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Medical Assisting Credentialing

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Medical Assisting Credentialing

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by

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ABSTRACT

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The purpose of this study was to investigate the hiring practices of physicians' offices as they relate to medical assistants and to gain insight into their hiring preferences. Knowing how physicians and medical office managers view the profession of medical assisting may help medical assisting professionals improve the standing of the profession and provide a consistent foundation for education programs.

I surveyed 15 physicians' practices in eight states across the country to obtain a cross-country perspective and found that many practices hire credentialed or non-credentialed individuals for clinical positions for various reasons. The reasons were minimally due to the lack of credentialed applicants and more due to personal preferences, financial decisions, and governmental regulations. This study contributes to medical assisting program directors, medical assisting professional organizations, and credentialing agencies in promoting medical assisting.

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CHAPTER 1

INTRODUCTION

"Medical Assistants are multi-skilled individuals who perform routine administrative and clinical tasks to keep the offices and clinics of physicians running smoothly" (AAMA, 2013, *Medical Assisting Career*). Medical assistants work in ambulatory care settings such as physicians' practices. In the administrative area, they complete tasks including check-in, check-out, scheduling appointments, scheduling out-of-office procedures and surgeries, insurance coding and billing, transcription, and referrals. In the clinical area, they complete such tasks as obtaining vital signs, confirming medical histories, administering medications, injections, phlebotomy, performing CLIA-waived laboratory tests on body specimens, EKGs, eye exams, sterile prep of patients, sterile room set-ups, assisting with surgical procedures, removal of sutures, vaccinations and immunizations of infants and children, and many more depending on the type of practice. Other types of knowledge and skills required in the profession include anatomy and physiology, medical terminology, keyboarding and computer applications, record-keeping and accounting, pharmacology, CPR and first aid, patient relations, and medical law and ethics. "Students also must complete a practicum (i.e. an unpaid, supervised on-site work experience in an ambulatory health care setting) as part of the program" (AAMA, 2014, W*hat is a CMA (AAMA)?*).

> The Certified Medical Assistant (American Association of Medical Assistants) (CMA [AAMA]) credential is the only medical assisting certification program that requires candidates to graduate from a medical assisting education program. Only graduates of the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools

(ABHES) accredited programs are eligible to take the CMA (AAMA) Certification Examination. The CMA (AAMA) is the only medical assisting certification that requires proof of current certification in CPR as a requirement for initial certification and recertification. The CMA (AAMA) is the only certification that uses the National Board of Medical Examiners (NBME) as a test consultant. The CMA (AAMA) is the only medical assisting credential that requires proof of continuing education in the general, administrative, and clinical categories as a condition for recertifying by continuing education (AAMA, 2014, W*hat is a CMA (AAMA)?*).

As the field of medicine changes rapidly, it is important to have the best educated medical assistants. Janeczko (2012) acknowledged that nurses were qualified clinical professionals, but there is a need for those trained in clinical and administrative skills in the physician's practice (p. 164). Therefore, Janeczko (2012) concluded that this demand for formally trained employees existed and that there is a trend towards employing more individuals who have attended accredited schools and earned appropriate credentials (p. 165).

Statement of the Problem

Since Medical Assisting is a voluntary credential, many physicians still hire individuals who have not completed medical assisting programs. These may even be a friend-of-a friend. I have personally spoken to many physicians who still continue to do this. Also, with the increase in demand for medical assistants, many proprietary schools established condensed programs that last six months or less. If an employee is to inject a patient with a certain medication and that medication must be given by a certain method (i.e. intradermal, subcutaneous, intramuscular), then having a non-educated, non-professionally trained individual can pose serious health risks

to patients and may possibly have legal implications. Neither friend-hiring nor short programs provide a solid foundation of the didactic methods of the medical skills that these individuals will be performing. Even the short programs are not long enough to fully teach the methodology behind the profession. Because the short programs are not accredited through CAAHEP or ABHES, graduates of those programs are not eligible to take the CMA (AAMA) exam. Graduates of the short programs have found that they do not find employment because of this reason. They have personally communicated that they cannot be hired because they lack the CMA (AAMA) credential.

I have also personally spoken to many physicians who have still hired the graduates of the short programs. The physicians have stated that because these individuals have had little time to study and practice, many do not understand the knowledge behind the skills they perform. They've also stated that many do not execute these skills correctly. This results in a bad reflection on the medical assisting profession. After speaking to these physicians, I have learned that many people associate all medical assistants as being the same, whether certified or not. This has also caused many practices to not hire medical assistants, in general, because the employer does not understand the differences.

Purpose of the Study

The purpose of this study was to investigate the hiring practices of physicians' offices as they relate to medical assistants and to gain insight into their hiring preferences. Knowing how physicians and medical office managers view the profession of medical assisting may help medical assisting professionals improve the standing of the profession and provide a consistent foundation for education programs.

Research Question

Why do physicians hire credentialed or non-credentialed medical assistants?

Delimitations

This study was delimitated to physicians' practices that:

(a) employ CMAs (AAMA), RMAs (AMT), Certified Clinical Medical Assistants (CCMA), or National Certified Medical Assistants (NCMA), or

(b) employ a combination of credentialed medical assistants from (1), plus licensed individuals (i.e. RN, LPN, EMT), or

(c) employ a combination of individuals from (1) and (2), plus non-credentialed individuals.

This study was also delimitated to the CAAHEP accredited programs that I have contact with through AAMA for assistance in finding the practices within their state that fall within the three delimitations above.

Limitations

1) The results were based on self-reported responses and could have included both participant bias and dishonesty.

2) CAAHEP accredited programs in Medical Assisting were not randomly chosen. I chose Program Directors that were closer acquaintances; therefore, they were more likely to participate.

3) Physician practice participants were not randomly chosen. Schools were allowed to choose practices in which participation was likely. Program Directors deliberately chose practices with which they had prior interaction.

4) As the investigator on this project and a Certified Medical Assistant who directs a program of study for medical assistants, I must acknowledge that my own bias in favor of credentialing for medical assistants is unavoidable. My desire to understand why physicians hire medical assistants who are not credentialed is rooted in my hope to move my profession toward higher professional standards and to better prepare my students for the realities of the job market.

Assumptions

I assumed that all participants could read and understand the survey instrument and that they responded in an open and honest manner. I also assumed that the CAAHEP accredited medical assisting programs chosen from a variety of states were willing to identify physicians' practices to receive surveys.

Operational Definitions

Medical Assistants: "Multi-skilled individuals who perform routine administrative and clinical tasks to keep the offices and clinics of physicians running smoothly. They should not be confused with Physician Assistants (PA-C) who examine, diagnose, and treat patients under the direct supervision of a physician" (AAMA, 2013, *Medical Assisting Career*).

Certified Medical Assistant (CMA) – "credential represents a medical assistant who has been credentialed through the Certifying Board of the American Association of Medical Assistants. The credential is awarded to candidates who pass the CMA (AAMA) Certification/ Recertification examination" (AAMA, 2014, *What is a CMA (AAMA)?*).

American Association of Medical Assistants (AAMA) – "established in 1956, continues to be the only association devoted exclusively to the Medical Assisting profession" (AAMA, 2014, *History*).

Commission on Accreditation of Allied Health Education Programs (CAAHEP) -

"is a programmatic postsecondary accrediting agency recognized by the Council for Higher Education Accreditation (CHEA) and carries out its accrediting activities in cooperation with 19 review committees (Committees on Accreditation). CAAHEP currently accredits over 2100 entry-level education programs in 23 health science professions" (CAAHEP, 2014, *About CAAHEP*).

Accrediting Bureau of Health Education Schools (ABHES) – "is recognized by the United States Secretary of Education for the accreditation of private, postsecondary institutions in the United States offering predominantly allied health education programs and the programmatic accreditation of medical assistant, medical laboratory technician, and surgical technology programs leading to a certificate, diploma, Associate of Applied Science, Associate of Occupational Science, Academic Associate degree, or Baccalaureate degree, including those offered via distance education" (ABHES, 2014, *Recognition*).

Centers for Medicare/Medicaid Services (CMS) – "1965 Medicare and Medicaid were enacted as Title XVIII and Title XIX of the Social Security Act, extending health coverage to almost all Americans aged 65 or older (e.g., those receiving retirement benefits from Social Security or the Railroad Retirement Board), and providing health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities. Seniors were the population group most likely to be living in poverty; about half had insurance coverage" (CMS, 2013, *History*).

Electronic Medical Record (EMR) - "is a digital version of a paper chart that contains all of a patient's medical history from one practice. An EMR is mostly used by providers for diagnosis and treatment" (Health IT, 2014, *What is an EMR?).*

Medical Assisting Education Review Board (MAERB) – "is an autonomous unit

within the American Association of Medical Assistants Endowment. They complete program review, based on the CAAHEP Standards and Guidelines for Accreditation of Educational Programs in Medical Assisting. As the medical assisting Committee on Accreditation of the CAAHEP, the MAERB makes accreditation recommendations for the status of accreditation of medical assisting programs" (MAERB, 2009, *Home*).

Occupational Safety and Health Administration (OSHA) – "created by Congress in 1970 with the Occupational Safety and Health Act of 1970, to assure safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education, and assistance. OSHA is part of the United States Department of Labor. The administrator for OSHA is the Assistant Secretary of Labor for Occupational Safety and Health. OSHA's administrator answers to the Secretary of Labor, who is a member of the cabinet of the President of the United States" (OSHA, 2014, *About OSHA*).

Clinical Laboratory Improvement Amendments (CLIA) – "The Centers for Medicare and Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through the CLIA. In total, CLIA covers approximately 239,000 laboratory entities. The Division of Laboratory Services, within the Survey and certification Group, under the Center for Clinical Standards and Quality (CCSQ) has the responsibility for implementing the CLIA Program. The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities" (CMS, 2013, *CLIA*).

Centers for Disease Control and Prevention (CDC) – "works 24/7 to protect

America from health, safety, and security threats, both foreign and in the U.S. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same. CDC increases the health security of our nation. As the nation's health protection agency, CDC saves lives and protects people from health threats. To accomplish their mission, CDC conducts critical science and provides health information to protect our nation against expensive and dangerous health threats, and responds when these arise" (CDC, 2013, *Mission*).

CHAPTER 2

REVIEW OF LITERATURE

Medical Assisting Profession

Medical Assisting is a relatively new profession started in 1956. This, combined with the fact that most medical assistants are not in a position to conduct research and publish papers, probably explains why there are so few peer review studies on the profession.

> Originally, physicians hired unskilled workers and trained them on-the-job for the duties necessary for their particular practice. Over time this became burdensome and they turned to the nursing profession. It was discovered that while nurses were qualified health care professionals, they did not possess the necessary skills needed in the physician's office. It was discovered that while nurses were qualified health care professionals, they did not possess the necessary skills needed in the physician's office. It is due to this wide range of duties that a demand for formally trained employees developed. Their desire is that an individual would be required to complete an accredited education program in medical assisting and obtain certification prior to employment. (Janeczko, 2012, pp. 164-165)

After many years of employees working as medical assistants in physician's practices (since 1955-56 when it was recognized as a profession), "it was not until 1978 that the Department of Education formally recognized a need for educators in this professional field" (Janeczko, 2012, p. 164) and the need to teach both administrative and clinical skills specific to physicians' practices (p. 165).

Janeczko (2012) pointed out that many medical assisting professional organizations have supported formal education and have set standards for accrediting schools and credentialing

eligibility. Some of these organizations should, but don't, require individuals to complete an accredited program to obtain certification before being employed as medical assistants. This trend to hire medical assistants rather than nurses in physicians' practices has developed over many decades. The Bureau of Labor Statistics has reported medical assisting as one of the top twenty fastest growing occupations from 2008 to 2018.

Janeczko (2012) argues that medical assistants today must be well-trained multi-skilled practitioners. In the administrative area, medical assistants must complete tasks such as check-in, check-out, scheduling appointments, scheduling out-of-office procedures and surgeries, insurance coding and billing, transcription, and referrals. In the clinical area, medical assistants must complete tasks such as obtaining vital signs, confirming medical histories, medication administrations, injections, phlebotomy, performing CLIA-waived laboratory tests on body specimens, EKGs, eye exams, sterile prep of patients, sterile room set-ups, assisting with surgical procedures, removing sutures, vaccinations/immunizations of infants/children, and many more depending on the type of practice. Other types of knowledge/skills required in the profession include anatomy & physiology, medical terminology, keyboarding and computer applications, recordkeeping and accounting, pharmacology, CPR/first aid, patient relations, and medical law and ethics (AAMA, 2014, *Frequently asked questions*). Therefore, Janeczko (2012) contends that advanced training within medical assisting will become necessary because health care continues to change.

The medical assisting profession must seize the opportunity for demand by "providing well-educated and credentialed medical assistants to fill the increasing number and variety of multi-skilled health positions available" (Janeczko, 2012, p. 165). A CMA (AAMA) has been credentialed by the Certifying Board of the American Association of Medical Assistants.

Therefore, Balasa (2009) stresses that "understanding why employers are aggressively recruiting CMAs (AAMA) is of the utmost importance for a medical assistant's entry into and advancement within the allied health work force" (p. 259).

Legal Issues

With the growing popularity of hiring medical assistants in physicians' practices, "employers of allied health professionals have correctly concluded that having credentialed personnel on staff will lessen the likelihood of a successful legal challenge to the quality of work of the employee. Thus, in the realm of medical assisting, the [certification] credential has become a means of protecting against potential plaintiffs who might seize upon the fact that the employer is utilizing unlicensed allied health personnel" (Janeczko, 2012, p. 164-5). According to Balasa (2010),

> it is the position of the American Association of Medical Assistants that potentially patient-jeopardizing procedures – such as phlebotomy; subcutaneous, intramuscular, and intradermal injections; and limited scope radiography – should only be delegable to medical assistants who fulfill the following requirements: (A) **Professionally educated**. They have graduated from a medical assisting program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES), and (B) **Suitably credentialed**. They hold a current, accredited medical assisting credential of acceptable breadth, depth, and rigor. Restricting such procedures to professionally educated and credentialed medical assistants would be considered limited licensure of medical assistants. Such restrictions would not be considered total licensure of medical assistants because

> non-potentially patient-jeopardizing tasks could still be delegated to medical assistants who have not received accredited medical assisting education and have not earned an accredited medical assisting credential (Balasa, 2010e, p. 6).

Delisio (2008) advocated that professional certification protection will be of benefit to the practice from an Occupational Safety & Health Administration (OSHA) standpoint and Fleming-Castaldy and Gillen (2013) added that this will also protect the public by ensuring qualified practitioners. This will give the physician the confidence that "the employee is knowledgeable in the use of the instruments they handle" (Delisio, 2008, p. 73).

Boltz, Capezuti, Wagner, Rosenberg, and Secic (2013) stressed that the clinician's knowledge and skill plays a critical role in preventing negative safety outcomes and reducing adverse events. This is not only in the physicians' practice, but Wiseman (2013) detailed how many hospitals are also requiring all of their professional staff to obtain certifications which prove their level of knowledge and skill.

Having professional staff obtain certifications seems to be a fairly new requirement from the governmental agencies regarding funding to physicians' practices and hospitals. "The latest focus of Medicare's Zone Program Integrity Contractors (ZPICs) is credentialing for hospital staff and physicians" (Hospital Case Management, 2013, p. 4). Even though the hospital hires many physicians and nurses to respond to most direct patient care needs, many non-licensed individuals are also hired in the hospital setting. Many of these individuals are being allowed to perform certain skills without having the appropriate education, training, and credentials. However, this has become a legal and financial issue.

> In additional to losing reimbursement when cases don't meet medical necessity, hospitals face additional lost revenue if the credentials of all personnel who

> provide care for patients are not up to date and staff are performing interventions for which they are not licensed (Hospital Case Management, 2013, p. 4).

The typical process to provide funding for credentialing has been

> ZPICs sending out letters requesting medical records as usual. Then they are showing up at the hospital and demanding to see the credentials of everyone who provided care for patients in those records. The ZPICs are asking for far more than the credentials of the physicians. They also want credentials from the nursing staff and the technical staff (Hospital Case Management, 2013, p. 4).

It is with these other technical staff that a problem occurs; they do not possess the appropriate education, training, and credentials.

If credentials of all personnel are not provided, then revenue is lost. If this extends for a long period of time, then hospitals are losing valuable reimbursement for services. This poses a large financial issue for many healthcare facilities.

> If someone who provided care for a patient doesn't have the proper license and credentials, then any service provided by that person can be disallowed. This can affect a vast amount of charges in a big hurry. The ZPIC could deny care for every patient he or she worked with for an entire year as a condition-of-payment violation (Hospital Case Management, 2013, p. 4).

Particular employees may lose their jobs and/or not be allowed to perform the tasks that had previously been taught on-the-job. These duties would then fall on the licensed or credentialed employees to cover. "Hospitals should determine where all of the records of staff credentials and licensure are located, that they are current and that the full records are available…and that every license is up to date, going back three years" (Hospital Case

Management, 2013, p. 5). This would prevent the hospital from being fined for allowing non-credentialed individuals to perform certain tasks and would be ready for any inspection by ZPICs.

"The ZPICs are based on the Medicare Administrative Contractor (MAC) jurisdictions and started by auditing hospitals but eventually will audit all providers of services to Medicare. ZPICs will review all providers of Medicare and Medicaid services" (Hospital Case Management, 2013, p. 5). As many individuals have lost jobs over the past few years, they have turned to Medicaid to take care of their medical financial needs. Therefore, if a physician's practice accepts Medicare and/or Medicaid insurance, it will have more credential auditing to occur.

> Employers of allied health professionals have correctly concluded that having credentialed personnel on staff will lessen the likelihood of a successful legal challenge to the quality of work of the employee. Thus, in the realm of medical assisting, the CMA (AAMA) credential has become a means of protecting against potential plaintiffs who might seize upon the fact that the employer…is utilizing unlicensed allied health personnel (Balasa, 2009, p. 259).

Most recently, the Center for Medicare and Medicaid Services (CMS) issued a notice of proposed rulemaking (NPRM) on March 20, 2015 for Stage 3 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

> In Stage 3, we propose to continue the policy from the Stage 2 final rule at 77 FR 53986 that orders entered by an licensed healthcare professional or credentialed medical assistant would count toward this objective. The person entering the order would be required to enter the order correctly, evaluate a Clinical Decision Support (CDS)

> intervention either using their own judgment or through accurate relay of the information to the ordering provider, and then either make a change to the order based on the information provided by the CDS intervention or bypass the intervention. The execution of this role represents a significant impact on patient safety; therefore, we continue to maintain for Stage 3 that a layperson is not qualified to perform these tasks (CMS, 2015, p. 82-83).

In addition, state and federal laws – especially certain provisions of the Occupational Safety and Health Act (OSHA) and the Clinical Laboratory Improvements Act (CLIA) – are making mandatory credentialing for medical assistants a logical next step in the hiring process (Balasa, 2009, p. 259).

How Other Professions View Medical Assisting

As Janeczko (2012) pointed out, since many nursing positions in physicians' practices were replaced by medical assistants, the nursing profession has been cautious about the medical assisting profession, and rightfully so. The problem exists in the regulatory arena.

> In some states, medical assistants are overseen by the board of nursing. In others, it is board of medicine which oversees medical assistants. In some states, there is no agency overseeing medical assistants. In that case, practices should write a policy stating what the medical assistant may do (and may not do), and stating that the physician in charge delegates the stated duties to the medical assistant (Buppert, 2008, p. 329).

Due to this inconsistency, Buppert (2008) suggests that employers monitor their medical assistants at least two hours per day in their interactions with patients. Even though the states may not have regulations regarding the medical assisting practice, medical assisting professional

organizations will provide guidance on scope-of-practice. This daily monitoring will allow the supervisor to see if the medical assistant is exceeding that scope and Buppert (2008) suggests informing the physicians of breach-of-practice so the medical assistant can bring his or her practice into compliance, if necessary.

The New Hampshire Nursing Board (2009) has indicated that because of the popularity of the profession, medical assisting programs seem to be opening overnight. The Board reported they "have compiled [a] letter to inform [their] colleagues of specific concerns [they] have encountered while working with medical assistants in recent years as they have been incorporated into [our] clinical arena:

- Lack of licensure, and therefore, not accountable to any professional board/organization for professional responsibility,
- Lack of clinical knowledge provides no "real" clinical training and therefore, poor clinical judgment skills,
- Certification process not required until 5 years after they have "gained experience,"
- Not subject to criminal background checks or fingerprinting,
- Not required to obtain continuing education and not current in practice,
- Allowed to triage patients without clinical expertise,
- Allowed to perform or assist with procedures without appropriate education/training and experience,
- Allowed to deliver patient education without appropriate education/training/experience,
- Referred to as 'nurses' therefore, impersonating a nurse" (p. 4).

The nurses of New Hampshire "feel that the decision to replace these nursing positions with

inexperienced, unprofessional, unaccountable personnel for the sake of the bottom line is a very risky proposition" (New Hampshire Nursing News, 2009, p. 4).

Some of the concerns posed by the New Hampshire nurses have been addressed by Donald A. Balasa, JD, MBA, Executive Director of the AAMA. In Balasa's (2010a) post "Legal Eye on Medical Assisting," he answers questions that show the AAMA is or is not promoting a certain function to be performed by its CMAs (AAMA). On behalf of the AAMA, Balasa (2010b) states that a medical assistant should "absolutely not call her/himself a nurse. The title 'nurse,' even when used generically, is restricted by state laws to those individuals licensed as RNs or LPNs. Medical assistants can be criminally and civilly liable if they call themselves 'nurse,' 'office nurse,' 'the doctor's nurse,' or any other variation of the title 'nurse' (Balasa, 2010b).

Even when the medical assistant does not call her/himself a "nurse," many of the remaining staff may continue to do so. Balasa (2010c) states,

> just as medical assistants are forbidden by state law from referring to themselves as nurses, a physician should not refer to medical assistants as nurses. However, a physician (or any other staff member) referring to a medical assistant as a nurse could indeed harm the practice from a malpractice standpoint in that a plaintiff could argue that the medical assistant should be held to the standard of care of an RN or LPN instead of that of a medical assistant (Balasa, 2010c).

Another problem that exists seems to be the creation of a credential. This occurs frequently with many hired medical assistants who have only received on-the-job training. As reported by medical assisting students of accredited programs while at externship sites, those who have not been through a post-secondary medical assisting program to learn cognitive,

psychomotor, and affective domain competencies have instructed students (of accredited programs) to sign patient's legal charts with a faux credential when entering information. Balasa (2010a) responds to this by saying,

> the AAMA never uses the initialism 'MA' when referring to medical assistants who do not have the CMA (AAMA) credential, or any other medical assisting credential. The confusion is that 'MA' can be confused with 'Master of Arts.' Medical assistants who have not obtained a credential are told that they can refer to themselves as 'medical assistants,' but are never told that they are permitted to convert this to the initialism of 'MA' and use these letters after their name (Balasa, 2010a).

Threats to the Integrity of the Medical Assisting Profession

Through direct observation and personal reporting, many CMAs (AAMA) are unhappy with those who work as medical assistants but have never been properly trained in a nationally-recognized program.

> According to Elizabeth Kraus, co-founder of website Myusearch.com, 'most students don't even think to ask whether their school is regionally or nationally accredited, but this can be a huge mistake. I think there is a severe lack of education concerning accreditation…and most students don't find out about it until it is too late' (Kraus in Snodgrass, 2010, p. 89).

Many students look for the quickest option, as shown by the many advertisements for six-months-or-less programs. Therefore, they turn away from the more formal programs. Snodgrass (2010) warns that students should be wary of advertisements and emails and should thoroughly investigate a program.

> Sometimes, the obscured details in the fine print or lack of information are keys to what an institution has to offer. Institutions that do not post detailed faculty information on their websites should be suspect. When requesting information, ask for background and education of faculty. If the program looks too good to be true, well then, it probably is (Snodgrass, 2010, p. 91).

This "too good to be true" situation has posed another topic discussed on Balasa's (2010d) blog:

> I graduated from an accredited MA [Medical Assisting] school over eight years ago, and I have been with my employer since graduation. At my time of hire, being an RMA or CMA was not required. Recently they have implemented a new pay scale for those that are certified (Balasa, 2010d).

Certification and Credentialing

Wiseman (2013) stated that certification is a relatively new concept and leads to confusion. Medical assisting certification is actually not a new concept; however, as Jeffries (2013) pointed out, educating the public about it needs to be important. In its basic concept, "certification generally is defined as the validation of cognitive knowledge" (Boltz et al., 2013, p. 27). Passing an exam with a certain score indicates at least an acceptable minimum level of knowledge or understanding of what is being tested. But as Wiseman (2013) asserted, formal recognition of specialized knowledge, skills, and experience demonstrated by achievement of standards is required of a medical profession.

Some credentials are provided by private, for-profit agencies and do not require the candidate to have completed an accredited medical assisting educational program. Such credentials are the Certified Clinical Medical Assistant (CCMA) by the National Healthcareer Association (NHA) and the National Certified Medical Assistant (NCMA) by the National

Center for Competency Testing (NCCT). Therefore, if a person who passes a certification exam has not been introduced to specialized knowledge, skills, and experience, then that person has not really grasped the concepts of what the certification certifies them to do. Mostly, "certification refers to specialty certification achieved from nationally recognized certifying organizations" (Wiseman, 2013, p. 241). However, the exams given by these private organizations are not nationally recognized by many employers.

"Certification has traditionally been viewed as optional, but that is changing" (Wiseman, 2013, p. 241). As discussed previously with the ZPICs, more requirements are being implemented by governmental agencies. "Certification also has been associated with professional opportunities (e.g., access to continuing education and job promotion) and higher salaries/benefits" (Boltz et al., 2013, p. 27).

Even when non-credentialed individuals are hired, career advancement within the profession is only obtained by having the appropriate credential for the position. Knudson (2013) spoke of certification as a career advancement and much research has been conducted to confirm its value such as "enhancing feelings of personal accomplishment, providing personal satisfaction and a professional challenge, enhancing professional credibility, and providing evidence of professional commitment" (p. C9). In addition, Lennon (2013) expressed that credentials are either strongly preferred or mandatory for certain jobs (p. 68).

As previously discussed, some private agencies do not require any previous formal education in order for an individual to take their exam. Exams by nationally-recognized accrediting agencies "are based on curriculums that are designed to test both your breadth and depth of knowledge, [to] come away with a strong understanding of the subject matter…both conceptually and tactically" (Lennon, 2013, p. 68). Those agencies expect an individual to go

through the professional program to learn the didactic knowledge behind the skills they perform on patients.

In many areas besides medical assisting there are more strict regulations on who is eligible to take an exam. "Having such qualifications is important in today's dynamic and highly competitive job market. In addition, since competition for credentialed resources is likely to be higher (lower supply), this drives higher potential earnings" (Lennon, 2013, p. 68). Lennon (2013) also notes that it does take dedication to attend a professional program and earning the credential is certainly an investment but pays off long term.

Lennon (2013) concludes that having a professional credential sends a signal to future employers of dedication to professional development throughout one's career and the ability to see ambitious goals through to completion.

In Other Allied Health Professions

Many other professions, even those that also require licensure, are delving into the certification process. "The American Health Information Management Association (AHIMA) credentials distinguish professionals from peers and colleagues that may be vying for the same position. Credentials offer candidates a significant competitive advantage immediately upon graduation, and could make the difference in landing a job" (AHIMA, 2013, p. 11).

The podiatry profession has also experienced this change. "More and more podiatrists are looking for assistants that are already trained" (Delisio, 2008, p. 68). Podiatrists realized that "certified assistants would add skilled personnel to a practice, possibly leading to more patients and more revenue" (Delisio, 2008, p. 67). However, many are still hesitant to hire Podiatric Medical Assistants (PMA). "There certainly is the potential for certified podiatric medical assistants. Many tasks don't require the hands-on skills of a podiatrist" (Delisio, 2008, p. 68).

The hope is that more podiatrists will realize the benefits of a credentialed employee. "Among the benefits for podiatrists of hiring trained PMAs are having a more credentialed, professional office; improved efficiency; and lower stress because of the ability to delegate tasks" (Delisio, 2008, p. 68). Podiatrists, too, experience working with those individuals who are executing skilled tasks without education and training, but many of their preferences in hiring lie with those certified instead. Ornstein, chairman of the American Academy of Podiatric Practice Management (AAPPM) states, "I would love to have high-caliber training at community colleges and technical schools; my choice would be community colleges. Assistants in our world are so important. They help me, they help our patients, and they help our profession" (Ornstein in Delisio, 2008, p. 74). Some podiatrists recognize that even paying PMAs a higher salary, "podiatrists still win because having better staff allows practices to grow, generating more revenue" (Ornstein in Delisio, 2008, p. 70).

Even the nursing profession has started requiring licensed nurses to obtain additional certifications. In addition to nurses, other licensed professionals (i.e. nurse midwives, nurse practitioners, pharmacists, physicians, physician assistants, psychologists) are eligible to sit for the exam. "The North American Menopause Society (NAMS)…developed a rigorous, periodic competency examination for licensed healthcare practitioners…which would validate their expertise in this area of women's health. Passing the examination would earn them the credential of 'NAMS Menopause Practitioner.' The NAMS Menopause Practitioner credential is valid for three years. There are two ways to maintain the Menopause Practitioner credential: (1) by submitting the appropriate continuing education hours, and (2) by reexamination. "To maintain certification through continuing education…45 credit hours must be earned. Of those 45 hours, 30 must have been awarded by NAMS" (Crandall, 2009, p. 15-7). Therefore, if the

nursing profession is calling for additional certifications, even of licensed nurses, then the medical assisting professional should need at least one.

Many healthcare professionals may ask why licensed nurses need additional certification. Knudson (2013) found that certified nurses…, had more tenure in nursing and their units, …, and were more likely to hold a BSN or higher degree than nurses who were not certified" (Knudson, 2013, p. C10). This gives a more prestigious standing within the workplace. "On the benefits side, the nurses expressed agreement with certification enhancing feelings of personal accomplishment, providing personal satisfaction and a professional challenge, enhancing professional credibility, and providing evidence of professional commitment" (Knudson, 2013, p. C9). Just as with a CMA (AAMA), "nurses have also reaped personal feelings of achievement from certification (Knudson, 2013, p. C10). They have more "positive patient outcomes [which] are associated with better work environments and higher proportions of nurses with bachelor's degrees and specialty certifications within hospitals" (Knudson, 2013, p. C9).

Continuing Education

Quoting from a recent commentary in the *Journal of the American Medical Association*, Crandall (2009) says "research suggests that, on average, clinical skills tend to decline over time; a meta-analysis by Choudry and Fletcher illustrates that practice does not make perfect and supports the argument that physicians must engage in continuous professional development to retain competency" (p. 15). Within the nursing field, "higher perceptions of overall workplace empowerment have been positively associated with certification. Moreover, because certification must be renewed periodically, it helps to address the Institute of Medicine's recommendation that ongoing education and periodic reexamination be required of health care providers" (Rauen, Shumate, Jacobson, Marzlin, & Webner, 2014, p. 66). As required by the

AAMA, the CMA (AAMA) credential must be renewed every five years. This may be accomplished by re-examination or continuing education. If continuing education is chosen, then 60 CEUs must be obtained in general, administrative, and clinical areas, with a minimum of 10 in each. This gives the CMA (AAMA) the knowledge base of the multi-skilled profession they were educated and trained in while in school.

The AAMA and its state and chapter affiliates hold conferences at which guest speakers present a variety of general, administrative, and clinical topics. Attending professional conferences gives the CMA (AAMA) the "personal and professional feelings of accomplishment [which] also come from attaining advanced knowledge and skills in a specialty area" (Knudson, 2013, p. C9). After one has worked in a particular practice, especially a medical specialty such as pediatrics, the individual may have forgotten much of what he or she learned in school in other focused areas. Therefore, "continuing competence is believed [to] more accurately reflect the ongoing nature of professional development" (Wiseman, 2013, p. 242). In addition, "advances in the depth and breadth of a professional's competence should be demonstrated throughout his or her career" (Wiseman, 2013, p. 242).

A nursing task force "recommended the term 'continuing competence,' which they believe more accurately reflects the ongoing nature of professional development" (Wiseman, 2013, p. 3). "In 2005, [the National Council of State Boards of Nursing] NCSBN defined competence as 'the application of the knowledge and interpersonal, decision-making and psychomotor skills expected for the nurse's role'" (Wiseman, 2013, p. 242).

Within the occupational therapy profession, "the American Occupational Therapy Association (AOTA, 2007) envisions evidence-based practice (EBP) as the profession's norm" (Fleming-Castaldy & Gillen, 2013, p. 365). According to Fleming-Castaldy and Gillen (2013),

EBP is "the integration of best research evidence with clinical expertise and patient values. We identify key issues that support the use of evidence, not tradition, to inform occupational therapy education, certification, and practice" (p. 365). Even in occupational therapy, a trend away from tradition is developing.

EBP has proven to be many professions' new norm and "for decades, leaders in our field have called for EBP, yet many in our profession remain wedded to tradition. This reluctance to assume accountability for the validity of our practices must be confronted. Maintaining misplaced loyalties and politely ignoring colleagues who do not remain current must cease" (Fleming-Castaldy & Gillen, 2013, p. 367). EBP may be proven by keeping current in one's healthcare field, which can be accomplished by continuing education as well as other means.

Since many physicians turned to trained medical assistants to provide clinical skills in their practices, then "practitioners [too] should avoid using outdated or obsolete measures, use evidence-based interventions as much as possible, take actions to ensure continuing competence, and practice on the basis of current knowledge and research" (Fleming-Castaldy & Gillen, 2013, p. 365). Physicians' practices should also encourage continuing education of their staff to have "fresh perspectives [that] can be brought to settings steeped in tradition" (Fleming-Castaldy & Gillen, 2013, p. 367).

Educators' Role

Educators too, must stay up-to-date on the latest advances in medicine and techniques to teach students properly. Fleming-Castaldy & Gillen (2013) argued that educators must be committed to developing students' competencies and this is accomplished by staying up-to-date on skills. If a new procedure or technique is described in a new edition of a textbook, then the educator must also be competent in it. "Faculty limitations must be acknowledged and needed

expertise acquired" (Fleming-Castaldy & Gillen, 2013, p. 367). Therefore, educators may need to have guest speakers and demonstrators to teach a new topic to them, as well as to the students.

However, some techniques that are no longer covered in textbooks, such as the Pegboard system of entering patient payment accounts, must still be taught in the classroom because the technique is still being used in some physician's practices. Therefore, the instructor must be educated in up-to-date, as well as, outdated techniques. "Educators, editors, authors, practitioners, and our profession's credentialing bodies must acknowledge the impact of continued inclusion of unsubstantiated and disproven approaches in their respective domains" (Fleming-Castaldy & Gillen, 2013, p. 368). However, they do need to address this with professional organizations so that textbooks may continue to include them. The opposite would also need to be addressed. There are some techniques that are obsolete in the profession, yet are still being included within the textbooks. Authors and publishers would need to know that these tasks/techniques are no longer part of the profession. "It is time to walk the talk of EBP and not require the demonstration of knowledge of obsolete techniques as a criterion for practice" (Fleming-Castaldy & Gillen, 2013, p. 368).

Summary

As the health related professions are focusing on EBP and continuing professional education, there is more emphasis on the credentialing of medical professionals, which supports the argument that medical assistants should be credentialed by education and training.

There are several reasons why physicians may still hire uneducated, untrained, and/or uncertified individuals to work in their practices, including no regulatory oversight (Buppert, 2008, p. 329), no requirement by some agencies for formal education in order to take their exam (Balasa, 2011), and lack of education concerning accreditation (Kraus in Snodgrass, 2010, p. 89).

According to the New Hampshire Nursing Board (2009), these questionable decisions include "replacing clinical positions with inexperienced, unprofessional, unaccountable personnel for the sake of the bottom line are a very risky proposition" (p. 4). However, Janeczko (2012) "acknowledged the need for those trained in clinical and administrative skills was required in the physician's practice" (p. 164).

CHAPTER 3

METHODOLOGY

Overview

The purpose of this study was to investigate the hiring practices of physicians' offices as they related to medical assistants and to gain insight into their hiring preferences. Knowing how physicians and medical office managers view the profession of medical assisting may help medical assisting professionals improve the standing of the profession and provide a consistent foundation for education programs.

I used the information gathered to interpret the overall understanding of physicians throughout the country to assist AAMA program directors in promoting their program and the CMA (AAMA) as the preferred credential.

Design of the Study

I used a quantitative study with descriptive statistics to gain insight into the hiring preferences of physicians within states across the country that have CAAHEP accredited medical assisting programs.

I used a pilot study to establish the responsiveness of the questions. "Volunteers must often be recruited to participate in studies, because it is not possible to use random selection and require those selected to participate" (Cottrell & McKenzie, 2011, p. 175). Due to the nature of the information desired from specifically chosen physicians, selection bias was unavoidable. I used a cross-sectional survey design to "collect data at one specific point in time to determine the current attitudes, opinions, beliefs, values, behaviors, or characteristics of a given population" (Cottrell & McKenzie, 2011, p. 196). I used Survey Monkey to distribute the survey and collect the data.

The participants were not randomly chosen but were a convenience sample composed of medical practices familiar to selected medical assisting program directors from across the country.

Ethical Considerations

The confidentiality of respondents was assured by anonymous surveys through Survey Monkey. Only the physician's state in which their practice resides was known. This was only to show if there was a common hiring practice among the selected regions of the country. At no time was anyone able to identify the respondents with their answers. Survey records and other materials will be stored in my home in a locked filing cabinet for at least five years. The ETSU Institutional Review Board for the protection of human subjects approved this study (approval # 0615.8e).

Participants

Participants for this study consisted of 15 physicians from seven of the nine AAMA regions (see Appendix A) (AAMA, 2014, *2014 Medical Assisting Compensation and Benefits Report*). The nine regions consist of: New England, Middle Atlantic, South Atlantic, East North Central, East South Central, West North Central, West South Central, Mountain, and Pacific. However, even though all 50 states were included in the Compensation and Benefits report, only the 46 states that have CAAHEP accredited medical assisting programs were considered for survey purposes. North Dakota, Rhode Island, Vermont, and Wyoming do not have CAAHEP accredited medical assisting programs.

Within these 46 states, there are 549 CAAHEP accredited programs in Medical Assisting (CAAHEP, 2014). To represent the country in a sampling population, at least one Medical

Assisting program was chosen from each of the nine regions. Each program was asked to identify three physicians, one from each of the following categories, to complete the survey.

(a) Employs CMAs (AAMA), RMAs (AMT), Certified Clinical Medical Assistants (CCMA), or National Certified Medical Assistants (NCMA), or

(b) Employs a combination of credentialed medical assistants from (1), plus licensed individuals (i.e. RN, LPN, EMT), or

(c) Employs a combination of individuals from (1) and (2), plus non-credentialed individuals.

I collected this information in June and July 2015.

Development of the Instrument

I developed the survey questions from round-table discussions of program directors at AAMA national conferences. Three physicians (one from each of the three categories) from my home town participated in the pilot study. I asked them to evaluate the appropriateness, thoroughness, and any potential bias of the questions to which they would respond. The questions (see Appendix B) were semi-structured and informal with some open-ended questions about their hiring practices.

Data Collection Procedures

I emailed at least one medical assisting program director of a CAAHEP accredited medical assisting program within each region using eBlast. The email included an explanation of my study. I asked the program directors if they would be able to secure three physicians (in practices that hire according to each of the three categories above) who were willing to complete the survey about medical assisting credentialing and hiring practices. If a program director was unable to participate, I contacted another program director from the same region until I had

secured one from each of the nine regions that have CAAHEP accredited medical assisting programs. Once confirmed, I then emailed the survey to the physician.

I sent the physicians (or those in charge of hiring) an email with an explanation of the research purpose, the informed consent document, and a link to the survey on Survey Monkey on July 19, 2015. I collected data during the summer and early fall of 2015.

Data Analysis

I grouped responses according to the three hiring categories using "axial coding which is the process of drawing a relationship between a category and its subcategories" (Cottrell & McKenzie, 2011, p. 234) and the specific survey question. I also reviewed the data for common themes for each question and across related questions.

I used descriptive statistics to "summarize data about a given population or variable so they can be easily comprehended" (Cottrell & McKenzie, 2011, p. 256).

CHAPTER 4

RESULTS

The purpose of this study was to investigate the hiring practices of physicians' offices as they related to medical assistants and to gain insight into their hiring preferences. Knowing how physicians and medical office managers view the profession of medical assisting may help medical assisting professionals improve the standing of the profession and provide a consistent foundation for education programs. I developed the survey questions based on issues of concern that arose in round-table discussions of Medical Assisting Program Directors at the annual, national AAMA conferences.

Pilot Study

I developed my questions and then created a survey using Survey Monkey. I then sent the web link to the online survey to 28 physicians' practices within my home town. I included at least one from each of the three hiring practices described in the Delimitations. I randomly selected physicians who work within their own practice setting and also from those who work within practices owned by corporations.

Of the 28 physicians/practices that I sent emails, 12 responded. However, seven were from category B and five were from category C. There was no participation from anyone from category A within the pilot group (see Appendix C).

The questions on the pilot survey were semi-structured and informal with some open-ended questions about their hiring practices. I asked each physician to evaluate the appropriateness, thoroughness, and any potential bias of the questions to which they would respond. The physicians responded that the questions were appropriate, thorough, and showed no bias.

Participants

The participants were a convenience sample composed of medical practices familiar to selected medical assisting program directors from across the country and who fell into one of the following categories:

(a) employ CMAs (AAMA), RMAs (AMT), Certified Clinical Medical Assistants (CCMA), or National Certified Medical Assistants (NCMA), or

(b) employ a combination of credentialed medical assistants from (1), plus licensed individuals (i.e. RN, LPN, EMT), or

(c) employ a combination of individuals from (1) and (2), plus non-credentialed individuals.

Of the 28 participants who responded, four (14.29%) were from category A, thirteen (46.43%) were from category B, and eleven (39.29%) were from category C.

Results

The raw data (see Appendix E) showed that factors taken into account when hiring staff were varied amongst the three different categories. Category A mainly focused on experience and attitude, category B on credentials/qualifications and needs of the practice at the time of hiring, and category C on budgeting.

When asked about potential medical or legal risks of hiring non-credentialed staff, categories A and B responded that there are risks involved and that is why they do not hire those individuals, but category C indicated that there are risks only if the individual is not properly supervised.

In regards to physicians hiring non-credentialed individuals in order to pay less, the general consensus of each group was that they do not, but when asked why about the pros of

hiring non-credentialed staff, the answers were mainly related to being able to pay less for non-credentialed employees.

The Meaningful Use requirement of the Centers for Medicare and Medicaid Services (CMS) to switch to Electronic Medical Records (EMRs) by 2014 includes a stipulation that only licensed or certified individuals may enter information into the EMRs. Participants were asked why physicians still hire non-credentialed employees if they would be unable to meet this requirement. Responses varied from not knowing the rules, to allowing non-credentialed staff to perform clinical skills but having another (credentialed) person to enter the procedure into the EMR, to paying less for non-credentialed employees.

Summary of Category A

Of the participants in category A, two out of three reported that hiring a medical assistant allows them to pay less than hiring a Registered Nurse (RN); however, this group always hires a credentialed medical assistant because they have graduated from an accredited school and have externship experience. Interview scenario responses, experience, attitude, education, and training contributed to the hiring decisions. In response to the question about why they think physicians still hire individuals without credentials, despite the Meaningful Use requirement, they indicated that no one checking credentials and cost were the primary reasons. The most common response among participants was in reference to the pros of hiring credentialed medical assistants. These responses were all related to the credentialed individuals being educated and trained.

Summary of Category B

Three out of six participants of this group described the procedures performed by certified medical assistants as more "hands-on" than the licensed personnel. Licensed personnel were used mainly for administrative functions and training purposes.

When deciding to hire certified medical assistants or licensed personnel, the main factors did not necessarily pertain to whether they were certified or licensed, but mainly due to who has applied at that specific time. With this group, qualities they looked for in hiring ranged from longevity, to experience, to professional appearance. These same qualities, as well as credentials, played a factor in determining pay. Therefore, a person who was certified who had these qualities would be considered at the same pay rate, even if they were not licensed.

This group of participants also shared positive opinions regarding the credentialed medical assistant and suggestions for improvement within the profession.

Summary of Category C

The participants in category C hire non-credentialed personnel and described the quality of work among credentialed staff was better than those non-credentialed; however, half of this group still allow non-credentialed individuals to perform invasive procedures. All participants of this group did report that there are medical and legal risks when non-credentialed individuals perform clinical procedures.

Budgeting, which included paying less for non-credentialed individuals, was the main factor involved in hiring non-credentialed individuals. However, this contradicted their response that physicians hire these individuals in order to pay less. While one's education and credential was not a main factor in hiring, it did factor into their level of pay.

This group acknowledged the benefits of hiring credentialed medical assistants including training, experience, knowledge, professionalism, educated, flexibility of administrative and clinical skills, and fulfilling CMS ruling, but they continue to hire non-credentialed individuals because they are cheaper and there are more of them available in the job market.

The additional comments provided by this group were encouraging. They reported a preference of medical assistants over RNs or Licensed Practical Nurses (LPNs) to work in physicians' practices and also recommended that community colleges acquire appropriate accreditations for graduates to become eligible for national certification, in which the employer needs. They also recommended that the community colleges increase their number of graduates to sufficiently supply the workforce demand.

Summary

The purpose of this study was to investigate the hiring practices of physicians' offices as they related to medical assistants and to gain insight into their hiring preferences. Of the respondents, only 14.29% were in Category A (those who hired only credentialed medical assistants), which was the least percentage to respond. Those that hired credentialed medical assistants plus licensed individuals (category B) as clinical staff were the largest percentage (46.43%) to respond. Those who hired a combination of individuals from a) or b), plus non-credentialed individuals (category C) in clinical staff positions were the second largest percentage (39.29%) to respond.

CHAPTER 5

CONCLUSIONS, DISCUSSION, AND RECOMMENDATIONS

Introduction

The purpose of this study was to investigate the hiring practices of physicians' offices as they related to medical assistants and to gain insight into their hiring preferences. Knowing how physicians and medical office managers view the profession of medical assisting may help medical assisting professionals improve the standing of the profession and provide a consistent foundation for education programs. The categories of the different employment options again were:

A - employ CMAs (AAMA), RMAs (AMT), Certified Clinical Medical Assistants (CCMA), or National Certified Medical Assistants (NCMA).

B – employ a combination of credentialed medical assistants from a), plus licensed individuals (i.e. RN, LPN, EMT).

C – employ a combination of individuals from a) or b), plus non-credentialed individuals.

An increasing emphasis on the credentialing of medical professionals (Knudson, 2013), supports the argument that medical assistants should be credentialed by education and training (Hospital Case Management, 2013, p. 4).

Many of the participants indicated that they hire individuals based on education, credentials, and experience. Through the literature review, I found that there are several reasons why physicians may still hire uneducated, untrained, and/or uncertified individuals to work in their practices. These reasons included no regulatory oversight (Buppert, 2008, p. 329), some agencies do not require any previous formal education to take their exam (Balasa, 2011), and lack of education concerning accreditation (Kraus in Snodgrass, 2010, p. 89). Some participants

stated that since they were not bound by CMS ruling regarding Meaningful Use, then they were not required to hire all credentialed individuals. Some participants also stated that while they know the difference between the various medical assisting credentials, there are other practices that do not. Many of those who understood the difference stated that they would only hire CMAs (AAMA) because of their thorough programs.

Conclusions

Although my original plan was to get participation from each AAMA region, I found that objective was not practical. Since many Medical Assisting program directors only teach core courses during the typical school year (August – May), I thought this would give them more free time during the summer to participate by responding to my emails and providing names and emails of participating physicians' practices. However, I did not take into account the fact that if they were not teaching during the summer, then they would not be responding to emails either. Many program directors did not respond at all and in addition, had automatic reply messages that they were off for the summer and to contact them when the new school year started again in August. My attempt to gain another program director in their region was also unsuccessful.

In addition, I do believe the wildfires in California, Oregon, and Washington (this 2015 summer) also contributed to the lack of participation in the Pacific region. Alaska and Hawaii have only two and one programs, respectively, within the entire state, which may have also contributed to the lack of participation in the Pacific region.

Even though the response rate was lower than I expected, I did gain valuable insight on the hiring practices. In addition, there doesn't seem to be any difference in the type of hiring preferences and the location in the country. The only minimal difference was in the responses

from New Mexico which regulated fewer procedures, than the other states, that medical assistants are allowed to perform.

Therefore, I feel that the results supported what I found in the literature that more employers are turning towards only credentialed individuals being allowed to performed invasive and critical procedures; however, many are still hiring non-credentialed individuals for a variety of reasons.

Discussion

As stated in the Limitations, as a program director of a CAAHEP accredited medical assisting program, I do acknowledge my bias in favor of credentialed medical assistants. I am passionate about making sure my students have a thorough program to step into the work force as a competent assistant. This includes making sure they have the cognitive knowledge, psychomotor skills, and affective behavior to perform as a legal and ethical member of the healthcare team. All of this also gives a better standing of the medical assisting profession. Due to the CAAHEP program accreditation, my graduates are eligible to take the CMA (AAMA) credentialing exam. This is a national credential and affects all states across the country; therefore, my research is needed by other program directors like myself.

As this is the driving force behind my research, I sought out the reasons that physicians' practices may or may not hire graduates such as mine. Even though I reached out to program directors and participants in all states, my response rate did not yield as much data as possible. For practices that hire non-credentialed individuals to perform invasive procedures, it is possible that they allow them to do so because these employees are directly supervised during the procedure; however, I didn't ask that question on the survey.

I concluded that each employer has his or her own reasons for hiring credentialed or non-credentialed individuals and I (or other program directors) may never have any influence over that decision. However, we may have some influence over the promotion of the medical assisting profession to the medical arena and the public, as well as educating them about the differences among medical assisting credentials.

A shortcoming of my research was the lack of participation due to timing of the summer semester and problems with certain regions of the country at the time. Another shortcoming was the possibility of responder bias. Since this was a convenience sample of medical practices chosen by program directors (of CAAHEP accredited programs like myself), the practices could be more friendly towards the credentialed medical assistant. Although there is no way to know this, it is important to note that while these responses offer insight, they cannot be generalized beyond those who participated in the study. Also, while I did not consider whether the physicians were used for practicum (externship) experience by the medical assisting program nearest them as relevant to the study, it is possible that an association with a medical assisting program could lead to bias in their responses.

The overall replies from the participants were generally more positive than negative and demonstrated an appreciation for the credentialed medical assistant. One area of concern that needs the attention of the AAMA is the repeated comments from participants that there aren't enough credentialed medical assistants in certain areas to meet the need. AAMA, and the Medical Assisting Education Review Board (MAERB), may consider starting more programs in states with no or little CAAHEP accredited programs.

It is encouraging that some participants acknowledged the difference between the abbreviated training and showed preference toward the longer, more detailed training programs. However, I do need to note again the possibility of participant bias.

The information obtained from the surveys should be beneficial to the Program Directors of medical assisting programs across the country, especially those programs whose graduates are eligible to take the CMA (AAMA) or RMA (AMT) credentialing examination. The information may also benefit the AAMA staff, the MAERB staff, the MAERB Certifying Board, and the CAAHEP site surveyors.

I plan to share my findings with the AAMA and to encourage other CAAHEP program directors to continue promoting the CMA (AAMA) and the value of credentialed medical assistants. My desire is that the AAMA will incorporate my research into an article for their publication, the *CMA Today*.

Recommendations

The first recommendation for future researchers would be to increase the sample size. One of the weaknesses in this research was the small sampling group within each region of the country. In order to strengthen the study, the future researcher could increase the sample size to include a minimum of at least two states within each of the nine regions. This would give a broader view of the country to see if any significant differences show among regions. It would also strengthen the study if the participants could be selected randomly.

In order for the first recommendation to be successful, the second recommendation would be to send the emails to program directors during fall and/or spring semesters. This may have the same consequence of little participation due to teaching and program director responsibilities

during the school year, but the likelihood of participation by program directors may increase which should also increase the number of physician participants.

After more program directors are contacted, the third recommendation would be to ask each to submit names and emails of more than one physician from each category in hopes of increasing participation.

This study included data from a small number of participants during a short period of time. A fourth recommendation would be to give participants more time to respond. Many in the healthcare industry are extremely busy and do not reply to emails or surveys as quickly as a researcher may like.

A fifth recommendation would be to make more specific differentiation between categories of practices. Category A participants may have been included with the numbers of category B because of interpretation misunderstanding; therefore, this may be one reason that category A respondents was low.

A last recommendation would be to specifically describe the type of employee being researched. Many participants may have overlooked the term *clinical* in the second question and therefore considered all individuals within their answers. In addition, specific tasks and skills of that clinical employee need to be asked to differentiate what is allowed amongst credentialed and non-credentialed individuals.

The results of the study were promising but preliminary and need to be expanded for future projects. It is my hope that this research will continue to increase the knowledge of the medical assisting profession and the differences among credentials.

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APPENDICES

APPENDIX A

AAMA Regions

1 East South Central: TN, KY, AL, MS = 4

2 New England: ME, NH, *VT*, MA, CT, *RI* = 6

3 Middle Atlantic: NY, PA, NJ, DE = 4

4 South Atlantic: MD, VA, WV, NC, SC, GA, FL = 7

5 East North Central: OH, IN, IL, MI, WI = 5

6 West North Central: MN, IA, MO, *ND*, SD, NE, KS = 7

7 West South Central: OK, TX, AR, LA = 4

8 Mountain: MT, ID, *WY*, CO, UT, NV, AZ, NM = 8

9 Pacific: WA, OR, CA, AK, HI = 5

Italicized states (VT, RI, ND, WY) denote those states that do not have CAAHEP accredited programs and therefore, were not considered in this study.

APPENDIX B

Medical Assisting Credentialing: Physician Offices' Survey

1) In which state does your practice reside?

2) Which category best describes the types of clinical employees you have:

(a) CMAs (AAMA), RMAs (AMT), CCMAs, and/or NCMAs;

(b) a combination of credentialed medical assistants from (a), plus licensed individuals (i.e. RN, LPN, EMT);

(c) a combination of individuals from (a) and (b), plus non-credentialed individuals.

3) If category (a) applies to your hiring practices, what is the reason(s) for choosing these credentials when hiring? Please choose one: cost, a particular credential is more abundant in the area you practice, past experiences, other. Please explain choice.

3) If category (b) applies to your hiring practices, please explain any differences in the quality of work performed by the different credentialed employees, if any.

3) If category (c) applies to your hiring practices, please explain any differences in the quality of work performed by credentialed individuals compared to non-credentialed individuals, if any.

4) If category (c) applies to your hiring practices, do you allow non-credentialed individuals to perform invasive and critical procedures (i.e. injections, venipuncture, medication administration)? Why or why not?

5) What factors do you take into account when hiring staff for your practice (i.e. salary or hourly wage, office budget, qualifications of employees, needs of the office)?

6) What qualities do you look for when hiring your staff?

7) Are there potential medical or legal risks when non-credentialed individuals perform clinical procedures? Please list any.

8) What factors to you use in determining an employee's rate of pay (i.e. credential, degree, and/or years of experience)? Please explain any differences.

9) Do physicians (in general) hire untrained or uncertified individuals in order to pay less salary?

10) In your experience, do individuals with credentials stay in the field longer than those who don't have credentials?

11) When staff leaves employment at your practice, for what reasons do they leave? (List all that apply.)

12) With the *Meaningful Use* requirement from the CMS to switch to EMRs by 2014 which included only certified or licensed individuals entering into the EMR system, in your opinion, why do physicians, facing increased regulatory scrutiny, hire un-credentialed individuals to perform the duties of a credentialed employee?

13) Please list the pros of hiring credentialed medical assistants.

14) Please list the cons of hiring credentialed medical assistants.

15) Please list the pros of hiring non-credentialed medical assistants.

16) Please list the cons of hiring non-credentialed medical assistants.

APPENDIX C

Pilot Study Results

Category B.

Please explain any differences in the quality of work performed by the different credentialed employees, if any.
RN is in a more supervisory role and responsible for more procedures. LPN and MA have the same responsibilities.
Clinical manager is a RN
Typically the higher the credentialing level and/or level of education the higher the quality of work and follow-through.
RNs are responsible for patient calls, test results, completion of forms, ACLS. MAs are responsible for vitals and chart work-up.
Concerning the quality of the work our expectations would be the same no matter what the credentials are. However there are some limitations as to what the professional can do based on regulations applied the credential, i.e. LPNs have more limitations regarding medications and assessments than that of an RN.
There is no difference in the quality of work between the CMAs and the LPN.
Do you allow non-credentialed individuals to perform invasive and critical procedures (i.e. injections, venipuncture, medication administration)? Why or why not?
(No participant in category B responded to this question.)
What factors do you take into account when hiring staff for your practice (i.e. salary or hourly wage, office budget, qualifications of employees, needs of the office)?
The need for the position is first and foremost, second would be to find a candidate that has the right attitude, qualifications next, and then wage.
Qualifications of employees, budget.
I only hire when we have a need. Experience, credentials, and pay rate.
Training, length of time on previous jobs. Credentialing status, current needs of office.
Qualifications of employees, staffing needs.
Our hourly wage is based on experience and qualifications. Consideration of the needs of our facility is always a priority for us in order to deliver the best patient care that we possibly can.
Hourly wage, qualifications and needs of our office.
What qualities do you look for when hiring your staff?
Someone who is friendly, outgoing, optimistic, and has a desire to help people. Someone who is knowledgeable, trainable, and responsible.
Hard working, dedicated, someone who wants to do a good job.
Work ethics, attitude, professional appearance, compatibility with present staff.
Professionalism, attendance, training and background.
Training, school attended, work history, experience, personality, professional appearance.
An important quality we look for in our staff is the ability to interact well with others. The

ability to prioritize and a willingness to help ill patients will personal needs while allowing him or her to keep their dignity.
Knowledge and dependability.
Are there potential medical or legal risks when non-credentialed individuals perform clinical procedures? Please list any.
The doctor always assumes 100% of the risk of the clinical staff who works for him/her. However, when there is a licensed employee, that employee's license is at risk as well. Non-credentialed employees do not have the risk of losing a license or certification.
Non credentialed employees do not perform clinical tasks.
Individuals with over 25 years experience may be ok; however, I want our clinical staff to have formal education from a reputable school.
Working outside scope-of-practice is both a legal and medical risk.
Non-credentialed individuals are not licensed to give IV drugs in emergencies, increase risk of medication errors, answering questions of patients that are out of their scope-of-practice.
We try to ensure the least amount of potential for medical and legal issues by having policies, guidelines and job descriptions for the different clinical personnel.
Non-clinical individuals do not perform any procedures.
What factors do you use in determining an employee's rate of pay (i.e. credential, degree, and/or years of experience)? Please explain any differences.
It depends on what you're comparing. Yes degree can be a factor when you're comparing an RN to a LPN or CMA. But not necessarily when comparing a LPN and CMA. Years of experience plays a role, years of experience in a medical field in general will be reason for a higher rate of pay, years of experience in our particular specialty could be a reason for more pay.
Experience
Credentials, years of experience, skill sets, and local pay rates.
Our hospital system determines the rate of pay based on pay in the area, years of service and areas of training and years of service.
Credential, and years of experience.
Both degrees and years of experience.
Years of experience
Do physicians (in general) hire untrained or uncertified individuals in order to pay less salary?
Yes, in general they do. We do not.
No
At my office, I do the hiring and I don't have the time nor desire to train someone.
We hire certified staff.
No
No
No
In your experience, do individuals with credentials stay in the field longer than those who don't have credentials?

Yes, because they are more prepared for their role and they are more successful. Individuals with limited or inadequate training are not prepared for what they are required to do and therefore fail.
Yes
In today's environment yes. Years ago you could hire & train but not today. Individuals need to hit the floor running. Put their book knowledge to work – hands on.
Yes
Nurses yes. MAs no due to salary expectations pay is essentially the same as someone flipping burgers.
I have not performed any data comparisons to accurately answer this question.
Yes
When a staff member leaves employment at your practice, for what reasons do they leave? (List all that apply.)
I have very little turnover. Because I have very little turnover I don't have an opportunity for advancement. So most leave for advancement.
Different employment
Staff rarely leaves; however, the last clinical person was going back to school to get her RN.
Pay, pregnancy, childcare issues, work hours.
Pay. Family responsibilities. Disciplinary actions.
Closer to home, better pay, child care issues.
Their choice. Advancement.
With the Meaningful Use requirement from the CMS to switch to EMRs by 2014 which included only certified or licensed individuals entering into the EMR system, in your opinion, why do physicians, facing increased regulatory scrutiny, still hire un-credentialed individuals to perform the duties of a credentialed employee?
The requirement is certified or licensed individuals entering "orders" into the EMR system. My clinical staff doesn't "order". However, costs continually rise and reimbursement falls and a practice must be lean. The transition to EMR costs over 100k initially and has a cost of at least 5k per year per physician and that cost is significantly higher every 3 – 5 years when all computers and servers need to be replaced.
I don't think they do. They may not know this requirement or they don't use EMR.
Pay
Many physician practices are taking penalties in reimbursement and not absorbing the high cost of an EMR therefore licensed or uncertified individuals are still able to perform duties. Long time employees are vested in the practice, and a valuable resource that physicians trust. Large corporations will require the switch.
Time constraints
We try not to hire un-credentialed employees.
Please list the pros of hiring credentialed medical assistants.
It depends on what you mean be credentialed. If you're talking about AAMA credentials. These students are educated and more prepared to be successful. If you're talking about an allied professional who has had 6 – 8 weeks training and now refer to themselves as a certified medical

assistant, they are not prepared to be successful. There is a huge difference. Also because the AAMA certified medical assistants' curriculum requires them to be well rounded with business and clinical training. Coding, ethics, insurance, as well as the clinical training. It definitely puts them on a path of success and an asset to a practice.
They are able to work the front desk and also act as a clinical employee.
Good foundation from their school. Usually professional and seek a long term career.
Hiring staff that have been trained and have passed certification. I believe that those MAs consider themselves to be part of a profession and on a career path.
Basic skills have been obtained (hopefully).
Better patient care and increased speed of patient flow.
They are passionate about what they are doing.
Please list the cons of hiring credentialed medical assistants.
Con is knowing the difference between the certifications. AAMA certification vs an allied health certification which requires very little training and education.
None
Some after working a little while to get their RN degree. Afterwards we can't afford to keep them and my desire when hiring is to find a long term employee. Better for staff, doctors, and patients to have less turnover.
Difficult to find in this market. Many went to school but have not completed the certification due to the costs.
Salary expectations. You are guessing as to whether a person has basic medical assisting skills. Some qualified people are not hired because they have not kept up certification or taken a certifying test.
None that I can attest to.
They always want to leave to get a higher paying position.
Please list the pros of hiring non-credentialed medical assistants.
Cost
None
None
The capability to perform more menial tasks that fit in the regulations and allow the provider to spend more time with the patient.
We try not to do this.
Please list the cons of hiring non-credentialed medical assistants.
Lack of knowledge and training.
Legal and medical liability.
Sometimes a non-credentialed MA will get very comfortable and may start performing tasks outside of their scope-of-practice.
They do not have the proper training.
Please include any additional comments you feel may be relevant to this survey.
Although schooling alone does not make a great medical assistant, it gives the best foundation to allow them to put into practice that which they learned. It gives them knowledge needed in

today's healthcare environment. This can only be accomplished, I feel, with a 1 – 2 year program. Programs that are shorter can in no way give adequate training.
The two-year CMA program is perfect and teaches the students everything they need to perform their job.

Category C.

Please explain any differences in the quality of work performed by credentialed individuals compared to non-credentialed individuals, if any.
Credentialed perform work they are certified for ex: phlebotomy, xrays. Non credentialed trained skills ex: BP, history.
None.
Do you allow non-credentialed individuals to perform invasive and critical procedures (i.e. injections, venipuncture, medication administration)? Why or why not?
No, liability. And I pay more for credentialed employees so I allow them to perform.
Yes.
What factors do you take into account when hiring staff for your practice (i.e. salary or hourly wage, office budget, qualifications of employees, needs of the office)?
Each position (problem) requires a solver. I pay based on how much the solving cost. If I pay an employee based on their need for money and it's more than what it cost me to solve the problem. They will never work enough for me to be satisfied, for I will always want them to do more to satisfy the salary.
Education, Experience, Needs of office.
Experience, availability
What qualities do you look for when hiring your staff?
Personality, cleanliness, honesty, team player
Personality, Ability to think forward/problem solve, Professionalism
Appearance, communication skills, confidence
Are there potential medical or legal risks when non-credentialed individuals perform clinical procedures? Please list any.
Yes. If the state requires a certificate than I am liable for breaking a rule. Many insurance companies require my therapist to be licensed to them to reimburse me for my services. If they are not they can deny payment or request refunds.
As there are with credentialed individuals
Unsure
What factors do you use in determining an employee's rate of pay (i.e. credential, degree, and/or years of experience)? Please explain any differences.
Pay is based on my degree of problem solving required not the employees credentials. Although, I would take into consideration the position if a certificate is required.

Job title and experience
Experience, credentials
Do physicians (in general) hire untrained or uncertified individuals in order to pay less salary?
They could. But I consider the state requirements.
No
Yes
In your experience, do individuals with credentials stay in the field longer than those who don't have credentials?
Yes
No
Yes
When a staff member leaves employment at your practice, for what reasons do they leave? (List all that apply.)
Usually more perks. Ex health insurance.
Fired, Job closer to home, Burn out of medical field
Weekends off
With the Meaningful Use requirement from the CMS to switch to EMRs by 2014 which included only certified or licensed individuals entering into the EMR system, in your opinion, why do physicians, facing increased regulatory scrutiny, still hire un-credentialed individuals to perform the duties of a credentialed employee?
Less perks, health ins. Lower salary
I have never hired someone who could not learn the basic skills required in our office. If you have never worked in our office then the training is about the same regardless of education or even experience. It is far more difficult these days to find the person with the right attitude, personality, passion and fit for the culture or your organization.
Unsure
Please list the pros of hiring credentialed medical assistants.
Less liability. Less training, more profession actions.
They tend to have a passion for the work and a proven investment towards professionalism.
Knowledge, commitment
Please list the cons of hiring credentialed medical assistants.
More financial responsibility, seminars, license fees, etc.
None
None
Please list the pros of hiring non-credentialed medical assistants.
Less financial requirement
Often loyal for the opportunity

Less expensive
Please list the cons of hiring non-credentialed medical assistants.
Less trained, more onsite training. More liability.
None
Inexperienced, less knowledge
Please include any additional comments you feel may be relevant to this survey.
(No participant in category C responded to this question.)

APPENDIX D

Participants by State

Region	States participating	Categories of participants
East South Central	Alabama Tennessee	AL – 3 b TN – 1 b
New England	No participation	
Middle Atlantic	Pennsylvania	PA – 1 c
South Atlantic	North Carolina	NC – 2 a NC – 1 b
East North Central	Ohio	OH – 1 a OH – 1 c
West North Central	Nebraska	NE – 1 b NE – 2 c
West South Central	Texas	TX – 1 c
Mountain	New Mexico	NM – 1 c
Pacific	No participation	

APPENDIX E

Participant Raw Data

Category A.

What is the reason(s) for choosing these credentials when hiring clinical employees?
NC – On-the-job training I know that they have performed and received through their externship.
NC – financial and skill level.
OH – with the reimbursement cuts over the past 15 – 20 years, our office replaced our RNs with MAs.
Do you allow non-credentialed individuals to perform invasive and critical procedures (i.e. injections, venipuncture, medication administration)? Why or why not?
(No participant in category A responded to this question.)
What factors do you take into account when hiring staff for your practice (i.e. salary or hourly wage, office budget, qualifications of employees, needs of the office)?
NC – qualifications and any personality "red flags" during interview that would conflict with my current office staff.
NC – qualifications primary, salary secondary.
OH – that they have graduated from an accredited school.
What qualities do you look for when hiring your staff?
NC – how well they are quickly answer scenarios I give them. Another thing is when I show them around the office I walk at a fast pace to see if they are able to keep up or if I need to stop to let them catch up, if they cannot keep up it lets me know they will probably have trouble keeping up in my fast paced multi-physician office.
NC – experience
OH – attitude, once they have completed their education/training you need someone who is understanding that each day will never be the same and the ability to be flexible, multi-task and place the patient's needs first.
Are there potential medical or legal risks when non-credentialed individuals perform clinical procedures? Please list any.
NC – yes in a sense that they are more likely to have "bad habits" or was trained improperly if they did not receive training from a credentialed entity or passed a standardized certification.
NC – not allowed in this office.
OH – no, it all starts with training and follow-through from the clinical coordinator.
What factors do you use in determining an employee's rate of pay (i.e. credential, degree, and/or years of experience)? Please explain any differences.
NC – the hospital has a grid that uses credentials and years of experience both to determine start pay.
NC – credentialed, experience

OH – compared salary locally, quality of work, error rate, interaction with patients and coworkers, attendance.
Do physicians (in general) hire untrained or uncertified individuals in order to pay less salary?
NC – no
NC – not in this office
OH – no
In your experience, do individuals with credentials stay in the field longer than those who don't have credentials?
NC – yes because they have invested time and money.
NC – yes
OH – no
When a staff member leaves employment at your practice, for what reasons do they leave? (List all that apply.)
NC – higher pay elsewhere
NC – it has been a long time since someone left – too stressful was the last time.
OH – further their education, we have longevity in our clinical department.
With the Meaningful Use requirement from the CMS to switch to EMRs by 2014 which included only certified or licensed individuals entering into the EMR system, in your opinion, why do physicians, facing increased regulatory scrutiny, still hire un-credentialed individuals to perform the duties of a credentialed employee?
NC – currently no one except in the physician office laboratory setting is anyone checking credentials. JCAHO and other organizations do not apply to physicians offices.
NC – n/a
OH – my opinion is cost.
Please list the pros of hiring credentialed medical assistants.
NC – A lot of my new hires came through my office during their externship so I had an opportunity to watch their work habits, ethics, and watch for personality conflicts, and they are already familiar with my office so I save time on training.
NC – knowing they are certified in their field.
OH – willingness to further their knowledge and continue to learn in their field or career.
Please list the cons of hiring credentialed medical assistants.
NC – I have been let down because of higher expectations of job performance of someone who is certified. But other than that there should not be any cons in hiring someone who has received enough training to get credentialed.
NC – none
OH – I don't feel there is a con to having credentials.

Please list the pros of hiring non-credentialed medical assistants.
NC – less pay
NC – not going to happen unless they are admin
OH – none
Please list the cons of hiring non-credentialed medical assistants.
NC – have to invest more time in training.
NC – to much liability
OH – none
Please include any additional comments you feel may be relevant to this survey.
(No participant in category A responded to this question.)

Category B.

Please explain any differences in the quality of work performed by the different credentialed employees, if any.
AL – CMAs (AAMA) actually perform better quality of work in our physician offices as they are trained in theory (to work in a clinic setting). RNs and LPNs actually learn from the CMA as nurses are only trained for a hospital setting. I'd rather hire a CMA (AAMA).
AL – my RN seems to be more knowledgeable in medications – ex. calculating dosages.
AL – CMA work primary with providers other level RN or LPN do more administrative duties teaching etc.
NC – LPN, RN seem to be a bit more comfortable clinically and more confident.
NE – as a specialty cardiology practice we use CMAs to go a lot of the "hands on" work such as rooming pts, getting vital signs, refilling medications etc. The RNs do phone triage, pt teaching and scheduling, and responding to patient issues.
TN – the licensed personnel are allowed to perform more invasive procedures.
Do you allow non-credentialed individuals to perform invasive and critical procedures (i.e. injections, venipuncture, medication administration)? Why or why not?
(No participant in category B responded to this question.)
What factors do you take into account when hiring staff for your practice (i.e. salary or hourly wage, office budget, qualifications of employees, needs of the office)?
AL – credentials first. I INSIST on the CMA (AAMA) credential. I then look at longevity. How long does the applicant work in an office. Behaviors (good and bad) tend to repeat themselves.
AL – all of the above. Of course qualifications of the employee is first to see if they fit the needs of the office. I try basing hourly wage on past experience. My budget sometimes is a determining factor, unfortunately.
AL – mainly just staff needed at time! Right now in AL there are a low number of certified MAs.
NC – usually the needs of the office, then qualifications and budget.

NE – needs of the office and qualifications.
TN – needs of the office and qualifications of the employee.
What qualities do you look for when hiring your staff?
AL – longevity attitude towards learning, attendance and cleanliness at the interview. If the "best you will see" is on the interview…then they better look clean.
AL – experience, knowledge, personality, willingness to learn, and compassion for patients.
AL – experience and certified.
NC – hard working, trustworthy, dependable and passion for taking care of patients.
NE – I look for someone who is well spoken and professional looking – someone who is enthusiastic and expresses interest in learning new things. One of the interview questions deals with conflict resolution and I am always interested in how that is answered.
TN – qualifications and personality.
Are there potential medical or legal risks when non-credentialed individuals perform clinical procedures? Please list any.
AL – each state is different. Of course there are some risks but in AL, the CMA practices under the physician's license. The physician may direct accordingly.
AL – yes, although my staff is covered under the physicians umbrella policy.
AL – yes you do have risk of judgment and qualifications.
NC – not performing correctly or not understanding put me at risk as nurse manager.
NE – n/a
TN – I will not hire non-credentialed personnel for the clinic work.
What factors do you use in determining an employee's rate of pay (i.e. credential, degree, and/or years of experience)? Please explain any differences.
AL – degree, credential, years of experience are all factored into an employee's rate of pay.
AL – I factor in all of the above. I prefer to hire someone that has had experience in a physician office setting, so that orientation and training is easier.
AL – years of experience
NC – both, I also compare what others of similar backgrounds are making. I try to never hire someone to make more than my best employee.
NE – degree and years of experience.
TN – years of experience and degree.
Do physicians (in general) hire untrained or uncertified individuals in order to pay less salary?
AL – not in my clinics
AL – yes
AL – no
NC – not here
NE – not in this office – I have seen in other offices.
TN – yes
In your experience, do individuals with credentials stay in the field longer than those who

don't have credentials?
AL – yes. This is almost always the case.
AL – yes
AL – yes
NC – not necessarily
NE – yes
TN – yes
When a staff member leaves employment at your practice, for what reasons do they leave? (List all that apply.)
AL – family situations that require them to stay at home and provide care. Continued education (back to school). Our turnover if very low (<0.4% annually).
AL – my most recent employee resigned to stay at home with family. I am very fortunate that I do not have a lot of employee turnover. In general, employees usually leave for other work, closer to home, more pay, etc.
AL – other employment or termination
NC – full-time position, terminated
NE – pay
TN – more money or to stay home with children.
With the Meaningful Use requirement from the CMS to switch to EMRs by 2014 which included only certified or licensed individuals entering into the EMR system, in your opinion, why do physicians, facing increased regulatory scrutiny, still hire un-credentialed individuals to perform the duties of a credentialed employee?
AL – I can't answer this as we don't hire "un-credentialed" employees. However, I'm sure they either don't know the rules or don't want to pay the increased rates for credentialed employees or…the trend now is that many providers are opting out of Meaningful Use requirements and are not filing Medicare because of the restrictive and idiotic rules for MU.
AL – my opinion would be cost
AL – we try not to. But if we do we give them a deadline on certification.
NC – yes, most definitely
NE – to save money – I have also heard physicians say that uncredentialed individuals are covered to function under the provider's license.
TN – this does not apply to my practice.
Please list the pros of hiring credentialed medical assistants.
AL – professionalism, professionalism, professionalism. Knowledge of physician practices.
AL – knowledge, experience, ability to cross train for administrative duties and clinical duties.
AL – meets meaningful use requirements. They are trained properly.
NC – can perform a variety of duties and skills.
NE – they are more prepared if they have gone through a structured program.
TN – they are well trained and more vested in the job due to the time and training they have received.
Please list the cons of hiring credentialed medical assistants.

AL – we constantly have to explain what CMAs are. To this day the general public and nursing professions don't know what a CMA can do. This is tragic because they are the BEST healthcare workers around. What a shame.
AL – I always try hiring credentialed medical assistants. The only con is pay scale, but I feel that it is very important to have credentialed people in my office.
AL – none
NC – lacks some knowledge in disease processes and pt teaching. Not too comfortable with all hands-on skills needed.
NE – I would not hire a non-credentialed MA.
TN – there are no cons in my opinion.
Please list the pros of hiring non-credentialed medical assistants.
AL – NONE!
AL – none
AL – none
NC – cheap, although we do not hire
NE – n/a
TN – there are none that I can think of. It is a dangerous practice to have non-credentialed personnel.
Please list the cons of hiring non-credentialed medical assistants.
AL – lack of knowledge, lack of professionalism, bad publicity for the true CMA, the list continues…not good.
AL – pay scale is higher for credentialed MAs but it is worth it.
AL – none
NC – multiple, we do not hire!
NE – n/a
TN – I do not hire them due to liability and lack of quality.
Please include any additional comments you feel may be relevant to this survey.
AL – I'm hopeful that this survey and the contents will broaden the knowledge-base for the layperson and for the healthcare worker about the capabilities of a true CMA (AAMA) in the healthcare delivery system.
NE – the best CMAs in our practice are the ones who stay active in the local MA organizations – I would encourage any instructor to stress that.

Category C.

Please explain any differences in the quality of work performed by credentialed individuals compared to non-credentialed individuals, if any.
NE – credentialed can perform blood draws and assist doctor.
NE – the only difference in their work I see is the LMHPs are not able to administer the same services as the licensed PhDs are.
NM – MAs need by our facility policy – direct oversight of all p.o. meds; they can perform

immunization but no deep IM injections – credentialed or not. They are all required to go through – CHILI, NMSIIS, and facility focused course on immunizations/injections prior to being signed off on 5 injections to give independently. MAs may not triage - period, according to the scope of practice of their position and education per New Mexico guidelines. RNs triage.
OH – the quality of work doesn't differ but the employee's confidence and pride does. Individuals that are not credentialed seem to lack confidence in their skills.
PA – CMS requiring "licensed" or credentialed MAs to enter medications in EMR
TX – credentialed individuals are better trained and have more knowledge than non-credentialed.
Do you allow non-credentialed individuals to perform invasive and critical procedures (i.e. injections, venipuncture, medication administration)? Why or why not?
NE – no, they aren't licensed and trained to do so.
NE – no, those services are not performed at this office.
NM – yes, but ONLY with the direct oversight of the RN or provider assigned for that day. We are also looking to enforce having the MAs take the Medication Administration exam on-line to seek further clarification of who is qualified and not to pass meds in the clinic setting.
OH – yes, but they are either slated to take their exam, or they were hired before I took over my position. I no longer hire non-credentialed individuals to work in my clinical areas.
PA – yes, limited only by CMS rule for Rx mgt.
TX – no, because they are not credentialed.
What factors do you take into account when hiring staff for your practice (i.e. salary or hourly wage, office budget, qualifications of employees, needs of the office)?
NE – budget #1, qualifications…and then into needs of office/salary.
NE – the type of professionalism and services they would bring to our clinic. Contracts, office budget, qualifications, personality, office needs, and client needs.
NM – need (part time/full time/pool), technical skills needed, background of potential candidates, experience of candidates, if they make it through the behavioral interview – will they blend with my current staffing mix? Where do they live (proximity) – will they be reliable to show on time? Years of experience – over ten – not interested. They come with baggage, bad habits, looking for 5 yrs of experience range.
OH – staffing needs, qualification of employees.
PA – education: preferred due to high educated student; credentialed MAs offer flexibility and wide range knowledge.
TX – office budget, needs of office, qualifications.
What qualities do you look for when hiring your staff?
NE – sense of urgency, detail-oriented, good people skills, team player.
NE – loyalty, trustworthy, HIPAA educated, professionalism, honesty, problem solving skills, team player.
NM – experienced, customer service background, less than 10 years of experience. Vast background, flexible, clinic experience, leadership roles in previous jobs on resume, a clean resume – no typos/spelling and local address or cover letter explaining they are moving here locally. MA with front and back office experience or training in school. Graduation from an accredited school (formal program) and certified/registered with a national board.

OH – dedication, skills, personality.
PA – energy, ambition, attitude, and education.
TX – qualifications and salary requirements
Are there potential medical or legal risks when non-credentialed individuals perform clinical procedures? Please list any.
NE – there would be yes, if anything went wrong.
NE – yes. Our office deals with a lot of court cases, Juvenile Services, custody cases, and at any time any of our providers may be subpoenaed to appear in court. We administer a lot of psych evals which LMHPs are not allowed to do. If one does administer testing, tests can be scored incorrectly, which greatly impacts a clients Dx. This is a huge legal issue.
NM – practicing on providers license, injury to patient with limited education of process/ procedure, compromise of sterility, knowledge deficit, see one do one mentality not fully understanding the complications that can occur or safety risks to patient by not doing time out, 7 rights of med administrations, etc. When utilizing sterilizers if not following process – can cross contaminate all gear infect patients, etc.
OH – there is always risk in medicine. I try to educate ALL of my staff to not work outside of their education level.
PA – yes, Meaningful Use EMR requires credentialed MAs to enter meds in electronic records
TX – more legal risks, as if non-credentialed performed clinical procedures they are under physician supervision.
What factors do you use in determining an employee's rate of pay (i.e. credential, degree, and/or years of experience)? Please explain any differences.
NE – for MAs, most of the time we have a base pay and then each year a performance review can increase base. Otherwise for salary employees – experience and degree definitely help.
NE – experience, knowledge, weekly hours worked. A potential new hire with no experience, training, no degree will not be paid as much as a person that has experience and can be more of an asset to the office.
NM – credentialed, certified/registered not just graduated from an accredited program, degree level, experience years, special qualifications (ACLS, PALS, AAACN, etc.), criticality of role.
OH – degree, experience
PA – all hires perform same clinical tasks – experience would yield higher pay entry level.
TX – credential, years of experience. Most physicians do not realize that LVNs have a certificate while CMAs have AAS degrees.
Do physicians (in general) hire untrained or uncertified individuals in order to pay less salary?
NE – no.
NE – no, not at this office.
NM – in my opinion only, yes. And clinical practices that are not governed by The Joint Commission or other accrediting bodies tend to hire non credentialed or boarded staff more, do OJT and use them in potential positions which would stretch them beyond the bounds of their job scope. MAs conducting phone triage and giving advice to patients in the lack of a RN or LPN.
OH – no.

PA – no.
TX – it would depend upon the role in the office. Front office, untrained and uncertified – less cost. Rural areas also have problems with finding certified/licensed individuals who will work for less pay.
In your experience, do individuals with credentials stay in the field longer than those who don't have credentials?
NE – yes, they tend to have experience and are committed to the job.
NE – yes.
NM – no, people stay where they feel valued and like they are contributing to the overall goal. Staff works hard to meet the challenge if they are being educated, trained and rewarded/recognized for their hard work.
OH – yes.
PA – yes.
TX – I think those with credentials eventually seek higher education.
When a staff member leaves employment at your practice, for what reasons do they leave? (List all that apply.)
NE – pay, FT opportunity if only working PRN.
NE – new job opportunity, going back to school, moving out of town.
NM – moving away to another state, going back to school, taking a teaching position, career path change, or I let them go for performance reasons.
OH – go back to school, move, find a higher paying position.
PA – personality conflicts among staff.
TX – money
With the Meaningful Use requirement from the CMS to switch to EMRs by 2014 which included only certified or licensed individuals entering into the EMR system, in your opinion, why do physicians, facing increased regulatory scrutiny, still hire un-credentialed individuals to perform the duties of a credentialed employee?
NE – maybe they don't know the rule yet, otherwise probably to get away with paying less.
NE – they are cheaper to pay.
NM – can't answer for them. They are asked to do more with less time to see the patient. Scribes, MAs, etc. have been hired to assist the provider vs involving the end user in the EMR development and use to make it easier to navigate and work in a way to enhance the visit and providers time vs – 50 check boxes. Invest $$$ for over the shoulder training during the go live process and training to get buy-in from the providers. Take their suggestions and do something about them vs just put them in a list and nothing. EMR usage takes time to document but there are ways to make the computer work for you – we just need to invest in the over the shoulder training for providers / develop their favorite order sets and phrases to make documentation easier not harder. Providers are still being held accountable for doing their COPE part at our organizations. The MAs will be required to eventually go and get their certification with assistance and review courses from our staff assisting them in this process. Going forward at our organization I only hire credentialed MAs.
OH – because it is hard to find employees that are willing and able to perform the required job duties. Plus, many of the employees I have are not credentialed and have been here many years,

some over 30 years. I'm not letting them go just because they don't have a certification.
PA – extremely difficult to find qualified certified MAs in our area. Local community colleges are not board eligible for certification.
TX – money and physicians will sign off on the entries.
Please list the pros of hiring credentialed medical assistants.
NE – Trained!
NE – experience, training, knowledge, professionalism.
NM – the program from which they have graduated focused on the national benchmarks that all MAs are held to for knowledge purposes coming out of school. Hiring an OJT MA – they do not grasp the same level of knowledge of a process that a MA from a formal program has, nor do they have the medical terminology/spelling capability as a graduate. There is a definite difference in their level of understanding and safety focus. They have knowledge of what is allowed by safe practice vs what you have been allowed to do in private practice in the absence of credentialed staff. Just knowing that they have at the minimal a national benchmark of knowledge to perform the task when credentialed.
OH – have stronger clinical skills because they went through an accredited school; take pride in their work because they did the credentialing; willingness to learn.
PA – FLEXIBILITY front and back (clinical) office knowledge and skills.
TX – better trained, better educated, fulfills CMS requirements.
Please list the cons of hiring credentialed medical assistants.
NE – more pay.
NE – lack of experience, more time spent training, more time for the PhDs to spend reviewing their cases.
NM – these are limited. They do have requirements to have 10CE/5 yrs. To recert – this is great, not sure it's enough.
OH – want a higher pay rate.
PA – less entry level knowledge of medications.
TX – more expensive than non-credentialed.
Please list the pros of hiring non-credentialed medical assistants.
NE – n/a, we don't unless we just need a front office member.
NE – less risk.
NM – I would assume cheaper. I do not hire un-credentialed staff as we have made it a policy to insure they are all certified/registered and pay accordingly in their salaries. I work hard to encourage my staff, if interested, to purse furthering their education if they want to do more than their job allows. Happy to assist them move up.
OH – more of them are in the market for a job.
PA – pay less.
TX – less expensive
Please list the cons of hiring non-credentialed medical assistants.
NE – they wouldn't be able to be cross-trained to do both front and back office work.
NE – higher risk.

NM – they do not know boundaries of their role and question why they can't do deep IM injections, etc. They do not always have the safety focus for patients and themselves in the forefront of their thoughts. They sometimes have bad habits or practices from non-credentialed facilities where they have worked and it bleeds over to my staff, thus creating issues for me to rectify. We usually have to do a complete training with these staff on TJC standards and why we follow these when they were hired.
OH – don't always have the right skills set for the position; not always committed to the position.
PA – can't use to enter medications in EMR.
TX – regulatory/legal ramifications
Please include any additional comments you feel may be relevant to this survey.
NM – MAs have a definite role in the ambulatory setting; however, they are not nurses and I think in private practices they are often times over-tasked beyond what is a safe situation to place them in – relaying results, answering patient concerns, triaging patients and advising them on care. Medical assistant is an entry-level position into the ambulatory medicine world. They work with teams of professionals which hopefully mentor and inspire them vs stretch them beyond their abilities. My goal is to replace myself and train up all those behind me to become all they can – they all have potential, maybe not the finances, but we can help them get there. Hone their skills and understand why there are boundaries of practice. MAs can work front and back office at a minimal rate of pay. If I had an LPN or RN I would only be able to use them in that role. MAs are versatile! I love my MAs and treat them with all the respect I can for the task they perform daily on the team but I also ask them to hold their providers and RNs accountable for their tasks on the team. We all have a job to do – each defined – work together to meet the goal of excellent patient care and outcomes. Thank you for allowing me to share.
PA – secondary colleges need to do better recruiting high school juniors and seniors. Local college graduates – 6 students annually – not sufficient for the area. The community colleges need to acquire accreditations to allow certification of their students. Students are misled and disappointed at graduation when they learn they are ineligible for certification testing and credentialing.

APPENDIX F

Informed Consent Letter

EAST TENNESSEE STATE UNIVERSITY
VETERANS AFFAIRS MEDICAL CENTER
INSTITUTIONAL REVIEW BOARD

INFORMED CONSENT DOCUMENT (ICD)
FOR PROSPECTIVE RESEARCH INTENDED FOR REVIEW

The purpose of this introduction statement is to identify this study as research to potential study recruits; however, the language may be slightly modified:

This Informed Consent will explain about being a participant in a research study. It is important that you read this material carefully and then decide if you wish to be a volunteer. PURPOSE: The purpose of this research study is as follows:

The purpose of this study is to investigate why physicians' practices do or do not hire credentialed medical assistants to perform clinical skills and to gain insight into their hiring preferences and why they choose these specific preferences. DURATION: The study will take place during the summer semester of 2015. One interview per physician/practice is all that is required.

Participants for this study will consist of at least 27 physicians (three physicians from each of the nine American Association of Medical Assistants (AAMA) regions). The nine regions consist of: New England, Middle Atlantic, South Atlantic, East North Central, East South Central, West North Central, West South Central, Mountain, and Pacific. However, even though all 50 states were included in the *Compensation and Benefits report*, only the 46 states that have CAAHEP accredited medical assisting programs will be considered for interview purposes. North Dakota, Rhode Island, Vermont, and Wyoming do not have CAAHEP accredited medical assisting programs. Within these 46 states, there are 581 CAAHEP

accredited programs in medical assisting (CAAHEP, 2014). To represent the country in a sampling population, at least one medical assisting program will be chosen from each of the nine regions. Each program is asked to identify three physicians (one from each of the three categories below) to be surveyed. These three physicians, per region, may or may not be used for Practicum (Externship) experience by their program. The categories are as follows:

(1) employ CMAs (AAMA), RMAs (AMT), Certified Clinical Medical Assistants (CCMA), or National Certified Medical Assistants (NCMA), or

(2) employ a combination of credentialed medical assistants from (1), plus licensed individuals (i.e. RN, LPN, EMT), or

(3) employ a combination of individuals from (1) and (2), plus non-credentialed individuals.

PROCEDURES: The procedures, which will involve you as a research subject, include:

The Principal investigator will contact the Program Director of at least one CAAHEP accredited medical assisting program within each region by email. The email will include an explanation of the study. The Program Directors will then be asked if they would be able to secure three physicians (in practices that hire according to each of the three categories above) that would be willing to complete the survey by Survey Monkey about medical assisting credentialing. If the Program Director is unable to participate, then another Program Director from the same region will be contacted until at least one from each of the nine regions that have CAAHEP accredited medical assisting programs is secured. Once confirmed, the researcher will then email the Survey Monkey link directly to the physician/practice. The survey should take no longer than 30 minutes to complete.

ALTERNATIVE PROCEDURES/TREATMENTS: The alternative procedures/treatments available to you if you elect not to participate in this study are:

There are no alternative procedures/treatments related to this study.

POSSIBLE RISKS/DISCOMFORTS: The possible risks and/or discomforts of your involvement include:

The only discomfort that exists in this study is the willingness to answer survey questions as to your hiring choices of clinical employees, whether they are credentialed or not, and if it is relevant to any legalities.

POSSIBLE BENEFITS: The possible benefits of your participation are:

The benefits include knowing how physicians and medical office managers view the profession of medical assisting which may help medical assisting professionals improve the standing of the profession and provide a consistent foundation for education programs. Another benefit is to understand why physicians hire medical assistants who are or are not credentialed in hopes to move the medical assisting profession toward higher professional standards and to better prepare students for the realities of the job market.

VOLUNTARY PARTICIPATION: Participation in this research experiment is voluntary.

You may refuse to participate. You can quit at any time. If you quit or refuse to participate, the benefits or treatments to which you are otherwise entitled will not be affected. You may quit by not completing the survey by Survey Monkey when it is sent to your email.

In addition, if significant new findings during the course of the research which may relate to the participants willingness to continue participation are likely, the consent process must disclose that significant new findings developed during the course of the research which may relate to the participant's willingness to continue participation will be provided to the participant.

In addition, if there might be adverse consequences (physical, social, economic, legal, or psychological) of a participant's decision to withdraw from the research, the consent process must disclose those consequences **and** procedures for orderly termination of participation by the participant.

CONTACT FOR QUESTIONS: If you have any questions, problems, or research-related medical problems at any time, you may call Karmon Kingsley, Principal Investigator, at 423-618-7028, or Dr. Deborah Dotson, ETSU advisor, at 423-439-1000. You may call the Chairman of the Institutional Review Board at 423-439-0654 for any questions you may have about your rights as a research subject. If you have any questions or concerns about the research and want to talk to someone independent of the research team or you can't reach the study staff, you may call an IRB Coordinator at 423-439-6055 or 423-439-6002.

CONFIDENTIALITY: Your responses will not be linked with your email by Survey Monkey. Therefore, your responses will be confidential. A copy of the records from this study will be stored in the home of the Principal Investigator for at least 5 years after the end of this research. The results of this study may be published and/or presented at meetings without naming you as a subject. Although your rights and privacy will be maintained, the Secretary of the Department of Health and Human Services, the ETSU/VA IRB, or the ETSU Allied Health Department has access to the study records.

By completing the survey through Survey Monkey, you are giving implied consent that you have read or had this document read to you. You have been given the chance to ask questions and to discuss your participation with the investigator. You freely and voluntarily choose to be in this research project.

VITA

KARMON L. KINGSLEY

Education:	M.S. Allied Health, East Tennessee State University Johnson City, Tennessee 2015
	B.S. Liberal Studies with Concentrations in Medicine and Education, Middle Tennessee State University Murfreesboro, Tennessee 2009
	A.A.S. Office Administration with Concentration in Medical Assisting, Cleveland State Community College Cleveland, Tennessee 2000
	A.S. General Transfer, Cleveland State Community College Cleveland, Tennessee 1999
	Public Schools, Cleveland, Tennessee
Teaching Experience:	Medical Assisting Program Director/Faculty Cleveland State Community College Cleveland, Tennessee 2005 – Present
	Medical Assisting Faculty Miller-Motte Technical College Chattanooga, Tennessee 2004 – 2005
	Medical Assisting Adjunct Faculty Cleveland State Community College Cleveland, Tennessee 2002 – 2004
Professional Experience:	Medical Assistant Blue Ridge Medical Oncology Cleveland, Tennessee 2003
	Pharmacy Technician CVS Pharmacy Cleveland, Tennessee 2002 – 2003
	Medical Assistant / Program Director Girl Scout Summer Camp Cloudland, Georgia 2002

Financial Benefits Coordinator
Bradley Memorial Hospital
Cleveland, Tennessee 2002

Administrative Assistant / Health & Nutrition Coordinator
Tennessee Christian Academy
Cleveland, Tennessee 2000 – 2001

Veterans' Benefits Clerk / Student Records
Cleveland State Community College
Cleveland, Tennessee 1996 – 1999

Secretary, Special Education Department
Bradley County Board of Education
Cleveland, Tennessee 1992 – 1994

Medical Secretary
Nicholas Newton, M.D., P.C.
Cleveland, Tennessee 1991

Medical Secretary, I.C.U. and O.R.
Bradley Memorial Hospital
Cleveland, Tennessee 1990 – 1991

Secretary
Park College, Quantico Marine Corps Base
Quantico, Virginia 1989 – 1990

Professional Certifications:

Certified Medical Assistant
American Association of Medical Assistants
2000 – Present

Certified CPR and First Aid Instructor
American Red Cross
1995 – Present

Professional Memberships:

American Association of Medical Assistants
Member

Tennessee Society of Medical Assistants
Chair, Continuing Education Committee
Chair, Membership Committee

Cherokee Chapter of Medical Assistants
Treasurer
Program Planner