RESOLUTION 51-23

Title: Medical Education for Medication Reconciliation

Introduced by: David Whalen MD, for the Muskegon County Delegation

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Referred To: Reference Committee E

House Action: **APPROVED**

Whereas, medical documentation has moved to electronic health records (EHR) and is now a required documentation modality through Centers for Medicare and Medicaid Services (CMS), and

Whereas, medical documentation in the EHR is protected through the Health Insurance Portability and Accountability Act (HIPAA), and

Whereas, use of the EHR and HIPAA have resulted in limited access and lack of interface between dissimilar EHRs, 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 no longer resides with the patient, 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 by a physician in each care setting 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 the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with Centers for Medicare and Medicaid Services and other relevant 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 medical education to ensure patient safety and quality of care related to medication errors; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask the AMA to work with the Accreditation Council for Graduate Medical Education to determine potential changes in graduate medical education requirements to improve medication reconciliation and to ensure improved patient safety and quality of care related to medication errors.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

Pharmacy: Cooperation to Insure Patient Medication Safety
MSMS works with the Michigan Pharmacists Association to assure patient safety, confidentiality, and continuity of care.

Pharmacy: Medication Information
MSMS supports the efforts of pharmacies to educate patients and prevent medication-induced problems.

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.

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.

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.

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
(7) supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.

Sources:

1. Hughes RB, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr, Chapter 38: Medication Reconciliation, p. 7.
2. Institute of Medicine, Committee on Identifying and Preventing Medication Errors, Preventing Medication Errors. National Academies Press; 2007:124-25.
3. Grissinger MC, et al. "The Role of Managed Care Pharmacy in Reducing Medication Errors." Journal of Managed Care Pharmacy 9, no. 1 (2003):62-65.