American Geriatrics Society

ELECTRONIC HEALTH RECORDS FOR GERIATRICS HEALTH CARE PROVIDERS

General Components of an EHR

1. Data should be in structured format for easy retrievability and monitoring over time.
2. 24 hour IT support should be available.
3. Automatic billing level suggestion (and submission of bill).
4. Retrievability of data for quality reporting and research.
5. Previous button to import last visits data into various (all or some) fields.
6. Reminders for preventive care that is due.
7. Options for users to add test, scales, etc. as knowledge and evidence develop and warrant it.
8. Designated area for caregiver information.

Specific Geriatric Components of an EHR

History	

o Cognitive Screening (Montreal Cognitive Assessment {MoCA}, Saint Louis University Mental Status {SLUMs}, etc.)
o Depression Screening (Geriatric depression scale, Patient Health Questionnaire {PHQ-9, etc})
o Pain level and location(s)
o Medication list:
  o sort by alphabet, entry date, deleted, category/ disease, and
  o include over the counter medications, oxygen, walker, hospital bed, physical therapy, etc.
o Problem list: sort by alphabet, entry date, category
o History of Present Illness (HPI) - import previous
o Home Health Agency
o Home Assessment: stairs, railings, heating, air, flooring, bathroom, smoke detector.
	o Facility Information
	o Risk Factors: falls, depression screening with link to tool, sexually transmitted disease risk, alcohol, drugs, nutrition, osteoporosis, cardiovascular disease, functional decline, pressure sores, etc.
	o Advanced Directives, Healthcare Power of Attorney (HCPOA)
	o Activities of Daily Living (ADLs): bathing, dressing, grooming, continence, walking, transfer, eating, etc.
	o Instrumental Activities of Daily Living (IADLs): finances, driving, telephone, medication, etc.
	o Physical Therapy, Occupational Therapy, Speech Therapy
	o Durable Medical Equipment
	o Oxygen
	o Review of Systems (ROS), include: ROS could not be obtained due to patient's condition (replace condition with dementia, aphasia, etc.)

Physical Examination	
o Supine and upright blood pressure (BP) and Pulse for orthostatic BP assessment in vital signs. o Eyes with last eye exam info. o Hearing with last audiology, use of hearing aids. o Breast with mammogram info. o Heart with echo, stress test, ankle brachial index, lab info, etc. o Skin with pressure ulcer field, button for Braden scale, hygiene.	o Musculoskeletal with falls evaluation, button for relevant tests (e.g."Get up and Go" test, Dual X-ray Absorptometry (DXA) or risk calculation) o Abdomen with rectal, guaiac and colonoscopy field. o Genitourinary with bladder scan, etc. o Neuro with stroke option for hemiparesis, tremor, sensation, aphasia, gait, range of motion. o Psych: cognition (include comparison with prior and date), visual/ auditory hallucinations.
Assessment and Plan	
o Some EHR systems import results under the respective diagnoses in the Assessment and Plan; others in the Physical Examination. Results of interest are lab, radiology, other tests, and risk calculators.	

Please note - This list is not meant to be comprehensive and instead is intended to help guide healthcare providers when choosing an Electronic Health Record.