



# Arizona Geriatrics Society

An Affiliate of the American Geriatrics Society

## IN THIS ISSUE:

### Arizona Reynolds Program Elder Care Provider Sheets:

Disease Screening in Older Adults

Don't Forget Dementia

Falls in Elders

Delirium in Elders

Diabetes in Older Adults

Urinary Incontinence-Diagnosis

Urinary Incontinence-Treatment

---

Learning from our Elders Project

Older Adult Suicide Prevention

Internet Resources on Aging

Cancer Pain in the Elderly

The Health Internet

Arizona Geriatrics Society

# JOURNAL

Volume 14 • Issue 1 2009



# Arizona Geriatrics Society

An Affiliate of the American Geriatrics Society

## EXECUTIVE BOARD

### Officers

President: Jan Dougherty, RN, MSN  
President-Elect: Joanne Gurin, MD  
Secretary/Treasurer: Kathryn Barnoski, APRN, BC  
Past President: William Arnold, PhD  
Director-at-Large, Central: Vicki McAllister, CNHA, CAS  
Director-at-Large, Northern: TBD  
Director-at-Large, Southern: Marlene Bluestein, MD

### Board of Directors

Margaret Behrens, MD  
Helle Brand, PA  
Sandra Brownstein, PharmD  
Joann Ceimo, MD  
Mindy Fain, MD  
Mary Fermazin, MD  
Gary Friedlander, DPM  
John Lingenfelter, MD  
Walter Nieri, MD, FACP, CMD  
Jill Preston, BA, GCM  
Gary Salzman, MD CMD  
Lori Waldberg, LCSW

### Staff

Executive Director: Trudy Kiesewetter  
Project Coordinator: Samuel Salinas

**Journal Editor:** Mindy Fain, MD

**Co-Editor:** Carol Howe, MD, MLS

**Associate Editors:** Rosemary Browne, MD

**Section Editor, Allied Health:** Michelle Vuke, RD, CDE

**Section Editor, Medical Humanities:** Donna Swaim, PhD

**Section Editor, Public Health & Policy:** M. Jane Mohler, MPH, PhD

**Managing Editors:** Trudy Kiesewetter

## Arizona Geriatrics Society Journal

Published two times per year

Annual Individual Membership Dues - \$125  
Healthcare Affiliate Membership Dues - \$250

5020 N. 8th Place • Suite C  
Phoenix, Arizona 85014

Phone (602) 265.0211 • Fax (602) 274.8086

[www.arizonageriatrics.org](http://www.arizonageriatrics.org)

## CLINICAL PRACTICE

### Disease Screening in Older Adults: When to Stop

Charles P. Mouton, MD, MS ..... 3-4

### Don't Forget Dementia

Barry D. Weiss, MD ..... 5-6

### Falls in Elders

Rosemary Browne, MD ..... 7-8

### Delirium in Elders

Rosemary Browne, MD ..... 9-10

### Diabetes – Special Considerations for Older Adults

Barry D. Weiss, MD ..... 11-12

### Peripheral Arterial Disease

Barry D. Weiss, MD ..... 13-14

### Urinary Incontinence – Diagnosis

Barry D. Weiss, MD ..... 15-16

### Urinary Incontinence – Treatment

Barry D. Weiss, MD ..... 17-18

## RESEARCH

### Learning From Our Elders: A Longevity Project

Kathleen A. O'Connor, BS; Brian W. Leonard, PhD;  
Walter Nieri, MD; David W. Coon, PhD ..... 19-22

### Older Adult Suicide Prevention: Lessons from a Pilot Program

Donna Carender, MS; Randal Scott, MSW, MBA .... 23-25

## USING TECHNOLOGY

### Internet Resources On Aging

Carol L. Howe, MD, MLS ..... 26-27

## REYNOLDS QUESTION OF THE MONTH

### Cancer Pain in the Elderly: Patient Experience and Provider Treatment

Carol L. Howe, MD, MLS ..... 28-29

## PERSPECTIVES

### The Health Internet

Brad Tritle, CIPP, Arizona Health-e Connection ..... 30-31

The Arizona Geriatrics Society (AzGS) Journal assumes no responsibility for any injury and/or damage to persons from any use of the instructions or ideas contained in the material herein. Statements reflect the views of the authors. All medication dosages should be checked. The information contained should never be used as a substitute for clinical judgement.

The AzGS Journal is peer-reviewed publication. Those opinions expressed, and findings from research discussed in articles, however, are those of the author(s) and do not necessarily represent the views or positions of the AzGS.

## *The Health Internet*

**Brad Tritle, CIPP**, Executive Director, Arizona Health-eConnection, [www.azhec.org](http://www.azhec.org)

*In the following Perspective, Brad Tritle, CIPP, Executive Director of Arizona Health-e Connection, discusses the recent history, future and importance of the electronic health record to improving the quality and safety of medical care in Arizona. Health information technology will play a particularly vital role in providing safe and effective care to older adults in Arizona. As just one example, transitional care—that care which occurs in the interfaces between home, emergency departments, hospital units, and rehabilitation and long-term care facilities--and which is currently so fraught with information and hence safety gaps,-- has the potential to be tremendously improved and transformed by making patients' records both digital and accessible digitally.*

### **Background**

Health information technology, and specifically electronic health records, is a topic of great interest and discussion nationally. This article explores the roots of the discussion, focusing on the desired outcomes, while also providing a simple analogy: creation of the Health Internet.

A great deal of emphasis nationally is currently being placed on implementation of electronic health records, including the establishment of incentives in the Federal Stimulus bill passed by Congress.<sup>1</sup> Several new words and phrases, formerly limited in usage to those in the health information technology industry, are making their way into use by doctors, nurses, caregivers, healthcare executives at all levels, and even patients. These words include "health information technology," "health information exchange," and "health information infrastructure." The purpose of this article is to briefly explore the roots of this discussion, introduce these and other terms, and frame the activity occurring around their current and future implementation here in Arizona.

### **Why**

The Institute of Medicine (IOM) started much of the momentum in the area of electronic health records back in 2001.<sup>2</sup> In the IOM publication, *Crossing the Quality Chasm*, its Committee on Quality of Health Care in America recommended a common purpose, six aims for improvement, and ten "Simple Rules for the 21<sup>st</sup>-Century Health Care System."

The common purpose as outlined in the IOM report is fairly generic, and recommends that essentially all stakeholders in the health care system should seek to continually reduce the burden of illness, injury and disability and to improve the health and functioning of U.S. citizens.<sup>2</sup>

To achieve this purpose, six aims for improvement from the perspective of the patient are described: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.<sup>2</sup> To further describe these aims, fictional, futuristic (though the technology is currently available) stories are related that show the patient (consumer) interacting with the health care system through various online tools. Some of these tools are used by individual physician offices --for example scheduling or online health risk appraisal. Others provide information to the consumer about treatment options, meanings of test results, side effects, and local resources, including support groups.

To accomplish these six aims, ten rules have been suggested. These rules are not intended to be ends in themselves, but guidance for behavior by health care professionals that would subsequently lead to innovation and creation of new systems to meet the aims. These rules are described by the IOM in a table which contrasts them with perceived present approaches.

It is easy to see that these rules are interrelated, and open to interpretation. This article will not seek to describe these rules, with the exception of clarifying one often misunderstood term, "evidence-based." Evidence-based medicine (EBM) is not merely "cookie-cutter medicine," but is instead meant to combine evidence from clinical studies with a clinician's expertise, and a patient's preferences and/or values.<sup>3,4</sup>

### **How**

Whether or not these aims and rules are adopted in whole by a clinician, the value of many of the aims and rules is clear. Clinicians, consumers, and others seeking to adopt any one of them can be aided by the implementation of 1) health information technology (HIT); and 2) health information exchange (HIE).

*The Arizona Health-e Connection Roadmap*, developed by hundreds of healthcare stakeholders throughout Arizona in 2005-2006 established definitions of these two terms. HIT refers to the local deployment of technology, often within the four walls of an organization (e.g., electronic medical record, patient management system. HIE refers to the technology needed to share information between HIT deployments (e.g., electronically access a patient's medication history across multiple providers).<sup>5</sup>

Since 2006, additional examples of health information technology and exchange (or sharing) have arisen, and innovations continue to occur. Health information technology is really intended to include all related technologies, including those used for exchange. Health information exchange has been redefined by the federal government as a verb, meaning the process of exchanging health information.

Blumenthal and Glaser described health information technology in the *New England Journal of Medicine* as "an enormously diverse set of technologies for transmitting and managing health information for use by consumers, providers, payers, insurers, and all the other groups with an interest in health and health care."<sup>6</sup>(p.2527) They went on to say that "(a)lthough it is helpful to be familiar with the types of HIT, the implications of the technologies for doctors and patients really depend on nontechnical considerations."<sup>6</sup>(p.2528)

It may then come as no surprise that Dr. David Blumenthal has since become the Director of the Office of the National Coordinator of Health Information Technology, with John Glaser as one of his advisors. Both Blumenthal and Glaser continue to emphasize the importance of both the technical and non-technical considerations.

These non-technical considerations include managing the changes that will occur within a practice when technology is implemented, helping consumers to understand and filter through the information and tools that become available,

TABLE 301 Simple Rules for the 21 <sup>st</sup> - Century Health Care System <sup>2</sup>	
Current Approach	New Rule
Care is based primarily on visits	Care is based on continuous healing relationships
Professional autonomy drives variability	Care is customized according to patient needs and values
Professionals control care	The patient is the source of control
Information is a record	Knowledge is shared and information flows freely
Decision making is based on training and experience	Decision making is evidence-based
Do no harm is an individual responsibility	Safety is a system property
Secrecy is necessary	Transparency is necessary
The system reacts to needs	Needs are anticipated
Cost reduction is sought	Waste is continuously decreased
Preference is given to professional roles over the system	Cooperation among clinicians is a priority

establishing governance and funding for technologies used by all stakeholders, and identifying policies that will be necessary for the successful implementation of the technologies. These are issues that are a top priority for the health care leaders that are members, committee members, and board members of Arizona Health-e Connection.

Arizona Health-e Connection's (AzHeC) Board adopted the following revised vision and mission on June 22, 2009:

**VISION:** Arizona Health-e Connection will be the international model for facilitation of health information infrastructure development and implementation.

**MISSION:** To facilitate the design and implementation of integrated statewide Health Information Technology and Health Information Exchange that supports the information needs of all healthcare stakeholders to reduce healthcare costs, improve patient safety, and improve the quality and efficiency of healthcare and public health in Arizona

To accomplish the above vision and mission, a variety of strategies will be implemented over the coming years, and AzHeC is encouraging involvement by clinicians, consumers, and others throughout Arizona, to ensure that the implementations reflect the values and needs of Arizona's stakeholders.

**Keeping it Simple, Yet not Easy**

The title of this article is "The Health Internet." That is perhaps the easiest way to describe the future health information infrastructure (which includes the technology and the policies that accompany that technology). It will be a network that allows the appropriate sharing of information by those that need to provide or view the information, and a yet-undeveloped economy of businesses and innovations that will show value through the creation or use of this information. This requires that information be placed in digital format when it is created (e.g., a clinician's electronic medical record, a laboratory information system), and that each point of care have an electronic interface that allows the appropriate sharing of the information. This is similar to the way that Internet users access information (e.g., websites) that resides on servers

located all over the world, or make such information available themselves through shared online tools (e.g., Facebook), or their own website or mobile device (e.g., smart phone).

An example might be a digital glucometer and scale at the home of a Type II diabetes patient that provide scheduled uploads of data to caregivers, care managers, and the patient's own personal health record (PHR) which will be available as needed by the patient's clinicians who can, in turn chart additional data. If the patient is a "snow bird" living in Arizona in the winter, lab results, medications, and information relative to the care provided in the patient's summer residence would now be available to Arizona clinicians. Likewise, if patients are traveling in Europe or Asia, they can either upload information through their smart phones to care managers back home, or, in the event of an emergency department visit in a foreign country, their health information (e.g., medication history) can, through health information exchange or a personal health record, be made available to the physicians caring for them abroad.

Simply described – yes. Easy to implement – no. It is going to take the cooperation of all, and interest in what's best for the patient, to ensure that solutions are win-win: improving experiences for both health care providers and health care consumers.

**References**

1. H.R. 1--111th Congress: *American Recovery and Reinvestment Act of 2009*.
2. Institute of Medicine (U.S.). Committee on Quality of Health Care in America. *Crossing the quality chasm: a new health system for the 21st century*. Washington, D.C: National Academy Press; 2001
3. Melnyk BM, Fineout-Overholt E. *Evidence-based practice in nursing & healthcare : a guide to best practice*. Philadelphia: Lippincott Williams & Wilkins; 2005
4. Sackett DL. *Evidence-based medicine : how to practice and teach EBM*. 2nd ed. Edinburgh ; New York: Churchill Livingstone; 2000
5. Arizona Health-eConnection, *The Arizona Health-e Connection Roadmap*. 2006 (<http://www.azhec.org/history.jsp>)
6. Blumenthal D, Glaser JP. Information technology comes to medicine. *N Engl J Med*. 2007;356(24):2527-34