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Introduction
As a clinical software system, Instant Medical History manages patient medical histories. For more information on Instant Medical History visit our website http://emr.healthpointmedicalgroup.com

Objectives and Summaries
This manual contains objectives which provide you with overall goals that you will achieve by the end of this training. This manual contains a summary for your review at the end of each lesson.

Special Symbols
Throughout this manual symbols will highlight areas that require additional attention.

- **NOTE** Indicates guidance information that expounds upon the provided information.
- **TIP** Indicates supplemental help to the supplied information.
- **STOP** Indicates important information that can include specific instructions that are required.
Lesson One: Instant Medical History

Objectives:
By the completion of this chapter, you will be able to:

- Successfully access Instant Medical History
- Retrieve the Instant Medical History note
- Run Unsigned Progress Note report
Access Standards

HealthPoint Medical Group and all our members have a responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of employment or assignment you will come into contact with confidential patient information. The following access standards will be followed:

- Only authorized persons will be granted access. This access will be appropriate to the job role.
- Only authorized persons may enter and view data.
- Passwords and system IDs will not be shared. Practice Partner keeps an audit trail of all entries and can generate reports of a user's access and activity within the system.
- Physical security of the workstations and files will be maintained.
Instant Medical History

The patients will access Instant Medical History from the Physicians tab on the Health Point Medical Group website.

Once the patient has searched and found a physician, they will be presented with the option to complete an online patient health questionnaire. Only those physicians who are at sites that are live with the EMR will have the ability to complete the online interview.
Once the patient has selected to complete the electronic form, the first screen will be the disclaimer screen. After reading the disclaimer, the patient selects “OK” to begin.

The patient then enters their home/primary phone number, and date of appointment for system verification.
If the patient is not active or does not have an upcoming appointment they will not have a match and will be prompted to contact the physician office.

The questionnaire will be available for completion beginning 30 days prior to their appointment and up to 1 day following the actual appointment day.

In the event of a duplicate or patient with the same number and date of birth, the system will request the patient’s first name to further validate the patient’s information.
Once the system verifies the patient, it will display their information for review. The patient then selects “Next” to begin the questionnaire.

The patient will then proceed through a series of questions, inputting information and selecting “continue” to move to the next page.
Once completed, the system will then return the patient to the “patient forms” page on the HMG website.

The completed questionnaire is then moved electronically to the McKesson Practice Partner EMR where the provider will be prompted on their dashboard of its arrival. The “O” in the Note Status column indicates that the IMH document has been placed in the patient record as an open note.
As these are shared notes, they will not appear in the provider’s note review.

When accessing the patient chart and selecting the “note” icon, the provider will be prompted that a shared note exists for this patient. The provider then has the option to select to view the shared note or begin a new note. There can only be one shared note for each patient.

With the shared note displayed, the provider can then review, make changes, or add documentation in the same way they would work with any other progress note. The note is then completed and signed. This will allow for the content of the document (past, family, and social history) to update the appropriate areas of the patient record.
Unsaved Progress Notes Report

The purpose of this report is to provide a task list that can be used to find, review, and sign progress notes that are in an open or shared note status. It is suggested that this report be run often so as to ensure that all notes are signed off within a reasonable time of seeing the patient.

From the Task list locate and select Unsaved Progress Notes.
The report can be run by provider with a specific date range. If left blank, the report will run for all providers. This is not recommended as it can cause the system to run slowly during peak times.

The provider can then work from the task list, accessing the patient notes by double-clicking the selection. This will take them into the chart and to the actual note for review and signature.
Workflow

Upon completion of the IMH questionnaire, the provider will access the document as a shared note prior to beginning the encounter note. The provider reviews and signs the document and then starts a new note for the day’s office visit. This is important to ensure the information from the IMH document updates the patient’s chart.

Once updated, the pertinent data elements (ex: past, family, social history) will be made available as part of the templates used during the patient encounter.