SIMPLICITY™ CONCISE PHYSICIAN MANUAL

"If you can use paper charts,
you can use Simplicity™ just as efficiently,
if not MORE efficiently"

Joint marketing

Simplicity ™ Concise Physician Manual

Turn computer on

Click on Simplicity

Log in

1. Type in user name
2. Type in password
3. Submit

A) Patient Queue

1. Open patient queue
2. Patients will be listed for the day
3. Evaluate codes:
    a. Room Number (Room #)
    b. Waiting Room (WR)
    c. Not Hear Yet (NHY)
4. Choose patient: click on folder icon

B) Patient's Chart

1. Evaluate: DOB; Allergies to Medication, Current Medications
2. Last office visit: view previous progress notes
3. Test tracking: review pending tests and results
4. Review of Systems: review, date and sign (customizable)
5. History and Physical: choose 1 of the 4 ways to record information (customizable)
    a. Write
    b. Type
    c. Handwriting recognition
    d. Digital template/ Digital progress note (customizable)

* Do steps i to iv only if you are using digital progress note *

i. Click on referral letters, choose who you want to send letter to:
   1. physician
   2. patient
   3. other
ii. Click on 'appropriate abnormalities' boxes (blue)
iii. Click on 'normals' boxes (black)
iv. Click save
   1. template note visible:
      a. yellow: abnormalities
      b. black: normal

6. <u>File Cabinets</u>:

   * where results/correspondences reside. 'Drawers' are customizable. *

   a. Click on '<u>drawer</u>'
      i. documents listed
      ii. choose document to review
      iii. review, date, sign and save/ or print page(s)
   b. <u>Orange</u>: empty cabinet
   c. <u>Red</u>: information new within 2 weeks or less
   d. <u>Green</u>: information present for greater than 2 weeks
7. <u>Prescription</u>: can be faxed; emailed; printed
   a. Click 'Add Prescription' (Rx)
   b. Choose medicine from customized list
      i. insert into prescription
   c. Write in medicine on prescription pad (if not in list)
   d. Epocrates available (located at bottom of the screen "panel")
   e. Calculator available (located at bottom of the screen "panel")
8. <u>Order future Tests</u>:
   a. To order test, click on name of tests, listed at the end of the Progress Note to the left of scheduling the next appointment. (It will automatically keep track of the different stages of the test/test results in the test tracking list.)

b. To view, click on the Test Tracking Center on the Welcome page in the Patient Check In area or when in the patient's chart, at the top of the Progress Note, all tests pending are listed after "current medications." When viewing via the Progress Note, click on the name of the test to update test tracking and click on "the number of pages" on the right to view the results.

c. The tests are listed chronologically from oldest to newest at the Test Tracking Center, but you can click on patient name heading and it will rearrange alphabetically, click on test name and it will rearrange by the name of the test, click on setup by and it will rearrange alphabetically by the name of the person who set up the test.

d. Click on edit to show all the fields of test tracking – all date edits are available by a drop down calendar. Click on edit, pick your date off the calendar then proceed down the list and update test when all changes are made. The fields consist of:

    1. name of patient
    2. test name
    3. ordering doctor
    4. test status
    5. comments
    6. date ordered
    7. setup by
    8. setup date
    9. test date
    10. test site name
    11. test done date
    12. estimated result date
    13. result date
    14. ordering doctor read date
    15. patient notified date
    16. final disposition date
    17. canceled date
    18. canceled by

9. Follow up appointment: write in estimate of desired return date (secretary will schedule specific appointment)
10. Coding for E/M (office visits):
    a. Click CPT/ICD coding (located on the right side, after the Progress Note (H&P))
    b. click on guide
    c. choose appropriate code based on:
        i. complexity of history
        ii. complexity of physical examination
        iii. complexity of overall case
    d. 'Link': visit code with diagnosis
    e. 'Link': procedure code with appropriate ICD
        i. for a procedure i.e.: audiometric studies or flexible fiberoptic scoping
            1. Click the procedure
            2. Link to one of the selected ICD approved by insurance companies (list of ICD customizable)
    f. Click submit only after All E/M and procedures are coded
11. Save:
    a. always click "SAVE" before clicking home (symbol of a house)
        i. this temporarily closes the file so you can move on to other patients
12. Finalize: when finished with patient chart
    a. Can amend a patient's chart within set time period after Finalizing
    b. Time period is customizable: limits length of time to amend chart
13. You can still order a test in "Test Tracking" after you have Finalized"
    a. Find the chart
    b. Scroll to the bottom of the Progress Note
    c. Order the test and click: "Order Test" at the end of the page

C) Messages

* Can be viewed in 'Patient Queue' or in 'Message Queue'

1. Method using ‘Patient Queue’ (see staff manual)
    a. The staff will take the message and perform paragraph D in the Concise Staff Manual
    b. Word ‘Message’ will be displayed (where would normally find Room #)
    c. Click on the “folder” symbol
    d. Go to the message written on the Progress Note by the staff. Enter your reply like you would in entering a Progress Note
    e. Click save and close the file by clicking on the Home icon. Do not Finalize.
    f. Go back to Patient Queue, click edit, type in “reply,” click save. This will send the reply to the staff, for the staff to take care of
2. ‘Message Queue’ – another way to take care of message from patients
    a. Find patient through ‘search’
    b. Click ‘add message’
    c. Type/write the message
    d. Send message to the doctor
    e. Click submit
    f. Close page
    g. Go to the ‘Home’ icon
    h. The doctor will notice there is a message at the message queue
    i. Click on ‘message’ to read at message queue
    j. Read and click ‘add reply’
    k. Write/type the reply
    l. Click submit
    m. The staff will notice the reply: they open, read the reply, address it; and store the message.
3. Without going through the staff, the doctor can document message for a specific patient by creating a new visit in the chart
    a. Find patient through ‘search’
    b. Click new progress note
    c. Access patient history in order to answer message by going back to previous notes
    d. Type/write the message on the progress sheet and document the action taken

    e. If for prescription re-fill, can write/type prescription and fax/email/print prescription
    f. Finalize chart and this will become the most recent encounter with patient, a phone encounter.

D) Dictation

1. Classic way
    a. Dictate into voice recorder
    b. Secretary type letter
        i. Send out to referral source
        ii. Input into Simplicity file cabinet under 'Doctor'
2. Partial Form Template
    a. Dictate into voice recorder
        i. Pertinent findings/ pathology/ diagnosis/ treatment
        ii. Remainder of examination indicated as 'normal'
    b. Secretary type letter- directly into Simplicity
    c. Physician can edit report on Simplicity
    d. Send Report
3. Digital Template

    * No dictation needed; No secretary needed*
    a. Information already in Simplicity, need to click whether you want to send letter to Patient, Doctor or Other.
        i. Pertinent findings listed
        ii. Remainder of examination listed as 'normal'
    b. Physician can edit report on Simplicity
    c. Send Report
4. Optional Voice Recognition (work in progress)

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