Eligible Professional Meaningful Use Core Measures Measure 12 of 13

Stage 1 (2014 Definition)
Last updated: May 2014

Clinical Summaries	
Objective	Provide clinical summaries for patients for each office visit.
Measure	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
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 the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.

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

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of office visits by the EP during the EHR reporting period.
- NUMERATOR: Number of office visits in the denominator for which the patient is provided a clinical summary within three business days.
- EXCLUSION: EPs who have no office visits during the EHR reporting period would be excluded from this requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

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 EHR technology.
- The provision of the clinical summary is limited to the information contained within certified EHR technology.
- 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.
- 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 should not charge patients a fee to provide this information.
- When a patient visit lasts several days and the patient is seen by multiple EPs, a single clinical summary at the end of the visit can be used to meet the meaningful use objective for "provide clinical summaries for patients after each office visit.
- The EP must include all of the items listed under "Clinical Summary" in the above "Definition of Terms" section that can be populated into the clinical summary by certified EHR technology. If the EP's certified EHR technology cannot populate all of these fields, then at a minimum the EP must provide in a clinical summary the data elements for which all EHR technology is certified for the purposes of this program (according to §170.304(h)):
    - Problem List
    - Diagnostic Test Results
    - Medication List
    - Medication Allergy List

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*	
§170.314(e)(2) clinical summary	(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: (A) Common MU Data Set** (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set) (B) 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.

*Additional certification criteria may apply. Review the ONC 2014 Edition EHR Certification Criteria Grid Mapped to Meaningful Use Stage 1 for more information.

Standards Criteria*	
§170.205(a)(3)	HL7 Implementation Guide for CDA Release 2: IHE Health Story Consolidation. The use of the "unstructured document" document-level template is prohibited.

*Additional standards criteria may apply. Review the ONC 2014 Edition EHR Certification Criteria Grid Mapped to Meaningful Use Stage 1 for more information.