

Using Instant Medical History™

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Version 1.42 This document applies to release build 360 and later of Instant Medical History™.

A note about Windows

This manual is not intended as an instructional guide to using Microsoft Windows ®. Certain assumptions are made about your familiarity with Windows and your ability to use standard Windows devices and icons. If you have difficulty understanding the use of drop down menus, tabs, check boxes, radio buttons, and text boxes, please consult your Microsoft Windows manuals.

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Section I. Installation of your software

Click the IMHSetup icon on your CD. Please see the installation instructions that come with your CD for more specific instructions.

Section II. Using Instant Medical History

Using the File drop down menu

Open Current Screening

This will open the results of the last patient interview administered. Depending upon the file format you select, it will open the results in your word processor or EMR. If you have not done any screenings during the session of Instant Medical History™ you have open, you will receive an error message. Use the Open a Screening options to open a screening that other than the most recently done screening.

Open a Screening

After pressing this button, a list of the available screenings will appear. You can select the desired patient interview to review from this list.

To select a screening to review, put the cursor over the Name field of the screening you wish to select, then click the left mouse button. Note that clicking any field other than the Name field has no effect. The fields labeled DOB (for "date of birth") Modified, and Filename are informational screens to help you select the proper screening.

Note also that you can change the way the screenings presented for selection are sorted by clicking on the title in the gray titles at the top of each column. Clicking on the Name title for example will force Instant Medical History™ to re-sort the list in reverse alphabetical order. Similarly, clicking on the DOB screen will change the list to be grouped in order by date of birth. This can be very useful for finding previous screenings based on date administered (the "Modified" field) or other characteristics.

Most of the time you will want to work with screenings that are in the Primary output location and are the original output from the screening. There may be times that you have made and saved modifications to the original screening or that you need to work from your secondary output location (if you are having network problems for example). You have the option to select Reviewed screenings and Secondary output locations in this window for those cases.

Manage Screenings

This will allow you to convert previous interview files to a different format and delete interview files. After selecting the interview or interviews, please press Create EMR files to convert interview files to your preferred EMR format. Pressing delete will

permanently delete the interview files. The Options button will take you to the Tools/Options screen to set your preferred file formats.

To select a screening to manage, put the cursor over the Name field of the screening you wish to select, then click the left mouse button. Note that clicking any field other than the Name field has no effect. The fields labeled DOB (for "date of birth") Modified, and Filename are informational screens to help you select the proper screening.

To select a screening to review, put the cursor over the Name field of the screening you wish to select, then click the left mouse button. Note that clicking any field other than the Name field has no effect. The fields labeled DOB (for "date of birth") Modified, and Filename are informational screens to help you select the proper screening.

Note also that you can change the way the screenings presented for selection are sorted by clicking on the title in the gray titles at the top of each column. Clicking on the Name title for example will force Instant Medical History™ to re-sort the list in reverse alphabetical order. Similarly, clicking on the DOB screen will change the list to be grouped in order by date of birth. This can be very useful for finding previous screenings based on date administered (the "Modified" field) or other characteristics.

[Print Current Screening.](#)

Selecting this option will print the most recently completed screening to whatever printer Instant Medical History™ is configured to use. It is provided as a convenience short cut to use as an alternate to using the Open Current Screening dialog box as a way of printing an output.

[Print Preview "Pick Complaints" List](#)

Selecting this will enable you to print out a list of all of the menu items available with your current version of Instant Medical History™. This will serve to guide you through a list of the menu choices to select when beginning a screening.

Using the Edit drop down menu

For physicians wishing to copy patient data, this function places the entire output for the current screening onto the Windows clipboard. Data can then be pasted into other applications.

Using the Screening drop down menu

The Start menu selection begins the screening process. An introductory screen and a screen asking for patient information will appear.

Patient Registration Screen

The next screen is titled Enter Patient Information (Who are you?). This screen requires entry of a patient name, date of birth in MM/DD/YYYY format, and patient gender. It also allows you to enter a patient identifier that you use in the office to identify patients as an option. Instant Medical History™ does not keep a registry of names of people that have used it before, so this information must be entered each time the program is used. (However, if your version of Instant Medical History™ has been customized to work with your EMR software, it may automatically fill all of these fields in and bypass this screen. Check with your computer support personnel). It only takes a few seconds to complete this information. Instant Medical History™ will use this information to select appropriate age and sex questions for the questionnaire and to label the output and the files in which the output is stored for retrieval. You can use the mouse to move to each item, or the Tab key. If you enter an illegal value in one of the fields, you will get an error message. When you have finished entering the patient information, click on the Next button.

The next screen is titled "Choose Provider". **This screen will only appear if you have more than one provider licensed to use Instant Medical History™.** If you only have one provider licensed to use Instant Medical History™, or if for some reason you have only entered one provider's name, you will not see this screen. The Choose Provider screen will contain a list of all of the valid providers for your practice. Move the cursor over the address of the provider who is seeing the patient for this visit and click the left mouse button. Your selection will be highlighted. Click the Next button to move to the next screen.

The next screen is titled "Choose Location". **This screen will only appear if you have chosen to enter more than one practice location.** If you only have entered one practice location, you will not see this screen. The Choose Location screen will contain a list of all of the valid locations for your practice. Move the cursor over the address of the location you wish to use and click the left mouse button. Your selection will be highlighted. Click the Next button to move to the next screen.

Enter the Chief Complaint

The next screen is titled "Enter Complaint (Why are you here?)". There are three different ways to choose questionnaires to administer, which can be used singly or in combination if needed. The three different ways are present in the three sections on this screen (separated by thin horizontal bars). Each of the three sections can be enabled singly by clicking on the check box to the left of the section, or they may be enabled in combination. By default, the first section ("I want to type in my complaint") is enabled for you. This is for convenience only. You may use any or all of the three choices to select a screening questionnaire for your patient. These choices are for your convenience and ease of use, and allow you to develop some shortcuts to starting a screening.

You should also be aware that you can enable a standard questionnaire that is automatically administered **in addition** to any questionnaires that you pick on this screen. If this is done, your patient will answer additional questions. You will not receive any notice by Instant Medical History™ if an additional screening questionnaire is to be administered, but your patient may tell you that some questions were asked that had nothing to do with the complaints or problems that he/she reported.

The decision about whether to type in a complaint, pick a complaint from a menu, or use a list of favorites is pretty straightforward. You can only pick from a list of favorites if a patient has been in before **and** you have constructed a favorite that matches his/her complaint(s), or if you anticipated today's visit and constructed a favorite for this visit. A situation that is appropriate to anticipate and to construct a favorite might be someone who comes repeatedly for follow up of the same complaint, or a group of patients who have similar needs. You may think of other situations. One example would be a patient with known diabetes and heart failure who comes in every three months for a follow up visit for these complaints. In this case, construction of a favorite for this patient would make it possible to use this favorite for that patient's routine visits, saving the task of remembering or looking up questionnaires. Another example would be patients who come in periodically for preventive visits. You could construct a favorite that matches common preventive questionnaires that are done in your office. You can use your imagination to create other examples of places where favorites would be useful. **The important point to remember is that a favorite must be built and available before you get to the "Enter Complaint" screen if you want to use the favorite this visit.** If you get to the "Enter Complaint" screen and you have not built a favorite to use for this visit for this patient, you are probably better off typing a complaint or using the menu.

If you are seeing a patient for whom an appropriate favorite already exists, you can simply choose that favorite. If you are faced with a long list of favorites and cannot seem to find a favorite that matches your patient's needs, there are a few tricks that can help. First check both the Patient Favorites and the Nurse Favorites if you are having trouble finding the correct favorite. Second, you can re-order the way the list of favorites is presented to you by clicking on the title that you want to use to create the ordering of the list. For example, if you have a patient for whom a favorite has been created and this favorite was assigned that patient's date of birth, you can group the favorites list by date of birth by clicking on the "DOB" title at the top of the favorites screen. This will cause all of the favorites that match the patient's date of birth to rise to the top of the favorites list as a group, simplifying your task of finding the right one. This re-ordering trick works for the Name and Description fields as well, but it most useful in conjunction with the Date of Birth (DOB) field to find a favorite created for a specific patient.

Once you have identified a favorite you want to use, choose that favorite. To do this, click on the box next to "I want to pick my complaint from a list of favorites". Instant

Medical History™ will respond by changing the background of the favorites list from gray to white, indicating that the favorites list is active and ready for use. There are two favorites lists on which the favorite might be found – the Patient Favorites list and the Nurse Favorites list. Depending on which list you assigned the favorite to when it was created, you will find it on the assigned list. To select a favorite to use as your choice for this visit, click the box on the same row as the favorite you wish to choose. A check mark will appear in the box on that row when you have done that. All of the screening questionnaires associated with that visit will be administered to the patient when you select a favorite. You may also select multiple favorites in case there are more than one favorite appropriate for this visit. If no favorites are found that are appropriate for this visit, you may choose to type the complaint or pick the complaint from a menu. If a favorite is found that is appropriate, but additional screening questionnaires are needed to make a complete visit, you may choose to type a complaint or pick a screening questionnaire from a menu **in addition** to your choice of a favorite. This process was designed to be as flexible as possible. Be sure to read and understand the section on how favorites are created to get the best use from favorites.

If a favorite is not the way you wish to pick a screening questionnaire, or if you need additional screening questionnaires, you may type a complaint in the text box, or you may press the Pick Complaint button. To use either method, you must click the box in front of your method of choice to enable it, which places a check mark in the box. Both methods of choosing will select questionnaires from the same menu of questionnaires. Which method you choose depends on how comfortable that you are selecting the questionnaire(s) that you want. When you first begin using Instant Medical History™, you will have some uncertainty about this, which is natural. Instant Medical History™ contains a large number of different questionnaires, and it is difficult to familiarize yourself with the entire list at first. That is why we have recommended that you start with a small group of questionnaires to start with, and gradually expand your use of the software as your familiarity with it increases. Instant Medical History™ was also designed to print out lists of the screening questionnaires that are available for you to use. Favorites were designed as a way to avoid having to deal with long lists. Even with a limited list, there can be some confusion when a patient has a problem that does not match exactly to a questionnaire. Some examples will make this clearer.

Example 1: The patient complains of a cough. You can choose a questionnaire on cough by one of two different methods. You can simply type "cough" (without the quotation marks) in the text box, and then click on the Next button, **or** you can click the Pick Complaint button (after clicking the box to the left of "I want to pick my complaint from a menu"), which opens a screen that looks like a series of tiny folders, with the topmost folder labeled Instant Medical History™. Beneath the folder labeled Instant Medical History™ are a series of boxes containing plus signs. Each box has a folder on its right, with a label for each folder signifying what the folder contains. Since cough is usually a Chief Complaint (or a new acute symptom), click on the box containing the plus sign to the left of the folder labeled Chief Complaint. This will open

the Chief Complaint folder, exposing a new set of folders beneath and indented to the right of the Chief Complaint folder. Use the scroll bars on the right of the screen to find the folder labeled Respiratory. Click on the box containing the plus sign to the left of the label Respiratory. This opens the Respiratory folder, revealing the questionnaires that are available under the Respiratory heading. Here you will find Cough. To select the cough questionnaire, click in the empty box to the left of the label Cough, and a green check mark will appear, as well as the text "cough" in the gray box beneath the folders. You have now chosen to do the Cough questionnaire, and can click the Next button to move to the next screen.

You can see from Example 1 that typing Cough in the Enter Complaint text box is far simpler once you know that a questionnaire exists for the complaint of cough. The main use of the Pick Complaint button is to allow you to explore the complete contents of Instant Medical History™, and to assist in finding questionnaires when you are having difficulty getting an appropriate questionnaire to start for a patient.

Example 2: The patient complains of "trouble peeing". You enter "trouble peeing" in the text box and click Next, but you get an error message that says "One or more of the complaints you entered was not found. Please re-enter the complaint and try again". What happened? Instant Medical History™ has a list of thousands of complaints and patient issues that it can map to a questionnaire, but "trouble peeing" just is not on the list (at least not yet – see below). So, what do you do now? One thing you could do is to enter another phrase that means the same thing. If that fails the Pick Complaint button can come to the rescue, even though it takes more steps. Using the process described in Example 1, press the Pick Complaint button, and open the Chief Complaint folder, then the Genitourinary folder, and then the Both Sexes folder. There you will find what you are looking for – the questionnaire labeled "Difficulty Urinating". You may have had trouble guessing that this would be the name of the questionnaire you were looking for, but now that you know what it is called, you will be ready the next time you need it. Click the box to the left of the label Difficulty Urinating to put a check in the box, then click the Next button and you are done.

Example 2A. The patient complains of "trouble controlling my pee". Remembering the last example, you think, "Is this the same as Difficulty Urinating?" You decide to check list of complaints using the Pick Complaint button. Going back to the Chief Complaint folder, the Genitourinary folder and the Both Sexes folder, you find a question set called "Incontinence". You confirm with the patient that he/she is having trouble with involuntary urination, and choose the Incontinence questionnaire as being more appropriate than the Difficulty Urinating questionnaire for this patient. It is important to note that Difficulty Urinating would not have necessarily been a "wrong" choice for this patient. If the Difficulty Urinating question set had been given, it might not have been the most efficient way to get at the symptoms that the patient has. Instant Medical History™ is constructed so that it can usually ask all of the questions needed if any reasonable starting point is chosen. The difference between the Difficulty Urinating

questionnaire and the Incontinence questionnaire is the understanding of what the exact problem is – Difficulty Urinating starts with a more general description (and asks more questions) while Incontinence starts with a fairly specific problem (and asks fewer questions to focus on the more specific complaint). In this example, Incontinence is more efficient a questionnaire to use, and will provide a somewhat shorter output for your provider.

There are several other important points to make while we are discussing the process of initiating questionnaires.

1. Look back at Example 2. The patient complained of “trouble peeing”, but that complaint was not recognized by Instant Medical History™. What you did not see was that Instant Medical History™ made a note in a file that recorded the fact that it did not recognize a complaint. This file can be sent back to Primetime Medical Software periodically, so that we can improve the ability of the software to recognize new complaints. Be sure to remind whoever in your office maintains your computer to periodically send us this file so that we can improve the program.
2. You may have noticed two other features that we did not describe when you clicked on the Pick Complaint button. One was the Expand All button, and its brother the Collapse All button. These buttons simply open ALL of the folders and close ALL of the folders when clicked. Use them as you see fit. The other is the two radio buttons in the small box labeled View in the lower right hand corner. The Provider view is the view we were describing. If you click the Patient button, the labels change on the questionnaires to attempt to create labels that allow patients to pick from the list on their own. These labels are less technical than the Provider view, but they otherwise describe the exact same set of questionnaires. In other words, questionnaires may have several different labels, but they ask the same questions.
3. The examples we used above all describe a patient with a single complaint or issue. Instant Medical History™ is capable of asking several questionnaires in sequence. You can enter multiple complaints in the Enter Complaint text box, separating each complaint with the word “and” (without the quotation marks) or separating each complaint with the character “&” (without the quotation marks). You can also check multiple boxes when choosing questionnaires from the Pick Complaint screen, which will also result in more than one questionnaire. When you begin using Instant Medical History™, you will be using a limited number of the questionnaires available, so you probably will not have a chance to try this out at first. As you increase the number of questionnaires that your office uses, this will become more common. Deciding when multiple complaints require more than one questionnaire can be a tricky issue. One disease can produce multiple symptoms, but require only one questionnaire. On the other hand, one visit might require multiple questionnaires, for example in the case of a periodic physical exam where

- you might want to administer the Personal and Family History questionnaire and the Surgical History questionnaire and the General Medical Exam questionnaire all together. Another example is a customized prevention visit that addresses areas of concern that are customized for your patient. You will need to check with your providers, especially when you are starting out. As time goes on, you will become more comfortable with making these decisions.
4. When you need to use more than one screening questionnaire, you can use a combination of methods to choose the questionnaires. You are not limited to only typing in a complaint, or only picking from a list. You could have three complaints, one chosen from a list, one typed in, and one that is on the favorite list. Whatever works for you can be handled by Instant Medical History™.
 5. There are a number of folders that do not deal with complaints in the usual sense. The Past Medical History folder, the Periodic, Prevention, Wellness Screening folder, Other folder and the Scales by Name folder deal with other kinds of issues. You will need to discuss how and when to start using the questionnaires in these folders with your providers.
 6. The Specialist folder contains folders that apply to specialists in various areas. Note that Specialist does not necessarily mean that the questionnaires do not apply to primary care providers. The Specialist folder simply contains sets of questionnaires that are commonly used by providers who practice in various specialties. Primary care providers may need to use questionnaires from these sets from time to time, especially if their practice takes them into an area of practice where they need a more detailed history.

Spend some time exploring the Pick Complaint listings to get a feel for what is in them. Although you will not be using many of them at first, having a sense of where to find what you are looking for before you use Instant Medical History™ with real patients will be very valuable to you later on. Exploring these folders can be made easier by using the Expand All and Collapse All buttons.

When you click the Next button from the "Enter your complaint" screen, you get different screens depending on whether you entered a single complaint or multiple complaints. If you entered a single complaint, you will go to the "Confirm Screening Settings" screen (described below). If you entered multiple complaints, you get a screen labeled "Select Chief Complaint". The "Select Chief Complaint" screen allows you to identify which one of the multiple complaints you entered for the patient is the main or chief complaint. You will see a box listing the complaints that you entered. Click on the complaint that you want to be the chief complaint, and then click on the button labeled Make Chief Complaint. The highlighted complaint becomes the Chief Complaint. Click the Next button when you are done.

You are next presented with a screen that is labeled "Confirm Screening Settings (Ready to start Interview)". This screen lists the complaints or issues that you entered, and below that lists the questionnaire or questionnaires that will be asked. This is presented for your information, and requires only that you review it to be sure that it matches your expectations, and then click the Next button. If you notice that you made a mistake when presented with the Confirm Complaints screen, you may use the Back button to return to the previous screen. **Note that if a favorite is one of the methods you used to select a screening questionnaire, the "Select Chief Complaint" screen and "Confirm Screening Settings" screen will list the name of the favorite rather than it's component elements.**

Stopping a Patient Screening

The Screening drop down menu can be used by physicians to terminate a patient screening. The stop selection can be made at any time during the screening. It will save the patient data that has been collected, and enable the physician to proceed without waiting for the patient to finish.

Using the Tools/Options drop down menu

Instant Medical History™ has a number of flexible options that allow you to customize the way the software interacts with the patient and the way that the output from questionnaires is presented, saved, and printed for the provider. Many of these options are self-explanatory, but also have implications that may not be immediately apparent. You should familiarize yourself with these options before deciding on how you will install and teach your office staff how to use Instant Medical History™, since these options contains all of the choices that allow you to customize it to your environment. Each option will be examined and explained in turn:

The Options Window

When you click on "Tools", then on the "Options" drop down, the Options window opens. The Options window has nine tabs across the top, labeled "General", "Complaints", "Favorites", "Passwords", "Providers/Locations", "Screening Detail", "Report Preview", "Print", and "EMR". There are also three buttons located at the bottom of the Options Window, labeled OK, Cancel, and Help. Clicking on the OK button is required to save any changes that you make to **any** of the options in any of the eight tabs and closes the Option Window. Clicking on the Cancel button closes the Option Window **without saving any of the changes** you make to any of the options in any of the eight tabs. Clicking the Help button brings up whatever help information is present in the documentation file for the software.

You can also click on one of the nine tabs (General, Complaints, Favorites, Passwords, Providers/Locations, Screening Detail, Report Preview, Print, and EMR) to choose which options you wish to customize. Each tab and its options are discussed in more detail below.

All of the options in all tabs can be customized differently on different machines if you prefer. This might be useful for setting up a machine with a single dedicated purpose, or could be used to configure output a certain way for use with the patient and another way for printed output to appear in the chart. In general, it is best to limit the range of customization when installing Instant Medical History™ on different machines in your office to avoid confusion. The range you can deal with and tolerate is up to your experimentation. Configuring different options on different machines implies that you are running each version of Instant Medical History™ as a local process on that machine. If you set up Instant Medical History™ to run from a server, then every instance of Instant Medical History™ that runs from that server will function identically. The choice between customization and uniformity can be a difficult one, and you should consult with an IT specialist to help you configure your system for ease of maintenance and flexibility.

The General Tab

The General tab presents four options to customize Instant Medical History™.

Skip Questions

The first option is in the box labeled "Skip Questions". This option determines whether to allow patients to skip a question (that is to go on to the next question without answering the current question). Clicking on the box next to "Allow patient to skip questions" toggles a check mark in the box. If the box is checked, then one of the possible answer choices for each question presented to a patient is a button labeled "Skip". Each time a patient chooses to skip a question, Instant Medical History™ will go on to the next question without recording an answer. The output text for questions that are skipped may optionally be set to report or ignore skipped questions (see the "Output Format Tab" section below). Allowing questions to be skipped is useful when patients are embarrassed by a question, do not understand the meaning of a question, or simply want the choice of not answering a question. This allows the patient to continue the questionnaire without interruption or intervention from the staff. We recommend that this option be set to *enabled* (that is the box should be checked).

Screening Complete Message

The second option under the General tab is in the box labeled "Screening complete message." This option is for setting your own message to the patient when the questionnaire has been completed. The default message (that is, the message that will be printed for the patient if you type nothing in this box) is "You have completed this screening." Any message that you type in the box will be added to the default message. You might choose to add a message that says, "Please let the receptionist know you have finished" for example or you might have the patient return a portable computer to the nurse. It's up to you. For this option, customizing the message for

each machine makes some sense, since machines in different locations might require different actions on the part of users when the questionnaire is completed.

Other Settings

The third option under the General tab is in the box labeled "Other settings". This is a collection of four additional miscellaneous options that are independent and unrelated. They will each be described in turn:

Only run the application maximized (disabled minimize and restore). This setting is enabled by clicking over the box to the left of the description, which places a check mark in the box. When this setting is selected, the minimize window and restore window buttons do not appear as part of the Instant Medical History™ program window in the upper right corner. Enabling this option will keep inexperienced users from accidentally reducing the size of the window that Instant Medical History™ runs in. It also helps keep people from playing with your computer and exploring what files are on your computer when used in conjunction with requiring a password to close the application (see Passwords above). This setting must be enabled to help create a secure and confidential computer environment for patients to use. We suggest that you keep this setting enabled on all computers that patients have access to.

Allow patient to select additional complaints after the initial screening is completed. This setting is enabled by clicking over the box to the left of the description, which places a check mark in the box. Enabling this option presents the patient with a choice of selecting one or more additional questionnaires to be administered after completion of the initial questionnaires. This can be useful in circumstances where a patient has multiple issues but it is unclear whether multiple questionnaires are needed to elicit a complete history. In general, it is most efficient to administer the minimal number of questionnaires necessary for both the patient to express his/her complaints and for the physician to get all of the information needed to care for the patient. Sometimes however, it may only be clear in retrospect exactly what is needed.

An example may clarify this:

A patient with known diabetes and hypertension comes in for a follow up visit. He complains of more frequent urination to your staff while they are setting up Instant Medical History™ for him. The diabetes and hypertension questionnaires are clearly appropriate, but should the difficulty urinating question set be administered as well? The likely scenario is that his frequent urination is related to diabetes or hypertension and will be adequately evaluated by these questionnaires. Allowing the patient to select an additional questionnaire if he has remaining unevaluated symptoms after completion of the diabetes and

hypertension sets is a reasonable way to do his interview. (Of course if the staff in your office has sufficient training, they could try to determine whether the frequent urination is related to the diabetes or seems to be a different problem before starting the Instant Medical History™ screening. This just creates another alternative path of action.)

The setting that Instant Medical History™ is being employed in should determine if this option is enabled. If enabled, it is important to clearly instruct the patient that he/she will be asked if they have any other complaints they wish to discuss after they complete the initial questionnaire. **The patient will need further guidance and assistance about whether and which additional question sets to choose if this option is enabled.** Otherwise, many patients will become confused if unprepared, and this may result in disruption for your staff.

Restart the screening wizard if no input for XX minutes. This setting is enabled by clicking over the box to the left of the description, which places a check mark in the box. If enabled, this setting further requires you to choose a number to put in the box to set a time after which the software will restart the initial screening dialog. The designed purpose of this feature is to allow a workstation to be set up for patients to use unattended without supervision. If for some reason the patient leaves the computer unattended part of the way through the interview, having the interview re-start after a period of time prevents others from deliberately or accidentally completing a questionnaire that was not intended for them and is labeled with another person's identifiers. It also re-starts the screening process so that the station does not become tied up with an uncompleted questionnaire. Enabling this option does create inconvenience if a questionnaire is terminated in mid process, since the questionnaire will need to be restarted from the beginning if completing it is considered important. A partially completed screening may be printed and the output examined, even if terminated prematurely by this option. Use of this feature is optional.

Restart the screening wizard when a screening is finished. This setting is enabled by clicking over the box to the left of the description, which places a check mark in the box. When Instant Medical History™ is first started, it automatically begins the screening process. If this option is enabled, it will re-initialize the screening process after every interview is completed. If this option is not enabled, each screening must be manually started by using the Screening drop down menu, and then clicking on Start (See Drop Down Menus below). Please note that if this setting is enabled, the new questionnaire session will start **immediately** after the previous one is completed. If you intend to view the output on this computer before starting a new questionnaire session, this may not be what you want to have happen. This setting is most useful when you are using one machine to administer questionnaires and another machine in another location to review the output. It is also useful if the output is automatically sent

to a printer, or if the output is exported directly to an electronic medical record. If you are unsure how a machine will be used, disable this option for now.

Answer Choices

These choices allow you to customize the buttons that patients use to select answers. The first two describe the position of the answers, which can be set to either appear in the center of the button or left-justified. The last two enable easier selection of the answer by giving patients a number or alphanumeric selection short-cut. For installations using a keyboard, this option is recommended.

Remember that if you change any of the options under the General tab, you must click on the "Okay" button to save your changes, otherwise Instant Medical History™ will revert to the previous settings.

The Complaints Tab

This option allows you to set Instant Medical History™ to function in a fundamentally different way. There are two options available in the box labeled "Screening, complaint". The top option, "Allow the patient to enter their complaint", enables the normal menu choices that you see when you run Instant Medical History™. A questionnaire can be chosen from the menu or by typing text into the box when this option is chosen. (If you have not yet run a questionnaire from Instant Medical History™, you might want to do so to help this make more sense to you). If you click on the lower circle labeled "Use the following complaint" you can set up Instant Medical History™ to run the same questionnaire or questionnaires repeatedly, and bypass having the patient or your staff select a questionnaire to run. This feature is useful if you are running a session for a period of time during which you are seeing patients who all have the same kind of problem. An example might be a diabetic clinic, where you know you want to administer the Diabetes questionnaire to every patient who is seen during that session. Note that using this method of setting Instant Medical History™ to ask a fixed screening questionnaire does not permit the addition of other questionnaires to be asked along with the default complaint. If you intend to specify a screening questionnaire that is asked in addition to other questionnaire chosen by the patient with your staff, see the description of "Favorites" in the next section.

To enable a specific questionnaire or set of questionnaires, click over the lower circular button (called a "radio button") in the box labeled Screening complaint. Then type into the text box labeled Complaint the text that describes the questionnaire you want to administer. You can choose to administer multiple questionnaires by typing multiple terms separated by "and" or by "&". For example if you wanted to administer the diabetes question set and the Zung depression scale, you could enter "diabetes and depression" or "diabetes & depression" (without the quotes). Once you have entered the description of the questionnaire you want to administer, click on the Lookup button,

and Instant Medical History™ will check to make sure it has a questionnaire that matches what you typed. If it does not find matches for all of the terms you type, it will give you an error message, and you must try again. If a match is found, it will list the questionnaire(s) that will be administered, and ask you to confirm that is what you want to do. Click the Yes button to confirm, or the No button to cancel.

To return to normal Instant Medical History™ function, click the radio button labeled "Allow the patient to enter their complaint". When you do, the Complaint box will retain whatever you typed there for future reference, but the box will turn gray instead of white, and you will not be able to type in the box. Now Instant Medical History™ will go back to asking for a questionnaire to be chosen with each screening.

The Favorites Tab

Favorites are simply a way of creating single screening questionnaires or groups of questionnaires that you can custom name, describe, and keep in a list for later use. Favorites are organized in two ways: A Patient list and a Nurse list. This allows you to create a list that patients can use without supervision to pick questionnaires from, and a separate use that is intended for nursing or ancillary staff to pick from on behalf of the patient. Each favorite can have attached to it a date of birth to make it easier to find a favorite that was designed for a specific patient. Each favorite can also have several characteristics assigned to it that make it behave in special ways (such as always being used regardless of what other questionnaires are selected). We will cover all of these options below. **The simplest way to think about favorites is a way to re-use a customized questionnaire or set of questionnaires that you administer repeatedly to a specific patient or a group of patients.**

Note that favorites are local to each computer. Favorites are only stored in a central location if you run Instant Medical History™ from a server. Each computer that you install Instant Medical History™ on will therefore have its own group of favorites. The favorites are stored in a special file with your program, and can only be transferred from one computer to another by transferring the file. If you need to have favorites replicated from one computer to another, please contact us. You may also choose to replicate favorites by re-entering them into a second computer.

The first time you click the favorites tab you will see a blank status screen, with the headings "Name", "Description", "Screenings", "DOB", "Show", "Always Ask", and "Status" across the top. Since no favorites have been created yet, there are no listings under any of these headings. This box gives information about favorites that have already been created. Let's examine each of the headings and what each heading describes.

Name: The Name column simply prints the name you have assigned to a favorite. Each favorite is assigned a name when you create it. The name can be the patient's name, or a shorthand description of what the favorite asks about

when it runs, or any other reminder to you of what the favorite does. It is designed to be a brief, short reminder. Name always appears as one of the headings for favorites on the screen when you are at the "Enter your complaint" screen.

Description: The Description column is a longer, more complete description of what the favorite does when it runs. It can contain any other reminder information that can help you and patients remember what the favorite does. Description can be detailed or brief (up to 60 characters), depending on what you expect it to do. Description always appears as one of the headings for favorites on the screen when you are at the "Enter your complaint" screen.

Screenings: This column shows the name of all of the questionnaires that are run by choosing this favorite. Since some of the names are more explicit and descriptive than others, the presence of a screening name may be more or less helpful than the description column. Screenings appears on the screen at the "Enter your complaint" screen if the favorite is made a "Nurse" favorite, but not if it is made a "Patient" favorite. (see "Show" below)

DOB: This column shows the optional date of birth associated with a favorite. The DOB column can either have a value of a specific date, or can be set to Any Date. If it is set to Any Date, that favorite will appear on the "Enter your complaint" screen for all patients regardless of the patient date of birth. If it is set to a specific date, it means that this favorite will only show up on the "Enter your complaint" screen if the patient's date of birth matches the value of the DOB field. This makes it possible to create a favorite that is intended for a specific patient to use and make it easy for that favorite to be found on the "Enter your complaint" screen. It also makes it possible to create a list of favorites that are intended for a single patient or a small group of patients without having to divulge a patient name (and violate privacy) to do so. At the "Enter your complaint" screen, the list of available favorites can be sorted so that the group that matches the patient's date of birth rises to the top, making it easier to choose an appropriate recurrent favorite for a patient.

Show: This column has only two possible attributes, Patient and Nurse. The Patient attribute means that a favorite was designed to be self-selected by a patient. It might or might not mean that other attributes were selected (such as DOB) to make it easier to find. The Nurse attribute means that a favorite was designed to appear on a list designed for a nurse to use to select a favorite. The Nurse list is a separate list from the patient list, and is designed to allow nurses to work from a focus list aimed at a group of patients rather than individual patients. Patient vs. Nurse list displays are chosen from the "Enter your complaint" screen, but the designation of which list a favorite appears on is made from the Options/Favorites tab.

Always Ask: Please see the section above on the Complaints tab to better understand what this option does. The Complaints tab allows you to configure Instant Medical History™ to repeatedly ask a single questionnaire or a set of questionnaires as a fixed function. If Always Ask is set to “Yes” for a favorite, that favorite will always be asked **in addition to** any other questionnaires that have been chosen for all patients. This allows a practice to pick a questionnaire or group of questionnaires that it always wishes to administer to all patients, regardless of their other needs. For example, a practice could choose to administer a depression screening questionnaire to all patients no matter what other questionnaires were picked. The valid values for Always Ask are No (if disabled) and either Yes, End (if enabled and set to be appended to the end) or Yes, Beginning (if enabled and set to precede the administration of other selection screening questionnaires). Note also that enabling Always Ask makes Instant Medical History™ behave in some ways similar to configuring a default complaint described in the section on the “Complaints” tab. The difference is that Always Ask appends questionnaires to other selected questionnaires, while using the choice under the “Complaints” tab disables the ability to select other questionnaires.

Status: A favorite can be Enabled or Disabled. Enabled means that it functions normally. Disabled means that you do not want that function to work or be visible, but that you are not ready to delete it yet and are keeping it around for some later use. Normally, a favorite is enabled. A favorite might be disabled to keep the lists less cluttered while waiting to see if deleting it entirely might be more appropriate.

Now let’s look at creation of a new favorite

New Favorites

Clicking the “New” button brings up a data entry screen titled “Add Favorite”, which has 3 required entries, and some optional ones. The three required entries for a favorite are “Name”, “Description”, and “Screening”.

“**Name**” is the shorthand name that you choose for the favorite you are creating. This can be any name of your choosing that will help you remember what this favorite does, and who are the intended recipients. There are no limitations of what characters can be used for “Name”. Note that duplicate names are prohibited and will generate an error message.

“**Description**” is a lengthier description of what the favorite contains and does. This is also a free text field that has no limitations on its entry.

“Screenings” is a little more complicated. The “Screenings” field must contain one or more valid Instant Medical History™ questionnaires to administer when the favorite is chosen. You may enter these screenings as free text entries **if** you are sure you know valid screening names to enter. You may enter a single screening, or you may enter multiple screening separated by the word “and” or by the character “&”. If you enter an invalid choice for one or more of the screenings, you will get an error message and have to enter valid names.

“Name”, “Description” and “Screenings” are the only fields that are **required** to enter a new favorite. If you click OK after filling in those three fields, the remaining fields will be filled by defaults. The defaults are Any Date for Date of Birth (see DOB above), Nurse Favorite list (see Show above), Disable the option to ask every patient this favorite (see Always Ask above), and Enabled (see Status above). If you need to specify settings for any of these options, you need to click the “Advanced” button at the bottom right of the Add Favorite dialog box to expand the option window. The “Advanced” button opens several additional properties for the favorite you are creating that you can enter. You can enter as many of these optional parameters as you need, depending on your purpose in creating the favorite. These are described in more detail below.

“DOB”. A date of birth can optionally be associated with a favorite. If you leave the DOB field blank, the favorite you are creating will be listed for all patients in either the Nurse favorite list or the Patient favorite list (see “Show” below). If you specify a date of birth associated with the favorite, then that favorite will only be listed if the date of birth entered by the patient matches the date of birth you have specified for the favorite (in either the Nurse or the Patient favorite list).

“Show”. A favorite can be specified to appear in either a “Nurse Favorite” or a “Patient Favorite” list. These two types of lists were intended to suggest use by patients without the assistance of ancillary staff or with the use of ancillary staff. These are not rigid ways to use them, just suggestions designed to assist the clinical staff in their everyday functions. The use of the Nurse vs. Patient list will make more sense if you look at the section designed to assist ancillary staff in their daily use of Instant Medical History™.

“Always Ask”. The Always Ask option allows you to designate that the favorite you have created is always administered to all patients, regardless of whatever other screenings may be administered. This is a feature that allows you to customize Instant Medical History™ to screen for certain conditions or risks. Clearly it is an option that should be used sparingly, since setting multiple favorites to “Always Ask” would create very long and cumbersome questionnaires. “Always Ask” is enabled by checking the box to the left of the description labeled “Ask every patient this favorite...”. If you do set this on, you need to additionally specify whether the “Always Asked” favorite appears at the beginning or at the end of the screening by selecting one of the two

radio buttons (“Ask at the beginning of a screening” or “Ask at the end of a screening”). These radio buttons will not be available unless the “Always Ask” option is enabled.

“Enable”. Normally, favorites are enabled so they can be used. Sometimes, you may consider paring down a list to reduce clutter when it is unclear whether a favorite is still in use. If you are considering deletion of a favorite, but are not sure whether it is still needed, consider checking the “Disable this favorite” box first. “Disable” will make the favorite invisible and unavailable from the “Enter your complaint” screen. That will allow you to see if it is still needed without having to go through the tedium of re-entering it.

Once you have finalized your properties for your favorite, click on OK at the top right of the Add Favorite box. If you decide that you want to discard the favorite you have just created, click Cancel instead.

Edit Favorites

Editing a favorite can be done to change its properties. This allows you to turn on or off such properties as “Always Ask” in special circumstances, or to disable a previously enabled favorite.

To edit a favorite, first select which favorite you want to edit by left clicking on the Name of the favorite you wish to edit in the Favorites screen. The dialog box for editing looks identical to the Add Favorite box, only now the label reads Edit Favorite. Refer to the section above on Add Favorites for a description of what each field configures. You may use standard Windows™ editing features to change the parameters in any of the fields. Click OK when you are done to save your changes, or click Cancel to quit editing and retain your original favorite.

Delete Favorites

Deleting a favorite is simply a matter of selecting the favorite you wish to delete from the Favorites screen, then clicking the Delete button. You will be shown a Delete Favorite confirmation. If you click *Yes* when prompted the favorite you have selected will be deleted. Deleted favorites are permanently deleted.

The Passwords Tab

The Passwords tab has two different areas for customization. There are two rectangular boxes that work in tandem to define the function of passwords in Instant Medical History™. The box on the right sets the application password, the box on the left sets the functions of the application password.

Application password

A password can be set to restrict certain normal program functions to qualified personnel. Each copy of Instant Medical History™ that you run in your office can have a different password if you like, or they can all be the same. Once you choose a password and type it into the box labeled Password, you must type the identical password in the box labeled Confirm Password. This is done to protect you from accidental typographical errors that could prevent you from using the software. Note that when you type a password, what you type does not appear in the box but that each character you type is replaced by an asterisk (*) character. This is to keep anyone from seeing what you have typed in this box. Since it also makes typographical errors impossible to see, the Confirm Password box helps to protect you from accidentally typing something you did not mean to type.

Once you have entered a password, the three check boxes on the upper left-hand box will control where the password is required:

Checking the top box, "Close the application", (by clicking on the box) will require that you type the password each time you try to exit from Instant Medical History™. This will be true however you try to exit from the program. This is useful for keeping patients from accidentally closing the software and requiring your staff's time to re-start it for the next patient.

Checking the middle box, "View screening output", (by clicking on the box) will require the password to view any output file that Instant Medical History™ has produced. This protects the confidentiality of your patients. Note however that if you save your Instant Medical History™ output as a text file that can be accessed by a word processor, this password will not provide any protection.

This password will only prevent unauthorized access to files using Instant Medical History™, but not access gained directly to files by use of a word processor. To fully secure Instant Medical History™ in a way that is compatible with HIPAA and other confidentiality legislation, you must contact Primetime Software and get instructions for making other modifications to your computer. Instant Medical History™ can be set up to be compliant with security and confidentiality legislation, but to do so requires special expertise.

Checking the bottom box, "Access application options", (by clicking on the box) will require the password to get back to the Options window. Enabling password protection will prevent unauthorized users from changing your options.

We highly recommend that you choose a password and enable all three password required boxes. We further recommend that you use the same password on all machines in your office to prevent confusion. If you lose or forget your password,

there you must call Primetime Software for instructions on resetting your password. We will give you detailed instructions once we verify your need to reset the password.

The Providers/Locations Tab

The functions under this tab allow your copy of Instant Medical History™ to serve multiple providers at multiple locations. Each time Instant Medical History™ runs a questionnaire, the user will be prompted to select the provider for the visit and the location from a visit from the lists that are created on this screen. See the section **“Starting a questionnaire for a patient”** in the section of this manual written for ancillary staff for a description of where this happens. If only a single provider and a single location are entered, no selection is required.

The top box (“Providers”) allows you to add or remove providers, and to manage the license number unique to each provider along with providing a specialty code for each provider. To add a provider, click the Add Provider button. To remove a provider, select the provider you wish to remove by putting the cursor over that person’s name, then left click, and then click the Remove Provider button. To change a provider’s ID, select the provider by putting the cursor over the provider’s name, and then click the Change Provider ID button. To set the specialty of each provider, select the provider then click on the Set Specialty button. Please note that setting the specialty for a provider may assist Instant Medical History in choosing an appropriate interview for a patient based on the style of practice of the physician or other provider that the patient will see for a visit.

The bottom box (“Locations”) allows you to add or remove practice locations from your list. To add a location, click the Add Location button. To remove a location, first select the location from the list you wish to remove by moving the cursor over that location and then left clicking. Then click the Remove Location button.

The location and provider chosen before each interview from these lists will appear on the screen and printer output from Instant Medical History™.

The Screening Detail Tab

A new Utility Option, Screening Detail, allows physicians to customize the number of questions presented to patients. Using a graphical slide bar, the number of questions can be adjusted. Choosing ‘No Questions’ eliminates questions about a topic. Choosing ‘All Questions’ asks every available question about a topic. Marks in between ask a fraction of the available questions. Increasing the screening detail increases the number of questions about a topic, although the correlation is not linear. For more information about this feature, please call us. Future versions of the software will fully explore this function.

The Report Preview Tab

The Report Preview tab contains all of the settings that allow you to configure the way the completed questionnaires are presented on the screen for your use and the location on your computer or network where the text files are stored. (Printer output is discussed below in a separate section.) Some experimentation will probably be needed here to optimize the way your output looks for your preference. One of the interesting features of Instant Medical History™ is that you can choose to view the results of a questionnaire in several different formats for different purposes. For example, you may choose to display only positive responses when you are reviewing the results of an interview with the patient (since the positive responses are “where the money is”), and display both positive and negative responses before printing the results for the chart. We will consider each option of this tab in turn. There are four sections to this option, “Formatting...”, “Report File Type”, “Report Preview Output locations...”, and “Filename Options...”, each of which is accessed by pressing the button within the box.

The Formatting Button

Clicking on the “Formatting” Button brings up a new window with multiple boxes. Each box contains check boxes or radio buttons that control various aspects of the output text. Each box has a label, and the discussion for each box below is keyed to that label.

History of Present Illness

Three options are available for History of Present Illness.

The first option is Include negative responses. If this option is enabled by clicking over the box to the left of the description, all of the negative responses to questions in the History of Present Illness category will be included in the output. If this option is disabled (no check mark in the box to the left of the description), then the negative answers to questions in the History of Present Illness category will be suppressed from the output. Disabling negative responses may be useful for reviewing the output with the patient before finalizing the output for the chart. This allows you to focus on the positive findings that are more useful for the diagnosis and care plan. The chart should eventually contain all of the positive and negative responses for billing and legal purposes.

The second option is to Use HCFA HPI symptom element headings. If this option is enabled by clicking over the box to the left of the description, the History of Present Illness output will contain additional subdivided headings that conform to HCFA guidelines. The output will not contain any different information, it will simply be organized differently under the new headings. Enabling this option

facilitates E/M coding for you and your staff by allowing you to easily see how many elements are captured under each heading. It may also make the output easier to read by providing more organization of the data. We recommend that you always leave this option enabled.

The third option is to use the Separate section for each complaint option, which enables the History of Present Illness to break the report into multiple sections, one for each complaint. This can make a report more readable and better organized. The separation of findings into different sections is a sophisticated intellectual process however, and often requires some intervention by trained professionals to make sure that all elements fall into the right compartments. If you use this feature, be prepared to move some elements around to get the report to correspond to your model of the disease process being described.

Past, Family, and Social History

The only option is Include negative responses. Please see the section above on History of Present Illness for a description of what this option does. It works the same way that History of Present Illness does for the Past, Family, and Social history.

Review of Systems

The only option is Include negative responses. Please see the section above on History of Present Illness for a description of what this option does. It works the same way that History of Present Illness does for the Review of Systems history.

Risk Factors

The only option is Include negative responses. Please see the section above on History of Present Illness for a description of what this option does. It works the same way that History of Present Illness does for the Risk Factors history.

Scales Questions

The options for Scales Questions are to Include positive responses and to Include negative responses. Please see the section above on History of Present Illness for a description of what these options do. Since the scales that Instant Medical History™ uses are reported as scores, it is not necessary (and lengthens the output) to report the individual elements of a scale as part of the output. However, some clinicians may wish to view all of the information that is gathered

in the process of computing the scaled output for a variety of purposes. These options allow the elemental scale responses to be viewed and printed.

Scale Charts

Sometimes the output for a standardized scale is a chart. The five radio buttons presented in this option control the appearance of the chart. It is recommended that you choose the default output for each scale.

Remember that if you change any of the options under the Output format tab, you must click on the "Okay" button to save your changes, otherwise Instant Medical History™ will revert to the previous settings.

Output text terminology

The Output text terminology box has three possible selections – doctor text, patient text, and abbreviated doctor text. One of these 3 options is selected by clicking on the radio button to the left of the description. This option determines the phrasing of the output. The doctor text is written so that it clearly reflects the question that was asked of the patient with as little ambiguity as possible. The purpose of making the output as accurate as possible resulted in answers that were often lengthy and interfered with readability of the output. For this reason, abbreviated doctor text was created as an option. Abbreviated text has been written to be as short as possible and to take advantage of as many abbreviations as possible. There may be times when the output using abbreviated doctor text results in ambiguity due to this brevity. Patient text output was designed so that patients could review a copy of their responses in lay language.

The choice of which output terminology to use depends on the purpose of the output. You may choose to look at or print out any or all of these output types for different purposes. Note that this option determines both the output terminology displayed on the screen **and** the output sent to the printer.

See also the sections on File/Open Current Screening, File/Open a Screening and File/Print Current Screening for more details on looking at and printing the output. Whatever radio button you have selected under Output text terminology will determine what the output looks like when you open or print a screening.

Other options

The Other options box contains some special features of the output that can be customized to your needs and preferences. The five options available in this box are independent and unrelated, and are described separately:

Include care plan items. Some Instant Medical History™ questionnaires contain questions that ask about specific recommended tests, immunizations, or screening procedures that apply to a patient based on age, gender, illness or other criteria. These are reported in the body of the output under an

appropriate heading under all circumstances. If you enable this option by clicking over the box to the left of the description, an additional subsection is created in the output that is labeled Care Plan. The Care Plan will have an additional reference to the needed immunization, test, or procedure that is worded specifically as recommendation rather than as an answer. For example, if a patient responds "no" to the question "Have you had a tetanus shot in the last 10 years?" the output will contain the phrase "no tetanus shot in the past 10 years". If you enable Care Plans, an additional section will be included in the output labeled Care Plan, and that section will contain the phrase "needs a tetanus shot". Note that not all questionnaires contain Care Plan items. If you enable care plans, but no care plan items are present in the questionnaires that are taken, no Care Plan subsection will be created.

Include skipped questions (See Allow patient to skip questions, above). Normally Instant Medical History™ ignores questions that are skipped. If you enable this option by clicking over the box to the left of the description, the output will list the questions that were skipped as a separate section at the end. This option can be useful to alert the clinician about items that were skipped, allowing these items to be specifically reviewed with the patient.

Include ICD-9 codes. Some of the questions asked by Instant Medical History™ correspond to a specific ICD-9 code. If you enable this option by clicking over the box to the left of the description, any ICD-9 codes that correspond to a question will be reported at the end of the output. Note that this feature is of limited value, since most ICD-9 codes require more information to support the code than is gathered from the history alone.

Double-space output headings. If you enable this option by clicking over the box to the left of the description, an extra blank line will be inserted in the output between headings. This can improve readability, at the expense of a longer output with more white space.

Upper case output headings. If you enable this option by clicking over the box to the left of the description, all output headings will appear in upper case.

Include patient signature line. If you enable this option by clicking over the box to the left of the description, the output will have a signature line for the patient to sign appended at the bottom. This signature line is an attestation for the patient to sign, signifying that he/she completed the history and agrees to the facts presented in the history.

Output term separator. This option does not have an enable check box. It is automatically enabled by typing a character or set of characters in the text box to the right of the label Output term separator. Each answer to each question

asked by Instant Medical History™ is reported in the output as a phrase. This option determines your preference for which character(s) to use separating each phrase from its neighbors. The character(s) that you type may include spaces. Some suggested separators to try are " | " (this is a vertical bar with a space before and after the bar – do not type the quotation marks), " / " (this is a slash with a space before and after the slash). You are free to experiment with any characters that make the output readable for you.

The Report File Type Button

Clicking on the Report File Type button brings up a new window with a box labeled "Report file type". The Report file type box determines what kind of program will serve as the "word processor" for the output, how the text file that is created will be saved, and to some extent determines what kinds of special features are available with the output. There are five different file type options, each of which has a special use and attributes described below. In addition, each output file type has associated with it a default file extension that is appended to the file name. You may override the default file extension if you wish, but for most purposes this is not necessary and you can ignore what is printed in the File extension box. When you open a screening and review it, a copy of that screening is saved in the Output Location (see Output Locations tab below) you have designated, using the appropriate file type and extension depending on what you have selected here.

To select a format, click over the small arrow on the right side of the text box next to the label Output file type. A drop down box will open with five different choices:

Microsoft Word™ Format. This is probably the most powerful and flexible format for routine use. If you want to use Microsoft Word™ format for your output, you must have Microsoft Word™ installed on your computer. When you choose to review a file, Instant Medical History™ will automatically start Word™ (if it is not already running), and display the file in Word format. **This is the only format in which each page is numbered and contains a footer with the patient's name on each page.** The reason for this is that Microsoft Word™ format is the only one that supports this level of information. This format also supports use of different colors, fonts, and underlining to help make the output more organized and readable. If you copy and paste or send the output to another program (such as an electronic medical record), the special formatting including page numbers and headers will be retained **if** the program that receives the output is capable of interpreting the special formatting.

Rich Text Format. This is the format the Microsoft Write™ uses as its native format. Write is a limited feature word processor that comes standard with all versions of Microsoft Windows®. If you do not own Microsoft Word™ or have not installed Word™ on your computer, this may be a good alternative Output

file type for you to use. Using Write™, different colors, fonts and underlining are preserved, keeping the information organized. Unlike Microsoft Word™ however, Write does not allow the use of page numbers or footers. If you copy and paste or send the output to another program (such as an electronic medical record), the special formatting will be retained **if** the program that receives the output is capable of interpreting the special formatting.

HTML Format. This is the format that Netscape™, Internet Explorer™, and other Internet Web browsers use. This format is acceptable for review of the output created by Instant Medical History™, but web browsers do not provide any editing tools. When you select output in this format, Instant Medical History™ will automatically start your default browser software. This format does not support page numbers or footers, but colors, fonts, and underlining are preserved. Output in this format was designed primarily to facilitate use of the output by other software rather than for review by a user. If your intent is to review and edit or add to the output, we suggest you use Word Format or Rich Text Format.

HTML with Search Format. See HTML format description above. This option adds a special embedded feature that allows you to select terms or phrases from the text of the output and to do an Internet search on that term or phrase for relevant articles or educational content related to that term. Your computer must be connected to the Internet for this feature to work. Use this format if you want to facilitate searching for pathways, protocols, journal articles, or instructional materials.

Text Format. This format starts Microsoft Notepad™ to view the output. Most of the special formatting characteristics of the output are lost when viewed with this format, such as underlining, bold face, and use of colors. Use this format if you are copying and pasting or sending the output to another program that cannot interpret the advanced formatting features.

Please note: You may view the output or send the output in as many different formats and ways as you like. Each time you select a different format, you simply choose to open the screening again and the output will be sent and displayed in the currently selected format

The Report Preview Output Locations Button

Clicking on the Report Preview Output Locations brings up a new window with two boxes labeled "Primary output location" and "Secondary output location". These boxes contain fields that you can use to specify where the text output from each Instant Medical History™ encounter is stored. A primary and secondary location can be specified. The secondary location is used if the primary location becomes unavailable

for any reason but is otherwise not used. The primary location is always the location of choice. Note that the output is saved in two different ways - in its original format which contains the actual data generated by the patient, and in a text format which preserves any editing or additions that are made to the displayed text output. Changes that you make to the text display never alter the original data file. This preserves the integrity of the data obtained from the patient, and creates an audit trail back to the original patient data in the event of a discrepancy.

Be aware that the file specification you enter for Report Preview Output Locations has two hidden default levels that are not shown. The bottom two levels for the Output Locations are always Screenings/Original and Screenings/Reviewed. If you are creating your own custom directories to store Output Locations, make sure that the bottom of the structure you create uses Screenings/Original or Screenings/Reviewed as the lowest two levels of the directory.

The available output locations will vary depending on your system configuration. Consult your Microsoft Windows® documentation and your system administrator for information on how to specify a path to a location. You can also use the Browse button to open a window that allows you to search for a location, the Create button to create a new location based on the information you have typed into the text window, and the Test button to verify that the location you have specified is available.

The Filename Options button

Clicking Filename Options brings up a dialog box that lets you customize the filenames that Instant Medical History™ uses to store the output from questionnaires. The two radio buttons at the top of the Filename Options box let you specify one of two different ways to configure filenames of output files. The first option uses a combination of the patient's name and date of birth to create a unique file name for each output. The second message requires additional choices by the user to fully customize the file name for each output. These options were designed to allow files to be passed from Instant Medical History™ to other programs that use the output of Instant Medical History™ in special ways. These options do not change the fundamental way that Instant Medical History™ works. We suggest that you use these options with careful consideration of how it will affect other programs on your computer that may be receiving Instant Medical History™ files.

The Print Tab

The Print tab functions in parallel with the Report Preview tab. While the Report Preview tab allows you to specify how the output looks when reviewed on the screen, the Print tab specifies the exact same set of options for output to your printer. This means that you can have two different configurations set at the same time, one for the screen and one for the printer. This allows you to configure your screen output one

way, and your printed output with an entirely different look. An example of the usefulness of this feature is that it allows you to review the positive findings without the negatives on the screen, while printing out both the positive and the negative findings for the chart for billing purposes.

The Print tab contains three boxes, labeled "Auto-print", "Formatting", and "Report file type".

Formatting and Report file type function exactly the same as their counterparts under the Report Preview tab. Please see the discussion on the Report Preview tab for details about how each section functions.

The Print tab contains one option that is new, namely the ability to automatically send the output to the printer. Clicking on the box in the Auto-print section sets Instant Medical History™ to automatically print when the patient completes the screening. This may be advantageous in reducing the amount of personnel intervention required to complete a questionnaire. However, setting this option also means that the output will print before it is reviewed or modified by the clinician. When this setting is selected, Instant Medical History™ will send the output of a screening to whatever printer is selected as the default printer and is connected to the computer on which Instant Medical History™ is running. This can be a printer that is directly connected to the computer, or a printer that is connected over a network. The physical location of the printer to which the output is sent is independent of the physical location of where you choose to store the files that are produced from a screening. Care should be taken to protect the confidentiality of output sent to a printer from Instant Medical History™. The printer should be in an area where an unauthorized person cannot intercept or view the pages that are printed.

The EMR Tab

The EMR tab has a set of options that determines the appearance, special formatting and connection options for automatically sending the output of Instant Medical History™ to your EMR. In general, these options will be set up for you by a systems integrator, and will not change once they are set up. These options should be set up by your systems integrator. Please call if you need information about how these options work. You can safely look at them for your interest, but they will have no effect on the way that Instant Medical History™ functions unless all of the necessary steps have been taken to use Instant Medical History™ with your EMR.

Section III. Getting started using Instant Medical History™

Introduction to Computerized History Taking

Instant Medical History™ is a computer program designed to be used by patients to organize and communicate details of their medical history to health care professionals who are caring for the patient. Patients can use a variety of input devices, including the computer keyboard, a mouse, or a touch screen to enter information about their medical needs and status. The program prompts the patient for information, beginning with an entry point determined by the health care provider and/or the patient. As the patient responds to questions, additional sets of questions may be asked in response to answers the patient gives. When all of the questions are completed, Instant Medical History™ saves the responses in a file. The file can then be reviewed, annotated, printed for the chart and saved for later use.

Patients can use Instant Medical History™ in two different ways. Patients may initiate their own questionnaire based on their need to organize communication to their physician or other health care provider. The patient's need may be based on a new symptom, a complication of an illness, or a failure to respond to treatment. The second way that Instant Medical History™ may be used is for a physician to initiate a questionnaire for a patient that will assist the physician or other health provider in caring for a specific health care need. A combination of patient agendas and physician agendas can easily take place during the same interview.

Instant Medical History™ is a very flexible tool, and one that is very easy to use as well. Its flexibility combined with the complexity of modern medical practice and the demands placed on medical records means that implementation in a medical office can be challenging. All of the office staff must understand the ways that using Instant Medical History™ impacts the workflow of the office, and each staff member must know his or her role in this workflow. This manual is meant to provide a focal point for initiating training, facilitating the workflow and communicating changes that must take place to succeed with Instant Medical History™ in your office.

Some of the following sections in this manual are written especially for a specific role player in the office process. The roles assigned to staff members are somewhat arbitrary and flexible, and are listed by description rather than by staff title so that specific tasks can be assigned based on role rather than title. Even though staff members do not need to know the details of roles they are not expected to perform, everyone can benefit from understanding the overall process. We therefore encourage everyone in the office to read all sections of this manual

For the Health Care Provider

Successful implementation of Instant Medical History™ requires the leadership of all of the providers who will be using the software to interview their patients. This leadership is needed to help your staff make the needed workflow changes, establish priorities that meet your needs, and set the expectations for the way that your staff communicates with patients about the use of the software. Without this leadership, you will be disappointed with the way the software is implemented.

You should think of the implementation as involving four discrete stages:

1. The pre-installation preparatory stage
2. The early implementation stage
3. The maturing stage
4. The update stage

Pre-installation preparation

Before using the software with patients, you should meet with your staff and review how you intend to use Instant Medical History™. Your review should briefly cover the following topics:

- How patients interact with the software
- Changes to the appointment scheduling and registration process that are required
- How your staff will initiate the patient interview process
- Which questionnaires you have chosen to use for your initial set of screenings
- What you staff will need to do when the patient finishes a questionnaire
- How your staff can get help to get questions answered
- An overview of your goals for getting from initial use to full use
- Additional optional topics to consider are future plans to allow patients to use the Internet to complete Instant Medical History™ questionnaires.

These topics do not need to be covered in detail, especially if you are still uncertain of what the details will be. At this point, you are simply “setting the stage” by giving your staff a glimpse of the end product and the path you will take to get there. More importantly, you must establish your own enthusiasm for using the software, and emphasize the importance to your practice of using the software. The tone that you set now will subconsciously be conveyed through your staff to your patients.

During this stage, you should explore some sample interviews that you enter yourself into Instant Medical History. Your goal is to pick 7-10 topics that you will have your staff use as the initial set of questionnaires for use in the first few weeks after installation. You are free to pick any of the topics that Instant Medical History™ covers that are relevant to your practice. In general you should try to choose based on the value to you, the frequency of patient visits for which a topic will be useful, and your comfort with the output that is produced by the questionnaire that covers that topic. In

group practices, you should try to collaborate within specialties on these choices to give your staff a modest load of question sets to familiarize themselves with. Remember that you will be fine-tuning and expanding the use of Instant Medical History™ in your practice over the coming months. You should also consider the creation of a small set of favorite screening questionnaire combinations to cover situations that you know commonly occur in your office.

Suggested starting questionnaires for primary care specialties during the first few weeks of implementation are as follows:

For Family Practice

Acute questionnaires (new acute complaints)

Difficulty urinating

Joint pain

Back pain

Headache

Syncope

Fever

Chronic follow-up questionnaires

Hypertension

Diabetes

Gastroesophageal reflux

Pediatrics

Adolescent

2-week-old well child

2-month-old well child

Obstetrics

First Obstetrical Visit

Gynecology

Gynecology exam

Dysmenorrhea

Change in menstrual periods

Periodic Visits

Prevention

Review of Systems

General medical examination

Follow up

For Primary Care Internal Medicine

Acute questionnaires

Difficulty urinating

Joint pain

Back pain

Headache

- Syncope
- Fever
- Chronic follow-up questionnaires
 - Hypertension
 - Diabetes
 - Gastroesophageal reflux
 - Congestive Heart Failure
- Periodic Visits
 - Prevention
 - Review of Systems
 - General medical examination
 - Follow up

For Pediatrics

- Adolescent
- 2-week-old well child
- 2-month-old well child
- 4-month-old well child
- 6-month-old well child
- 9-month-old well child
- Sick child
- Wheezing

For Obstetrics/Gynecology

- Obstetrics
 - First Obstetrical Visit
 - Follow-up Obstetrical visit
- Gynecology
 - Gynecology exam
 - Dysmenorrhea
 - Change in menstrual periods
 - Pelvic Pain
 - Menopause
 - Amenorrhea unspecified

For Specialty Practices – read through the list and choose about 7 questionnaires.

Choose about 7 of the questionnaires that you think will be most effective for your practice. Teach your staff how to select questionnaires using text entry, using the menu lists, and using favorites. Teaching all methods is redundant to a degree, but it will help them to visualize how to search for new content as they need it and to understand that the all methods lead to the same administration of appropriate questionnaires. It is important to emphasize to them that entering a complaint and picking a questionnaire from a list will produce the same result with one important

difference – entering a complaint inserts the text of that complaint into the output as a chief complaint.

You should pay special attention to the output of Instant Medical History™ at this time. Be sure to read the section on Output Format, and choose the options that meet your needs. Consider whether you will be working with printed output during your face-to-face time with patients. Will you be printing the output for your permanent note in the chart? Do you want a temporary copy printed for the face-to-face visit that is different from the final copy for the chart (for example with negatives turned off)? Reading Instant Medical History™ notes is a learning experience, similar to learning to read a chart written by a new colleague. You must familiarize yourself with the organizational structure, use of language, and headings. Since Instant Medical History™ is consistent in its display of the output, you will soon learn to read its notes as comfortably as you read those of a close colleague.

During this time you must also consider what you will do with the output once it is finalized. There are a number of possible ways to use the output:

1. The raw output can be printed out as soon as the patient finishes the questionnaire. The review of the output is done with the paper printout, with corrections, additions and annotations made with pen on the paper output. The remainder of the note (exam, assessment and plan) can be written or dictated.
2. The output can be reviewed on screen with the patient. Annotations, corrections and additions can be made on screen. The corrected output is then printed on paper, and the remainder of the note can be written or dictated.
3. The output can be reviewed on screen with the patient. Annotations, corrections and additions can be made on screen. The remainder of the note can be input via template, shorthand software provided by another vendor, or by dictation for later transcription. The final completed note is then printed for the chart, creating a seamless paper note.
4. The output can be reviewed on screen with the patient. Annotations, corrections, and additions can be made on screen. The corrected output is then ported to an electronic medical records program for the remainder of the documentation. The output can be sent via copy and paste, or through direct file import. A shortcut method to copy text has been developed. With a screening output open, click "Edit" then click "Copy Current Screening" to copy the entire block of text from the currently open screening. You can then switch to whatever program will be used to paste the text, position your cursor, and paste the block of text that was copied.
5. The output can be automatically integrated with an electronic medical records program and presented and reviewed in the context of the EMR. The text or data is transferred automatically.

Which of the above options you use will determine many of the options that you choose and will strongly affect the training issues for your staff. Think about how your practice is going to use the output as you make plans for training.

Early Implementation

During the first few weeks, you must stay in close contact with the staff members who are responsible for scheduling patients who will be doing automated interviews and those who are starting the questionnaires for patients. They must feel that they are getting support from you and must feel free to ask for help. It is especially useful and rewarding to your staff if you share the results of a questionnaire that you have found particularly helpful. Remember that change is stressful for everyone, and that your staff will feel especially burdened during this time and need feedback to know that they are being helpful to you.

As you are learning to read the output from Instant Medical History™, get into the habit of jotting down quick notes about your likes and dislikes. Some of your initial dislikes may disappear as you become accustomed to reading the output, but we would like to know about them anyway. We value your feedback, and will work hard to tune the software to meet your needs. Just as you cannot read the minds of your patients, we need to hear from you to be able to respond to your needs. One useful tool is to print out an extra copy of a history that concerns you. Please delete the patient name to conform to privacy requirements. Make some notes about your criticisms on the print out, or create an edited print out that reflects how you would like to see it modified. Send us your comments. We will do our best to respond.

Now is the time to start thinking about which questionnaires you will teach your staff to use next. When you see patients who have not been interviewed with Instant Medical History™, consider whether their visit would have been handled more efficiently with a pre-visit questionnaire. Look at the questionnaires available to handle these issues, and pick another 5-7 questionnaires to implement for the next round. Meet with your staff when you have chosen these next questionnaires, and show them how to access them.

If you and your staff members have used the text box to pick questionnaires, you may have encountered some terms for which no mapping currently exists, that is you will have seen the error message that there is no available set for that complaint. Each time that happens, Instant Medical History™ keeps a record of that event in a file called QWebNLQlog.txt. This file is automatically placed on your C drive in the primary root directory. If you will send us this file once a month, we will add new mapping entries to correct the problem in the next release. Again, we need your feedback to improve the function. We will map misspellings as well as new terms whenever possible, which reduces the frustration with using the software.

Finally, talk with your staff about the Favorites option and ways that it can be used to facilitate getting patients started with screening questionnaires. Favorites are potentially very powerful, but their use requires anticipation on the part of your staff. Favorites are only useful if the favorite item to be used is constructed before a patient arrives. Favorites must be constructed with a logical naming convention that everyone agrees with. Favorites are easiest to find if the name and description of the favorite uses language that makes sense to everyone in your office and meets people's expectations. Think creatively about designing favorites for unusual combinations of problems that match a patient's profile. Finally, the use of a date of birth associated with a favorite that is designed for a specific patient will make finding and using that favorite later on a much simpler task. You should experiment a bit with the creation of favorites so that everyone is comfortable with how they work.

Maturing Implementation

At this point you should be getting into a rhythm of looking for new ways to implement Instant Medical History™. Evaluate and implement several new questionnaires every few weeks. Try having your staff put questionnaires together by using multiple complaints separated by "and" to create new sets from existing modules. This is especially useful for periodic visits such as complete physical exams. You can string together several related questionnaires for your complete physicals by specifying General Medical Exam and Review of Systems and Personal History and Social History (for example). Any duplicate, overlapping questions between sets will be detected by the software so that questions are only asked once.

Be sure to continue meeting with the staff members who are setting up the questionnaires for patients. If they are having problems that you cannot solve, you should let us know before these problems grow to create significant obstacles to use. We have lots of experience in helping to resolve difficulties. The frequency of your meetings with staff will decrease, based on your mutual needs, but it is important that any misunderstandings get resolved promptly. Your staff will also perform better if they continue to get the message that using Instant Medical History™ is important and valuable to you.

You will find that some questionnaires work better than others. Some may need additional questions, or you may feel that answers can be worded better. We respond to all criticisms promptly, and will almost always resolve your problems by the next release. In the rare case of a critical problem, we will seek resolution within a week of notification.

Remember to send us a copy of the file QWebNLQLog.txt from the main directory of your C drive once a month. This will help us expand the terms that are mapped to

questionnaires, and make it more usable by your staff and patients. This is a task that should be assigned to whoever does the technical support and maintenance of your system. See the section that discusses initiating questionnaires for patients for information on why this is important.

As you begin seeing patients for return or follow-up visits, you may experience reduced need for staff involvement in setting the computer up for patients. Patients returning for regular hypertension, diabetes, asthma and other chronic illness follow-up visits can begin to become independent in their use of Instant Medical History™. Some patients may also be able to enter their own complaints to initiate a questionnaire. Your valuable staff time should be reserved for those who need assistance.

The Update Stage

You will receive periodic updates to Instant Medical History™, containing entirely new questionnaires, re-writes of existing questionnaires and corrections, and fine-tuning of existing content, as well as new features for configuring the software. Each update will include a list of all of the changes. You should install the update and review the changes with your staff promptly. It is very important that when we respond to your criticisms we know that you are using the most recent version. Please include the version and build numbers (you can find them by using the Help drop down menu and clicking on About).

You should use the same evaluation process for implementing new questionnaires as you did for the early implementation of Instant Medical History™. Be sure that you understand what a questionnaire does before you use it in a live clinical situation.

For the appointment schedulers

Overview

Your office will soon begin to use Instant Medical History™ to allow patients to enter information about their medical histories directly into the computer. The Instant Medical History™ program is a tool. Like any tool, it has some uses for which it is ideal, some for which it is useful but not perfect, and some for which it does more harm than good. The time at which an appointment is made for the patient is the first opportunity to decide if Instant Medical History™ is the right tool for that visit.

The management and clinical staff in your office will decide which of the many question sets contained in Instant Medical History™ will be used in your office during the first few weeks. They will add more of the questionnaires later as everyone gains confidence and skills in using the software. Your first job will be to make sure that you

understand which questionnaires are going to be used in the early phase of implementation, and how to decide whether a patient you are scheduling for a visit is a good candidate for that questionnaire. There are several issues you must think about when making the decision of whether a patient should be asked to complete a questionnaire using Instant Medical History™.

1. Does the patient's problem(s) or issue match what the question set is designed to do? As an example, your office may have decided to use the question set called "Difficulty Urinating". A patient is scheduled for an appointment, complaining, "I think I have a bladder infection". Is this patient a good match for the Difficulty Urinating questionnaire? Another example: Does a complaint of "burning when I urinate" warrant the use of the Difficulty Urinating questionnaire? (It turns out that both of these problems are well covered by Difficulty Urination, but you might not guess that unless you knew more about what questions it asks). You will need to be familiar enough with the questionnaires that your office wants to use to make these decisions. You will also need to feel comfortable asking for help in the first few weeks as you become accustomed to scheduling patients who will be interviewed with Instant Medical History™.
2. Does the patient have any impairments that will make it impossible for him/her to use the computer? Visually impaired patients will either need to have the assistance of another person or have a specially equipped computer. Patients with serious impairment of their thinking will need to be accompanied by a caregiver who knows them and is familiar with their problems. Note that age and previous computer experience do **not** keep people from using the computer. And some impairments, such as hearing loss, make the patient ideally suited for using the computer.
3. Is the patient too ill to use the computer? Someone who might ordinarily be a good candidate based on their complaint and lack of impairments might be unable to sit in front of a computer and enter their information if they are too sick or in too much pain. Usually, patients will tell you if this is the case if you simply ask them.

Your personal knowledge of the patients who come to your office is your most valuable tool in helping patients begin their use of Instant Medical History™.

Preparing for Installation

Before Instant Medical History™ is installed, meet with the physicians and other health care providers in your office. Learn the kinds of problems or issues that the first questionnaires they want to use can deal with. Make some notes on what these problems are, and keep them on hand. You might even want to try a few of the questionnaires yourself to get a feel for what the patients will be doing.

Prepare a short description for your patients of what they will be asked to do when they come for their visit. Once you start scheduling appointments for patients who will be using the computer before their visit, they will be much better prepared if you let them know in advance. Your description should tell them that they will use the computer to provide information to the health care provider who will see them the day of their appointment. Make it clear that their use of the computer is not a substitute for their time with their provider, but rather helps the provider to spend more of the visit helping them rather than to spend time writing things down. Also make sure the patient understands that the computer results will be reviewed with them.

Because Instant Medical History™ will be used with some but not all of the patients seen in your office, you need to devise a way of flagging the appointments of patients who will be doing questionnaires before their visits. This will alert the registration personnel when the patient arrives. You need to look at your current scheduling system for ways that you can flag these appointments, and discuss with the other staff the ways that you will communicate with them about patients who will use Instant Medical History™.

You will start using Instant Medical History™ with a limited number of questionnaires. Instant Medical History™ is capable of handling multiple complaints and very complex visits, but when you limit the number of questionnaires you will use, you also limit the ability of the software to handle multiple complaints. This means that if you have a complex patient scheduled, you may not be able to address all of his/her problems with the limited number of questionnaires you will have initially available. You need to discuss how to handle this before you start using Instant Medical History™ in your office. You can decide not to use it on complex patients at first, or to use it only to address the complaints and issues that are covered by your choice of initial questionnaires.

After Installation

Once your office starts using Instant Medical History™, you will need to make sure that patients who will be doing questionnaires have enough time to complete the questionnaires. You may want to tell patients to come in a few minutes early for their visit, perhaps up to thirty minutes early if you anticipate a long session with the computer for that patient. Patients who need more time are typically elderly, or have many problems, or may not have ever used a computer before. The other factor to consider is how long patients in your practice usually wait for their appointments. If your office has patients wait in the waiting room for a long time before they are seen, you can often use this time for the questionnaires. But be careful. Some patients learn not to come on time for their visit if they always wait to be seen, so you still must be sure they understand they will need a little time before their scheduled appointment.

Periodically the health care providers in your office will want to add new questionnaires to the repertoire. You must be sure that when this happens you are kept informed of all of the information that you need in order to properly schedule patients.

Try to have whoever starts the questionnaire for the patient keep track of how long patients take to complete the questionnaire for the first few weeks. If you can learn how long it typically takes patients in your practice to complete a questionnaire, it will help you to schedule more appropriately. Remember, you can prematurely end a questionnaire if necessary and use the data collected up to that point.

Illiteracy is often a hidden problem for patients. It is often a source of embarrassment that patients will go to considerable trouble to hide. If you encounter unexpected resistance from patients when you tell them about using the computer, this is often the source. Being prepared for this can avoid creating a difficult situation. Discuss resistance with your supervisor and make the provider in your office aware of the situation if you meet resistance. They may want to provide additional help for these patients to complete the computerized questionnaire.

As your office increases the number of questionnaires that you are using, you can begin to use Instant Medical History™ with increasingly complex patients. You need to look for opportunities to use combinations of questionnaires where appropriate for the patient's needs. Keep in mind that as the complexity increases, patients will need more time to complete questionnaires.

For registration personnel

Overview

Your office will soon begin to use Instant Medical History™ to allow patients to enter information about their medical histories directly into the computer. As the person who registers the patients when they arrive in the office, you will need to guide the patient into the hands of whoever will instruct him/her on using the computer interview. You will need to set up a communication process with whoever schedules appointments for patients that will tell you that a patient has been scheduled to do a questionnaire with Instant Medical History™. That way you will know as soon as you register the patient that a computer questionnaire is scheduled for the patient.

You should also read the section for appointment scheduling personnel. Many offices see patients without appointments on a walk-in basis. When these patients are registered, you will need to make the same assessment at the scheduling staff does about whether a patient is a candidate for using a questionnaire in Instant Medical History™. Familiarizing yourself with the issues that confront appointment schedulers

will help you to make these decisions when dealing with walk-in patients.

For ancillary clinical staff helping patients to start questionnaires

Overview

Starting questionnaires for the patient is a central role in making a successful transition to using Instant Medical History™. Your job is to make sure that the questionnaire addresses the patient's reason(s) for the visit, to make the patient comfortable with using the computer, and to ensure that the time the patient spends using the computer maximizes the efficient use of resources throughout the office.

The most important, expensive, and scarce resource that your office has is the time of your health care providers. Instant Medical History™ helps to improve the efficiency of your providers in three important ways. It has the potential to save minutes of provider time for each patient visit; it can save up to 60% of the dictation/transcription costs for each visit; and it provides the documentation to ensure appropriate billing charges for each visit. Whether your office achieves these efficiencies with Instant Medical History™ or not is in large part determined by the way that you use the software.

First, you must be certain that using Instant Medical History™ does not keep your providers waiting to see patients or slow down patient flow. This means that you must be constantly aware of where your providers are in their schedule. Instant Medical History™ should not be used in a way that causes providers to get behind (or further behind) in their schedules while waiting for a patient to complete a questionnaire. A provider who is idle because of an unfilled slot in the schedule is not a reason to prematurely end a questionnaire. A provider who is idle while waiting for a patient to complete a questionnaire on the other hand **may** suggest that the patient should end the questionnaire before completion. The trade off is patient flow against information flow. Provider time is very valuable, but so is the information obtained from questionnaires in Instant Medical History™. This can be a tricky issue, and there is no hard and fast rule. The best course is to stay aware of how both patient and providers are matching up to your schedule, and to try to reach the best patient flow through the office while at the same time making the best possible use of Instant Medical History™. Communicate with your providers to make sure that their needs and expectations are being met. You can prematurely end a questionnaire by using the Screening drop down menu, then click on Stop.

Second, you must stay aware of how patients are progressing with their computer questionnaires. The wide variety of patient's personalities, computer experience and skills, communication skills, and illnesses combine to produce many different behaviors

when entering information into a computer. Some patients will ask for help easily, some will not. Until they have successfully completed a questionnaire and reviewed it with their provider, they will be uncertain regarding their comfort and attitude with the questionnaire. Your job is to provide supervision where needed, a feeling of security, and sometimes be a cheerleader. Remember too that your attitude towards the computer and the software will affect the patient's attitudes towards using the software. Especially when you begin using the software with patients, your uncertainty will be reflected by the patients. They may need reassurance with this new and unfamiliar process in part because they see that you need reassurance.

The best way to prepare to use Instant Medical History™ is to try some of the questionnaires yourself. Although you may not be able to mimic an illness, you need to understand the types of questions that patients are asked and the way they will answer them. You also need to get a sense of how long the questionnaires are. Going through the whole process a few times will help you give them instructions and feedback.

Instant Medical History™ has a feature that allows you to preview a list of all of the questionnaire names that it can ask, so that you can print it out and work from a printed menu. To preview a list, click on "File" to open the drop down menu. The fourth choice down on the drop down menu is "Print Preview 'Pick Complaints' List". Click the fourth choice. The Print Preview menu offers you two radio button options. The first option is whether you choose to preview the list terms that are intended for a patient or a health care professional. The second option is whether you want to preview the list on the screen (in a format that can be sent to a printer) or whether the preview list is exported to a file that you can print out later. Whichever you choose for the second option, you will probably need some assistance from one of the computer technicians in your office to get it sent to the printer for your use. Be sure to read through the list and get a general feel for the number and kinds of complaints that Instant Medical History™ can address with patients before you begin using it.

Before Implementation

Before you put the first patient through an Instant Medical History™, you need to learn how to start the program, find the questionnaire you want, begin the questionnaire, end the questionnaire, and pass the results to the provider. We will cover each of these areas. In addition, you may need some instructions on turning on the computer, on using Microsoft Windows®, and on using a mouse. If you need instructions about the computer or about Windows®, ask your office manager for training.

Read through the section on Options. Pay special attention to the third section on Favorites. Favorites are a way of customizing Instant Medical History™ for your patients.

Starting Instant Medical History™ software

Computers can be customized to an amazing degree by the people who set them up and install the programs. This customization can be both a blessing and a curse. Since we cannot know for sure how your computers have been set up, you should ask the staff in your office that installed Instant Medical History™ how to start the software if that will be part of your responsibility. In general Instant Medical History™ can be left running once it is started so that it does not have to be restarted for each patient.

Starting a questionnaire for a patient

Instant Medical History™ treats each questionnaire session with a patient as a unique experience. Although the result of each questionnaire is saved and stored as a permanent record, the program (currently) has no awareness of the contents of previously administered questionnaires, or even that a patient previously completed a questionnaire. Every encounter must be started as a new encounter.

Instant Medical History™ starts the process of entering a patient name and choosing a new questionnaire automatically when the program is first started. After the first questionnaire is completed, Instant Medical History™ may wait for you to start a new questionnaire session, or may automatically start a new questionnaire session without any intervention depending on how it is configured (See Section II on configuring options above if you want to know how this is done). If it is waiting for you, a blank screen with the title "Instant Medical History Professional Edition" followed by your doctor's name or the practice name will be at the top of the screen. The line below the title has five menu choices: "File", "Edit", "Screening", "Tools", and "Help". Click on "Screening", and two choices appear: "Start" and "Stop". Click on "Start". (If your computer was set up to automatically start a new questionnaire when the last one was finished, you will see the Welcome to Instant Medical History screen when the last questionnaire was completed.)

You will next see a screen appear that is labeled Welcome to Instant Medical History, below which is written some general information on starting the questionnaire. **You only need to read the information on this screen one time, not each time you use it.** The information is intended primarily to help patients use it without your assistance on future questionnaires. If for some reason you do not want to begin a new questionnaire session, click on the Cancel button in the lower right corner of the Welcome to Instant Medical History window. If you want to proceed with starting a new questionnaire, click on the Next button, or press the Enter key (either one will take you to the next screen).

The next screen is titled Enter Patient Information (Who are you?). This screen requires entry of a patient name, date of birth in MM/DD/YYYY format, and patient sex. It also allows you to enter a patient identifier that you use in the office to identify

patients as an option. Instant Medical History™ does not keep a registry of names of people that have used it before, so this information must be entered each time the program is used. (However, if your version of Instant Medical History™ has been customized to work with your EMR software, it may automatically fill all of these fields in and bypass this screen. Check with your computer support personnel). It only takes a few seconds to complete this information. Instant Medical History™ will use this information to select appropriate age and sex questions for the questionnaire and to label the output and the files in which the output is stored for retrieval. You can use the mouse to move to each item, or the Tab key. If you enter an illegal value in one of the fields, you will get an error message. Check with the staff in your office to see what value you should use for Patient ID (again, the Patient ID field is optional and does not need to be completed to go to the next screen). When you have finished entering the patient information, click on the Next button.

The next screen is titled "Choose Provider". **This screen will only appear if you have more than one provider licensed to use Instant Medical History™.** If you only have one provider licensed to use Instant Medical History™, or if for some reason you have only entered one provider's name, you will not see this screen. (See Providers/Locations section under Tools). The Choose Provider screen will contain a list of all of the valid providers for your practice. Move the cursor over the address of the provider who is seeing the patient for this visit and click the left mouse button. Your selection will be highlighted. Click the Next button to move to the next screen.

The next screen is titled "Choose Location". **This screen will only appear if you have chosen to enter more than one practice location.** If you only have entered one practice location, you will not see this screen. (See Providers/Locations section under Tools). The Choose Location screen will contain a list of all of the valid locations for your practice. Move the cursor over the address of the location you wish to use and click the left mouse button. Your selection will be highlighted. Click the Next button to move to the next screen.

The next screen is titled "Enter Complaint (Why are you here?)". There are three different ways to choose questionnaires to administer, which can be used singly or in combination if needed. The three different ways are present in the three sections on this screen (separated by thin horizontal bars). Each of the three sections can be enabled singly by clicking on the check box to the left of the section, or they may be enabled in combination. By default, the first section ("I want to type in my complaint") is enabled for you. This is for convenience only. You may use any or all of the three choices to select a screening questionnaire for your patient. These choices are for your convenience and ease of use, and allow you to develop some shortcuts to starting a screening.

You should also be aware that your system administrator might have chosen to enable a standard questionnaire that is automatically administered **in addition** to any

questionnaires that you pick on this screen. If this has been done, your patient will have to answer additional questions. Your system administrator should notify you if this has been done. You will not receive any notice by Instant Medical History™ if an additional screening questionnaire is to be administered, but your patient may tell you that some questions were asked that had nothing to do with the complaints or problems that he/she reported.

The decision about whether to type in a complaint, pick a complaint from a menu, or use a list of favorites is pretty straightforward. You can only pick from a list of favorites if a patient has been in before **and** you have constructed a favorite that matches his/her complaint(s), or if you anticipated today's visit and constructed a favorite for this visit. A situation that is appropriate to anticipate and to construct a favorite might be someone who comes repeatedly for follow up of the same complaint, or a group of patients who have similar needs. You may think of other situations. One example would be a patient with known diabetes and heart failure who comes in every three months for a follow up visit for these complaints. In this case, construction of a favorite for this patient would make it possible to use this favorite for that patient's routine visits, saving the task of remembering or looking up questionnaires. Another example would be patients who come in periodically for preventive visits. You could construct a favorite that matches common preventive questionnaires that are done in your office. You can use your imagination to create other examples of places where favorites would be useful. **The important point to remember is that a favorite must be built and available before you get to the "Enter Complaint" screen if you want to use the favorite this visit.** If you get to the "Enter Complaint" screen and you have not built a favorite to use for this visit for this patient, you are probably better off typing a complaint or using the menu.

If you are seeing a patient for whom an appropriate favorite already exists, you can simply choose that favorite. If you are faced with a long list of favorites and cannot seem to find a favorite that matches your patient's needs, there are a few tricks that can help. First check both the Patient Favorites and the Nurse Favorites if you are having trouble finding the correct favorite. Second, you can re-order the way the list of favorites is presented to you by clicking on the title that you want to use to create the ordering of the list. For example, if you have a patient for whom a favorite has been created and this favorite was assigned that patient's date of birth, you can group the favorites list by date of birth by clicking on the "DOB" title at the top of the favorites screen. This will cause all of the favorites that match the patient's date of birth to rise to the top of the favorites list as a group, simplifying your task of finding the right one. This re-ordering trick works for the Name and Description fields as well, but it most useful in conjunction with the Date of Birth (DOB) field to find a favorite created for a specific patient.

Once you have identified a favorite you want to use, choose that favorite. To do this, click on the box next to "I want to pick my complaint from a list of favorites". Instant

Medical History™ will respond by changing the background of the favorites list from gray to white, indicating that the favorites list is active and ready for use. There are two favorites lists on which the favorite might be found – the Patient Favorites list and the Nurse Favorites list. Depending on which list you assigned the favorite to when it was created, you will find it on the assigned list. To select a favorite to use as your choice for this visit, click the box on the same row as the favorite you wish to choose. A check mark will appear in the box on that row when you have done that. All of the screening questionnaires associated with that visit will be administered to the patient when you select a favorite. You may also select multiple favorites in case there are more than one favorite appropriate for this visit. If no favorites are found that are appropriate for this visit, you may choose to type the complaint or pick the complaint from a menu. If a favorite is found that is appropriate, but additional screening questionnaires are needed to make a complete visit, you may choose to type a complaint or pick a screening questionnaire from a menu **in addition** to your choice of a favorite. This process was designed to be as flexible as possible. Be sure to read and understand the section on how favorites are created to get the best use from favorites.

If a favorite is not the way you wish to pick a screening questionnaire, or if you need additional screening questionnaires, you may type a complaint in the text box, or you may press the Pick Complaint button. To use either method, you must click the box in front of your method of choice to enable it, which places a check mark in the box. Both methods of choosing will select questionnaires from the same menu of questionnaires. Which method you choose depends on how comfortable that you are selecting the questionnaire(s) that you want. When you first begin using Instant Medical History™, you will have some uncertainty about this, which is natural. Instant Medical History™ contains a large number of different questionnaires, and it is difficult to familiarize yourself with the entire list at first. That is why we have recommended that you start with a small group of questionnaires to start with, and gradually expand your use of the software as your familiarity with it increases. Instant Medical History™ was also designed to print out lists of the screening questionnaires that are available for you to use. Favorites were designed as a way to avoid having to deal with long lists. Even with a limited list, there can be some confusion when a patient has a problem that does not match exactly to a questionnaire. Some examples will make this clearer.

Example 1: The patient complains of a cough. You can choose a questionnaire on cough by one of two different methods. You can simply type “cough” (without the quotation marks) in the text box, and then click on the Next button, **or** you can click the Pick Complaint button (after clicking the box to the left of “I want to pick my complaint from a menu”), which opens a screen that looks like a series of tiny folders, with the topmost folder labeled Instant Medical History™. Beneath the folder labeled Instant Medical History™ are a series of boxes containing plus signs. Each box has a folder on its right, with a label for each folder signifying what the folder contains. Since cough is usually a Chief Complaint (or a new acute symptom), click on the box containing the plus sign to the left of the folder labeled Chief Complaint. This will open

the Chief Complaint folder, exposing a new set of folders beneath and indented to the right of the Chief Complaint folder. Use the scroll bars on the right of the screen to find the folder labeled Respiratory. Click on the box containing the plus sign to the left of the label Respiratory. This opens the Respiratory folder, revealing the questionnaires that are available under the Respiratory heading. Here you will find Cough. To select the cough questionnaire, click in the empty box to the left of the label Cough, and a green check mark will appear, as well as the text "cough" in the gray box beneath the folders. You have now chosen to do the Cough questionnaire, and can click the Next button to move to the next screen.

You can see from Example 1 that typing Cough in the Enter Complaint text box is far simpler once you know that a questionnaire exists for the complaint of cough. The main use of the Pick Complaint button is to allow you to explore the complete contents of Instant Medical History™, and to assist in finding questionnaires when you are having difficulty getting an appropriate questionnaire to start for a patient.

Example 2: The patient complains of "trouble peeing". You enter "trouble peeing" in the text box and click Next, but you get an error message that says "One or more of the complaints you entered was not found. Please re-enter the complaint and try again". What happened? Instant Medical History™ has a list of thousands of complaints and patient issues that it can map to a questionnaire, but "trouble peeing" just is not on the list (at least not yet – see below). So, what do you do now? One thing you could do is to enter another phrase that means the same thing. If that fails the Pick Complaint button can come to the rescue, even though it takes more steps. Using the process described in Example 1, press the Pick Complaint button, and open the Chief Complaint folder, then the Genitourinary folder, and then the Both Sexes folder. There you will find what you are looking for – the questionnaire labeled "Difficulty Urinating". You may have had trouble guessing that this would be the name of the questionnaire you were looking for, but now that you know what it is called, you will be ready the next time you need it. Click the box to the left of the label Difficulty Urinating to put a check in the box, then click the Next button and you are done.

Example 2A. The patient complains of "trouble controlling my pee". Remembering the last example, you think, "Is this the same as Difficulty Urinating?" You decide to check list of complaints using the Pick Complaint button. Going back to the Chief Complaint folder, the Genitourinary folder and the Both Sexes folder, you find a question set called "Incontinence". You confirm with the patient that he/she is having trouble with involuntary urination, and choose the Incontinence questionnaire as being more appropriate than the Difficulty Urinating questionnaire for this patient. It is important to note that Difficulty Urinating would not have necessarily been a "wrong" choice for this patient. If the Difficulty Urinating question set had been given, it might not have been the most efficient way to get at the symptoms that the patient has. Instant Medical History™ is constructed so that it can usually ask all of the questions needed if any reasonable starting point is chosen. The difference between the Difficulty Urinating

questionnaire and the Incontinence questionnaire is the understanding of what the exact problem is – Difficulty Urinating starts with a more general description (and asks more questions) while Incontinence starts with a fairly specific problem (and asks fewer questions to focus on the more specific complaint). In this example, Incontinence is more efficient a questionnaire to use, and will provide a somewhat shorter output for your provider.

There are several other important points to make while we are discussing the process of initiating questionnaires.

7. Look back at Example 2. The patient complained of “trouble peeing”, but that complaint was not recognized by Instant Medical History™. What you did not see was that Instant Medical History™ made a note in a file that recorded the fact that it did not recognize a complaint. This file can be sent back to Primetime Software periodically, so that we can improve the ability of the software to recognize new complaints. Be sure to remind whoever in your office maintains your computer to periodically send us this file so that we can improve the program.
8. You may have noticed two other features that we did not describe when you clicked on the Pick Complaint button. One was the Expand All button, and its brother the Collapse All button. These buttons simply open ALL of the folders and close ALL of the folders when clicked. Use them as you see fit. The other is the two radio buttons in the small box labeled View in the lower right hand corner. The Provider view is the view we were describing. If you click the Patient button, the labels change on the questionnaires to attempt to create labels that allow patients to pick from the list on their own. These labels are less technical than the Provider view, but they otherwise describe the exact same set of questionnaires. In other words, questionnaires may have several different labels, but they ask the same questions.
9. The examples we used above all describe a patient with a single complaint or issue. Instant Medical History™ is capable of asking several questionnaires in sequence. You can enter multiple complaints in the Enter Complaint text box, separating each complaint with the word “and” (without the quotation marks) or separating each complaint with the character “&” (without the quotation marks). You can also check multiple boxes when choosing questionnaires from the Pick Complaint screen, which will also result in more than one questionnaire. When you begin using Instant Medical History™, you will be using a limited number of the questionnaires available, so you probably will not have a chance to try this out at first. As you increase the number of questionnaires that your office uses, this will become more common. Deciding when multiple complaints require more than one questionnaire can be a tricky issue. One disease can produce multiple symptoms, but require only one questionnaire. On the other hand, one visit might require multiple questionnaires, for example in the case of a periodic physical exam where

- you might want to administer the Personal and Family History questionnaire and the Surgical History questionnaire and the General Medical Exam questionnaire all together. Another example is a customized prevention visit that addresses areas of concern that are customized for your patient. You will need to check with your providers, especially when you are starting out. As time goes on, you will become more comfortable with making these decisions.
10. When you need to use more than one screening questionnaire, you can use a combination of methods to choose the questionnaires. You are not limited to only typing in a complaint, or only picking from a list. You could have three complaints, one chosen from a list, one typed in, and one that is on the favorite list. Whatever works for you can be handled by Instant Medical History™.
 11. There are a number of folders that do not deal with complaints in the usual sense. The Past Medical History folder, the Periodic, Prevention, Wellness Screening folder, Other folder and the Scales by Name folder deal with other kinds of issues. You will need to discuss how and when to start using the questionnaires in these folders with your providers.
 12. The Specialist folder contains folders that apply to specialists in various areas. Note that Specialist does not necessarily mean that the questionnaires do not apply to primary care providers. The Specialist folder simply contains sets of questionnaires that are commonly used by providers who practice in various specialties. Primary care providers may need to use questionnaires from these sets from time to time, especially if their practice takes them into an area of practice where they need a more detailed history.

Spend some time exploring the Pick Complaint listings to get a feel for what is in them. Although you will not be using many of them at first, having a sense of where to find what you are looking for before you use Instant Medical History™ with real patients will be very valuable to you later on. Exploring these folders can be made easier by using the Expand All and Collapse All buttons.

When you click the Next button from the "Enter your complaint" screen, you get different screens depending on whether you entered a single complaint or multiple complaints. If you entered a single complaint, you will go to the "Confirm Screening Settings" screen (described below). If you entered multiple complaints, you get a screen labeled "Select Chief Complaint". The "Select Chief Complaint" screen allows you to identify which one of the multiple complaints you entered for the patient is the main or chief complaint. You will see a box listing the complaints that you entered. Click on the complaint that you want to be the chief complaint, and then click on the button labeled Make Chief Complaint. The highlighted complaint becomes the Chief Complaint. Click the Next button when you are done.

You are next presented with a screen that is labeled "Confirm Screening Settings (Ready to start Interview)". This screen lists the complaints or issues that you entered, and below that lists the questionnaire or questionnaires that will be asked. This is presented for your information, and requires only that you review it to be sure that it matches your expectations, and then click the Next button. If you notice that you made a mistake when presented with the Confirm Complaints screen, you may use the Back button to return to the previous screen. **Note that if a favorite is one of the methods you used to select a screening questionnaire, the "Select Chief Complaint" screen and "Confirm Screening Settings" screen will list the name of the favorite rather than it's component elements.**

Instructions for the patient

Once the questionnaire has started, it is time to turn over the computer to the patient. You could sit and help the patient do the questionnaire if you have a patient with reading difficulties or some impairment that prevents him/her from using the computer. Most patients will be able to learn the simple mouse, touch screen, or keyboard skills they need in a minute or two. Now is the time to find out what kind of help, if any, they need. If the patient already has computer skills, you will just need to give them a few instructions and watch them do the first few questions. If they need some instructions on using a mouse or touch screen, you may need to spend a couple of minutes more.

Before you let the patient begin, there are a few simple rules for completing question sets that they need to know.

1. There are no "wrong" answers. The questionnaires are designed to get information, not to test the patient. If you make a mistake, you can sometimes go back to a previous question depending on where you are in the questionnaire.
2. The results of the questionnaire will be reviewed with the patient by their health care provider. If there are any misunderstandings or additions, they can be corrected at the time of the review.
3. If the patient is not sure how to answer a question about whether they have a problem or symptom, they should answer yes. It can be corrected at the review, but at least they will not deny having a symptom that might be an important clue because they did not understand what was being asked.
4. The computer is not very smart. It sometimes asks questions that are similar to previous questions (although it never asks the identical question twice). It also does not understand the meaning of the answers. Be patient, and answer all of the questions. Even though some questions may appear to be very similar, they often have very different meanings.
5. If the patient feels too ill to use the computer, he/she should be given the chance to ask not to use it.

6. Depending on the options you have chosen, patients may be able to skip questions using the Skip button, or to go back to a previous question using the back button. Check how your software is configured before you give instructions about using these options.
7. Give them instructions about what to do when the questionnaire is finished.

This may seem like a lot of material. Once you start using it, everything becomes much simpler. We have covered this in a lot of detail to consider all of the possibilities, but in practice the software is pretty easy to use.

Ending a questionnaire

Questionnaires can end in two ways. The normal way for a questionnaire to end is for all of the questions to be completed. When this happens, Instant Medical History™ displays a screen that says, "You have completed this screening". This screen may also display an optional customized message that your office wants to display (see Section II. Configuring Options). The other way for a questionnaire to end is to use the Screening drop down menu and select Stop. This terminates the questionnaire prematurely, and saves the output information that has been gathered so far. The option to prematurely end a questionnaire before its completion is included to allow you to shorten a questionnaire when it is taking longer for the patient to complete it than you can allow.

Depending on how you have configured Instant Medical History™, one of three things will happen when a questionnaire is completed:

1. The program waits for you to start a new questionnaire or look at the output;
or
2. The program asks if there are any other complaints that you wish to discuss. Clicking the Yes button allows another questionnaire to be appended to the once just completed. Clicking the No button finishes the questionnaire, and the program waits for you to initiate a new questionnaire or look at the output; or
3. The program automatically initiates a new questionnaire with a new patient entry screen.

(See Section II. Configuring Options to see how this is determined)

Sending the output to the provider.

The way that the output from Instant Medical History™ finds its way to the provider who uses it depends to a great extent on how the computers in your office are configured and the location of printers and computers in your office. Since we have no way of knowing in advance what any of that will look like, we must address the output

issue in a very general way. You should discuss this with your providers and with the technical staff who set up and maintain your computers for more of the details of what (if anything) you need to do to send output to the provider and to the patient's chart.

When a questionnaire is completed, its output becomes what we call the "Current Screening". If you click on the File dropdown menu, you will see three choices that address things that you can do with output (and a fourth, Exit, that closes the Instant Medical History™ program). Two of the choices are Open Current Screening and Print Current Screening. These choices are available only immediately after a questionnaire is completed. Open Current Screening will create a text output of the most recently completed questionnaire. This text output will be viewed in a word processing program or in an Internet browser, depending on how your system is configured. You can edit the text if necessary, and can save it to a file.

Print Current Screening sends the output to the default printer for the computer you are using (see Microsoft Windows® documentation for information about default printers).

Open a Screening allows you to view and edit any of the output from any questionnaire that your computer has access to. Access to questionnaire output locations is configured by your technical support staff, and you should discuss how to access locations with them. When you select Open a Screening, you are presented with a window that allows you to look at a variety of identifying characteristics from which you can decide which screening it is you want to look at. The criteria are the patient name, the patient date of birth, the date that the file was last modified, and the name of the file the information is stored in. You can also change the way that the list is sorted to make it easier to find what you are looking for. The labels Name, DOB, Modified, and Filename at the top of each column are actually buttons. When you click the button, the list is re-sorted based on the column you have clicked. For example, if you click the Name button, the list is sorted alphabetically by name. If you click name a second time, the list will be sorted by name but in reverse order. This sorting works for all four columns.

There are two other choices for finding output to review or print. One is the Screening Location text box, which can have values of Primary output location and Secondary output location. Usually you do not have to do anything with this text box and can leave it set to Primary output location. See Section II. Configuring Options for more information about primary and secondary output locations. The second choice is regarding whether to review the original output or reviewed output. Original output is the questionnaire results that were present at the time the patient finished the questionnaire. This output cannot be changed or modified (for legal purposes). The reviewed output however is a separate file that may have changes or additions that were added after the Original file was reviewed. Whenever you review an output file, a second copy of that file is automatically saved, which preserves any additions or changes that you have made.

To select an output to review, click on the name of the patient whose output you wish to review. This will select the name and the name will become highlighted. You can then open the output by clicking on the Open button, or print the output by clicking on the Print button.

Once an output is open, you have additional options that are determined by whatever program you are using to view the output. In general, you can save yet another copy of the output, print the output, or send it anywhere in your system. You should talk with your technical support staff and your providers about what, if anything, you need to learn about this process to finish your work with the output. A shortcut method has been developed within Instant Medical History™ for copying the text of whatever screening is open so that it can be pasted elsewhere. With a screening output open, click "Edit" then click "Copy Current Screening" to copy the entire block of text from the currently open screening. You can then switch to whatever program will be used to paste the text, position your cursor, and paste the block of text that was copied.

One other item needs to be mentioned. Instant Medical History™ can be configured with passwords to keep patients and other unauthorized users from viewing the output from within Instant Medical History™. You will need to know the password if part of your job is to open, print, or review output. Instant Medical History™ can also be configured to prevent patients from ending or exiting from the program, which helps keep the computer safe from unwanted access. Ultimately however, the security of the information stored on the computer or on your computer network is the responsibility of everyone in the office. You must stay aware of who is using the computers you are responsible for, and what they are trying to do.

Early Implementation

As you start using Instant Medical History™ with patients, make some brief notes on any areas that are causing problems in communication, or difficulties that patients are having. Discuss these problems with your office manager and your providers as appropriate. Often they will be able to offer suggestions that will resolve your problems. When needed, contact the staff at Primetime Software. We have lots of experience that can help you through early problems with implementation.

If you need more help:

There are three ways for you to get more help.

You can contact Primetime Software directly by telephone at 803-796-7980 or e-mail through our web site.

You can go to our Web page on the Internet at www.medicalhistory.com/imh2000/usersguide_homepage.htm to look at our online documentation.

You can arrange for a consultation with one of our staff.

We pride ourselves on our customer service. If we disappoint you in any way, please let us know and we will do our best to resolve your dissatisfaction.

Frequently Asked Questions.

Occasionally, a customer will ask us a question about an issue that is not covered in the manual, and for which there is no real heading in the manual to create an answer regarding that question. We decided to create a frequently asked questions section to address these questions for everyone's benefit so that customer issues are addressed

Q: What happens when a patient is answering a screening questionnaire and the power goes off to the computer causing the computer to die?

A: If a computer is turned off in the middle of a screening questionnaire, all of the results of the questionnaire are lost. The answers to a questionnaire are only saved when a screening is finished or terminated by the user. Power failures are luckily rare events (in the United States in 2001), so this should not be a big deal. If you are concerned about power loss in the middle of an interview, there are two things you can do to prevent data loss from a power failure.

1. You can install a non-interruptible power supply on your computer so that the computer will continue to operate through a power failure.
2. You can use a laptop computer, which automatically switches to battery power when the computer is unplugged or otherwise loses power

Either of these precautions will prevent you from losing information that a patient is entering on your office computer.

Q: Why did the hot keys disappear (underlined characters that substitute as keyboard "shortcuts" for commands) in the menus and on the answer buttons?

- A. Newer versions of Windows™ make the presence of hot keys and option rather than a fixed part of the operating system. Unless you explicitly enable hot keys, they will not appear in any of your program. This is now the default setting for Windows™ NT, Windows™ 2000 and Windows™ XP. It is easy to fix, but must be done for each of your computers. To enable hot keys to be visible:

- Put your cursor on the desktop
- Right click on the desktop. This should bring up a dialog box. Click on the first item in the dialog box labeled "Active Desktop", then click on "Customize My Desktop"
- In the "Display Properties" window that opens, click on the tab labeled "Effects".
- In the "Visual effects" box there is a series of check boxes. Disable the last item ("Hide keyboard navigation indicators unless I use the Alt key") by clicking on the checkbox before this item.
- Click on OK

This should make the hot keys (keyboard navigation keys) visible in all of your applications.

Q: My patients get impatient answering questions. How can I avoid this?

A.: Patient dissatisfaction with using computerized interviews can result from many sources. In general, dissatisfaction results from an unmet (and possibly unspoken) expectation of the interaction with the software. The best way to deal with this is to reach a formal understanding with the patient before the interview begins about the purpose and outcome of the interview. This document contains some specific recommendations about issues to discuss with each patient before they use the software. In addition to those recommendations, we suggest that you specifically address two areas where appropriate with patients:

- a. Screening questionnaires. If you are using Instant Medical History™ to do an interview designed to screen a patient for problems rather than to perform a diagnostic interview, they will be asked many more questions that seem irrelevant. Discussing the purpose of a screening interview as opposed to a diagnostic interview with the patient will help them understand the purpose of these questions.
- b. Branching questions. Sometimes Instant Medical History™ will branch into an area of inquiry that seems unrelated to the primary reason for the interview, when suggested by an answer to a previously asked question. Patients need to understand that these branches may seem unrelated, but are administered as part of a thorough and appropriate exploration of their problem. Patients may be unaccustomed to being asked psychosocial questions as part of this evaluation because of the natural reluctance to avoid deeply probing questions. They should be made aware that the computer is programmed specifically to probe these areas so that areas important to their care are not overlooked.