

Information Summary and Recommendations

Medical Assistant Sunrise Review

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Sunrise Review Process

The purpose of a sunrise review is to evaluate a proposal to change laws regulating health professions in Washington. The legislature's intent is to permit all qualified people to provide health services, while protecting the interests of the public by restricting entry into the profession.

The Sunrise Act says a health care profession should be regulated or scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

If the legislature identifies a need and finds it necessary to regulate a health profession, it should select a method of regulation consistent with the public interest. These types of regulation may be considered as set forth in RCW 18.120.010(3):

1. *Stricter civil actions and criminal prosecutions.* To be used when common law, statutory civil actions and criminal prohibitions are not enough to end harm.
2. *Inspection requirements.* A process enabling a state agency to enforce violations in court. This may include regulating the business itself rather than the employees of the business, when a service could harm public health.
3. *Registration.* A process where the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practices and, if required, a description of the service provided. A registered person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.
4. *Certification.* A voluntary process which grants recognition to a person who has met certain qualifications. Non-certified people may perform the same tasks, but may not use "certified" in the title.¹ A certified person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.
5. *Licensure.* A method of regulation which grants permission to engage in a health care profession only to people who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensed person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

¹ Although the law defines certification as voluntary, many health care professions have a mandatory certification requirement such as nursing assistant – certified, home care aides, and pharmacy technicians.

Executive Summary Proposal

Medical assistants, or MAs, are health care professionals who commonly work in ambulatory settings, such as physicians' offices, clinics, and group practices. MAs are trained to perform administrative and clinical procedures as part of a health care team. "Medical assistant" is not a legislatively created credential in Washington, although there is a nationally recognized certifying organization.

"Health care assistant" is currently a credential in Washington. Health care assistants (HCAs) are certified to perform very specific tasks such as blood draws, injections, limited medication administration, skin tests, and hemodialysis. The existence of these two professions, one with a commonly used title but no credential, the other with a credential but seldom used title, causes significant confusion for health care professionals in the state of Washington.

The demand for health care services has been increasing, and with it the demand for assistive personnel. This includes medical assistants and health care assistants. Chapter 43, Laws of 2009 broadened the HCA's scope of practice for administering medications, and also expressed a need to "look for new ways to harness the training of our health care practitioners, and those that assist them, in order to alleviate the stress on our current health care delivery system." This law directed the department to conduct a review under chapter 18.120 RCW of regulation and scope of practice of medical assistants.

After the 2011 session, the legislature submitted House Bill 2009 (Appendix B), to the department for the sunrise review. The Washington State Medical Association (WSMA) submitted a brief applicant report (Appendix A).

As written, House Bill 2009 would require medical assistants in Washington to be registered by the department.² Health care practitioners, clinics, and group practices may certify a medical assistant to perform the functions authorized in the bill. The bill requires MAs to work under the supervision of a physician, osteopathic physician, podiatric physician, registered nurse, advanced registered nurse practitioner, naturopath, physician assistant, or osteopathic physician assistant. The bill would authorize registered medical assistants to perform the following duties.

- Following clinical procedures to include:
 - Performing aseptic procedures.
 - Preparing and assisting in sterile procedures.
 - Taking vital signs.
 - Preparing patients for examination.
 - Venous and capillary blood withdrawal and nonintravenous injection.
 - Observing and reporting patient signs or symptoms.
- Administering basic first aid.
- Assisting with patient examinations or treatment.
- Operating office medical equipment.
- Collecting routine laboratory specimens.

² Although the bill would require registration, it referred to a medical assistant as being an "unlicensed person." Chapter 18.130 RCW (the Uniform Disciplinary Act) defines "license" to include "certification" and "registration." Calling registered persons unlicensed will cause unnecessary confusion.

- Administering medications by unit, single, or calculated dosage including vaccines.
- Performing basic laboratory procedures.

The bill does not address the relationship or significant overlap between the existing HCA scope of practice and the proposed scope for MAs. We must clear up confusion about current HCA credentialing categories and remove the overlap so that scope of practice for each is clearly defined. We asked for input from the applicant and stakeholders, and also researched how these credentials could be blended, or whether creation of a MA credential could eliminate one or more existing HCA categories.

Recommendations

The department supports credentialing medical assistants. However, if we do not also address similarities in the HCA credential we will add to the confusion. The department makes these recommendations to ensure public safety and assure professional ability:

1. Blend the existing HCA categories with a medical assistant certification³ in the following way:

- Replace the current HCA categories C and E with medical assistant, which will include phlebotomy as a permitted task.
- Replace the current HCA categories A and B with phlebotomist.
- Replace the current HCA category G with hemodialysis technician.
- Remove the requirement that new certifications be issued each time a credential holder leaves a facility or delegator. Replace it with a portable credential, which is standard for most health care professions.
- Require a credential holder to submit a practice arrangement plan when there is a new delegator, similar to the physician assistant requirement (See Appendix E).

2. Require the following for all new applicants:

- Medical assistant:
 - Satisfactory completion of a medical assistant program approved by the Secretary of Health.
 - Satisfactory completion of a medical assistant examination approved by the Secretary of Health.
- Phlebotomist: Retain the requirements for HCA categories A and B.
- Hemodialysis technician: Retain the requirements for HCA category G.

³ Although the law defines certification as voluntary, many health care professions have a mandatory certification requirement. This is intended to be a mandatory certification. The medical assistant credential cannot be called “Certified Medical Assistant” because the term is registered to the AAMA through the United States Patent and Trademark Office.

3. Transfer the 17,600⁴ health care assistants who are currently certified:

- Categories C and E into the new medical assistant certification when they renew their credentials, and require submitting a practice arrangement plan. This would affect 7,150 currently certified HCAs.
- Categories A and B into the new phlebotomist certification. This would affect about 9,600 currently certified HCAs.
- Category G into the new hemodialysis technician certification. This would affect about 730 currently certified HCAs.
- More research is needed to learn how the HCAs in categories D and F are being used, and whether these categories should be retained. There are currently 130 people holding only category D and/or F credentials.

4. Amend the tasks proposed in House Bill 2009 to address the following issues in addition to those recommended above:

- Set parameters for the medication administration task in Section 5(6) by using those in the current HCA regulations.
- Identify drugs or classes of drugs that should be prohibited for MAs because of a high risk for patient harm.
- Set parameters for operating office medical equipment to better define this topic.
- Include criteria to identify tasks a medical assistant can perform, that spells out what tasks may or may not be performed.

⁴ Department of Health Integrated Licensing and Regulatory System, August 9, 2011.

Background and Proposal for Sunrise Review

Medical assistants, or MAs, are health care professionals who commonly work in ambulatory settings, such as physicians' offices, clinics, and group practices. MAs are trained to perform administrative and clinical procedures as part of a health care team. They are often confused with health care assistants (HCAs) in Washington. However, MAs are not currently credentialed by the department. Health care assistants are certified to perform very specific tasks such as blood draws, certain types of injections, limited medication administration, skin tests, and hemodialysis, depending on their licensing categories. "Medical assistant" is a very commonly used title in the national health care arena, but "Health care assistant" is unique to Washington and not widely used in educational or practice settings.

The demand for health care services has been increasing, and with it the demand for assistive personnel. This includes MAs and HCAs. Chapter 43, Laws of 2009 made changes to the HCA scope of practice for administering medications, and also expressed a need to "look for new ways to harness the training of our health care practitioners, and those that assist them, in order to alleviate the stress on our current health care delivery system." This law directed the department to conduct a review under chapter 18.120 RCW of regulation and scope of practice of medical assistants.

After the 2011 session, the Legislature submitted House Bill 2009 (Appendix B), to the department for the sunrise review. The Washington State Medical Association (WSMA) submitted a brief applicant report (Appendix A).

As written, House Bill 2009 would require medical assistants in Washington to be registered by the department. Health care practitioners, clinics, and group practices may certify a medical assistant to perform the functions authorized in the bill. The bill requires MAs to work under the supervision of a physician, osteopathic physician, podiatric physician, registered nurse, advanced registered nurse practitioner, naturopath, physician assistant, or osteopathic physician assistant. The bill would authorize registered medical assistants to perform the following duties.

- Following clinical procedures to include:
 - Performing aseptic procedures.
 - Preparing of and assisting in sterile procedures.
 - Taking vital signs.
 - Preparing patients for examination.
 - Venous and capillary blood withdrawal and nonintravenous injection.
 - Observing and reporting patient signs or symptoms.
- Administering basic first aid.
- Assisting with patient examinations or treatment.
- Operating office medical equipment.
- Collecting routine laboratory specimens.
- Administering medications by unit, single, or calculated dosage including vaccines.
- Performing basic laboratory procedures.

The bill does not address the relationship or significant overlap between the existing HCA scope of practice and the proposed scope for MAs. We must clear up confusion about current HCA credentialing categories and remove the overlap so that scope of practice for each is clearly defined. We asked for input from the applicant and stakeholders, and also researched how these credentials could be blended, or whether creation of a MA credential could eliminate one or more existing HCA categories.

Public Participation and Hearing

The department received the sunrise request from the legislature April 12, 2011, and the applicant report from the WSMA July 1, 2011 (Appendices A and B). The department shared the proposal with interested parties and began accepting comments July 15, 2011. We held a public hearing August 16, 2011, in Tumwater, Washington. Twenty-five people testified. We continued to accept written comments through August 26, 2011. We also sent a draft report to interested parties and asked for corrections and rebuttals. The rebuttal comments are addressed at the end of the report.

The department received many comments about the proposal through oral testimony at the hearing and in writing. (See Appendix F for the public hearing summary and Appendix G for written comments). Many who participated in the process told us that MAs are a vital part of the health care team and we must clearly spell out specific tasks they can and cannot do. We received comments that the HCA credential is the only one they can use for their MAs, but it is inadequate because it only addresses certain limited tasks. We received a clear message that the current HCA credential is outdated, confusing, and inadequate to support health care delivery.

Many hearing participants stated that proper delegation to MAs is critical as part of new health care reform, especially meaningful use of electronic medical records. They told us that in order to receive Medicare and Medicaid reimbursement, physicians are required to legally delegate tasks to other members of the health care team.

All participants supported credentialing MAs. Most, though, had concerns with the way the proposal is currently written. An overwhelming concern was the need to clear up confusion about scope of work for MAs and HCAs. Some felt the credentials should be combined, rather than just adding a new credential for MAs.

Many argued both sides of whether MAs should be authorized to perform telephone triage, and call in prescriptions and refills under orders from a physician. Some stated that both of these tasks are safe for MAs to perform as long as there are protocols in place. Others stated these tasks involve clinical judgment and the risk of patient injury if an error occurs is very high. We also received these concerns:

- There are additional tasks (or clarifications) that should be authorized. These tasks include removing sutures and staples, changing dressings, providing patient education, setting up non-stress tests for fetal monitoring and EKGs.
- X-rays and MRIs should be specifically excluded under the task of operating office medical equipment because they require specialized training.
- The cost of the new credential may be prohibitive.

- State certified MAs should not be required to hold an HCA certification for any of their duties.
- One person commented that pharmacists should be included as “health care providers” who can supervise MAs.
- One person commented that the health care practitioners who can supervise MAs should be broadened.
- Some stated that categories D and F are not used as MAs because administration of IV medications is not part of MA training programs. Some felt that HCAs should not even be performing IV injections because of the high risk of harm.

We also received the following comments about the language used in House Bill 2009:

- The MA credential should not be tied to a health care practitioner, clinic, or group practice because that creates barriers to portability. Many thought this issue was unclear in the bill because of the language in Section 4 that requires a health care practitioner, clinic, or group practice to certify the medical assistant.
- The vagueness of the language in Section 5 makes it difficult to determine what tasks are actually authorized. Parameters need to be clearly set in statute.
- The medication administration language is unclear in Section 5(6). Some stated the medication administration language should align with the health care assistant law, RCW 18.135.120 and .130 for category C and E. That language was vetted through medical, nursing, and health care assistant groups.
- There is contradictory language about whether the intent is to register or certify medical assistants, or whether they are “unlicensed” personnel.
- The types of office medical equipment should be clarified because there are many interpretations of what this includes. We heard a specific example of conflicting interpretations at the hearing on whether Albuterol nebulizers are included. Many stated concern that x-rays and MRIs may be included. They feel these should be specifically excluded.
- Some felt the minimum educational requirements need to be identified in statute.
- Some urologists and urogynecologists commented that medical assistants should be authorized to insert urinary catheters and bladder instillations if they have specific training.
- Some hearing participants commented that medical assistants should not be performing catheterizations because of the potential for harm to patients.

Current Regulation and Practice

MAs are not regulated in Washington. They are trained either through a formal education program in medical assisting or on the job. Many facilities require formal training for the MAs they hire. Some facilities also require a national certification, and some offer a pay increase to those who choose to get a national certification.

There are two national accreditation agencies for medical assisting programs: the Commission on Accreditation of the Allied Health Education Programs (CAAHEP) and the Accrediting Bureau of Health Education Schools (ABHES). There are a number of national certifications offered to medical assistants, including:

- The American Association of Medical Assistants (AAMA) awards the Certified Medical Assistant (CMA) credential to medical assistants who have successfully completed an accredited educational program and have passed the AAMA certification examination. Recertification is required every five years through examination or continuing education credits.⁵
- The American Medical Technologists (AMT) awards the Registered Medical Assistant (RMA) credential to medical assistants who have successfully completed an accredited educational program and have passed the AMT certification examination.⁶
- The American Society of Podiatric Medical Assistants (ASPMA) awards the Podiatric Medical Assistant Certified (PMAC) credential to medical assistants who have been employed in a podiatry office and have successfully passed the ASPMA certification examination. There are no educational requirements to qualify for the examination.⁷
- The Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO) awards the Certified Ophthalmic Assistant, Certified Ophthalmic Technician, and Certified Ophthalmic Medical Technologist credentials to candidates who have completed an approved home study course with work experience or an accredited training program and have successfully passed the JCAHPO certification examination. Recertification is required every three years through continuing education or retesting.⁸

In addition, there are institutional accreditations that are awarded through agencies such as the Accrediting Council for Independent Colleges and Schools (ACICS)⁹. Schools holding institutional accreditation are required to meet and maintain high standards of faculty qualifications, student retention and student placement. However, there are no core curriculum requirements for their medical assistant programs.

There are a large number of MAs working in Washington.¹⁰ Their training ranges from on-the-job to completion of accredited medical assistant programs and national certifications. However, because MAs are not credentialed in this state, there is confusion around what they are legally authorized to do. They are used in vastly different capacities by different practitioners and facilities. We heard testimony that many clinics use HCAs in categories A, C, and E to work as medical assistants. At this time, MAs who perform blood draws, injections, and administer medications and oral vaccines must obtain an HCA credential.

HCAs are regulated in Washington. They are certified by category to perform specific functions such as blood draws, injections, and administering medications and vaccines. An authorized licensed health care practitioner must delegate and supervise specific functions that are under his or her own scope of practice. The health care facility or licensed practitioner must certify the

⁵The examination costs \$125 for AAMA members or recent graduates of CAAHEP and ABHES certified medical assistant programs and \$250 for all others. <<http://www.aama-ntl.org/>>, accessed August 25, 2011.

⁶ American Medical Technologists Web page, <<http://www.americanmedtech.org/default.aspx>>, accessed August 25, 2011.

⁷American Society of Podiatric Medical Assistants Web page, <<http://www.aspma.org/certification.html>>, accessed August 25, 2011.

⁸ “Medical Assisting Career,” <<http://www.aama-ntl.org/resources/library/07MACareer.pdf>>, accessed on August 25, 2011.

⁹ Accrediting Council for Independent Colleges and Schools Web page, <<http://www.acics.org/>>, accessed August 25, 2011.

¹⁰ We only have anecdotal information on MAs working in Washington State since they are not regulated.

HCA with the department, and this certification is not transferrable to another health care facility or practitioner. As of August 25, 2011, there were 17,600 certified HCAs.¹¹

The categories of HCA and their authorized tasks are:

- A and B: Perform blood withdrawal (Category A by venous and capillary routes and B by arterial route);
- C and E: Perform intradermal, subcutaneous and intramuscular injections and skin tests (Category C for diagnostic agents and E for therapeutic agents);
- D and F: Perform intravenous injections (Category D for diagnostic agents and F for therapeutic agents);
- G: Hemodialysis technician.

We did not receive input from facilities that use HCAs with categories D and F. There are currently about 130 HCAs certified in only category D and/or F.¹² The majority of them also hold certification as radiologic technologists. In addition, about a dozen HCAs holding category D and/or F certifications work in eye clinics and ophthalmology offices. The applicant believes categories D and F should remain separate categories from the MA credential.

Podiatrists use unlicensed personnel they call medical assistants. WAC 246-922-100 addresses delegation of duties to non-podiatric personnel, with a list of duties podiatrists are authorized to delegate. A majority of the tasks are specific to podiatry, and the list does not include injections or blood withdrawal. Some are certified as HCAs, while others hold no credential. These assistants are not required to be certified, but are encouraged to take the national exam to become certified podiatric medical assistants.

Comparison of MA and HCA Training

Medical Assistant Training Requirements

MA programs are typically accredited by CAAHEP and ABHES, and are required to cover a core curriculum that includes the clinical tasks included in House Bill 2009 (except operating office medical equipment). The laboratory tests included in the curriculum are specifically CLIA waived tests.¹³ Basic medication administration is included. Both accreditations require a 160-hour externship prior to graduation. The length of the program is not specified in either accreditation.¹⁴

- The CAAHEP programs in Washington require one to two years to complete, including Associate of Art (AA) programs. Certificate programs range from 60-92 credits, and AA programs range from 75 to 98 credits.¹⁵
- Some of the ABHES schools require only 30-34 credits.¹⁶

¹¹ Department of Health Integrated Licensing and Regulatory System, August 9, 2011.

¹² Ibid.

¹³ CLIA is the Clinical Laboratory Improvement Amendments, which requires certification of all sites performing clinical laboratory testing.

¹⁴ <<http://www.caahep.org/documents/file/For-Program-Directors/MA2008Standards0209.pdf>> and <http://www.abhes.org/assets/uploads/files/Accreditation_Manual_16th_Edition_7_15_2011.pdf>, accessed August 25, 2011.

¹⁵ Independent internet research of CAAHEP accredited programs conducted by department staff.

¹⁶ Such as Pima Medical Institute – Seattle.

The programs within schools with institutional accreditation, such as ACICS, do not have specific core curriculum requirements.

There are currently 21 programs in Washington that are certified by the CAAHEP and four that are certified by the ABHES. A representative of Everett Community College testified at the public hearing that 85 percent of their students take the AAMA examination, and pass with 94 percent. We also learned at the hearing that some colleges, such as Everest College, include the AAMA examination (payment and registration) in their program curriculum.

Health Care Assistant Training Requirements

Categories A and B

HCA's performing blood withdrawals must obtain documented on-the-job training from a qualified trainer. A qualified trainer is defined as a delegator with at least two years of experience within the last five years, a delegatee from the appropriate category of health care assistants with two years experience in the last five years, or a licensed nurse who meets the criteria for education and experience.

Categories C and E

HCA's performing intradermal, subcutaneous and intramuscular injections for diagnostic, therapeutic, and skin tests must complete one year of formal post-secondary education in subjects to include anatomy, physiology, pharmacology, concepts of asepsis, and microbiology. Category E also requires medication administration and mathematics. They also must receive specific training on procedures for injection of agents, including dosage, technique, acceptable routes of administration and appropriate anatomic sites, expected reactions, possible adverse reactions, appropriate intervention for adverse reaction, and risks to patients and employees.

Categories D and F

HCA's performing intravenous injections for diagnostic and therapeutic agents must complete two years of formal post-secondary education in subjects to include anatomy, physiology, pharmacology, mathematics, chemistry, concepts of asepsis, and microbiology. Category F also requires medication administration. These categories also require specific training on procedures for injections of agents, including dosage, technique, acceptable routes of administration and appropriate anatomic sites, expected reactions, possible adverse reactions, appropriate intervention or adverse reaction and risks to patients and employees.

Category G

HCA's who assist with hemodialysis in direct patient care must complete a training program of a minimum of six to eight weeks, provided by a health care facility or health care practitioner. The training program must include didactic and supervised clinical instruction so the health care assistant can perform the competencies and skills defined in the rule. The dialysis facility must verify the HCA is qualified, skilled, and knowledgeable to perform all procedures to be delegated to him or her.

Regulation of Medical Assistants in Other States

One state credentials medical assistants: South Dakota. Several states address similar education and authorized tasks for medical assistants as House Bill 2009 (See Appendix D for state regulations):

- South Dakota registers MAs to perform an almost identical list of tasks as those listed in House Bill 2009. The South Dakota Boards of Nursing, Medicine and Osteopathy interpreted that MAs are permitted to telephone prescriptions to a pharmacy with a supervising physician's written or verbal order. (See Appendix D, page 49.) Applicants are required to be graduates of an accredited program.
- Arizona does not credential MAs, but a statute defines that directly supervised MAs may perform all the procedures listed in the "Standards and Guidelines for an Accredited Educational Program for the Medical Assistants". The statute also lists additional treatments MAs may administer, including small-volume nebulizer treatments. In order to perform these tasks, an MA must complete an accredited training program, or one offered by a licensed allopathic physician, that meets or exceeds those in the accredited training programs.
- California does not credential MAs, but defines in statute what tasks an MA may perform. The list of tasks is similar to those listed in House Bill 2009. In order to perform these tasks, an MA must complete either formal education or on-the-job training. MAs who wish to perform medication administration, injections, or venipuncture must also obtain specific training in these areas. California allows MAs to call in prescription refills under direct supervision, if the refills are exact and have not changed in dosage level.
- Florida does not credential MAs, but addresses in statute an almost identical list of tasks MAs may perform as those in House Bill 2009. The statute does not seem to address training or educational requirements.
- Maryland does not credential MAs, but defines in statute an almost identical list of tasks MAs may perform as those in House Bill 2009. Maryland law specifically states MAs may transmit prescriptions to a pharmacy and apply tuberculin skin tests. Statute does not dictate specific training.

Defining the Problem

From public comments at our hearing, we know that MAs are a crucial part of the health care team. Some large practices testified that they employ hundreds of MAs. Many feel MAs will become even more important in our state due to significantly higher numbers of insured people because of health care reform. Allowing MAs to perform specific tasks for which they are trained frees up physicians and nurses to focus on higher level tasks. MAs are trained to perform many tasks in addition to blood draws, injections and medication administration. However, the only credential available to them is the HCA certification. Because of this, it is unclear what additional clinical tasks MAs are legally allowed to perform.

Health care facilities are turning to each other to develop standards identify tasks medical assistants are authorized to perform. Interpretations vary from facility to facility because of the lack of clarity and guidance. May MAs perform tasks like taking vital signs, assisting with minor office procedures, performing blood draws, obtaining throat cultures, calling in prescriptions,

and performing telephone triage? We need to clarify these tasks so MAs are being used consistently regardless of who employs them. If tasks like telephone triage and calling in prescriptions are included, clear guidance must be in the rule about required training and protocols. The requirements must ensure MAs have the proper tools to perform these tasks.

Using the HCA certification categories confuses MAs, the providers who delegate to them, and the schools that train MAs. It also limits MAs from performing many tasks for which they are trained. The HCA credential is outdated, confusing, and not portable. Every time an HCA moves to a different facility or is under a new delegator, he or she must reapply to the department for a new certification. This incurs costs to the department, which are passed on to the HCA. The language of the current HCA statute creates confusion about whether the facility, delegator, or HCA is responsible for renewing the HCA's credential. This leads to disciplinary action and professional liability when HCAs practice with expired credentials.

According to the applicant, the HCA law was developed in 1984 for a very limited purpose: to address whether assistive personnel were practicing medicine by piercing the skin to give injections. Since then, health care delivery has changed. The need for the broader array of tasks MAs are trained to perform has grown, while the work of HCAs in categories C and E has blended with what MAs are doing. Therefore, it would relieve confusion to combine them. HCAs performing only blood draws or hemodialysis can be easily separated from category C and E health care assistants who are functioning as MAs.

It is unclear whether there is still a need for categories D and F. These categories perform IV injections for diagnostic and therapeutic agents. It's possible their work has been absorbed into new credentials like radiologic technologists, which were created in the 1987 legislative session, or radiology assistants, which were created in the 2008 session. More research is needed to determine whether categories D and F should be retained, eliminated, or whether these functions fit more appropriately into other health care credentials.

Review of Proposal Using Sunrise Criteria

First Criterion: Unregulated practice can harm or endanger health or safety.

Neither the applicant nor the department identified specific examples of actual harm caused by unregulated MAs. We heard testimony and received written comments stating some MAs are performing invasive tasks such as placing catheters, which are not included in many medical assistant training programs. We also heard about confusion as to whether MAs should perform X-rays and MRIs, which require specific training not included in MA programs.

In our experience as a regulatory agency, the department has received inquiries from practitioners and employers about the scope of HCA and MA practice. We have received countless questions about if there is a scope of practice for MAs, and if HCAs or MAs can apply a splint, administer a nebulizer treatment, start an IV, place a catheter, and much more. In addition, we have taken disciplinary action against existing HCAs for practice outside their current scope of practice, such as an HCA who did not hold category C or E certification giving vaccinations by injection, and accidentally giving the wrong injection to the wrong sibling. We have also taken action against physicians and other providers for inappropriately delegating to HCA or MAs, such as blood draws and injection of medications to staff who did not hold HCA certification.

The lack of clarity and guidance on what tasks can be delegated to MAs pose a threat to public health and safety in the following ways:

- Lack of clarity around medication administration and calling in prescriptions can lead to medication errors and patient harm.
- When all members of a health care team cannot use their training, it creates challenges to access to care. Because of the lack of clarity on whether MAs can perform certain tasks within their training and education, higher level providers such as nurses and physician assistants must perform many of these tasks. This takes these providers away from more critical tasks they should be performing.
- Inefficiencies in health care delivery lead to higher health care costs. When facilities must use nurses and physicians to perform tasks an MA is trained to do they must pay more for these providers, and these costs are passed on to patients.

Second Criterion: Public needs and will benefit from assurance of professional ability.

The proposal meets this criterion. Guidance in law and a clear scope of practice will lead to safe and efficient delegation of health care tasks to medical assistants. The tasks in HB 2009 are mostly taught to MAs in their training programs. Clarification is needed and supervision should be identified to ensure tasks are done safely.

If changes are made to the applicant's proposal simplifying the HCA credential and using titles commonly used in health care, it will clear up much of the confusion. This will benefit the public by creating safer and more efficient health care delivery.

Third Criterion: Public protection cannot be met by other means.

The proposal meets this criterion. The other option the applicant identified was clarifying delegation to MAs under the physician statute. However, this option does not address confusion and inefficiencies in the existing HCA laws. It also does not address the fact that many types of providers supervise or delegate to MAs. If the changes recommended by the department are incorporated into the applicant's proposal, the public will be best protected.

Detailed Recommendations to the Legislature

The department supports the proposal to credential medical assistants. However, we feel that adding a credential without addressing the HCA credential issues will add to the confusion already experienced. The department makes the following recommendations to ensure public safety and assure professional ability:

1. Blend the existing HCA categories with a medical assistant certification issued by the Department of Health¹⁷:

- Replace the current HCA categories C and E with medical assistant to include phlebotomy as a permitted task.
- Replace the current HCA categories A and B with phlebotomist.
- Replace the current HCA category G with hemodialysis technician.
- Remove the requirement that new certifications be obtained each time a credential holder leaves a facility or delegator. Replace it with a portable credential similar to what exists for nearly every other health care profession.
- Require submission of a practice arrangement plan when a credential holder has a new delegator, similar to the physician assistant requirement (See Appendix E).

Rationale: This proposed regulatory scheme will remove confusion and offer a more efficient credentialing plan. The title “Health Care Assistant” is not used anywhere else in the country or within practice settings in Washington. The term should be eliminated and replaced with terms that are used in medical practice.

Eliminating the need to tie the certification to the delegator will grant better portability, while adding a practice arrangement plan will retain provider accountability.

2. Require the following for all new applicants:

- Medical Assistant:
 - Satisfactory completion of a medical assistant program approved by the secretary of the Department of Health. Programs accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or Accrediting Bureau of Health Education Schools (ABHES) should be included in this requirement.
 - Satisfactory completion of a medical assistant examination approved by the Secretary of Health.
- Phlebotomist: Retain the requirements for HCA categories A and B.
- Hemodialysis Technician: Retain the requirements for HCA category G.

Rationale: Accredited medical assistant schools in Washington train their graduates in the clinical tasks listed in the proposed scope of practice. Requiring all newly certified

¹⁷ Although the law defines certification as voluntary, many health care professions have a mandatory certification requirement. This is intended to be a mandatory certification. The medical assistant credential cannot be called “Certified Medical Assistant” because the term is registered to the AAMA through the United States Patent and Trademark Office.

medical assistants to graduate from an accredited program will ensure they are competent to enter the profession and will ensure consistency across all credential holders.

The existing requirements for categories A and B (phlebotomists) and category G (hemodialysis technician) already offer sufficient public protection and should be retained as written in the HCA law.

3. Transfer the 17,600¹⁸ currently certified health care assistants as follows:

- Categories C and E into the new medical assistant certification when they renew their credentials, with a requirement to submit a practice arrangement plan if that requirement is adopted. This would impact 7,150 currently certified HCAs.
- Categories A and B into the new phlebotomist certification. This would impact approximately 9,600 currently certified HCAs.
- Category G into the new hemodialysis technician certification. This would impact approximately 730 currently certified HCAs.
- More research is necessary into how the HCAs in categories D and F are being used and whether these categories should be retained. We suspect there is less need for these categories has receded, as the functions have been incorporated into new credentials like radiological technologist, cardiovascular invasive specialist, and radiologist assistant. There are currently 130 health care assistants that are certified as D and/or F, that are not also certified as C or E.

Rationale: The HCAs in categories C and E that would transfer into the medical assistant certification were required to obtain one year of post-secondary education to qualify for the HCA certification. They were also required to obtain training, evaluation and assessment of skills in specific topics. Requiring MAs to submit a practice arrangement plan will protect against them from performing tasks for which they have not been properly trained.

4. Amend the tasks proposed in House Bill 2009 to address the following issues in addition to those recommended above:

- Set parameters for the medication administration task in Section 5(6) using those in the current HCA regulations as a starting point.
- Identify drugs or classes of drugs that should be prohibited for MAs because of a high risk for patient harm. For example, those drugs included on the *List of High-Alert Medications* that is published by the Institute for Safe Medication Practices.
- Set parameters around the operation of office medical equipment to better define this topic. While specific tasks can be addressed in rulemaking, this controversial topic should be narrowed in the bill. We suggest language to exclude machines that require specialized training or have a risk of negative impact to the patient if operated incorrectly, at the very least MRIs and X-ray equipment.

¹⁸ Department of Health Integrated Licensing and Regulatory System, August 19, 2011.

- Include criteria that identify the nature of the tasks a medical assistant can perform, to be both inclusive of what may be performed and exclusive of what may not be performed.
- Ohio includes language to address physician delegation to unlicensed personnel. Though Ohio law does not specifically address medical assistants, it includes a list of criteria a physician must evaluate before delegating a task.¹⁹ Some of the criteria that may be used in Washington includes tasks that:
 - Can be performed without requiring the exercise of judgment based on medical knowledge.
 - Can be performed without a need for complex observations or critical decisions.
 - Can be performed without repeated medical assessments.
 - Tasks that, if performed improperly, would not present life threatening consequences or the danger of immediate and serious harm to the patient.

Rationale: The language in RCW 18.135.120 has been vetted through stakeholders and includes some safety measures. However, this regulation would need some clarification. The task of operating office medical equipment is too broad, eliciting a wide range of interpretations that included potentially dangerous equipment. Setting some parameters for tasks medical assistants can and cannot perform will remove many concerns stakeholders had during the sunrise review.

REBUTTALS TO DRAFT REPORT

We shared a draft report with interested parties and received 20 rebuttal comments from individuals and associations. The comments were generally supportive of the draft recommendations, with a few issues to be addressed. The applicant (WSMA) is generally supportive of the draft recommendations, as were associations with an interest in this topic, such as Washington State Nursing Association, American Association of Medical Assistants, and the Washington State Society of Medical Assistants (WSSMA).

Here are the issues identified and the department’s response to each.

Scope of Practice

- **Training on the placement of urinary catheters**

The department made a statement in the draft report that we did not find training on catheters in any of the medical assistant training programs. Nine graduates of Wenatchee Valley College, including one who is also a clinical instructor at the college, stated that their program includes extensive training in urinary catheters in the curriculum.

Department Response: The department removed the statement from the final report.

- **Requests to clarify the following issues in the scope of practice:**

¹⁹ Ohio Administrative Code 4731-23-02, delegation of medical tasks, <<http://codes.ohio.gov/oac/4731-23>>, accessed August 31, 2011.

- Inclusion of catheters in scope of practice.
- Triage.
- Protocols and standing orders.
- Entering medication orders into electronic medical records (EMRs).

Department Response: We did not make any changes in the report to address these topics. The department recommended amending House Bill 2009 to include criteria to identify the nature of tasks MAs are authorized to perform, which should address these tasks.

- **Medication Administration**

The draft recommendations included setting parameters for medication administration. We received a number of comments about this issue, some of them conflicting:

- The current list of medications in the HCA law is very limited. This creates challenges for community health clinics providing common care when a licensed nurse is not readily accessible.
- MAs must only be allowed to administer drugs as described in RCW 18.135.130 because medication errors are the most frequent medical error. More discussion is needed about what drugs MAs should be prohibited from administering, and whether practice setting influences medication administration.
- WAC requirements for HCAs should be amended if used for MAs because they are inconsistent for what medications can be administered in different practice settings. More discussion on this issue is needed.
- The current list of authorized drugs in RCW 18.135.130 is very restrictive and poorly written and should not be incorporated into the MA proposed law. The lists contain a mixture of brand and generic name drugs, combination drugs, and undefined abbreviations for drugs.
- The HCA rules create confusion for ambulatory care settings and the potential for misinterpretation for which injectable medications can be administered by MAs. We also received a comment that the medications are inconsistent with findings of the Institute of Medicine's recent report, *Preventing Medication Errors* and on the Institute of Safe Medication Practices, *List of High-Alert Medications*.
- It is not practical to list specific medications in statute or rule. The delegating provider must ensure the MA is trained and competent. A list of medications should be part of the practice arrangement plan. MAs must be able to demonstrate competency on medication administration by practicing techniques in a simulated situation, or observing and performing procedures on patients until the MA demonstrates proficiency to administer the medications listed on the practice arrangement plan.

Department Response: The department recognizes there are challenges with the current regulations for HCA medication administration. We revised the draft recommendations to indicate the HCA regulations should be used as a starting point for setting parameters for MAs, which should include a list of prohibited drugs or classes of drugs that pose a high risk for patient harm.

- **Office Medical Equipment**

The draft recommendations included setting parameters for operating office medical equipment. We received the following comments:

- The statute should not include a limiting list. The delegating provider must ensure the MA is trained and competent. This should be part of the practice arrangement plan.
- It must be clear that operation of medical equipment by MAs is limited for the purposes of data collection, not interpretation of results, assessing a patient's condition, or any other analysis that requires independent clinical judgment.

Department Response: The department did not make any changes in response to these comments because our recommendations already address these issues.

- **Other Items**

The Washington State Nurses Association stated that medical assistants must not be allowed to delegate health care tasks to other personnel or teaching or counseling (except for pre-printed literature) due to lack of education and training.

Department Response: We did not make any changes in the report. The department feels our recommendation to include criteria to identify the nature of tasks MAs are authorized to perform would address this issue.

Requirements for Certification

- **Examination for new applicants is unnecessary**

The draft report included requirements for successful completion of an approved medical assistant program and successful completion of an examination approved by the Department of Health for new applicants. We received one comment stating professional exams are expensive and do not improve skills. The commenting individual stated this is an unnecessary expense and may create a barrier to certification. They stated the better approach is to ensure accredited programs teach the right skills and that employers provide appropriate supervision and training.

Department Response: The department did not change this recommendation because we feel an examination is necessary to evaluate whether an applicant's training and skills meet minimum standards. Under the proposal, MAs will be providing direct patient care, administering medications and operating machinery that could pose a risk to patients if not properly trained. In addition, other certified assistive credentials, such as nursing assistants, home care aides, and pharmacy technicians require an examination to ensure minimum competency.

- **Is the examination in addition to or an alternative for completion of an MA program?**

The draft report included a recommendation requiring that new applicants pass a medical assistant examination approved by the secretary of health. We received a comment that it was unclear whether we were recommending this requirement in addition to completion of an approved medical assistant program, or as an alternative qualification.

Department Response: We added the word “and” to clarify that successful completion of both an approved MA program and an examination are recommended.

- **Secretary approval of medical assistant programs and examinations**

We received a comment that the secretary of health should only approve accredited MA programs, and examinations accredited by the National Commission for Health Certifying Agencies. We also received a conflicting comment that programs without these accreditations should be able to apply to the department for approval.

Department Response: We did not make any changes in response to these comments. These issues would be addressed during rulemaking.

- **Practice arrangement plan**

The draft report included a recommendation to require submission of a practice arrangement plan when an MA has a new delegator, similar to the physician assistant requirement. We received one comment that this requirement might limit portability. We received another comment that further discussion is needed to figure out how it will be used and monitored, and how the plan will assure MAs are only performing tasks for which they have been educated and trained.

Department Response: We did not make any changes in the report because these issues would be addressed during rulemaking.

New credentialing framework

- **Concern that more than one credential will be required**

The draft report recommended replacing the existing HCA categories with certified MA, certified phlebotomist, and certified hemodialysis technician. We received a few comments asking that we ensure MAs will not be required to pay for more than one credential. Some comments stated that many HCAs hold categories A, C, and E, and they would not want to be required to pay for an MA and a phlebotomist credential under the recommended regulatory scheme.

Department Response: Our intent is that under the proposed new credentials, the MA scope of practice will include phlebotomy. The proposed bill included venous and capillary blood withdrawal, and the department feels that should remain in the scope of practice for MAs. The department added a statement in the recommendations that the new MA credential would include phlebotomy.

- **Concern that the cost of certification will increase for hemodialysis technicians**

The draft recommendations stated that the HCAs currently certified in category G should be transferred into the new hemodialysis technician credential, with no changes to their requirements or scope of practice. However, Fresenius Medical Care has some concerns about how this will impact the cost of the credential. They worry that the proposal will increase the fees of this very small group. They are aware that each profession must be self-supporting and worry that splitting this credential from a group of 17,600 licensees to a group of under 1,000 certified hemodialysis technicians may increase their fees.

Department Response: The department’s intent is that the proposal will not create conditions that will increase fees for any of the impacted credentials. This is not typically a concern in professions with a low rate of disciplinary actions, like hemodialysis technicians. The law could be written so that MAs, phlebotomists and hemodialysis technicians comprise a single licensing type, similar to X-ray technicians, radiologic technologists, radiologist assistants, and cardiovascular invasive specialists. This would keep the fees similar to the current rates.

Use of the Title “Certified Medical Assistant”

- **“Certified Medical Assistant” is registered to the American Association of Medical Assistants**

The draft recommendations call the new MA credential a certification. The American Association of Medical Assistants and the Washington State Society of Medical Assistants submitted rebuttal comments stating that the term “Certified Medical Assistant” is registered through the United States Patent and Trademark Office for their credential. Because of this intellectual property right, these associations request we remove the term “certified” from the new credential.

Department Response: The department amended the recommendations to remove “certified” from the title of the credential. We included a footnote that “certified medical assistant” cannot be used since it is a registered term. However, the credential type would remain a certification.

- **Other concern about title**

We received a request to clarify that the use of the title “Certified Medical Assistant” is intended to apply to state certification, and not to preclude Registered Medical Assistants (certified by the AMT) from qualifying for state certification.

Department Response: The department did not make any changes to the report to address this concern because it is not applicable. The recommendations do not include acceptance of existing national credentials such as RMA or CMA.

Other Issues

- **Authorized delegators and supervisors**

We received a request to add pharmacists to the list of health care practitioners who are authorized to supervise or delegate to MAs because pharmacists are playing a more direct role in patient care and medication management through patient-centered medical home models and the use of anticoagulation clinics.

Department Response: The department did not change the recommendations to address this issue because we are unsure whether there is general support for this change. We would not be opposed to this addition if there is support for it.

- **Medical assistants in podiatry offices**

The president of the American Society of Podiatric Medical Assistants provided comments about podiatric medical assistants. These assistants are not currently required

to be certified, and they receive most of their training on the job. There is a national examination that staff are encouraged to take, which is specific to podiatry: the Podiatric Medical Assistant Certified exam.

Department Response: The department did not make any changes to the recommendations in response to this issue. WAC 246-922-100 addresses delegation by podiatrists to assistive personnel, and identifies specific tasks they may do. Those podiatric assistive personnel who do not meet the qualifications for MA will not be able to call themselves MAs.

- **Reciprocity**

We received a concern that MAs coming from other states could find our regulation to be a barrier. Facilities could have difficulties recruiting from out of state or employment would be delayed while the out-of-state MA met the requirements for certification.

Department Response: The requirements of credentialing places a burden on all applicants. Any health care provider coming from another state must meet Washington standards in order to practice. True reciprocity is not possible for MAs because only one other state credentials them. However, certain accommodations could be considered such as allowing for temporary practice permits that would give applicants a limited amount of time to practice while actively working toward meeting the examination requirement.

Appendix A

Applicant Report

Applicant Report Cover Sheet and Outline
Washington State Department of Health Sunrise Review

COVER SHEET

- **Legislative proposal being reviewed under the sunrise process (include bill number if available):**

HB 2009 regarding Medical Assistants.

Chapter 43 laws of 2009 (HB 1414); Section 1(2); “Within the existing resources, the department of health shall conduct a review under chapter 18.120 regarding the regulation and the scope of practice of medical assistants.”

- **Name and title of profession the applicant seeks to credential/institute change in scope of practice:**

Create the profession of Medical Assistants as distinct and separate scope of practice from Health Care Assistants (RCW 18.135)

- **Applicant’s organization:**

Washington State Medical Association

Address: 1800 Cooper Point Rd. SW, Bldg 7 Suite A
Olympia, WA 98502

Contact person: Carl Nelson

Telephone number: 360.352.4848

Co-applicant organization: Washington State Society of Medical Assistants

Contact: Pat Hightower, CMA

Address: 9206 S. 200th St
Kent, WA 98031

Phone work: 206.625.7373 x68289

Phone cell: 206.265.2873

- **Approximate number of individuals practicing in Washington:**

There were 15,991 Health Care Assistants registered with DOH in 2010. The number of working Medical Assistants in Washington State is unknown and may exceed the number of health care assistants. Also see the link to the US Department of Labor, Bureau of Statistics, below.

- **Name(s) and address (es) of national organization(s) with which the state organization is affiliated:**

American Association of Medical Assistants
20 N. Wachter Dr., Ste. 1575

Chicago, IL 60606

- **Name(s) of other state organizations representing the profession:**
Washington State Society of Medical Assistants with about 1,300 members.

OUTLINE OF FACTORS TO BE ADDRESSED

Please refer to RCW 18.120.030 (attached) for more detail. Concise, narrative answers are encouraged. Please explain the following:

(1) Define the problem and why regulation is necessary:

Medical assistants (MA's) are commonly employed in physician practices, clinics and other health care facilities in the state. Medical and other tasks are delegated to Medical Assistants by physicians. Unlike many states, the title "Medical Assistant" does not exist in statute however, some of these individuals are registered as Health Care Assistants (HCAs) under RCW 18.135.

RCW 18.135 was enacted to provide greater oversight of a small part of the medical assisting scope of practice of certain assisting personnel, trained by their physician employers, in the areas of injections and blood withdrawal. RCW 18.135 has been amended several times in recent years to expand the functions of HCA's particularly in the areas of immunization and drug administration; however, the statute does not address the broader category of tasks commonly performed by MA's. As more states adopt statutes and regulations that specifically address the standards and procedures to be followed when medical tasks are delegated to MAs the question arises whether additional statutory or regulatory guidance is necessary in Washington.

Since RCW 18.135 does not comprehensively address the MA's scope of practice it is common for questions to arise as to whether or not a particular task may or should be delegated. In the absence of being able to obtain guidance from the DOH on the topic of MA practice issues, medical practices have resorted to collaborating with each other to develop "community standards" of practice. Using these community standards for guidance, each organization assesses the safety and appropriateness of practice and makes its own determination about which tasks can be delegated to MAs.

This process is not ideal and there is a sense of urgency to have clarity from the state. Practitioners have contacted various entities within the DOH seeking guidance however, without a statutory or regulatory frame of reference the questions often go unanswered or the answer may vary depending on the interpretation of the staff person providing the information. This causes confusion within the healthcare community. Some practitioners seek help from one another to see if there is agreement regarding whether the delegation of a task is appropriate but consensus is not always reached. This degree of uncertainty is not productive and does not advance the goal of providing quality care and holding down costs.

National health care reform implementation in 2014 will increase the demand for access to health care at the same time there is a growing shortage of primary care physicians. In Washington

state the number of Medicaid enrollees alone is estimated to increase by nearly half a million. In addition, with the aging baby boom population the number of Medicare patients will increase dramatically over the next several years. For practitioners to cost-effectively meet this increased demand for medical care they must have an adequate workforce including MAs, to assist them.

Left unresolved this issue would likely create ongoing problems with access to care. With an increased demand for care due to healthcare reform and the aging population it is essential to remove any barriers that restrict access to care and make healthcare less efficient. Delivering the right care at the right time by the right people will help improve efficiency and cost-effectiveness and improve outcomes.

Finally, Federal regulations regarding medical practice reimbursements, specifically, the new CMS regulations regarding “meaningful use” require clarity with respect to the scope of practice of individuals performing medical tasks. If the issues related to MA’s scope of practice are left unresolved, practices face uncertainty with respect to reimbursements. There needs to be clarity regarding the type of tasks that can be delegated to Medical Assistants.

(2) The efforts made to address the problem:

RCW 18.135 has been amended several times in the past decade to delineate a MA/HCA scope of practice. The amendments addressed one issue at a time but have not comprehensively addressed the legal requirements and parameters of a scope of practice for MA’s

Medical practices have continually sought guidance from the DOH but without some type of regulatory or statutory framework, DOH is not able to provide the guidance and clarity that these medical practices are seeking.

Many organizations have collaborated extensively over the last few years to determine community standards of practice. They have used these community standards to guide the development of standards of practice that they apply within their own organizations.

There needs to be clarity regarding the tasks that can be assigned to MA’s. This is especially important because new regulations related to “meaningful use” of electronic medical records requires that tasks performed by members of the medical team have to be legally delegated to those individuals.

(3) The alternatives considered:

An alternative to this legislation would be to have the Medical Quality Assurance Commission (and other appropriate health profession licensing bodies) clarify that physician delegation to certain properly trained assistant personnel, including MA’s, is permitted and to establish guidelines for such delegation. A number of states have addressed the questions related to physician delegation to MA’s by seeking a legal interpretation of the existing laws and or adoption of rules that provide clarity on the delegation of medical tasks to MA’s.

Substitute legislation to HB 2009 is being written that goes further in addressing the issues raised in this application and may be an alternative to HB 2009.

(4) The benefit to the public if regulation is granted:

The current statute regulating HCAs is confusing for medical practices. Furthermore, it does not accurately reflect the training nor the manner in which care is currently being delivered. Healthcare delivery reforms being considered on both the national and state level make it even more imperative for clarity regarding the tasks that can be assigned to MA's and the authority of physicians to delegate those tasks. HB 2009 or the substitute mentioned in (3) above will provide that clarity and more accurately reflect the appropriate responsibilities of various medical assistant personnel based on their education and training.

Clarifying the delegation authority of physicians and providing flexibility regarding the tasks that can be performed by MA's will increase efficiency in medical practices. Providing more preventive care and care coordination have been identified as ways to help control healthcare costs. For many practices these approaches to care requires the flexible use of MA's. Medical practices throughout the state have been using MA's to the full extent of their education and training and that flexibility needs to be retained.

In a changing health care environment this change is necessary to ensure access to care.

(5) The extent to which regulation might harm the public:

If regulation were to limit the ability of physicians to delegate appropriate tasks to Medical Assistants this would unnecessarily affect care efficiency and harm efforts to increase access and manage costs of care. Further if regulations were to cause an increase in the costs of care by requiring registration of MA's, most of whom are already registered as HCA's. These additional duplicative regulation costs would ultimately be borne by the public increasing their healthcare costs.

Physicians, particularly in primary care, are serving more patients. To manage this increased patient load physicians need to use other practitioners and assistants in their practice to the fullest extent of their training. Existing law is confusing regarding the delegations of task to MA's and thus is sometimes interpreted in a way that limits Medical Assistants from working to their highest potential.

Failure to clarify the delegation authority of physicians and ensure that Medical Assistants can work to the full extent of their education and training raises both efficiency and reimbursement issues for practices. Limiting the manner in which MA's and other assistants can be utilized reduces a practice's efficiency. This not only drives up healthcare costs but also limits the practice's ability to see more patients. This further exacerbates an existing shortage of providers who currently see Medicare and Medicaid patients thereby decreasing access to health care services for seniors and the most vulnerable.

(6) The maintenance of standards:

We believe these are addressed in the proposed legislation and through existing structures already in place within the Department of Health.

(7) A description of the group proposed for regulation, including a list of associations, organizations, and other groups representing the practitioners in this state, an estimate of the number of practitioners in each group, and whether the groups represent different levels of practice.

Medical Assistants (MA) who are performing the duties regulated under the HCA law are currently registered under RCW 18.135 as Health Care Assistants along with several other types of assistant personnel.

The Washington State Society of Medical Assistants currently represents MA's in Washington State. This includes 10 regional chapters in the state as well as at large members.

Nationally, MA's are represented by American Association of Medical Assistants.

(8) The expected costs of regulation:

HB 2009 would permit many currently registered Health Care Assistants to become MA's, as would proposed substitute to HB 2009 mentioned in (3) above. This shift in registration – and registration fee of other MAs not currently registered - could be handled at negligible cost as the existing mechanism within the Department of Health for handling Health Care Assistant registrations could be utilized.

(9) List and describe major functions and procedures performed by members of the profession (refer to titles listed above). Indicate percentage of time typical individual spends performing each function or procedure:

See HB 2009 and proposed substitute mentioned in (3) above as well as the CAAHEP “Standards and Guidelines for an Accredited Educational Program for the Medical Assistant.”

You may also find the following resources helpful:

HB 2009: <http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2009&year=2011>

DOH Sunrise Review Process: http://www.doh.wa.gov/hsqa/sunrise/process_2005.htm

MA educational program guidelines: <http://www.caahep.org/Documents/MA%20Standards.pdf>

WSSMA: www.wssma.org

AAM A: <http://www.aama-ntl.org/>

Bureau of Statistics: <http://www.bls.gov/oes/current/oes319092.htm#st>

Bureau of Statistics: <http://www.bls.gov/oco/ocos164.htm>

Appendix B

Proposed Bill

HOUSE BILL 2009

State of Washington

62nd Legislature

2011 Regular Session

By Representative Cody

Read first time 03/04/11. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to medical assistants; adding a new chapter to
2 Title 18 RCW; and creating new sections.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 NEW SECTION. **Sec. 1.** The legislature finds that medical
5 assistants are health professionals specifically trained to work in
6 ambulatory settings, such as physicians' offices, clinics, and group
7 practices. These multiskilled personnel are trained to perform
8 administrative and clinical procedures. Physicians value this unique
9 versatility more and more because patients ask them to contain costs
10 and manage human resources efficiently. The demand for medical
11 assistants is expanding rapidly.

12 NEW SECTION. **Sec. 2.** The definitions in this section apply
13 throughout this chapter unless the context clearly requires otherwise.

14 (1) "Delegation" means direct authorization granted by a licensed
15 health care practitioner to a medical assistant to perform the
16 functions authorized in this chapter which fall within the scope of
17 practice.

18 (2) "Health care practitioner" means:

1 (a) A physician licensed under chapter 18.71 RCW;

2 (b) An osteopathic physician or surgeon licensed under chapter
3 18.57 RCW; or

4 (c) Acting within the scope of their respective licensure, a
5 podiatric physician and surgeon licensed under chapter 18.22 RCW, a
6 registered nurse or advanced registered nurse practitioner licensed
7 under chapter 18.79 RCW, a naturopath licensed under chapter 18.36A
8 RCW, a physician assistant licensed under chapter 18.71A RCW, or an
9 osteopathic physician assistant licensed under chapter 18.57A RCW.

10 (3) "Medical assistant" means an unlicensed person who assists a
11 licensed health care practitioner in all aspects of outpatient
12 ambulatory health care pursuant to this chapter. A medical assistant
13 assists with patient care, executes administrative and clinical
14 procedures, and performs managerial functions.

15 (4) "Supervision" means supervision of procedures permitted
16 pursuant to this chapter by a health care practitioner who is
17 physically present and is immediately available in the facility, but
18 need not be present during procedures to withdraw blood.

19 (5) "Secretary" means the secretary of health.

20 NEW SECTION. **Sec. 3.** The secretary shall adopt rules that
21 establish the minimum requirements necessary for a health care
22 practitioner, clinic, or group practice to certify a medical assistant
23 qualified to perform the duties authorized by this chapter.

24 NEW SECTION. **Sec. 4.** Any health care practitioner, clinic, or
25 group practice may certify a medical assistant to perform the functions
26 authorized in this chapter under the supervision of a health care
27 practitioner.

28 NEW SECTION. **Sec. 5.** A medical assistant under the supervision of
29 a health care practitioner may perform the following duties:

30 (1) Performing clinical procedures to include:

31 (a) Performing aseptic procedures;

32 (b) Preparing of and assisting in sterile procedures;

33 (c) Taking vital signs;

34 (d) Preparing patients for examination;

1 (e) Venous and capillary blood withdrawal and nonintravenous
2 injection;

3 (f) Observing and reporting patients signs or symptoms;

4 (2) Administering basic first aid;

5 (3) Assisting with patient examinations or treatment;

6 (4) Operating office medical equipment;

7 (5) Collecting routine laboratory specimens;

8 (6) Administering medications by unit, single, or calculated dosage
9 including vaccines; and

10 (7) Performing basic laboratory procedures.

11 NEW SECTION. **Sec. 6.** No person may practice as a medical
12 assistant unless that person is registered with the department of
13 health.

14 NEW SECTION. **Sec. 7.** (1) In addition to any other authority
15 provided by law, the secretary may:

16 (a) Adopt rules, in accordance with chapter 34.05 RCW, necessary to
17 implement this chapter;

18 (b) Establish forms and procedures necessary to administer this
19 chapter;

20 (c) Establish administrative procedures, administrative
21 requirements, and fees in accordance with RCW 43.70.250 and 43.70.280.
22 All fees collected under this section must be credited to the health
23 professions account as required under RCW 43.70.320;

24 (d) Issue a registration to any applicant who has met the
25 requirements for registration and deny a registration to applicants who
26 do not meet the minimum qualifications for registration. However,
27 denial of a registration based on unprofessional conduct or impaired
28 practice is governed by the uniform disciplinary act, chapter 18.130
29 RCW;

30 (e) Hire clerical, administrative, and investigative staff as
31 needed to implement and administer this chapter;

32 (f) Maintain the official department of health record of all
33 applicants and registrants; and

34 (g) Establish requirements and procedures for an inactive
35 registration.

1 (2) The uniform disciplinary act, chapter 18.130 RCW, governs
2 unregistered practice, the issuance and denial of a registration, and
3 the discipline of persons registered under this chapter.

4 NEW SECTION. **Sec. 8.** The secretary shall adopt rules to implement
5 this act by July 1, 2012.

6 NEW SECTION. **Sec. 9.** Sections 2 through 7 of this act constitute
7 a new chapter in Title 18 RCW.

--- END ---

Appendix C

Applicant Follow Up

Medical Assistant Sunrise Follow Up from Applicant

Responses to July 27, 2011 Questions from Department

1. RCW 18.120.030(1)(a) asks about the nature of the potential harm to the public if the health profession is not regulated, and the extent to which there is a threat to public health and safety. Please address.

Response: Lack of clarity in the law and regulations leads to inefficiency in the delivery of health care services which in turn leads to increased health care costs. Higher costs can reduce access which is a clear threat to public health.

2. RCW 18.120.030(1)(b) asks about the extent to which consumers need and will benefit from a method of regulation identifying competent practitioners. Please address.

Response: Consumers clearly benefit from the safe and efficient delegation of health care tasks. Clear guidance regarding delegation of tasks improves medical team efficiency and thus patient care.

3. RCW 18.120.030(1)(c) asks the extent to which the health profession calls for independent judgment and the extent to which they are supervised. Please address.

Response: Medical assistants perform tasks ordered by a physician or other licensed healthcare practitioner authorized to delegate the task. They perform those tasks that they were trained to perform as part of their formal education and training, and do not make independent judgments.

4. RCW 18.120.030(3)(f) asks why the use of the alternatives specified would not be adequate to protect the public interest. You provide an alternative in your applicant report, but do not address whether you feel it would be adequate to protect the public? Please address.

Response: Physicians currently delegate tasks to other limited authority providers. This carries with it the responsibility of ensuring that those providers are properly trained and practicing safely. The physician disciplinary authority is the MQAC which is charged with ensuring public safety. That would also apply were the MQAC to grant physicians the authority to delegate to medical assistants.

5. In addition, the department asked the applicant to address the possible overlap with health care assistants, i.e., how MAs would be the same or different and whether the two professions could be combined in any way.

Response: We acknowledge questions to a potential overlap our work needs to forces on that overlap and adopting statute that deal with that overlap. However, one could anticipate that MA's would be compelled to do so particularly in response to implementation of the ACA and CMS rules that talk about "meaningful use" and clear definitions of provider scopes of practice. I would expect that what would remain of the HCA's would be the categories that are unique.

Follow Up After Public Hearing

We would like to offer the following comments on three issues raised during the Sunrise Review hearing.

First, we agree with a recommendation that Washington should look to other state for examples of duties that should be performed by medical assistants. It is relevant to note that substantive parts of HB 2009 are taken directly from existing statues in other states. For example, Section 5 is taken directly from South Dakota which has had a successful medical assistant program for some time. Attached is a copy of the South Dakota law.

The exception to using the South Dakota language is concerning the administration of medications which was taken from another state. As you review other statutes from other states you will find that the language in section 5 is the basis for many medical assistant statutes throughout the nation.

Second, there was a suggestion that a “shopping list” of tasks be placed in statute. This would have the effect of creating a policy and procedure manual in the statute. This is not the function of statutes. Instead the statute should specify the “nature” of tasks to be performed with more detailed language to be put into WAC as needed. The latter approach complies with the Bill Drafting Guide issued by the Statute Law Committee, Office of the Code Reviser.

Finally, the question of portability was raised during the hearing. Portability is a licensing issue not a registration issue as called for in the bill. The bill calls for registration of medical assistants. Certainly providers including MA’s who are regulated at the level of registration can change employers and then register at the new facility.

Responses to August 23, 2011 Questions from Department

1. Some of your panel members mentioned at the hearing that HB 2009 is based on successful legislation that passed in several other states. Please identify which states have passed similar legislation and the session year/bill numbers in those states.

Answer: Attached is a link to several state statutes. These include references that will help to locate the relevant legislation and corresponding rules.

2. Please identify which office medical equipment should be included, as well as which types of medical equipment should be excluded in the scope of practice.

Answer: It is not necessary to include a list of medical equipment in statute. These are the kinds of details that can be dealt with in the rulemaking, incorporating input from all the interested parties. The proper inquiry is what types of activities can be safely and appropriately delegated to medical assistants. The purpose of the statute is to identify the type of tasks that can be delegated. An example is Ohio (page 13 in attached link), which provides a broad outline of the nature of the tasks that can be delegated to medical assistants who have received the appropriate education and training.

Laws & Regulations – Section 4731.23 Ohio Administrative Code Delegation of Medical Tasks

(B) Prior to a physician’s delegation of the performance of a medical task, that physician shall determine each of the following:

- (1) That the task is within that physician’s authority;
- (2) That the task is indicated for the patient;
- (3) The appropriate level of supervision;
- (4) That no law prohibits the delegation;
- (5) That the person to whom the task will be delegated is competent to perform that task; and,
- (6) That the task itself is one that should be appropriately delegated when considering the following factors:
 - (a) That the task can be performed without requiring the exercise of judgment based on medical knowledge;
 - (b) That results of the task are reasonably predictable;
 - (c) That the task can safely be performed according to exact, unchanging directions;
 - (d) That the task can be performed without a need for complex observations or critical decisions;
 - (e) That the task can be performed without repeated medical assessments; and,
 - (f) That the task, if performed improperly, would not present life threatening consequences or the danger of immediate and serious harm to the patient.

3. Please identify what laboratory procedures should be included, as well as any that should be specifically excluded.

Answer: It is not necessary to include a list of laboratory procedures in statute. These are the kinds of details that can be dealt with in the rulemaking, incorporating input from all the interested parties. The purpose of the statute is to identify the type of tasks that can be delegated. An example is Ohio (see above and page 13 in attached link), which provides a broad outline of the nature of the tasks that can be delegated to medical assistants who have received the appropriate education and training.

4. What do categories D and F do? Can you provide information on who uses them and how?

Answer: These categories do not apply to medical assistants. Both of these categories include IV therapy as a key skill. This skill is not part of a medical assistant's formal education and training, and is not used by MAs in their jobs. Medical assistants fall under categories C and E. Categories D and F cover Healthcare Assistants.

Follow Up Comments Provided After Hearing

We would like to offer the following comments on three issues raised during the Sunrise Review hearing.

First, we agree with a recommendation that Washington should look to other state for examples of duties that should be performed by medical assistants. It is relevant to note that substantive parts of HB 2009 are taken directly from existing statutes in other states. For example, Section 5 is taken directly from South Dakota which has had a successful medical assistant program for some time. Attached is a copy of the South Dakota law.

The exception to using the South Dakota language is concerning the administration of medications which was taken from another state. As you review other statutes from other states you will find that the language in section 5 is the basis for many medical assistant statutes throughout the nation.

Second, there was a suggestion that a "shopping list" of tasks be placed in statute. This would have the effect of creating a policy and procedure manual in the statute. This is not the function of statutes. Instead the statute should specify the "nature" of tasks to be performed with more detailed language to be put into WAC as needed. The latter approach complies with the Bill Drafting Guide issued by the Statute Law Committee, Office of the Code Reviser.

Finally, the question of portability was raised during the hearing. Portability is a licensing issue not a registration issue as called for in the bill. The bill calls for registration of medical assistants. Certainly providers including MA's who are regulated at the level of registration can change employers and then register at the new facility.

If you have further questions please feel free to contact me.

Carl

Appendix D

Regulation of Medical Assistants in Other States

Other States that Address Education and Tasks for Medical Assistants (Similar to House Bill 2009)

Arizona	<p><u>Ariz. Rev. State § 32-1401</u> – defines “medical assistant” as “an unlicensed person who meets the requirements of section 32-1456, has completed an education program approved by the board, assists in a medical practice under the supervision of a doctor of medicine, physician assistant or nurse practitioner and performs delegated procedures commensurate with the assistant's education and training but does not diagnose, interpret, design or modify established treatment programs or perform any functions that would violate any statute applicable to the practice of medicine.”</p> <p><u>Ariz. Rev. Stat. § 32-1456</u></p> <ul style="list-style-type: none">A. Medical assistants may perform certain procedures under <u>direct supervision</u>, such as taking body fluid specimens and administering injections.B. The Arizona Medical Board has authority to “prescribe other medical procedures which a medical assistant may perform under the direct supervision of a doctor of medicine, physician assistant or nurse practitioner on a determination by the board that the procedures may be competently performed by a medical assistant.”C. “Without the direct supervision of a doctor of medicine, physician assistant or nurse practitioner, a medical assistant may perform the following tasks:” which include billing and coding, verifying insurance, making patient appointments, scheduling, recording a doctor’s findings in patient charts, performing visual acuity screening during routine PE, and taking and recording patient vital signs.D. The AMB shall prescribe medical assistant training requirements.E. A person using the title “medical assistant” is guilty of a crime if he/she is not working under the direct supervision of a MD, PA or ARNP. <p><u>Ariz. Rev. Stat. § 32-1491</u></p> <ul style="list-style-type: none">D. A doctor shall dispense only to the doctor's own patient and only for conditions being treated by that doctor. The doctor shall provide direct supervision of a medical assistant, nurse or attendant involved in the dispensing process. In this subsection, "direct supervision" means that a doctor is present and makes the determination as to the legitimacy or the advisability of the drugs or devices to be dispensed. <p><u>Ariz. Admin. Code §R-16-301</u> – Medical Assistant Training Requirements</p> <ul style="list-style-type: none">A. A supervising physician or physician assistant shall ensure that a medical assistant satisfies one of the following training requirements before employing the medical assistant:<ul style="list-style-type: none">1. Completion of an approved medical assistant training program; or2. Completion of an unapproved medical assistant training program and passage of the medical assistant examination administered by either the American Association of Medical Assistants or the American Medical Technologists. <p><u>Ariz. Admin. Code R4-16-302</u> – Authorized Procedures for Medical Assistants</p> <ul style="list-style-type: none">A. A medical assistant may perform, under the direct supervision of a physician or a physician assistant, the medical procedures listed in the 2003 revised edition, Commission on Accreditation of Allied Health Education Program's, "Standards and Guidelines for an Accredited Educational Program for the Medical Assistant, Section (III)(C)(3)(a) through (III)(C)(3)(c)." This material is incorporated by reference, does not include any later amendments or editions of the incorporated matter, and may be obtained from the publisher at 35 East Wacker Drive, Suite 1970, Chicago,
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	<p>Illinois 60601, www.caahep.org, or the Arizona Medical Board at 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258, www.azmd.gov.</p> <p>B. In addition to the medical procedures in subsection (A), a medical assistant may administer the following under the direct supervision of a physician or physician assistant:</p> <ol style="list-style-type: none"> 1. Whirlpool treatments, 2. Diathermy treatments, 3. Electronic galvation stimulation treatments, 4. Ultrasound therapy, 5. Massage therapy, 6. Traction treatments, 7. Transcutaneous Nerve Stimulation unit treatments, 8. Hot and cold pack treatments, and 9. Small volume nebulizer treatments.
<p>California</p>	<p>See the web page for medical assistants in California: http://www.medbd.ca.gov/allied/medical_assistants_questions.html .</p> <p><u>Cal Bus. & Prof. § 2069, et seq</u></p> <p>A "medical assistant" is a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services for a licensed physician and surgeon or a licensed podiatrist.</p> <p>Medical assistants may undertake certain activities <u>under the supervision</u> of a physician or podiatrist, or in certain conditions a PA or ARNP or nurse midwife:</p> <ul style="list-style-type: none"> • Administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services (simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist); <ul style="list-style-type: none"> ○ Specific technical supportive services may be found at <u>Cal. Code Regs. Title 16 § 1366(b)</u>; ○ This category was created in 1988 to allow the Medical Board of California to adopt regulations expanding the scope of practice of medical assistants. • Perform basic administrative and clerical functions; and • Perform venipuncture or skin puncture for withdrawing blood upon the “specific authorization” of the supervising health care provider. <p>Training Requirements:</p> <ul style="list-style-type: none"> • Administrative requirements related to medical assistants are found in <u>Cal. Code Regs. Title 16, § 1366</u> • A medical assistant may be trained by a physician, who must also ascertain the proficiency of the individual. In addition, a medical assistant may be trained in a qualified educational program (<u>Cal Code Regs. Title 16 § 1366.3</u>). • The training physician or instructor must certify in writing the content and duration of the training, and other factors. No special form is required for physicians certifying medical assistants in their offices.
<p>Florida</p>	<p>Title XXXII, Section 485.3485, Florida statutes</p> <p>458.3485</p> <p>A professional multiskilled person dedicated to assisting in all aspects of medical practice under the direct supervision and responsibility of a physician. This practitioner assists with patient care management, executes administrative and clinical procedures, and often performs managerial and supervisory functions. Competence in the field also requires that a medical assistant adhere to ethical and legal standards of professional practice, recognize and respond to emergencies, and demonstrate professional characteristics.</p>

	<p>(2) Duties</p> <ul style="list-style-type: none"> • Performing clinical procedures, to include: <ol style="list-style-type: none"> 1. Performing aseptic procedures 2. Taking vital signs. 3. Preparing patients for the physician’s care. 4. Performing venipunctures and nonintravenous injections. 5. Observing and reporting patients’ signs or symptoms. • Administering basic first aid. • Assisting with patient examinations and treatments. • Operating office medical equipment. • Collecting routine laboratory specimens as directed by the physician. • Administering medication as directed by the physician. • Performing basic laboratory procedures. <p>Performing office procedures including all general administrative duties required by the physician.</p>
<p>Maryland</p>	<p>“The state has regulations regarding the delegation of routine “technical” tasks that are part of the practice of medicine to unlicensed persons. These regulations are carefully drafted to avoid the implication that the delegates are a type of health care provider.”</p> <p>Regarding different standards for cosmetic use of drugs and medical use: “There is a pending attempt to prohibit the delegation of any part of the performance of cosmetic procedures, such as laser and botox, to unlicensed person.”</p> <p><u>MD. Code Ann., Health Occ. § 14-306</u> – Duties delegated by a licensed physician</p> <p>(a) <i>Scope of exemption.</i>- To the extent permitted by the rules, regulations, and orders of the Board, an individual to whom duties are delegated by a licensed physician may perform those duties without a license as provided in this section.</p> <p>(b) <i>Practitioners of other health occupations included.</i>- The individuals to whom duties may be delegated under this section include any individual authorized to practice any other health occupation regulated under this article or § 13-516 of the Education Article.</p> <p>(c) <i>Board required to adopt rules and regulations.</i>- The Board shall adopt rules and regulations to delineate the scope of this section. Before it adopts any rule or regulation under this section, the Board shall invite and consider proposals from any individual or health group that could be affected by the rule or regulation.</p> <p>(d) <i>Joint adoption of rules and regulations relating to other occupations.</i>-</p> <p>(1) If a duty that is to be delegated under this section is a part of the practice of a health occupation that is regulated under this article by another board, any rule or regulation concerning that duty shall be adopted jointly by the Board of Physicians and the board that regulates the other health occupation.</p> <p>(2) If the two boards cannot agree on a proposed rule or regulation, the proposal shall be submitted to the Secretary for a final decision.</p> <p>(e) <i>X-rays.</i>- An individual may perform X-ray duties without a license only if the duties:</p> <p>(1) Do not include:</p> <p>(i) Computerized or noncomputerized tomography;</p> <p>(ii) Fluoroscopy;</p>

- (iii) Invasive radiology;
 - (iv) Mammography;
 - (v) Nuclear medicine;
 - (vi) Radiation therapy; or
 - (vii) Xerography.
- (2) Are limited to X-ray procedures of the:
- (i) Chest, anterior-posterior and lateral;
 - (ii) Spine, anterior-posterior and lateral; or
 - (iii) Extremities, anterior-posterior and lateral, not including the head.
- (3) Are performed:
- (i) By an individual who is not employed primarily to perform X-ray duties;
 - (ii) In the medical office of the physician who delegates the duties; and
 - (iii) By an individual who, before October 1, 2002, has:
 1. Taken a course consisting of at least 30 hours of training in performing X-ray procedures approved by the Maryland Radiological Society in consultation with the Maryland Society of Radiologic Technologists; and
 2. Successfully passed an examination based on that course that has been approved by the Maryland Radiological Society in consultation with the Maryland Society of Radiologic Technologists.

MD. Code Regs. 10.32.12.02 – 05

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

- (1) "Assistant" means an individual to whom only routine technical acts are delegated by a physician and who is:
 - (a) Trained as defined in §B(9) of this regulation and not certified, registered, or licensed by the Board or any other State health occupation board; or
 - (b) Certified, registered, or licensed by the Board or any other State health occupation board and is not acting under the authority of that certification, registration, or license granted by a State health occupation board.
- (2) "Board" means the Board of Physicians.
- (3) "CLIA" means the federal Clinical Laboratory Improvement Amendments of 1988 (42 U.S.C. §263a) and the regulations promulgated under them, and 42 CFR Part 493, Subparts B and M.

(4) "Delegating physician" means a physician possessing an active license to practice medicine in this State who directs an assistant to perform technical acts.

(5) "Direct supervision" means oversight exercised by a delegating physician who is:

(a) Personally treating the patient; and

(b) In the presence of the assistant and the patient.

(6) "On-site supervision" means oversight exercised by a delegating physician who is present at the site and able to be immediately available in person during the course of the performance of a delegated act.

(7) "Site" means any facility or location including those defined in Health-General Article, §§19-114 and 19-3B-01(b), Annotated Code of Maryland, used for the delivery of health services not covered in this chapter.

(8) "Technical act" means a routine medical or surgical act which does not require medical judgment and is performed with the supervision as specified within this chapter.

(9) "Trained" means possessing the knowledge, skills, and abilities, as determined by the physician, to perform delegated acts.

.03 Standards for the Delegating Physician.

A. A physician who delegates shall:

(1) Evaluate the risk to the patient and the outcome of the delegated acts;

(2) Delegate only those technical acts that are customary to the practice of the supervising physician;

(3) Delegate only those technical acts for which the assistant has been trained;

(4) Be responsible for the acts of the assistant; and

(5) Supervise the assistant.

B. The responsibility for the delegated act cannot be transferred from the delegating physician to another physician without:

(1) The expressed consent of the other physician; and

(2) Informing the assistant.

.04 Scope of Delegation.

A. A physician may not delegate to an assistant technical acts which are exclusively limited to any individual required to be licensed, certified, registered, or otherwise recognized pursuant to any provision of the Health Occupations Article and the Education Article, Annotated Code of Maryland.

B. A physician may delegate technical acts consistent with national standards in the medical community and the approved policies and procedures of the sites for the delivery of health services in the following categories:

- (1) Surgical technical acts that the delegating physician directly orders while present, scrubbed, and personally performing the surgery in the same surgical field; and
- (2) Nonsurgical technical acts while the assistant is under the physician's direct supervision or on-site supervision if the assistant performs the act in accordance with procedures of the site.

C. At sites included in Health-General Article, §§19-114 and 19-3B-01(b), Annotated Code of Maryland, or any unit of those sites, a physician may delegate technical acts in compliance with State regulations and the policies, procedures, and supervisory structures of those sites.

D. At sites not included in Health-General Article, §§19-114 and 19-3B-01(b), Annotated Code of Maryland, when providing the following specified levels of supervision, a physician may delegate to an assistant technical acts which include but are not limited to:

(1) Without on-site supervision:

- (a) Patient preparation for physician examination;
- (b) Patient history interview;
- (c) Collecting and processing specimens, such as performing phlebotomy and inoculating culture media;
- (d) Preparation of specimens for selected tests including:
 - (i) Pregnancy tests,
 - (ii) Dipstick and microscopic urinalysis, and
 - (iii) Microbiology (rapid streptococcal testing and throat cultures);
- (e) Laboratory tests that the physician is satisfied the assistant is qualified to perform under State and CLIA regulations;
- (f) Clinical tests such as:
 - (i) Application of tuberculin skin tests,
 - (ii) Electrocardiography,
 - (iii) Administering basic pulmonary function tests; and
 - (iv) Visual field tests;
- (g) Transmitting prescriptions to a pharmacy;
- (h) Providing sample packets of medication, selected by a physician who is physically

present at the time of selection, to patients as directed by the delegating physician and in conformance with Health Occupations Article, §12-102(a), (d), and (f), Annotated Code of Maryland; and

(i) Preparing and administering oral drugs;

(2) With on-site supervision:

(a) Preparing and administering injections limited to intradermal, subcutaneous, and intramuscular (deltoid, gluteal, vastus lateralis) to include small amounts of local anesthetics;

(b) Establishing a peripheral intravenous line; and

(c) Injecting fluorescein-like dyes for retinal angiography; and

(3) With direct supervision, injecting intravenous drugs or contrast materials.

E. A physician may not delegate to an assistant acts which include but are not limited to:

(1) Conducting physical examinations;

(2) Administering any form of anesthetic agent or agent of conscious sedation other than topical anesthetics or small amounts of local anesthetics;

(3) Initiating independently any form of treatment, exclusive of cardiopulmonary resuscitation;

(4) Dispensing medications;

(5) Giving medical advice without the consult of a physician; and

(6) Providing physical therapy.

.05 Prohibited Conduct.

A. An assistant acting beyond the scope of this chapter may be:

(1) Considered to be engaged in the unlicensed practice of medicine; and

(2) Subject to all applicable penalties and fines in accordance with Health Occupations Article, §§14-602 and 14-607, Annotated Code of Maryland, and COMAR 10.32.02.

B. A delegating physician, through either act or omission, facilitation, or otherwise enabling or forcing an assistant to practice beyond the scope of this chapter, may be subject to discipline for grounds within Health Occupations Article, §14-404(a), Annotated Code of Maryland, including, but not limited to, practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine.

C. A delegating physician may not require an assistant to perform a delegated act.

**South
Dakota**

Medical assistants are licensed under South Dakota statute (S.D. Codified Laws § 36-9B-1 – 9).

S.D. Codified Laws § 36-9B-1 – Medical assistant defined

For the purposes of this chapter, a medical assistant is a professional multiskilled person who assists in all aspects of medical practice under the responsibility and direct supervision of a person licensed to practice medicine in the State of South Dakota. A medical assistant assists with patient care management, executes administrative and clinical procedures, and performs managerial and supervisory functions over unlicensed personnel.

S.D. Codified Laws § 36-9B-2 - Duties

A medical assistant under the responsibility and direct supervision of a person licensed to practice medicine in the State of South Dakota may perform the following duties:

- (1) Performing clinical procedures to include:
 - (a) Performing aseptic procedures;
 - (b) Taking vital signs;
 - (c) Preparing patients for examination;
 - (d) Phlebotomous blood withdrawal and nonintravenous injections; and
 - (e) Observing and reporting patients' signs or symptoms
- (2) Administering basic first aid;
- (3) Assisting with patient examinations or treatment;
- (4) Operating office medical equipment;
- (5) Collecting routine laboratory specimens;
- (6) Administering medication by unit dosage;
- (7) Performing basic laboratory procedures; and
- (8) Performing office procedures including all general administrative duties.

S.D. Codified Laws § 36-9B-3 – Registration required

No person may practice as a medical assistant unless that person is registered with the Board of Medical and Osteopathic Examiners pursuant to this chapter.

The Joint Boards of Nursing and the Medicine and Osteopathy have made the following determinations regarding the scope of practice of medical assistants, available at:

<http://doh.sd.gov/Boards/Nursing/medasst.aspx>

South Dakota Scope of Practice Determinations Relating to Medical Assistant Practice

1. Supervision: The Joint Board committee approved the following definition of physician “direct supervision” of the medical assistant:

Direct supervision of a medical assistant means supervision of all activities performed by the MA. Should the physician be unable to provide on-site supervision, such supervision by a properly supervised physician’s assistant, nurse practitioner, or nurse midwife shall satisfy the supervisory requirement. June 1994.

2. Administration of Medications: The Joint Board affirmed at their meeting conducted on September 15, 1993, the following in regards to the medical assistant scope of practice:

- a. Does not include injection of insulin;

- b. Does not include arterial withdrawal of blood, but does include venous withdrawal of blood;
- c. Does include administration of medications by unit dose, which means medication prepared in the exact amount, in an individual packet, for a specific patient; and
- d. Does not include patient education.

3. The Joint Board committee met on April 25, 1994 and provided additional clarification on these scope of practice questions regarding the medical assistant:

- a. The medical assistant may report diagnostic lab findings to patients only after appropriate interpretation by the physician;
- b. The medical assistant may only provide education information to the patient and may not perform health teaching or counseling;
- c. The medical assistant may perform EKG's and glucose testing;
- d. The medical assistant may not administer medications which require calculation of a dose;
- e. *
- f. The medical assistant may only distribute pre-printed information to a patient on medications and inhalers;
- g. **
- h. *
- i. The medical assistant may not perform irrigations for ostomy/stoma care;
- j. The medical assistant may apply ace bandages and splints to extremities; and
- k. The medical assistant may only perform suprapubic catheterizations involving an established fistula.

* *Item e. and Item h. above were reversed September 1995 and the statements were deleted.*

** *Item g. above was reversed April 2009 and the statement was deleted.*

4. Medical Assistant Role

In response to a request for clarification, these areas were identified as appropriate for medical assistants by a Joint Board committee December 1994:

- a. Skin testing performed by intradermal technique.
- b. Skin testing performed by the scratch technique.

5. At the September 20, 1995 Joint Board Meeting, discussion was held regarding medical assistant letters of inquiry. It was determined that:

Medical Assistants are permitted to administer medications from either a single or multi dose vial as along as the supervising physician assures appropriate training, competence, and assumes ultimate responsibility for administration of such drugs; and

6. Telephoning of Prescriptions

At the September 20, 1995 Joint Board Meeting, discussion was held regarding medical assistant letters of inquiry. It was determined that:

Medical Assistants are permitted to telephone prescriptions to a pharmacy pursuant to their supervising

physician's written or verbal order.

7. Medication Administration

At the April 8, 2009 Joint Board Meeting, it was determined that:

Certified Medical Assistants are permitted to administer medications by inhalation route as long as the supervising physician assures appropriate training, competence, and assumes ultimate responsibility for administration of such drugs.

Appendix E

Physician Assistant Practice Arrangement Plan



Physician Assistant Practice Arrangement Plan and Standardized Procedures Reference & Guidelines

Choose One: <input type="checkbox"/> Certified <input type="checkbox"/> Non-Certified		
<p>Certified Physician Assistant: In Washington State a certified physician assistant is an individual who has graduated from an accredited physician assistant program and has passed the initial National Commission on Certification of Physician Assistants (NCCPA) examination.</p> <p>Non-Certified Physician Assistant: In Washington State a non-certified physician assistant is an individual who is not eligible for or who has never passed the NCCPA examination.</p>		
Physician Assistant Data (Required)		
Physician Assistant Name	License #	NCCPA Certification #
Primary Business Address		
City	State	Zip Code
Supervising Physician Data (MD Only) (Required)		
Physician Name	License #	Specialty?
Primary Business Address		
City	State	Zip Code
Contact Number & Email Address		Work Phone #
Alternate Supervising Physician Data (MD or DO)		
Physician Name	License #	Specialty?
Primary Business Address		
City	State	Zip Code
Contact Phone # & Email Address		Work Phone #
Physician Group		
Business Name		
Primary Business Address		
City	State	Zip Code
Contact Name	Contact Phone #	
Contact Email Address	Medical Staff Office Phone #	

Standardized Procedures Reference and Guidelines

Responsibility:

The supervising physician (MD) and physician assistant (PA) are both professionally and personally equally responsible for any act performed by the PA as it relates to the practice of medicine.

Supervision of the PA by the MD is the defining hallmark of PA practice and is viewed by MDs and PAs as the major strength of their professional relationship.

Scope of Practice:

PAs may only provide those services that they are competent to perform based on their education, training, and experience and which are consistent with this practice plan. The supervising MD(s) and the PA shall determine which procedures may be performed and the degree of supervision under which the PA performs the procedure.

No MD who is designated as a supervising or alternate MD for any PA shall allow that PA to practice in any area of medicine or surgery that is beyond the MD's own usual scope of expertise and practice.

A non-certified PA licensed after June 30, 2004, may not practice in remote sites. All charts of a non-certified PA must be reviewed and countersigned by the supervision MD within two working days.

Prescriptive Authority:

This practice plan allows the certified or non-certified PA to prescribe, to order, to administer and to dispense legend drugs and Schedule II-V controlled substances. If a supervising or alternate MD's prescribing privileges are restricted, the PA will be deemed similarly restricted.

Practice Site: (Mark all that apply.)

- A. The PA will be in the same practice site as the supervising MD. When the MD assistant is on duty, the supervising MD or the alternate MD(s) or MD member of the group practice will be available for on-site supervision or telephone consultation at all times.
- B. The PA will be practicing in a remote site. **If applicable, complete the attached Remote Site Request Form.** Individuals holding an Interim Permit may not practice in a Remote Site. A remote site is defined as a setting physically separate from the supervising MD's primary place for meeting patients. Or a setting where the MD is present less than twenty-five percent of the practice time of the licensee. (**WAC 246-918-120**)

Practice Sites	Hours PA spends at each setting
Primary Care or Specialty Care Clinic	
Mental Health Facility	
Chemical Dependency Settings	
Home Visit	
Hospital	
Correctional Facility	
Ambulatory Surgical Center	
Adult Family Home Visits	
Nursing Home/Rehabilitation	
Free Standing Urgent Care Clinics	
Emergency Rooms	
Retail Clinics	
Medical Spas	
Hospice Care	
Occupational Medicine	
Other – Please describe	

Practice Arrangements

- Describe the general duties to be performed by PA in each of the practice settings selected above. (Attach additional paper if necessary)

- Describe the plan for supervision, such as face to face discussion, chart reviews, joint rounding, conference calls, performance evaluations, etc. (Attached additional paper if necessary)

- No MD may supervise more than three PAs without written authorization by the Commission. ([WAC 246-918-090](#)) If approval of this practice plan results in the supervision of more than three physician assistants, please explain the necessity.

Appendix F

Public Hearing Summary



Medical Assistants
Public Hearing Summary
August 16, 2011

Kristi Weeks called the meeting to order at 9:11 A.M.

Ms. Weeks introduced herself. She is the Director of Legal Services and also the legislative liaison for Health Systems Quality Assurance. She introduced Sherry Thomas as the sunrise review coordinator.

She then introduced the panel members, and clarified that it is their role to make sure we have all the information we need to make a sound recommendation.

- Teresa Corrado, Licensing Manager for the Nursing Care Quality Assurance Commission at the Department of Health.
- Larry Berg, Staff Attorney for the Medical Quality Assurance Commission at the Department of Health.
- Kim Baccus, Legislative & Communications Coordinator in the Prevention and Community Health Division.

Ms. Weeks explained that today's hearing is for the proponents to make their presentation, and for opponents and other interested parties to comment on the proposal. Panel members and department staff will ask questions during the proponents' presentation and public testimony. After the hearing, there will be a 10-day written comment period before we draft the initial report. She stated the department wants to allow participants to provide additional information on topics brought up today, and allow those who could not attend the hearing to submit information.

The recommendations in the department's report will be based in part on this hearing. She stated we expect the report to go to the Secretary of Health for approval in October.

Ms. Weeks gave additional instructions for participants regarding signing in to testify. She reminded participants that the sunrise review process has statutorily mandated criteria that we try to stick to as much as possible. This is not a legislative hearing, so political arguments or other factors outside the criteria will not help or hurt the proposal we are reviewing. It is the legislature's job to take those into account; they have specifically asked us to look at certain criteria. She stated it is her job to try to keep the testimony within the time limits as well as the limits of the review.

She stated that the focus is typically on the applicant report. However, in this particular case, because the department is looking at a new profession, medical assistant, that has a huge overlap with an existing profession, health care assistant, she asked to hear the public's thoughts on what to do with that overlap. That's not exactly in the proposal but that's what she requested to hear ideas on.

Ms. Weeks then introduced the first member of the applicant group to present. He is Carl Nelson, Director of Political Affairs for the Washington State Medical Association (WSMA). Ms. Weeks said Mr. Nelson will introduce the rest of his group.

Applicant Presentation

Carl Nelson, Director of Political Affairs for WSMA

Mr. Nelson introduced himself. He explained WSMA brought this proposal forward because there is a lack of clarity in trying to adequately define what medical assisting is by using the health care assistant (HCA) statutes. He gave some brief history that the health care assistant statute was a result of a couple of attorney general opinions in the mid 1980s. He provided handouts of the attorney general opinions and a letter from WSMA to then Governor Spellman, to give an idea of how long this has been going on. The issue at that time was whether medical assistants (MAs) and other assistive personnel were actually practicing medicine by piercing the skin to give injections and do other procedures. These assistive personnel were doing procedures which they had been individually trained by the physicians they worked for to perform. There were some questions on whether the physician was able to delegate those procedures, or whether it was the practice of medicine or surgery.

He stated they (WSMA, the Washington State Nursing Association and others) then passed the health care assistant statute. He said it has morphed into what it is today, a conglomeration of ideas that don't work very well. He said they introduced house bill 2009 as a placeholder, understanding there will be changes offered, which they are working on now. He said House Bill 2009 is based almost solely on successful legislation from other states. However, he stated we are a unique state in many respects, including the number of health care categories. He said Washington probably has 20-25% more health care categories than any other state. He then turned it over to the first of three panels presenting on behalf of the applicant group.

Mr. Nelson then introduced the next panel, which included Dr. Dean Martz, WSMA President, and Don Balasa, Executive Director of the American Association of Medical Assistants. He stated the second panel will include physicians and other practitioners, while the third panel will include an education manager from a clinic and a practicing, certified medical assistant.

Dr. Dean Martz, WSMA President

Dr. Martz introduced himself and stated he was in support of the bill. Medical assistants are the vital glue that keeps medical practices running smoothly. He stated that for specialists like him, they are the first point of contact with referring physicians' offices. In this capacity, they are faced with decisions on a daily basis, listening to symptoms being described from another office and deciding whether a patient needs to be seen that day, on an urgent basis, or can wait until the next scheduled appointment. When they are interacting with established patients, they have to decide if a patient calling with new symptoms needs to be sent to the emergency room or can wait for a call back from a nurse or doctor in the clinic.

He stated they also fill an advocating role for patients. The MA is working with the insurance company, trying to get a diagnostic study or procedure authorized. To do this they need a deep understanding of the kinds of disease processes the office is dealing with. He stated as this category of work has developed in his office, as things have become more complex and as these individuals have demonstrated capabilities, the MAs have been rewarded with more responsibilities.

In addition to medication administration, MAs may obtain vital signs, initiate the patient interview, and do dressing changes in some offices. Their presence is the thing that allows physicians, nurses, and PAs to focus on the more complex tasks they need to focus on. Given the existence of this kind of job, he said an appropriate regulatory and registration environment is important.

He stated that the association has heard a loud and clear message statewide that they need to fix the current situation. There are several reasons this has become more urgent. First, there is extreme confusion in practices and government about the role of a medical assistant. Informal groups in this void are developing community standards because of this lack of guidelines. Second, with healthcare reform

right around the corner, there is an expectation that the health delivery team will be organized into groups of practitioners. Medical assistants will be an important part of these groups. Third, the federal health care act is expected to significantly increase the number of insured people in our state. With that will come a shortage of providers. Properly trained MAs must be available in sufficient numbers to deal with this influx of new patients. Finally, medical assistants will be part of the evolving team approach to delivering services that is being driven by the changing economics of care and the growing gap between patient demand and the capacity of the physician and nurse practitioner community to absorb that demand.

He stated that medical assistants are currently being registered as health care assistants. This is not because the two are the same but because medical practices and clinics throughout the state believe their assistive personnel should be registered with the Department of Health. The Center for Medicaid and Medicare Services, CMS, is implementing “meaningful use” rules for their incentive programs. CMS is clear that to maintain eligibility for this program, practice personnel must work within a defined scope of practice.

He summarized that medical assistants fill an important role in the medical practice. He stated they allow him to free up nursing staff to perform a higher level of tasks within their scope of practice, tasks that they would not be free to do without MAs.

Panel Question: Teresa Corrado

Ms. Corrado asked whether she is correct in hearing that MAs are triaging patients.

Applicant Response

Yes, they are the people answering the phones.

Panel Question: Teresa Corrado

Ms. Corrado asked about the history Mr. Nelson gave of health care assistants from the eighties. She stated that it sounded like the health care assistant credential was created to go out into clinics and be taught by physicians to perform certain duties, correct?

Applicant Response

Dr. Martz said that was pretty much true in those days. Formalized training has evolved from there. The main theory of the legislation was to deal with the notion that when they used needle sticks, they were doing surgery. That was what the health care assistant statute was designed to fix.

Panel Question: Teresa Corrado

She asked whether he knows if that is why the health care assistant credential needs to be tied to a physician or provider in the community. She explained the current credential must be tied to a provider and does not move to other providers with them.

Applicant Response

Dr. Martz stated he thinks that’s part of the evolution but he didn’t know for sure. With the creation of the statute that developed, eventually, seven categories of HCAs and the supervision requirements in the statute, he guessed that was a natural history. The other thing that changed was the creation of the Department of Health and a different philosophy from the Department of Licensing.

Don Balasa, Executive Director of the American Association of Medical Assistants (AAMA)

Mr. Balasa introduced himself as the executive director and legal counsel of the AAMA in Chicago. He stated it is his position with the Washington Society of Medical Assistants and the AAMA that there is an urgent need for this legislation in Washington State. He thinks this is a different approach than conventional sunrise application processes. He asserted that the current legal ambiguity limits access to care for Washington citizens. It is leading to inefficiencies in the delivery of health care. Most of the

sunrise processes start from the point of view of looking at regulating a profession, whether licensing, certification, or registration. Based on his analysis and familiarity with the laws of all the states, he said the system in Washington State is inefficient and is causing some negative impacts.

There is no other state that has a health care assistant type of regulation. Health care assisting is not a profession, but a statutorily created category from the early 1980s to address a specific problem. However, the issue is that because the health care assistant law just addresses blood withdrawal and injections, the interpretation by the department has been that because of the expression of one area (to use some legal terminology) that occupies the field, it means there are no other duties that can be delegated to MAs. Because the statute just addresses these procedures, the conclusion is therefore no other procedures are delegable. He stated that is inefficient and there is no other state with that type of regulatory system.

In regard to the national framework mentioned earlier, he stated that President Obama's patient protection and health care reform act has increased the demand for health care in general. Because of some of the incentives in that legislation, there is a greater emphasis on outpatient care and less of an emphasis on inpatient care. Part of the increase in demand is not only because more people will be insured under the law, but also because more health care will be delivered in ambulatory, outpatient care settings. He stated that is pertinent to today's issue because MAs are specifically trained, educated and credentialed in outpatient care, in both the clinical and administrative dimensions. Preventing MAs from being fully used will have a greater impact in the future because of the transition of care from inpatient to outpatient care.

Per the U.S. Bureau of Labor Statistics (Occupational Outlook Handbook) medical assisting is one of the fastest growing allied health professions. Mr. Balas said it is actually one of the fastest growing of any professions. There has been a shift in emphasis toward team-based care, whether you call it patient-centered medical home or the accountable care organizations, which are mandated by statute and are being incorporated into the regulations of the Department of Health and Human Services. Health care needs to be delivered according to a different philosophy, a team philosophy. He said we can no longer use the traditional model we have seen in the past. Because of these factors, there is a greater need for legislation to provide more rational, clear-cut guidance into what physicians are permitted to delegate.

He stated the primary legislative objectives of both the AAMA and the Washington State society are to enhance the quality of health care for all patients; to increase the availability of care for all patients while minimizing the effects on cost. He stated this legislation is necessary for both of those reasons, to ensure quality of care and ensure health care can be delivered efficiently, without barriers to entry. The current law has created a barrier to entry so sunrise in this instance would be a way of making care more efficient to deliver, rather than restricting access or routes of entry into a profession. He stated that from his experience on a national level, there are an increasing number of states passing legislation that either names MAs or authorizes specific regulations to be adopted by state agencies. This is usually the Board of Medical Examiners, but in states with a super-agency, sometimes it is the Department of Health or Public Health. There is a great need for recognizing the abilities of MAs. States have taken that action to ensure MAs will be able to work to the top of their training and education and will free up other health care professionals to concentrate on their areas of concern.

Panel Question: Larry Berg

Mr. Berg stated that part of his focus has been to understand what is not working with health care assistants. There are approximately 16,000 health care assistants registered in 2010. He said we know that a lot of these entry level positions are not all working, but he wondered why the HCA designation has not worked very well. He asked where the medical assistant designation will fill in the gap. He stated he presumes we are looking to remove situations where there are various standards from practice to practice, based on on-the-job training. He feels we want this particular work segment to be consistent across the board. When someone talks about medical assistant in one practice, we want to know it is the same as a medical assistant in another practice. That might be a little convoluted, but he asked whether Mr. Balasa or Dr. Martz are familiar with this aspect and can help with this issue.

Applicant Response

Dr. Balasa responded that the problem with the health care assistant law is that the statute and regulations just address injections and various means of blood withdrawal. He said the MA profession encompasses a much wider scope of duties, like taking vital signs, doing EKGs, doing CLIA-waived tests, and many other clinical aspects. The health care assistant law just focuses on one segment, while medical assisting is a much broader profession with a wider range of tasks, duties and responsibilities. He said the reason we need legislation is because of the interpretation that because we have the health care assistant statute that addresses that narrow range, physicians are not able to delegate anything other than injections and blood withdrawal procedures. He stated it comes back to statutory interpretation, “the expression of the one is the exclusion of the other.” He said people in this state, like physicians, office managers, and MAs are being told that because the statute addresses those, nothing else can be delegated. He stated that if the intent of the legislature in 1981 were to allow physicians to delegate other duties, they would have incorporated it into the statute. He doesn’t believe that was the statutory intent back then. He stated that is contrary to good public policy and public health. There should be a mechanism for physicians to know for certain what is legal.

Dr. Kevin Haughton, MD, Providence Medical Group Primary Care Section Chief

Dr. Haughton introduced himself as a family doctor who has been practicing in Olympia for about 15 years. He stated that is the context in which he has been working with MAs. He has seen medicine change. He said if you go back 60 years, that’s when the system we are using now was created. At that time, doctors mostly dealt with acute issues like a broken leg, appendicitis, or a heart attack. Now, according to the World Health Organization, over 70% of the burden of illness is chronic disease. Because of technology, chronic disease has become more complicated. Frequently it is asymptomatic. He referred to diseases like diabetes, high cholesterol, and high blood pressure that need to be managed with a lot of laboratory follow-up, medications, referrals, etc.

Dr. Haughton said this leads to team-based care that they were discussing earlier. In the primary care setting it’s hard to imagine any other way than team-based care. MAs have grown to become a very essential part of that team. They can help tune up the patients prior to him seeing them, and make sure all the checkpoints that have to be checked on these chronic diseases are set out so he won’t forget any of them. That helps make sure they are on the right medications with the correct referrals. He stated that is the main reason he supports MAs. They play a big role in access and are less expensive than other providers, which plays a big role in containing costs. The MAs he works with are frequently entry-level, and many of them show large initiative and intellectual curiosity, so this becomes a stepping stone to becoming an RN on up the ladder.

Panel Question: Larry Berg

He stated he was interested in Dr. Haughton’s experience as a clinician in ongoing practice on how this works in his office. He asked him how the shift from a long-term perspective of certain duties from, for example, an RN to a medical assistant, has changed in his office. He stated he presumed that though there may be efficiency in using someone more entry level to do certain duties, it is not being done at a risk to the patient. He assumed these are still tasks within the abilities of an entry level person and possibly helps better utilize the more skilled assistants like RNs. He stated he wanted to give Dr. Haughton a wide-open door to talk about the change to his practice over time.

Applicant Response

Dr. Haughton replied that maintaining quality is of utmost importance. He said if you go back a long time, it was common to have an RN put the patients in the room for them. The RN would also do things like answer the phone and do the triage in the office. Now, it would be more common to have a medical assistant bring the patient back and have the RN either see the patients independently on some issues or do the phone triage on a separate line of work.

He gave an example of when he sees a patient with diabetes, he has a checklist of about eight things in his mind that he wants to take care of in every visit they have. He has written all those out and the medical assistant puts the patient in the room. He said he sometimes has the MA see the patient prior to their visit with him so all the labs will be back by the time Dr. Haughton sees them. He said they call them MA diabetes (word was garbled) visits, so we call them madam visits. The patient sees the MA for a madam visit. The MA checks his list for what the doctor needs checked. They get the labs, such as cholesterol and hemoglobin A1C which is a long-term measure of their blood sugar. The MA will also set it up to have the patient referred to the ophthalmologist if it is time for that. They will set it up to have their foot checked if it's time for that. When the doctor walks into the room his list of eight tasks is already done.

He stated the difference between walking in and seeing a patient that has been pre set up by a medical assistant and the way they used to do it is dramatic. He stated it has added a lot of quality, making sure they are getting all the eight points they need to hit on every patient with diabetes. He said it even makes it more fun to see patients because they can breeze through the appointment more easily.

Panel Question: Larry Berg

He asked Dr. Haughton whether he utilizes RNs more than in the past.

Applicant Response

Dr. Haughton replied that the RNs do a lot of teaching, probably more than they have in the past. Some of the telephone answering type triage is done by the MAs. He said they use just as many RNs, but a lot of the tasks that used to be done by RNs are now being done by medical assistants. There is not an excessive supply of RNs out there, so that's partly out of necessity.

Panel Question: Teresa Corrado

Ms. Corrado stated that what she's also seen morph in the last 15 years that has not yet been brought up is the use of LPNs in the clinic, not just RNs. She asked how that change came about. She also stated she is a bit confused about the team-based office discussed earlier in the hearing. It sounds like medical assistants are practicing beyond the health care assistant scope already, so where is the problem? If they are already doing it, is this just a reassurance to the physicians that it's alright to delegate? It sounds like they are already doing it with duties beyond skin puncture.

Applicant Response

Dr. Haughton responded that he worked with LPNs a lot in Minnesota, but he has not worked with them very much here in Washington. However, he felt he could answer the question about MAs working beyond the scope of the old-fashioned strategies. That is what team-based care is. He stated they are working together all the time, discussing what needs to be done with the patients. He gave an example of deciding that all diabetic patients should be updated on their pneumonia vaccines. He said it is particularly helpful with well-child care. He stated that last time he counted there were over 20 shots they were required to receive by two years old, and that is always going up. The MAs have algorithms they use to track that stuff and show him what they should be doing, and he will authorize it. He said they are working together all time so he doesn't feel uncomfortable with what they are doing. He said maybe the accountability should be at the team level, rather than the MA level. He said they are very closely supervised and they have RNs in the office who also supervise them for shots, etc.

Question from Kristi Weeks

Ms. Weeks asked what his training includes for MAs and whether it is consistent across the board.

Applicant Response

He stated MAs have an initial training required before they can work in his office, but that may not be what Ms. Weeks was asking about.

Question from Kristi Weeks

She stated she wants to know their education level, whether he is training on the job or requiring an MA degree from one of the tech schools.

Applicant Response

Dr. Haughton stated that all the MAs in his office are required to have the MA degree and certification. However, once they are working there, because they have a medical home, his office does more training. He spoke about the diabetes example he gave earlier, that requires some training. He said one of the things the MA does is tee up the conversation about what the patient is going to do to manage his or her own diabetes, and whether they would be interested in nutritional changes or physical activity changes. He said he teaches about motivational interviewing and things like that so they become comfortable talking to patients. He said that some people become MAs without an interest in talking more to patients, so they work with the MAs on that.

Dr. Erica Peavy, Medical Director for the Everett Clinic

Dr. Peavy introduced herself and said that the Everett Clinic has 400+ providers in its medical group in Snohomish County. They have been focused on adding value and reducing the cost of health care. She said they were one of 10 groups to participate in a national Medicare Demonstration Project to demonstrate higher quality and lower costs to the health care system. The clinic employs hundreds of MAs.

She stated that the discussions being held in the hearing have illustrated the need for better clarity about what is within the scope for an MA. She stated she is a medical director responsible for the appropriate use of the various medical resources. She stressed that better clarity and direction on what MAs are and aren't permitted to do, and what tasks physicians may legally delegate to them, are directly related to the need to improve quality and reduce costs.

The Federal Meaningful Use Initiative requires physicians to legally delegate tasks to other members of the health care team. She gave the example of wanting to ensure that every patient that comes to the Everett Clinic has vital signs taken and recorded in the electronic record. She asked whether the physician must do that, or if not, to whom they can delegate. She stated there is no statute to refer to for guidance on whether she can delegate that to an MA.

She stated that in order to improve quality and reduce cost, they and other groups must carefully and systematically ensure the use of valuable resources at the right time, at the right place, by the right person. She stated physicians, nurse practitioners, nurses and medical assistants all have important skills and education for delivering this care, but responsible, thoughtful use of each resource is needed to serve patients safely and cost-effectively. She said they cannot afford to have physicians performing tasks a nurse can do, or nurses performing tasks medical assistants are trained and capable to do.

She stated there is a critical need for MAs to perform key activities they are trained and capable of performing. They cannot do this without a recognized, defined scope of practice. It is not clear whether MAs may perform tasks like taking vital signs, assisting with minor office procedures, blood draws, or obtaining throat cultures.

Some MAs may be performing tasks beyond their skills and training while other are not performing all they are capable of because of the lack of clarity. She stated the Everett Clinic requested the Department of Health recommend quick passage of legislation to clarify the MAs role and the authority of physicians to legally delegate appropriate tasks to them.

Question from Kristi Weeks

She asked what the training is for medical assistants.

Applicant Response

She deferred the response to Claire Glover, a later presenter.

Elizabeth Adolphsen, Everett Community College Program Director of the Medical Assistant Program

She stated that as a program director, she has national curriculum standards she must ensure are included in her program. When implementing an accredited program, there are always minimum standards that must be met, including cognitive theory and psychomotor skills. She is responsible for implementing over 300 requirements into the MA program. In looking at scope of practice and legality, they currently have to use the HCA to address a very limited set of skills with students. This is not optional, and does not begin to address the breadth of skills they must teach their students if they choose to stay an accredited program. The only real guidance they have when talking with students across the state is the limited skills in the HCA regulations and the curriculum standards. Students are very aware of what they may or may not do based on national standards. They are limited when trying to help students with developing critical thinking and legal and ethical standards.

They are required to have advisory committees of community members, as educational institutions in the community and technical college system. It must be an active committee of community employers. With the team approach, she wondered how they merge community members' needs, curriculum standards, and state law. She stated this proposal would clarify all the team member roles and responsibilities.

Panel Question: Teresa Corrado

She asked the length of Everett Community College's medical assistant program.

Applicant Response

Ms. Adolphsen responded that it is 83 quarter credits, with some based on clock hours, some based on quarter credits, and some based on semester credits. The curriculum standards lay out the number of credits or contact hours required. Each institution has its own system for this. She said hers is about a year and a half.

Panel Question: Teresa Corrado

She asked whether Ms. Adolphsen knows if this is consistent throughout the state.

Applicant Response

She stated that is her program. She said there are 16 programs around the state that fall under the CAAHEP accreditation, and she thinks 12 programs accredited by ABHES. These are the two accrediting bodies. She said the standards are the same nationally. She said schools can fit the standards into their own structures, but there are minimum standards they must meet.

Panel Question: Teresa Corrado

She asked whether the accrediting bodies provide an exam.

Applicant Response

Ms. Adolphsen stated there are two different types of exams. One is the CMA, certified medical assistant. The other is the RMA, registered medical assistant exam. She said the CMA exam is comprehensive. This is the one with which she is most familiar and that they encourage their students to take, and she has taken. She said it addresses all parts of the curriculum.

Panel Question: Teresa Corrado

She asked whether Ms. Adolphsen is aware of what community members are looking for. Are they looking for certified MAs?

Applicant Response

She responded that they are requesting it more and more. And in order to take the CMA exam, you must have graduated from an accredited program. There was a grandfather clause that ended in around 1997. Now everyone must graduate from an accredited program.

Question from Kristi Weeks

She asked what the difference is between the registered and certified exams.

Applicant Response

Ms. Adolphsen said she thinks the registered exam is also comprehensive, but is a registry. The CMA exam is often viewed as a professional standard, and is a title. If someone has not passed the certification exam, he or she cannot use the title. It speaks to a level of professionalism. She stated it is a much preferred credential in her hiring community, and sometimes includes a pay differential.

Question from Kristi Weeks

She stated this is title protection. If the department creates a medical assistant profession and certifies them, as opposed to registering or licensing them, they will be certified medical assistants and will use that title. She asked whether Ms. Adolphsen feels they must also pass the national certification test.

Applicant Response

She stated she personally feels they should, because as a certified medical assistant she thinks it shows a level of professionalism. Ms. Adolphsen said she can't speak to whether the medical association in this state will choose this level. She said her students are always encouraged to take the CMA exam because it adds to their professionalism.

Question from Kristi Weeks

She said we don't want to put a bunch of people out of work. She asked whether those hiring MAs require certification.

Applicant Response

They responded that they do require certification.

Panel Question: Teresa Corrado

She asked whether there are non-accredited programs in this state.

Applicant Response

Ms. Adolphsen responded that she can't speak to that specifically but she is working on a curriculum evaluation project. She is looking at how the curriculum is delivered in different programs, even though they all have the same standards. She has not found non-accredited programs, but the avenue she is looking through is an accredited program process, so that has been her focus.

Panel Question: Teresa Corrado

She wondered if there are non-accredited programs, how the physicians would know the difference.

Kristi Weeks then asked the final panel to present.

Claire Glover, Registered Nurse and Manager, Clinical Education Department at the Everett Clinic

Ms. Glover introduced herself and included that she is an associate faculty member with the medical assistant program at Everett Community College. She is also chair of the Coalition for the Washington State MA Scope of Practice. She stated it is important for this state to provide clarity on the MA scope of practice quickly. She entered ambulatory care practice over three years ago after working in the hospital setting. She said her clinic relies on her heavily to advise on appropriate RN, LPN, and MA practice. She stated she had not worked with MAs in hospitals, so she had to work to better understand their role using

state statute and Department of Health resources. She said it quickly became clear that this issue was not addressed in statute outside the HCA categories, which she said addressed only administration of injectable medications and vaccines at that time. She said her phone calls to the department showed that clear direction was challenging for staff there as well.

She said her clinic has relied on community standards to guide practice because of the absence of clear direction. She strongly advocates for following direction and advice from state licensing boards and the Department of Health, so she finds the lack of clarity inadequate. She said she entered ambulatory care skeptical of the role of the MA because of her lack of knowledge about MA practice, education, and training. After studying MA program requirements, speaking to MA educators across the state, and becoming an associate faculty member of an MA program, she now attests that MAs with appropriate formal education and training are qualified to safely provide many aspects of care not addressed in statute or regulations.

Ms. Glover stated the lack of clarity makes it extremely difficult to advise MAs, and also nursing and medical provider staff. This leaves them with many questions on how to function as fellow team members. She also stated health care reform includes new federal regulations on the meaningful use of electronic medical records. These regulations require any tasks performed by a member of a medical team to be legally delegated to that person. She said providers face uncertainty about reimbursements if the MA scope of practice remains undefined.

She said her organization wants to use each team member to the fullest extent of their formal education and training. They seek further clarity from the sunrise review to provide resolution to the questions regarding medical assistant practice and help them provide more efficient, quality care to patients. She requested the department recommend the legislature pass legislation to clarify the role of medical assistants.

Question from Kristi Weeks

She asked Ms. Glover to talk about education.

Applicant Response

Ms. Glover replied that the Everett Clinic only hires category C and E health care assistants, and a few in category A, which has been the case for many years. She clarified that category A HCAs only work as phlebotomists. Because there is not an established scope for medical assistants, she doesn't know how to guide people. Under the current health care assistant law, it only addresses injections and vaccines.

Question from Kristi Weeks

Ms. Weeks asked when Ms. Glover hires category C and E, are they required to have formal training and national certification?

Applicant Response

Ms. Glover said they are required to have formal training but are not required to have the CMA certification. MAs are encouraged to get certified, but the exam incurs costs so they don't require it.

Question from Kristi Weeks

She asked whether Ms. Glover would be opposed to the department requiring certification.

Applicant Response

Ms. Glover said she personally would not be opposed to it but she can't speak for the Everett Clinic. She worries about the impact to the work force. She does recommend it because it shows a higher level of professionalism. However, she said she has several students at the college who are very well qualified who choose not to take the CMA exam because of the cost. She said she would hire them, and they are qualified to be HCA registered, and have a high level of professionalism. She would encourage the

certification, but she would not want to limit it. She said the department really needs to look at the formal education requirements of the colleges and programs providing the education.

Panel Question: Teresa Corrado

She asked whether Ms. Glover is familiar with the challenges and barriers of these medical assistants when trying to obtain a health care assistant license.

Applicant Response

Ms. Glover said they don't have a struggle with registering as health care assistants. She said she has looked at the Department of Health regulations for health care assistants and there are educational requirements that must be met. That has not been a struggle if they have completed these programs.

Panel Question: Teresa Corrado

She stated she has received calls where they are confused about the HCA categories.

Applicant Response

Ms. Glover said it is quite confusing because there are seven categories. Medical assistant focus has educated them to perform skills in categories C and E, but that is not all encompassing. Part of the issue is that when you call for guidance it is difficult for the Department of Health to help because there are no guidelines for medical assistants. They fall under the umbrella of the health care assistant statute and that umbrella encompasses many professions besides medical assistants. She said they want clarity around medical assistant practice.

Panel Question: Teresa Corrado

She asked whether Ms. Glover knows if the health care assistant program staff look at the full education of the medical assistant in determining which category they fall under.

Applicant Response

Ms. Glover stated they look at (she believes) the number of months of training completed. She said she would defer to community college representatives on the specifics they look at. She doesn't believe the department looks at formal education and training specific to an MA.

Question from Kristi Weeks

She asked whether Ms. Glover (or if there is someone in the audience who could speak to this later) if she has issues with the portability, or lack of portability, of the health care assistant credential being tied to a facility or provider.

Applicant Response

Ms. Glover said she is not the right person to speak to this issue.

Panel Question: Larry Berg

He stated he wasn't sure if this question should go to Ms. Glover or Dr. Peavy. He asked whether he could go down the list of duties for MAs in the proposed legislation (HB 2009 section 5) to see how the Everett Clinic is currently using MAs. He said Ms. Glover is in a unique role since she is also an instructor in a program preparing MAs for entry into the profession. He ran down the list and asked Ms. Glover to response to each:

<u>Task</u>	<u>Applicant Response</u>
• Performing clinical and aseptic procedures	Yes – clean procedures, setting up for physician exams, setting up for procedures the provider is going to perform.
• Preparing of and assisting with sterile procedures	Yes – that would include setting up a sterile field prior to a procedure, perhaps getting out instruments (not necessarily

putting them on the sterile field but getting them out).

Panel Question: Teresa Corrado

Ms. Corrado interjected a clarifying question: You stated “preparing for aseptic procedures” but the bill language states “performing aseptic procedures.” To me that is actually performing the procedure. She used the example of catheterization.

Applicant Response

Ms. Glover stated they do not allow that because it is considered invasive and they do not permit it done in her clinic. Putting on her “chairman of the coalition hat,” she stated that most of the organizations she has spoken with would not consider it a community standard.

Panel Question: Larry Berg continued with the list of tasks above.

<u>Task</u>	<u>Applicant Response</u>
• (1)(c) Vital signs	Yes
• (d) Preparing patients for examination	Yes. Clean procedures, setting up for physician exams, setting up for procedures the provider is going to perform.
• (e) Venous and capillary blood withdrawal and nonintravenous injection	Yes
• (f) Observing and reporting patient signs or symptoms	Yes. It has to be done under the direction of a provider or a nurse and usually they have written guidelines, standards, and precise explanations of what they are supposed to be observing, and reporting them immediately to the RN or provider.
• (2) Administering basic first aid	Yes. Putting on a bandaid basically.
• (3) Assisting with patient examination or treatment	Yes. An example would be if a patient was having an asthma attack and the provider had written an order for an albuterol nebulizer treatment. Under the HCA statute, the MA is permitted to administer inhaled albuterol nebulizer treatments under physician order. There are other examples that would require a nurse or provider making an assessment prior to ordering the MA to provide that care to the patient.
• (4) Operating office medical equipment	Yes. She stated she has had to call the Department of Health about whether an MA can assist with setting up a patient for a phototherapy treatment in dermatology. These people have been trained and have received written verification they are competent to perform this skill but that is not addressed in statute.
• (5) Collecting routine laboratory specimens	Yes. Urinary specimens would be one. She stated they don't have clarity on that. Issues such as urine specimens, throat cultures, and swabs have not been addressed yet. They are looking for clarity on those.

- (6) Administering medications by unit, single or calculated dosage including vaccines
They are currently adhering to the health care assistant law, which states they can administer limited oral, topical, inhaled, injectable medications by physician order only. However, this is very limiting to their practice, which is why they are seeking to have more definition around that.
- (7) Performing basic laboratory procedures
Yes. She stated that they do tests like pregnancy tests, but they don't have clarity on this issue.

Question from Kristi Weeks

Ms. Weeks asked for clarification about operating office medical equipment. She asked what types of limitations would be placed on that.

Applicant Response

Ms. Glover stated that radiological equipment would be one. They are looking at equipment like exam lights, blood pressure monitoring machines, and that type of equipment. She wanted to defer to someone in the audience or Dr. Peavy for more examples.

Question from Kristi Weeks

She added that we need to know not only what they can do, but also what they can't do, and that's a pretty wide open statement. She also asked about administering medications by unit, single or calculated dosage. She asked whether they are implying the MA can calculate the dosage.

Applicant Response

Ms. Glover said no, they are not. She said MAs are trained to do that, but the standard has become that they do not. The Joint Commission wants dosages to be standardized with limited calculations.

Panel Question: Teresa Corrado

Back to (f), observing and reporting patient signs or symptoms kind of sounds like triage.

Applicant Response

Ms. Glover said they don't advocate for triage, which they feel is in the realm of the RN. If they have an MA participating in questioning patients over the phone, there is a workflow they follow using a written tool to collect data and then take that back to a nurse or provider for further evaluation before providing any advice to the patient. She said that's where they are going with it. They haven't perfected it, but have done a good job. She said she closely follows the Department of Health rules and tries to deliver a workflow to her organization that is in compliance.

Pat Hightower, CMA

Ms. Hightower introduced herself as being employed by Virginia Mason Medical Center as a practicing medical assistant. She has been a medical assistant for over 30 years and a certified medical assistant by the AAMA for 12 years. She is a past president of the Washington State Society of Medical Assistants and is currently co-chair of their legislative committee. She is also a trustee on the board of the American Association of Medical Assistants.

She believes Washington State needs to pass legislation giving clear guidance to medical assistants and their employers regarding the tasks that can be performed by medical assistants. As the legislative co-chair for the WSSMA, she gets the questions that come into the organization through the web site. These questions have become very focused from medical assistants and employers, asking where they can find the medical assistant scope of practice. These questions are about medications, procedures, protocols, and triage. She asked to clarify what they mean by triage. She said that triage in her mind is not medical decision-making, which is what she would pass on to an RN. Anyone who picks up a phone and talks to a patient is gathering facts about the patient and at some level triaging them to see whether they need an

appointment today or tomorrow, or whether the calls needs to go to someone with more clinical background. Medical assistants are trained to know the difference between trauma and acute triaging versus decision-making at a simple level.

She said currently they are only able to reference the HCA law to address medication, direct them to DOH or to the curriculums of CAAHEP schools. Larger clinics like hers have policies in place for medical assistants and have developed checks and balances for internal verification of their skills. She is not sure whether this is the case or not in private practices. She is often asked by MAs in small practices if they should be doing a certain task. Sometimes they are asking to protect themselves, as well as protecting the patient. Some are afraid of losing their jobs if they refuse to do something they are not comfortable with. A defined scope of practice would alleviate their stress.

She said it is indisputable that MAs are an important part of the ambulatory care team, and are relied on by physicians and nurses they work with. Clarity of scope based on the training curriculum would only enhance the patient experience and improve patient and public safety. It will also enable small and large clinical settings to use staff to their highest abilities. This would free up RNs and physicians to deal with more complex ill patients. She said she has attached ads from a simple Internet search showing the skills required by some employers advertising for medical assistant positions. Some mention triage, but she is not sure what their meaning is. Some are very detailed and even with her experience she would feel shy of applying for some of these jobs.

She stated she represents herself and WSSMA in support for this legislation creating a scope of practice for medical assistants. She recognized that HB 2009 is broad and it would need a finite scope with further detail in WAC.

Panel Question: Larry Berg

Mr. Berg asked whether they expect the rulemaking process to address issues such as limitation to scope of practice.

Applicant Response

Mr. Nelson replied they expect to build a structured RCW and have it fleshed out in WAC.

Panel Question: Larry Berg

He asked if there were some appropriate limitations on the type of operating equipment the MA would be able to work on, or lab procedures they could perform. Is it the applicant's expectation in supporting HB 2009 that those issues would be worked out in rulemaking?

Applicant Response

Mr. Nelson replies yes, and added that the language in HB 2009 may actually be different than what is currently drafted. But he said the key is to give general guidelines so there is some clarity at the department level when looking at creating the WAC.

Public Testimony

Jim Polo, MD, Medical Director, Mary Bridge Children's Hospital & Health Center MultiCare Health System

Dr. Polo introduced himself. He supports the proposed legislation to clarify and define the role of medical assistants. He is the delegator for the health care assistants at Mary Bridge Children's Health Center. Mary Bridge is transitioning from using nursing assistants to medical assistants because the MA education focuses on medical office practice. He said MAs are more appropriately trained for patients in this setting. He feels MAs have the pharmaceutical knowledge to be capable of updating medication histories, which saves valuable time for providers and RNs. In addition, MAs are trained to give immunizations and injections that have been ordered by a licensed physician directly or by approved

protocol. Including MAs as part of the medical team is good for staff and patients because it improves the flow of patients. It increases productivity and efficiency in the clinic.

MAs are a critical medical team member. He stated they need to be able to use all of their health care providers, practicing at the top of their licenses in order to meet the challenges coming with the implementation of health care reform. This proposed legislation keeps pace with the direction of medical practice reform.

He said when you think of the comprehensive medical team and the complexity that goes into making sure individuals get the best treatment, the MAs are the glue that allows the transfer of the patient through the patient flow process from one professional to the next to assure the whole team is well-connected. This legislation provides a standard that allows them to look very carefully to ensure practice is consistent across the board and that quality is ensured because it is actually looked at in terms of how those roles are defined.

Debbie Quinn

Ms. Quinn introduced herself as a registered nurse and the systems clinical educator for ambulatory services at MultiCare. She is responsible for providing orientation to their newly hired clinical staff which involves RNs, LPNs, MAs, and also emergency service technicians. She is also responsible for providing or facilitating ongoing education to all of the clinical staff. She said that one of her frustrating informal roles as an educator is defining the scope of practice for a medical assistant.

She said she often ends up calling several sites in the community to see what their MAs are doing today, and she gets a variety of answers. To define the role of the MA or the tasks the MA can do will be greatly appreciated. She said the current health care assistant regulations address only medication administration and skin puncture, excluding category G of course. In reality she said they have some clinics that do not do any of those things. How does she tell them what they can and cannot do and base it on good rules and regulations that will cover the doctor under whose license they are practicing, the MA or the clinic supervisor, or their organizations? She said part of her responsibility is to make sure to have continuing education for new and innovative tasks to better serve patients and provide safe patient care. She said that is a challenge when they cannot call up the Department of Health, who she said she calls frequently to see if they can do tasks, and is basically told they cannot tell her what an MA can do, only what a health care assistant can do. She said that is why she is looking for this.

Chad Krilich

Dr. Krilich introduced himself as a family physician who works as the regional medical director for Multicare health system in south King county. He testified in support of the legislation that would help to clarify and define the role for medical assistants. He said Multicare employs 195 medical assistants at 17 primary care sites, eight urgent care sites and several specialty clinics throughout Pierce County & south King County. He said their medical assistants are valuable members of the health care team as has already been stated earlier. He said they perform tasks that are supervised and demonstrated through ongoing competency testing.

He said in his role he oversees the Multicare clinics in south King County where he said they greatly rely on the use of medical assistants. They have two medical home pilots in clinics in Sumner and Maple Valley. In the Maple Valley clinic their medical assistants help with tasks such as initiating orders based on a patient's conditions and specific goals. MAs assist with addressing a patient's psychosocial needs and facilitating a patient-centered model as part of the health care team. In Sumner their medical assistants greet and register patients, collect payment, obtain vital signs and pertinent history, and remain in the exam room to document in the electronic health record. This allows the physician to actually have eye contact with the patient rather than the computer screen. The physician then supervises and provides a resource for the MA during the patient care activities.

He said they also have a chronic disease management pilot in Gig Harbor where their medical assistants play an important role with patients helping to provide health care services under the supervision of a physician. Some specific examples of how they use medical assistants include comprehensive medication reconciliation, updating a patient's health maintenance, assisting with focused exams with clinical oversight such as checking a diabetic for numbness. In addition, MAs review population health dashboards and, based on clinical protocols, perform tasks such as scheduling follow-ups, placing lab orders, helping to forward refill requests, updating the patient's problem lists, and placing referrals, much like the madam visits that were presented previously. The list goes on. He stated he strongly believes medical assistants are a critical member of the medical team to meet the challenges of health care reform. They need to be able to use all their health care providers at the top of their license. Medical assistant training, proctoring, and annual competency verification is accomplished through in-services, preceptorship, skills day & self-learning or on-line modules just to name a few. He said as we all know, there is an increased demand for health care or access to health care while at the same time shrinking access to primary care.

Sherry Stoll

She introduced herself as an administrative director with Virginia Mason Medical Center. She said her role at Virginia Mason is to be administrator over many medical specialty clinics, primary care clinics, and ambulatory surgery centers. She is also accountable for the overall role of the MA at Virginia Mason Medical Center and gets the weekly calls asking whether an MA can do this or that. She supports HB 2009. She said medical assistants are important members of the health care team. As providers face implementing health care reform, they must have appropriate alignment of skills and tasks for all team members. Washington needs a scope of practice for medical assistants to guide them.

She said the proposed legislation is an admirable first step, but they have concerns about the lack of appropriate guidance around medication administration. Virginia Mason supports this legislation with the addition of regulations around medication administration like those in the current HCA law.

Tom Wolf

Mr. Wolf introduced himself as a CMA working at the Everett Clinic, Silver Lake internal medicine department. He said he has been working as a medical assistant for about 19 years, and was an air medical technician in the United States Air Force for 21 years. He supports legislation to regulate medical assistants. Mr. Wolf is also the legislative co-chair for the Washington State Society of Medical Assistants. He is also a member of the American Academy of Medical Assistants Task Force for test construction for a national certification test governed by the National Board of Medical Examiners. He is available to answer questions about the test.

Mr. Wolf stated that over the past several years, medical assisting in this state has been in constant turmoil regarding scope of practice. He said it has been difficult to perform his job when it's not clear what tasks he can perform. He said that since there is nothing in writing except for the limited HCA "Vampire Law," any time a clinical administrator made a scope of practice inquiry to the Department of Health the answer was usually not in their favor. He discussed one that personally impacted him, an opinion that medical assistants are not qualified to interpret PPDs. He said he had been placing and interpreting PPDs in flight medicine, primary care and occupational medicine, for over 30 years. If he had a questionable positive reaction he referred the patient to his provider per protocol. He was certified to interpret readings through county health department training sessions. He said he is no longer able to read PPDs and the occupational medicine department has had to hire an LPN to perform the task.

He said he does not wish to debate this opinion. That can happen during a rules hearing if the legislation passes. He just wanted to point out there is nothing in writing to debate the issue. He added that a couple of years ago, the Department of Health recommended the MA Scope of Practice Coalition develop community standards for clinics to reference for an MA scope of practice. He feels this is a poor substitute for clear regulatory guidance and presents potential risk management issues when it comes to

patient safety. Practitioners should not have to guess whether an MA can legally do a certain procedure or have to call on the DOH or the risk manager for a legal opinion. HB 2009 is a compilation of some of the best comprehensive legislative bills passed in other states which have been through political processes and met the challenge. He requested the Department of Health find a solution to this problem by passing this type of legislation.

Question from Kristi Weeks

What is a PPD? She stated she doesn't know what that acronym stands for.

Response from Tom Wolf

A tuberculin skin test.

Panel Question: Larry Berg

Mr. Berg asked how long ago Mr. Wolf was discharged from active service.

Response from Tom Wolf

He responded about 19 years.

Panel Question: Larry Berg

He asked Mr. Wolf when he entered the medical field as a medical assistant.

Response from Tom Wolf

He stated he worked as a medical assistant basically in the military, working as an air medical technician.

Panel Question: Larry Berg

He said he is leading to the question of transitioning from practice within the armed forces to civilian practice and how Mr. Wolf perceived the transition to medical assistant versus other professions? He asked if it is an overall good fit or whether that depends on where one comes from in the military.

Response from Tom Wolf

He said in most cases it is a good fit. The only problems they have being in the military is they don't get to deal with a lot of the administrative, insurance, and billing aspects and that's some of the areas where they need more training once they get out.

Panel Question: Teresa Corrado

She asked whether Mr. Wolf attended a medical assistant program or whether he transitioned from his military.

Response from Tom Wolf

He said in 1998 he was able to challenge the test without actually going through a formal school. He also has an associate's degree in health sciences, all his training in the military, and is a nationally registered EMT.

Panel Question: Teresa Corrado

She asked where he obtained his training about tuberculosis skin testing.

Response from Tom Wolf

He said in the military and through the Snohomish County Health District.

Someone asked which branch of the military he was in.

Response from Tom Wolf

The Air Force.

Sally Watkins

Ms. Watkins introduced herself as a registered nurse and the assistant executive director of nursing practice, education and research for the Washington State Nurses Association. They support this legislation but have some concerns. They agree medical assistants should be regulated for public protection and to protect patient safety. They are working not only in physicians' offices but offices with ARNPs and other providers, and in large and small, urban and rural practices. RNs in outpatient and ambulatory care settings also work side by side with MAs, so it is appropriate and necessary that registered nurses also be authorized to appropriately delegate to MAs who demonstrate a minimal level of education, training and competency.

She stated that delivery of care must be provided safely and guard against raising the risk of possible harm to patients. The scope of practice for MAs must be a consistent and practical statewide standard. These standards must take into account the limited oversight ability of smaller rural practices.

Ms. Watkins identified the following concerns:

- Credentialing described in the proposed language is confusing and inadequate. Section 2 defines an MA as an unlicensed person. However Section 3 requires an MA to be certified by a health care practitioner, clinic or group practice. Then Section 6 requires MAs to register with the Department of Health.
- Providing MA credentials only through health care practitioners, clinics or group practices is a barrier for portability and creates inconsistent standards of practice from facility to facility.
- Registration as a credential does not require a minimum level of education and training. There needs to be clear language around minimum education, including potential testing to qualify. The broad scope of practice in Section 5 requires establishing a minimum level of education and training for MAs and calls into question the adequacy of registration as the required credential.
- The proposed duties in Section 5 are very broad and need limitations. Medical equipment has already been questioned today. Does that include an MRI?
- They agree with the proposed limitation on medication administration by unit, single or calculated dose, including vaccines. However, medication administration is not just a task to be delegated. The most common type of medical error is medication errors. Additional safeguards need to be provided to protect the patient, such as prohibiting known high risk situations or high risk medications.
- The level of supervision should be defined to include language that MAs cannot delegate tasks. They should be prohibited from performing higher level activities that are not compatible with their education. Patient education should be called out and perhaps limited to providing pre-printed literature and the health care assistant statute should be revised to avoid role confusion.

Sherry Hawkins

Ms. Hawkins introduced herself as representing Wenatchee Valley Medical Center in Wenatchee. She said they are a multi-specialty clinic with 200 practitioners and about 130 medical assistants. She said all their medical assistants are category A, C, E health care assistants. They hire category A because in some of their rural sites, they draw blood.

She said she supports this issue because she represents their clinics as well. Obviously there is a need for clarity in Washington. In Wenatchee there are two other organizations (Wenatchee Valley Medical Center is the largest) and they all have different standards and different duties that medical assistants can do. They communicate with each other on what their MAs are allowed to do.

She said they are fortunate in Wenatchee to have a college that trains medical assistants and she is on that advisory board. They hire medical assistants and get them certified at A, C, E. She said their education is so good that they know what is normal and so can recognize abnormal. She said that when you talk about

symptoms and observing and reporting, of course if an MA sees a patient crumpled over in the exam room, they know enough to get help and provide some basic first aid and CPR if needed.

She said her clinic sees 600,000 patients a year and they support medical assistants. They only hire categories A, C, and E. They encourage them to take the CMA exam and AAMA. They give a pay differential because the certifications require MAs to get continuing education. Washington lags behind many, if not all states, in providing continuing education. If medical assistants are credentialed with this certification they will need continuing education as well. She stated she is very supportive of House Bill 2009.

Gena Wickstrom

Ms. Wickstrom introduced herself as the executive director of the Northwest Career Colleges Federation. They represent the state's private career colleges. She said 11 of their member institutions offer medical assisting training and provide the health care industry with hundreds of educated medical assistants annually. She said they support the sunrise process that is occurring and think it is essential the scope of practice be defined for medical assistants for all of the reasons discussed at the hearing. She said they also recognize it is a work in progress. She said they see this legislative action as a means to define the necessary education to ensure public safety for the tasks and the process being provided by medical assistants in this state. They would like to engage in the development of the statute and encourage the support of the sunrise process to continue this effort.

Steve Lindstrom

Mr. Lindstrom introduced himself as also working for the Northwest Career Colleges Federation. He said he wanted to reinforce the value of bringing the education and training along with the other requirements to the rule making process in establishing the MA credential. He said that career colleges are very able to respond to the changing demands and conditions within the health care field. They want to be sure they are included early enough to appropriately respond and help support this effort as it matures.

He said he commends the WSMA and joked that when he saw Carl Nelson supporting the sunrise activity, he thought he was in the wrong room. He wanted to add something regarding an earlier reference by panel member, Larry Berg about the people involved at the practitioner level. He in his transition from a middle-sized family practice clinic to VA, has seen dozens of very well-qualified professional people going about their business with good attitudes and providing very conscientious care. He has talked with one now and then and said he would bet half of them are in school at the same time. They are using the job they currently have to advance in their careers to benefit their families, their quality of life, and of course to satisfy that curiosity that got them into those positions to begin with. He said he thinks anything that helps provide them clarity (although it's not a specific part of the sunrise statute) is an additional dimension to the many other things being discussed today. He said speaking to those personal interests also helps raise the bar for all involved.

Panel Question: Teresa Corrado

Ms. Corrado asked to clarify something she brought up earlier. She had asked questions about triage. She wanted to clarify that she does not doubt that a medical assistant would know whether or not CPR needed to be rendered. She said she was looking at it from the nursing outlook. When she thinks of triage, she gave an example of a mother calling to say her six year old has a tummy ache. The doctor doesn't have an appointment available for 2 days, so you say to keep an eye on him. She said a nurse is trained to ask more questions. She was not saying medical assistants aren't trained for this, but Ms. Corrado stated her thought process was more along the lines of asking more questions like, if he has a fever, or hasn't had a bowel movement in a six or seven days. That's the kind of thing a nurse is trained in doing when they triage.

She just wanted to clarify that she wasn't implying medical assistants are not trained for certain things like that. She just knows that true triage on the phone is when you know the right questions to ask to find out what is truly wrong with a patient.

Tim Fuller

Mr. Fuller is a pharmacist consultant for the Board of Pharmacy and health profession facilities so he gets those questions along with the health care assistant questions. He stated he is glad this is moving forward. He said he'd really like us to look at what education MAs are getting in detail so when we look at what activities to include, there is a parallel. He also thinks we need to define the extent of the activities.

He said he heard someone mention earlier meaningful use and electronic health information. He said at this point in time, that means electronic prescriptions. He gets a lot of copies of electronic prescriptions from pharmacists that have been sent by medical assistants asking if they can they do this or not. That is one area of concern for him, what the MA training is in this area. He said he is also curious about who the head of the teams are and who is supervising them. He's also not clear on who supervises health care assistants in the various offices and thinks it probably varies.

Barbara Hyland-Hill

Ms. Highland-Hill introduced herself as representing Group Health Cooperative where she is the director of nursing. She said she covers practice across the state and in northern Idaho. She said Group Health employs over 400 medical assistants who support over 1,000 providers. They also employ registered nurses and LPNs. She said Group Health agrees that medical assistants should be regulated for the protection of the public and to protect patient safety. She said they support legislation that will clearly define the scope of practice for medical assistants, and determine the minimum level of education, training and competency, as well as the appropriate level of supervision.

She said she believes the current proposed bill is too broad and does not provide enough specificity in defining the duties of the medical assistant. In particular, she is concerned about the lack of restrictions around medication administration. The proposed bill would permit a licensed health care practitioner to delegate administering medications by unit, single or calculated dosage, including vaccines, with the only other limitation of non-intravenous injections. This would allow a licensed health care practitioner to delegate to a medical assistant the preparation of and administration of categories of medications by all routes except intravenous. She said they believe this really poses a risk to patient safety. Medical assistants primarily support physicians and nurse practitioners in their practices. The programs take various lengths of time, curriculum, and they are really not regulated by the state. The curriculum content on medications is really very basic and focuses mainly on psychomotor skills in medication administration.

She stated that we have already heard that medication errors are the most frequently occurring errors. That's why they recommend including the HCA regulations for medication administration. They also suggest considering what other states have enacted to decrease the risk of untoward medication administration outcomes.

Heidi Clark

Ms. Clark introduced herself as from Columbia Basin College in Pasco, Washington. She said she is the medical assistant instructor and a certified medical assistant. Her program is also accredited through the AAMA. She said she was originally going to ask for clarity but doesn't want to repeat what others have said. She said one of the things she had written down was one of the things Tim Fuller had just talked about. One of their larger clinics came to her recently asking if medical assistants could call in refills for medications due to a new EMR program they were working on. They went through many channels, including the Department of Health, trying to find clarification to see if medical assistants could call in or send in prescriptions to pharmacies but were unable to get clarity. As a result, that task has been taken

away from medical assistants and put back onto a physician's desk. She said that when a physician gets 50, 60, or 70 emails a day asking for prescription refills, things are going to fall through the cracks.

She said medical assistants are the vital link in a medical office that helps to "cross the t's and dot the i's" so that physicians are free to do the things they want to do, which is to care for patients. She said in her area, which is more rural than some of the other clinics, there are many clinics where the physicians don't obtain HCA certification for their employees simply because they don't understand how it pertains to them or their practice.

She said they are unclear about the education requirements of the HCA and believe they can pick up a textbook and that somehow meets the education requirements in the HCA law. When they call the Department of Health they are told it does not meet the standards, and then she gets the phone calls. She said the colleges don't want to be the local experts on the law. They want it to be clear enough so everyone understands it, so that even their small rural doctors who are single practitioner offices would be able to get their employees registered.

Question from Kristi Weeks

She asked both Mr. Fuller and Ms. Clark what their positions are on MAs calling in refills or sending electronic refills

Response from Tim Fuller

He said he doesn't support MAs doing this task, and the Board feels that way as well.

Response from Heidi Clark

She said she understands there is some question on clarity in education. But she said her medical assistants have 110 hours of theory, which is five college credit hours and they are very well versed in their medication classifications and the side effects. She said they are able to use their resources to look up medications they may be unfamiliar with because just like any nurse or anyone else who has not dealt with the medication, the important thing is to learn how to become familiar with it so you can talk about it in a reasonable fashion. She said she believes MAs should be able to call in a refill that has been authorized by their physician. She said the medical assistants will send authorization to the physician and ask if they can refill a specific medication. The physician will look at it and say, no problem with a refill and we'll see them in September. The MA would send that refill off to the pharmacy. She said she doesn't think a medical assistant would ever look at something and decide it could be refilled on their own. She said they don't have that kind of authorization. As long as it's been authorized by a physician, they should be able to call in a refill or send it off by electronic medical record as long as it has been reviewed by a physician.

Brad Tower

Mr. Tower introduced himself as representing the Optometric Physicians of Washington, the statewide professional association of doctors of optometry. He said he signed in with concerns. He said the proposal and bill language raises a number of questions he wants the department to consider.

He said it appears the definition of medical assistants links a one-to-one relationship with a limited number of health care practitioners under this particular definition. However, the duties of a medical assistant are very broad and have overlap with more than just health care assistants. He said there are optometric techs, and other people who work in fields for practitioners other than optometrists who are also not listed in this particular list. He thinks the bill creates a situation where if they are practicing independently as optometrists and have somebody performing the proposed duties within their offices, they are not obliged to have that person be a registered medical assistant. He said they are fine with that.

Mr. Tower said the questions arise when you have, for instance, a co-management practice and multiple licensed providers, like MDs, ODs, etc. He asked, can an OD delegate tasks to an MA? They aren't on

the list of practitioners listed in the bill. Can an MD delegate to someone who is an optometric tech, because they aren't registered as an MA? He said it's those sorts of administrative issues, especially with multiple licensed practitioners; they would like the department to watch out for. Philosophically speaking, he said he feels the issue of legally delegating tasks should be addressed in the laws that deal with the delegator as opposed to the delegatee. If they were going to need clarity around their authority to delegate to a tech or MA, he believes it should go in the statute that governs their practice.

Question from Kristi Weeks

You have identified a problem but not a solution. Do you think optometrists should be one of the groups that can supervise an MA?

Response from Brad Tower

He replied they would not support that. He said he might suggest that instead of an explicit creation of a scope of practice where you could be practicing as a medical assistant without a license or registration; rather it would be a designation where one would not hold oneself out to be a medical assistant without meeting certain criteria. He said to have those capabilities related to those criteria clearly defined in the law. But he said not a strict prohibition against someone providing first aid, for example, at a swimming pool. It's a very broad definition of the tasks an MA would perform that captures a lot of people besides just MAs, health care assistants, etc.

Panel Question: Teresa Corrado

She asked to clarify whether Mr. Tower is asking for the ability to delegate to a medical assistant a task that might be under their practice as a duty that's not necessarily in the assistant's scope but would they want the opportunity that if something arose with a patient, they could delegate a duty to the medical assistant that is within their scope, such as a dressing change.

Response from Brad Tower

He said there are a number of different levels of education and accreditation for people that work in eye care, optometric techs., etc. Those are not registered or licensed positions, but they're education positions. So, he said they would not support moving those to a more broad category of license like an MA. He apologized for not having an answer to how to fix the problem, but said he was only prepared to raise the question.

Brenda Suiter, Vice President of Rural and Public Health, Washington State Hospital Association (WSHA)

Ms. Suiter introduced herself. WSHA supports the proposal to create a defined scope of practice for medical assistants. They commented because their association members are employers of medical assistants. Their comments aren't at the same level of detail of some of the other associations or clinicians who testified. She said rural and urban hospitals in health systems throughout the state employ medical assistants in medical clinics. They play an important role in supporting providers and are part of the medical team. But medical assistants are currently unregulated. There are no clear guidelines on what medical assistants may or may not have delegated to them. While they may register as health care assistants, it doesn't fit all the tasks they typically perform. She said that as she talks to hospitals, particularly rural hospitals, they are not registering their medical assistants as health care assistants because of the confusion out there. This is caused by the lack of clarity of the role of medical assistants and what may be delegated to them. This is clearly a problem that must be addressed through the scope of practice. Regulation of medical assistants will improve patient safety by establishing a clear, statewide standard and defining the MA role. She said it will also do the following:

- Assure all MAs are included under the Uniform Disciplinary Act;
- Help providers work efficiently. She said they currently face a workforce shortage in this state and expect this to continue into the future. They need the medical team to understand how they can fully use each member in their team, including MAs;

- Address the need to have all tasks performed by the medical team be legally delegated to them as required in the new Medicare regulations (the meaningful use regulations);
- Address issues about when an employer may terminate a medical assistant for unsafe practice. For example, a rural hospital terminated a medical assistant for distributing medication to another staff member. Unemployment compensation was assigned because the MA was terminated. The MA appealed the decision and won the appeal. It is important that they are appropriately regulated.

A scope of practice needs to define clear parameters under which medications may be administered.

Steve Barger, Dean for Nursing and Allied Health at Everett Community College

Mr. Barger introduced himself. They are in favor of this legislation. He would like to provide a “how-to.” Define the scope of practice that can be done with groups of people who are capable of doing that, and he will take the items and build a curriculum. The problem has been, what is the scope of practice and how do you get it to the practitioner? He said they have a lot of experience building a curriculum based on criteria. The criteria come from the scope of practice, but that has been undefined. They would then work with community partners. All the programs have community advisors to help define what practice needs to happen in the community. They would match that up with the education requirements, and then have the people with the appropriate education and training do the tasks described.

For “grandpersoning” in the people already in practice, there could be continuing education like what they have in several professions now. They could develop educational programs to help them bridge the pieces they don’t have, so they could become certified. In their program, they currently have 85% of the students take the AAMA exam and a 94% pass rate. He feels it’s possible to educate almost everyone to that standard. He brought a sample of their curriculum that includes very specific details, because they are accredited by the AAMA. They want them to do lots of things for lots of time.

Kay Kvam, Washington Academy of Physician Assistants

She represents two groups. The first one she is representing is herself. She is a physician assistant (PA) working in family practice. She’s been a PA for 30 years and currently works for Group Health. She said in her organization, MAs play an important role in the medical health care team. Each provider from MD, DO, and nurse practitioner are assigned an MA to work with on a regular basis. MAs are key in helping them provide efficient, cost-effective health care to their patients. However, this is not always the case. She hopes the following example will show that we do need rules and guidelines for MAs. When she orders a nebulizer albuterol treatment for a patient experiencing respiratory distress, her MA is not allowed to carry out this order. The MA cannot take a well-marked unit vial dose of albuterol, open it, put it in, and turn on the machine. The MA has to find a busy LPN or RN to do it. Not only is this inefficient, and an inconvenience to patients, it is time-consuming and frustrating on a busy day. Most days are busy days.

She said there was another group who said their MAs can do this task, so there is a lot of discrepancy out there and it would be nice to get clarification. It is her observation that MAs are being under-utilized in her clinics because of the uncertainty about what they can perform. She strongly supports them being used to their highest potential based on their training and education. She asked how else they are going to be able to handle increasing health care demands in a cost-effective, efficient, and safe manner. She includes “safe” because they are running around trying to get RNS that are already very busy. If the MAs could do the job they are trained to do, things would be safer and work more efficiently. She asked the department to recommend the legislature pass House Bill 2009. Other states have done this and it’s time for Washington to do it.

One more important thing she wanted to bring up was that she is a PA and the department has established rules, regulations, and a scope of practice for her. Physicians also have a scope of practice. She asked,

when we have MAs who are graduating in one of the most popular professions out there, why don't we have a scope of practice just for them? The HCA regulations are not enough.

She also provided comments from the president of the Washington Academy of Physician Assistants, Randall Dixon. The academy's 22,000 members work closely with MAs throughout Washington. Please support HB 2009 to define the scope of practice for MAs. PAs work in every aspect of medicine in this state and rely heavily on medical assistants as part of their team to provide excellent care to patients. With their level of education and training, MAs could be performing more tasks to efficiently reduce patient time spent in clinics, emergency rooms and hospitals.

Judy Mitacek

She has been a registered nurse for 44 years, with 18 years in the hospital setting and 25 years in the outpatient setting. She works for the PolyClinic, a large specialty group with roughly 11 sites, employing RNs, LPNs, medical assistants, physicians, PAs, and ARNPs. She is responsible for new employee orientation of RNs, medical assistants, LPNs, PSRs, and employee health and safety for the entire clinic. She also manages the float pool, which includes MAs and RNs that they send out to all those specialties. Over the 25 years she has worked with MAs, she has seen an increase in the level of education they are receiving, their abilities, and responsibilities. It's much different than when she first started at the clinic. She was also skeptical, but she has seen a large change.

Being responsible for education, she is responsible for defining the scope of practice for the RNs, LPNs, PSRs, and medical assistants. That is really difficult with the current HCA information that is available so they also have a difficult time. They would like to see definition on educational requirements, an outline of specific tasks, not a broad statement but something very clear. Then it would be easy to talk to MAs about their scope of practice. They frequently hire new MAs directly out of school, as well as experienced MAs who may have had a broader scope in another facility. Trying to bring everyone into an organization and make sure they are functioning according to what the Department of Health requires can be difficult. If there was an outline of specific tasks, as well as specific responsibilities of those who can supervise, for the physicians and RNs, it would be good to have it really defined. She supports HB 2009 to clarify the role of the MA.

Ashley Sturdevant

Ms. Sturdevant introduced herself as a recent graduate of a radiologic technologist program in Seattle. She asked for clarification on operating office medical equipment, and on administering medications by unit, single or calculated dosage. She is concerned that operating office medical equipment in a small office could include operating x-ray equipment. Being a recent graduate, she has had over 2,000 dedicated hours of training on what radiation does to people. MAs seem to be grossly undereducated in this.

Also, radiation is medication prescribed by a physician, and it's up to the technologist to interpret the order and give a calculated dose at the lowest rate possible to the patient. If an MA is undereducated in this, they can overdose people. Radiation is cumulative to your life and you don't ever get rid of that dose, so watching that dosage requires a lot of education that MAs are not trained to do. It also requires them to interpret the order and to give the best views possible. MAs have a 50% repeat rate in a small clinic, which means that half the time there will be more cost to the patient, to their insurance, and more exposure to them to have it redone. She said someone with her education has a 3% repeat rate, so there is a huge variance in this.

She said she has also heard concern that an MRI could be included. She works in MRI at Providence St. Peter's Hospital, and there are a tremendous number of contraindications for MRIs. They are also extremely expensive to everyone, so she thinks this needs to be excluded from the office medical equipment. She said a lot of small offices do not have MRI machines, but there are chiropractor office

MAs who take x-rays and this area needs to be addressed and limited and not included in an MAs scope of practice.

Tanya Van Buskirk

She hadn't planned on testifying but changed her mind after listening to other testimony. She is an instructor at Everest College. She had two of her students with her in the audience that are in their fourth mod of training. Ms. Van Buskirk is also a drill sergeant in the U.S. Army and trains privates in needle chest compressions and is a combat life saver. She has some experience outside of medical assisting. She took her certification exam and is CMA certified. At Everest College they pay for their students' certification as part of their formal program. Before they leave school, they are set up to do their exam and within six months, the students take the exam, and the school finds out if the student has passed.

She also wanted to address a previous question about portability of the HCA license. Her concern is that when she transitioned from the field to teaching, she did not get to take her license with her. There was nobody that could get her certified under them, so now as an educator, she doesn't have her HCA license. She is concerned about that.

Panel Question: Larry Berg

He was interested in hearing her perspective on transitioning from a military career to civilian practice.

Response from Tanya Van Buskirk

She stated she was surprised when she was with the military that as a private she was able to perform needle chest compression and IV placement but now medical assistants aren't able to do that as part of their training and is not part of their scope of practice. She thinks that might be something to think about in the future, getting MAs certified to do that. As far as transitioning her military education, she also has a Master's in Public Health and a Bachelor's in Communications, and an Associates Degree. She has that background on top of her military education. The combat life saver is very similar to what is taught in first aid and CPR, but takes it out to the field. Moving from the field environment where there is a lot of dirt to a facility where there is hand hygiene, it was different in that way. It definitely prepares you for the professionalism aspect, dealing with patient care and customer service. It gets you ready as a medical assistant.

Panel Question: Teresa Corrado

To clarify, you did not graduate from an accredited MA program?

Response from Tanya Van Buskirk

She stated that she graduated from Everest College, which is accredited, and where she currently teaches.

Panel Question: Teresa Corrado

She clarified, that Ms. VanBuskirk picked up some other skill through the military and Ms. Van Buskirk agreed.

Panel Question: Teresa Corrado

You are asking the department to potentially look at broadening the scope

Response from Tanya Van Buskirk

She stated that's just her personal opinion of something she has noticed as an educator, being from the military, and the way they teach there. The people teaching there have no education or training in IV placement and are learning it so she thinks they could train MA students to do that sort of task. She thinks it could be considered in the future.

Tracey Hugel

Ms. Hugel stated she is from Bellingham and is the Chief Clinical Officer, working with 12 clinics with about 130 clinical staff. About six years ago, 60% of those staff were medical assistants. Unfortunately, with the limitations in the scope, they are down to about 40% and have been hiring LPNs and RNs instead. She said part of that is risk management. One of her concerns she was hoping would be addressed was the requirements for the employers. In reality, much of the training MAs receive is on the job. When you look at a lot of the schools, they are very different in how long they train students. If you look at the programs, some are six months, while some are two years. If you look at schools out of state, some are only four months. She has looked at a lot of the requirements and some require only a D average, which is very scary. She said you hire them thinking they will do a great job and then three to six months into employment, you realize they don't know what they are doing. They are not giving shots correctly. She said she would like a minimum standard on how long they should be in school. If they come from a school out of state, the program needs to be evaluated because four months is inappropriate and unsafe.

She said there also needs to be a requirement for the employers to mandate annual reviews and clarity around standing orders, and whether they are authorized. Other states like Texas don't allow standing orders, but there are no guidelines here in Washington. There are a lot of clinics using standing orders for refills of medications and procedures. She said the reality is that it's happening so it needs to be addressed whether MAs should be doing it or not. Also, immunizations should be in line with what is required for immunizations for children. It needs to be defined so everything that is required by the state or CDC should be trained in all the programs and defined in all the protocols.

She said employers have to bear a level of responsibility for ensuring there are policies, procedures, annual review, and whether they have authorized an MA to do medical procedures like lab testing, it must be CLIA-waived only. If they do anything beyond a CLIA-waived test, they must have certification from the manufacturer. Also, the sanctioning guidelines are in place for RNs and LPNs but there are no sanctioning guidelines for medical assistants.

Question from Kristi Weeks

She stated she has a question nobody has addressed and requested someone come up and address her question. She stated health care assistants are categories A-G and people have talked about A and B, and C and E are generally considered medical assistants. Has anyone in the audience hired D and F as a medical assistant and why not?

Someone from the audience asked Ms. Weeks to remind them which ones are D and F. Someone read all of the categories, and clarified that category D shows IV injections for diagnostic agents and F shows IV injections for therapeutic agents.

One of the representatives from Everett Clinic responded that in their clinic, they don't want medical assistants or other personnel in those categories because that is enabling IV medication administration. This uses faster-acting drugs, has more risk to the patient, and medical assistants are not trained in administering IV medications in the programs she is aware of. She teaches pharmacology and she doesn't teach the medication administration piece of the curriculum. She only touches on the fact that IV medications are fast-acting and pose a faster risk to the patient if you give one in error. These folks are not trained to administer IV medication so any category that would define that is not appropriate.

Ms. Weeks asked whether they employ Ds or Fs at all.

Someone in the audience said they might hire them in radiology, but the representative from the Everett Clinic said RNs and radiologic technologists are the only ones they hire to administer the contrast agents.

Kristi Weeks stated the category Ds and Fs seem to be an unknown factor so she was trying to get some insight from the participants on this topic.

A representative from Everett Community College

She stated she teaches the medication administration class and her students are taught they cannot initiate IVs because when a patient has a reaction, it would require assessment and triage and a plan, which are not currently within the MA scope. They talk about IVs and why potentially in an outpatient setting a patient may get an IV and the physician may ask the MA to get vital signs during administration of the IV. But they do not initiate the line. The educational requirements of D and F categories require two years of postsecondary education versus one year for categories C and E.

Panel Question: Teresa Corrado

She asked what about IV removal and was told it may be allowed but the person replying was unsure.

Kristi Weeks then wrapped up the hearing and gave next steps.

- There is an additional 10-day written comment period starting today through August 26 at 5:00 for anything you feel has not been addressed.
- We will share an initial draft report with interested parties by early September for rebuttal comments. Those of you participating today will receive the draft as long as we have contact information for you.
- We will incorporate rebuttal comments into the report and submit it to the Secretary of the department for approval in October.
- Once the Secretary approves the report, it is submitted to the Office of Financial Management for approval to be released to the legislature. OFM provides policy and fiscal support to the Governor, legislature, and state agencies.

Ms. Weeks closed the hearing at 11:40 A.M.

Hearing Participants

Name	Representing	Position
James Polo	MultiCare	Support
Marylee Morris	Legacy Health	None Indicated
Tedra Demitrious	Legacy Health	None Indicated
Claire Glover	The Everett Clinic	Support
Deborah Quinn	MultiCare	Support
Andrea Tull	MultiCare	Support
Sherry Stoll	Virginia Mason	Support with Concerns
Tom Wolf	WSSMA	Support
Sally Watkins	WSNA	Support with Concerns
Sherry Hawkins	Wenatchee Valley Medical Center	Support
Chad Krilich	MultiCare	Support
Gena Wikstrom	NW Career Colleges Federation	Support with Comments
Steve Lindstrom	NW Career Colleges Federation	Support with Comments
Pat Hightower	Self and WSSMA	Support
Tim Fuller	Board of Pharmacy	None Indicated
Barbara Hyland-Hill	Group Health	Support with Concerns
Virginia Ramos	SeaMar CHC	None Indicated
Heidi Clarke	Columbia Basin College	None Indicated
Brad Tower	Optometric Physicians of Washington	Concerns
Brenda Suiter	Washington State Hospital Association	Support with Comments
Erica Peavy, MD	The Everett Clinic	Support
Elizabeth Adolphsen	Everett Community College	Support
Stuart Barger	Everett Community College	Support
Kaye Kvam PA-C	Self and Washington Academy of PAs	Support
Peter McGough	Washington State Medical Association	Support
Mike Hatchett	The PolyClinic	Support
Judy Mitacek	the PolyClinic	Support
Peg Gerber	PIMA Med. Inst.	None Indicated
Carolyn Fuller	SPSCC Medical Assisting	None Indicated
Dorene Hersh	PHSKC	None Indicated
Amy Myrtue Nelson		None Indicated
Susie Tracey	WA Academy of Eye Physicians & Surgeons	None Indicated
Vicki Christophersen	Providence	None Indicated
Ashley Sturdevant	Radiology Tech.	Not as Written
Tanya VanBuskirk	Everest College	None Indicated
Tracey Hugel	Family Care Network	None Indicated

Appendix G

Written Comments

Medical Assistant Sunrise
Written Public Comments
August 26, 2011

Comments Received Prior to Hearing

Your documentation makes it sound like licensing an MA means they will no longer need an HCA license. At this point my concern is the cost of the license. Right now CNA licenses are pretty steep for CNA's considering their wage in the market place. I have sent a copy to our clinic managers to get their feedback on the content of the proposed law. Barbara White

May I ask what needs is the review based on and what is the dominant goal in the review? As I reviewed the document I didn't see any significant change from those standards and expectations already taught in the Medical Assistant program. I did see language regarding clinics, providers, etc. being able to make the recommendation for certification, is this in support of on the job training or simply related to the process of the institution applying for HCA certification through the state? If so what is the speculated impact on teaching institutions/MA programs? Richard St. Clare RMA, CAHI, BSHHS, MBA

I'm a pharmacist practitioner working in an anticoagulation clinic and lipid clinic and MAs are part of our team. I am one of the providers (along with two other providers and a nurse practitioner) and am concerned with language here that does not include pharmacists as "health care practitioner". Does this mean an MA can't work with me? Could lead to grey area and decreased access to care if we cannot use MAs to support what we do. Melissa Hull, PharmD, CACP, CLS

I am a registered nurse and am concerned that this is an attempt to use more MAs in practice as a source of cheaper labor than RNs. I would think that it would be imperative that there be an RN overseeing MAs in some form in the new regulation. Patients really do get better, more comprehensive care when there is an RN with a broader prospective and knowledge base involved in their care. I understand that the physician is legally responsible, but MDs and RNs also have a very different approach to anticipating patient needs. A patient deserves the full team-based approach of an MD, RN, and MA if used. Sheila Malmberg, MN, RN

Is an opportunity available to us here for, for example, sorting out the renewal of prescriptions issues? I believe that Nevada has already imposed some restrictions – such as prohibiting MA's involvement with controlled substances. Thomas K. Hazlet

I wanted to know if this proposed regulation just means that every MA will now need to be registered within the state of WA? Jainalyn Doolin, MA

Some concerns I have with this issue is, currently Private Physicians especially use the MA as a RN but without the pay or recognition. This sounds as if it will incur licensing costs for the Medical Assistant. Currently a student directly out of school is making in Washington state from 13.00 to 15.00 per hour. If they are a Certified Medical Assistant they already have CE credits and re-certification fees at this time. I feel it is good to regulate what the scope of practice is, however I do not feel that a HCA can be certified as a Medical Assistant without going through the actual schooling required for all others. The HCA and

MA depending on where they work do different things, just like the CNA and MA. One is more hands on and one is more patient care. I think that this proposal is just so the state can make more fees and the Doctors can continue to use the MA's to the max without the pay recognition of a Nurse. Within some settings the RN and MA parallel their work, except for IV's. and yet the physicians pay a huge amount of salary different just to have them on staff. I believe that if years of service and knowledge will be a part of this new registration than it should be recognized differently as well. There is such a shortage of nurses and I have seen many nurses come out of school without any real clinic experience and a trained MA can do circles around them. I would like to see different grades or levels of the Medical Assistant. More like the CNA, LPN, RN, PA, FNP. This would encourage the MA to take more CE credits and broaden their knowledge. Maybe a MA1, MA2, etc. As the CMA is now recognized as a person with more training and experience so could an MA title. I have taken CE's for my recertification, and I found the studies very interesting, however I never used them in my scope of practice. I would love to be able to do more things under my scope, I feel I myself have the knowledge and experience just not the title to go along or official schooling, but there is nothing like on the job training!

Please keep me advised. I just received this email today from our HR department but will share with my MA staff. Things like this are very informative to our group. Thanks for sharing!
Charlene Funderburg, CMA Supervisor

I would just like to submit my comments for your review of Medical Assistants using x-ray as part of their jobs.

My personal belief is that Medical Assistants should not be able to perform x-rays on patients under any circumstances, as they have not had any education in school that prepares them to take or administer x-rays. The education component is extremely important because it not only teaches technologists how to correctly position patients to allow for the best diagnostic read, but also prepares the tech to safely use radiation and to understand the health risks associated with radiation doses. These subjects are covered over a *two year* time period in a Radiology Technology program which proves how much education and training one really requires in order to perform this job safely. I don't think an MA can fully grasp the significance of these issues without having gone through the necessary courses (radiation safety, radiation biology, radiological positioning, etc.) If I were at a clinic that used an MA to take the x-rays, I would kindly ask to go elsewhere.

If MA's are allowed to continue taking x-rays, their scope should be strictly limited and a educational component should at the very least be added to their program of study. Beth Rathbun

I have made phone contact with you regarding the new house bill review. I am a Medical Assistant with Department of Corrections. As a medical Assistant I would like Clarified the need for the HCA certification. When I was searching for employment I was turned down multiple times by Kaiser for local positions because I did not hold an HCA which I did not have due to being unemployed for almost 2 years. And now that I am with the Department of Corrections working as a medical assistant I am in the process of getting my HCA but it is not something that is paid for by the department of corrections I have to pay for it out of my pay check. My primary job with the department of corrections is Medical Records (administrative) as well as clinical. I think clarification does need to be defined as to what a Medical Assistant can and can not do in the clinical aspect. I also think that the levels of the HCA needs to be cleaned up. The PA-C that over sees me is questioning the classes and what the differences are for a HCA. There are a lot of overlap. I in the clinical portion have been trained to do vaccines, blood draws as well as take vitals. Please send information on how the review goes as I will not be able to attend because I am currently in extensive training for the correctional facility setting. Sheri Landers-Walker

I think the idea of licensing MAs separately from the HCA is a step in the right direction. Does this mean their license is transferable within Washington State? That is one barrier for us is the filling out of the application and the high cost for the HCA license and then if that employee changes jobs their HCA license does not follow them to another office. We always struggle with new hires who have a hard time at their rate of pay to pay for the HCA right at the time of hire without knowing if this job or office is the right fit. Jennifer

I am happy to see this field recognized and regulated. As a nurse, I have watched this field blossom and grow into the primary care field. It is not uncommon to see a provider office run by Medical Office Assistants. Does this mean the training programs would also become accredited by the State?

I would like more clarification on what is meant under Section 5(6) "Administering medications by unit, single, or calculated dosage including vaccines." What does calculated dosage mean? Is it intended to mean the Medical Assistant could calculate the amount of medication needed from a multi-dose vial (i.e. Streptomycin, Lidocaine or epinephrine) and administer it to a patient? Jeni Nybo

I have read through the sunrise information and have a couple of questions and possible concerns. I believe this indicates that all medical assistants will now be required to obtain a certification? Is there a new certification being developed or will it fall under the Health Care Assistant (HCA) levels of certification?

If it does fall under the HCA classification, my concern is with the difficulty employers have in obtaining a primary source verification (as required by The Joint Commission). On the DOH website, it only lists HCA and does not indicate the specific level of certification (A, C, etc). This requires Human Resources to then call and verbally verify only that piece, unnecessarily increasing both our time spent verifying and the number of calls into the DOH. Adrian Barajas

I am Edythe Hudson ARNP Women's Health Care and Urogynecology. I have been working in this field for 11 years and utilizing MA's extensively in my practices. Kitsap Urology Associates in Bremerton Washington 10 years and now Franciscan in Gig Harbor, Washington.

We had MA's sent off to SUNA (society of urological nurses association) training programs for certification in urodynamics testing as well as general urological assisting which was inclusive of percutaneous tibial nerve stimulation techniques, bladder catheterization with irrigation and instillation of soothing drugs to the mucous membranes of the bladder for interstitial cystitis. Straight catheterization to measure residual urine and obtain sterile samples for culture is also a common procedure in our practice. These are all part of the SUNA Certification process and these highly trained MA's then were of great benefit to our practice. Enclosed is the general statement from SUNA and having personally attended their conferences I can say this is very in-depth training and a difficult exam to pass for certification. Enclosed is also a conference brochure for your review. These MA's also attend the local Chapter in Seattle updates and workshops for CME.

When KUA joined with Franciscan these SUNA certified MA's have been restricted from placing catheters which are required for these procedures because it is felt Washington law supercedes the SUNA certification. I have supervised and mentored and developed parameters for functioning and now must train an LPN who has no SUNA training to do these procedures. Please revise your standards to allow for SUNA certification to be accepted for expanded privileges in urological settings. I understand that in the past bladder catheterization was part of MA training and has been removed from current programs. I do not understand WHY -- since in my opinion it is an easier skill to learn than venipuncture (at least in women) and a way to administer medication to a mucous membrane which is allowed under category D thru F. Also under allowed drugs LOCAL ANESTHETIC agents and MUCOUS MEMBRANE agents are permissible drugs.

This has been our community standard in all the Kitsap County Urology offices from before the time I joined KUA. Having to replace these people with LPN's is costly and also underutilizing the skill level of the LPN who then must also room my patients when she could be supervising a whole floor of a skilled nursing inpatient facility.

Since the regulations are vague about provider office teaching of MA's and assuming liability I am also enclosing a copy of my office protocol which I developed for my MA when I joined Franciscan for clarification. This is a format I used when I was also licensed as a Surgical PA in this state and in Oregon where we were required to submit to the state our practice protocols as to PA privileges in our individual office MD-PA roles. Licensure was based on this and revisions or new skills had to be requested individually as acquired.

I think that MA's would be best regulated by either the Board of Nursing allowing them to stepladder to LPN, etc. OR the Board of Medicine allowing them to stepladder to PA's.

These are my comments and suggestions and I regret that I cannot testify in person. I would very much appreciate being kept informed of this legislation as it progresses thru the channels to a new and improved status. Edythe E Hudson WHC ARNP

As the Human Resources Director at Wenatchee Valley Medical Center (WVMC) for the past 20 years, I have witnessed a growing reliance on Medical Assistants to deliver patient care in outpatient practices. Increasing government regulation and declining reimbursements for medical services have forced medical clinics to find ways to reduce costs while continuing to provide safe and effective patient care. The expanded use of Medical Assistants in lieu of more highly trained and increasingly expensive RNs has been a significant and successful part of this effort and will continue to be throughout this era of healthcare reform. Medical Assistants at WVMC very successfully perform many routine tasks in line with the education and training they have received. This has enabled us to better utilize our RNs in more complex roles that are more meaningful and satisfying and reflective of their education and training. A shortage of primary care doctors and increased demand for healthcare requires that medical clinics have increasing flexibility in delivering healthcare, including the delegation of appropriate tasks to Medical Assistants. For patients, our primary focus, this flexibility helps control their costs and provide increased access to care.

Unfortunately, the State of Washington has lagged behind most other states in providing guidance relative to tasks that can be legally performed by Medical Assistants. The existing Health Care Assistant law is outdated, confusing and not reflective of the formal college education and national certification Medical Assistants can obtain. The law serves as an obstacle to our efforts to manage our clinical human resources with the goal of providing the most cost effective care.

I am in favor of legislation like HB 2009 that will address this concern. Thank you for the opportunity to comment. Alan J. Patterson

Thank you for the opportunity to comment on the Department of Health's Sunrise Review of Medical Assistants. We agree that medical assistants should be regulated for protection of the public and protect patient safety. Furthermore, MA's are not only physician's offices, but that of Advanced Registered Nurse Practitioners as possibly other providers. We not only support an MA scope of practice that provides for patient safety, but liability protection for ARNPs and their practices. Registered nurses in outpatient and ambulatory care settings work side by side with medical assistants, so it is appropriate that registered nurses can delegate to MA's under HB 2009. It is in the interest of the profession to be able to delegate tasks to medical assistants who demonstrate a minimum level of education, training, and competency.

The sunrise review application emphasizes the need to support reimbursement and cost effective care. However, delivery must be balanced against the cost of harm to patients, the devastating consequences to patients and their families when harm has occurred, and the cost to the healthcare system. For example, medication errors are the most frequently occurring medical error so careful attention to appropriate safeguards is necessary. Medical assistants are working in practices both large and small, urban and rural. A medical assistant scope of practice must be a practical statewide standard, taking into consideration the limited oversight ability of small and rural practices.

The following comments are on the current proposed bill HB 2009 and accompanying Applicant Report Cover Sheet. We anticipate more opportunity to provide additional comments on a pending substitute bill as indicated in the sunrise review. Main concerns include:

Credentialing requirements in the bill are confusing and inadequate

Section 2(3) defines a medical assistant as an unlicensed person. Under RCW 18.130.020(8), "License," "licensing," and "licensure" shall be deemed equivalent to the terms "license," "licensing," "licensure," "certificate," "certification," and "registration" as those terms are defined in RCW 18.120.020. Thus, under the proposed bill, medical assistants have no credential at all. This is contradictory to Section 3 that requires a medical assistant to be certified by a health care practitioner, clinic, or group practice. Meanwhile, Section 6 that requires MAs to register with the Department of Health. Providing MAs credentials only through health care practitioners, clinics, or group practices is a barrier to portability for the MA and creates inconsistent standards of practice from facility to facility. Furthermore, multiple credentials for an MA is not efficient and would drive up costs for supervising practices as well as the state. Registration as a credential does not require meeting a minimum level of education and training.

The broad scope of practice proposed under Section 5 necessitates establishing a minimum level of education and training for MAs and calls into question the adequacy of registration as the required credential.

The proposed duties of a medical assistant under Section 5 is too broad and needs limitations, calling into question the proposed level of supervision

While the sunrise review appropriately describes the activity of an MA to be limited to "tasks," HB 2009 is not as specific. Clinical procedures outlined in the bill are written vaguely and as mere examples, necessarily calling in question the level of supervision required in the bill. For example "operating office medical equipment" can mean anything from a common desk calculator to highly complex medical machinery such as MRIs. Not only is more specificity needed for many of the duties listed, the vague description also calls into question the level of supervision under Section 2(4). Without a more defined set of duties, we are unable to support the proposed supervision standard.

The proposed bill lacks additional limitation on medication administration, creating a patient safety risk

We agree with the current proposal's limitation on medication administration by unit, single, or calculated dose, including vaccines under Section 5(6). However, more safeguards need to be in place. The most common type of medical error are medication errors. Additional safeguards are needed to provide protection for the medical assistant and delegator by prohibiting known high-risk situations and reducing the likelihood that medical assistants will be placed in situations where they do not understand or recognize the risks, are uncomfortable in challenging the delegator, and consequently make an error.

For example, The Institute for Safe Medication Practices (ISMP) has published two lists of high-alert medications for the hospital and community or ambulatory setting. The medications on the lists are known to have an increased risk of causing significant harm to patients when used or administered in error. These medications on the list are known to have an increased risk of causing significant harm to patients when used or administered in error. These medications requires safeguards be in place to reduce the risk of errors and minimize harm to patients. Hospitals have implemented many safety practices including specific medication ordering processes and dose calculation requirements, independent double

checks by two licensed clinicians, label alerts, restriction of administration to physicians, registered nurses or credentialed registered nurses, etc. The function of medication administration must include oversight by a qualified professional who can assure clinical assessment, monitoring, and evaluation of medications. Many medications require assessment prior to administration. This clinical assessment and subsequent clinical judgment to administer a medication is not within the scope of MA practice.

Additional Recommendations

In addition to addressing the concerns above, we offer the following additional recommendations:

- More clearly describe the scope of medical assistant activities as tasks and by type of task.
- Include language that a medical assistant cannot delegate tasks.
- Require a minimum level of education and training.
- Prohibit medical assistants from performing higher level activities that are not compatible with their level of education and training, such as nursing assessment.
- Patient education is not called out, and should be limited to providing pre-printed literature and should not include health teaching or counseling.
- Include revising the Health Care Assistant statute and rules to avoid confusion with any new established MA scope.
- Include language that prohibits certain medications, procedures, or activities that puts patient safety at risk and are not appropriate for medical assistant training and education.

Thank you for the opportunity to comment. We look forward to working with you on this important effort. Sofia Aragon, JD, RN, Senior Governmental Affairs Advisor, Washington State Nurses Association

This letter is regarding the sunrise review of a proposal to regulate medical assistants in Washington State. As you know, medical assistants (MAs) are commonly employed in physician practices and clinics throughout the state, including MultiCare clinics. MultiCare Health System is a not-for-profit, integrated health care system with over 93 sites of care throughout Pierce, King, Thurston, and Kitsap counties. MultiCare currently employs 195 medical assistants at 17 primary care, 33 specialty care, and 8 urgent care clinics throughout Pierce County and South King County.

At MultiCare, MAs are an important part of the health care team and help improve efficiency. Healthcare providers delegate clinical and other tasks to MAs. Unlike other states, the term “Medical Assistant” does not exist in Washington State statute. Legislation was enacted to provide oversight of Health Care Assistants (HCAs) and to enumerate tasks that can be performed by HCAs; however, the statute does not address additional tasks commonly performed by MAs. This lack of clarity within statute leads to some confusion regarding the tasks that can be performed by MAs.

As you know, there is an increased demand for access to health care while at the same time there is a growing shortage of primary care physicians. National health care reform implementation in 2014 will only increase this demand and exacerbate the shortage of health care providers. As health care providers, if we want to cost-effectively meet this growing demand for health care, we must have an adequate workforce. To be efficient and manage costs, providers need flexibility in assigning tasks to members of their team. We view the role of MAs to be an integral part of the health care team and key to our ability to leverage the expertise of our physicians, nurse practitioners, and physician assistants to meet the needs of the people of Washington.

MultiCare MAs assist in a wide variety of clinical, administrative, and clerical duties. MAs serve as a critical role in our chronic disease management pilots and medical home pilots at Tacoma Family Medicine, Maple Valley, Sumner and Gig Harbor Primary Care clinics. These duties range from medication reconciliation; scheduling following up appointments; placing orders for lab and screening studies based on clinical protocols; forwarding refill requests to providers; placing orders for medications

based on verbal orders from clinicians; scribing clinical documentation based on a clinician's verbal direction; to administration of immunizations.

If we are going to meet the challenges and demands of health reform and continue to provide safe care to the community, we need to have the ability for all of our health care team, including MAs, be able to practice at the top of their education, training, and credentials. Smokey Stover, MD, Senior Vice President, MultiCare Health System

We are writing on behalf of University of Washington Medical Center (UWMC) in Seattle, WA. We do not support HB 2009 as currently written. The proposed bill creates the category of Medical Assistant [MA] and defines the scope of practice. Our primary concern stems from the proposed scope of practice defined for the category. Whereas MAs are an important part of the health care team, the inclusion of broad medication administration functions is beyond the scope of MA training and practice.

The proposed bill would permit a licensed health care practitioner to delegate "administering medications by unit, single, or calculated dosage including vaccines" with the only other limitation of "non-intravenous injection." This would allow a licensed health care practitioner to delegate to a medical assistant the preparation and administration of all categories of medications by all routes except the intravenous route.

The medication administration functions in the bill must have parameters to assure patient safety. Medication errors are among the most frequently occurring medical errors and pose a serious threat to patient safety. High risk medications require safeguards be in place to reduce the risk of errors and minimize harm to patients. Many, if not most, medications require assessment prior to administration. This breadth and depth of clinical assessment and subsequent clinical judgment essential to administering a medication is neither within the training for nor the scope of MA practice.

Currently, the proposed bill provides no parameters and does not include the current language in the Health Care Assistant regulations. The regulations for MA medication administration should at a minimum, include the current HCA regulations for medication administration. Medical Assistants in Washington presently must obtain Health Care Assistant (HCA) certification as a category C or E to administer medications. The current regulations provide a specific list of medications by route that may be delegated to and administered by the medical assistant (HCA).

UWMC supports a defined scope of practice for medical assistants as it will decrease variation and confusion about what is appropriate to be delegated. Without legal clarity about what can be delegated by physicians to medical assistants, physicians face uncertainty regarding Medicare reimbursement. Reimbursement and cost effective care delivery must be balanced against the cost of harm to patients. The regulations for medical assistant medication administration should at a minimum, include the current HCA regulations for medication administration.

Lorie Wild, PhD, RN, NEA-BC, Chief Nursing Officer, Senior Associate Administrator, Patient Care Services

Grace Parker, MN, RN, Associate Administrator, Ambulatory Care
University of Washington Medical Center

I am writing a letter to support and unleash some unfair restrictions on medical assistance who are under direct supervision of physicians in our office. As a board certified urologist for over 15 years I have come to depend on the skill of medical assistance to perform simple urinary catheterizations. This frees me up to practice and provide for more patients needs. I believe in the proper setting with good instruction, that a qualified and certified medical assistant can safely and properly insert a foley catheter. Under the present interpretation of the state's guidelines this is no longer allowed; but this should be reversed and permitted. Since medical assistance practice under the supervision of physicians in their office, I am

unaware of any event where a medical assistant caused any harm in this procedure. Yet I have been called many times to evaluate and provide treatment where unsupervised nurses (RN and LPN) have mispositioned these catheters. Therefore it is my opinion that an office medical assistant should be allowed to place a urethral catheter.

Scott A. Bildsten, D.O., Staff Urologist, Franciscan Medical Group

I am a Urogynecologist in Gig Harbor, practicing with the Franciscan Medical Group, also the Chief of the Surgery department at St. Anthony Hospital in Gig Harbor.

Speaking for the Urologists and Urogynecologists within Franciscan, we all have medical assistants whom we have trained specifically to insert urinary catheters, and perform bladder instillations and urodynamics. These are very specific procedures which are not taught in school for either MAs or in nursing schools. Several months ago the legal department for Franciscan performed a review of current MA duties and compared it to the current law, and the conclusions were that MAs should not be performing catheterizations because it was not allowed by current state law.

I am writing to support the passage of HB2009 to increase the allowed duties of MAs. I would encourage you to specifically include “urethral catheterizations” in section 5. Although line 1a “perform aseptic procedures” could certainly be interpreted to include catheter placements, some conservative lawyers could restrict this function because it was not clearly specified. I would also ask you to include performing wound care (changing dressings for an open wound).

There are many procedures performed by MAs in surgical practices. Most doctors offices don't employ LPNs because of the cost differential, and as you know, doctors are under pressure to cut costs as much as possible in order to lower overall healthcare costs. Our MAs have been trained and observed by us, most of them have been doing their jobs faithfully and well for many years and are completely able to do the above procedures, and are frustrated by the fact that they have recently been limited by a more strict interpretation of the law.

On behalf of the surgeons of Franciscan Medical Group, I urge you to pass this bill to increase the legal scope of practice for MAs to reflect their current abilities and historical practice patterns.

Cindy Mosbrucker MD

I am writing in support of the bill currently before the house allowing the expansion of duties defined for medical assistants. As a practicing urologist I have utilized MA's in my office for over 25 years and feel that they have skillfully and capably performed catheterizations, bladder instillations, catheter removals, and other minimally invasive procedures under our direct training and supervision. Several of our MA,s have also received additional training and certification from other established bodies such as the Society of urologic nurses and associates(SUNA).

Despite all these qualifications the DOH now tells us that these procedures can only be performed by licensed nurses or physicians. As a result our well trained MA's now find themselves training inexperienced nurses to perform the duties that they have been capably performing for years. While being inherently unfair I feel it also results in unnecessary risk and suffering to our patients having less skilled and less experienced providers performing these duties. I can only surmise that the current restriction is driven more by economic concerns of special interests, than concern over patient safety.

Keith A Schulze MD, Kitsap Urology Associates

This note is in response to the upcoming public hearing regarding medical assistants. I have been a practicing Urologist in Washington for the last 31 yrs and have utilized MAs in our practice for the entire time. My partners and I have taught our MAs to assist us in the office providing timely, compassionate,

professional, and cost effective urologic care. Our MAs placed catheters for multiple procedures in the office under our supervision with technical competence superior to many Nurses I have worked with on hospital floors and ERs. I do not wish to denigrate Nurses, but only wish to point out that careful training and daily experience allows MAs to provide excellent care for patients. I also find it a bit ironic that the training for Urodynamics; a complex, invasive diagnostic procedure to evaluate nerve and muscular function of the urinary tract has been taught by an MA for years in the Northwest to MAs and RNs. It would certainly be unfortunate if the most experienced personnel would be unable to continue to provide this needed service. Patients would have to travel long distances and care very likely would be compromised since many of these patients are disabled or elderly. Allowing MAs to perform aseptic procedures results in better access and improved care for my patients. John C. Hedges MD Urologist



August 3, 2011

Ms. Sherry Thomas
Department of Health
PO Box 47850
Olympia, WA 98504-7850

Dear Ms. Thomas:

The purpose of this letter is to express our concern regarding the Sunrise Review process for Medical Assisting.

We are writing on behalf of the three Charter College campuses in Pasco, Bellingham, and Vancouver, Washington. We would like to commend the Department of Health, the Washington State Medical Association, and the Washington State Medical Assistants for requesting and initiating these hearings. We, like you, are vitally concerned with the quality of Medical Assistants in the state. Medical Assistants play an active and important part in the delivery of health care services. For patient safety it is imperative that state statutes clearly detail the scope of practice and realistic, minimum competency requirements for this important profession.

We strongly support the requirement of successful completion of a formal educational program as a minimum professional requirement. We believe external validation of competency is essential, but we oppose any single accreditation or recognition as the indicator of such competency or precursor to educational acceptance.

Currently we are teaching nearly 500 students in the medical assisting programs on our three campuses. Each graduate will enter the work force well prepared having a sound academic background, proven clinical skills, and certification by National Center for Competency Testing. We hold dearly the public trust given us to help educate members of health professions.

If we can be of any help as the Sunrise Review continues please do not hesitate to contact us.

Sincerely,

Larry Capps
Campus President
Charter College – Bellingham
410 W. Bakerview Rd. Suite 112
Bellingham, WA 98226

Josh Swayne
Campus President
Charter College – Pasco
5278 Outlet Drive
Pasco, WA 99301

Philip H. Lundberg, Ph.D.
Campus President
Charter College – Vancouver
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>> CharterCollege.edu



GroupHealth[®]

August 11, 2011

Department of Health
310 Israel Road SE
Tumwater, Washington 98501

Group Health Cooperative
Group Health Headquarters
320 Westlake Avenue N.
Suite 100
Seattle, WA 98109
www.ghc.org

Dear Department of Health,

Thank you for the opportunity to comment on the Department of Health's Sunrise Review of Medical Assistants. Group Health Cooperative employs over 400 medical assistants across the state of Washington. We agree that medical assistants (MA's) should be regulated for the protection of the public and to protect patient safety. We are in support of legislation that will clearly define the scope of practice for MA's, the minimum level of education, training and competency required, and the appropriate level of supervision.

We believe the current proposed bill HB 2009 is too broad and does not provide enough specificity in defining the duties of the medical assistant. In particular, we are concerned about the lack of restrictions around medication administration. The proposed bill would permit a licensed health care practitioner to delegate "administering medications by unit, single, or calculated dosage including vaccines" with the only other limitation of "non-intravenous injection." This would allow a licensed health care practitioner to delegate to a medical assistant the preparation and administration of categories of medications by all routes except intravenous. Group Health believes the medication administration function requires explicit parameters to assure standard safety measures in medication administration by medical assistants.

The rationale for our position includes:

- Medical assistants primarily support physicians and nurse practitioners in their office practices. They are trained in vocational-technical schools, which typically requires one year of study. MA programs are not regulated by the state and have considerable variation in curriculum. The programs provide only basic content on medications and the psychomotor skill to administer oral and parenteral (excluding intravenous) medications.
- Medical assistants have limited training, are unlicensed and may not diagnose, treat, interpret or perform tasks that are invasive or require assessment.
- The function of medication administration must include appropriate oversight by a qualified professional who can assure clinical assessment, monitoring, and evaluation of medications. Many medications require patient assessment prior to administration and patient monitoring post administration. Both of these activities are not within the proposed scope of MA practice.
- Medical assistants in Washington presently must obtain Health Care Assistant (HCA) certification as a category C or E to administer medications. The current regulations provide a specific list of medications by route that may be delegated to and administered by the medical assistant who is HCA certified. The list was expanded in 2009 to include selected oral, topical, and inhaled medications.

- Medication errors are among the most frequently occurring medical errors. Medication administration is recognized as a care process with increased risk to cause significant patient harm.
- There is currently great variation in medication safety practices in physician offices. There is limited information about types and consequences of medication errors in physician offices because of the lack of error reporting systems and error reporting requirements.
- The Institute for Safe Medication Practices (ISMP) has published a list of high-alert medications in community/ambulatory settings. The medications on the list are known to have an increased risk of causing significant harm to patients when used or administered in error. These medications require safeguards be in place to reduce the risk of errors and minimize harm to patients. The proposed legislation is silent on this issue.
- There are a number of states that have defined medication situations that cannot be delegated to medical assistants or have specified actions that must be taken to increase medication administration safety and reduce the risk of adverse event. These provisions are not included in the proposed legislation
- Any new law must stipulate the conditions under which medication administration by medical assistants is permitted and when it is not. These provisions will provide protection for the medical assistant and delegator by restricting known high-risk situations and reducing the likelihood that medical assistants will be placed in situations where they do not understand or recognize the risks, are uncomfortable in challenging the delegator, and consequently make an error.

Group Health recognizes the important role medical assistants play in supporting physicians and nurse practitioners in their office practices. The ability of health care practitioners to delegate specific tasks, including medication administration, is key for many practices to operate efficiently and ensure access to care. However, reimbursement and cost effective care delivery must also be balanced against the cost of harm to patients, the devastating consequences to patients and their families when harm has occurred, and the cost to the healthcare system. Group Health supports a defined scope of practice for medical assistants believing it will decrease variation and confusion about what is appropriate to be delegated.

We believe that legislation on medical assistants must include provisions that restrict medication administration by medical assistants that:

- At a minimum, include the current HCA statutes for medication administration
- Give consideration to what other states have enacted to decrease the risk of untoward medication administration outcomes, and
- Be based on the findings of the IOM recent report on *Preventing Medication Errors* and on the ISMP *List of High-Alert Medications*

Thank you for the opportunity to comment. We look forward to working with you on this important topic.

Sincerely,



Barbara Trehearne, PhD, RN
Vice President of Clinical Excellence, Quality and Nursing Practice

8-12-11

August 12, 2011



Jack C. McRae
Senior Vice President

Secretary of Health Mary Selecky
Washington State Department of Health
P.O. Box 47850
Olympia WA 98504-7850

RE: Health Profession Sunrise Review of Medical Assistants

Dear Secretary Selecky:

On behalf of Premera Blue Cross, thank you for the opportunity to provide comments as part of the Department of Health (DOH) health profession sunrise review process regarding medical assistants in Washington State.

I am writing to express our support for legislation and regulations that provide clarity regarding the role of medical assistants in the healthcare workforce. Medical assistants are important members of the healthcare delivery system and can be delegated key activities to support physician practices and clinics in managing patient care and office administration.

We urge the Department of Health to clearly delineate the roles and responsibilities of medical assistants as well as define the criteria for education, training, and certification, including ongoing assessments of clinical competence. Defining medical assistants and their scope of practice and provider delegation responsibilities can help ensure patient safety and improve the delivery of quality patient care, while also reducing healthcare costs. We believe, with appropriate regulations, healthcare professionals such as medical assistants can be a key cornerstone in bringing down the cost of healthcare.

Federal healthcare reform will provide millions of currently uninsured individuals access to healthcare services, and it will be critical to ensure the healthcare workforce can provide cost effective care with quality outcomes to Washington residents.

Sincerely,

Jack C. McRae

JM/dgw



August 12, 2011

Sherry Thomas
Washington State Department of Health
Health Systems Quality Assurance, Assistant Secretary's Office
PO Box 47850
Olympia, WA 98504-7850

Dear Ms. Thomas:

Please accept these comments on behalf of Planned Parenthood Votes Northwest. Planned Parenthood protects and advances reproductive health and rights on behalf of the four affiliates (independent Planned Parenthood affiliated non-profits) in Washington. Collectively, the affiliates provide clinical and education services at 37 Planned Parenthood health centers in 20 counties around the state.

The Department of Health has drafted sunrise legislation pertaining to the classification of Medical Assistants. Planned Parenthood believes this new classification will be beneficial.

We recognize that this process is at the beginning stages. At the same time there are many unanswered questions regarding scope of practice, training and education requirements, certification procedures and the portability of that certification. We hope the law and ensuing regulations will provide flexibility on these procedures to address the needs and circumstances of different providers. We also urge restraint in any certification/registration fees that are assessed, per the sunrise requirements.

Thank you for the opportunity to comment on this proposed legislation.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Rose', written over a white background.

Elaine Rose
CEO

Planned Parenthood Votes Northwest

August 12, 2011

Department of Health
sunrise@doh.wa.gov

Harborview Medical Center does not support HB 2009 as currently written. The proposed bill creates the category of Medical Assistant [MA] and defines the scope of practice. While medical assistants are an important part of the health care team, the inclusion of broad medication administration functions is beyond the scope of MA training and practice.

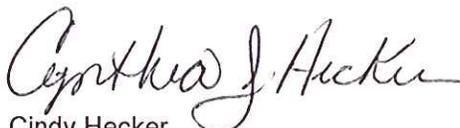
The proposed bill would permit a licensed health care practitioner to delegate "administering medications by unit, single, or calculated dosage including vaccines" with the only other limitation of "non-intravenous injection." This would allow a licensed health care practitioner to delegate to a medical assistant the preparation and administration of all categories of medications by all routes except intravenous.

The medication administration functions in the bill should have parameters to assure patient safety. Medication errors are among the most frequently occurring medical errors. High risk medications require safeguards be in place to reduce the risk of errors and minimize harm to patients. Many medications require assessment prior to administration. This clinical assessment and subsequent clinical judgment to administer a medication is not within the scope of MA practice.

Currently, the proposed bill provides no parameters and does not include the current language in the Health Care Assistant regulations. The regulations for MA medication administration should at a minimum, include the current HCA regulations for medication administration. Medical Assistants in Washington presently must obtain Health Care Assistant (HCA) certification as a category C or E to administer medications. The current regulations provide a specific list of medications by route that may be delegated to and administered by the medical assistant (HCA).

The medical centers support a defined scope of practice for medical assistants as it will decrease variation and confusion about what is appropriate to be delegated. Without legal clarity about what can be delegated by physicians to medical assistants, physicians face uncertainty regarding Medicare reimbursement. Reimbursement and cost effective care delivery must be balanced against the cost of harm to patients. The regulations for medical assistant medication administration should at a minimum, include the current HCA regulations for medication administration.

Sincerely,



Cindy Hecker
Chief Nursing Officer & Sr. Associate

Administration

Comments Received After Hearing

Since I did not write anything prior to the Medical Assitant Sunrise session, I am sending you my comments.

1. I want to see the MA's training match those activities they are authorized to do. I think they should have a list of activities rather than a scope of practice as this fits with a technical profession
2. I want to see those activities defined in terms of extent, rather than just stating an acitivity, which leads to my concern about
3. Medications. I have been sent many prescriptions by pharmacy that are sent to the pharmacy by medical assistants. This "meaningful use" activity can be a very large source of errors.
4. I want to know just who is supervising the MA in the 'team' office.

Tim Fuller

Board of Pharmacy feedback regarding Medical Assistant Sunrise
August 2011

- 1) A portable license that follows the MA, not the facility
- 2) Limit supervision by RN or MD to a ratio of 3 to 1 (3 MAs to 1 MD)
- 3) Defined scope of practice or preferably task list
 - a) core responsibilities
 - b) specialties that they could perform with special training certification
- 4) If clinics are training MAs, they would have to submit a training plan to the MA board/commission for approval
- 5) Clinics would also have to submit a utilization plan for the MAs
- 6) MAs can't call in prescriptions to pharmacies (to decrease the potential for medications errors). This one is especially important because I sat in on a clinic admin meeting today and they were having a discussion about the signing of prescriptions, and trying to figure out how to make this work electronically (a bigger discussion, out of this scope). Anyway, the lead administrator said, "well as a fix to the electronic problem, we could just have an MA call it in". This scared me, because of the rate of errors associated with verbal orders in general, let alone with MAs.
- 7) Formal didactic training on meds
 - Didactic on med errors
 - Didactic on side effects of medications
 - Didactic on toxic manifestations of medications
 - Didactic regarding narrow therapeutic index of meds
 - Didactic on meds that sound a like
 - Administration of opth and ear meds
 - SQ administration
 - IM administration
 - Administering medications via NG tube
 - Didactic on which meds should not be mixed (ie. Put in apple sauce etc)

- 9) CPR Certification
- 10) Med dosing math
- 11) Pharmacology lite

I think Medical Assistants should be record keepers and nothing more. They should not be the person who calls in RXS to a pharmacy, they should not have anything to do besides take medication dialog.
Rebecca

I represent a privately owned physician specialty practice in Olympia, WA, consisting of 6 physicians and 4 ARNPs, OB/GYN specialty. We employ ARNPs, RNs, LPNs, and Medical Assistants. Our physicians could not work at the “top of their license” without this support. Nor could we afford to exclusively hire RNs and LPNs. With proper supervision, we find medical assistants meet a large portion of our support needs.

From a global perspective, we prefer medical assistants have a “**portable**” state certification to both reduce the cost of administration and to also know that we are hiring someone who already meets state criteria for a defined scope of practice. It does not seem necessary to tie the medical assistant’s certification to a specific facility or supervisor, since they can’t work without the defined supervision. Also, from a practical standpoint, each of our medical assistants work with multiple providers which means they have multiple supervisors, although presently there may be only one person listed on their HCA application.

Our medical assistants need to be able to work when their providers are away from the office (perhaps they are in surgery or in the labor and delivery unit at the hospital), so from our perspective, as long as there is a “health care practitioner” in the office, that person has an oversight role for all the medical assistants. **We would like to see the “supervision” definition broadened to allow for this, not requiring physical presence of a specific supervisor, but rather the physical presence of a health care practitioner.**

We also feel there is a strong need for **required continuing education** related to retaining a state Medical Assistant certification. This comment also applies to RN and LPN licensure.

In section 5 – proposed clarifications of scope of practice are noted in bold print:

“A medical assistant under the supervision of a health care practitioner may perform the following duties:

- (1) Perform clinical procedures to include:
 - (a) Performing aseptic procedures;
 - (b) Preparing for and assisting in sterile procedures;
 - (c) Taking vital signs;
 - (d) Preparing patients for examination,
 - (e) Venous and capillary blood withdrawal and non intravenous injections;
 - (f) Observing and reporting patient signs or symptoms;
 - (g) **Remove sutures, staples, change dressings; (not clear if these activities are already included b above but want to be sure)**
- (2) Administering basic first aid:
- (3) Assisting with patient examinations or treatment **including explaining procedures and providing patient information/education;**
- (4) Operating Office medical equipment **excluding equipment requiring a state permit to install and operate;**
- (5) Collecting **and preparing routine and specialized** laboratory specimens;
- (6) Administer medications by unit, single, or calculated dosage including vaccines;

- (7) Prepare medication for administration (depot lupron, rocephin, as examples);**
- (8) Perform basic laboratory procedures;
- (9) Authorize medication refills from pharmacies per practitioner protocol; (birth control refills are a routine example)**
- (10) Maintain supplies and equipment utilized by health care practitioner;**
- (11) Set up Non Stress Tests for fetal monitoring and EKGs; (may fall under 4 which is very broad)**
- (12) Care and sterilization of instruments (not sure if instruments fall under 4 above)**

Some of this may be too specialty specific to include, but wanted to note for example purposes.

While not applicable to us, I was not sure if chiropractors were covered in the definition of health care practitioner, but assume covered under one of the referenced sections. I know they utilize medical assistants also.

Deb Cannon, Practice Administrator

I very much appreciate the opportunity to submit comments on the proposed Medical Assistants regulations. Our office recommends the ability for individual Physicians to be responsible and able to decide for their office the ability for Medical Assistants to perform triage services.

Most of our Medical Assistants triage phone calls from patients. The Medical Assistant education program in our area does have triage as an aspect of their training. A Medical Assistant that does not have experience in pediatrics typically works for us for a year before we consider them for triage service. Our Physicians established an in-house step-wise triage training program specifically for our practice. There is ongoing monitoring until we are confident that issues will be handled appropriately. In addition there is an excellent resource for pediatrics that our office has used since approximately 1998 called Pediatric Telephone Protocols by Barton D. Schmitt, MD, FAAP and published by the American Academy of Pediatrics. Primarily in an outline/decision tree format it provides a definition, potential causes and action plan. These triage protocols provide guidance with regard to further questions to ask and final disposition. Our triage process is a partnership between our staff and our Pediatricians. When there is any question the default is schedule an appointment as appropriate or referring to an emergency department. In addition the staff member works closely with a Pediatrician for the best interest of the patient. We believe that this process works very well for our patients and our office in that we can save time and money for both our patients and their insurance companies while ensuring good quality of pediatric care.

Regarding most issues discussed, I agree with those who testified. Over the years we have struggled with what Medical Assistants can and cannot do. For the most part I think we are supportive of efforts to define the position but not place burdensome regulations/requirements on the practice. Different practices have different needs for Medical Assistants and this flexibility is essential. I am a pediatrician in the Spokane Valley. There are eight physicians and three nurse practitioners that provide healthcare at two locations. We are open 9 AM to 8 PM Monday through Thursday, 9 AM to 5 PM on Friday and 9 AM to noon on Saturdays.

Over the years we have slowly migrated from the majority of our back office staff being RN's to our present majority of them being Medical Assistants. This migration has been acceptable along with being necessary. It has been acceptable as we have been able to continue to provide top quality pediatric care; and necessary because overhead especially personnel costs have increased more than reimbursements.

Bruce Abbotts, MD, MPH, Valley Young People's Clinic

The following comments on the Department of Health's "sunrise review" of regulating the medical assistant profession are submitted on behalf of American Medical Technologists (AMT). AMT is a

national, non-profit certification organization and professional membership association for medical assistants, clinical laboratory professionals, phlebotomists, and other allied health personnel. AMT is headquartered in Rosemont, Illinois, has nearly 50,000 active members in good standing, and maintains an active Northwest State Society serving its membership in Washington, Idaho and Montana.

Among the certifications awarded by AMT is the Registered Medical Assistant (RMA). A candidate can be credentialed as an RMA by completing either an accredited medical assisting education program or five years of documented experience performing the functions of a medical assistant, and successfully passing AMT's competency-based RMA certification examination. Individuals who have been initially certified after January 1, 2006 are additionally required to comply with AMT's Certification Continuation Program, a recertification program that promotes continued competency. All of AMT's certification programs, including the RMA, are fully accredited by the National Commission for Certification Agencies (NCCA), the accrediting arm of the Institute for Credentialing Excellence.

AMT supports the enactment of legislation and regulations establishing a scope of practice and minimum qualification standards for medical assistants in Washington State. There are a number of shortcomings in the current regulatory system for registration of health care assistants (HCAs) under RCW Chapter 18.135 and WAC Chapter 246-826. Chief among those shortcomings is the limited scope of practice acknowledged in the statute and regulations, which has created confusion and conflicting interpretations as to the breadth of clinical tasks that health care practitioners may delegate to unlicensed assistive personnel. The fact that there are seven different classifications of HCAs adds to the confusion and the unwieldy nature of the current regulatory system.

The placeholder bill that was introduced during the 2011 Legislature, House Bill 2009 (HB 2009), represents a good start towards an appropriate regulatory model for medical assistants, but can be improved upon. AMT recommends that any future legislative vehicle combine the existing regulation of HCAs with the regulation of medical assistants, so that there is a single regulatory program establishing the qualifications and scope of practice for unlicensed assistive personnel. Given the substantial overlap between the functions performed by HCAs and medical assistants (MAs), it makes no sense to regulate both categories of personnel separately. Nor could many individuals who function as both a HCA and a MA afford the dual registration fees if the Department were to require registration for both categories. We suggest that the legislation eliminate the title "health care assistant," and replace it with the far more prevalent title "medical assistant." The clinical functions currently regulated under RCW Chapter 18.135 and WAC Chapter 246-826 could easily be merged into the new regulatory framework for MAs.

The new legislation should also recognize the expanded scope of practice of modern medical assisting, which includes not only the venipuncture and injection procedures covered under the HCA regulations, but numerous other clinical and administrative functions. The list of functions set forth in Section 5 of HB 2009 generally encompasses the range of functions performed by entry-level MAs. We recognize that, consistent with some of the comments received in this review proceeding, some limitations may need to be established for certain clinical functions, such as restrictions on the types of drugs that a MA can administer. However, Section 5 of this year's bill is an excellent starting point, and largely reflects the appropriate scope of practice jointly agreed to by AMT and the American Association of Medical Assistants (AAMA) when the two organizations developed a model bill for regulation of MAs in 2001.

To promote job mobility for MAs, we also suggest that once an MA has been registered with the Department, that registration should be portable from one employer to the next, such that each new employer of the MA is not required to newly certify the MA's qualifications to the State. Washington is unique among the 50 states in its requirement that each MA be certified by his or her current employer.

In establishing minimum entry-level qualifications for medical assistants, AMT suggests that the Legislature and/or the Department consider requiring either: (1) completion of a medical assistant

education program of at least 720 hours (including an externship of at least 160 hours) in an institution accredited by an agency recognized by the U.S. Department of Education, or (2) certification as a medical assistant by an organization accredited by the NCCA or other independent accrediting agency. These requirements are similar to those imposed in other states with successful regulatory programs for MAs, such as New Jersey, Arizona, and North Dakota.

We also wish to take this opportunity to clear up some apparent confusion regarding the RMA certification that was expressed by a few participants at the August 16, 2011 sunrise hearing. During a question-and-answer exchange between panelist Kristi Weeks and witness Elizabeth Adolphsen, Ms. Adolphsen stated that she believed the RMA is merely a “registry,” with the implication that it is not a full-fledged certification such as the CMA(AAMA) credential. (See p. 9 of Draft Hearing Summary). This common misconception stems from the name of AMT’s credential – Registered Medical Assistant – which unfortunately tends to obfuscate the fact that the RMA is indeed a professional *certification*, to the same extent as is the CMA(AAMA) credential. Both the RMA(AMT) and CMA(AAMA) credentials are comprehensive certifications covering clinical, administrative and general medical assisting practice, and are issued by national certifying bodies that enjoy NCCA accreditation.

In closing, we reiterate that AMT fully supports the concept of enacting a statute and implementing regulations defining the scope of practice and establishing minimum qualification standards for medical assistants in Washington State. We look forward to working with the Department of Health as it completes its sunrise report and moves to the implementation phase.

Please contact the undersigned legal counsel or AMT’s Executive Director, Christopher A. Damon, JD (cdamon@americanmedtech.org) if the sunrise review committee needs further information about the organization or the RMA certification program.

Michael N. McCarty, AMT Legal Counsel

I have been a Certified Medical Assistant since 1985 after many years of working in the outpatient setting as an office nurse. I have taught medical assisting for close to 30 years, recently retired as Program Director of the CAAHEP Accredited MA Program at Whatcom Community College. I am a past state president of WSSMA and have served on the chapter, state and national levels of the AAMA for many years. I have been the WSSMA Legislative Committee Chair/Co-Chair for the past 15 years. I have co-authored a comprehensive medical assisting textbook currently going into its 5th edition.

I came into medical assisting from a background of practical nursing so I think my perspective is unique to this discussion. When I began my career of office nursing in 1975, I realized very quickly that I did not have the skills to provide my physician employer with the assistance he needed.

My practical nursing curriculum targeted inpatient care and did not cover the MA skills/outpatient procedures such as setting up for casting, removal of casts, performing EKG/ECG, performing urinalysis dips, surgical instruments, setting up for and assisting in sterile minor office surgeries, ear lavage, assisting in pelvic exams, blood draws, finger sticks, well patient exams, immunization schedules, CLIA Waived lab tests and certainly not the administrative skills with billing, coding and telephone techniques. So I took individual courses, attended workshops, studied texts and learned as much on the job as I could. I never attended a formal Medical Assisting Program, but was finally able to obtain enough knowledge and skills to challenge the national certification exam to gain my CMA credentials.

This all speaks to the uniqueness of the medical assistant, her training and education is specific to current ambulatory health care settings, no other profession provides the specificity of training for assisting in outpatient care.

But, medical assisting isn’t a licensed health care profession, and, not having a clear Scope of Practice in Washington state leaves us trying to utilize our breadth of knowledge and training while being challenged as to the appropriateness and legality of performing our jobs. We are capable and able to perform a wide range of supportive duties but we are being restricted by the ambiguity of the current HCA Law.

Originally piercing the skin was the only procedure that we thought needed to be legally defined. We thought that our physician employers could delegate the other duties to us as they saw fit. The ‘rule of

thumb' was that the physician could delegate duties that 'did not constitute the practice of medicine' as long as they were assured that the delegatee had the knowledge and skills to perform the delegated task. That delegation authority has been challenged and we now need a clearly defined law that allows credentialed medical assistants to assist to the full extent of our knowledge and training and which allows the physician/provider to delegate duties as needed and supported by legislature.

I have read the testimony and the questions/answers and would like to weigh in on a few points.

1. Ambulatory clinical care requires a unique set of technical skills, knowledge and abilities provided only in medical assisting programs, although many skills may transfer and cross train from military medic programs, nursing, and/or, less comprehensively, on the job. Without the medical assistant, clinics and physician would have no staff specifically dedicated, trained and educated to assist in ambulatory care. It is long past time for the MA to have a clear and comprehensive Scope of Practice.
2. The medical assistant works in a team with her physician employer and other allied health professionals. S/he is not working alone without supportive direction from the physician, physician's assistant or nurse practitioner. Medical assistants do not have to make independent decisions (except in emergency situations perhaps, like any other CPR/First Aid trained person.)
3. *Triage* has many connotations nowadays. It has become a 'forbidden' duty for medical assistants because it assumes a certain amount of assessment. In reality, the determination of patient needs begins at the front desk with the initial phone conversation and continues throughout the office visit. Risk management will always advise that official, written, formal protocol should be followed by all health care personnel; no matter the credential. Questioning a patient about symptoms is not necessarily an assessment nor is it a plan of treatment. It is often/usually the gathering of information according to a set of questions, guidelines and/or flow sheets and it is essential that medical assistants be allowed to assist their physician employers by performing this duty. MA curriculum covers patient questioning and analysis of symptoms (does it hurt, where does it hurt, how long have you had the pain, does anything make it better, etc, etc) and CAAHEP Accreditation standards require the Affective Domain of applying critical thinking skills in patient assessment and care, verbal skills for understanding all levels of patient needs, communication skills across the ages, applied verbal and nonverbal skills, subjective and objective information, just to mention a few.
4. Non-portability of the HCA certification has always been a confusing issue, but was tied to the delegator due to the responsibility of that delegator testifying to the skill and abilities of the medical assistant. With the implementation of a very clear Scope of Practice, perhaps the state certification/licensure could be portable. The cost would then fall to the individual rather than the clinic or the delegator, though.
5. Delegation in the HCA Law is described as 'direct delegation' from the physician/provider to the medical assistant (HCA). This prevents the (indirect) handing down of an order from an RN to an MA. Medical assistants cannot take an order from a nurse if it was not within the nurse's scope to order that procedure, and can only accept delegation directly from the physician/provider who can legally prescribe that procedure/treatment. This has been difficult for the MA and the RN, and confusing since MAs cannot be expected to know what the RN can delegate or what is not within the nursing scope. Additionally, the WA Nursing Delegation Act forbids a nurse to delegate to a non-licensed health care professional, forcing many medical assistants to become nursing assistants (a definite back step) in order to work efficiently with delegating nurses. And, then, the RN is not allowed to delegate the administration of medications or the piercing of the skin or sterile procedures. It has always seemed safer and clearer for the medical assistant to assist the physician/provider only.
6. Variation in standards is going to be an ongoing problem unless we limit the Scope of Practice to graduates of nationally accredited programs. CAAHEP Accreditation of a program is a seriously intense, comprehensive and expensive process involving the entire college, its faculty, resources, and infrastructure. It includes a two-year self-study and an on site accreditation team visit. No aspect is left unexamined. This guarantees that standards are being met in the educational component.

7. The individual certification/registration through national exams such as the CMA (AAMA) or the RMA (AMT) proves that the individual has comprehended and assimilated the knowledge base necessary for the profession. I believe the credential is necessary to attest to the competency of the individual even given the additional commitment and investment for the initial certification and ongoing re-certifications. Registering with the state does not prove competency nor the knowledge base and skill set needed in the profession, nor do competency checks at the clinic level and/or ongoing CEUs. Although I am not advocating that clinics should not check competency (for all clinical personnel), but it shouldn't be a required process at the sacrifice of continuity and consistency.
8. Meaningful Use Initiative limits EMR documentation to licensed personnel and even though the language in the final rule tries to be inclusive to 'established professions', individual clinical interpretation is ambiguous and confusing. Many clinics need to hear the word 'license' in order to believe they are in compliance. I am not advocating licensing necessarily, but stating an issue.
9. Prescription medications always require a physician/providers order and clearly stated protocol for refills, to be initialed by the health care professional and the physician/provider. It is well within the ability of the properly educated and trained medical assistant to follow official written protocol. This pertains to faxing and electronically transferring prescriptions to pharmacies. The relaying of a written order should be allowed.
10. Interpreting PPD (TB/Mantoux test) results requires measuring of the size of induration (raised, hardened area) if any, of the injection site. A simple millimeter measuring tool is used, like a small ruler. It is certainly within the MA skill set to follow the measuring guidelines set up by the CDC and DOH. Positive (and questionable) results require a physician/provider plan of action. Negative results are clear and obvious. The results of the PPD/Mantoux test does not diagnose TB, that is for the physician/provider to determine with further studies. The measurement of the induration is a screening tool only.
11. Sterile procedures are part of what medical assistants do in assisting within the clinic. Setting up sterile surgical trays, assisting in sterile procedures and surgeries and maintaining sterile fields are all performed as a daily part of most clinics and offices. These range from assisting in cystoscopy to assisting with simple laceration repairs. The difference between assisting in a minor office surgery and being a surgical assistant was clearly defined in our state surgical assistant law in which we determined that the patient is not within the sterile field in a minor office procedure (WAC 246-939-030)
12. Laboratory procedures/test – CLIA clearly defines the Waived category as being safe and causing minimal harm to the patient if performed incorrectly. Medical assistants are routinely taught the CLIA waived tests and may be the only office staff having had formal training and education in the laboratory area outside of medical technicians. In fact, during a WA State quality outcome study a few years ago it was determined that medical assistants did a better than average job of performed lab tests correctly in the POL (Physician Office Laboratory) as compared to other health care professionals. I'm sorry I cannot cite the study right now, but I may be able to locate it if needed.
13. IV discontinuation is something that medical assistants should be authorized to perform. Category A (HCA) routinely invade the veins during blood draws and blood donations and the discontinuation of an IV is a similar procedure of applying pressure to the vein after removal of the catheter. Of course the discontinuation would be with a physician/provider's written order.

I apologize for the length of this letter, and I thank you for giving it your attention. I am available for clarification on any of these issues. Thank you for the opportunity to be heard.

Barbara M. Dahl, CMA (AAMA), CPC (Retired)

Thank you for the opportunity to comment on the status of Medical Assistants (MAs) in Washington State. As a health system that believes strongly in the value of each member of our care team, we believe that it is very important for our state to provide clarity regarding the oversight of Medical Assistants, and to clearly define boundaries regarding the tasks that can be performed by this group into the future.

In a country where the number of primary care providers and registered nurses is projected to be insufficient to meet demand, it is imperative that we leverage the talents of other members of the team to appropriately care for our communities. In addition, to more effectively curtail the rising costs of delivering care, we must have a flexible workforce with the appropriate training, skills and abilities to deliver the right care in the right location. Currently, the gap in regulation of Medical Assistants in Washington State is a barrier to the provision of such efficient care; the ambiguity surrounding the work that can be delegated to MAs has, in more recent years, resulted in a tendency to underutilize this work group in an effort to mitigate the perceived risk of their undefined practice.

In addition to the benefits that transparent oversight will provide to MAs and to the public, such comprehensible boundaries will also benefit physicians, nurse practitioners, and other licensed independent providers of care. New federal laws regarding the meaningful use of electronic medical records require that tasks performed by the care team be legally delegated to them. If the Medical Assistant scope of practice remains undefined and subject to interpretation, providers and health care systems face uncertainty with respect to qualification for reimbursements to which they would otherwise be entitled.

Providers need certainty regarding the appropriate role of the Medical Assistant; working from “community standard” is a poor substitute for clear and consistent regulatory guidance. We urge the Department of Health to recommend to legislators that they take action to clarify the role of Medical Assistants, and pass legislation to accomplish this important goal.

Jennifer Graves, RN, MS, ARNP, Nurse Executive, Swedish Medical Center / Ballard

Below are additional comments in light of the medical assistant sunrise review hearing held earlier this week where Department staff urged stakeholders to provide more specific and concrete input.

As you are aware, development of the medical assistant scope of practice is related to recent legislation for health care assistants. This is because many individuals completing medical assisting programs obtain a health care assistant certification.

Passage of SHB 1304 passed to allow certain health care assistants to administer a limited list of drugs through certain routes. Among the seven classes of health care assistants, only categories C and E are allowed to administer a limited list of drugs because they can demonstrate completion of a medical assisting program prior to employment. This provision terminates in July of 2013, in anticipation of establishing a medical assistant scope of practice by that time.

Since the list of drugs of SHB 1304 (now 1304-S.SL) has been well vetted between medical, nursing, and medical assistant advocates over the last two years, the medical assistant scope of practice should be limited to the current list of medications and associated routes in 1304-S.SL.

Furthermore, consideration of existing language with regards to education and training for categories C and E should be the starting point for a minimum level of education, training, work experience, demonstrated ability to obtain certain laboratory specimens, and nature of clerical support expected by a provider. While a final proposal may require more rigorous standards, using the existing language as a starting point would provide consistency and predictability for the medical community regarding the medical assistant scope of practice.

Thank you for the opportunity to comment, we look forward to further discussions on this issue.
Sofia Aragon, JD, RN, Senior Governmental Affairs Advisor, WA State Nurses Association

Thank you for sending this out. It looks like it was a great hearing. I am a CMA at a small clinic in Spokane WA. There are six doctors and three nurse practitioners on the floor that I work on. Each one works with a MA, so there are nine of us. We are an eclectic group of girls. Half of us have been doing

this for over 15 years. The other half are new enough to have come out of the school's here in Spokane. This means that some of us are CMA's and some are not. A few of us have been in the medical field a long time and have pieced together our training here and there and have years of on the job training and valuable experience. One of us has military training and certificates to start IV's.

After reading through the presentations we can see how important defining an MA's scope of practice is and we have seen how important it is in our own jobs. However, we have concerns:

1. There are many MA's in the field that are not CMA's, they have years of on the job training and experience. They have worked for the same employer for many years and have been trained by that employer. They have no interest at this point in their careers in going back to school. We have a couple at our clinic and it would be a great loss to our clinic if they couldn't continue as MA's
2. MA's like doctors and nurses can be found everywhere: pediatricians, internal medicine, orthopedic, dermatology. With so many different skills and settings to consider it will be hard to write up our scope of practice without limiting future growth and possibilities. Tracey Hugel had an excellent point about employers being responsible for ensuring there are policies and procedures.
3. Losing the oversight of the Licensed practitioner aka: physician, NP, PA
As we interpret what an MA can do now: An MA operates under the supervision of a doctor, NP, PA. We do not make medical decisions on our own or prescribe. The language of what ever is developed will need to be clear about what we can and cannot do and who is responsible for what we do. If we can call in a prescription then define that; a clinic protocol/ doctor protocol and how do we protect ourselves through documentation. can we decide to give immunizations to a patient based on clinic protocol? Can we operate independently, how much and how far?
4. Schools-There are schools that are not accredited on the Internet. It was discussed that they were not aware of any. There are. We had an MA pay money and take an Internet course and then find out that she couldn't sit for the CMA exam. She ended up going to Apollo.
5. Apollo now known as Carrington college here in Spokane is known for passing everyone no matter what. The idea seems to be that people payed money to go so they deserve to pass. The CMA exam has a reputation as being irrelevant. it has hardly anything to do with what an MA actually does during the course of a day. It has been about 12 years since I sat for the exam but I am told that it has not changed much. It would be nice to see changes to the schools and the exam that reflect the CMA field.

I really hope that the employers role in providing education and protocols for MA's is given serious thought. April May

The National Healthcareer Association (NHA) was not aware of the public meeting held August 16th to discuss proposed House Bill 2009 regulating medical assistants. We apologize for missing the meeting, but would like to submit these comments for consideration.

NHA was established in 1989 after recognizing a need for properly trained and certified individuals involved in the care of patients. The NHA began with a phlebotomy certification exam offered where there was, and still is, little regulation on the training and credentialing of those drawing blood. The NHA soon developed several other exams in the allied health areas and began working with schools to credential their graduates as external validation of their skills and competencies. The NHA has established and maintains an advisory board comprised of industry leaders, experts and important stakeholders which has the responsibility for oversight over all certification and recertification decisions, including governance, eligibility standards, and the development, administration and scoring of assessment instruments.

Many allied health practice areas are unregulated and those working in the fields are often trained on the job. As reflected in the testimony of many at the hearing, the complexity of the healthcare system, the prevalence of chronic disease and the anticipated increase in demand for healthcare due to the impending regulatory changes has many questioning the need for formalized training and certification. At NHA we

believe the safety of the patient is of prime importance and credentialing is an accepted external validation for employers and patients that an individual has met the minimum standards of competence as defined by their profession.

The testimony from the August meeting was overwhelmingly in support of the proposed bill and NHA would support further regulation of medical assistants by rule with a few considerations. Credentialing as described in the proposed language should be specific and based on an external standard, but should not limit the entities that offer the credentialing as long as they meet the external standards.

For example, if national certification is going to be required, the certification entity should be accredited by a program that accredits certifying agencies. Today accreditation of certification programs is available through the National Commission for Competency Assessment (NCCA) or American National Standards Institute (ANSI). There are several nationally accredited medical assistant programs available today. Publication of accredited certification programs is available on the following websites:

- NCCA -
<http://www.credentialingexcellence.org/NCCAAccreditation/AccreditedCertificationPrograms/tabid/120/Default.aspx>
- ANSI -
<https://www.ansica.org/wwwversion2/outside/ALLdirectoryListing.asp?menuID=2&prgID=201&status=4>

If registration is to include a minimum level of training, we would recommend that training programs be based on an external accreditation standard. Today, most allied health programs are accredited by either the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES).

The scope of practice identified by statute should be flexible enough to accommodate changes in the healthcare system while protecting public safety and should also be congruent with the national certification exams. Each certification exam publishes a list of expected competencies and domains of knowledge for their exams. Accredited programs re-assess this list through a job task analysis every 3-5 years.

We thank you for considering these comments as the process for regulating medical assistants progresses. We respectfully ask to be placed on your notification list so we may be a resource for the Agency and participate in future discussions particularly around the rule-making.
Gary Pederson, General Manager, NHA and ATI Allied Health

The Everett Clinic supports the Department of Health's (DOH) sunrise review for Medical Assistants and proposed House Bill 2009. Under current law, medical assistants have the authority to perform tasks delegated to them by medical practitioners. Medical assistants have been safely performing these tasks for years in Washington and that authority is not in question. Due to the expanded use of electronic medical records and the need to comply with federal "meaningful use" regulations, practitioners need to have a high degree of certainty that tasks delegated to and being performed by medical assistants are legally within the medical assistant's "scope of practice." Without this certainty, reimbursements from the federal government may be at risk.

The current healthcare assistant law is sometimes interpreted as a definitive list. Tasks not included on the Healthcare Assistant list, are presumed by some to be excluded. This interpretation is incorrect but it persists. This problem is not unique to Washington. Some states, for example South Dakota (see attached), provide broad categories of permitted duties rather than an explicit list of tasks. This approach takes into account that healthcare is constantly changing and in the future the education and responsibilities of medical assistants may need to change as well. Rather than constantly revising the statute, additional guidance can be provided in the rules.

As the review proceeds, it is important to seek an approach that protects patient safety, improves quality and helps to control costs. This requires that all members of the medical team be allowed to perform to the top of their education and training. We agree that a review of how other states regulate medical assistants will provide valuable insights. Attached is a summary of the rules and regulations in several states.

There is an impending shortage of primary care doctors and nurses. For practitioners to cost-effectively meet the growing demand for medical care, they must have an adequate workforce. Medical assistants are an important part of the medical team and the efficient use of each team member helps ensure the delivery of safe, cost-effective care. Access to care may be unnecessarily restricted if medical assistants are not employed to the full extent of their training.

Mark Mantei, Chief Operating Officer and Jude Bulman, Senior Administrator
The Everett Clinic

Sea Mar Community Health Centers support the provision of legislation to define the role of Medical Assistant in the outpatient setting. We have 20+ family practice and OB clinics in Western Washington that utilize medical assistants in a variety of roles ranging from one on one assistance to providers, coordination of specialty referrals, laboratory work and beyond. They are an essential part of our workforce.

In looking at the House Bill 2009 and the Public Hearing Summary, Nursing Managers at the Sea Mar Community Health Centers have prepared the following comments.

- If medical assistants are to remain in the medical model without jurisdiction by the nursing commission, nurses may not be appropriate delegators for this category of professional. Training by nurses could be incorporated into a clinical competency process. However the actual delegation of tasks should be under the directive of the doctor or equivalent provider, since it is this health care provider for whom the assistance is occurring.
- Though portability is convenient, the competency of medical assistants at this point is highly determined by the training that they receive on the job. It seems there could be a much higher

risk of medical assistant performing duties for which they claim competency from another facility that they do not actually hold. In agreement with Ms. Hugel whom spoke at the hearing, the employer needs to bear a level of responsibility to ensure the competencies of the medical assistant. The current process that forces the employing facility to assign a delegator and to certify that the delegator is responsible for the practice of the MA is a way to help remind providers that this health professional does not have his/her own license and is acting as an assistant to the provider.

- Though expansion of scope is requested by the AMA and supported by physicians, carefully considering the language of what duties can be delegated is important. We are concerned about compromising quality of care for patients if the scope of the MA is expanded to duties such as triage unless curriculum is designed to address the broad spectrum of potential issues that come up in a community health center, family practice or other specialty areas. This would be true for a number of tasks that can be performed in the outpatient setting.
- We feel it would be very beneficial to establish a consistent method for determining competency to graduate from a medical assisting program. Programs should have a minimum number of credits that students must complete with a passing score in order to take the competency test. Optimally a minimum score on the exam should be required in order to apply for certification. Coordination to the national standard would be beneficial.
- The HCA certification process currently allows the MA to work before they are assigned certification from their application. We wait until the forth week of employment to send the application. This gives us some time to determine the competency of the person. If the process for credentialing a Medical Assistant means that they cannot work until it is approved, how will the organization know that they are competent? Lag time to register an MA if they cannot work in the interim could be very costly to the clinic. Due to the dependency we have on our MAs and the number that we currently hire, we ask that every effort be made to have an expedient way to register the MA once an application is made if all criteria are met.
- The proposal of administrative and managerial functions should be clearly defined. Can they answer phones, supervise others, delegate duties?
- It will be important to fully define the credentials and authority for the varying professional titles that might be used i.e. Certified MA, Registered MA etc.

In conclusion we support the provision of legislation specifically defining the role of a Medical Assistant; however we do feel this change must be carefully laid out to protect patient safety and quality of care.
Sea Mar Community Health Centers, Tamara Fitzpatrick RN, BSN, Representative for Nursing Managers

I have been in the healthcare field for over 30 years and have been certified under CNA, EMT and CMA. Currently fall under the category of HCA with A B C E categories. Education was obtained through Yakima Valley Community College. I work for Swofford & Halma Clinic, which is Family Medicine and OB. We are a RHC clinic and our practice is very busy. We employ 2 MDs, 1 DO along with 3 PACs, all of our nursing staff is CMAs, HCAs and 1 NA-R.

Upon reviewing the minutes from the hearing I found that the topic of triage really was a concern. In our office we have Adult and Pediatric telephone protocol books that are used by our triage HCA. Over 80 protocols listed to follow for problems abdominal pain to trauma, vomiting and more. Any further detailed information is then reviewed by a provider in the office and additional information is given to patient. Our nursing staff has close access to physicians in the office to direct HCA and MAs with triage questions. MAs having the ability to triage alleviates unnecessary appointments in the office.

Scope of practice definitely needs to be outlined. MAs have the capabilities to do so much more than what is outlined in the HCA licensing. Education and externships allow MAs to work in clerical and clinical aspects of the office, so not just limited to blood draws and injections.

I fully support House Bill 2009 to have MAs classified under their own entity, with scope of practice outlined with specifics to include blood draws, injection administration, triage, perform CLIA waived testing, narcotic counting, assist in minor surgeries/procedures (prepping the patient, setting up clean & sterile fields), applying durable medical equipment.
Delia Sandoval, HCA (recertifying, CMA)

Marylee Morris is Director of Primary Care Clinics for Legacy Medical Group. Tedra Demitriou is the Ambulatory Nurse Specialist for Legacy Medical Group. We are speaking as professionals interested in provision of safe care to patients, not as representatives of Legacy Health.

Legacy Medical Group has four Primary Care clinics and five Specialty clinics in Washington State. We rely heavily on Medical Assistants as vital members of the clinical care team. We support this effort to define the scope of practice for Medical Assistants in the state. We agree with the majority of the public comments given on Tuesday, August 16th - the bill, as written, needs clarification and detail.

In the section regarding “procedures performed” by a Medical Assistant: It is not possible to attempt to specify every procedure a MA may or may not do. Instead, for every procedure performed outside of those taught at an accredited MA program, (taking vital signs, giving injections, performing EKG, etc) we would require the MA to complete required training which is documented, be deemed competent upon completion of training, and demonstrate proficiency. This approach allows employers to train the MA to duties specific to their patient population and needs, while assuring that Medical Assistants are competent. Some examples of procedures that could fall into this category are urinary catheterization, processing medication refill requests, and operating office medical equipment.

A similar training requirement should be in place for an MA to “operate office medical equipment”. We agree that a rad tech or an MA with extensive, additional formal training best operates x-ray equipment.

As professional nurses, we ask that Medication Administration be limited to medications outside the “high-risk, high-alert” category.

We would like to see additional requirements of a minimum level of education and training for Medical Assistants. Graduation from an accredited Medical Assistant school would be a good start, and in fact, is a requirement at Legacy Health. We do not feel that the state should require the “Certified Medical Assistant” designation, but that this is best left to the employer.

We support portability of credentials by providing credentialing through the State rather than through the employer.

Marylee Morris, RN and Tedra Demitriou, RN

Appendix H

Rebuttals to Draft Recommendations

Medical Assistant Sunrise Rebuttal Comments

I received my Medical Assistant training at Wenatchee Valley College which has a CAAHEP certified program. Part of our clinical training included urinary catheter placement. I was surprised when I read the following paragraph in the draft:

In addition, some urologists and urogynecologists commented that medical assistants should be authorized to insert urinary catheters and bladder instillations if they have specific training. We did not find this training in any of the medical assistant training programs. On the opposite side of this issue, many participants commented that medical assistants should not be performing catheterizations because of the potential for harm to patients.

Which training programs did you query? Obviously not Wenatchee Valley College. Urinary catheters are part of most Medical Assistant program curriculums, some just choose not to teach it.
Coby Towers CMA, CPC, Wenatchee Valley Medical Center

I am a CMA and a Certified Research Coordinator at the Wenatchee Valley Medical Center. I went back to school about 10 years ago to get my Certification so I could do injections within our Research Dept. It is always hard to understand all this state language put into these proposals so often I don't say too much. I just need the state to know that most of what we do has training on the job just like nurses. You come out of school and you have a certain set of skills but what really matters is that you are trained carefully on the job in what area you are going to work in. I carry the D and E category but WVMC will not allow me to start IV's or do IV injections. The one main thing I would like to address is that Wenatchee Valley College CMA program provided us with detailed training on inserting urinary catheters. We have several CMA's that work closely with RN's in our Urology dept. It would be a shame for them to lose their jobs because the state doesn't know what our well trained individuals do at the medical centers. Please be sure that we don't lose the credentials to do ECG's or we will be a world of hurt. I do them every day in my job. Dispensing oral drugs would also be nice to do since I work in Research. I did this for 12 years and suddenly the state said no. I can inject someone with medication but I can't hand them a bottle of study medication. Makes no sense.

Joan Horner, CMA, CCRC, Wenatchee Valley Medical Center

As a graduate of the Medical Assistant Program at Wenatchee Valley College, I have been following this with great interest. I have several comments. My first is that if this training and program is not sanctioned or regulated by the state, then why is this being offered in state sanctioned educational facilities. The educators certainly do not inform the students who are spending 1 to 2 years time and thousands of dollars to these schools, that the state has not really recognized this training and that you may not be able to use any of this training. That you may or may not be able to find a job where any these skills will be allowed to be utilized. In fact, because of lack of clarification of regulations, thousands of Washington State employees are in good faith utilizing skills they have been trained for and are now told they may not continue in these roles and are therefore in jeopardy of losing their jobs. This has in fact happened at the large multi-specialty clinic where I am employed. An entire department had to be restructured and employees transferred due to limitations regarding catheterizations. At this time, this is a sad state of affairs, people all over this state are trying to educate themselves and remain employed. The comments made at the meeting were of great interest to me. The Nursing personal have a view of the Medical Assistant role that is very limited. The AAMA, has CME that is required to maintain our certification. As for the Triage issue that was brought up at the meeting was also interesting. Any

healthcare worker, reception, lab tech, RN, and CMA will encounter patients on a day to day basis. To say that because a person is a CMA, they aren't qualified to ask more than one question regarding a person's healthcare issue is in fact ridiculous. Every receptionist in an out- pt setting has to have common knowledge about the practice they serve and know what to ask to get an appointment scheduled correctly with a provider. This is common sense and is short sided. No one is implying that a CMA is anyway as well educated as an RN or LPN. But, there is a role for this personnel as MD practices are unable to staff all positions with RNs, nor should they. We need to have the right person doing the right job. Fear and lack of understanding of the role of the CMA, is putting limitations on a trained and willing workforce.

Theresa Filbeck CMA, Wenatchee Valley Medical Center

I was trained at Wenatchee Valley College. Our training included catheterization.
Tammy Grigg

I am a Certified Medical Assistant through the AAMA. I currently have a Health Care Assistant Certification category A,C,E. I graduated from the Health Care Assistant program at Wenatchee Valley College in Wenatchee WA six years ago. This program included education of how to insert a urinary catheter. We were taught all aspects of this procedure for all ages of patients. I am not sure why it was not found that this is part of the curriculum of this program when this particular question was researched. This program is accredited by the Commission on Accreditation of Allied Health Education Programs (www.caahep.org) upon recommendation of the curriculum review board of the American Association of Medical Assistants Endowment (AAMAE). Here is a link to the college program website:
<http://www.wvc.edu/directory/departments/medassist/default.asp>

The comment that a medical assistant performing a catheterization on a patient could cause "potential harm to patient" is upsetting. If this was part of the curriculum why would it cause potential harm? There would be a greater chance of potential harm to a patient to have another licensed professional (RN, LPN) whom has not performed this task for many years or months then it would if you were to have a CMA that had been appropriately trained and who does this on a daily bases perform this task. With appropriate education, and understanding of sterile technique, there would not be "potential for harm to the patient".
Amber Zones CMA, Endocrinology

It has been brought to my attention that apparently no one could find a MA program in Washington state that taught placement of urinary catheters. I am a graduate of the Medical Assisting program at Wenatchee Valley College, in Wenatchee Washington, and this was in the curriculum. I have also been a clinical instructor there since 2005 and once again this is taught in the program as a regular part of the curriculum. Please feel free to contact myself or our program director, Jan Kaiser RN for any further information.

Andrea Goodwin CMA (AAMA)

As acurrent Medical Assistant working for a busy ambulatory care clinic in Spokane I find it imperative that changes are made in the laws governing our scope of practice. As of recent our clinic has reviewed the HCA's and interpreted them fairly loosely. Taking away many of the procedures and tasks that I performed previously putting much more strain on our other medical staff as well as patients. I welcome registration of or certification of Medical Assistants with a **WELL DEFINED SCOPE OF PRACTICE** in the laws.

My name is Beth Vaughn and I recently completed my training as a Medical Assistant at Wenatchee Valley College. There were 26 students in my classes, and we were all well trained in catheters. We were not only instructed in proper technique but also well informed of the importance of doing the procedures associated with catheters in the correct way to maintain a sterile field. We were taught the importance of and how to prevent UTIs in our patients. Thank you for letting me share this with you.

Beth Vaughn

In my review of the aforementioned document, I was surprised to see on page 9 the reference to urinary catheter placement and the comment that no medical assistant training programs provided instruction in this procedure. I am a graduate of the Healthcare Assistant program at Wenatchee Valley College in Wenatchee, Washington and most heartily disagree with your remarks. As part of the program we were trained in the insertion and removal of urinary catheters on male and female patients. The training and precautions were quite thorough.

Kirsten Ryles, CMA

I attend Wenatchee Valley College, I had complete training in urine catheter. I have full knowledge of both female and male catheter placement. Just thought you should know.

Katie Ferguson MA~C

We have many medical assistants come apply to work for us. We treat the lower calf all the way down to the through the toes in a podiatry office. It is NOT a requirement to be a certified Medical Assistant to work in a podiatry office. Experience in a back office medical setting is helpful but not necessary. We do most of our training on the job. We DO recommend our assistants become certified in podiatry by taking an exam. this exam will soon be offered on line. It is quite an honor to become certified in podiatry as the exam is difficult. The exam covers area such as x-rays, medical emergencies, anatomy of the foot, biomechanics, etc. To take the exam, one must be a member of ASPMA and obtain study material for the over 400 question exam. Once passing the exam, the assistant will receive PMAC status- Podiatric Medical Assistant Certified. This certification is specific to podiatry. It is not a general certification. I hope this is helpful.

Lisa Crouch, PMAC

The following comments are sent on behalf of Fresenius Medical Care. Fresenius has 21 dialysis facilities in the State of Washington that provide dialysis to 1,158 Washingtonians.

We read with interest the recommendation in the Medical Assistant Sunrise draft report to eliminate the health care assistant designation. Of relevance to Fresenius, we note that the report recommends that persons currently included in category G for health care assistants would now be titled "Certified Hemodialysis Technicians." The report also states that the requirements for this new designation would be identical to what is now contained in category G.

While the impact of this change on our facilities would appear to be neutral, we do have concerns about whether dividing up the health care assistant categories into different professions could potentially increase the fees of the smallest group, Certified Hemodialysis Technicians. As you know, each profession pays its own way for the costs of regulation, and professions with smaller numbers of members tend to pay higher fees than larger professions.

During these challenging economics times, we need to be assured that our fees will not be increased

because Certified Hemodialysis Technicians are part of a group that comprises less than 1,000 members.
Thank you for considering these comments.
Gail McGaffick for Fresenius Medical Care, NA

This writing is in response to the draft Department of Health Medical Assistant Sunrise Review dated December 2011.

We agree that registration of medical assistants is not enough, and certification is preferred because of accompanying educational and training requirements. However, there is some confusion about certification being defined as “voluntary.” For public protection, certification for medical assistants should be required, including specific education and training. We ask the Department to consider revising the definition of certification.

We support re-classifying current Health Care Assistants category C and E to medical assistants with limited ability to administer medications and operate some medical equipment.

Because medication errors are the most frequently occurring medical error, medications administered by medical assistants must be limited. Medical assistants must only be allowed to administer drugs as described in 18.135.130 RCW. This list has been well vetted between medical, nursing, and medical assistant advocates over the last two years. For consistency, only medical assistants may administer vaccines. Currently, all HCA categories A, B, C, D, E, F and G are allowed to do so. Along these same lines, 246-826-200 WAC allows only C,D, E, or F categories of health care assistants to administer yet a different list of medications in hospitals and nursing homes. This inconsistency warrants more discussion about how or whether practice settings influence what medications medical assistants/health care assistants are allowed to administer. In addition, we support additional discussion on what drugs medical assistants would be prohibited from administering. We look forward to discussions that re-examine the entire approach towards medication administration for health care assistants/ medical assistants.

We agree that the proposed scope of medical office equipment to be operated by medical assistants is too broad. We agree that medical assistants must not operate medical equipment that require specialized training or have a risk of negative impact to the patient if operated incorrectly, including MRIs and X-Ray equipment. Because medical assistants do not exercise independent clinical judgment, it must be clear that operation of medical equipment by medical assistants be limited for the purposes of data collection. Only an authorized delegating or supervising provider may interpret results for the purpose of assessing a patient’s condition or other analysis requiring independent clinical judgment.

Additional discussion is needed about the implications of using a practice arrangement plan. While the sunrise review recommends a practice arrangement plan to protect against grandfathered medical assistants performing tasks for which they have not been properly trained, this may be a barrier against the goal of a portable credential.

Finally, medical assistants must not be allowed to perform the following due to lack of education, and training: telephone triage, delegation of health care tasks to other personnel, and health teaching or counseling with the exception of providing pre-printed literature.

Thank you for the opportunity to comment, we look forward to further discussions on this issue. We greatly appreciate the efforts of the Department of Health, and regard the draft sunrise review as a positive step forward towards appropriately regulating medical assistants.
Sofia Aragon, JD, RN, Senior Governmental Affairs Advisor, WA State Nurses Association

The American Association of Medical Assistants (AAMA) and the Washington State Society of Medical Assistants (WSSMA) commend the Washington State Department of Health for its draft *Medical Assistant Sunrise Review*. We offer the following for your consideration.

I. Change “Certified Medical Assistant” to “Medical Assistant.”

The Certifying Board of the American Association of Medical Assistants (AAMA) first bestowed its “Certified Medical Assistant®” credential in 1963, and has used this mark continually since that time throughout the United States. The Certifying Board of the AAMA has Registration No. 2,509,034 issued by the United States Patent and Trademark Office for the mark “Certified Medical Assistant®.” The registration is on the Principal Register, and is registered for use by persons authorized by the AAMA to indicate that the medical assistant services performed or to be performed have been or will be performed by a person whose services are competent in the medical assistant field, such individual’s services having met certain educational standards in the medical assisting field set by the certifier, and the individual having passed an examination administered by the certifier.

The phrase “Certified Medical Assistant,” or “certified medical assistant,” is not a generic phrase that can be used interchangeably with the phrase “medical assistant.” Because of the intellectual property rights of the American Association of Medical Assistants, the AAMA and the WSSMA respectfully request that the new category proposed by the Washington State Department of Health be labeled “medical assistant,” and not “Certified Medical Assistant” or “certified medical assistant.”

II. Satisfactory Completion of a Medical Assisting Educational Program and a Medical Assisting Examination

The American Association of Medical Assistants and the Washington State Society of Medical Assistants support the recommendation that all *new* applicants for the Medical Assistant category be required to demonstrate “satisfactory completion of a medical assistant program approved by the secretary of the Department of Health,” and “satisfactory completion of a medical assistant examination approved by the secretary of the Department of Health.” (page 3) The AAMA and WSSMA also urge the secretary of the Department of Health to only recognize in rule postsecondary medical assisting academic programs that are accredited by either the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES). (page 15) Also, the AAMA and the WSSMA take the position that the secretary should only approve those medical assisting examinations that are accredited by the National Commission for Health Certifying Agencies (NCCA) and that have sufficient depth, breadth, and rigor to protect patients and employers from substandard and potentially patient-jeopardizing medical assisting services. (page 3)

III. Category C and E HCAs Grandfathered Into the Medical Assistant Category

The AAMA and the WSSMA do not object to the proposal that current Health Care Assistants in categories C and E be grandfathered into the Medical Assistant category. We do take issue, however, with the recommendation that these individuals be “required to obtain one year of post-secondary education.” (page 16) In agreement with the Department, it is the position of the American Association of Medical Assistants and the Washington State Society of Medical Assistants that requiring “submission of a practice arrangement plan will protect against grandfathered MAs performing tasks for which they have not been properly trained.” (page 16) In addition, it is our recollection that—during the very early years of the Health Care Assistant program—some HCAs were grandfathered into categories C and E and were exempted from completion of the requisite postsecondary education. If this is the case, it would seem that substantive due process principles would argue against requiring these individuals to now be required to obtain one year of post-secondary education.

The AAMA and the WSSMA are grateful for this opportunity to offer rebuttal comments to the Washington State Department of Health in regard to the draft *Medical Assistant Sunrise Review*. Please let us know how we can be of further assistance.

Sea Mar Community Health Centers

Please find comments in the boxes below each recommendation from the DOH.

Recommendations from DOH to move forward with separate credentialing for Medical Assistants.

1. Blend the existing HCA categories with a medical assistant certification in the following way:

- Replace the current HCA categories C and E with Certified Medical Assistant.
- Replace the current HCA categories A and B with Certified Phlebotomist.
- Replace the current HCA category G with Certified Hemodialysis Technician.
- Remove the requirement that new certifications be issued each time a credential holder leaves a facility or delegator, and replacing it with the portable credential that exists for every other health care profession. A practice arrangement plan similar to the one required for physician assistants could be required to ensure that MAs are practicing within their training and education. (Appendix E).

CONCERN: We would like our staff to be certified as both a phlebotomist and a Medical assistant as we utilize them in both roles in many clinics. We currently certify our staff in A, C, E categories to address this need. Hopefully we will not need to pay for two certifications to have our Medical Assistants credentialed to draw blood?

2. Require the following for all new applicants:

- Certified Medical Assistant:
 - o Satisfactory completion of a medical assistant program approved by the secretary of the Department of Health;
 - o Satisfactory completion of a medical assistant examination approved by the secretary of the Department of Health.
- Certified Phlebotomist: Retain the requirements for HCA categories A and B.
- Certified Hemodialysis Technician: Retain the requirements for health care assistant category G.

AGREEMENT: Makes sense to establish common standards and require that MAs being certified meet this consistently.

3. Grandfather the 17,600 currently certified health care assistants as follows:

- Categories C and E into the new medical assistant certification when they renew their credentials, with a requirement to submit a practice arrangement plan. This would impact 7,150 currently certified HCAs.
- Categories A and B into the new Phlebotomist credential. This would impact approximately 9,600 currently certified HCAs.
- Category G into the new Hemodialysis Technician credential. This would impact approximately 730 currently certified HCAs.
- More research is necessary into how the HCAs in categories D and F are being used and whether these categories should be retained. There are currently 130 people holding only category D and/or F HCA credentials.

CONCERN: Our staff is currently certified in A, C, E categories as we cross-train our MAs for the laboratory and performing phlebotomy. What credentials would a current HCA that has A, C, E be given in the grandfather process?

4. Amend the tasks proposed in House Bill 2009 to address the following issues:

- Set parameters for the medication administration task in Section 5(6) similar to those in the current HCA regulations;
- Set parameters around office medical equipment to narrow this topic; and
- Include criteria that identify the nature of the tasks a medical assistant can perform, to be both inclusive of what may be performed and exclusive of what may not be performed.

CONCERN: Currently the list of medications is limited thus without a licensed nurse, community health clinics are challenged to provide some common care that an MA could easily be trained to do for example, give a nitrostat tab to a patient, give certain types of compounded medication that is used for OB patients etc. Though we want to protect patient safety, too strict of a list might actually compromise. We ask that there might be a slightly more comprehensive list of medications allowed and would be happy to provide additional information for your review.

AGREEMENT: Making clear areas of practice that are included and those that should be excluded is important to protect patient safety. The training focus for MAs is broad and the level of training is not intended to replace licensed nurses, only assist providers with patient care.

Tamara Fitzpatrick RN, BSN, Nurse Manager

For Medical Assistants receiving their education and training at Wenatchee Valley College, urinary catheter training is one of our first laboratory classes. We spend most of the first quarter labs learning sterile technique and insertion of catheters.

The Program Director/Instructor, Jan Kaiser, R. N., spends a great amount of time with each student to assure technique is correct and the student understands the procedure. Individual testing of each student is also completed at the end of the quarter and prior to graduation.

I feel we have received quality education with regard to urinary catheters and all aspects of our training at Wenatchee Valley College.

Lori VanLith, CMA (AAMA) CRC, Wenatchee Valley Medical Center, Oncology Research Coordinator

American Medical Technologists (AMT) submits these brief comments on the draft Medical Assistant Sunrise Review released earlier this month by the Health Systems Quality Assurance division of the Washington Department of Health.

As noted in our written comments submitted August 25, 2011, AMT is a national, non-profit certification organization and professional membership association for medical assistants, clinical laboratory professionals, phlebotomists, and other allied health personnel. AMT, headquartered in Rosemont, Illinois, has nearly 50,000 active members in good standing, of which approximately 30,000 hold the Registered Medical Assistant (RMA) certification.

AMT enthusiastically supports the recommendations contained in the Department's draft Sunrise Review report. We especially applaud the recommendations to establish regulatory programs for certified medical assistants and phlebotomists; to eliminate the existing Health Care Assistant categories and merge their functions into the regulatory programs for medical assistants and phlebotomists; and to promote portability of the new medical assistant and phlebotomist certifications by allowing the certification to follow the certified professional when he or she moves from one employer to another. (AMT is not qualified to comment on the Department's proposal to create a new certification category for hemodialysis technicians.)

AMT has just a few comments and requests for clarification, which we hope the Department will consider in producing a final report:

1. In the Executive Summary on p. 3, the report recommends the following requirements for new Certified Medical Assistant applicants:

2. Require the following for all new applicants:

- Certified Medical Assistant:
 - o Satisfactory completion of a medical assistant program approved by the secretary of the Department of Health;
 - o Satisfactory completion of a medical assistant examination approved by the secretary of the Department of Health.

AMT believes that these are appropriate qualification requirements. We support the recognition of independently accredited medical assistant certification examinations administered by private, non-profit organizations, such as the RMA exam administered by AMT and the CMA(AAMA) exam administered by the American Association of Medical Assistants (AAMA).

However, in the section entitled Detailed Recommendations to the Legislature, on p. 15, the mention of approved exams disappears entirely, while the educational qualifications are stated in greater detail, as follows:

2. Require the following for all new applicants:

- For Certified Medical Assistant:
 - o Satisfactory completion of a medical assistant program approved by the secretary of the Department of Health. Programs accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or Accrediting Bureau of Health Education Schools (ABHES) should be included in this requirement.

AMT urges the Department to reconcile the differences between the recommended qualifications for Certified Medical Assistants in the Executive Summary and in the Detailed Recommendations to the Legislature. Specifically, the Detailed Recommendations should include the Executive Summary's criterion of a medical assistant examination approved by the secretary of the Department of Health. The Department should also clarify whether these are being recommended as alternative qualification routes (*i.e.*, approved education program *or* passing an approved exam), or instead must *both* be satisfied to qualify for State certification (*i.e.*, approved education program *and* passing an approved exam).

2. AMT would appreciate the Department's clarifying that the use of the title "Certified Medical Assistant" is intended as a regulatory term-of-art, applicable only to the State's certification program for medical assistants, and is not to be confused with the CMA(AAMA) credential awarded by the AAMA, nor is the title intended to preclude Registered Medical Assistants certified by AMT from qualifying as Certified Medical Assistants in the State of Washington.

AMT thanks the Department and HSQA for the opportunity to review and comment on the draft Medical Assistant Sunrise Review. We very much hope the Legislature adopts the Department's recommendations.

Michael N. McCarty, *AMT Legal Counsel*

This letter is in response to the Department of Health's request for feedback on the draft Department of Health Medical Assistant Sunrise Review dated December 2011 . Group Health Cooperative believes the Department of Health did a commendable job with the Medical Assistant Sunrise Review of acknowledging the issues and concerns raised regarding proposed House Bill 2009, exploring the issues, and putting forth a set of recommendations to address the concerns.

We have several questions and comments we are submitting for further consideration and clarification:

1. We agree that certification of medical assistants over registration is preferred because it establishes minimum requirements for education and training and a process for verifying minimum knowledge level through the satisfactory completion of an examination. Approval of medical assistant programs by the secretary of the Department of Health assures minimum curriculum content is met in educating medical assistants. The process for certification of medical assistants educated and trained in programs outside of Washington will need to be defined.
2. We support the reclassifying of Health Care Assistant category C and E to certified medical assistants with well defined limitations on medication administration , parameters around the use of office medical equipment, and establishment of criteria, both inclusion and exclusion, around what tasks and activities can and cannot be performed by certified medical assistants.
3. For Health Care Assistants who are currently category A, C and E, how would they be handled in the migration to the Certified Medical Assistant and Certified Phlebotomist categories? Would they have to apply to be certified in both categories?
4. We support use of the current HCA regulations to set parameters for medication administration for certified medical assistants. We request that clarification and clear parameters are established for medications that can and cannot be administered by injection. We believe WAC 246.826.200 creates confusion for ambulatory care settings and the potential for misinterpretation around which injectable medications can be administered by medical assistants in ambulatory care. Additionally, the medications listed are not consistent with the findings of the Institute of Medicine's (IOM) recent report on *Preventing Medication Errors* and on the Institute for Safe Medication Practices (ISMP) *List of High-Alert Medications*.
5. Clarity regarding vaccine administration is needed. Currently all HCA categories A, e, C, D, E, F, and G are allowed to administer oral, topical and nasal vaccines. With medication administration being limited to Certified Medical Assistants, we support this applying to all vaccines as well.
6. We support the portability of the credential but believe additional discussion is needed about the proposal to use a practice arrangement plan for the grandfathered MAs. We have Questions about the purpose of the practice arrangement plan, how it will be used, the monitoring and oversight of the plans, and how it will assure MAs are only performing tasks for which they have been educated and trained.

Thank you for the opportunity to comment. We appreciate the efforts of the Department of Health and believe the draft sunrise review is a positive step toward appropriately regulating medical assistants in Washington. We look forward to further discussions on this issue.

Barbara Trehearne, PhD, RN, Vice President of Clinical Excellence, Quality and Nursing Practice

This letter is regarding the draft sunrise review of a proposal to regulate medical assistants in Washington State. Thank you for the opportunity to provide rebuttal comments on the Department of Health's draft recommendations. As you know, we testified at the August 16th hearing in support of further clarification

on the role of medical assistants (MAs). We are pleased that the Department of Health is considering the proposal, but a few concerns remain that we would like you to consider.

Medication List

Because medications and medical technology are developing rapidly, it is not practical to list specific medications or medical office equipment that can or cannot be used by medical assistants in a WAC or RCW. Medications and medical office equipment differ dependent upon the practice specialty and/or the patient population served. The delegating provider needs the ability to determine what medications and medical equipment are safe and appropriate for the medical assistant to administer and operate. The delegating provider must ensure the MA is trained, competent and will assume full responsibility of the MA's action. A list of medications and medical office equipment should be part of the Practice Arrangement plan. The basic requirements in WAC 246-826-100 should be retained with some alterations.

For example, medications administered by the medical assistant are restricted to the oral, topical, rectal, otic, intranasal, inhalation and ophthalmic routes in unit, single or calculated dosage. A written order from a delegating health care practitioner authorizing the administration of drugs-must be provided to the medical assistant. Use of radiographic equipment is restricted to the codes and rules of WAC 246-926 and RCW 18.84.

Medical assistants must be able to demonstrate initial and ongoing competency to the supervisor or delegator on the administration of medications and the operation of medical office equipment as listed in the Practice Arrangement plan. Competency may be demonstrated by:

- (a) Practicing techniques in a simulated situation; or
- (b) Observing and performing procedures on patients until the medical assistant demonstrates proficiency to administer medications and operate medical office equipment as listed on the Practice Arrangement plan.

Documentation of all training on a checklist appropriate to the facility of the administration of medications and operation of medical office equipment by the medical assistant must be completed with the MA's and delegator's signature on the form. The form is placed in their employee personnel file; or other methods determined by the delegator.

The supervisor or delegator is responsible for the patient's care. The tasks delegated to medical assistant must be based on the medical assistant's individual education and training and can be performed without requiring the exercise of judgment based on medical knowledge; can be performed without a need for complex observations or critical decisions; can be performed without repeated medical assessments; and tasks that, if performed improperly, would not present life threatening consequences or the danger of immediate and serious harm to the patient. (Excerpt from Ohio law).

Current List of Authorized Drugs Listed in RCW 18.135.1.0

The current authorized drugs listed in RCW 18.135.130 are very restrictive and poorly written. The lists consist of a mixture of brand and generic name drugs, combination drugs and undefined abbreviations for drugs. For example, the health care assistant (HCA) can apply Neosporin®, but not bacitracin; can administer an antibiotic injection, but not provide an oral antibiotic; and can "lat" be found in a drug reference book? Our HCA can administer an albuterol small volume nebulizer (SVN) treatment, but is not able to administer an albuterol/ipratropium SVN treatment, which is a very common combination medication for SVN. These are just a few examples of some of the issues with listing individual drugs. Again, we recommend that the delegating provider needs the ability to determine which medications are safe and appropriate for the medical assistant to administer.

Use of Protocols and/or Standing Orders

Another issue that needs to be addressed is the use of protocols or standing orders. Currently WAC 246-826-03 (supervision of health care assistants) states, "A health care assistant may be supervised by either the delegator or by another practitioner who can order that act under his or her own license."

This WAC was overlooked during the H1N1 pandemic and local pertussis outbreak, when HCA's were used to administer vaccines under the supervision of a registered nurse. The delegating practitioner was not immediately available in the facility and the registered nurse did not have the authority to order the administration of vaccines. These incidents illustrate why we need to allow medical assistants to follow protocols or standing orders under the supervisor of a health care practitioner as defined in the proposed draft bill.

Addition of Pharmacist as Health Care Practitioner

Adding the pharmacist as a health care practitioner that can supervise or delegate to medical assistants is recommended. With the implementation of patient-centered medical home models and the use of anticoagulation clinics, pharmacists are providing a more direct role in patient care and medication management. Utilizing the medical assistant in these settings provide support to the pharmacist to provide care to a larger patient population.

Thank you for the opportunity to provide rebuttal comments of the Department of Health's draft sunrise review for medical assistants. Please contact me at (253) 403-1087 or smokey.stover@multicare.org with questions.

Smokey Stover, MD, Senior Vice President, MultiCare Health System

The Everett Clinic appreciates the work of the Department of Health to develop a draft report for the sunrise review of medical assistants. We believe the report *is* very thorough and agree with many of the findings and recommendations.

There are a few issues that we believe need further *consideration* or clarification.

First, The Everett Clinic agrees with the recommendation that to become certified, a medical assistant must graduate from an accredited medical assistant program. Our organization only hires medical assistants who have graduated from these programs and we have been very *satisfied* with their qualifications and training. These programs provide the foundation necessary for medical assistants to carry out the tasks delegated to them by other members of the healthcare team.

We are confused about the proposed recommendation that medical *assistants* be required to "complete a medical assistant examination approved by the secretary of the Department of Health." This is mentioned on page 3 of the draft report, but on page 15 under Detailed Recommendations to the Legislature there is no mention of a test. It is also not clear what type of exam is being recommended.

We do not support the recommendation that medical assistants be required to take a separate professional exam in order to become certified. Professional examinations are expensive and in most cases have to be renewed periodically. These tests do not improve the skills of the medical assistants and do not necessarily lead to an increase in pay. They are an unnecessary expense for an entry-level position and for some may serve as a barrier to obtaining certification. For many years The Everett Clinic has used medical assistants to help deliver safe and cost-effective care. We do not require these employees to incur the

expense of a professional exam. Rather than rely on a test, the better approach is to ensure that accredited programs are teaching the rights skills. In addition, employers need to provide appropriate supervision and training.

Second, there needs to be flexibility regarding the medication and medical equipment that medical assistant can administer and operate. Healthcare is rapidly changing and it would not be appropriate to list in statute of all the medication and equipment that medical assistants may use or dispense. A detailed list will quickly become obsolete. Broad categories of medications might be included in statutes, but specific types of medications should only be referenced in the regulations.

The objective should be to reinforce that medical assistants can operate equipment or dispense medications if they have the required education and training to do so and if an appropriate medical practitioner delegates the task to them. The delegating provider should have the ability and responsibility to ensure that the MA has the necessary training and skills to safely accomplish assigned tasks.

Third, DOH is recommending that a practice arrangement plan be required when a medical assistant changes jobs. We agree that this option is worth considering if it alleviates concerns regarding portability. Clearly the practice plan would need to be tailored to reflect the duties, supervision requirements and practice settings appropriate for medical assistants. The practice plan should include broad categories of responsibilities, and not a detailed and specific list of tasks.

Thank you for the opportunity to comment. We look forward to working with you to address these issues.

Al Frisk, MD, The Everett Clinic, Chief Medical Director

Jude Bullman, The Everett Clinic, Senior Administrator

My input is centered around the confusion surrounding the MAs scope regarding entering "pending" medication orders into the electronic medical records (EMR) and forwarding this pending order for the provider to co-sign. Many health care organizations are using EMRs, and the MA/HCA scope described by the DOH does not offer language that states that entering pending medication orders are "not" in the scope of MA/HCA. The absence of this language leaves a grey area, and consequently, HCAs (MAs) are being asked by physicians to queue up pending orders. In many cases, the HCA enters the order for injection (immunization), and gives the injection prior to confirming that the physician has co-signed the order. I am desperately seeking clarity around this issue. I would appreciate your feedback and/or your assistance with assuring that the language in the draft states whether or not entering pending orders into an EMR "is" or "is not" in the HCA scope. This clarity will remove all doubts about this matter, and will give health care organizations solid support for the State of Washington when management is challenged about the lack of legislative language available to ensure the staff is working within their scope.

Charlotte Foster, RN, BSN, MHA

The Northwest Career Colleges Federation (NWCCF) supports the proposal to credential medical assistants. We strongly support a requirement for formal education for medical assistants as a critical means to ensure public safety and assure professional ability.

Within the Sunrise report there is reference to programmatic accreditation, currently offered by the Accrediting Bureau of Health Education Schools (ABHES) and the Commission on Accreditation of Allied Health Education Programs (CAAHEP):

2. Require the following for all new applicants:

- For Certified Medical Assistant:
 - Satisfactory completion of a medical assistant program approved by the secretary of the Department of Health. Programs accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or Accrediting Bureau of Health Education Schools (ABHES) should be included in this requirement.

The NWCCF concurs with this requirement *provided* reference in the first sentence is intended to allow medical assisting programs that are not programmatically accredited by the two referenced agencies to apply for approval from DOH for program recognition. Programmatic accreditation should not be mandatory. We suggest that programs that are accredited by CAAHEP or ABHES receive automatic recognition of approval by DOH. Continued recognition without evaluation should be contingent upon proof of ongoing approval by one of those agencies

LouGena J. Wilkstrom, Executive Director, Northwest Career Colleges Federation