Whereas, increasingly medical documentation is housed in electronic health records (EHR); and

Whereas, the lack of interoperability between dissimilar EHRs remains problematic related to the sharing of information throughout the continuum of care; and

Whereas, skilled nursing facilities (SNF) and other patient care settings and primary providers in these facilities often do not have access to the same EHR as acute care facilities, primary care physicians, and specialty physicians within their geographic domain; and

Whereas, many older patients have complex care needs that may result in transitions for care with documentation for their health care in multiple care settings with dissimilar EHRs; and

Whereas, the medication list within one EHR may not be accurate in any care setting due to these transitions and dissimilar EHRs; and

Whereas, the “source of truth” for the medication list may be fragmented and difficult to determine, especially if the patient has a degree of cognitive impairment; and

Whereas, medication errors have been shown to result in severe illness, hospitalization, and death for 1.5 million patients annually in the United States with an estimated cost of $77 billion (with the majority of health care dollars spent on patients over the age of 65; and

Whereas, careful medication reconciliation utilizing all relevant EHR resources and patient input in each care setting and at each visit is imperative to ascertain and maintain accuracy of the medication list; and

Whereas, many physicians rely on other health care professionals, such as licensed pharmacists, to perform medication reconciliation, although thorough reconciliation including diagnostic indications for each medication and consideration of overlapping side effects may exceed their scope of practice; therefore be it

RESOLVED, that our American Medical Association work with Centers for Medicare and Medicaid Services and other appropriate organizations to study current medication-reconciliation practices across transitions of care with dissimilar electronic health records to evaluate the impact on patient safety and quality of care, and to determine the potential need for additional training to reduce medical errors and ensure patient safety and quality of care (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association work with other appropriate organizations to determine whether education for physicians-in-training is sufficient to attain the medication
reconciliation core competencies necessary to reduce medical errors and ensure patient safety and quality of care and provide recommendations for action as applicable. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 9/26/23

REFERENCES

RELEVANT AMA POLICY
Pharmacy Review of First Dose Medication D-120.965
1. Our AMA supports medication reconciliation as a means to improve patient safety.
2. It is AMA policy that (a) systems be established to support physicians in medication reconciliation, and (b) medication reconciliation requirements should be at a level appropriate for a particular episode of care and setting. [BOT Action in response to referral for decision Res. 808, I-06; Reaffirmation A-10; Reaffirmation A-15]

Hospital Discharge Communications H-160.902
1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician’s narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
   a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient’s needs, goals of care and treatment preferences.
   b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
   c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman’s terms, and whenever possible, using the patient’s preferred language.
   d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
   e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.
4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.
5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
   a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.
b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.

c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.

d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.

6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.

7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly. [CMS Rep. 07, I-16]

Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928
1. Our AMA will work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter.

2. Our AMA along with other appropriate organizations encourages physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health.

3. Our AMA will work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.

4. Our AMA will work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens. [Res. 515, A-22]

Continuity of Care for Patients Discharged from Hospital Settings H-125.974
Our AMA:
(1) will advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge;

(2) supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient’s health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge;

(3) supports strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients;

(4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;

(5) will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program;

(6) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so without disruption to EHR usability and minimal to no cost to physicians and hospitals, providing financial support if necessary; and