Stage 2
Eligible Professional
Meaningful Use Core Measures
Measure 8 of 17

Date issued: October, 2012

Clinical Summaries	
Objective	Provide clinical summaries for patients for each office visit.
Measure	Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.
Exclusion	Any EP who has no office visits during the EHR reporting period.

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Definition of Terms

Clinical Summary – An after-visit summary that provides a patient with relevant and actionable information and instructions containing in no particular order:

- Patient name.
- Provider's name and office contact information.
- Date and location of the visit.
- Reason for the office visit.
- Current problem list.
- Current medication list.
- Current medication allergy list.
- Procedures performed during the visit.
- Immunizations or medications administered during the visit.
- Vital signs taken during the visit (or other recent vital signs).
- Laboratory test results.
- List of diagnostic tests pending.
- Clinical instructions.
- Future appointments.
- Referrals to other providers.
- Future scheduled tests.
- Demographic information maintained within certified electronic health record technology (CEHRT) (sex, race, ethnicity, date of birth, preferred language).
- Smoking status.
- Care plan field(s), including goals and instructions.
- Recommended patient decision aids (if applicable to the visit).

Office Visit – Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include: (1) Concurrent care or transfer of care visits,

(2) Consultant visits, or (3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.

Attestation Requirements

DENOMINATOR/ NUMERATOR/THRESHOLD/EXCLUSION

- DENOMINATOR: Number of office visits conducted by the EP during the EHR reporting period.
- NUMERATOR: Number of office visits in the denominator where the patient or a patient-authorized representative is provided a clinical summary of their visit within one (1) business day.
- THRESHOLD: The resulting percentage must be more than 50 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who has no office visits during the EHR reporting period.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified electronic health record technology (CEHRT).
- The provision of the clinical summary is limited to the information contained within CEHRT.
- The clinical summary can be provided through a PHR, patient portal on the web site, secure e-mail, electronic media such as CD or USB fob, or printed copy. If the EP chooses an electronic media, they would be required to provide the patient a paper copy upon request. They may also default to providing paper copies, in which case an electronic form of the EP's choice would need to be provided upon request.
- If an EP believes that substantial harm may arise from the disclosure of particular information, an EP may choose to withhold that particular information from the clinical summary.
- Providers may not charge patients a fee to provide this information.
- When a patient visit lasts several days or a patient is seen by multiple EPs, a single clinical summary at the end of the visit should be counted only once in both the numerator and denominator.
- In the event that a clinical summary is offered to and subsequently declined by the patient, that patient may still be included in the numerator of the measure.
- In circumstances where there is no information available to populate one or more of the fields previously listed, either because the EP can be excluded from recording such information (for example, vital signs) or because there is no information to record (for example, no medication allergies or laboratory tests), an indication that the information is not available in the clinical summary would meet the measure of this objective.

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§170. 170.314(e)(2) Clinical summaries (Ambulatory setting only)	(i) Create - Enable a user to create a clinical summary for a patient in human readable format and formatted according to the standards adopted at §170.205(a)(3). (ii) Customization - Enable a user to customize the data included in the clinical summary. (iii) Minimum data from which to select - EHR technology must permit a user to select, at a minimum, the following data when creating a clinical summary: • Common MU Data Set (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set). • The provider's name and office contact information; date and location of visit; reason for visit; immunizations and/or medications administered during the visit; diagnostic tests pending; clinical instructions; future appointments; referrals to other providers; future scheduled tests; and recommended patient decision aids.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria	
§170.205(a)(3) Clinical summary	HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, (incorporated by reference in § 170.299). The use of the "unstructured document" document level template is prohibited.