Donald A. Balasa, JD, MBA
AAMA Chief Executive Officer and Legal Counsel

Best practices for practices

Protect your office by employing CMAs (AAMA)®

Increasing numbers of employers prefer to hire, or insist on hiring, CMAs (AAMA) or, more specifically, medical assistants who have attained and maintained certification by the Certifying Board of the American Association of Medical Assistants. This article presents some of the legal reasons why employing CMAs (AAMA) is advantageous for all employers.

1. The delegating physician, the practice as a whole, and the medical assistant can be subject to disciplinary actions by the state if a medical assistant is delegated the following responsibilities:

   a. Any procedures that constitute the practice of medicine, and require the skill and knowledge of a licensed physician

   b. Any procedures that can only be delegated by state law to certain health professionals other than medical assistants

   An example of the latter is physical therapy. Although some states—explicitly or implicitly—permit physicians to delegate very minor physical therapy modalities to competent and knowledgeable medical assistants working under the physician's direct supervision, no state allows a physician to delegate the full range of physical therapy to anyone other than a licensed physical therapist.

2. State disciplinary actions can result in fines and other criminal or quasi-criminal penalties for the delegating physician, the practice, and the medical assistant. Professional liability (malpractice) insurance policies do not provide coverage for violations of state laws. These policies only offer coverage in civil matters, such as malpractice and wrongful death suits.

3. A medical assistant should never be referred to as a "nurse," "office nurse," or "doctor's nurse." In every state this is a violation of the Nurse Practice Act, and can result in fines and penalties. All office personnel should avoid referring to medical assistants as "nurses." If a patient addresses a medical assistant as a nurse, the patient should be corrected politely and pleasantly.

4. The delegating physician, the practice, and the medical assistant can be sued for negligence if the medical assistant does not perform a duty up to the standard of care of a reasonably competent medical assistant. The physician is potentially liable under the legal doctrine of *respondeat*

superior, and can also be liable under the theory of *negligent delegation.*

5. The fact that the practice's medical assistants are current CMAs (AAMA) is powerful evidence in a malpractice action. Having a staff of current CMAs (AAMA) can lessen the likelihood that physicians will be held liable for negligent delegation.

6. The "standard of care of a reasonably competent medical assistant" is not necessarily the same in all parts of the United States. The standard may vary from state to state, or even from one region of a state to another. This is a compelling reason for employing CMAs (AAMA). The fact that the CMA (AAMA) credential is nationally accredited by the National Commission for Certifying Agencies (NCCA), and that the National Board of Medical Examiners (NBME) serves as test consultant for the CMA (AAMA) Certification Examination, can be used as evidence demonstrating that the CMA (AAMA) has met or exceeded the "reasonably competent medical assistant" standard. In addition, the CMA (AAMA) must maintain currency to use the credential.

7. A court may hold a CMA (AAMA) to a higher standard of care than a medical assistant who does not have the CMA (AAMA) credential. This is another reason why continuing professional education is so important for the CMA (AAMA) and why more employers are supporting the continuing education of their CMAs (AAMA).

8. A delegating physician, however, can also be liable for the negligence of a *licensed* professional, such as a registered nurse (RN) or a licensed practical/vocational nurse (LP/VN). Contrary to common belief, the physician is not sheltered from civil liability when delegating to a licensed professional. A health professional—licensed or unlicensed—can be held civilly liable for negligent acts. Likewise, a supervising and overseeing physician is responsible for the negligent acts of professionals to whom the physician delegates—whether such professionals are licensed or unlicensed.

9. An increasing number of malpractice insurance carriers are requiring medical assistants to have a professional credential, and some even insist that the credential be the CMA (AAMA).

10. The CMA (AAMA) is the only medical assisting credential that requires graduation from a postsecondary medical assisting academic program that is accredited by either the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES). The CMA (AAMA) Exam is the only medical assisting credentialing exam that uses the NBME as test consultant.

11. There is an important difference between programmatic (specialized) accreditation and institutional accreditation. Programmatic accreditation of a medical assisting program provides a greater degree of scrutiny and accountability of the program than institutional accreditation of a school that has a medical assisting program. CAAHEP and ABHES are the only accreditors that provide medical assisting programmatic accreditation.

12. The CMA (AAMA) certification/recertification program is accredited by the NCCA, a national accreditor of certifying boards and programs. Accreditation is an attestation of the high standards of the CMA (AAMA) credential. The proven quality of the CMA (AAMA) can be beneficial in many legal contexts, including malpractice actions.

13. Since the CMA (AAMA) represents a medical assistant who has attained and maintained certification by the Certifying Board of the AAMA, the AAMA can enforce its intellectual property rights in federal and state courts. The Certifying Board of the AAMA receives complaints against medical assistants who are unlawfully using the CMA (AAMA) credential, and takes appropriate action.

14. Only those medical assistants who have earned the CMA (AAMA) may use the credential. Other medical assistants, such as Registered Medical Assistants (RMAs), National Certified Medical Assistants (NCMAs), California Certified Medical Assistants (CCMAs), National Registered Medical Assistants (NRMAs), and their employers can be in legal jeopardy if they use the "CMA (AAMA)" initialism.

During this era of increasing litigation, all health care professionals should make sure that they and those they supervise have the education (initial and continuing) and credentials necessary to prevail against any type of legal challenge. Physicians and other employers would be prudent to employ CMAs (AAMA), see to it that the "CMA (AAMA)" appears on name badges, and make sure CMAs (AAMA) are referred to as CMAs (AAMA).

Questions may be directed to Executive Director Donald A. Balasa, JD, MBA, at dbalasa@aama-ntl.org or 800/228-2262.

Donald A. Balasa, JD, MBA,
Executive Director, Legal Counsel

CMAs (AAMA): Linchpins of the Patient-Centered Medical Home

At its November 2008 planning session, the Board of Trustees of the American Association of Medical Assistants (AAMA) directed AAMA Executive Director and Legal Counsel Donald A. Balasa, JD, MBA, to represent the AAMA at the December 2008 Conference on Practice Improvement: Blueprint for the Medical Home, *sponsored by the American Academy of Family Physicians and the Society of Teachers of Family Medicine. The meeting focused on providing resources and sharing experiences about how primary care medical practices can incorporate elements of the Patient-Centered Medical Home (PCMH) model into the delivery of care. What follows is Executive Director Balasa's report.*

The Patient-Centered Medical Home

In 2007 the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA)—representing approximately 333,000 physicians—issued *Joint Principles of the Patient-Centered Medical Home (Joint Principles)*.[1] This document defined the Patient-Centered Medical Home (PCMH) as follows:

> The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth, and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The following are the seven principles agreed to by the AAFP, AAP, ACP, and AOA to describe the characteristics of the PCMH:

1. Personal physician
2. Physician directed medical practice
3. Whole person orientation
4. Care is coordinated and/or integrated
5. Quality and safety
6. Enhanced access
7. Payment reform

Linchpins of the PCMH

During the *Conference on Practice Improvement* it became apparent that CMAs (AAMA) are vital and important allied health professionals that will be needed for the successful implementation of the PCMH approach to primary care. Indeed, the *2008 Core Curriculum for Medical Assistants,* published by the Medical Assisting Education Review Board (MAERB), offers elements ideally targeted to prepare medical assisting students for crucial roles in the PCMH. The *2008 Core Curriculum* is appended to the *2008 Standards and Guidelines for the Accreditation of Educational Programs in Medical Assisting,* published by Commission on Accreditation of Allied Health Education Programs (CAAHEP).[2]

Essential Joint Principles and educational elements

Five of the seven joint principles are particularly relevant to the role of the CMA (AAMA) and are supported by the *2008 Core Curriculum for Medical Assistants*:

1. ***Physician directed medical practice***—*the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.*

   As reflected in this principle, *all* members of the primary health care team—not just the physicians—are responsible for the care and well-being of all patients. The following element of the *2008 Core Curriculum* prepares a CMA (AAMA) for this important responsibility: *Apply critical thinking skills in performing patient assessment and care*. For a CMA (AAMA), care of patients is not just performing tasks assigned by the supervising or delegating physician. Rather, by necessity, patient-centered care requires the CMA (AAMA) to exercise critical thinking skills and refer appropriate information pertaining to issues worthy of special attention to the physician and other care team members.

2. ***Whole person orientation***—*the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all states of life; acute care; chronic care; preventive services; and end-of-life care.*

   The PCMH philosophy does not end when the patient leaves the delivery setting. The primary care provider and the provider's "teammates" must be able to immediately and seamlessly arrange ancillary care with other professionals (e.g., social workers, counselors, and physical therapists). The role of the CMA (AAMA) is central for making this "whole person orientation" a reality. Note the following *Core Curriculum* element: *Develop and maintain a current list of community resources related to patients' health care needs.*

3. ***Care is coordinated and/or integrated*** *across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, and nursing homes) and the patient's community (e.g., family, and public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to ensure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.*

   The health care system is indeed complex. Information technology is a useful means for assuring that patients "get the indicated care when and where they need and want it." However, "electronically-facilitated" information can lose most or all of its value if it is not communicated to the patient "in a culturally and linguistically appropriate manner." The following *Core Curriculum* elements demonstrate the expertise of CMAs (AAMA) for communicating in appropriate and understandable ways:

   - *Use language/verbal skills that enable patients' understanding.*
   - *Demonstrate respect for diversity in approaching patients and families.*
   - *Demonstrate empathy in communicating with patients, family, and staff.*
   - *Apply active listening skills.*
   - *Demonstrate respect for individual diversity, incorporating awareness of one's own biases in areas including gender, race, religion, age, and economic status.*

4. ***Quality and safety*** *are hallmarks of the medical home:*

   - *Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.*

   The *Core Curriculum* contains two related elements:

   1. *Recognize the role of patient advocacy in the practice of medical assisting.*
   2. *Advocate on behalf of patients.*

   Therefore, CMAs (AAMA) are educated not only to be "communication liaisons," but also to be "advocates" that speak on behalf of patients (with the authorization by the overseeing/delegating physician and other designated health professionals) to third-parties so that the best interests of patients are always in mind.

   - *Patients actively participate in decision making and feedback is sought to ensure patients' expectations are being met.*

   If patients are to "actively participate in decision making" in the Patient-Centered Medical Home, and provide feedback about whether their expectations are being met, at least one "point person" in the delivery setting must be available as the following:

   1. An effective and empathetic communicator *to* patients
   2. An effective and accurate communicator *from* patients to members of the health team.

The following elements of the *Core Curriculum* ensure that CMAs (AAMA) are educated in these skills and professional attributes:

- *Explain the rationale for performance of a procedure to the patient*
- *Show awareness of patients' concerns regarding their perceptions related to the procedure being performed*
- *Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.*

Within the "Medical Business Practices" of the *Core Curriculum* is the following element: *Execute data management using electronic health care records, such as the electronic medical record (EMR)*. Quite often, a CMA (AAMA) becomes the "expert" among all health team members on the electronic medical record (also known as the electronic health record, or by other similar designations).

5. ***Enhanced access*** *to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.*

CMAs (AAMA) have also become competent and adept schedulers in primary care settings—whether such settings incorporate few or many elements of the Patient-Centered Medical Home paradigm. The following *Core Curriculum* elements provide convincing evidence as to why CMAs (AAMA) are such skilled and knowledgeable schedulers:

- *Manage appointment schedule, using established priorities.*
- *Schedule patient admissions and/or procedures.*

Revolutionized care

The Patient-Centered Medical Home will revolutionize the delivery of primary health care and will dramatically increase the welfare of all Americans. In addition, preliminary reports point to the fact that the PCMH philosophy will be reflected in the health care reform proposals of the Obama Administration.

The CMA (AAMA) will quickly become the linchpin of the Patient-Centered Medical Home model. What evidence supports this assertion? First, "The CMA (AAMA) is the only allied health professional who is required to complete an accredited postsecondary medical assisting program that provides specific training for work in medical offices, clinics, and other outpatient care centers."[3] But more specifically, as demonstrated above, the *2008 Core Curriculum for Medical Assistants* of the Medical Assisting Education Review Board ensures that CMAs (AAMA) are educated in the cognitive knowledge elements, psychomotor skills, and affective behavior and professional attributes that are key to the successful operation of a PCMH.

The indispensable role of the CMA (AAMA) in the Patient-Centered Medical Home revolution is another reason why medical assisting will continue to be one of the fastest-growing professions during the next ten years.

References

1. Patient Centered Primary Care Collaborative. Joint Principles of the Patient Centered Medical Home. http://www.pcpcc.net/node/14. Published February 2007. Accessed January 14, 2009.
2. Commission on Accreditation of Allied Health Education Programs. 2008 Standards and Guidelines for the Accreditation of Educational Programs in Medical Assisting. http://www.caahep.org/Documents/MAStandards2008.pdf. Accessed January 14, 2009.
3. Balasa, DA. New roles for the Certified Medical Assistant to enhance quality and effectiveness of care. *J Med Pract Manage.* 2008;23(5):276-8.

Donald A. Balasa, JD, MBA
Executive Director, Legal Counsel

Medical assistants must not refer to themselves as "nurses"

It is unethical, illegal, and a disservice to the medical assisting profession for medical assistants to refer to themselves as "nurses," "office nurses," "doctors' nurses," or any other generic term that even remotely implies that medical assistants are nurses.

The *Model Nurse Practice Act* published by the National Council of State Boards of Nursing (NCSBN) includes the following language:

> **Article VII. Title and Abbreviations**
> Section 1.
> a.
> …
> b. It shall be unlawful for any person to use the title "nurse," "registered nurse," "licensed practical/vocational nurse," "advanced practice registered nurse," their authorized abbreviations, or any other title that would lead a person to believe the individual is a licensed nurse unless permitted by this Act.

Note that this NCSBN document not only forbids the use of certain terms and abbreviations, but also prohibits "any other title that would lead a person to believe the individual is a licensed nurse." In other words, if a title or abbreviation or any other type of designation would cause a reasonable person to conclude that a certain health professional is a "nurse" of some sort, there could be a violation of the law.

The following excerpts from state Nurse Practice Acts provide examples of how states are addressing this issue:

> Texas—**Chapter 301, Section 301.251**
> …
> (d) Unless the person holds a license under this chapter, a person may not use, in connection with the person's name:
> (1) the title "nurse"; or
> (2) any other designation tending to imply that the person is licensed to provide nursing care.

> New York—**Article 138, Nursing, Section 6903**
> …No person shall use the title "nurse" or any other title or abbreviation that would represent to the public that the person is authorized to practice nursing unless the person is licensed or otherwise authorized under this article.

> Indiana—**Article 23, Nurses, Section 25-23-1-27, Violations; penalty**
> A person who:
> …
> (4) uses in connection with the person's name any designation tending to imply that the person is a registered nurse or a licensed practical nurse unless licensed to practice under this chapter…;
> …
> commits a Class B misdemeanor.

> Florida—**Chapter 464, Nursing, Part I, Nurse Practice Act, Section 464.016, Violations and penalties**
> …
> (2) Each of the following acts constitutes a misdemeanor of the first degree…
> (a) Using the name or title "Nurse,"…or any other name or title which implies that a person was licensed or certified as same, unless such person is duly licensed or certified.
> (b) Knowingly concealing information relating to violations of this part.

> Illinois—**225 ILCS 65, Nurse Practice Act, Article 50, General Provisions, Section 50-50, Prohibited acts**
> (a) No person shall:
> …(6) Use any words, abbreviations, figures, letters, title, sign, card, or device tending to imply that she or he is a registered professional nurse, including the titles or initials, "Nurse,"…or similar titles or initials with intention

of indicating practice without a valid license as a registered professional nurse;

…

(b) Any person, including a firm, association or corporation who violates any provision of this Section shall be guilty of a Class A misdemeanor.

As this author has frequently written and spoken about during the last 20 years, it is imperative that medical assistants scrupulously avoid conveying the message that they are nursing personnel, or members of any profession other than medical assisting. Recall the following admonition in "Your Office Staff Can Get You Sued":

> A medical assistant should never be referred to as a "nurse," "office nurse," or "doctor's nurse." In every state this is a violation of the Nurse Practice Act, and can result in fines and penalties. All office personnel should avoid referring to medical assistants as "nurses." If a patient addresses a medical assistant as a nurse, the patient should be corrected politely and pleasantly.[1]

As the medical assisting profession and, especially, the CMA (AAMA) become more prominent in the 21st century health workforce because of the Patient-Centered Medical Home movement, and in greater demand because of President Obama's Patient Protection and Affordable Care Act, it is more important than ever that medical assistants proudly and unambiguously identify themselves as members of one of the fastest growing and most important professions in the United States of America. ◂

References

1. Balasa DA. Your office staff can get you sued: protect your practice by employing CMAs (AAMA). *CMA Today.* 2010; 43(3): 6–7. Published July 1, 2006. Reprinted May 1, 2010.

Questions may be directed to Executive Director Donald A. Balasa, JD, MBA, at dbalasa@aama-ntl.org or 800/228-2262.

Donald A. Balasa, JD, MBA
Executive Director, Legal Counsel

Frequent questions about medical assistants' scope of practice

As the utilization of medical assistants—especially CMAs (AAMA)—within the American health care delivery system continues to increase and diversify, different types of questions regarding permissible scope of practice are being directed to the American Association of Medical Assistants. Here are examples of this "new wave" of scope of practice questions and the answers.

Are medical assistants permitted to accept verbal orders from the delegating physician?

Medical assistants are permitted to receive and execute orders from the overseeing, delegating, or supervising physician(s) as long as such orders do not require the medical assistant to exercise independent professional judgment in the execution of the orders, or to make clinical assessments or evaluations.

Are physicians allowed to delegate patient education to medical assistants?

Physicians are allowed to delegate patient education to competent and knowledgeable medical assistants as long as the content of such education has been approved by the delegating physician, and the patient education process does not require the medical assistant to make any interpretive judgments or answer any questions from the patient or patient representative that require a diagnosis, assessment, or evaluation. Medical assistants should not go beyond the patient education information that has been approved by the physician.

Are medical assistants permitted to call in prescription refills or new prescriptions?

In most states medical assistants are permitted to transmit (by telephonic, electronic, or other means) verbatim the physician's orders for new prescriptions or refills. Such transmission must be verbatim, and must not require the medical assistant to make interpretive judgments about the prescription before transmission.

Is it legal for medical assistants to sign prescriptions on behalf of the physician?

It is *not* legal for medical assistants to sign, authorize, or approve prescription orders on behalf of the physician. Medical assistants may draft scripts and forward them to the overseeing physician for the physician's review, approval, and signature. They must not transmit prescriptions until the physician has reviewed, approved, and executed the prescription order.

Are medical assistants permitted to triage patients?

In order to answer this question correctly, it is essential that terms be precisely defined and thoroughly understood. In interacting with patients or their representatives—by telephone or in person—medical assistants are allowed to convey verbatim physician-approved information and directions without exercising independent professional judgment or making clinical assessments or evaluations. This communication process is frequently called *screening*. Communication that *does* require the health professional to exercise independent judgment or to make clinical assessments or evaluations is frequently called *triage*. The general legal principle is that physicians are allowed to delegate screening, but not triage, to competent and knowledgeable medical assistants working under their direct supervision in outpatient settings.

It is likely that medical assisting scope of practice questions will increase in complexity and urgency. Feel free to direct such questions to Executive Director Balasa at dbalasa@aama-ntl.org.