



Providing Patients in Ambulatory Care Settings with a Clinical Summary of the Office Visit

FACT SHEET

Provided By:

The National Learning Consortium (NLC)

Developed By:

Health Information Technology Research Center (HITRC)

The material in this document was developed by Regional Extension Center staff in the performance of technical support and EHR implementation. The information in this document is not intended to serve as legal advice nor should it substitute for legal counsel. Users are encouraged to seek additional detailed technical guidance to supplement the information contained within. The REC staff developed these materials based on the technology and law that were in place at the time this document was developed. Therefore, advances in technology and/or changes to the law subsequent to that date may not have been incorporated into this material.

NATIONAL LEARNING CONSORTIUM

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and tools designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs ([REC](#), [Beacon](#), [State HIE](#)) and through the [Health Information Technology Research Center \(HITRC\)](#) Communities of Practice (CoPs).

The following resource is an example of a tool used in the field today that is recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

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.

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. Although the clinical summary should be available electronically, there is real value in providing the patient with a printed copy as a way to communicate important information at the end of the office visit.

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
- Provider name
- Date and location of visit
- Reason(s) for visit
- Vitals (temperature, blood pressure, height, weight, BMI, exercise status in minutes/week)
- Problem list/current conditions*
- Medication list*
- Medication allergies*
- Diagnostic test/lab results*

- Patient instructions

**Required for Stage 1 of Meaningful Use*

Additional information in the summary may include:

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

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	NOT FAMILY PRACTICE	PAULA SMITH, MD
If you have questions or need further information, call this department at 208-527-7100 or send a secure message to your provider.				

Vitals	Blood Pressure	Pulse	Temperature	Height	Weight
	100/60	80	98.7° (36.7° C)	5' 0" (1.52 m)	160 lbs (72.56 kg)

Body Mass Index: 28.63

Health Reminders			
This section shows your upcoming office visits and recommended preventative care measures. If you contact your primary care provider.			
Reason for Visit	Diabetes Blood Pressure	Appointments	Date & Time
			10/22/2007 9:00 AM
			11/26/2007 11:30 AM
		Provider	Barbara Cabeling, Physician
			Barbara Lueking, Physician
		Department	Sim Family Practice
			Sim Family Practice
Diagnoses	DM W/O COMPLI FINGER SPRAIN NEED FOR VACC BIRTH CONTROL		
For Health Improvement	Name	Date/Date	
	ANNUAL LIPO PROFILE FOR DIABETICS	10/20/1057	
	HIGH RISK: 1 YEAR COLONOSCOPY	10/20/1070	
	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 Health medical center for these lab tests. For orders with an "available" date, go on that date or as a date.				
Recurring Orders	Date	Provider	Ordered	Lab
	HEMOGLOBIN A1C (S3058.001)	DMER, JANE ANN S	7/11/2007	Ev
	LIPOPROTEIN PANEL (GHC) (S3051.002)	AFFOLTER, WILLIAM T	8/15/2007	Ev
	Instructions			
Outlines to Follow This laboratory test requires fasting prior to specimen collection. For fasting you must not eat or drink anything, except water, after 10:00 P.M. the night before the lab. This includes gum, candy, tea, and coffee.				

Patient Instructions
 Diabetes Conc
 Learn the basi
 your blood glu
 information ab
 diabetes.
 Check out the
<https://membe>
 Home treatme
<https://membe>

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.