WHEREAS, Medical service professional are gatekeepers for patient safety through implementation of a stringent credentialing process that ensures quality patient care, medical service professionals are highly trained professionals with specific expertise in credentialing processes and regulatory compliance; and

WHEREAS, Medical service professionals have the responsibility for coordinating the activities of the organized staff; These activities may include all aspects of the services provided by the department, including accreditation compliance, credentials verification, medical staff committee support, policy and procedure, and bylaws development; and

WHEREAS, National Association Medical Staff Services (NAMSS) was first formed in California in 1978 and has grown to include over 5,500 medical staff professionals from all 50 states and abroad; and

WHEREAS, Included in the NAMSS’ 2021 – 2024 Strategic Plan is a critical imperative to obtain a standard occupational classification (SOC) from the U.S. Bureau of Labor Statistics (BLS) for medical service professionals (MSPs); currently the BLS does not recognize the medical service professional profession and instead classified MSPs as human resource (HR) professionals; this designation is incorrect—and from the medical staff standpoint, egregious; and

WHEREAS, SOC code is the gold standard for workforce data, serving to establish a profession by definition and scope and make a case for hiring, retaining, and promoting within a profession; and

WHEREAS, Medical service professionals petitioned for a unique SOC code in 2010 and 2018; and

WHEREAS, BLS denied both petitions stating medical service professionals fall under Human Resources and are “sufficiently covered in existing Human Resources and compliance operations”; and

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1 https://www.bellevuehospital.com/services/medical-staff-services
2 https://samples.jbpub.com/9780763784416/84416_CH01_Gassiot.pdf
3 https://www.namss.org/About/NAMSS-Timeline
4 NAMSS, Synergy, Q1,2022
5 National Association Medical Staff Services Webinar, Obtaining Professional Recognition for MSPs: Standard Occupational Classification (SOC), August 15, 2022.
6 ibid
7 ibid
WHEREAS, An SOC code is critical for the growth and independence of a profession; without a designated SOC code, government entities cannot formally collect and analyze a profession’s data; A lack of systematic data on a profession, especially one that continues to evolve, will prevent it from growing and make it susceptible to scope creep from other professions⁸; therefore be it

RESOLVED, That our American Medical Association collaborate with leadership of the National Association of Medical Staff Services’ Advocacy and Government Relations teams to advocate to the U.S. Department of Labor Statistics for obtaining a unique standard occupational classification code during the next revision for medical service professionals to maintain robust medical credentialing for patient safety (Directive to Take Action).

Fiscal Note: Modest: Between $1,000 and $5,000 to implement.

Received: 9/30/2022

⁸ NAMSS, Synergy, Q1,2022
RELEVANT AMA POLICY

Medicare Payment Schedule Conversion Factor (H-400.966)

(1) The AMA will aggressively promote the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy with Congress and the Administration concerning physician payment under Medicare. (2) The AMA will work aggressively with CMS, the Bureau of Labor Statistics, and other appropriate federal agencies to improve the accuracy of such indices of market activity as the Medicare Economic Index and the medical component of the Consumer Price Index.


Revisions to AMA Policy on the Physician Workforce (H-200.955)

It is AMA policy that:
(1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.  
(2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research. 
(3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector. 
(4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians. 
(5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups. 
(6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need. 
(7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career. 
(8) Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agencies physician workforce projections process, to potentially include more detailed projection inputs,
with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.

(9) Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

Citation: CME Rep. 2, I-03; Reaffirmed: I-06; Reaffirmed: I-07; Reaffirmed: CME Rep. 15, A-10; Reaffirmed: I-12; Reaffirmed: A-13; Appended: Res. 324, A-17; Appended: CME Rep. 01, A-19