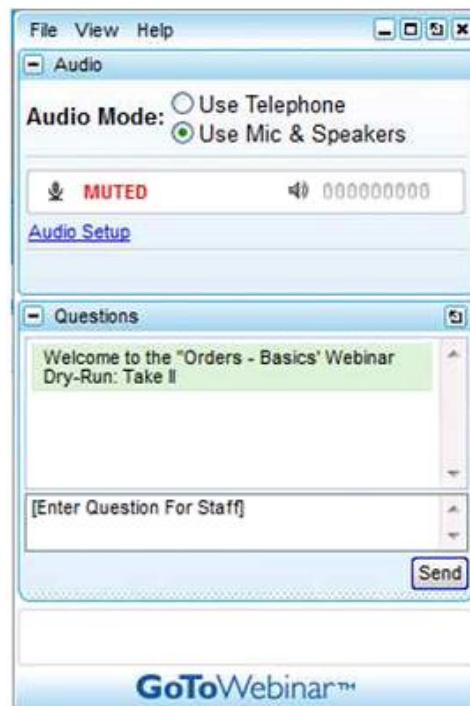


# Clinical Summary

Empowering Extraordinary Patient Care

## All phone lines have been placed on mute To ask Questions during the Webcast

Please enter them in the Questions section of your Webcast Control box



# Introduction



## Stacey Murdic

- Consultant with Galen Healthcare Solutions
  - Over 10 years in healthcare including 1 year of EHR experience
  - Galen Enterprise EHR Certified



## Crystal Vervaecke

- Consultant with Galen Healthcare Solutions
  - Over 20 years in healthcare including 9 years of EHR experience
  - Galen Enterprise EHR Certified

- **Agenda**
  - Overview/Definition
  - Options
  - Considerations
  - Setup

# Poll Question #1

- **Does Your organization currently utilize or plan on utilizing clinical summaries?**

**Reminder:** *Once you have finished answering the poll question you will need to close the poll window.*

## Definition of a Clinical Summary

*The Meaningful Use Rules define a Clinical Summary as an after-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to, the following:*

- *The patient name*
- *The provider's office contact information*
- *The date and location of visit*
- *An updated medication list and summary of current medications*
- *Updated vitals*
- *The reason or reasons 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*
- *A summary of topics covered or considered during visit*
- *The time and location of next appointment or testing if scheduled or a recommended appointment time if not scheduled*
- *A list of other appointments and testing the patient needs to schedule with contact information*
- *Laboratory and other diagnostic test orders*
- *Test or laboratory results (if received before 24 hours after visit)*
- *Symptoms*

## Meaningful Use Final Rule:

**Core Objective States that: “Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.”**

- Calculation:
  - Numerator: The number of patients in the denominator who are provided a clinical summary of their visit within three business days.
  - Denominator: The number of unique patients seen by an eligible professional (EP) for an office visit during the EHR reporting period.
- Exclusions: Any eligible professional (EP) who have no office visits during the EHR reporting period.
- Clinical Summaries are generated only for **Arrived** appointments

# Options

- Pre-delivered
  - RTF
  - CED
- Client Driven
  - V10 or v11 Structured Note Output



# What are the differences between using RTF & CED versus Structured Note Output?

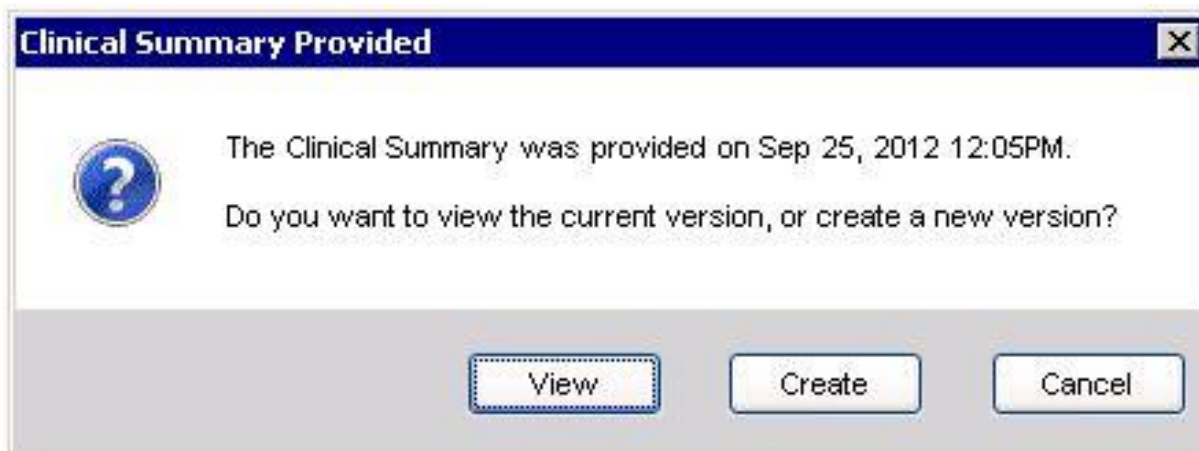
## RTF & CED

- Separate from a structured note
- Standardized layout and **limited customization**
- Can be generated from Daily Schedule and/or Encounter Summary
  - Benefit from E/S is to set up as part of workflow, no extra clicks

## Structured Note Output

- Cannot generate from Daily Schedule or Encounter Summary
- Can customize what sections are included as in a typical note output based upon the visit note
- Limitations:
  - Must create note to generate – possibly more than just one click or no click
  - Abide to the section settings and behavior in the note template

## V11.2.3 HF 5



# RTF

## – **Structure**

- Pre-delivered clinical summary designed to be brief and simple
- Less details
- Sections appear “as needed” – when data exists

## – **Patient and Site Details**

- Patient Details: Displays Patient data - Name, phone, address, appointment date, MRN, DOB, Language
- Document/Provider Details: Doc Name, Site, Provider Name and address

## – **Problems**

- Only Assessed problems will display
- Does not show all active problems
- Does not show resolved problems

## – **Reason for Visit**

- Chief Complaint displays in this section
- Additional comments can be pulled in from a note associated with encounter

# RTF continued:

## – Treatment Plan

- Medication Changes: Displays a bulleted list of any medications that were added, renewed, or discontinued during the current encounter.
  - Order D/C are shown and have [STOP] suffix
  - Newly Prescribed Meds show with [START] suffix
- Labs/Procedures:
  - Orders display – just the name; no date displays
- Instructions:
  - Orders display – just the name; no date displays; no instruction details
- Follow-up/Referrals:
  - Orders display – just the name; no date displays

## – Current Medications

- D/C Meds do not appear
- Active Meds appear
- Newly prescribed meds are also listed here

## – Allergies

- Active allergies are listed

# RTF continued:

- **Results**
  - Vitals
    - Vitals collected for the encounter
  - Results
    - Results display with the name and result, no date
    - Set preference to determine how many days prior to pull in
- **Future Appointments**
  - Displays future appointments with Date, Time, and Provider
- **Additional Notes**
  - When v10 or v11 structured note is done with visit - the ability exists to include free text notes into the Reason for Visit and Treatment Plan sections

# RTF Example

## Clinical Summary-RTF

Date of Service: 12/05/2011

MRN: 700076162

ALAN TEST  
NEED ADDRESS  
SUITE 109  
SAN DIEGO,CA 92130

---

## Clinical Summary

### Patient

**Name :** ALAN TEST  
**Phone :** (858) 234-9812  
**Address:** NEED ADDRESS  
SUITE 109  
SAN DIEGO, CA 92130

**Appointment Date:** 12/05/2011 10:30:00 AM  
**MRN :** 700076162  
**Date Of Birth :** 02/23/1940  
**Language:** ENGLISH

### Assessed Problems

- Hemochromatosis

# CED

## – Structure

- Pre-delivered clinical summary designed to be more robust
- More detailed
- Sections consistently appear
- The CED is a summary of the entire patient record, and is not based solely on the current encounter.

## – Patient and Site Details

- Patient Details: Displays Patient data - Name, phone, address, appointment date, MRN, DoB, Language, Marital Status, gender
- Healthcare Providers: PCP and Pharmacy
- Patient Contacts: Emergency contact and personal/guarantor contact(s)
- Document/Provider Details: EHR Version, encounter date, site, provider name and address

## – Problems

- Shows the list of active problems
- Assessed problems show as "last assessed" in the active problem list

# CED continued:

## – Reason for Visit

- Reason for Visit: Displays reason for visit from v11 note section accumulator free text comments
- Chief Complaint: Chief Complaint is not added as a bullet point, however the Chief Complaint note section free text comments are cited in

## – Treatment Plan

### ▪ Medication Changes

- Bulleted list of medications that were added, renewed, or D/C during the current encounter
- Existing medications that were unchanged and Record D/C are not listed.

### ▪ Orders (Labs/Procedures/Imaging, Instructions, Follow-ups/Referrals, and Supplies)

- All orders ordered during the encounter will display as bulleted list with the “To Be Done” date displaying with the order.
- Orders completed in this encounter will display the Done date .



# CED continued:

## – Medications

- Displays a bulleted list of all current active medications for the patient.
- Will display "No Active Medications." if no medications exist on the chart
- Includes active medications with the Record w/o Ordering flag selected.

## – Historical and Other Elements

- **Allergies and Adverse Reactions:** Displays allergies
- **HPI:** pulls in HPI section from v10/v11 structured note tied to the same encounter; otherwise this states that one was not given
- **Past Medical History:** Displays any past medical history otherwise states none given
- **Procedures:** Displays surgery history, procedure date, date completed, and status
- **Family History:** Displays family history otherwise states none given
- **Social History:** Displays social history otherwise states none given
- **Immunizations:** Displays immunizations and date administered (approximate dates don't accurately display)
- **Directives:** Displays directives, otherwise states one was not given
- **Reason for Referral:** Displays a reason for referral otherwise states one was not given

# CED continued:

- **Results**
  - Vitals
    - Vitals collected for the encounter display, as well as the ability to pull in certain number of past days of vital data
  - Results
    - Results display with the name and result, no date
    - Set preference to determine how many days prior to pull in
- **Future Appointments**
  - Displays the Appointment Type, Provider, Appointment Status, Time, and Date in the Encounters section
- **Additional Notes**
  - When v10 or v11 structured note is done with visit - the ability exists to include free text notes into the Reason for Visit and Treatment Plan sections

# CED Example

## Clinical Summary-CED

Date of Service: 12/05/2011

MRN: 700795760

ALAN5 TEST  
 2745 WHEATSTONE ST  
 #55  
 SAN DIEGO, CA 92111

## San Diego Family Practice Clinic

Patient Detail for ALAN5 TEST		MRN: 700795760	
Contact	ALAN5 TEST	Date Of Birth	September 22, 1987
Address	2745 WHEATSTONE ST #55 SAN DIEGO, CA 92111	Gender	Male
		Marital Status	
	(858)993-9999 (Home phone)		
		Language	

### Reason for Referral

No Reason for Referral was given.

### History of Present Illness

No HPI available.

### Problems

- ◆ Acute Bronchitis Last Assessed: 12/05/2011 4:10:10 PM (466.0); (Active)
- ◆ Narcolepsy (347.00); (Active)
- ◆ Need For Vaccination Hepatitis A (V05.3); (Active)

# V10 or v11 Structured Note Output

## – Structure

- Created and customized by client
- Takes Note Output with its document type marked as a clinical summary
- Sections defined by the note output

## – Sections

- Clients can choose which sections to display based upon their setup for the v10 or v11 structured note
- For v10 note: A separate note needs to be set up for a patient summary
- For v11 note: A Pt. Summary note output, for example, can be added to any v11 note input template.

# V11 Note Example

## Visit Summary

Date of Service: 12/05/2011

MRN: 700407039

ALAN2 TEST  
\*\*\*NEEDS NEW ADDRESS\*\*\*  
\*\*\*NEEDS NEW ADDRESS\*\*\*

---

## Plan

### Health Maintenance (V20.2)

1. You need to quit smoking. Requested for: 05Dec2011

### Urinary Tract Infection (599.0)

2. Urinalysis, Dipstick only Done: 05Dec2011 03:58PM
3. Follow-up visit in 2 weeks Outpatient Follow-up Requested for: 05Dec2011

### Unlinked

4. Sulfamethoxazole-Trimethoprim 400-80 MG Oral Tablet, TAKE 1 TABLET DAILY; Therapy: 05Dec2011 to (Evaluate:12Dec2011); Last Rx:05Dec2011

## Allergies

1. Bactrim SUSP
2. Penicillins

## Poll Question #2

- **How do you distribute or how do you plan on distributing the clinical summaries?**
  - Physician
  - Nurse
  - Check-Out Desk
  - Mailed to the patient
  - Electronically to the HIE or Portal

**Reminder:** *Once you have finished answering the poll question you will need to close the poll window.*

# Customizing the Clinical Summary

<http://blog.galenhealthcare.com/2012/09/19/customizing-the-clinical-summary/>

# Setup

## Preferences –

*\*\* Note – for the items below that can be set at User level – be sure to determine if the user should be able to override the preference.*

### General:

**Allow Clinical Summary When Note UnFinal** – Set this to Yes at the ENT level to allow for unfinalized notes linked to the encounter to be provided as Clinical Summary

**CS Default Reason for Visit Note Section** – Pulls comments from specified section of the v11 note tied to encounter

- Reason for Visit
- Chief Complaint
- None

Preference can be set at Ent/Org/User – Allow User level override

CSDefaultReasonForVisitNoteSection	Sets the default structured note section to pull comments into Clinic...	None
CSDefaultTreatmentPlanNoteSection	Sets the default structured note section to pull comments into Clinic...	Reason for Visit
CSIncludeProblemSection	Includes a Problem section in the Visit Summary-CED	Chief Complaint
DaysBeforeInstructionExpirationDateToConsider ...	Days Before Instruction Expiration Date To Consider Near Due	None



# Setup continued

**CS Default Treatment Plan Note Section** – Pulls comments from specified section of the v11 note tied to encounter

- Order/Plan
- Discussion Summary
- Orders (v10 Note only)
- None

Preference can be set at Ent/Org/User – Allow User level override

CSDefaultTreatmentPlanNoteSection	Sets the default structured note section to pull comments into Clinic...	Plan
CSIncludeProblemSection	Includes a Problem section in the Visit Summary-CED	Plan
DaysBeforeInstructionExpirationDateToConsider ...	Days Before Instruction Expiration Date To Consider Near Due	Discussion Summary
DaysBeforeScheduledOrderExpirationDateToCon...	Days Before Scheduled Order Expiration Date To Consider Near Due	Orders (v10 Note only)
DefaultClinicalSummaryDocument	Sets the default Clinical Summary document to be used when visiti...	None

# Setup continued

**CS Include Problem Section** – Controls if the Problem section will appear on the Clinical Summary (CED Only)

Y or N

Preference can be set at Ent/Org/ only

CSIncludeProblemSection	Includes a Problem section in the Visit Summary-CED	N	<input type="checkbox"/>
DaysBeforeInstructionExpirationDateToConsider...	Days Before Instruction Expiration Date To Consider Near Due	Y	<input checked="" type="checkbox"/>
DaysBeforeScheduledOrderExpirationDateToCon...	Days Before Scheduled Order Expiration Date To Consider Near Due	N	<input checked="" type="checkbox"/>

**Default Clinical Summary Document** – which Clinical Summary to use

CED or RTF

Ent/Org level only

**Enable CS on Schedule Daily** – determine if the “CS” column for is on schedule

Y or N

Ent/Org/User – allow User level override

**Enable CS on Schedule Provider** - determine if the “CS” column for is on schedule

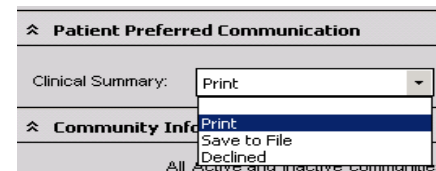
Y or N

Ent/Org/User – allow User level override

\$	N	TC	CS	A	Pt
		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Arr	
		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Arr	
		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Arr	
		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Arr	
		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Arr	

# Setup continued

- **Encounter Summary: Always Provide Clinical Summary** – allows the clinical summary to be created from the encounter summary once data is committed
  - Y – When data is committed, the Provide Clinical Summary is checked. The Clinical Summary is generated once the user hits Save and Continue
  - N – When data is committed, the Provide Clinical Summary is enabled but not checked. The user must manually check the box, then hit Save and Continue to generate the clinical summary.
    - Disable – The user cannot generate a clinical summary from the encounter summary
    - Preference can be set at Ent/Org/User – recommend using “Disable” at the Enterprise level, then Y or N at User level depending on workflow decision
- **Pt Communication Clinical Summaries Editable** – determines if users can set the preferred communication for clinical summaries in the patient profile
  - Y or N
  - Preference can be set at Ent/Org Only



# Setup continued

- **Results:**
  - **Number of Days of Results to Include in Clinical Exchange Document**

(Preference can be set at Ent/Org - only)

    - Sets the CED/RTF number of days to include results
    - Numeric value
  - **Number of Days of Vital Signs to Include in Clinical Exchange Document**

(Preference can be set at Ent/Org - only)

    - Sets the CED number of days to include vitals
    - Numeric value
  - **Security**
    - Chart View and Chart Print
  - **Document Admin (headers)**
    - 1<sup>st</sup> Page Header – can avoid having a header on each page

# Demonstration of RTF Clinical Summary

# MU Reporting- Eligible Encounters

## Determining Eligible Encounter

1. Patient scheduled and arrived
2. Billing Provider (If no Billing Provider, go to Step 3)
3. Note Owner (If no Note Owner, go to Step 4)
4. Scheduling Provider
5. If EP not listed in Billing, Note Owner or Scheduling Provider. Appointment is excluded from all measures.

**\*\* Caution: Different Billing and Scheduling providers**

- **Unique patient:** Patient may only be counted once for reporting purposes, even if they make multiple visits during the EHR reporting period.
- **Unique Medication:** Accounts for each individual medication ordered during the reporting period
- **Unique Order:** Accounts for each instance of a medication order entered during the reporting period
- **Unique Patient Visits:** Accounts for all patient visits during the reporting period

# Considerations

- Who, what, when, where, and how?
  - *What type of Clinical Summary will you use?*
  - *Who will generate this Clinical Summary?*
  - *Where will this Clinical Summary be provided?*
  - *When will this clinical summary be generated?*
  - *How will you generate the clinical summary?*
- Users who generate
- Generate from Daily Schedule and/or Encounter Summary
- Where to generate: Auto-Print Defaults
- Headers – can be customized for Document
  - *Less of a header (Site/Org Logo and Date/Time) for RTF/CED*
  - *More of a header (Site/Org Logo, Date/Time, Patient Info, and Encounter) for v10/v11 Structured Note Output*

# Q&A

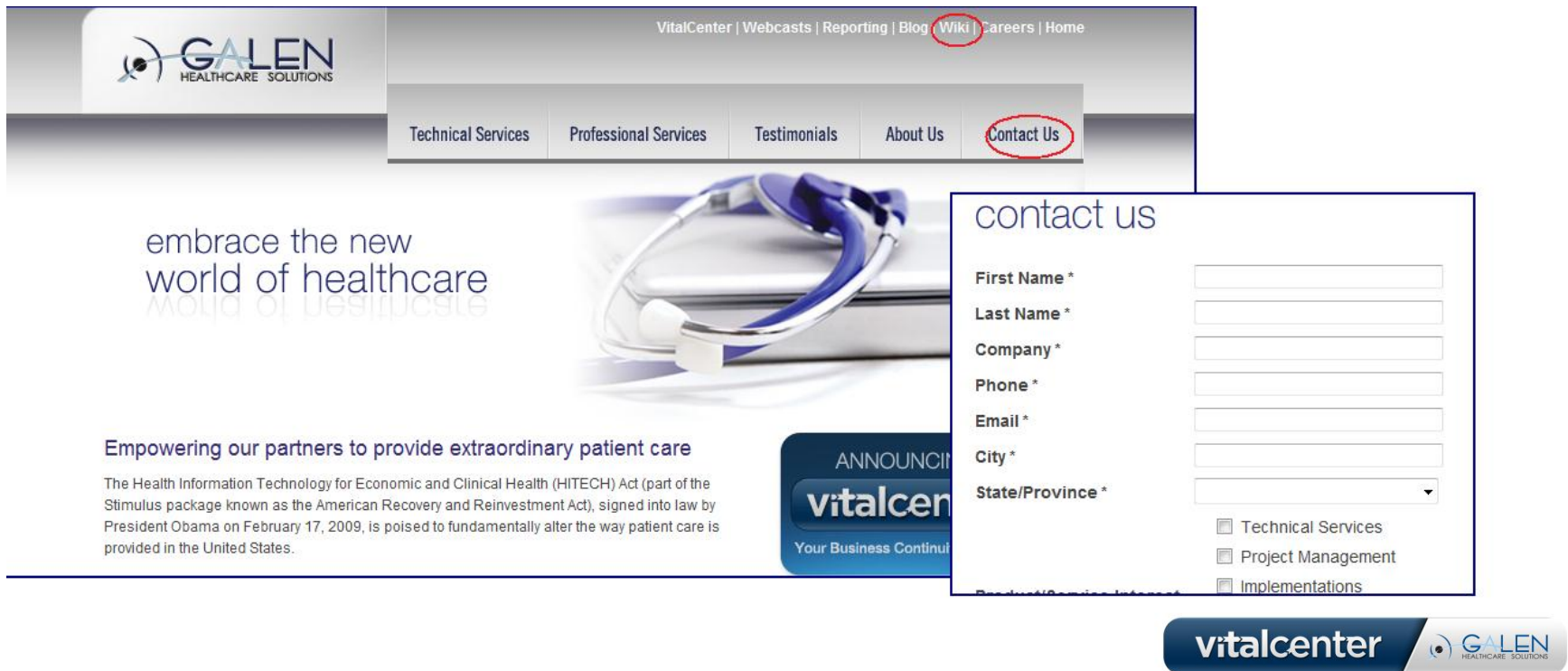
## ❖ Question Review

- Submit further questions to [education@galenhealthcare.com](mailto:education@galenhealthcare.com)
- Visit <http://galenhealthcare.com/calendar/> for future webcasts
- Slides and Q&A will be posted at [http://wiki.galenhealthcare.com/Clinical\\_Summaries](http://wiki.galenhealthcare.com/Clinical_Summaries)
- Galen Wiki page on Clinical Summaries can be found at [http://wiki.galenhealthcare.com/Patient\\_Summary\\_Information \(AKA Clinical Summary\)](http://wiki.galenhealthcare.com/Patient_Summary_Information_(AKA_Clinical_Summary))



Thank you for joining us today, for additional assistance....

You can contact us through our website at [www.galenhealthcare.com](http://www.galenhealthcare.com)



The screenshot shows the Galen Healthcare Solutions website. The top navigation bar includes links for VitalCenter, Webcasts, Reporting, Blog, Wiki, Careers, and Home. A secondary navigation bar contains links for Technical Services, Professional Services, Testimonials, About Us, and Contact Us. The main content area features the slogan "embrace the new world of healthcare" and a section titled "Empowering our partners to provide extraordinary patient care" with text about the HITECH Act. A "vitalcenter" logo is also present. A contact form overlay is displayed on the right side of the page, titled "contact us".

contact us

First Name \*

Last Name \*

Company \*

Phone \*

Email \*

City \*

State/Province \*

Technical Services

Project Management

Implementations

vitalcenter

