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<CodingSystem>ICD9</CodingS

> PROVIDING PATIENTS IN AMBULATORY CARE SETTINGS WITH A CLINICAL SUMMARY OF THE OFFICE VISIT

A core meaningful use requirement for patient and family engagement is to provide patients with a clinical summary of the office visit. This summary supports continuity of patient care by providing patients and their families with relevant and actionable information. Also, it can reduce calls and extra work for you.

It is designed to be given to patients at the end of an office medical visit as a summary of what happened during the visit and to provide information and instructions to guide their next healthcare steps. An office visit is any billable visit, including concurrent care or transfer of care visits, consultant visits, or prolonged physician service without direct (face-to-face) patient contact, such as telehealth.

Although the clinical summary was designed to be provided to the patient at the conclusion of the office visit, Stage 1 of meaningful use requires it to be provided to the patient within 3 days. Stage 2 requires it to be provided to the patient within 1 business day. You may deliver the summary through an electronic health record (EHR) patient portal, secure e-mail, electronic media (such as a CD or USB flash drive), or as a printed copy. If the patient requests it, the healthcare provider *must* provide a printed copy.

Importance of the Printed Copy

During recent conversations with a large integrated health system about "going green" and reducing the use of paper in their facilities, the consensus was that the clinical summary is the one paper document they will definitely continue using, as it is an invaluable communication tool.

Information in the Clinical Summary

The clinical summary provides an opportunity for the clinician to verbally review the information with the patient, reinforce the importance of the summary itself, and explain key pieces of information, such as special medication instructions or necessary follow-up care. Don't underestimate the importance of reviewing the summary with patients, as they are more likely to see the value of the summary if it is acknowledged and addressed during the office visit.

Core information in the clinical summary includes:

Patient name	Problem list/current conditions*
Provider name	Medication list*
Date and location of visit	Medication allergies*
Reason(s) for visit	Diagnostic test/lab results*
Vitals (temperature, blood pressure, height, weight, BMI, exercise status in minutes/week)	Patient instructions
Smoking status**	Recommended patient decision aids**
Demographic information**	Care plan field**

* = required for Stage 1 of meaningful use.

** = required for Stage 2 of meaningful use.

Additional information in the summary may include:

Referrals	Appointments/testing already scheduled
Problem history	Medication instructions
Topics covered during the visit	Personalized instructions/notes
Immunizations or medications administered during visit	Links to (or copies of) relevant educational information
When next appointment is recommended	Care gaps
Other appointments/testing that patient needs to schedule	Preventive screenings due
	Personalized message/closing

Healthcare providers may withhold certain information if it is believed that such information would cause substantial harm to the patient or another individual.

Tips for a Successful Clinical Summary

- Use formatting, such as bold type, to highlight important health information.
- Highlight categories or major sections of information, such as health reminders, referrals, procedures, and medications.
- Display actionable information as well as the clinic phone number prominently and clearly.
- Use plain language and define or explain terms that may be difficult for some patients to understand.
- Keep the length to one or two pages.
- Consider the needs of the patient population when deciding what information to include. If possible, involve patients in the development and design to help ensure the desired impact.
- Tailor the content to meet patient needs and preferences. Also, ask for patient feedback during rollout to help ensure that the information/messages are easily understood.

Clinical Summary Example

Jill Ellis (03000144)

After Visit Summary

This document contains confidential information about your health and care. It is provided directly to you for your personal, private use only.

Visit Information

Appointment Information

Date	Time	Department	Provider
08/22/2007	1:28 PM	NGT FAMILY PRACTICE	PAULA SMITH, MD

If you have questions or need further information, call this department at 206-527-7100 or send a secure message to your provider.

Vitals

Blood Pressure	Pulse	Temperature	Height	Weight
160/90	80	98 °F (36.7 °C)	5' 5" (1.65 m)	160 lbs (72.58 kg)

Body Mass Index
26.63

Reason for Visit Diabetes
Blood Pressure

Diagnoses DM W/O COMPLI
FINGER SPRAIN
NEED FOR VACC
BIRTH CONTROL

Patient Instructions Diabetes Cond

Learn the basic
your blood gluc
information abo
diabetes.

Check out the
https://member

Home treatmen
https://member

Health Reminders

This section shows your upcoming office visits and recommended preventative care measures. If you
contact your primary care provider.

Appointments

Date & Time	Provider	Department
10/2/2007 9:00 AM	Barbara Detering, Physician	Brn Family Practice
11/2/2007 11:00 AM	Barbara Detering, Physician	Brn Family Practice

For Health Improvement

Name	Due Date
ANNUAL LIPID PROFILE FOR DIABETICS	**10/20/1987**
HIGH RISK: 1 YEAR COLONOSCOPY	**10/20/1970**
PAP TEST	07/18/2010

Upcoming Lab Tests

This section lists all lab tests you need to do after today. This may include tests ordered at previous v
Health medical center for these lab tests. For orders with an "available" date, go on that date or as so
date.

Recurring Orders

Order	Provider	Ordered	Inte
HEMOGLOBIN A1C [83036.001]	DIMER, JANE ANN S	7/11/2007	Eve
LIPOPROTEIN PANEL (GHC) [80061.002]	AFFOLTER, WILLIAM T	8/15/2007	Eve

Instructions

Guidelines to Follow
This laboratory test requires fasting prior to specimen collection. For fasting blo
you must not eat or drink anything, except water, after 10:00 P.M. the night befo
the lab. This includes gum, candy, tea, and coffee.

The Office of the National Coordinator for
Health Information Technology