REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-I-16

Subject: Hospital Discharge Communications

Presented by: Peter S. Lund, MD, Chair

Referred to: Reference Committee J
(Candace E. Keller, MD, Chair)

At the 2016 Annual Meeting, the House of Delegates adopted the recommendations of Council on Medical Service Report 6, which addressed communication and care coordination between hospital physicians and their community counterparts during patient hospitalizations (see Policy H-225.946). While developing that report, the Council agreed that communications during the hospital discharge process, which can be a confusing and potentially dangerous time for patients, should be examined in a separate report.

This report, initiated by the Council, provides background on communications during the hospital discharge process, summarizes relevant AMA policy and principles, and makes recommendations for new policy to help safeguard patients as they transition home from hospitals or to continuing care facilities.

BACKGROUND

Suboptimal or delayed communication between hospital and community physicians, and between physicians and patients, can lead to serious and costly post-discharge problems, including adverse events and hospital readmissions. Conversely, effective communication during the discharge period results in more seamless and safe care during this critical transition. An estimated 19 to 23 percent of patients experience an adverse event in the period following hospital discharge,[1] costing the health care system an estimated $12 - $44 billion per year.[2] Twenty percent of Medicare patients are readmitted to hospitals within 30 days of discharge, and approximately one-third of these readmissions could be avoided with improved transitional care.[3] Notably, more than one-third of post-discharge follow-up testing is never completed.[4] Hospitals are penalized financially for excess readmissions associated with certain conditions and, this year, Medicare's readmission penalties have reached a new high.

At the time of discharge, hospital-based physicians—generally hospitalists or proceduralists—hand over clinical responsibility for patients to primary care or other community physicians, or post-acute care facilities. The discharge summary is typically used during discharge transitions to document diagnostic findings and plans for post-discharge follow-up care. The Joint Commission stipulates that discharge summaries include the following elements: the reason for the hospitalization; significant findings; procedures and treatments provided; the patient's condition at discharge; instructions for patients and families, including necessary follow-up, medication changes and dietary needs; and the attending physician's signature. Notwithstanding these standards, hospital discharge summaries vary in terms of content, quality and relevancy. Discharge summaries may be incomplete or lack salient patient information such as pending diagnostic or laboratory tests. Transmittal of discharge summaries to outpatient physicians may be delayed or

never reach the appropriate treating physicians. Patients and/or their families may not fully understand discharge instructions and the importance of follow-up appointments and treatment.

Evidence in the literature has identified widespread deficits in communication at the time of discharge[5] between physicians overseeing hospital care and community physicians. Many errors and adverse patient events during this time period are the result of communication failures,[6] with the majority of post-discharge problems related to medications. A recent meta-analysis of interventions to improve care transitions for adults with chronic illnesses suggests that high intensity interventions may be needed to prevent hospital readmissions in the early time period following hospitalization.[7] This study found an association between reduced 30-day hospital readmission rates and interventions consisting of communication between the hospital and primary care provider, care coordination by a nurse, and a home visit by a nurse within three days of discharge.

Quality improvement projects that have demonstrated reductions in hospital readmissions by improving hospital discharge processes are numerous and varied. Examples of effective, multifaceted interventions include the SafeMed care transitions model, Project BOOST (Better Outcomes for Older Adults through Safe Transitions), and Project RED (Re-Engineered Discharge). SafeMed uses intensive medication reconciliation, home visits and telephone follow-up to manage high-risk/high needs patients as they transition from the hospital to outpatient setting. As part of its *STEPS Forward*™ initiative, the AMA developed a module for implementing the SafeMed model within primary care practices. Project BOOST is the Society of Hospital Medicine's signature mentoring program for improving the care of patients as they transition home from the hospital or to other care facilities. Project RED, developed by Boston University Medical Center, is a multilayered intervention that includes dedicated discharge advocates, improved medication reconciliation and enhanced discharge instructions.

Patient/Family Engagement

Communication between physicians and patients and those persons who will be caring for patients post-discharge is an important component of successful care transitions, and a review of the literature has found deficits in this area as well.[8] Failure to adequately educate patients about health care decisions and follow-up care; lower levels of health literacy among some patients; and time constraints have been found to contribute to suboptimal care transitions.[9] Patients with limited education and non-English speakers are less likely to have adequate discharge understanding and more likely to be re-hospitalized. Shared decision-making and patient-centered discharge planning are two factors identified as countering barriers to patient engagement.

A proposed rule by the Centers for Medicare & Medicaid Services (CMS), in the fall of 2015 highlighted the importance of focusing on patients' goals and preferences during the hospital discharge process, and also better preparing patients and their families/caregivers to be active partners in post-discharge care. The proposed rule implements the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. It proposed modifying hospital Conditions of Participation by requiring all hospital inpatients, as well as many outpatients– including those receiving observation care or undergoing same-day procedures that require sedation–to be evaluated for their discharge needs and have a written plan developed. Discharge plans would need to be developed within 24 hours of admission, completed before the patient is discharged, and sent to the physician responsible for follow-up care within 48 hours of discharge. The proposed rule would also require a medication reconciliation process and a post-discharge follow-up process. Hospitals would be required to provide detailed discharge instructions to

patients going home and to continuing care facilities for patients being discharged to these settings. A post-discharge follow-up process to check on patients who return home would also be required.[10]

Physician Payment

Current Procedural Terminology (CPT) Codes 99238 and 99239 can be used by hospital-based physicians to bill for a hospital discharge day management service if there is a face-to-face encounter between the patient and attending physician. Medicare also pays for transitional care management (TCM), or services delivered during the 30 days after hospital discharge. TCM services must be furnished to patients who have medical and/or psychosocial problems that require moderate or high complexity medical decision-making.[11] Providers are required to contact patients within two business days by telephone or e-mail, or meet them face-to-face. Face-to-face visits are required within seven to 14 days, depending on whether the moderate complexity code (CPT 99494) or the high complexity code (CPT 99496) is used.

AMA POLICY

The AMA has extensive policy on care transitions, including hospital discharge. Policy H-160.942 established comprehensive, evidence-based principles addressing discharge criteria, teamwork involved in discharge planning, contingency plans for adverse events, and communication. Policy H-160.942 makes clear that responsibility and accountability for patients transitioning care settings rests with attending physicians, who are responsible for ensuring that physicians and facilities providing care in new settings are fully informed about the patient. Policy H-160.942 also maintains that the transfer of all pertinent information about the patient, and the discharge summary, should be completed before or at the time the patient is transferred to another setting. Policy H-160.942 in its entirety is appended to this report.

AMA policy recognizes the importance of effective communication between hospital-based and primary care physicians. Policy D-160.945 directs the AMA to advocate for timely and consistent inpatient and outpatient communications among hospital-based physicians and the patient's primary care referring physician to decrease gaps that may occur in the coordination of care process. Policy D-160.945 directs the AMA to explore new mechanisms to facilitate and incentivize this communication and the transmission of important data. Policy H-155.994 encourages the sharing of patients' diagnostic findings and urges hospitals to return information to attending physicians at patient discharge.

Policy D-120.965 supports medication reconciliation as a means to improve patient safety, and calls for systems to support physicians in medication reconciliation. The AMA has numerous policies on usability and interoperability of electronic health records (EHRs), including Policy D-478.995 on health information technology (health IT).

DISCUSSION

The Council recognizes that the health care landscape is evolving in terms of care delivery models and improvements in health IT, and that implementation of a single hospital discharge standard across diverse clinical practice settings is impractical at this time. Improved EHR capabilities, which will enable more widespread use of direct messaging (e.g., admit/discharge/transfer messaging) and standardized electronic forms (e.g., the Continuity of Care Document), have the potential to enhance communication and the timely exchange of patient information among providers across multiple care settings. The Council recognizes that the AMA continues to engage in extensive advocacy to improve EHRs and address technology barriers that impede the exchange

of meaningful patient information during care transitions, and that numerous AMA policies guide this work. The Council recommends reaffirming Policy D-478.995, which directs the AMA to continue its advocacy to expedite interoperability of EHR systems, standardize key EHR elements, and engage the vendor community to promote improvements in EHR usability.

After reviewing the literature and extensive AMA policy on care transitions, the Council appreciates the need for a more refined discharge process that improves the quality and safety of patient care and reduces the incidence of adverse events and hospital readmissions. Recognizing that multi-component interventions are more likely to reduce readmissions, the Council has identified several critical elements that can be adapted locally.

The Council further recognizes that consistent physician-to-physician communication across care settings is integral to achieving an efficient, patient-centered discharge process. Because community physicians who are knowledgeable of their patients' hospitalizations are better prepared to provide appropriate discharge follow-up, Council on Medical Service Report 6-A-16 recommended prompt notification to community physicians of patient hospitalizations, and also the timely exchange of relevant patient information. Communication between hospital and community physicians at the time of discharge, and the timely transfer of patient information between hospitals and providers responsible for patients' follow-up care, are also addressed in Policies H-160.942 and D-160.945. The Council believes that the comprehensive, evidence-based discharge principles and criteria outlined in Policy H-160.942 remain relevant and recommends that this policy be reaffirmed. The Council further recommends reaffirmation of Policy D-160.945, which supports timely and consistent communication between physicians in inpatient and outpatient care settings. AMA policies recommended for reaffirmation are appended to this report.

The Council discussed timing of discharge planning and completion of discharge summaries and points to existing policy stating that discharge summaries should be completed before or at the time of patient transfer, and discouraging discharge timing requirements by Congress for specific treatments or procedures (Policy H-160.942). The Council believes engagement of patients and their families/caregivers at the time of hospital admission, and before hospitalization for surgical patients, will lead to greater patient self-management and participation in their care, especially during brief hospitalizations. Accordingly, the Council recommends that the AMA encourage the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and before patients scheduled for surgery are hospitalized.

The Council recognizes the frustration with lengthy discharge documents that do not highlight key points, often requiring physicians to sift through numerous pages of patient information. Accordingly, the Council recommends that the AMA encourage the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlights salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.

The Council discussed the importance of engaging patients and their families/caregivers in the discharge process to increase patient involvement in discharge planning and encourage self-management of care after hospitalizations. Communication with patients, and those persons who will be caring for patients post-discharge, is critical to improving patient outcomes and preventing re-hospitalizations and emergency department visits. The Council believes it is good clinical practice to not only provide detailed discharge instructions and education, but also to confirm understanding of this information by patients and their families/caregivers. Accordingly, the Council recommends new AMA policy that encourages active engagement of patients and their families/caregivers in the discharge process, and offers guidelines to ensure that patient needs,

including communication needs, are taken into account and that discharge instructions are fully understood.

In its review of the literature, the Council found that medication reconciliation is an effective strategy for preventing adverse patient events in the post-discharge period. Medication reconciliation is the process of creating the most accurate list of medications a patient is taking, and comparing that list against the medications included in the physician's discharge summary. The Council recommends that the AMA encourage implementation of medication reconciliation as part of the hospital discharge process, and outlines strategies to help ensure that patients take their medications correctly post-hospitalization.

The Council also found that successful discharge interventions often include protocols for post-discharge follow-up. Communicating with patients post hospitalization—in their homes or continuing care facilities, or by telephone or e-mail—helps ensure adherence to discharge instructions and may also uncover symptoms that need attention. Accordingly, the Council recommends that our AMA encourage 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.

Finally, the Council maintains that hospitals should evaluate their discharge processes on a regular basis to ensure that they incorporate patients' post-discharge needs. The Council therefore recommends that the AMA encourage hospitals to review early readmissions and modify their discharge processes accordingly. Taken together, the Council is optimistic that these recommendations will be an impactful addition to existing AMA policy on care transitions, including the discharge period.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-478.995, which directs the AMA to continue its extensive advocacy to expedite interoperability of electronic health record (EHR) systems, standardize key EHR elements, and engage the vendor community to promote improvements in EHR usability. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-160.942, which outlines evidence-based discharge criteria and principles regarding discharge planning, teamwork, communication, responsibility/ accountability among attending physicians and continuing care providers, as well as the transfer of pertinent patient information and the discharge summary. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-160.945, which directs the AMA to advocate for timely and consistent communication between physicians in inpatient and outpatient care settings to decrease gaps in care coordination and improve quality and patient safety, and to explore new mechanisms to facilitate and incentivize this communication. (Reaffirm HOD Policy)

4. That our AMA encourage 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. (New HOD Policy)

5. That our AMA encourage 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. (New HOD Policy)

6. That our AMA encourage 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. (New HOD Policy)

7. That our AMA support 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. (New HOD Policy)

8. That our AMA support 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. (New HOD Policy)

9. That our AMA encourage 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. (New HOD Policy)

10. That our AMA encourage hospitals to review early readmissions and modify their discharge processes accordingly. (New HOD Policy)

11. That our AMA develop model guidelines for physicians to improve communications to other physicians, hospital staff and patients, and promote these guidelines to payers, hospitals and patients. (Directive to Take Action)

Fiscal Note: Less than $500.

REFERENCES

[1] Kripalani S, Jackson AT et al. Promoting Effective Transitions of Care at Hospital Discharge: a review of key issues for hospitalists. *Journal of Hospital Medicine*. 2007: Vol. 2, No. 5, Sept./Oct. 2007.
[2] Hansen LO, Young RS et al. Interventions to reduce 30-day rehospitalization: a systematic review. *Annals of Internal Medicine*. 2011;155:520-528.
[3] Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies. *Federal Register*: Nov. 3, 2015.
[4] Moore C, MdGinn T et al. Tying up loose ends: Discharging patients with unresolved medical issues. *Archives of Internal Medicine*. 2007: 167(12):1305.
[5] Kripalani S, LeFevre F et al. Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians: Implications for Safety and Continuity of Care. *JAMA*. Vol. 297, No. 8. February 28, 2007.
[6] Kripalani S, Jackson AT et al. Promoting Effective Transitions of Care at Hospital Discharge: a review of key issues for hospitalists. *Journal of Hospital Medicine*. 2007: Vol. 2, No. 5, Sept./Oct. 2007.
[7] Verhaegh, KJ et al. Transitional Care Interventions Prevent Hospital Readmissions for Adults with Chronic Illness. *Health Affairs*. 2014: 33, no. 9.
[8] Kripalani S, Jackson AT et al. Promoting Effective Transitions of Care at Hospital Discharge: a review of key issues for hospitalists. *Journal of Hospital Medicine*. 2007: Vol. 2, No. 5, Sept./Oct. 2007.
[9] The Joint Commission. Transitions of care: Engaging patients and families. Quick Safety – Issue 18, November 2015.
[10] Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies. *Federal Register*: Nov. 3, 2015.
[11] Centers for Medicare & Medicaid Services. Medicare Learning Network: Transitional Care Management Services. March 2016.

Appendix

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

(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, he or she is 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. (CSA Rep. 4, A-96; Reaffirmation I-96; Modified by Res. 216, A-97; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 1, A-08)

D-160.945 Communication Between Hospitals and Primary Care Referring Physicians
Our AMA: (1) advocates for continued Physician Consortium for Performance Improvement® (PCPI) participation in the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM) work to develop principles and standards for care transitions that occur between the inpatient and outpatient settings; (2) advocates for timely and consistent inpatient and outpatient communications to occur among the hospital and hospital-based providers and physicians and the patient's primary care referring physician; including the physician of record, admitting physician, and physician-to-physician, to decrease gaps that may occur in the coordination of care process and improve quality and patient safety; (3) will continue its participation with the Health Information Technology Standards Panel (HITSP) and provide input on the standards harmonization and development process; (4) continues its efforts with The Joint Commission, the Centers for Medicare & Medicaid Services, and state survey and accreditation agencies to develop accreditation standards that improve patient safety and quality; and (5) will explore new mechanisms to facilitate and incentivize communication and transmission of data for timely coordination of care (via telephone, fax, e-mail, or face-to-face communication) between the hospital-based physician and the primary physician. (BOT Rep. 1, A-08; Reaffirmed in lieu of Res. 731, A-09; Appended: Res. 722, A-11; Reaffirmed: CMS Rep. 3, I-12)

D-478.995 National Health Information Technology
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden

to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems. 3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs. 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery. 5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process. 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability. 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability. (Res. 730, I-04 Reaffirmed in lieu of Res. 818, I-07 Reaffirmed in lieu of Res. 726, A-08 Reaffirmation A-10 Reaffirmed: BOT Rep. 16, A-11 Modified: BOT Rep. 16, A-11 Modified: BOT Rep. 17, A-12 Reaffirmed in lieu of Res. 714, A-12 Reaffirmed in lieu of Res. 715, A-12 Reaffirmed: BOT Rep. 24, A-13 Reaffirmed in lieu of Res. 724, A-13 Appended: Res. 720, A-13 Appended: Sub. Res. 721, A-13 Reaffirmed: CMS Rep. 4, I-13 Reaffirmation I-13 Appended: BOT Rep. 18, A-14 Appended: BOT Rep. 20, A-14 Reaffirmation A-14 Reaffirmed: BOT Rep. 17, A-15 Reaffirmed in lieu of Res. 208, A-15 Reaffirmed in lieu of Res. 223, A-15 Reaffirmation I-15)