AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 4
(I-25)

Introduced by: John B. Luster, MD and Matthew D. Gold, MD

Subject: Integrating Inpatient and Outpatient Care

Referred to: OMSS Reference Committee
(xxxx, MD, Chair)

Whereas, the American Medical Association's stated mission is "to promote the art and science of medicine and the betterment of public health;" and

Whereas, the development of the concepts of inpatient hospital specialty was devised to enable more continuous care of the patient during that status; and

Whereas, the acute management team may not be aware of both the full context and prior health care, including testing and treatment, of a patient in many instances which can lead to reduplicative testing or treatment. This often increases length of stay, overall healthcare costs, and the potential for avoidable adverse effects of testing or treatment. Also, treatment choices may be adversely affected by lack of a full history; and

Whereas, while the patient's longitudinal outpatient physician most often knows most if not all relevant details of medical and social history which could benefit the safety and efficiency of acute care management, so often that physician is not directly included in the inpatient management process; and

Whereas, a search of the American Medical Association Policy Finder yields no returns when asking for either integration or continuity of inpatient and outpatient care, though there are those that address general concepts of continuity of care, patient choice, and the doctor-patient relationship, issues of continuity upon discharge, and longitudinal physician care in other settings; therefore be it

RESOLVED, that our American Medical Association advocate for integration of outpatient and inpatient medical care as the default condition of admission to temporary/acute care institutions (Directive to Take Action); and be it further

RESOLVED, that our AMA lead a study with relevant interested healthcare and regulatory parties to determine a practical, continuous process that incorporates the familiarity of longitudinal outpatient physicians with the patient into the inpatient care management of acute illness, as well as the transition back to outpatient care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that, by the permission of the patient on admission, the outpatient longitudinal physician(s) be empowered to interact with their patient as a paid, insurance-covered service without formal consultation of the hospitalist, so long as the ultimate management authority still resides with the hospitalist during the inpatient status (Directive to Take Action); and be it further

RESOLVED, that this resolution be forwarded to the American Medical Association House of Delegates for consideration at I-25 (Directive to Take Action).

Fiscal Note: (Assigned by HOD)

Received: 10/3/2025

RELEVANT AMA POLICY

Admitting Officer and Hospitalist Programs H-285.964

AMA policy states that: (1) managed care plan enrollees and prospective enrollees should receive prior notification regarding the implementation and use of "admitting officer" or "hospitalist" programs; (2) participation in "admitting officer" or "hospitalist programs" developed and implemented by managed care or other health care organizations should be at the voluntary discretion of the patient and the patient's physician; (3) hospitalist programs when initiated by a hospital or managed care organization should be developed consistent with AMA policy on medical staff bylaws and implemented with the formal approval of the organized medical staff by at least the same notification and voting threshold required to approve a bylaws change to assure that the principles and structure of the autonomous and self-governing medical staff are retained; (4) Hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to "Hospitalists" and that no punitive measure should be imposed on physicians or patients who decline participation in "hospitalists programs"; and (5) AMA opposes any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants.

Citation: Sub Res. 714, I-95; Amended: CMS Rep. 4, A-98; Reaffirmed: Res. 819, A-99; Reaffirmed: I-99; Reaffirmed: Res. 812, A-02; Reaffirmed: BOT Rep. 15, A-05; Reaffirmed in lieu of Res. 734, A-05; Modified: Res. 731, A-07; Reaffirmed: CMS Rep. 01, A-17

Ethical Impetus for Research in Pregnant and Lactating Individuals D-140.949

Our American Medical Association Council on Ethical and Judicial Affairs will consider updating its ethical guidance on research in pregnant and lactating individuals.

Citation: Res. 013, A-24

Boundaries of Practice for Health Professionals H-275.976

The health professional who coordinates an individual's health care has an ethical responsibility to ensure that the services required by an individual patient are provided by a professional whose basic competence and current performance are suited to render those services safely and effectively. In addition, patients also have a responsibility for maintaining coordination and continuity of their own health care.

Citation: BOT Rep. NN, A-97; Reaffirmed: Sunset Report, I-97; Reaffirmed: CEJA Rep. 8, A-11; Modified: CEJA Rep. 1, A-21

Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901

Our AMA supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation.

Citation: Res. 815, I-16

Continuity of Care for Patients Discharged from Hospital Settings H-125.974

1. Our American Medical Association 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. Our AMA 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. Our AMA 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. Our AMA 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. Our AMA will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program.
6. Our AMA 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.
7. Our AMA supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.

Citation: CMS Rep. 2, A-21; Modified: CMS Rep. 2, I-21

Evidence-Based Principles of Discharge and Discharge Criteria H-160.942

(1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.

(2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.

(3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.

(4) The AMA promotes the local development, adaption and implementation of discharge criteria.

(5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.

(6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.

(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:
(a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.
(b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.
(c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the

family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, they are responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.

Citation: CSA Rep. 4, A-96; Reaffirmed: I-96; Modified: Res. 216, A-17; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 1, A-08; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 16, A-19; Modified: Speakers Rep. 02, I-24

Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901

Our AMA supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation.

Citation: Res. 815, I-16

Hospice Care H-85.955

1. Our American Medical Association approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care.
2. Our AMA encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment.
3. Our AMA supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare.
4. Our AMA believes that each patient admitted to a hospice program should have their designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program.
5. Our AMA supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers.
6. Our AMA seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure.
7. Our AMA will advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital.

Citation: CCB/CLRPD Rep 3., A-14; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 212, A-19; Modified: Speakers Report 02, I-24

Continuity of Care in Nursing Homes H-280.957

Our AMA: (1) establishes policy that as long as the physician complies with applicable state and federal laws and regulations, medical directors in nursing homes should be strongly discouraged from taking over the routine medical care of a physician's patient without the request of the patient, the patient's family, or the patient's physician; and (2) encourages the American Medical Directors Association to incorporate this policy into its model nursing home medical practice agreement.

Citation: Sub. Res. 725, A-98; Reaffirmed: A-07; Reaffirmed: CMS Rep. 01, A-17