After Visit Summaries: A Tool Whose Time Has Come for Use in Dentistry

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After Visit Summaries: A Tool Whose Time Has Come for Use in Dentistry

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In dentistry, an after visit summary (AVS) can be thought of in both the context of a standalone dental practice and as a combined summary integrating oral health-related information with medical information. In this commentary, the authors explore the AVS from both perspectives and make a case for considering the AVS as an important piece of the larger puzzle needed to improve oral health and general health literacy for all patients.

The concept of providing patients with an AVS is gaining attention as a result of the electronic health record (EHR) incentive program commonly known as “meaningful use” (MU). MU is a part of the Health Information Technology for Economic and Clinical Health (HITECH) Act that went into effect in February 2009 (DesRoches et al, 2013). However, the authors believe that AVS remains a foreign concept among the vast majority of dental practices in the United States that are either not eligible for MU or not aware of it (Schroeder et al, 2013).

In medical practice, an AVS is a clinical summary document that provides a patient with relevant and actionable information and instructions. It contains basic information, such as the patient’s name, provider’s office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures performed and follow-up instructions based on clinical discussions that took place during the office visit. It may also include any updates to a problem list and immunizations or medications administered. An important part of the AVS is the information provided on next steps for the patient, such as the time and location of the next scheduled appointment or a recommended appointment time, a list of additional appointments to schedule for needed laboratory or other diagnostic tests with contact information, recommended patient decision aids, and test or laboratory results (if received before 24 hours after visit) (CMS, 2013).

For patients with chronic disease or conditions that require self-management support, the content and methods of communication with patients and families are of critical importance (Horowitz et al, 2012). The AVS is a potential cornerstone of the self-management effort, whether the oral health care services are delivered alone or as part of an integrated health care system. In the hospital setting, many hospital outpatient ambulatory clinics have begun using an AVS in some cases, spurred on by MU incentives. The dental clinics within many of these hospitals also have begun using an AVS.

1 The authors are participants in the activities of the IOM Roundtable on Health Literacy.
The potential exists to expand use of medical and dental AVS information to help patients understand their health conditions and guide them to self-manage their chronic diseases. Because people receive and process information differently and act on changing life and health practices when they are ready, it is important to ask patients directly how they learn best. The authors believe that educational materials, both print and electronic, need to be

- developed and tested with the ultimate target population,
- science-based in content,
- written in plain language,
- culturally appropriate,
- consistent with principles of health literacy, and
- aligned with the information given verbally.

The overall dental practice approach and how the care team delivers the prevention messages to patients are important (Horowitz et al, 2013; Maybury et al, 2013). Further, we believe it is important that the communication skills of providers with their patients should be enhanced (Rozier et al, 2011).

A previous Institute of Medicine report called for closer integration between dentistry and medicine on all levels of the health care system: research, education, and patient care (IOM, 1995). One of the first institutions to respond to the report was the Marshfield Clinic Health System (MCHS). Through its network of 50+ regional medical centers operated by Marshfield Clinic and nine federally qualified dental centers operated by Family Health Center of Marshfield, Inc., care is provided to approximately 400,000 patients residing in mostly rural counties of central, northern, and western Wisconsin by integrating medicine and dentistry in patient care, research, and educational endeavors.

Recognizing the impact of oral disease on both quality of life and systemic health, MCHS undertook the challenge of coordinating seamless care to its largely rural population across regional medical and dental centers by developing the first integrated medical-dental EHR (iEHR) in the country (Acharya et al, 2012). This integrated environment allows medical and dental providers to share real-time information about their patients’ medication, problems, adverse and allergic reactions, vitals, appointments, and demographics and administrative records from any of its regional centers and collaborating hospitals using its system. With the focus on patient-centric care, MCHS has also developed an AVS for both medical and dental practices, a printed copy of which is given to patients following each visit and is also available to the patients through the patient portal. The Health IT solution allows for the provider to select appropriate sections to be included in the patient’s AVS. For example, dental providers can remove the sections “immunization administered during visit” and “test/laboratory results” since dental providers usually are not involved in administering immunizations or conducting lab tests during office visits.

We believe strongly that oral health providers are key members of the multi-disciplinary health team. Apart from the systemic diseases such as diabetes that are interconnected with oral diseases, there are several oral manifestations of systemic conditions. MCHS’s involvement in the Patient Centered Medical Home and Accountable Care Organization models is an important effort that will aid in increased understanding of the role of oral health within these models. As a pilot initiative, MCHS is coordinating its efforts in the management of about 16,000 diabetic patients it serves and the importance of
their oral health. The AVS could serve as an important care-coordination tool for the patients and the multi-disciplinary teams inside and outside of the health system, as it currently encapsulates core clinical summaries like referrals, medications, diagnostics information, problem lists and others as defined by the Centers for Medicare & Medicaid Services (CMS) (CMS, 2013). Early diagnosis and treatment can result from oral cavity examination findings that indicate an underlying systemic condition. Such findings can be shared by the dental providers with their patients and the patients’ medical providers. An AVS would clearly facilitate a better multi-disciplinary care team approach for managing not only diabetes but similar chronic conditions that require management of the oral health component. MCHS is also currently working on generating a combined AVS for the patients who may have had both medical and dental visits on the same day, which could be ideal for integrated health systems. However, there are still several challenges to achieving this.

The authors have found that there is a lack of formal definition of MU for dentistry within the context of the regulatory definition (ADA, 2010). Also lacking are interoperable electronic medical and dental health records in the EHR vendor community. However, since health IT has been rapidly changing the landscape of American health care in recent years, future capabilities exist not only to digitize the paper-based workflow but also to improve quality, efficiency, and patient-centered care (Buntin et al, 2010). Doing so will, we believe, result in integrating dentistry into the mainstream health care delivery model.

In our opinion, the adoption of the AVS could be extremely beneficial in transforming healthcare to a patient-centric care model in which patients can be engaged in their own health, assisted in remembering the activities that occurred during specific office visits (Lukoschek et al, 2003; Throop and Seidman, 2009), and facilitated in better self-management of their chronic conditions (Coulter, 2012). At the same time, by virtue of patients/guardians access to their own health information, health care providers may be incentivized to optimize the quality of the patient notes entered into the her (Markle Foundation, 2012). Yet, enabling the adoption of the AVS in dental practice will not be a trivial task because it will require substantial workflow changes, carry significant costs, and require smart Health IT solutions and support from dental vendors. However we believe that the benefits outweigh the challenges. Aside from hospital-based dental practices and community health centers, dental schools are excellent venues to test the use of the AVS, especially those that are located on the same campus as medicine, nursing, and pharmacy, where students can learn together to use EHR and AVS.

Although there is currently little evidence to support improved outcomes from using an AVS, the authors believe that providing information to patients about their disease, including their individual risk for disease, along with health support tools, has the potential to benefit individual patients and patient populations overall. We recommend research be conducted to build the evidence base on how best to construct an AVS that will be effective in fostering better self-management skills and behavior change that would lead to improve oral health and overall health outcomes.
REFERENCES


