option to print the clinical summary will be available.



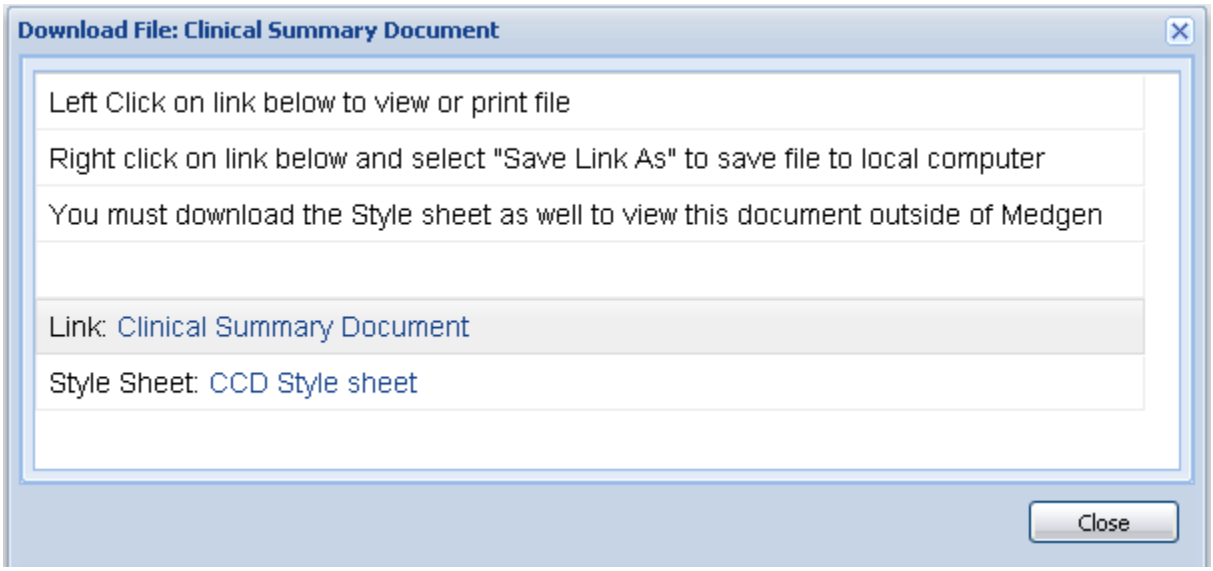
Click 

.

The system will ask you, whether you would like to encrypt the file or not. Since you are only producing the summary of the chart for printing purposes and not to actually sending the information electronically you may select "No" to encrypt the file. If you select "Yes", the resulting report would be unreadable.

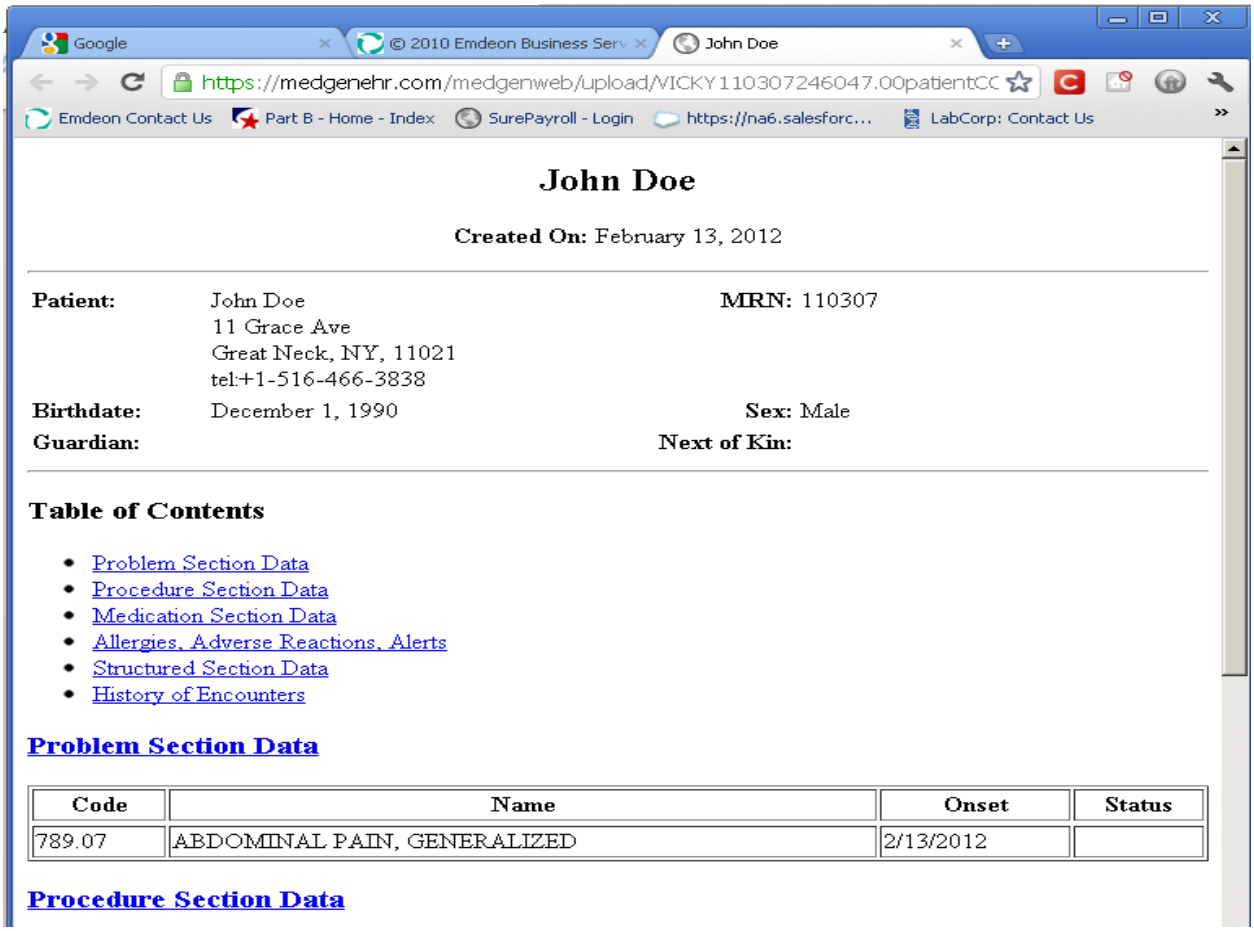
After you click 

this window will appear:

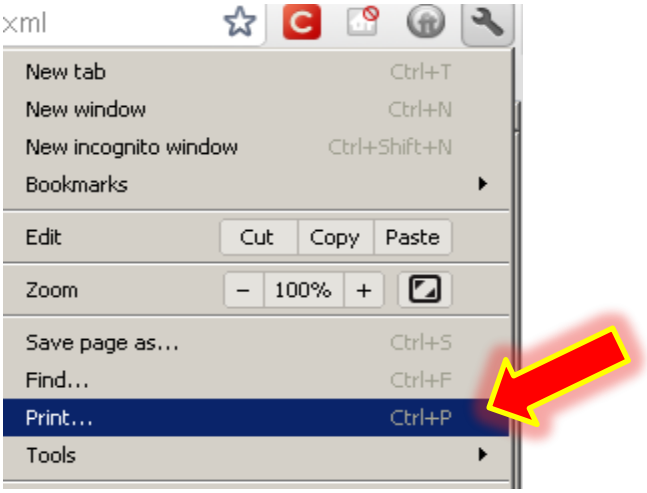


You will have to click: 

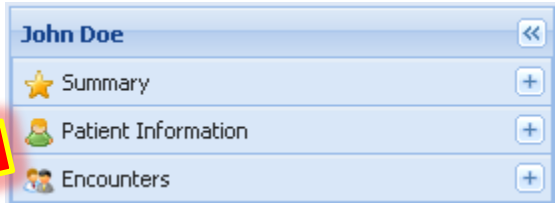
and the patient's Clinical Summary will re-open in another window:



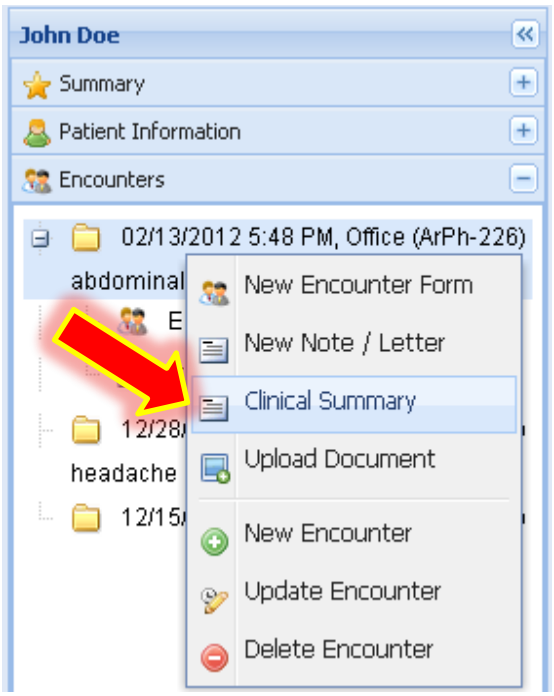
To print this patient's Clinical Summary you may right click on the page to 'Print' the Summary for the patient.



Another way of printing your patient's Clinical Summary is from the encounter tree. First you will have to Open Chart. Then go to the Encounters section.



When you are in the encounter section you will see your encounter tree. Click on an encounter and several options will appear;



After clicking on the Clinical Summary option, follow the instructions mentioned above to print it.

CORE MEASURE 14 (Electronic Exchange of Health Information)

Core Measure 14 (Electronic Exchange of Health Information)

Tip: You must find another provider with a certified EMR system to perform this test, (note: they must be using an EMR other than Medgen). The Medgen system has the ability to generate a CCD document which all certified EMRs must have the ability to read. You can create this document for a particular patient in Open Chart -> Patient Information -> Demographics -> Patient Reports -> Electronic Copy of Health Information. When creating this file you have the ability to save it to your computer which you then can send to another provider to complete the test.

Core measure number 14 is one of the measures that states Must Perform which means that Medgen cannot account if you have completed this measure, even though you may have done it, it will still say Must Perform, until you have manually marked that this measure was completed.

The first thing that you need to do in order to perform this measure is to find another provider that is using a certified EHR system other than Medgen EHR. After you find such provider, we suggest you use a TEST PATIENT this measures since we will be sending patient sensitive data over e-mail which is unsecure, if a TEST PATIENT does not exist you may always create one.

As soon as you Open Chart for your Test Patient, go to Patient Information.

In the Patient Information section of the chart you will have to click on Demographics

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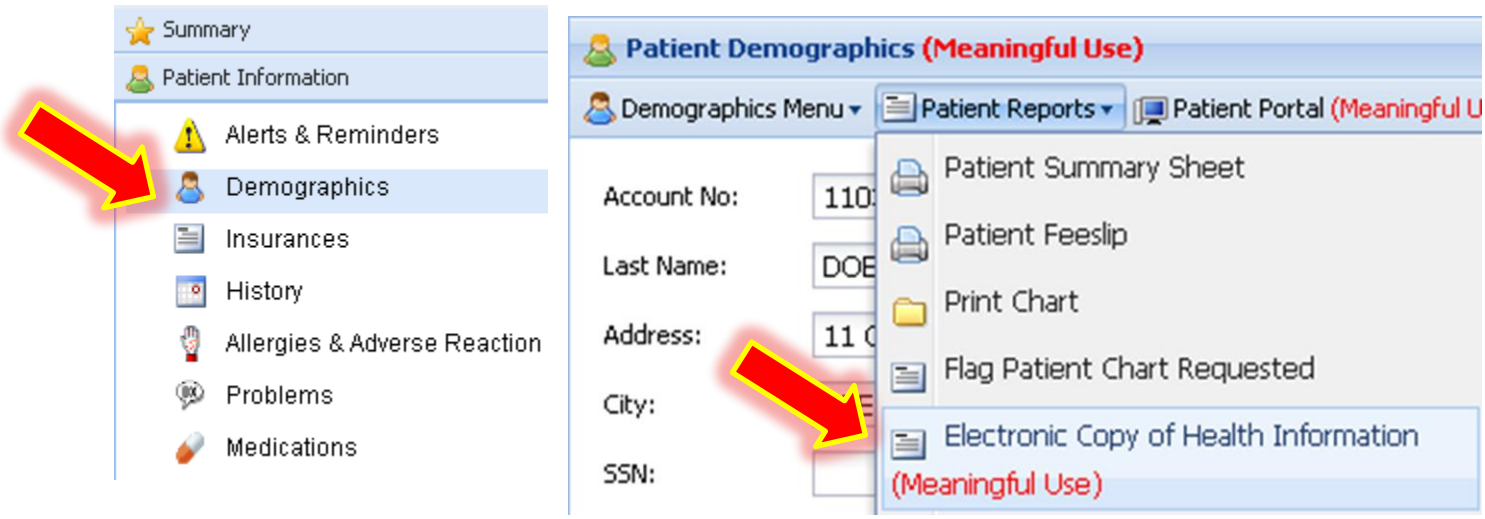
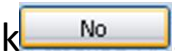
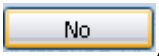
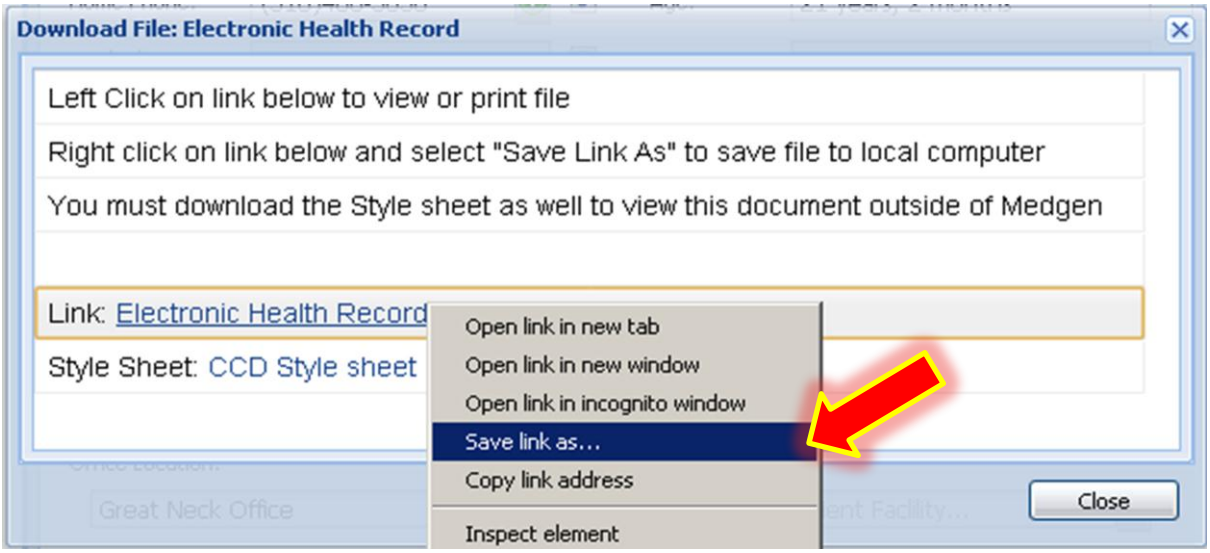
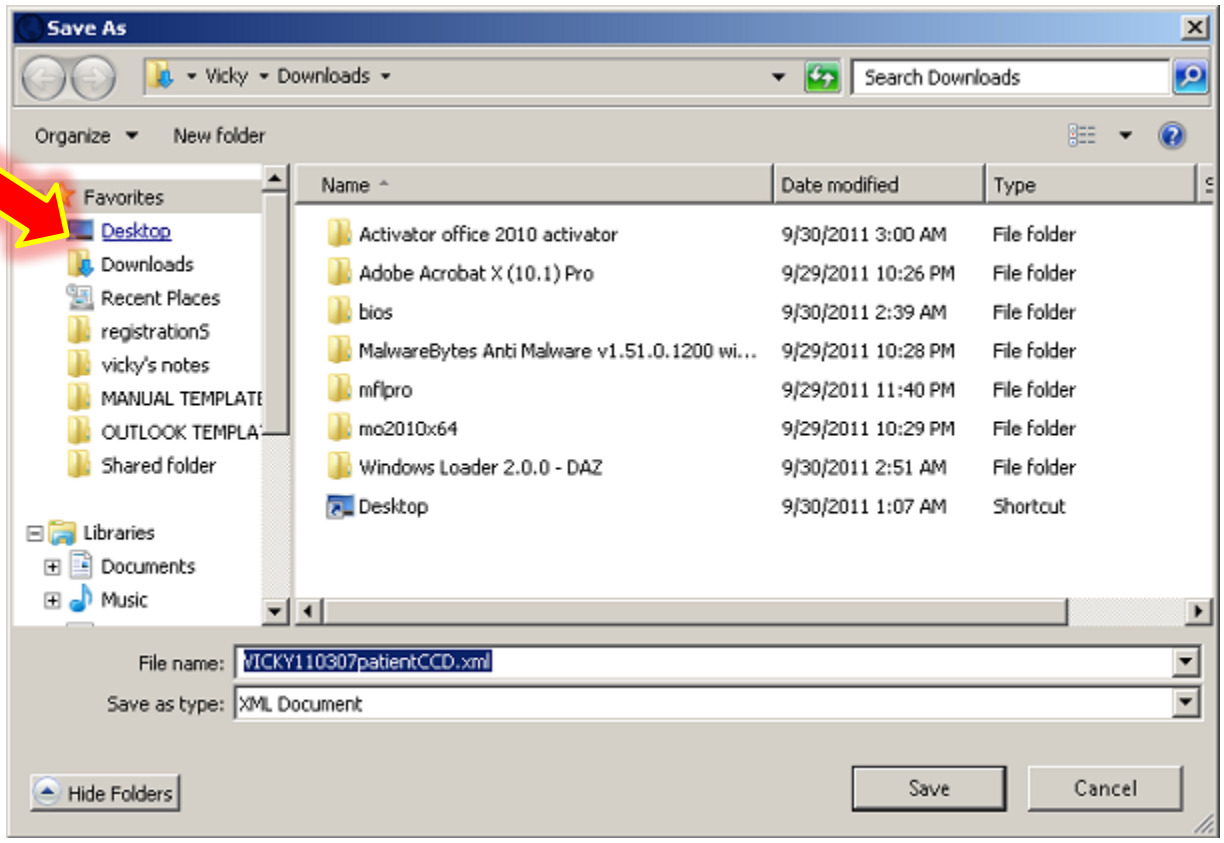


After you click in  the system will ask you:

Click  . Since you are sending TEST PATIEBT data there is no need to protect this info.

After clicking on  , right click with your mouse on top of the link that says: 

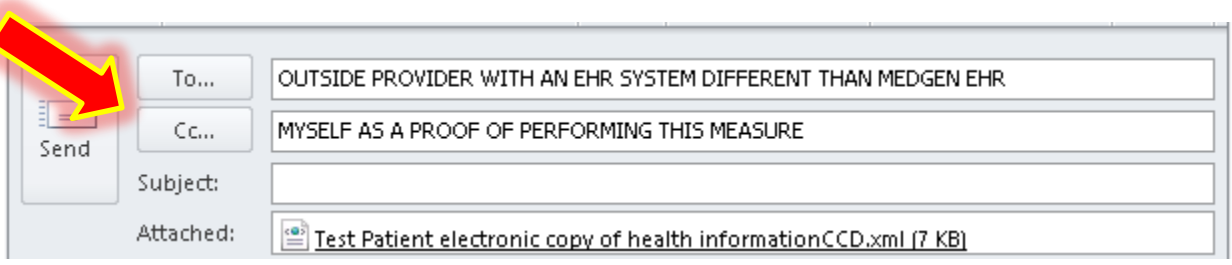




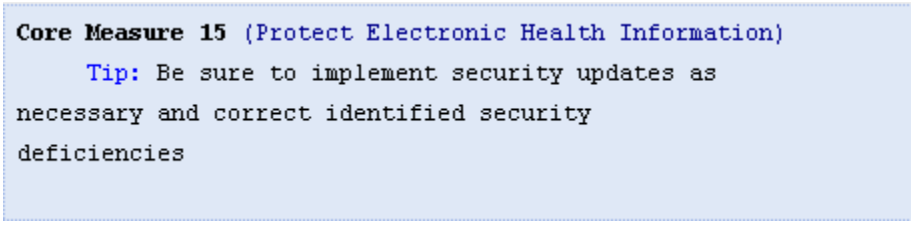
Your computer will open a window asking where you want to save this file, we recommend you to save it in your DESKTOP, so you can find it easily in order to attach it in an e-mail. Also, you can change the name of that file if you want to i.e.: “Test patient electronic copy of health information”.

After selecting the desired location to 

the file, open your email and attach this file in the email for this doctor. We recommend you Cc. yourself *in that email, so you may have a record of completing this measure.*



CORE MEASURE 15 (Protect Electronic Health Information)



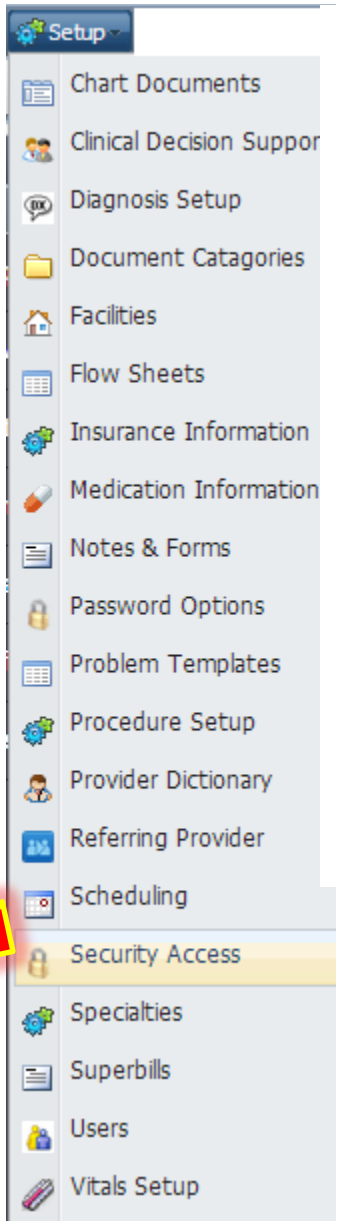
Core Measure 15 is one of the measures that states Must Perform this means that Medgen cannot account if you have done it or not, even though you may have done it, it will still say Must Perform until you have manually marked that this measure was completed.

To comply with this measure you must conduct or review a security risk analysis of your practice and EHR and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.

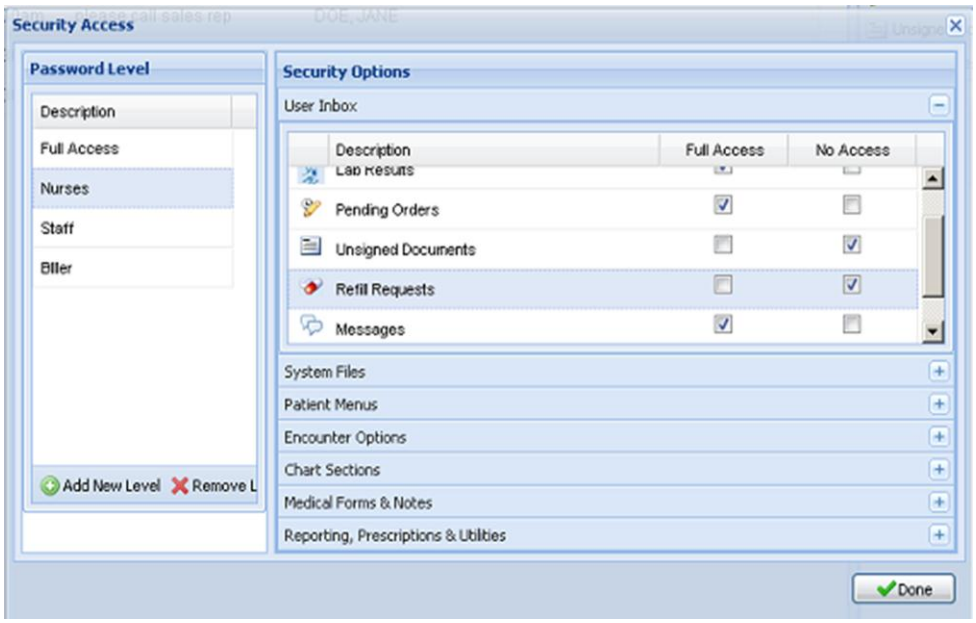
Some ideas to help ensure that patient information is secure are to create different security levels in the system as well as different usernames and passwords for each person that will use Medgen and manage your patient's healthcare records. You may also set up specific password restrictions to ensure that strong passwords are used by all users. Medgen is automatically configured with a default time-out period that will automatically lock your screen if it is idle for a specific period of time, this duration of time may be customized by you.

Comtron Corp. 2012 Medgen EHR
medgensupport@comtronusa.com

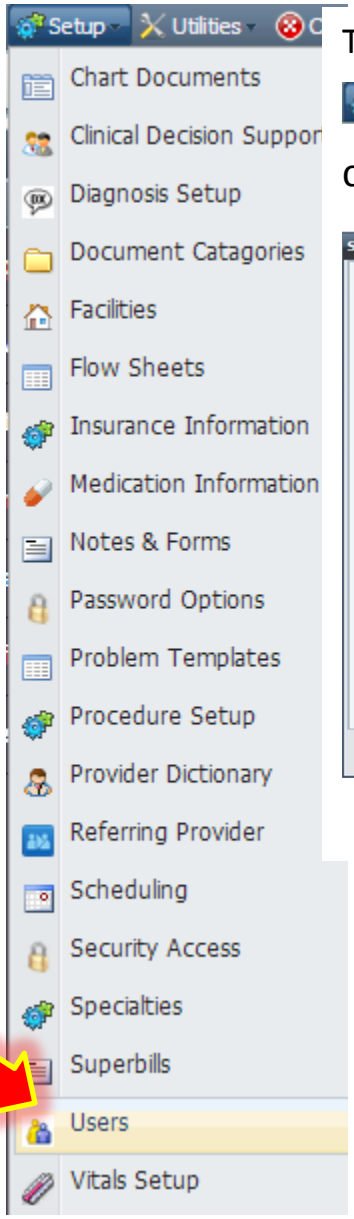
You can create different security access levels under 



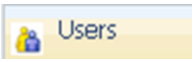
Here you will create different security levels for your staff that you may select when creating users for your practice.



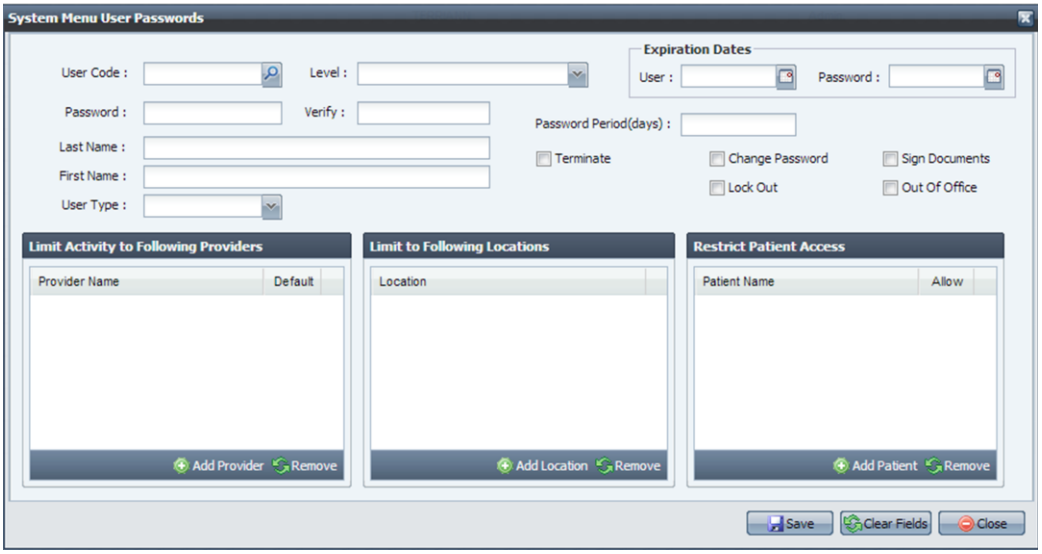
You may also create different users for Medgen. 



To create usernames and passwords you will have to go to 

and find 

at the bottom of the menu. Then click Add on the bottom of the window.



You may review the risk assessment tools that are available through the ONC web page. NOTE: We recommend that you go to the ONC web page to review the risk assessment tools as the links and information available are subject to change.

http://nyehealth.org/wp-content/uploads/2012/07/NYeC_Introduction-to-the-NYeC-ONC-Tool-HIT-Security-Risk-Assessment-Questionnaire-v3-0-032911.pdf

http://csrc.nist.gov/publications/nistpubs/800-30-rev1/sp800_30_r1.pdf