



Costs and Limitations
For Certified Healthcare IT EHR
KeyChart 6.0

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KeyMed, LLC

Costs and Limitations for KeyChart 6.0

Capability and Description

2015 Edition criteria applicable to KeyChart 6.0 a5, a6, a9, a11, a12, a13, a14, b1, b2, b4, b5, d1, d2, d3, d4, d5, d6, d7, d8, f2, g3, g4, g5, g6

KeyChart 6.0 is a server based EHR that supports healthcare professionals in ophthalmology and optometry in outpatient ambulatory environments. . It allows users to perform a wide range of functions such as to:

- document, review, and edit patient health information including but not limited to problem lists, medication lists, medication allergy lists, family health history, and all aspects of the patient's eye exam,
- perform CPOE (computerized provider order entry) for medications, laboratory orders and imaging procedures,
- electronically create prescriptions and prescription-related information for electronic transmission to pharmacies,
- measure CQMs (clinical quality measures) and to export these in standard file formats*,
- be alerted to possible CDS (clinical decision support) interventions, and
- Report information to PHAs (public health agencies) and clinical data registries.

Types of Costs or Fees and Additional Types of Costs or Fees

The costs and fees to purchase the software license or use the software in the Software as a service model will vary with the number of providers and users. Onsite training is available for separate per day fees. This certified product-version will require the signing of a contract when purchasing the product. The term of the contract will vary by whether the software as a service option the option for using an in-house server is chosen.

There is a monthly fee per provider fee for unlimited ePrescribing services.

Online portal service including direct secure messaging functionality are subject to a monthly fee per provider.

Specialized registry reporting service is available for a monthly fee per practice with no volume limitations.

Clinical Quality Measures processing is available via PopHealth and is subject to an Annual fee per provider with no volume limitations.

Limitations (Contractual/Business)

This certified product-version will require the signing of a contract when purchasing the product. The term of the contract will vary by whether the software as a service option the option for using an in=house server is chosen.

The provider may send direct secure messages to any provider whose HISP is allowed to send and receive messages from Surescript's HISP

Limitations (Technical/Practical)

We request that the mass export functionality for Data Export be used no more than once every 24 hours to ensure optimal system performance.

CMS has a file upload size limit when submitting CQMs via the CMS Quality Net portal. QRDA I files can be only 20 MB or less. Larger files will have to be divided.

*The Regulatory Compliance Platform Version 1.2 is used as part of an EHR solution package. It allows users to perform a wide range of functions such as monitor MIPS Performance, CQM calculation, PHA reporting, Bulk Export of CCD files, Send/receive messages and attached documents to/from the HISP via Direct Edge Protocol, create gold standard documents required for referrals and transitions of care

This Complete EHR is 2015 Edition compliant and has been certified by an ONC-ACB in accordance with the applicable certification criteria adopted by the Secretary of the U.S. Department of Health and Human Services. This certification does not represent an endorsement by the U.S. Department of Health and Human Services.

Vendor	Version	Date Certified	Certification Number
KeyMedical Software	KeyChart 6.0	Nov 15, 2017	15.04.04.1768.KeyC.06.00.1.171115

Criteria Certified

- 170.315 (a)(5) Demographics
- 170.315 (a)(6) Problem List
- 170.315 (a)(9) Clinical Decision Support
- 170.315 (a)(11) Smoking Status
- 170.315 (a)(12) Family Health History
- 170.315 (a)(13) Patient-Specific Education Resources
- 170.315 (a)(14) Implantable device list
- 170.315 (b)(1) Transitions of Care
- 170.315 (b)(2) Clinical Information Reconciliation and Incorporation
- 170.315 (b)(4) Common Clinical Data Set Summary Record – Create
- 170.315 (b)(4) Common Clinical Data Set Summary Record - Receive
- 170.315 (d)(1) Authentication, Access Control and Authorization
- 170.315 (d)(2) Auditable Events and Tamper-resistance
- 170.315 (d)(3) Audit Report(s)
- 170.315 (d)(4) Amendments
- 170.315 (d)(5) Automatic Log-off
- 170.315 (d)(6) Emergency Access
- 170.315 (d)(7) End-user Device Encryption
- 170.315 (d)(8) Integrity
- 170.315 (f)(2) Transmission to Public Health Agencies – Syndromic Surveillance
- 170.315 (g)(3) Safety-enhanced Design
- 170.315 (g)(4) Quality Management System
- 170.315 (g)(5) Accessibility- Centered Design
- 170.315 (g)(6) Consolidated CDA Creation Performance

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