ABSTRACT

The electronic health record (EHR) at the MUHC (OACIS) assists in care delivery by coding tests, procedures and drug information. The knowledge on functioning provided unique information that predicted hospitalization, institutionalization, and death in a cohort of 7,000 elderly persons from primary care practices. Within a hospital setting health care professionals assess the presence and severity of functioning but none of this unique patient information is captured. Consequently, no information on patient functioning exists on the EHR and relevant questions about the impact of and change in function cannot be addressed. If patient functions that are not captured could be coded, patients could be screened for functional problems. The International Classification of Functioning, Disability and Health provides such a coding system. This study purports to identify the barriers, facilitators, and benefits of using a standardized method of identifying functional limitations that would render a patient at high risk for a problem. Geriatric professionals at the MUHC developed and deployed a paper version of the checklist in the geriatric units as a step toward the electronic one.