



INSTANT MEDICAL HISTORY

## 2011 Winter Release Notes

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Enclosed is your CD to update Instant Medical History. Please install by clicking "IMHSetup.msi" on the CD, and following the prompts to upgrade your program. Your preferences and settings will not be changed. We will briefly describe new features in the following sections, and invite you to web training to learn more.

### New Questionnaires

#### *New Content Releases*

##### **Pediatrics**

Pediatric History continues to be improved and extended to pre-natal maternal health as well as antenatal and peri-natal details. Use questionnaire "Pediatric History" with for children to obtain the pediatric history.

The Asthma Control test was previously available for adults and children over 5 years of age. A new instrument, Test for Respiratory and Asthma Control in Kids (TRACK), has been added for children 1-4 years of age.

Respiratory complaints, skin rash, and gastrointestinal complaints are expanded for all ages as low as 1 month of age.

##### **Musculoskeletal**

New standardized instruments include:

- Cincinnati Knee Rating System
- Tegner Lysholm Knee Scoring Scale
- Hip Disability and Osteoarthritis Outcome Score
- Total Hip Replacement Questionnaire
- Oxford Shoulder Score

##### **Dermatology**

Skin rash is expanded with greater detail to match the earlier enhancement of urticaria. The comprehensive interview makes diagnosis easier for web users with less-than-ideal pictures sent by patients. This improvement also permits better documentation for the difficult-to-diagnose rashes and more accurate coding.

## Neurology

**Headaches** - Perhaps the most dramatic improvement of this release is the significant work in the diagnosis and treatment of complex headache. Using the text phrase “Headache Consult” as the chief complaint, the detailed evaluation can help detect and differentiate many forms of headache as well as allow treatment evaluation much more thoroughly than the other six optional headache interviews previously offered. The new “headache consult” adds new scales including the Migraine Treatment Optimization Questionnaire (M-TOQ) which when the Option “Care Plan” is activated in the Tools menu will help select evidenced-based treatment recommendations based on the patient entered data. This interview is for both new and returning headache patients.

**Fibromyalgia** – The Fibromyalgia Rapid Screening Tool is a helpful new interview for the difficult diagnosis of fibromyalgia and the Fibromyalgia Impact Questionnaire (FIQ) can be especially helpful in following treatment with new drugs approved for treatment.

**Fatigue** - The Fatigue Severity Scale (FSS) is a 9-item questionnaire added as an additional screening tool for patients with multiple sclerosis and lupus although it can be used in any fatigue condition. This tool augments the Brief Fatigue Inventory (BFI) and the Iowa Fatigue Scale already offered as optional scales to measure fatigue symptoms.

**Multiple Sclerosis** – The Multiple Sclerosis Quality of Life Scale is a 54-item interview helpful in following patients with MS.

## Psychiatry

The newer Generalized Anxiety Disorder Scale (GAD-7) has been made the default for anxiety screening in the interviews replacing the Hamilton Anxiety Scale (HAM-A) as a result of user community feedback and evidenced-based recommendations. For users more comfortable with the HAM-A, the default screening can be easily reset by using the Tools menu under the Scales Option or calling Primetime Medical Software Technical Support 803-796-7980 or e-mail: [support@medicalhistory.com](mailto:support@medicalhistory.com).

Additional options are added for domestic violence screening including HITS Tool for Intimate Partner Violence Screening (HITS) as well as the default Women Abuse Screening Test (WAST).

## Endocrinology

Comprehensive screening for osteoporosis evaluation is added for consultation and referral. Osteoporosis risk is useful for primary care screenings.

## Surgery

To improve screening for Pre-operative evaluations, two additional screening interviews were added as well as the Beta-blocker Pre-Op Assessment Tool. Current evaluations for general or regional anesthesia are unchanged by these additions.

## Urology

Urinary incontinence screening is improved to allow outcomes measurement in males as well as the Urogynecological scales currently in place for females. In addition, new standardized tools, the Incontinence Impact Questionnaires in both the long and short formats (IIQ-7 and IIQ-30), were added.

The International Index of Erectile Function (IIEF-15) is the expanded form of the 5-item Sexual Health Inventory of Males and supplements this scale in more difficult cases or for outcomes management by Urologists. The NIH interview for Chronic Prostatitis Symptom Index is added as a standardized instrument for management of this chronic disease. As with other chronic disorders, if you add the text string “followup” to the complaint screen, the context of the interview will start for an established patient.

## Geriatrics

Evaluation and prevention of falls in the Geriatric population is improved with the addition of the Falls Risk Assessment Tool (FRAT). FRAT is a simple 5-item questionnaire that is easily added as favorite using the Advanced Features in Favorites in the Tools/Options/Menu so this can be administered to all patients over 65.

## Otolaryngology

The Sino-Nasal Outcomes Test (SNOT-20) is an excellent tool for evaluation and outcome management for recurrent sinus and nasal conditions.

# Meaningful Use

Instant Medical History™ can impact several bullet points in the qualification process:

*[9] Objective: Record smoking status for patients 13 years old or older.*

**Measure:** At least 80% all unique patients 13 years old or older seen by the Eligible Professional (EP) “smoking status” recorded.

Is an 80% requirement reasonable for a busy staff that must remember to ask? IMH can ask every patient about smoking. In addition, IMH generates the documentation for quality audits that would prompt the office nurse to do brief intervention for smokers and facilitate the appropriate charges for 99406. This would generate follow up office visits for care and treatment and improve smoking cessation efforts. (Figure 1)

Figure 1

### Care Plan

#### 1. USPSTF A Recommendation: Fecal Occult Blood

fecal occult blood test performed : No

#### 2. USPSTF A Recommendation: Lower intestinal endoscopy

lower gastrointestinal endoscopy : No

#### 3. USPSTF A Recommendation: Smoking cessation procedure

interested in smoking cessation : Yes

currently uses tobacco : Yes

smoking cigarettes : Yes

#### 4. USPSTF A Recommendation: Lipid Screening

cholesterol has been measured : No

### Chief Complaint

John Doe is a 58 year old male presenting with cough.

### Past, Family, and Social History

#### Social History

##### Tobacco Use

History of: Smoking cigarettes.

**[17] Objective:** Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request.

**Measure:** At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours.

**[19] Objective:** Provide clinical summaries to patients for each office visit.

**Measure:** Clinical summaries provided to patients for at least 80% of all office visits.

Instant Medical History™ is designed to save documentation time for the physician. The HPI, PMH, SH, and ROS make up 70% of the volume of the medical record. By substantially reducing the data entry portion of the subjective, real-time documentation can occur. If the subjective can be completed before the clinical physical exam begins, then the objectives of providing a clinical summary or an electronic version of the visit note become achievable.

The Objective can usually be documented by exception in most EMR systems using. Depending on workflow, this could frequently be done with the patient after the examination is performed. The Assessment can be selected from a list of diagnoses and the Plan can be reused with simple keystrokes while the patient is being treated. If real time documentation occurs, then the patient could be handed a copy of the medical office visit routinely, realizing Bachman's Law<sup>1</sup> of efficient EHR use.

## Free Training

We are scheduling web tutorials to introduce these new options and discuss patient scheduling and physician workflow. A full schedule is at <http://www.medicalhistory.com/usertools/trainingclasses.asp> Please telephone us at 803-796-7980 or send an e-mail to [support@medicalhistory.com](mailto:support@medicalhistory.com) if we can be of assistance to you. We appreciate your comments and feedback as an important source of improving Instant Medical History, and thank you in advance for suggestions.

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<sup>1</sup> Bachman's Law – "hand the patient a copy of the visit note at the end of the visit" from Garte, Richard, Electronic Health Records - Understanding and Using Computerized Medical Records, 2006, Pearson-Prentice Hall, New Jersey, page 417.