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David Brailer, MD
Office of the National Coordinator Health Information Technology
Department of Health and Human Services
Attention: NHIN RFI Responses
Hubert H. Humphrey Building, Room 517D
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Brailer:

The American Geriatrics Society (AGS), an organization of nearly 7,000 geriatrics' healthcare professionals who are specially trained in the management of care for frail, chronically ill older patients, appreciates the opportunity to provide comments on the National Health Information Network (NHIN).

Geriatric patients, defined generally as persons with some combination of multiple chronic conditions, functional limits and dementia, have unique needs. Geriatric patients typically receive care across multiple settings. Geriatric patients typically have multiple prescribers and often one prescriber fails to take responsibility for reconciliation. Geriatric patients typically have family caregivers who play an integral part in the execution of their care plan, and, as such, should be recognized in an electronic health care system. Geriatric patients have physical and cognitive deficits that should be featured prominently in an electronic health record (EHR).

We believe the more specific comments below will meet the needs of geriatric patients as laid out above.

1. **Adverse Drug Events.** There is probably no population for whom the risks of adverse drugs events are greater than that of seniors. Thus, successful e-Health information sharing should include both Computerized Physician Order Entry for Medications (CPOE) as well as Medication Therapy Management Services (MTMS) (with a prospective drug review.) Ideally, this information would be drawn from multiple sites, as in the case of an integrated delivery system rather than each facility and site of care having a separate "information box" in medications listed. As such it should be able to interface with treatment

templates and specific formularies. In order to provide a comprehensive evaluation this information needs to be linked to all pharmacy providers from community based pharmacies (providing medications under the new Medicare Part D benefit) to institutional providers (providing medications under Medicare Part A and B) so that complete management of medications can occur.

2. **Care Transitions.** Transitional care involves the coordination and continuity of health care as patients transfer between different locations. Representative locations include (but are not limited to) hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, assisted living and long-term care facilities. Older adults experiencing transitions often end up without adequate management through these discrete encounters and would benefit greatly from the inherent management associated with a NHIN. Controlled trials have demonstrated improved clinical and resource utilization (decreased Medicare expenditures) outcomes for high-risk older adults who were provided care through the use of an EHR. The EHR potentially could link sites of care and providers of care. It would require common format for sharing, a defined set of information "fields" that are required, assessment data and goals of treatment to be identified. Standards for such would need to be defined and required, recognizing the need for flexibility to allow for regional variation in assessment tools, etc.

3. **Personal Health Record.** Another powerful tool for use in a successful NHIN is the development of a personal health record, an electronic based record "saved" (either on CD or flash card or memory chip or paper) that has a defined set of information fields that belongs to the patient. The personal health record would be on a secure web-based EHR that allows for a patient or someone authorized by the patient to download information as read-only from the same site(s) as the medical record. Ideally there would be one primary care site where all information is coordinated. The patient would have "ownership" of their EHR with a designated clinician as the primary care provider who would have responsibility for altering parts as is medically relevant. The EHR would include the core, patient-specific information such as advanced directives and the designation of a durable power of attorney or decision-maker.

4. **Settings of Care.** An EHR could have unique applications for certain settings of care. For instance, skilled nursing facilities could establish an EHR within the facility that included electronic tracking of patient data such as weight, meal intake, in addition to vital signs, nurses notes, medications, labs and diagnostics. Physicians, using web-based "portal" models, could assess critical patient information from home or office and use it in a meaningful way to address changes of condition, family calls, transfers, etc. A similar model could be used in home health care. This application would both improve quality of care, save money and result in more system efficiencies. However, it would be critical to ensure actual data exchange capability among authorized systems to maximize

across settings the use of the EHR. In addition, specific state and federal documentation requirements that are determined by settings of care must populate these required forms through information obtained through direct patient care rather than requiring a duplication of document through a separate process. An example would be the completed skilled nursing facility required Minimum Data Set (MDS) data through information obtained through the direct resident care process versus a separate MDS completion process.

5. **Decision Support/Screening Tools.** A successful NHIN should include embedded decision support for geriatric syndromes as well as specific high-risk events. In this regard, we recommend that such support be built around specific geriatric syndromes, such as urinary incontinence, depression, health risk status, caregiver status, dementia, and falls risk and mobility problems. This system needs to assure that the record be "smart", leading physicians through recommended care processes. This should include automated prompts to facilitate attention to screening recommendations and abnormal findings, e.g. laboratory tests, imaging tests, etc. Last, an individual physician should be able to monitor the response to treatment or progression of conditions through patient-specific longitudinal information about tests (e.g., HbA1C for diabetes, BNP for heart failure, depression scores).

6. **Caregiver Support.** A major benefit of a successful EHR is to promote and enhance the engagement of patients and caregivers in the discussions and solutions surrounding their care. Family caregivers often represent the first and last line of defense when it comes to patient safety. The NHIN envisioned by the Department of Health and Human Services does not address this clearly. Patients and caregivers should have means to access their health information and to promote their active involvement in the care process in order to optimize "best care" and ensure safety. In fact, even when looking at the definition of a network, some accommodation should be made to include patients and caregivers.

7. **Care Coordination Component.** The NHIN needs to provide a care management component that allows multiple providers access to needed information that facilitates the delivery of appropriate services. The care management component would include the following components: advanced directive delivery, alternate decision maker selection, social work section, nurse case manager section, and a community services previously and currently used section.

8. **Quality Improvement.** The information used for quality improvement must originate from the direct patient care database, allowing for complete and integrated data acquisition. The EHR must have the ability to run activity reports that can be used for quality improvement projects, utilization and outcome measurements.

We hope to work with you on the development of the NHIN. If you should have questions or comments on this letter, please contact Susan Emmer in our Washington office at (301) 320-3873.

Sincerely,

Meghan Gerety, MD, AGSF
President
American Geriatrics Society