AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(I-16)

Introduced by: Medical Student Section

Subject: Support a Study on the Minimum Competencies and Scope of Medical Scribe Utilization

Referred to: Reference Committee F
(Gary R. Katz, MD, Chair)

Whereas, There will be an estimated 100,000 medical scribes in 2020 with no national standardization of training in place;[1] and

Whereas, Because medical scribes have no patient care responsibilities, they are not currently required to undergo specific training or meet any background requirements prior to starting their positions;[2] and

Whereas, Federal law inhibits medical scribes from entering certain patient information including but not limited to prescription medication and lab and imaging orders, but there is no enforcement mechanism to ensure adherence;[3] and

Whereas, Nearly 1 in 5 physicians currently employ medical scribes who are unlicensed workers hired to enter patient history and physical exam findings into the electronic health record (EHR) at the direction of a physician or practitioner;[4] and

Whereas, Several studies suggest that medical scribes improve clinician satisfaction, productivity, time-related efficiencies, revenue, and patient-clinician interactions since EHR-use can be cumbersome and time-consuming;[5] and

Whereas, ScribeAmerica, the largest professional medical scribe training and management company in the United States, provides only two weeks of training for new medical scribes;[1] and

Whereas, Health information technology experts, health informaticists, and the American College of Medical Scribe Specialists would be useful partners in establishing standardized training for medical scribes; therefore be it

RESOLVED, That our American Medical Association partner with The Joint Commission and other stakeholders to study the minimum skills and competencies required of a medical scribe regarding documentation performance and clinical boundaries of medical scribe utilization. (Directive to Take Action)

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[1] Conn J. Medical scribes lack consensus on training, certification. Modern Healthcare 2013. Available at: http://www.modernhealthcare.com/article/20130905/news/309059952. Accessed April 20, 2016.
[2] ACEP. Scribe FAQ // 2015. Available at: https://www.acep.org/physician-resources/practice-resources/administration/financial-issues-/-reimbursement/scribe-faq/. Accessed April 19, 2016.
[3] Use of Unlicensed Persons Acting as Scribes. The Joint Commission- Standards FAQ Details. Available at: http://www.jointcommission.org/mobile/standards_information/jcfaqdetails.aspx. Accessed February 8, 2016.
[4] Gillespie L. The Unregulated Rise of the Medical Scribe. The Atlantic 2015. Available at: http://www.theatlantic.com/health/archive/2015/12/why-so-many-doctors-are-hiring-scribes/419838/?utm_source=sffb. Accessed February 8, 2016.
[5] Shultz CG, Holmstrom HL. The Use of Medical Scribes in Health Care Settings: A Systematic Review and Future Directions. The Journal of the American Board of Family Medicine 2015;28(3):371–381. doi:10.3122/jabfm.2015.03.140224.

Fiscal Note: Not yet determined

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Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians D-478.976 - 1. Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs-open source and proprietary-to create more transparency and support more informed decision making in the selection of EHRs. 2. Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs. 3. Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes. 4. Our AMA will make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.
BOT Rep. 23, A-13; BOT Rep. 24, A-13; Reaffirmed: BOT Rep. 17, A-15

Status and Utilization of New or Expanding Health Professionals in Hospitals H-35.996 - (1) The services of certain new health professionals, as well as those professionals assuming an expanded medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three criteria specified below: (a) As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care. (b) They participate in the management of patients under the direct supervision or direction of a member of the medical staff who is responsible for the patient's care. (c) They make entries on patients' records, including progress notes, only to the extent established by the medical staff. Thus this statement covers regulation of such categories as the new physician-support occupations generically termed physician assistants, nurse practitioners, and those allied health professionals functioning in an expanded medical support role. (2) The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws: (a) Application for use of such professionals by medical staff members must be processed through the credentials committee or other medical staff channels in the same manner as applications for medical staff membership and privileges. (b) The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant. (c) In those cases involving use by the physician of established health professionals functioning in an expanded medical support role, the organized medical staff should work closely with members of the appropriate discipline now employed in an administrative capacity by the hospital (for example, the director of nursing services) in delineating such functions.

BOT Rep. G, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10; Reaffirmation A-12

Health Workforce H-200.994 - The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency.
BOT Rep. C, I-81 Reaffirmed: Sunset Report, I-98 Modified: CME Rep. 2, I-03; Reaffirmed: CME Rep. 2, A-13

Protecting Physician Led Health Care H-35.966 - Our American Medical Association will continue to work with state and specialty medical associations and other organizations to collect, analyze and disseminate data on the expanded use of allied health professionals, and of the impact of this practice on healthcare access (including in poor, underserved, and rural communities), quality, and cost in those states that permit independent practice of allied health professionals as compared to those that do not. This analysis should include consideration of practitioner settings and patient risk-adjustment.
Res. 238, A-15

Council on Medical Education. B-6.2
6.2.1 Functions.
6.2.1.1 To study and evaluate all aspects of medical education continuum, including the development of programs approved by the House of Delegates, to ensure an adequate continuing supply of well-qualified physicians to meet the needs of the public;
6.2.1.2 To review and recommend policies for medical and allied health education, whereby the AMA may provide the highest education service to both the public and the profession;
6.2.1.3 To consider and recommend means by which the AMA may, on behalf of the public and the medical profession at-large, continue to provide information, leadership, and direction to the existing inter-organizational bodies dealing with medical and allied health education; and
6.2.1.4 To consider and recommend the means and methods whereby physicians may be assisted in maintaining their professional competence and the development of means and criteria for recognition of such achievement.
6.2.2 Membership.
6.2.2.1 Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student.

AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care D-35.982 - 1. Our AMA will continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners. 2. Our AMA will assist state medical societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety. 3. Our AMA will actively oppose health care teams that are not physician-led.
Res. 240, A-13; Reaffirmation A-15

Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital H-35.978 - The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of

patients served by that hospital, and for outpatient educational programs provided by that hospital.
BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13

Patient Protection and Clinical Privileges H-230.989 - Concerning the granting of staff and clinical privileges in hospitals and other health care facilities, the AMA believes: (1) the best interests of patients should be the predominant consideration; (2) the accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant's education, training, experience, and demonstrated current competence. In implementing these criteria, each facility should formulate and apply reasonable, nondiscriminatory standards for the evaluation of an applicant's credentials, free of anti-competitive intent or purpose; (3) differences among health care practitioners in their clinical privileges are acceptable to the extent that each has a scientific basis. However, the same standards of performance should be applied to limited practitioners who offer the kinds of services that can be performed by limited licensed health care practitioners or physicians; and (4) health care facilities that grant privileges to limited licensed practitioners should provide that patients admitted by limited licensed practitioners undergo a prompt medical evaluation by a qualified physician; that patients admitted for inpatient care have a history taken and a comprehensive physical examination performed by a physician who has such privileges; and that each patient's general medical condition is the responsibility of a qualified physician member of the medical staff.
Sub. Res. 36, A-84; Reaffirmed: CME Rep.8, I-93; Reaffirmed: Res. 802, I-99; Reaffirmed: CME Rep. 2, A-09