Report to the General Assembly

An Act Concerning the Department of Public Health's Oversight Responsibilities relating to Scope of Practice Determinations:

Scope of Practice Review Committee Report on
Medical Assistants

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State of Connecticut

Department of Public Health

Report to the General Assembly

An Act Concerning the Department of Public Health's Oversight Responsibilities relating to Scope of Practice Determinations for Health Care Professions: Medical Assistants

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Executive Summary

In accordance with Public Act 11-209, the Connecticut Society of Medical Assistants (CSMA) and the American Association of Medical Assistants (AAMA) jointly submitted a scope of practice request to the Department of Public Health to enable physicians to delegate medication administration to certified medical assistants in outpatient settings, and establish mandatory education and training requirements and a recognized scope of practice for medical assistants who engage in medication administration.

The scope of practice review committee reviewed and evaluated all of the information provided in the scope of practice request submitted by the CSMA and the AAMA and the evidence they provided in support of the proposed changes, as well as additional information that was requested as a result of committee discussions. In reviewing and evaluating the information presented, the scope of practice review committee focused on assessing any public health and safety risks associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training.

Literature and other information reviewed and evaluated by the scope of practice review committee demonstrated that certified medical assistants are educated and trained to administer medication under the direct supervision of a licensed physician. Accredited education and training programs that lead to certification as a medical assistant have been in place for many years in Connecticut and other states and include coursework and clinical training in pharmacology and medication administration. The American Association of Medical Assistants and American Medical Technologists offer examination and certification programs that could be utilized in Connecticut as the standard for medical assistants who are delegated the task of medication administration. Mandatory certification would ensure that all medical assistants who administer medication have met the same minimum qualifications.

Medical assistants are able to administer medications under the direct supervision of a physician in most other states. Restrictions related to setting, types of medication and route of administration vary from state to state. Although no evidence was provided by the requesters that demonstrates that enactment of these changes in other states has enhanced access to quality and affordable care, it is anticipated that allowing medical assistants to administer medication, for example routine vaccinations, will enable physicians and nurses who may be practicing with them to see more patients and focus on clinical care. The potential impact on access to care that may result if this proposal is not enacted was not evaluated by the committee. Implementation of this scope of practice request would enhance the ability of certified medical assistants to practice to the full extent of the profession's education and training.

In reviewing and discussing all of the information provided, the majority of scope of practice review committee members agreed that the concerns that were identified regarding potential quality and safety risks associated with allowing licensed physicians to delegate medication administration to certified medical assistants can be addressed through legislation. While there are no specific

recommendations as to whether or not this proposal should move forward, committee members agreed that the following issues must be addressed if a bill is raised and prior to any legislation being enacted:

- The term “physician” must be clearly defined to include only doctors of medicine (M.D.) and doctors of osteopathic medicine (D.O.).

- The term “certified medical assistant” must be defined and the law must clearly articulate the credentials an individual must hold in order to use that designation in Connecticut and administer medications as delegated by a physician. Physicians must be aware of which tasks can be delegated and to whom such tasks can be delegated.

- The term “outpatient setting” must be defined and the law must clearly identify any settings that may be excluded (e.g., hospitals including emergency departments, ambulatory surgical centers, physician offices during routine surgical procedures).

- The term “direct supervision” must be clearly defined to require the physician to remain on the premises at all times that treatment orders for medication administration are being carried out by the medical assistant, be within reasonable proximity to the treatment room and able to observe, assess and take any necessary action regarding effectiveness, adverse reaction or any emergency.

- Existing statutory provisions that currently allow medical assistants in ophthalmology and optometric practices to administer medication to patients under supervision should not be impacted or altered in any way.

- Any medications that should be excluded to assure patient safety must be clearly articulated (e.g., excluding certain substances such as anesthetic agents and controlled substances in Schedules I, II and III).

- Any exclusions related to routes of administration and limitations related to location on the body to assure patient safety must also be articulated (e.g., excluding intravenous administration and inhalation as routes of administration and limiting injections to extremities and the back).

- Mechanisms to ensure that patients are aware of a practitioner’s qualifications and the services that he or she may provide must be considered as a part of any proposal that moves forward.

Draft statutory language was not provided for review by scope of practice review committee members. Should the Public Health Committee decide to raise a bill related to this scope of practice request, the Department of Public Health along with the organizations that were represented on the scope of practice review committee (the Connecticut Society of Medical Assistants, the American

Association of Medical Assistants, the American Medical Technologists, the Connecticut State Medical Society , the Connecticut Association of Optometrists, the Connecticut Dermatology and Dermatologic Society, the Connecticut ENT Society, the Connecticut Urology Society, the Connecticut Society of Eye Physicians, the Connecticut Hospital Association, the Connecticut Society for Respiratory Care and the Connecticut Association of Nurse Anesthetists) respectfully request the opportunity to work with the Public Health Committee on statutory language.

Background

Public Act 11-209, An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to Scope of Practice Determinations for Health Care Professions, established a process for the submission and review of requests from health care professions seeking to revise or establish a scope of practice prior to consideration by the General Assembly. Under the provisions of this act, persons or entities acting on behalf of a health care profession that may be directly impacted by a scope of practice request may submit a written impact statement to the Department of Public Health. The Commissioner of Public Health shall, within available appropriations, establish and appoint members to a scope of practice review committee for each timely scope of practice request received by the Department. Committees shall consist of the following members:

1. Two members recommended by the requestor to represent the health care profession making the scope of practice request;

2. Two members recommended by each person or entity that has submitted a written impact statement, to represent the health care profession(s) directly impacted by the scope of practice request; and

3. The Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, non-voting member of the committee.

Scope of practice review committees shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. Upon concluding its review and evaluation of the scope of practice request, the committee shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The Department of Public Health (DPH) is responsible for receiving requests and for establishing and providing support to the review committees, within available appropriations.

Scope of Practice Request

The Connecticut Society of Medical Assistants (CSMA) and the American Association Medical Assistants (AAMA) jointly submitted a scope of practice request to enable physicians to delegate medication administration to certified medical assistants, and establish mandatory education and training requirements and a recognized scope of practice for medical assistants who engage in medication administration. More specifically, CSMA and AAMA are requesting a scope of practice change that would enable licensed physicians to delegate: (1) the administration of medication orally or by inhalation; and (2) the administration of intramuscular, intradermal, and subcutaneous injections (including vaccinations/immunizations) to medical assistants working under their direct supervision in outpatient settings who (1) have graduated from an accredited, postsecondary medical assisting program that is accredited by either the Commission on Accreditation of Allied Health Education Programs or the Accrediting Bureau of Health Education Schools; and (2) have a current medical assisting credential acceptable to and recognized by the Connecticut Department of Public Health. For purposes of this request, "direct supervision" is defined as the overseeing/delegating/supervising physician being on the premises and reasonably available although not necessarily in the same room.

Impact Statements and Responses to Impact Statements

Written impact statements in response to the scope of practice request submitted by CSMA and the AAMA were received from the Connecticut State Medical Society, the Connecticut Hospital Association, the Connecticut Association of Nurse Anesthetists, the American Medical Technologists, the Connecticut Society for Respiratory Care, the Connecticut Association of Optometrists, the Connecticut Dermatology and Dermatologic Society, the Connecticut ENT Society, the Connecticut Urology Society, and the Connecticut Society of Eye Physicians. The CSMA and the AAMA submitted a written response to each of the impact statements submitted by the previously referenced organizations, which were reviewed by the scope of practice review committee.

Scope of Practice Review Committee Membership

In accordance with the provisions of Public Act 11-209, a scope of practice review committee was established to review and evaluate the scope of practice request submitted by the Connecticut Society of Medical Assistants and the American Association of Medical Assistants. Membership on the scope of practice review committee included:

1. Two members recommended by the Connecticut Society of Medical Assistants and the American Association of Medical Assistants;

2. Two members recommended by the Connecticut State Medical Society;

3. Two members recommended by the Connecticut Hospital Association;

4. Two members recommended by the Connecticut Association of Nurse Anesthetists;
5. Two members recommended by the American Medical Technologists
6. Two members recommended by the Connecticut Society for Respiratory Care;
7. Two members recommended by the Connecticut Association of Optometrists;
8. Two members recommended by the Connecticut Dermatology and Dermatologic Society;
9. Two members recommended by the Connecticut ENT Society;
10. Two members recommended by the Connecticut Urology Society;
11. Two members recommended by the Connecticut Society of Eye Physicians; and
12. The Commissioner's designee (chairperson and ex-officio, non-voting member).

Scope of Practice Review Committee Evaluation of Request

The scope of practice request submitted by the Connecticut Society of Medical Assistants (CSMA) and the American Association of Medical Assistants (AAMA) included all of the required elements identified in PA 11-209.

Health & Safety Benefits

The CSMA and the AAMA identified the following health and safety benefits associated with implementing their proposal:

-*Increase the supply of allied health personnel and enhance the efficiency of the delivery of health care services*

Expanding the scope of services that can be delegated by a physician to include medication administration by qualified medical assistants would increase the supply of allied health personnel available to work with physicians and allow physicians and nurses to focus on clinical assessment and care rather than spending time on tasks such as administering "routine" injections.

-*Mandating specific education, training and competency requirements for medical assistants who engage in medication administration under the direct supervision of a physician*

There are currently no mandatory education, training or certification requirements for medical assistants in Connecticut. Establishing mandatory education and training standards for medical

assistants, who administer medication as delegated by a physician and performed under the direct supervision of the physician, ensures quality without jeopardizing the health, safety and welfare of patients because only those medical assistants with specific qualifications will be authorized to administer medication.

Access to Healthcare/Economic Impact

Although they are not licensed and there is no statutorily recognized scope of practice, medical assistants do practice in Connecticut but are currently prohibited from administering medications to patients. The CSMA and the AAMA assert that if their scope of practice request is implemented, patients in Connecticut would benefit by having greater access to and availability of health care, and that allowing physicians to delegate certain types of medication administration to educated and trained medical assistants would increase the supply of allied health professionals and consequently enhance the efficiency of health care.

The CSMA and AAMA indicate that delegation of medication administration to medical assistants would enable physicians to see a greater number of patients in a shorter time without diminishing the quality of care provided to patients. It is important to note that, with few exceptions, under current Connecticut law physicians, physician assistants and nurses are the only health care practitioners who are legally authorized to administer medications in the outpatient settings being considered in this request. The lack of a statewide repository of data to track who is administering medications to patients in all outpatient settings made it unfeasible to prepare a cost/ benefit analysis. While they stated that according to basic microeconomic principles an increase in the supply of allied health professionals would permit the employers/supervisors to increase their output of medical care, CSMA and AAMA did not provide any literature or specific data to demonstrate that implementation of the proposed changes will have an impact on access to care or costs to the health care system in Connecticut.

CSMA and AAMA also stated that if the scope of practice request is not implemented, the Connecticut health care system, physicians and patients would be deprived of the efficiencies of fully utilizing competent and knowledgeable medical assistants, and medical assistants would continue to be prohibited from practicing to the full extent of their education and training. The potential impact on access to care that may result if this proposal is not enacted was not evaluated by the committee.

Laws Governing the Profession

There are no federal laws that have direct bearing on medical assistants and their scope of practice and there are no Connecticut laws or regulations specifically governing the practice of medical assistants.

Current Requirements for Education and Training and Applicable Certification Requirements

There are currently no mandatory requirements for education, training and/or certification for medical assistants who are practicing in Connecticut.

-Education/Training

- Accredited medical assistant programs are offered in postsecondary academic institutions.

- Medical assistant education programs are accredited by either the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES). There are 23 accredited medical assistant programs located in Connecticut.

- Accredited medical assistant education programs include both classroom instruction in a core curriculum (see Appendices F, G and H) and a minimum of 160 hours unpaid, supervised practicum in an ambulatory healthcare setting. The core curriculum includes didactic content necessary to ensure that graduates can safely perform medication administration, including intramuscular, intradermal and subcutaneous injections. In addition, students are required to demonstrate psychomotor competence in these procedures in order to graduate – this psychomotor competence can only be demonstrated on mannequins under current Connecticut law.

- Key coursework related to medication administration:
  - *foundations for clinical practice*- includes demonstration of knowledge base in identifying classification of medications, including desired effects, side effects and adverse reactions and describing the relationship between anatomy and physiology of all body systems and medications used for treatment in each – skill demonstration includes: select proper site for administering parenteral medication; administer oral medications; and administer parenteral (excluding IV) medications;
  - *applied mathematics*- includes identifying both abbreviations and symbols used in calculating medication doses and analyzing charts, graphs and/or tables in the interpretation of healthcare results – skill demonstration includes: prepare proper dosages of medication for administration; and
  - *pharmacology* –includes math and metric conversions; use of drug references; common abbreviations; legal aspects; and laws and regulations.

- There is no specified number of hours in pharmacology/medication administration that is mandated as part of a medical assistant education program. Students must meet specific educational outcomes to graduate. Typically, approximately 30 to 35 hours of the medical

assistant program is devoted to the topic of pharmacology/medication administration. Nurses and/or medical assistants with experience in medication administration teach this portion of the course.

-Examination/Certification Requirements

Certification for medical assistants is voluntary and available through organizations such as the American Association of Medical Assistants (AAMA) and American Medical Technologists (AMT).

In order to obtain initial certification, both the AAMA and the AMT require candidates to complete basic education and training that meet identified competencies and successfully complete an extensive examination.

In order to maintain certification, registrants must complete continuing education activities.

Summary of Known Scope of Practice Changes

There have been no scope of practice requests submitted and no recent proposed legislation related to medical assistants.

Impact on Existing Relationships within the Health Care Delivery System

The CSMA and AAMA identified that implementation of the scope of practice request would have minimal impact on existing relationships within the health care delivery system and that the request would only have an impact on the relationship between physicians and medical assistants. If this proposal is implemented, physicians would continue to delegate to all medical assistants the limited duties they are currently permitted to perform as unlicensed assistive personnel (e.g., taking vital signs, taking patients into examination rooms, entering data into the medical record, administrative tasks, etc.) in addition to delegating medication administration to medical assistants who meet specified education and credentialing requirements.

Regional and National Trends

The CSMA and the AAMA reported that most state laws permit physicians to delegate to unlicensed allied health personnel such as medical assistants, working under their direct supervision in outpatient settings, any duties except those which (1) constitute the practice of medicine or require the skill and knowledge of a licensed physician; (2) are restricted in state law to other health or allied health professionals; and (3) require the medical assistant to exercise independent judgment or to make clinical assessments or evaluations. Some states require medical assistants to meet educational and/or examination requirements in order to be delegated certain “advanced” medical assisting duties. The New Jersey medical assisting regulations (See Appendix I) are very specific with regard to injections. South Dakota requires medical assistants to have graduated from a formal, postsecondary educational program that meets the joint standards of the South Dakota Board of

Medical and Osteopathic Examiners and the South Dakota Board of Nursing in order to be registered to work as a medical assistant. In addition to the laws in New Jersey and South Dakota, there are statutory and/or regulatory provisions that establish requirements for medical assisting scope or practice in California, Washington and Arizona.

Other Health Care Professions that may be Impacted by the Scope of Practice Request as Identified by the Requestor

The CSMA and the AAMA indicated in their scope of practice request that physicians would be directly impacted if their request is implemented and that they are working closely with the Connecticut State Medical Society. They anticipate no significant opposition from the physician community.

The CSMA and the AAMA also indicated in the scope request that registered nurses (RNs) and licensed practical nurses (LPNs) sometimes work under physician supervision in outpatient settings and are delegated administration of medication, and that consequently this scope request may have indirect impact on RNs and LPNs. It is important to note that although this may be the AAMA's experience in other states, the practice of nursing by a registered nurse in Connecticut is defined as the process of diagnosing human responses to actual or potential health problems, providing supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen, and executing the medical regimen under the *direction* of a licensed physician, dentist or advanced practice registered nurse. RNs carry out physicians' directives and orders and medication administration falls within their scope of practice. In addition, under Connecticut law, physicians cannot delegate to LPNs who may only work under the supervision of RNs and APRNs.

Implementation of the medical assistant scope of practice request as proposed would require that medical assistants graduate from an accredited postsecondary medical assisting program and receive either a one-year certificate or diploma or an associate's degree in order to be able to engage in medication administration. The CSMA and the AAMA reported that the accreditation standards for medical assistant education programs are somewhat comparable to accreditation standards for LPN education programs. No actual comparison of a medical assistant and LPN education program was provided. While neither program mandates a specific minimum number of required hours in medication administration, approved LPN programs must include a minimum of 1,500 hours, half of which must be in direct client care and observational experiences. Graduates of both medical assistant and LPN education programs must meet specific educational outcomes related to medication administration.

Since medication administration falls within the scope of practice of nursing and nurses administer medications to patients in all of the outpatient settings identified in this proposal, nursing would certainly be impacted if this proposal moves forward. Although the Connecticut Nurses Association

did not submit an impact statement, nurses did participate in the scope of practice review committee process, including representatives from the Connecticut Association of Nurse Anesthetists.

Description of How the Request Relates to the Profession's Ability to Practice to the Full Extent of the Profession's Education and Training

Current law in Connecticut restricts a physician's ability to delegate medication administration to certified medical assistants. Medication administration is included within a certified medical assistant's education and training. Implementation of this scope of practice request would provide physicians with additional options in the hiring of competent and knowledgeable allied health personnel into their practices and allow medical assistants in Connecticut to practice to the full extent of their education and training.

Additional Information Reviewed

-*Definition of supervision*

Qualified medical assistants would administer medications under the direct supervision of a physician. For purposes of this proposal, "direct supervision" means the physician is on the premises and is reasonably available when the medical assistant is administering medication to a patient but is not necessarily in the same room. By delegating this task to the medical assistant, the physician is accepting responsibility for the medical assistant's actions and may be held accountable should any issues arise.

-*How many medical assistants are currently practicing in Connecticut?*

Data was not available to identify the number of medical assistants who are currently practicing in Connecticut. It is estimated that there are approximately 30,000 medical assistants who are certified by the AAMA nationally, almost 900 with a Connecticut address. There are approximately 584 active Registered Medical Assistants (RMAs) certified by American Medical Technologists (AMT) with a Connecticut address. Neither of these organizations designate by specialty.

-*Where do medical assistants practice?*

Medical assistants practice primarily in outpatient settings (e.g., medical offices and clinics). In Connecticut, outpatient settings include, but are not necessarily limited to, physician offices and group practices, outpatient clinics, other clinics such as urgent care centers, outpatient dialysis units, ambulatory surgical centers, and in some instances emergency rooms. Although medical assistants and some physicians would like to see minimal restrictions in place concerning the setting in which a qualified medical assistant may administer medications, discussions made it

very clear that exclusions should be considered. For example, in hospitals, ambulatory surgical centers and some physician offices where surgical procedures are performed, patient acuity and the high likelihood of critical changes in patient status require more advanced skills and competencies to assure patient safety.

-Existing laws in Connecticut governing other unlicensed assistive personnel and medication administration

Except where specific exemptions have been made in statute, unlicensed assistive personnel are prohibited from administering medication to patients. The exceptions are noted below. Injections and intravenous administration are not permitted in these settings and medication must be administered by trained individuals who have successfully completed approved medication administration training programs that are prescribed in state law or regulation and are typically 30 to 40 hours long.

- Medication administration provided by trained persons who have successfully completed an approved medication administration training program to clients in day programs and residential facilities under the jurisdiction of the Departments of Children and Families, Corrections, Developmental Services and Mental Health and Addiction Services.

- A licensed physician who specializes in ophthalmology may delegate to an appropriately trained medical assistant the use or application of any ocular agent, provided such delegated service is performed only under the supervision, control and responsibility of the licensed physician. For purposes of this section, "appropriately trained medical assistant" means a medical assistant who has completed on-the-job training in the use and application of ocular agents under the supervision, control and responsibility of an employing, licensed physician, an affidavit in support of which shall be kept by the employing physician on the premises.

- A licensed optometrist may delegate to an optometric assistant, optometric technician or appropriately trained person the use and application of any ocular agent, provided such delegated service is performed only under the supervision, control and responsibility of the licensed optometrist. "Optometric assistant" means a person who has either completed two hundred hours of on-the-job training, an affidavit in support of which shall be kept by the employing optometrist on the premises, or graduated from a vocational program in optometric technicianry. "Optometric technician" means a person who has either completed a two-year college program in optometric technicianry, or passed the national optometric technician registration examination given by The American Optometric Association. "Appropriately trained person" means a person who has completed on-the-job training in the use and application of ocular agents under the supervision, control and

responsibility of an employing, licensed optometrist, an affidavit in support of which shall be kept by the employing optometrist on the premises.

- Unlicensed personnel may administer medication to residents in licensed residential care homes provided the unlicensed personnel are certified and comply with all requirements within the residential care home licensure regulations, and the facility has written policies and procedures governing the administration of medications. Upon completion of medication administration training and prior to the administration of any medication to clients, program staff must successfully complete a written examination and practicum. Medication is administered based on the written order of an authorized prescriber and the written permission of the resident (or resident's conservator, guardian, or legal representative).

- Unlicensed home health care aides may administer medication to patients in their homes as delegated by a licensed registered nurse provided the aide has completed an approved training program, is deemed competent to administer medications by the delegating registered nurse, and the registered nurse completes an initial patient assessment to determine that it is safe for the aide to administer medication to the patient and periodically assesses the patient in accordance with statutory provisions. Home health care aides are certified in medication administration by the training program provider.

-Types of medications to be administered

The initial scope of practice request did not include any limitations on the types of medications to be administered by medical assistants. Committee discussions identified concerns related to whether medical assistants should be excluded from administering anesthetic agents and controlled substances in Schedules I, II and III. Reasons cited include, but are not limited to, the potential for abrupt and critical alterations of patient physiology that demands more advanced training as administration of these substances requires critical thinking to assess the patient, determine/evaluate appropriate choice of medication, route of administration and appropriate dosing.

-Method/route of administration

The initial scope of practice request included the administration of medication orally or by inhalation and intramuscular, intradermal and subcutaneous injections. Committee discussions identified concerns related to whether medical assistants should be excluded from specific routes of administration. Reasons cited include, but are not limited to, the potential sudden alteration in patient status that demands more advanced training.

Physician members of the committee clarified that they would be amenable to the following provisions:

- skin injections that are subcutaneous, intradermal or intramuscular, limited to the upper and lower extremities and the back;
- topical application to skin unlimited with respect to location on the body; and
- application via intranasal, ocular, aural, oral and inhaled routes.

-*Public perception*

If this proposal is enacted, only those medical assistants who administer medications will be required to hold and maintain certification. Committee members discussed concerns regarding how patients will know whether the medical assistant in their physician's office is appropriately educated and trained. How will the public differentiate between medical assistants who are able to administer medications and those who are not? Although the majority of committee members supported the concept of requiring medical assistants to wear identification badges, other mechanisms to ensure that patients are aware of a practitioner's qualifications and the services that he or she may provide must be considered as a part of any proposal that moves forward.

Findings/Conclusion

The scope of practice review committee reviewed and evaluated all of the information provided in the scope of practice request submitted by the CSMA and the AAMA and the evidence they provided in support of the proposed changes, as well as additional information that was requested as a result of committee discussions. In reviewing and evaluating the information presented, the scope of practice review committee focused on assessing any public health and safety risks associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training.

Literature and other information reviewed and evaluated by the scope of practice review committee demonstrated that certified medical assistants are educated and trained to engage in medication administration under the direct supervision of a licensed physician. Accredited education and training programs that lead to certification as a medical assistant have been in place for many years in Connecticut and other states and include coursework and clinical training in pharmacology and medication administration. The American Association of Medical Assistants and American Medical Technologists offer examination and certification programs that could be utilized in Connecticut as the

standard for medical assistants who are delegated the task of medication administration. Mandatory certification would ensure that all medical assistants who administer medication have met the same minimum qualifications

Medical assistants are able to administer medications under the direct supervision of a physician in most other states. Restrictions related to setting, types of medication and route of administration vary from state to state. Although no evidence was provided by the requesters to demonstrate that enactment of these changes in other states has enhanced quality and affordable care, it is anticipated that allowing medical assistants to administer medication, for example routine vaccinations, will enable physicians and nurses who may be practicing with them to see more patients and focus on assessment and clinical care. The potential impact on access to care that may result if this proposal is not enacted was not evaluated by the committee. Implementation of this scope of practice request would enhance the ability of certified medical assistants to practice to the full extent of the profession's education and training.

In reviewing and discussing all of the information provided, the majority of scope of practice review committee members agreed that the concerns that were identified regarding potential quality and safety risks associated with allowing licensed physicians to delegate medication administration to certified medical assistants can be addressed through legislation. While there are no specific recommendations as to whether or not this proposal should move forward, committee members agreed that the following issues must be addressed if a bill is raised and prior to any legislation being enacted:

- The term "physician" must be clearly defined to include only doctors of medicine (M.D.) and doctors of osteopathic medicine (D.O.).

- The term "certified medical assistant" must be defined and the law must clearly articulate the credentials an individual must hold in order to use that designation in Connecticut and to administer medications as delegated by a physician. Physicians must be aware of which tasks can be delegated and to whom such tasks can be delegated.

- The term "outpatient setting" must be defined and the law must clearly identify any settings that may be excluded (e.g., hospitals including emergency departments, ambulatory surgical centers, physician offices during routine surgical procedures).

- The term "direct supervision" must be clearly defined to require the physician to remain on the premises at all times that treatment orders for medication administration are being carried out by the medical assistant and be within reasonable proximity to the treatment room and able to observe, assess and take any necessary action regarding effectiveness, adverse reaction or any other emergency.

- Existing statutory provisions that currently allow medical assistants in ophthalmology and optometric practices to administer medication to patients under supervision should not be impacted or altered in any way.

- Any medications that should be excluded to assure patient safety must be clearly articulated (e.g., excluding certain substances such as anesthetic agents and controlled substances in Schedules I, II and III).

- Any exclusions related to routes of administration and limitations related to location on the body to assure patient safety must also be articulated (e.g., excluding intravenous administration and inhalation as routes of administration and limiting injections to extremities and the back).

- Mechanisms to ensure that patients are aware of a practitioner's qualifications and the services that he or she may provide must be considered.

Although the requesters are not opposed to establishing a new licensure category, allowing physicians to delegate medication administration to certified medical assistants can be accomplished through statutory recognition. Statutory recognition is another option that would ensure that all certified medical assistants who administer medication have met the same minimum qualifications related to competence and that they are practicing safely in accordance with a recognized scope of practice, and would have no cost to the state. Under the statutory recognition model, physicians who delegate medication administration to certified medical assistants are held accountable. The Department of Public Health would have no authority to take disciplinary action against the certified medical assistant. Although licensing fees generate revenue for the State's General Fund, there would be a fiscal impact to the Department of Public Health associated with implementing a new licensing program.

Draft statutory language was not provided for review by scope of practice review committee members. Should the Public Health Committee decide to raise a bill related to this scope of practice request, the Department of Public Health along with the organizations that were represented on the scope of practice review committee (the Connecticut Society of Medical Assistants, the American Association of Medical Assistants, the American Medical Technologists, the Connecticut State Medical Society , the Connecticut Association of Optometrists, the Connecticut Dermatology and Dermatologic Society, the Connecticut ENT Society, the Connecticut Urology Society, and the Connecticut Society of Eye Physicians, the Connecticut Hospital Association, the Connecticut Society for Respiratory Care and the Connecticut Association of Nurse Anesthetists) respectfully request the opportunity to work with the Public Health Committee on statutory language.

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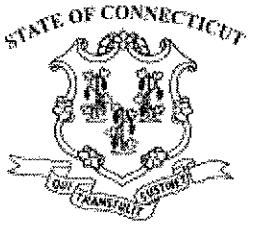

Substitute House Bill No. 6549

Public Act No. 11-209

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S OVERSIGHT RESPONSIBILITIES RELATING TO SCOPE OF PRACTICE DETERMINATIONS FOR HEALTH CARE PROFESSIONS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2011*) (a) Any person or entity, acting on behalf of a health care profession that seeks to establish a new scope of practice or change a profession's scope of practice, may submit a written scope of practice request to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(b) (1) Any written scope of practice request submitted to the Department of Public Health pursuant to subsection (a) of this section shall include the following information:

(A) A plain language description of the request;

(B) Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of any harm to public health and safety should the request not be implemented;

(C) The impact that the request will have on public access to health care;

(D) A brief summary of state or federal laws that govern the health care profession making the request;

(E) The state's current regulatory oversight of the health care profession making the request;

(F) All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request;

(G) A summary of known scope of practice changes either requested or enacted concerning the health care profession in the five-year period preceding the date of the request;

(H) The extent to which the request directly impacts existing relationships within the health care delivery system;

(I) The anticipated economic impact of the request on the health care delivery system;

(J) Regional and national trends concerning licensure of the health care profession making the request and a summary of relevant scope of practice provisions enacted in other states;

(K) Identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact and efforts made by the requestor to discuss the request with such health care professions; and

(L) A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.

(2) In lieu of submitting a scope of practice request as described in subdivision (1) of this subsection, any person or entity acting on behalf of a health care profession may submit a request for an exemption from the processes described in this section and section 2 of this act. A request for exemption shall include a plain language description of the request and the reasons for the request for exemption, including, but not limited to: (A) Exigent circumstances which necessitate an immediate response to the scope of practice request, (B) the lack of any dispute concerning the scope of practice request, or (C) any outstanding issues among health care professions concerning the scope of practice request can easily be resolved. Such request for exemption shall be submitted to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(c) In any year in which a scope of practice request is received pursuant to this section, not later than September fifteenth of the year preceding the commencement of the next regular session of the General Assembly, the Department of Public Health, within available appropriations, shall: (1) Provide written notification to the joint standing committee of the General Assembly having cognizance of matters relating to public health of any health care profession that has submitted a scope of practice request, including any request for exemption, to the department pursuant to this section; and (2) post any such request, including any request for exemption, and the name and address of the requestor on the department's web site.

(d) Any person or entity, acting on behalf of a health care profession that may be directly impacted by a scope of practice request submitted pursuant to this section, may submit to the department a written statement identifying the nature of the impact not later than October first of the year preceding the next regular session of the General Assembly. Any such person or entity directly impacted by a scope of practice request shall indicate the nature of the impact taking into consideration the criteria set forth in subsection (b) of this section and shall provide a copy of the written impact statement to the requestor. Not later than October fifteenth of such year, the requestor shall submit a written response to the department and any person or entity that has provided a written impact statement. The requestor's written response shall include, but not be limited to, a description of areas of agreement and disagreement between the respective health care professions.

Sec. 2. (NEW) (*Effective July 1, 2011*) (a) On or before November first of the year preceding the commencement of the next regular session of the General Assembly, the Commissioner of Public Health shall, within available appropriations allocated to the department, establish and appoint members to a scope of practice review committee for each timely scope of practice request submitted to the department pursuant to section 1 of this act. Committees established pursuant to this section shall consist of the following members: (1) Two members recommended by the requestor to represent the health care profession making the scope of practice request; (2) two members recommended by each person or entity that has submitted a written impact statement pursuant to subsection (d) of section 1 of this act, to represent the health care professions directly impacted by the scope of practice request; and (3) the Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, nonvoting member of the committee. The Commissioner of Public Health or the commissioner's designee shall serve as the chairperson of any such committee. The Commissioner of Public Health may appoint additional members to any committee established pursuant to this section to include representatives from health care professions having a proximate relationship to the underlying request if the commissioner or the commissioner's designee determines that such expansion would be beneficial to a resolution of the issues presented. Any member of such committee shall serve without compensation.

(b) Any committee established pursuant to this section shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. The committee, when carrying out the duties prescribed in this section, may seek input on the scope of practice request from the Department of Public Health

and such other entities as the committee determines necessary in order to provide its written findings as described in subsection (c) of this section.

(c) The committee, upon concluding its review and evaluation of the scope of practice request, shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The committee shall provide the written findings to said joint standing committee not later than the February first following the date of the committee's establishment. The committee shall include with its written findings all materials that were presented to the committee for review and consideration during the review process. The committee shall terminate on the date that it submits its written findings to said joint standing committee.

Sec. 3. (NEW) (*Effective July 1, 2011*) On or before January 1, 2013, the Commissioner of Public Health shall evaluate the processes implemented pursuant to sections 1 and 2 of this act and report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes, on the effectiveness of such processes in addressing scope of practice requests. Such report may also include recommendations from the committee concerning measures that could be implemented to improve the scope of practice review process.

Approved July 13, 2011

Medical Assistants 2012 Scope of Practice Review Committee Participants

Jennifer Filippone, Department of Public Health
Jennifer Lefkowski, Department of Public Health

Holly Martin, CMA, Connecticut Society of Medical Assistants
Donald Balasa, JD, MBA, Executive Director, Legal Counsel, American Association of Medical Assistants

Karen Buckley-Bates, Connecticut Hospital Association
Elizabeth Beaudin, PhD, Connecticut Hospital Association

Phillip Kerr, MD, Connecticut Dermatology & Dermatologic Surgery Society
Debbie Osborn, Executive Director, Connecticut Dermatology & Dermatologic Surgery Society

David Boisoneau, MD, Connecticut ENT Society
William Malitsky, Connecticut ENT Society

Art Tarrantino, MD, Connecticut Urology Society
Tom Buckley, MD, Connecticut Urology Society

Bill Ehlers, MD, Connecticut Society of Eye Physicians
David Emmel. MD, Connecticut Society of Eye Physicians

Howard Shaw, MD, Connecticut State Medical Society
Steve Levine, MD, Connecticut State Medical Society

Lisa Mariani, Connecticut Society for Respiratory Care
Susan Albino, Connecticut Society for Respiratory Care

Jerry Hardison, OD, Connecticut Association of Optometrists
Brian Lynch, OD, Connecticut Association of Optometrists

Robert Boston, RMA (AMT), American Medical Technologists
Catherine Dettey Valluzzo, RMS (AMT), American Medical Technologists

Ann Bassett, MS, CRNA, APRN, Connecticut Association of Nurse Anesthetists
Mike Dugan, Connecticut Association of Nurse Anesthetists

CONNECTICUT | Society of Medical Assistants

AN AFFILIATE OF THE AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

August 10, 2012

Jennifer L. Filippone, Chief
Practitioner Licensing and Investigations Section
Department of Public Health
401 Capitol Avenue, MS#12MQA
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Filippone:

Attached is a scope of practice request for the medical assisting profession submitted by the Connecticut Society of Medical Assistants (CSMA) and the American Association of Medical Assistants (AAMA).

It is the position of the CSMA and the AAMA that legislation is needed in Connecticut to permit physicians to delegate to formally educated and credentialed medical assistants working under their direct supervision in outpatient settings the administration of medication orally, by inhalation, and by intramuscular, intradermal, and subcutaneous injections. Such legislation would enhance the availability of health care for the people of Connecticut without decreasing the quality of such care or threatening the health and welfare of patients. Also, because medical assistants would continue to work under direct physician supervision (defined as the delegating/overseeing/supervising physician being on the premises and reasonably available in case of emergency), such legislation would not disrupt the current health care delivery system. Finally, such legislation—if similar to the injection regulation of the New Jersey Board of Medical Examiners (attached)—would not have to create a licensure mechanism for medical assistants, and therefore would not necessarily increase regulatory costs for the Department of Public Health or the State of Connecticut.

Thank you for your consideration. If you have questions about the attached scope of practice request, feel free to contact the following individuals:

Holly Martin, CMA (AAMA)
Public Policy Chair
CT Society of Medical Assistants
P.O. Box 124 Winchester Center, CT 06094
860/379-1235 hollyb5681@yahoo.com

Donald A. Balasa, JD, MBA
Executive Director, Legal Counsel
American Association of Medical Assistants
20 N. Wacker Drive, Suite 1575
Chicago, IL 60606
800/228-2262 dbalasa@aama-ntl.org

Very truly yours,

Donald A. Balasa

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

Scope of Practice Request for the Medical Assisting Profession in Connecticut
Submitted to the Connecticut Department of Public Health Pursuant to Public Act No. 11-209
Submitted by the Connecticut Society of Medical Assistants and the American Association of Medical Assistants
August 10, 2012

Holly Martin, CMA (AAMA)
Public Policy Chair
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860/379-1235 hollyb5681@yahoo.com

Donald A. Balasa, JD, MBA
Executive Director, Legal Counsel
American Association of Medical Assistants
800/228-2262 dbalasa@aama-ntl.org

(A) Plain language description of the request

Background: Medical assistants are allied health professionals educated and trained to work in outpatient settings (e.g., medical offices and clinics) under direct physician supervision. Direct physician supervision is defined in the laws of other states as the overseeing/delegating/supervising physician being on the premises and reasonably available, although not necessarily in the same room. Medical assistants do not work under *general* physician supervision, as do physician assistants and nurse practitioners, and are not educated and trained to work without direct physician supervision.

A scope of practice for medical assistants is not set forth in Connecticut statutes or regulations. (However, the Connecticut Department of Public Health (DPH), pursuant to Public Act 04-82, provides a list of Connecticut registrants who hold a current Certified Medical Assistant [CMA (AAMA)] credential granted by the Certifying Board of the American Association of Medical Assistants (AAMA).) Chapter 370, Section 20-9(a) of the General Statutes of Connecticut states that no person may practice medicine unless licensed under Section 20-10 of the statute. 20-9(b) lists exceptions to this prohibition. Medical assistants are not included in the list of exceptions.

The Connecticut Department of Public Health in a document entitled "Medical Assistant Information" provides informal advice about the duties physicians may delegate to medical assistants. In this document the DPH states that medical assistants may not be delegated "medication administration by any route (including oxygen, immunizations, and tuberculin testing)."

Request: The Connecticut Society of Medical Assistants and the American Association of Medical Assistants request that the Connecticut General Assembly enact legislation that would enable licensed physicians to delegate:
(1) the administration of medication orally or by inhalation; and
(2) the administration of intramuscular, intradermal, and subcutaneous injections (including vaccinations/immunizations)
to medical assistants working under their direct supervision (as defined above) in outpatient settings who:
(1) have graduated from an accredited, postsecondary medical assisting program that is accredited by either the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accredited Bureau of Health Education Schools (ABHES)—the only academic accrediting bodies that are recognized by either the United States Department of Education or the Council for High Education Accreditation; and
(2) have a current medical assisting credential acceptable to, and recognized by, the Connecticut Medical Examining Board and the Connecticut Department of Public Health.

Licensure not necessarily required to fulfill this request: Although the above request could be fulfilled by creating a licensure mechanism for medical assistants, licensure is not absolutely required to meet this request. For example, New Jersey has a provision in the regulations of the New Jersey Board of Medical Examiners that permits physicians to delegate certain injections to medical assistants who meet educational and credentialing requirements (see attached). However, there is no licensure mechanism for these medical assistants. Rather, the provisions of the New Jersey medical assisting regulation are enforced by requiring licensed physicians to delegate medication administration only to medical assistants meeting the requirements of the regulation. Physicians who do not abide by the provisions of the regulation are subject to discipline by the New Jersey Board of Medical Examiners.

(B) Potential public health and safety benefits, and potential harm to public health and safety, should the request not be implemented

If a law described immediately above were enacted, the people of Connecticut would benefit by having greater access to, and availability of, health care. Under current law, physicians are restricted in the categories of allied health professionals to whom they may delegate medication administration. Allowing physicians to delegate certain types of medication administration to educated and credentialed medical assistants would increase the supply of allied health professionals, and consequently the efficiency of the provision of health care. This would enable physicians to see a greater number of patients in a shorter time, without any diminishment of the quality of care provided to patients.

If the above request for legislation were not granted, the Connecticut health system, delegating physicians, and patients would be deprived of the efficiencies of fully utilizing competent and

knowledgeable medical assistants. In other words, the availability of health care involving certain types of medication administration would be less than it would be if educated and credentialed medical assistants were able to use their full range of abilities under direct physician supervision.

(C) The impact on public access to health care

See (B) immediately above.

(D) Summary of state and federal laws regarding medical assisting

There are no federal laws that have a direct bearing on medical assistants and their scope of practice in regard to medication administration.

Most state laws permit physicians to delegate to unlicensed allied health professionals (such as medical assistants) working under their direct supervision in outpatient settings any duties *except* those which:
(1) constitute the practice of medicine, or require the skill and knowledge of a licensed physician;
(2) are restricted in state law to other health or allied health professionals;
(3) require the medical assistant to exercise independent professional judgment, or to make clinical assessments/evaluations.

Some states require medical assistants to meet educational and/or examinational requirements in order to be delegated certain "advanced" medical assisting duties. The New Jersey medical assisting regulation pertaining to injections has been discussed above. South Dakota requires medical assistants to have graduated from a formal, postsecondary educational program that meets the joint standards of the South Dakota Board of Medical and Osteopathic Examiners and the South Dakota Board of Nursing in order to be registered and to work as a medical assistant (see attached).

(E) Connecticut's current regulatory oversight of medical assisting

As stated above, Connecticut has no oversight of the medical assisting profession other than the Department of Public Health's position that medical assistants may not be delegated any administration of medication. As also stated above, the DPH makes available a list of Connecticut residents who hold the CMA (AAMA) certification awarded by the Certifying Board of the American Association of Medical Assistants.

(F) Current education, training, and examination requirements

There are no education, training, or examination requirements for medical assistants in Connecticut law, or in the laws of most other states.

(G) Scope of practice requests within the past five (5) years

There have been no scope of practice requests for medical assistants in Connecticut within the past five (5) years.

(H) The extent to which the request directly impacts existing relationships within the health care delivery systems

This request would only have an impact on the relationship of physicians as delegators to medical assistants, and medical assistants as delegatees of physicians. There would be no change in the requirement that medical assistants work under direct physician supervision. If the request were granted, physicians would be permitted to delegate certain types of medication administration to medical assistants meeting the educational and credentialing requirements. If the General Assembly enacts the requested legislation, physicians would continue to be able to delegate to *all* medical assistants (those who meet the educational and credentialing requirements and those who do not) the limited duties they are now permitted to delegate, such as taking vital signs, rooming patients, administrative tasks, and—as directed by the overseeing physician—entering data into the medical record.

(I) The anticipated economic impact of the request on the health care delivery system

As presented in B above, expanding the scope of delegation of physicians to medical assistants who meet the educational and credentialing requirements would increase the supply of allied health professionals to whom doctors could delegate medication administration. According to basic microeconomic principles, an increase in the supply of allied health professionals would permit the employers/supervisors of these delegatees to increase their output of medical care—especially medical care that involves medication administration.

It is important to note that this increase in supply of allied health professionals would not decrease the quality of health care, and thus would not jeopardize the health, safety, and welfare of Connecticut patients. This is due to the fact that, under the proposed legislative request, only educated and currently credentialed medical assistants would be permitted to be delegated the administration of medication.

(J) National trends in state medical assisting laws

In addition to the aforementioned laws in New Jersey and South Dakota, there are statutory and/or regulatory provisions that establish requirements for medical assisting scope of practice in California, Washington, and Arizona. Legislation was signed into law in Washington in 2012. Laws from these states are attached.

(K) Health care professions that may be directly impacted by the request

Physicians would be directly impacted by this scope of practice request. The Connecticut Society of Medical Assistants is working closely with the Connecticut State Medical Society on this request, and therefore no significant opposition from organized medicine is anticipated.

Registered nurses (RNs) and licensed practical nurses (LPNs) sometimes work under physician supervision in outpatient settings and are delegated administration of medication. Consequently, this scope of practice request could have an *indirect* impact on RNs and LPNs. This request stipulates that medical assistants must graduate from a postsecondary, programmatically accredited (by either CAAHEP or ABHES) medical assisting program and receive either a one-year certificate or diploma or a two-year associate's degree in order to be delegated administration of medication. The CAAHEP and ABHES accreditation standards for medical assisting programs are somewhat comparable to the accreditation standards for LPN programs. Once this fact is brought to the attention of the Connecticut Board of Nursing and the nursing societies in this state, it is not anticipated that there will be significant nursing opposition to legislation embodying this scope of practice request.

(L) How this request relates to the ability of educated and suitably credentialed medical assistants to practice to the full extent of the profession's education and training

There are 23 medical assisting programs in Connecticut that are accredited by either CAAHEP or ABHES. Graduates of these programs have been taught the didactic knowledge necessary to safely perform medication administration, including intramuscular, intradermal, and subcutaneous injections. In addition, they have been required to demonstrate psychomotor competence in these procedures in order to graduate—even though this psychomotor competence can only be demonstrated on mannequins, not live subjects, because of the Connecticut law.

The current state of Connecticut law is preventing these educated and credentialed medical assistants from being delegated duties to the full extent of their education and training. This scope of practice request would remedy this situation, and would provide physicians and other employment decision makers with more options in the hiring of competent and knowledgeable allied health personnel. Most importantly, this scope of practice request would increase the availability of health care for Connecticut residents without lessening the quality of care they would be receiving.

Connecticut Association of Optometrists

35 Cold Spring Road, Suite 211
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860 529-1900
860 529-4411 (FAX)
www.cteyes.org

October 1, 2012

Ms. Jennifer L. Filippone
Chief, Practitioner Licensing and
Investigations Section
Department of Public Health
410 Capitol Avenue, MS #12MQA
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Filippone:

The Connecticut Association of Optometrists submits this impact statement with regard to a Scope of Practice proposal submitted by the Connecticut Society of Medical Assistants. As you know, the proposal in question would permit medical assistants to administer medications including those that would treat eye and vision disorders. We question whether an unlicensed profession such as medical assistants should be permitted to administer such critical patient care.

If you decide to create a scope of practice review committee, we would request that we be able to participate in the deliberations. Thank you.

Sincerely,

Brian T. Lynch, O.D.
Legislative Chair

CC: Holly Martin, CMA (AAMA)
Donald A. Balasa, JD, MBA (AAMA)

Connecticut Society for Respiratory Care

P.O. Box 130
Stratford, CT 06615-0130

October 1, 2012

Ms. Jennifer L. Filippone
Chief, Practitioner Licensing and
Investigations Section
Department of Public Health
410 Capitol Avenue, MS #12MQA
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Filippone:

The Connecticut Society for Respiratory Care (CTSRC) submits this impact statement with regard to a Scope of Practice proposal submitted by the Connecticut Society of Medical Assistants. As you know, the proposal in question would permit Medical Assistants to administer medications, including inhalation. The medical assistants are not trained to the level of other professions which administer inhaled meds as part of their scope of practice. Of all health care providers who deliver/teach the use of inhaled medications, Respiratory Therapists have the highest positive impact on the patient's ability to deliver the medication effectively (MDIs). Respiratory therapists are the experts when it comes to training and education in metered-dose inhaler techniques.

Further, we would question whether this is the appropriate forum to decide this issue. The scope of practice review law appears to relate to creating a new scope of practice or modifying an existing scope of practice for professions that are already licensed and recognized in statute. The profession of medical assistants is not licensed or regulated by the state.

Nonetheless, if you decide to create a review committee, the CTSRC would like to participate in it. We believe only individuals who have received comprehensive training and are competency tested should be administering inhaled medicines to patients. The Medical Assistant Society's proposal does not appear to contain sufficient guidelines that would ensure patient safety in this area.

Sincerely,

Susan Albino
President – CTSRC

CC: Holly Martin, CMA (AAMA)
Donald A. Balasa, JD, MBA (AAMA)

Connecticut Association of Nurse Anesthetists

October 1, 2012

Ms. Jennifer L. Filippone
Chief Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue
MS #12MQA
P.O. Box 340308
Hartford, CT 06134

RE: Scope of practice request for the medical assisting profession submitted by the Connecticut Society of Medical Assistants (CSMA) and the American Association of Medical Assistants (AAMA)

Dear Ms. Filippone:

The Connecticut Association of Nurse Anesthetists (CANA) has public safety concerns regarding the scope of practice request submitted by the Connecticut Society of Medical Assistants and the American Association of Medical Assistants. Specifically, CANA has concerns with physician delegation to formally educated and credentialed medical assistants working under their direct supervision in outpatient settings when it involves the administration of medication orally, by intramuscular, intradermal, and subcutaneous injections and by inhalation.

Therefore, CANA seeks clarification regarding medications administered by medical assistants under physician delegation. Connecticut's accredited training programs for Licensed Practical Nurses, Registered Nurses and Advance Practice Registered Nurses require rigorous training in critical thinking, while Medical Assistants are trained to follow directions. For that reason Medical Assistant's scope of practice as defined in various states' legislation and regulation, includes restrictions upon the administration of controlled substances[1], anesthetic agents [2], medications which require calculation of a dose[3], et cetera. Safety warrants that the medications medical assistants can administer be limited to exclude local anesthetics and controlled substances schedules II, III, IV and V. In addition, inhalation medication administration by medical assistants should specifically exclude inhalation anesthetics. These inhalation anesthetics are as follows: nitrous oxide, isoflurane, sevoflurane and desflurane.

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[1] NJ 13:35-6.4(d), Washington SB-6237§6(1)(f)(i)
[2] CA Bus&ProfCode § 2069
[3] SD 36-9B-1 et seq

The above mentioned drugs carry significant risks of untoward cardiac and respiratory side effects, including death, and are best administered by licensed providers with the necessary education and skills to administer such medications as are possessed by a Certified Registered Nurse Anesthetist (CRNA)/Advanced Practice Registered Nurse (APRN).

Thank you for your attention to this matter. Please feel free to contact me if you have any questions.

Sincerely,
Pauleen Consebido MS, CRNA, APRN
President, Connecticut Association of Nurse Anesthetists

377 Research Parkway Suite 2D
Meriden, CT 06450
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October 1, 2012

VIA E-MAIL: jennifer.filippone@ct.gov

Jennifer L. Filippone, Chief
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12MQA
PO Box 340308
Hartford, CT 06134

Dear Ms. Filippone:

This impact statement is respectfully submitted on behalf of the nearly 330 members of the Connecticut Chiropractic Association (CCA) practicing in Connecticut under the provisions of Chapter 372 of the General Statutes in response to the "Scope of Practice Request" submitted by the Connecticut Naturopathic Physicians Association (CNPA) on August 15, 2012.

The CCA offer the following comments on the scope of practice changes suggested by the CNPA. Other groups not as highly trained as the Naturopathic Physician can confuse the patient about their qualifications and are not licensed in Connecticut. The Naturopathic Physicians are best suited to assist a patient who wants to avoid medications and proceed to more natural healthcare. As such a DEA, Drug Enforcement Administration, number is required. Naturopathic Physicians are educated in Pharmacology and utilize this knowledge in their internships. They should have a scope of practice that is reflective of that knowledge and which is on par regionally with other New England states that have an expanded scope of practice.

If you move forward with a scope of practice review committee at the DPH on this particular proposal, CCA would respectfully request to be able to participate fully in the deliberations of the committee and be permitted to designate two members to the panel.

Respectfully Submitted,

Francis J. Vesci, DC
President

CONNECTICUT HOSPITAL ASSOCIATION

MEMORANDUM

TO: Jennifer L. Filippone, Chief
Practitioner Licensing and Investigation Section

FROM: James Iacobellis, Senior Vice President, Government and Regulatory Affairs

DATE: September 28, 2012

SUBJECT: Impact Statement – Scope of Practice Request – Medical Assistants

CHA, a trade association representing Connecticut's 29 acute care hospitals, submits this impact statement, in accordance with Chapter 368a of the Connecticut General Statutes, in response to the scope of practice change requested by the Connecticut Society of Medical Assistants (CSMA) and the American Association of Medical Assistants (AAMA). CSMA and AAMA are requesting to establish a scope of practice for medical assistants that would allow physicians in Connecticut to delegate to medical assistants, under direct supervision, the administration of medication orally, by inhalation, and intramuscular, intradermal, and subcutaneous injections.

Connecticut hospitals employ or utilize a multitude of healthcare professionals with varying scopes of practice. Any change in the scope of practice for medical assistants could impact the scope of practice for practitioners employed or utilized by a hospital.

If the Department appoints a Scope of Practice Review Committee, CHA respectfully requests an appointment to the Committee.

JDI:kbb
By e-mail

Connecticut State Medical Society
FOUNDED IN 1792

160 St. Ronan Street, New Haven, CT 06511-2390 (203) 865-0587 FAX (203) 865-4997

October 1, 2012

Jennifer L. Filippone, Chief
Practitioner Licensing and Investigations Section
410 Capitol Avenue, MS # 12MQA
P.O. Box 340308
Hartford, CT 06134

Dear. Ms. Filippone:

On behalf of the more than 7,000 physicians and physician in training members of the Connecticut State Medical Society (CSMS) we submit these comments regarding the Connecticut Society of Medical Assistants (CSMA) and the American Association of Medical Assistants (AAMA) submission as consistent with the requirements of Public Act 11-209.

You currently have before you an impact statement submitted by CSMA and AAMA. These organizations have provided comprehensive and significant information as to why the proposal is in the best interest of public health and safety by permitting physicians to delegate to formally educated and credentialed medical assistants working under their direct supervision in outpatient settings the administration of medication orally, by inhalation, and by intramuscular, intradermal, and subcutaneous injections. CSMS supports the intent of the submission before you. We fully understand the potential significance such a change in an established scope of practice could have. Therefore we respectfully request the establishment of a scope of practice review committee with the appropriate representation from CSMS.

Thank you for the opportunity to submit these comments in support to this submission.

Sincerely,

John Foley, M.D.
President

AMT
American Medical Technologists
Certifying Excellence in Allied Health

Michael N. McCarty, Legal Counsel
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September 25, 2012

Jennifer L. Filippone, Chief
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12MQA
P.O. Box 340308
Hartford, CT 06134

RE: Comments on Scope of Practice Request for Medical Assistants

Dear Ms. Filippone:

American Medical Technologists (AMT) submits this letter and attached materials in support of the Scope of Practice Request for the Medical Assisting Profession that was submitted under date of August 10, 2012, by the Connecticut Society of Medical Assistants and the American Association of Medical Assistants (collectively, "AAMA"). AAMA's request was made pursuant to Public Act 11-209, *An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to Scope of Practice Determinations for Health Care Professions*.

AMT is a national nonprofit certification organization and professional society for allied health personnel that was founded in 1939. Headquartered in Rosemont, Illinois, AMT has approximately 51,000 active member-certificants nationally. Of AMT's active members, a majority – about 31,000 – are certified as Registered Medical Assistants (RMAs). AMT began certifying RMAs in 1972. Like the AAMA's certification program for Certified Medical Assistants [CMA(AAMA)], AMT's certification program for Registered Medical Assistants is fully accredited by the National Commission for Certifying Agencies (NCCA), the accrediting arm of the Institute for Credentialing Excellence.

AMT fully supports AAMA's request to establish a professional scope of practice for medical assistants (MAs) in Connecticut. Connecticut is among a very small minority of States that has failed to recognize a practice scope for MAs appropriate to the profession's education, training and skills. In fact, to our knowledge Connecticut is one of only two States nationally (the other being New York) where it has been expressly determined to be unlawful for MAs to administer non-intravenous injections – a core entry-level competency taught by every accredited education program for MAs.

We have attached a recently published article authored by the undersigned counsel for AMT, entitled "*The Lawful Scope of Practice of Medical Assistants – 2012 Update*." The article discusses and provides citations to the laws and regulations addressing the practice of medical assisting in the various states. You will note that the article singles out Connecticut as a state that is significantly "behind the times" with its policy towards MAs.

Also attached is a detailed outline of the AMT Registered Medical Assistant (RMA) Certification Examination Competencies and Construction Parameters. This document provides a content outline of the RMA(AMT) certification exam and a listing of many of the entry-level competencies for which the exam is designed to test.

In addition to supporting AAMA's scope of practice request, AMT requests the opportunity to nominate a member of any scope of practice review committee that the Department may appoint pursuant to Public Act 11-209 to evaluate AAMA's request.

In closing, AMT appreciates the opportunity to comment and urges the Department to act favorably on the Scope of Practice Request for the Medical Assisting Profession.[1]

Sincerely,

Michael N. McCarty
AMT Legal Counsel

Enclosures:

1. AMT Registered Medical Assistant (RMA) Certification Examination Competencies and Construction Parameters
2. *The Lawful Scope of Practice of Medical Assistants – 2012 Update*, AMT EVENTS (June 2012).

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[1] While AMT fully supports AAMA's request to establish a practice scope for MAs, and supports the requirement that MAs have a current medical assisting credential acceptable to the Department, AMT does not believe it necessary to limit the practice of medical assisting to graduates of education programs accredited by either the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES), as suggested by AAMA. AMT believes the Department should also accept graduates of formal medical assisting programs accredited by other organizations recognized by the U.S. Dept. of Education or the Council on Higher Education Accreditation (CHEA), provided that the program includes at least 720 clock-hours (or equivalent) of training in medical assisting, including a clinical externship of no less than 160 hours in duration.

cc: Christopher A. Damon, J.D., Executive Director
American Medical Technologists
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Donald A. Balasa, J.D., MBA, Executive Director
American Association of Medical Assistants
20 N. Wacker Drive, Suite 1575
Chicago, IL 60606

Memo to : Jennifer Filippone, MA Scope of Practice Committee

From: Martha Murray, JD, Connecticut Association of Nurse Anesthetists
Pauleen Consebido, RN, APRN, CRNA, President, CANA

Subject: Medical Assistant Scope of Practice Limits

Date: January 17, 2013

The application submitted by the Medical Assistants [MAs] requests that Connecticut physicians be permitted to delegate to MAs as follows:

(1) The administration of medication orally or by inhalation;

(2) The administration of intramuscular, intradermal, and subcutaneous injections (including vaccinations and injections)

Following a review of the content of training programs for Certified Medical Assistants and MA legislation from other states, the Connecticut Association of Nurse Anesthetists proposes the following exclusions from the practice of Medical Assistants in Connecticut to promote patient safety .

I. **Routes of administration excluded** from MA practice
   - A. Intravenous administration
   - B. Administration via inhalation
   - C. Rationale: The potential for sudden alteration in patient status demands more advanced training with these routes of administration.

II **Substances excluded** from MA administration
   - A. Anesthetic agents
   - B. Controlled substances Schedules I, II and III
   - C. Rationale: The potential for abrupt and critical alterations of patient physiology demands more advanced training. Administration of these substances requires critical thinking to determine/evaluate appropriate choice of medication, route of administration, and appropriate dosing. Immediate pre and post administration assessment is critically important.

III **Practice settings excluded** from MA practice
   - A. Hospitals, including the Emergency Department
   - B. Ambulatory surgical centers
   - C. Physicians offices during routine surgical procedures
   - D. Rationale: Patient acuity and the high likelihood of critical changes in patient status require more advanced training for practitioners. The proposed proximity of physician oversight is insufficient to assure patient safety in these settings.

Thank you for the opportunity to participate in the Scope of Practice Review Committee.

Curriculum Review Board of the American Association of Medical Assistants Endowment (CRB-AAMAE)

Content Requirements for CAAHEP Accredited Medical Assisting Programs

Taken from the 2003 Standards and Guidelines for Medical Assisting Educational Programs

To provide for student attainment of the Entry-Level Competencies for the Medical Assistant, the curriculum must include, as a minimum:

a. Anatomy and Physiology

(1) Anatomy and physiology of all body systems
(2) Common pathology/diseases
(3) Diagnostic/treatment modalities

b. Medical Terminology

(1) Basic structure of medical words
(2) Word building and definitions
(3) Applications of medical terminology

c. Medical Law and Ethics

(1) Legal guidelines/requirements for health care
(2) Medical ethics and related issues

d. Psychology

(1) Basic principles
(2) Developmental states of the life cycle
(3) Hereditary, cultural and environmental influences on behavior

e. Communication

(1) Principles of verbal and nonverbal communication
(2) Recognition and response to verbal and nonverbal communication
(3) Adaptations for individualized needs
(4) Applications of electronic technology
(5) Fundamental writing skills

f. Medical Assisting Administrative Procedures

(1) Basic medical assisting clerical functions
(2) Bookkeeping principles
(3) Insurance procedures and diagnostic coding
(4) Operational functions

g. Medical Assisting Clinical Procedures

(1) Asepsis and infection control
(2) Specimen collection and processing
(3) Diagnostic testing
(4) Patient care and instruction
(5) Pharmacology

(6) Medical emergencies
(7) Principles of IV therapy

h. Professional Components

(1) Personal attributes
(2) Job readiness
(3) Workplace dynamics
(4) Allied health professions and credentialing
(5) Provider level CPR certification and first aid training

Externship

(1) Supervised and unpaid
(2) Minimum of 160 contact hours
(3) Placement in an ambulatory health care setting
(4) Perform administrative and clinical procedures
(5) Completed prior to graduation

Curriculum Review Board of the American Association of Medical Assistants Endowment (CRB-AAMAE)

Entry Level Competencies for the Medical Assistant
Taken from the 2003 Standards and Guidelines for Medical Assisting Educational Programs

The Entry-Level Competencies for the medical assistant include, but are not limited to:

a. Administrative Competencies

(1) Perform Clerical Functions
- (a) Schedule and manage appointments
- (b) Schedule inpatient and outpatient admissions and procedures
- (c) Organize a patient's medical record
- (d) File medical records

(2) Perform Bookkeeping Procedures
- (a) Prepare a bank deposit
- (b) Post entries on a day sheet
- (c) Perform accounts receivable procedures
- (d) Perform billing and collection procedures
- (e) Post adjustments
- (f) Process credit balance
- (g) Process refunds
- (h) Post NSF checks
- (i) Post collection agency payments

(3) Process Insurance Claims
- (a) Apply managed care policies and procedures
- (b) Apply third party guidelines
- (c) Perform procedural coding
- (d) Perform diagnostic coding
- (e) Complete insurance claim forms

b. Clinical Competencies

(1) Fundamental Procedures
- (a) Perform handwashing
- (b) Wrap items for autoclaving
- (c) Perform sterilization techniques
- (d) Dispose of biohazardous materials

(2) Specimen Collection
- (a) Perform venipuncture
- (b) Perform capillary puncture
- (c) Obtain specimens for microbiological testing
- (d) Instruct patients in the collection of a clean-catch mid-stream urine
- (e) Instruct patients in the collection of fecal specimens

(3) Diagnostic Testing
- (a) Perform electrocardiography
- (b) Perform respiratory testing
- (c) **CLIA Waived Tests:**
  - (i) Perform urinalysis
  - (ii) Perform hematology testing
  - (iii) Perform chemistry testing
  - (iv) Perform immunology testing
  - (v) Perform microbiology testing

(4) Patient Care
- (a) Perform telephone and in-person screening
- (b) Obtain vital signs
- (c) Obtain and record patient history
- (d) Prepare and maintain examination and treatment areas
- (e) Prepare patient for and assist with routine and specialty examinations
- (f) Prepare patient for and assist with procedures, treatments, and minor office surgeries
- (g) Apply pharmacology procedures to prepare and administer oral and parenteral (excluding IV) medications
- (h) Maintain medication and immunization records
- (i) Screen and follow-up test results

General (May be addressed in administrative, clinical or both)

(1) Professional Communications
- (a) Respond to and initiate written communications
- (b) Recognize and respond to verbal communications
- (c) Recognize and respond to nonverbal communications
- (d) Demonstrate telephone techniques

(2) Legal Concepts
- (a) Identify and respond to issues of confidentiality
- (b) Perform within legal and ethical boundaries
- (c) Establish and maintain the medical record
- (d) Document appropriately
- (e) Demonstrate knowledge of federal and state health care legislation and regulations

(3) Patient Instruction
- (a) Explain general office policies
- (b) Instruct individuals according to their needs
- (c) Provide instruction for health maintenance and disease prevention
- (d) Identify community resources

(4) Operational Functions
- (a) Perform an inventory of supplies and equipment
- (b) Perform routine maintenance of administrative and clinical equipment
- (c) Utilize computer software to maintain office systems
- (d) Use methods of quality control

AMT
American Medical Technologists
Certifying Excellence in Allied Health

REGISTERED MEDICAL ASSISTANT CERTIFICATION EXAMINATION
COMPETENCIES AND CONSTRUCTION PARAMETERS

Number of Items	
	[Work Area]
	[Category]
	[Sub-category]
	[Competency]

86 **I. GENERAL MEDICAL ASSISTING KNOWLEDGE**

A. **Anatomy and Physiology**

1. Body systems

Identify the structure and function of the following systems:

a. skeletal
b. muscular
c. endocrine
d. urinary
e. reproductive
f. gastrointestinal
g. nervous
h. respiratory
I. cardiovascular/circulatory
j. integumentary
k. special senses

2. Disorders and diseases

Identify and define various:

a. disease processes
b. conditions or states of health
c. health-related syndromes

3. Wellness

a. Identify nutritional factors that are required for, or influence wellness
b. Identify factors associated with exercise that are required for, or influence wellness
c. Identify factors associated with lifestyle choices that are required for, or influence wellness

B. **Medical Terminology**

1. Word parts

a. Identify word parts: root, prefixes, and suffixes

2. Definitions

a. Define medical terms

3. Common abbreviations and symbols

a. Identify and understand utilization of medical abbreviations and symbols

4. Spelling

a. Spell medical terms accurately

C. **Medical Law**

1. Medical law

Identify and understand the application of:

a. types of consent used in medical practice
b. disclosure laws and regulations (including HIPAA Security and Privacy Acts, state and Federal laws)
c. laws, regulations, and acts pertaining to the practice of medicine
d. scope of practice acts regarding medical assisting
e. Patient Bill of Rights legislation

2. Licensure, certification, and registration

a. Identify credentialing requirements of medical professionals
b. Understand the application of the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88)

3. Terminology

a. Define terminology associated with medical law

D. **Medical Ethics**

1. Principles of medical ethics and ethical conduct

a. Identify and employ proper ethics in practice as a medical assistant
b. Identify the principles of ethics established by the American Medical Association
c. Identify and understand the application of the AMA Patient Bill of Rights
d. Recognize unethical practices and identify the proper response
e. Recognize the importance of professional development through continuing education

E. **Human Relations**

1. Patient relations

a. Identify age-group specific responses and support
b. Identify and employ professional conduct in all aspects of patient care
c. Understand and properly apply communication methods
d. Identify and respect cultural and ethnic differences
e. Respect and care for patients without regard for age, gender, sexual orientation, or socioeconomic level

2. Interpersonal relations

a. Employ appropriate interpersonal skills with:
   1. employer/administration
   2. co-workers
   3. vendors
   4. business associates

b. Observe and respect cultural diversity in the workplace

F. **Patient Education**

1. Patient instruction

Identify and apply proper written and verbal communication to instruct patients in:

a. health and wellness
b. nutrition
c. hygiene
d. treatment and medications
e. pre- and post-operative care
f. body mechanics
g. personal and physical safety

2. Patient resource materials

a. Develop, assemble, and maintain appropriate patient brochures and informational materials

3. Documentation

a. Understand and utilize proper documentation of patient encounters and instruction

51 **II. ADMINISTRATIVE MEDICAL ASSISTING**

A. **Insurance**

1. Terminology

a. Identify and define terminology associated with various insurance types in the medical office

2. Plans

a. Identify and understand the application of government, medical, disability, and accident insurance plans
b. Identify and appropriately apply plan policies and regulations for programs including:

   1. HMO, PPO, EPO, indemnity, open, etc.
   2. short-term and long-term disability
   3. Family Medical Leave Act (FMLA)
   4. Workers' Compensation
      a. Complete first reports
      b. Complete follow-up reports

5. Medicare (including Advance Beneficiary Notice (ABN))
6. Medicaid
7. CHAMPUS / Tricare and CHAMPVA

3. Claims

a. Complete and file insurance claims
   1. File claims for paper and Electronic Data Interchange
   2. Understand and adhere to HIPAA Security and Uniformity Regulations
b. Evaluate claims response
   1. Understand and evaluate explanation of benefits
   2. Evaluate claims rejection and utilize proper follow-up procedures

4. Coding

a. Identify HIPAA-mandated coding systems and references
   1. ICD-9-CM
   2. CPT
   3. HCPCS
b. Properly apply diagnosis and procedure codes to insurance claims

5. Insurance finance applications

a. Identify and comply with contractual requirements of insurance plans
b. Process insurance payments and contractual write-off amounts
c. Track unpaid claims
d. Generate aging reports

B. **Financial Bookkeeping**

1. Terminology

a. Understand terminology associated with medical financial bookkeeping

2. Patient billing

a. Maintain and explain physician's fee schedules
b. Collect and post payments
c. Manage patient ledgers and accounts
d. Understand and prepare Truth in Lending Statements
e. Prepare and mail itemized statements
f. Understand and employ available billing methods
g. Understand and employ billing cycles

3. Collections

a. Prepare aging reports and identify delinquent accounts
b. Perform skip tracing
c. Understand application of the Fair Debt Collection Practices Act
d. Identify and understand bankruptcy and small claims procedures
e. Understand and perform appropriate collection procedures

4. Fundamental medical office accounting procedures

   a. Employ appropriate accounting procedures
      1. Pegboard / double entry
      2. Computerized
   b. Perform daily balancing procedures
   c. Prepare monthly trial balance
   d. Apply accounts receivable and payable principles

5. Banking procedures

   a. Understand and manage petty cash account
   b. Prepare and make bank deposits
   c. Maintain checking accounts
   d. Reconcile bank statements
   e. Understand check processing procedures and requirements
      1. Non-sufficient finds (NSF)
      2. Endorsements
   f. Process payables and practice obligations
   g. Understand and maintain disbursement accounts

6. Employee payroll

   a. Prepare employee payroll
      1. Understand hourly and salary payroll procedures
      2. Understand and apply payroll withholding and deductions
   b. Understand and maintain payroll records
      1. Prepare and maintain payroll tax deduction/withholding records
      2. Prepare employee tax forms
      3. Prepare quarterly tax forms and deposits
   c. Understand terminology pertaining to payroll and payroll tax

7. Financial mathematics

   a. Understand and perform appropriate calculations related to patient and practice accounts

C. **Medical Receptionist / Secretarial / Clerical**

1. Terminology

   a. Understand and correctly apply terminology associated with medical receptionist and secretarial duties

2. Reception

   a. Employ appropriate communication skills when receiving and greeting patients
   b. Understand basic emergency triage in coordinating patient arrivals
   c. Screen visitors and sales persons arriving at the office
   d. Obtain patient demographics and information
   e. Understand and maintain patient confidentiality during check-in procedures
   f. Prepare patient record
   g. Assist patients into examination rooms

3. Scheduling

a. Employ appointment scheduling system
    1. Identify and employ various scheduling styles (wave, open, etc.)
b. Employ proper procedures for cancellations and missed appointments
c. Understand referral and authorization process
d. Understand and manage patient recall system
e. Schedule non-office appointments (hospital admissions, diagnostic tests, surgeries)

4. Oral and written communication

a. Employ appropriate telephone etiquette
b. Perform appropriate telephone
c. Instruct patients via telephone
d. Inform patients of test results per physician instruction
e. Receive, process, and document results received from outside provider
f. Compose correspondence employing acceptable business format
g. Employ effective written communication skills adhering to ethics and laws of confidentiality
h. Employ active listening skills

5. Records and chart management

a. Manage patient medical record system
b. Record diagnostic test results in patient chart
c. File patient and physician communication in chart
d. File materials according to proper system
    1. Chronological
    2. Alphabetical
    3. Problem-oriented medical records (POMR)
    4. Subject
e. Protect, store, and retain medical records according to proper conventions and HIPAA privacy regulations
f. Prepare and release private health information as required, adhering to state and Federal guidelines
g. Identify and employ proper documentation procedures adhering to standard charting guidelines

6. Transcription and dictation

a. Transcribe notes from dictation system
b. Transcribe letter or notes from direct dictation

7. Supplies and equipment management

a. Maintain inventory of medical / office supplies and equipment
b. Coordinate maintenance and repair of office equipment
c. Maintain equipment maintenance logs according to OSHA regulations

8. Computer applications

a. Identify and understand hardware components
b. Identify and understand application of basic software and operating systems

c. Recognize software application for patient record maintenance, bookkeeping, and patient accounting system
d. Employ procedures for integrity of information and compliance with HIPAA Security and Privacy regulations
    1. Encryption
    2. Firewall software and hardware
    3. Personnel passwords
    4. Access restrictions
    5. Activity logs

9. Office safety

a. Maintain office sanitation and comfort
b. Develop and maintain office safety manual
c. Develop emergency procedures and policies
d. Employ procedures in compliance with Occupational Safety and Health Administration (OSHA) guidelines and regulations
    1. Hazard communication
    2. Engineering and Work Practice Controls
    3. Employee training program
    4. Standard Precautions
e. Maintain records of biohazardous waste and chemical disposal

III. CLINICAL MEDICAL ASSISTING

A. **Asepsis**

1. Terminology

a. Know and understand terminology associated with asepsis

2. Bloodborne pathogens and Universal Precautions

a. Identify modes of transmission of infectious pathogens
b. Identify procedures that prevent transmission of infectious pathogens
c. Understand and apply state and Federal OSHA guidelines regarding bloodborne pathogens
d. Employ Universal Precautions when risk of contact with infectious pathogens
e. Develop and employ training of personnel regarding employee safety and bloodborne pathogens

3. Medical asepsis

a. Identify and employ aseptic procedures
    1. Understand proper hand washing procedures
    2. Understand and employ barrier precautions

4. Surgical asepsis

a. Identify and employ proper surgical aseptic techniques
    1. Understand and practice proper surgical hand wash
    2. Practice surgical antiseptic skin preparation

3. Understand and respect sterile field boundaries
4. Identify and employ appropriate sterile barrier procedures
5. Employ sterile glove techniques
6. Employ mask, gown, cap, eye protection, and drape techniques

B. **Sterilization**

1. Terminology

a. Define terminology associated with sanitization, disinfection, and sterilization, procedures

2. Sanitization

a. Identify procedures for sanitization
    1. Equipment
    2. Examining room
    3. Instruments
b. Identify chemicals used for sanitization

3. Disinfection

a. Identify procedures for disinfection
    1. Equipment
    2. Instruments
b. Identify chemicals used in disinfection

4. Sterilization

a. Identify appropriate procedures for sterilization of
    1. Instruments
    2. Surgical equipment
    3. Surgical towels, drapes, or dressings
    4. Solutions
b. Identify modes of sterilization
    1. Autoclave
    2. Chemical
    3. Gas
c. Utilize proper instrument and tray packaging for sterilization
d. Identify appropriate packaging materials used for sterilization
e. Identify quality control procedures
    1. Indicator strips
    2. Biological culture capsules
    3. Date labeling

5. Record keeping

a. Identify and employ record keeping procedures
    1. Sterilization logs
    2. Equipment cleaning and maintenance records

C. **Instruments**

1. Identification

a. Identify instrument classifications
b. Identify common and specialty instruments
c. Identify instrument parts
    1. Handles
    2. Locks
    3. Ratchets
    4. Serrations
    5. Teeth

2. Instrument use

a. Know the use of common instruments (hemostats, forceps, and scissors)
b. Identify instruments used for examinations (gynecological, pediatric, and physical examinations)

3. Care and handling

a. Understand the procedure for care of non-disposable instruments
    1. Sanitization
    2. Lubrication
    3. Sterilization
    4. Storage
b. Understand the proper procedure for discarding disposable instruments

D. **Vital signs and Mensurations**

1. Terminology
a. Define terminology associated with vital signs and mensurations

2. Blood pressure

a. Understand physiology of blood pressure measurement
b. Identify the steps in blood pressure measurement
c. Accurately determine systolic and diastolic pressures
d. Identify proper recording of blood pressure reading
e. Recognize normal and abnormal blood pressure readings

3. Pulse

a. Understand pulse physiology
b. Identify pulse points and appropriate use of each
c. Employ proper procedure for accurate pulse measurement
d. Record pulse measurement using accepted charting standards
e. Recognize normal values and deviations from normal

4. Respiration

a. Understand respiration cycle and physiology

b. Accurately observe and measure respiratory rate
c. Record respiratory rate using accepted charting standards
d. Recognize normal measurements and deviations from normal

5. Temperature

a. Identify types of thermometers and understand use of each
b. Understand the procedures for obtaining temperature measurements
    1. Aural
    2. Oral
    3. Rectal
    4. Axillary
c. Identify normal and abnormal temperature values for each method
d. Recognize fever classifications and emergent values for each age group
e. Record temperature measurements using accepted charting standards

6. Mensurations
a. Understand the significance of height and weight in relation to nutrition, health, and disease
b. Identify the steps to accurately measure patient height and weight
c. Identify proper procedures in measuring pediatric weight and length, chest and head circumference
d. Record mensurations using accepted charting standards
e. Recognize changes indicating normal versus deviation from normal

E. **Physical Examinations**

1. Medical history

a. Obtain patient history employing appropriate terminology and abbreviations
b. Differentiate between subjective and objective information
c. Understand and employ SOAP and POMR charting systems for recording information

2. Patient positions

a. Identify patient positions for examinations
    1. Sims', knee-chest, Fowler's, lithotomy
    2. Understand draping method for each position
b. Identify and define body positions
    1. Supine, prone, decubitus, dorsal recumbent

3. Methods of examination

a. Define methods of examination
    1. Auscultation
    2. Palpation
    3. Mensuration
    4. Percussion
b. Understand use of each examination method

4. Specialty examinations

Identify examination procedures in specialty practices

a. Pediatrics
    1. Apgar scores
    2. Growth charts
    3. Infant and child mensurations
        a. Length and weight
        b. Head and chest circumference
b. Obstetrics and gynecology
    1. Routine obstetrical examinations
        a. Fundal height
        b. Fetal heart tones
        c. Ultrasound
        d. Pregnancy tests: urine and serum
    2. Papanicolaou (PAP) smears
    3. Breast and pelvic examinations
c. Proctology
    1. Occult blood and guaiac stool examination
    2. Proctoscopy, sigmoidoscopy, and colonoscopy
d. Urology
    1. Urinalysis
    2. Cystoscopy
e. Radiologic / diagnostic imaging procedures

5. Visual acuity

a. Identify and perform procedures for measuring visual acuity in adult and pediatric patients
b. Identify and perform procedures for measuring color vision acuity
c. Identify normal measurements and deviations from normal

6. Allergy

a. Identify procedure for performing scratch test
b. Identify procedure for performing intradermal skin testing
c. Define RAST and MAST testing
d. Identify and perform allergy injections

7. Terminology

a. Define terminology associated with specialty examinations

F. **Clinical Pharmacology**

1. Terminology

a. Define terminology associated with pharmacology
b. Identify and define common prescription abbreviations

2. Parenteral medications

a. Identify steps in administering injections
    1. Intramuscular
    2. Subcutaneous
    3. Intradermal

4. Z-tract

b. Identify proper needle size and syringe for each injection type
c. Identify syringe parts
   1. Plunger and rubber stopper
   2. Tip (slip and Luer-Lok™)
   3. Flange
   4. Barrel
d. Identify available injection systems (Tubex and Carpuject®)
e. Identify injection sites and maximum volume for each
f. Perform calculations for dosages, including conversions
g. Perform 6 "rights" when dispensing medications
h. Identify medication availability
   1. Multidose vials
   2. Ampules
   3. Unit dose vials
   4. Pre-filled cartridge-needle units
i. Define hazards and prevention measures associated with parenteral medications
j. Understand proper disposal of parenteral equipment

3. Prescriptions

a. Identify and define drug schedules and legal prescription requirements for each
b. Understand procedures for completing prescriptions and authorization of medical refills
c. Identify and perform proper documentation of medication transactions

4. Drugs

a. Identify Drug Enforcement Agency regulations for ordering, dispensing, prescribing, storing, and documenting regulated drugs
b. Identify and define drug categories
c. Identify commonly used drugs
d. Identify and describe routes of medication administration
   1. Parenteral
   2. Rectal
   3. Topical
   4. Vaginal
   5. Sublingual
   6. Oral
   7. Inhalation
   8. Instillation
e. Demonstrate ability to use drug references (Physician's Desk Reference)

G. **Minor Surgery**

1. Surgical supplies

a. Identify instruments commonly used in minor surgery
b. Identify supplies commonly used in minor surgery (drapes, bandages, sutures, antiseptics, anesthetics, etc.)

2. Surgical procedures

a. Identify common surgical procedures
b. Identify surgical tray preparation
    1. Sterile drapes
    2. Sterile packs and containers
    3. Sterile set-up, aseptic preparation
c. Understand and perform surgical aseptic hand wash
d. Perform surgical skin preparation
e. Understand aseptic technique with sterile gloving
f. Identify potential contamination sources
g. Demonstrate respect for sterile field
h. Identify procedures to prevent transmission of bloodborne pathogens
I. Identify biohazard waste disposal procedures
j. Identify procedures for patient protection in laser and electrosurgery
k. Perform dressing and bandaging techniques
l. Understand post-operative patient and incision care
m. Perform suture and staple removal
n. Identify disinfection and maintenance procedures for surgical equipment

H. **Therapeutic Modalities**

1. Modalities

a. Identify procedures for heat treatments
    1. Hot pack
    2. Moist compress
    3. Heat lamp
    4. Paraffin bath
    5. Whirlpool bath
b. Identify procedures for cold treatments
    1. Ice pack
    2. Cold compress
c. Identify procedure for ultrasound treatments
d. Maintain familiarity with range-of-motion exercises
e. Recognize isotonic and isometric exercises

2. Alternative therapies

a. Identify and define alternative therapies
    1. Chiropractic
    2. Message
    3. Acupuncture and acupressure

3. Patient instruction

a. Instruct patients in the use of assistive devices
    1. Crutches and canes
    2. Wheelchairs
    3. Walkers
    4. Splints and slings
b. Instruct patients in home therapeutic treatments
c. Instruct patients in proper body mechanics

I. **Laboratory Procedures**

1. Safety

   a. Employ Universal Blood and Body Fluid Precautions
   b. Identify and comply with Occupational Safety and Health Administration (OSHA) Guidelines
      1. Material Safety Data Sheets
   c. Develop and maintain policy and procedures manual

2. Clinical Laboratory Improvement Amendments of 1988 (CLIA '88)

   a. Understand and comply with quality assurance regulations for
      1. Training
      2. Quality control procedures
      3. Proficiency testing
      4. Test verification
      5. Level of competency as pertains to medical assistants

3. Quality control program

   a. Follow testing protocols
   b. Maintain testing records and performance logs
   c. Perform daily equipment maintenance and calibration
   d. Perform daily control testing
   e. Monitor temperature controls
   f. Store reagents properly

4. Laboratory equipment

   a. Identify equipment commonly used in the laboratory
      1. Blood collection systems
      2. Microscope
      3. Analyzer equipment
      4. Centrifuge
      5. Incubator
      6. Sterilizer
   b. Identify equipment components
   c. Care for, and maintain equipment and supplies

5. Laboratory testing and specimen collection

   a. Identify procedures for specimen collection and handling of
      1. Urine (random, clean catch, timed, and drug screen)
      2. Blood (venipuncture and capillary stick)
      3. Throat culture swabs
      4. Stool for occult blood
      5. Sputum
      6. Spinal fluid
   b. Perform waived laboratory procedures
      1. Microhematocrit and hemoglobin
      2. Blood glucose by reagent or personal monitor
      3. Sedimentation rate

4. Urine human chorionic gonadotropin
5. Urine luteinizing hormone
6. Urinalysis by reagent dipstick
7. Prepare specimen slides for evaluation
8. Prepare culture plates for incubation

c. Know training requirements for moderate and complex laboratory procedures
d. Recognize normal and abnormal values of common laboratory results
e. Know common laboratory tests and proper patient preparation for each

6. Terminology

a. Define terminology associated with laboratory equipment, procedures, and results

J. **Electrocardiography** (ECG)

1. Standard, 12-lead electrocardiogram

a. Identify procedure for obtaining 12-lead electrocardiogram
1. Patient preparation
2. Lead placement
3. Identify leads and marking codes
4. Obtain electrocardiograph reading
b. Identify and eliminate artifacts
c. Identify cardiac cycle during electrocardiogram

2. Mounting techniques

a. Identify procedure for mounting readings
b. Recognize abnormal readings for mounting

3. Other electrocardiographic procedures

a. Identify rhythm strip
b. Identify treadmill examination (exercise ECG)
c. Identify Holter monitor

K. **First Aid and Emergency Response**

1. First Aid procedures

a. Identify criteria for, and steps in performing CPR and the Heimlich maneuver
b. Maintain emergency (crash) cart
c. Identify injuries, recognize emergencies, and provide appropriate response

2. Legal responsibilities

a. Understand protection and limits of the Good Samaritan Act
b. Understand scope of practice when providing First Aid
c. Understand mandatory reporting guidelines and procedures

TASK INVENTORY NOTE

The tasks included in this inventory are considered by American Medical Technologists to be representative of the medical assisting job role. This document should be considered dynamic, to reflect the medical assistant's current role with respect to contemporary health care. Therefore, tasks may be added, removed, or modified on an ongoing basis.

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Commission on Accreditation of Allied Health Education Programs

Standards and Guidelines

for the Accreditation of Educational Programs in Medical Assisting

Essentials/Standards initially adopted in 1969;
revised in 1971, 1977, 1984, 1991, 1999, 2003, 2008

Adopted by the
American Association of Medical Assistants
American Medical Association
and
Commission on Accreditation of Allied Health Education Programs

The Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredits programs upon the recommendation of the Medical Assisting Education Review Board (MAERB).

These accreditation **Standards and Guidelines** are the minimum standards of quality used in accrediting programs that prepare individuals to enter the medical assisting profession. Standards are the minimum requirements to which an accredited program is held accountable. Guidelines are descriptions, examples, or recommendations that elaborate on the Standards. Guidelines are not required, but can assist with interpretation of the Standards.

Standards are printed in regular typeface in outline form. *Guidelines* are printed in italic typeface in narrative form.

Preamble

The Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the American Association of Medical Assistants and American Medical Association cooperate to establish, maintain and promote appropriate standards of quality for educational programs in medical assisting and to provide recognition for educational programs that meet or exceed the minimum standards outlined in these accreditation **Standards and Guidelines**. Lists of accredited programs are published for the information of students, employers, educational institutions and agencies, and the public.

These **Standards and Guidelines** are to be used for the development, evaluation, and self-analysis of medical assisting programs. On-site review teams assist in the evaluation of a program's relative compliance with the accreditation Standards.

Description of the Profession: Medical assistants are multiskilled health professionals specifically educated to work in ambulatory settings performing administrative and clinical duties. The practice of medical assisting directly influences the public's health and well-being, and requires mastery of a complex body of knowledge and specialized skills requiring both formal education and practical experience that serve as standards for entry into the profession.

I. Sponsorship

A. Sponsoring Educational Institution

A sponsoring institution must be one of the following:

1. A sponsoring institution must be a post-secondary academic institution accredited by an institutional accrediting agency that is recognized by the U.S. Department of Education, and must be authorized under applicable law or other acceptable authority to provide a post-secondary program, which awards a minimum of a diploma/certificate at the completion of the program.

2. A foreign post-secondary academic institution acceptable to CAAHEP, and authorized under applicable law or other acceptable authority to provide a post-secondary education program, which awards a minimum of a diploma/certificate in medical assisting upon completion of the program.

B. Consortium Sponsor

1. A consortium sponsor is an entity consisting of two or more members that exists for the purpose of operating an educational program. In such instances, at least one of the members of the consortium must meet the requirements of a sponsoring educational institution as described in I.A.

2. The responsibilities of each member of the consortium must be clearly documented in a formal affiliation agreement or memorandum of understanding, which includes governance and lines of authority.

C. Responsibilities of Sponsor

The Sponsor must ensure that the provisions of these **Standards and Guidelines** are met.

II. Program Goals

A. Program Goals and Outcomes

There must be a written statement of the program's goals and learning domains consistent with and responsive to the demonstrated needs and expectations of the various communities of interest served by the educational program. The communities of interest that are served by the program must include, but are not limited to, students, graduates, faculty, sponsor administration, employers, physicians, and the public.

Program-specific statements of goals and learning domains provide the basis for program planning, implementation, and evaluation. Such goals and learning domains must be compatible with the mission of the sponsoring institution(s), the expectations of the communities of interest, and nationally accepted standards of roles and functions. Goals and learning domains are based upon the substantiated needs of health care providers and employers, and the educational needs of the students served by the educational program.

B. Appropriateness of Goals and Learning Domains

The program must regularly assess its goals and learning domains. Program personnel must identify and respond to changes in the needs and/or expectations of its communities of interest.

An advisory committee, which is representative of at least each of the communities of interest named in these **Standards**, must be designated and charged with the responsibility of meeting at least annually, to assist program and sponsor personnel in formulating and periodically revising appropriate goals and learning domains, monitoring needs and expectations, and ensuring program responsiveness to change.

C. Minimum Expectations

The program must have the following goal defining minimum expectations: "To prepare competent entry-level medical assistants in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains."

Programs adopting educational goals beyond entry-level competence must clearly delineate this intent and provide evidence that all students have achieved the basic competencies prior to entry into the field.

Nothing in this Standard restricts programs from formulating goals beyond entry-level competence.

III. Resources

A. Type and Amount

Program resources must be sufficient to ensure the achievement of the program's goals and outcomes. Resources must include, but are not limited to: faculty; clerical and support staff; curriculum; finances; offices; classroom, laboratory, and, ancillary student facilities; clinical affiliates; equipment; supplies; computer resources; instructional reference materials, and faculty/staff continuing education.

B. Personnel

The sponsor must appoint sufficient faculty and staff with the necessary qualifications to perform the functions identified in documented job descriptions and to achieve the program's stated goals and outcomes.

1. Program Director

a. Responsibilities: The program director must be responsible for program effectiveness, including outcomes, organization, administration, continuous review, planning and development.

b. Qualifications: The program director must have a minimum of an associate degree and instruction in educational theory and techniques.

The program director must be credentialed in medical assisting by a credentialing organization accredited by the National Commission for Certifying Agencies (NCCA) unless a full-time medical assisting faculty member is so credentialed.

The program director must have a minimum of three (3) years experience in healthcare, including a minimum of 40 hours of experience in an ambulatory healthcare setting performing or observing administrative and clinical procedures performed by medical assistants.

The program director must have teaching experience in postsecondary and/or vocational/technical education.

Program directors approved under previous CAAHEP *Standards* will continue to be approved only as long as they remain continuously employed in that position in the same program.

Instruction in educational theory and techniques may include college courses, seminars or in service sessions on topics such as learning theory, curriculum design, test construction, teaching methodology, or assessment techniques.

2. **Faculty and/or Instructional Staff**

a. Responsibilities: Faculty must utilize instructional plans, direct and assess student progress in achieving theory and performance requirements of the program.

b. Qualifications: Faculty must be knowledgeable in course content, as evidenced by education and/or experience, effective in directing and evaluating student learning and laboratory performance, and be prepared in educational theory and techniques.

3. **Practicum Coordinator**

a. Responsibilities: The Practicum Coordinator must select and approve appropriate Practicum sites; provide orientation for the on-site supervisors; and provide oversight of the Practicum experience, including on-site assessment of student experiences and the quality of learning opportunities at least once during each term students are assigned to the Practicum site.

b. Qualifications: The Practicum Coordinator must be knowledgeable in program curriculum, as evidenced by education and/or experience, and effective in evaluating student learning and performance.

The responsibilities of the Practicum Coordinator may be fulfilled by the Program Director, faculty member(s), or other qualified designee.

C. Curriculum

The curriculum must ensure the achievement of program goals and learning domains. Instruction must be an appropriate sequence of classroom, laboratory, and clinical activities. Instruction must be based on clearly written course syllabi that include course description, course objectives, methods of evaluation, topic outline, and competencies required for graduation, which must be provided prior to implementation of each segment of the curriculum.

1. **Content and Competencies**

The program must demonstrate that the content and competencies included in the program's curriculum meet or exceed those stated in the latest edition of the *MAERB Core Curriculum* (Appendix B).

Program length should be sufficient to ensure student achievement of the MAERB Core Curriculum.

Appropriate course sequencing is defined as a logical progression of learning.

2. Practicum

An unpaid, supervised practicum of at least 160 contact hours in an ambulatory healthcare setting, performing psychomotor and affective competencies, must be completed prior to graduation. On-site supervision of the student must be provided by an individual who has knowledge of the medical assisting profession.

The program should ensure that the practicum experience and instruction of students are meaningful and parallel in content and concept with the material presented in lecture and laboratory sessions. Sites should afford each student a variety of experiences.

D. Resource Assessment

The program must, at least annually, assess the appropriateness and effectiveness of the resources described in these **Standards**. The results of resource assessment must be the basis for ongoing planning and appropriate change. An action plan must be developed when deficiencies are identified in the program resources. Implementation of the action plan must be documented and results measured by ongoing resource assessment.

The format for resource assessments should be: Purpose statement, Measurement Systems, Dates of Measurement, Results, Analyses, Action Plans, and Follow-up.

IV. Student and Graduate Evaluation/Assessment

A. Student Evaluation

1. Frequency and purpose

Evaluation of students must be conducted on a recurrent basis and with sufficient frequency to provide both the students and program faculty with valid and timely indications of the students' progress toward and achievement of the competencies and learning domains stated in the curriculum.

"Validity" means that the evaluation methods chosen are consistent with the learning and performance objectives being tested. Methods of assessment are carefully designed and constructed to measure stated learning and performance objectives at the appropriate level of difficulty. Methods used to evaluate skills and behaviors are consistent with stated practicum performance expectations and designed to assess competency attainment.

2. Documentation

Records of student evaluations must be maintained in sufficient detail to document learning progress and achievements.

Documentation should include, but is not limited to, appropriate written, practical and/or oral evaluations of student achievement that are based on all components of the Core Curriculum for Medical Assistants.

B. Outcomes

1. Outcomes Assessment

The program must periodically assess its effectiveness in achieving its stated goals and learning domains. The results of this evaluation must be reflected in the review and timely revision of the program.

Outcomes assessment must include, but are not limited to: national credentialing examination(s) performance, programmatic retention/attrition, graduate satisfaction, employer satisfaction, job (positive) placement, programmatic summative measures. The program must meet the outcomes assessment thresholds established by the Medical Assisting Education Review Board.

"Positive placement" means that the graduate is employed full or part-time in a related field; and/or continuing his/her education; and/ or serving in the military.

"National credentialing examinations" are those accredited by the National Commission for Certifying Agencies (NCCA). Participation and pass rates on national credentialing examination(s) performance may be considered in determining whether or not a program meets the designated threshold, provided the credentialing examination(s) is/are available to be administered prior to graduation from the program.

2. Outcomes Reporting

The program must periodically submit to the MAERB the program goal(s), learning domains, evaluation systems (including type, cut score, and appropriateness), outcomes, its analysis of the outcomes, and an appropriate action plan based on the analysis.

Programs not meeting the established thresholds must begin a dialogue with the MAERB to develop an appropriate plan of action to respond to the identified shortcomings.

V. Fair Practices

A. Publications and Disclosure

1. Announcements, catalogs, publications, and advertising must accurately reflect the program offered.

   Catalogs and/or web sites should include the current curriculum and award granted by the medical assisting program.

2. At least the following must be made known to all applicants and students: the sponsor's institutional and programmatic accreditation status as well as the name, mailing address, web site address and phone number of the accrediting agencies; admissions policies and practices, including technical standards (when used); policies on advanced placement, transfer of credits, and credits for experiential learning; number of credits required for completion of the program; tuition/fees and other costs required to complete the program; policies and processes for withdrawal and for refunds of tuition/fees.

   The required language for publicizing the CAAHEP status of accreditation for medical assisting program can be found MAERB web site.

3. At least the following must be made known to all students: academic calendar, student grievance procedure, criteria for successful completion of each segment of the curriculum and for graduation, and policies and processes by which students may perform clinical work while enrolled in the program and that students must be supervised and not receive compensation for practicum.

4. The sponsor must maintain, and provide upon request, current and consistent information about student/graduate achievement that includes the results of one or more of the outcomes assessments required in these **Standards**.

   The sponsor should develop a suitable means of communicating to the communities of interest the achievement of students/graduates.

B. Lawful and Non-discriminatory Practices

All activities associated with the program, including student and faculty recruitment, student admission, and faculty employment practices, must be non-discriminatory and in accord with federal and state statutes, rules, and regulations. There must be a faculty grievance procedure made known to all paid faculty.

C. Safeguards

The health and safety of patients, students, and faculty associated with the educational activities of the students must be adequately safeguarded.

All activities required in the program must be educational and students must not be substituted for staff.

Safeguards may include OSHA and CDC guidelines, and any state, local or institutional guidelines/policies related to health and safety.

D. Student Records

Satisfactory records must be maintained for student admission, advisement, counseling, and evaluation. Grades and credits for courses must be recorded on the student transcript and permanently maintained by the sponsor in a safe and accessible location.

E. Substantive Change

The sponsor must report substantive change(s) as described in Appendix A to CAAHEP/MAERB in a timely manner. Additional substantive changes to be reported to MAERB, within the time limits prescribed, include:

1. Change in the institution's legal status or form of control;
2. Change/addition/deletion of courses that represent a significant departure in content;
3. Change in method of curriculum delivery;
4. Change of the degree or credential awarded;
5. Change of clock hours to credit hours or vice versa; and
6. Substantial increase/decrease in clock or credit hours for successful completion of a program.

Policies for reporting the above changes can be found in the MAERB Program Policy Manual.

F. Agreements

There must be a formal affiliation agreement or memorandum of understanding between the sponsor and all other entities that participate in the education of the students describing the relationship, roles, and responsibilities of the sponsor and that entity. Practicum agreements must include a statement that students must be supervised and must not receive compensation for services provided as a part of the Practicum.

These documents should be reviewed periodically to ensure the availability of resources for the provision of effective education.

APPENDIX A

Application, Maintenance and Administration of Accreditation

A. Program and Sponsor Responsibilities

1. Applying for Initial Accreditation

a. The chief executive officer or an officially designated representative of the sponsor completes a "Request for Accreditation Services" form and returns it to:

Medical Assisting Education Review Board
American Association of Medical Assistants Endowment
20 N. Wacker Drive, Suite 1575
Chicago, IL 60606

The "Request for Accreditation Services" form can be obtained from MAERB, CAAHEP, or the CAAHEP website at www.caahep.org.

Note: There is **no** CAAHEP fee when applying for accreditation services; however, individual committees on accreditation may have an application fee.

b. The program undergoes a comprehensive review, which includes a written self-study report and an on-site review.

The self-study instructions and report form are available from the MAERB. The on-site review will be scheduled in cooperation with the program and once the self-study report has been completed, submitted, and accepted by the MAERB.

2. Applying for Continuing Accreditation

a. Upon written notice from the MAERB, the chief executive officer or an officially designated representative of the sponsor completes a "Request for Accreditation Services" form, and returns it to:

Medical Assisting Education Review Board (MAERB)
American Association of Medical Assistants Endowment
20 N. Wacker Drive, Suite 1575
Chicago, IL 60606

b. The program may undergo a comprehensive review in accordance with the policies and procedures of the MAERB.

If it is determined that there were significant concerns with the on-site review, the sponsor may request a second site visit with a different team.

After the on-site review team submits a report of its findings, the sponsor is provided the opportunity to comment in writing and to correct factual errors prior to the MAERB forwarding a recommendation to CAAHEP.

3. Administrative Requirements for Maintaining Accreditation

a. The program must inform the MAERB and CAAHEP within a reasonable period of time (as defined by the MAERB and CAAHEP policies) of changes in chief executive officer, dean of health professions or equivalent position, and required program personnel.

b. The sponsor must inform CAAHEP and the MAERB of its intent to transfer program sponsorship. To begin the process for a Transfer of Sponsorship, the current sponsor must submit a letter (signed by the CEO or designated individual) to CAAHEP and the MAERB that it is relinquishing its sponsorship of the program. Additionally, the new sponsor must submit a "Request for Transfer of Sponsorship Services" form. The

MAERB has the discretion of requesting a new self-study report with or without an on-site review. Applying for a transfer of sponsorship does not guarantee that the transfer of accreditation will be granted.

c. The sponsor must promptly inform CAAHEP and the MAERB of any adverse decision affecting its accreditation by recognized institutional accrediting agencies and/or state agencies (or their equivalent).

d. Comprehensive reviews are scheduled by the MAERB in accordance with its policies and procedures. The time between comprehensive reviews is determined by the MAERB and based on the program's on-going compliance with the **Standards**; however, all programs must undergo a comprehensive review at least once every ten years.

e. The program and the sponsor must pay MAERB and CAAHEP fees within a reasonable period of time, as determined by the MAERB and CAAHEP respectively.

f. The sponsor must file all reports in a timely manner (self-study report, progress reports, annual reports, etc.) in accordance with MAERB policy.

g. The sponsor must agree to a reasonable on-site review date that provides sufficient time for CAAHEP to act on a MAERB accreditation recommendation prior to the "next comprehensive review" period, which was designated by CAAHEP at the time of its last accreditation action, or a reasonable date otherwise designated by the MAERB.

Failure to meet any of the aforementioned administrative requirements may lead to administrative probation and ultimately to the withdrawal of accreditation. CAAHEP will immediately rescind administrative probation once all administrative deficiencies have been rectified.

4. Voluntary Withdrawal of a CAAHEP- Accredited Program

Voluntary withdrawal of accreditation from CAAHEP may be requested at any time by the Chief Executive Officer or an officially designated representative of the sponsor writing to CAAHEP indicating: the last date of student enrollment, the desired effective date of the voluntary withdrawal, and the location where all records will be kept for students who have completed the program.

5. Requesting Inactive Status of a CAAHEP- Accredited Program

Inactive status may be requested from CAAHEP at any time by the chief executive officer or an officially designated representative of the sponsor writing to CAAHEP indicating the desired date to become inactive. No students can be enrolled or matriculated in the program at any time during the time period in which the program is on inactive status. The maximum period for inactive status is two years. The sponsor must continue to pay all required fees to the MAERB and CAAHEP to maintain its accreditation status.

To reactivate the program the chief executive officer or an officially designated representative of the sponsor must notify CAAHEP of its intent to do so in writing to both CAAHEP and the MAERB. The sponsor will be notified by the MAERB of additional requirements, if any, that must be met to restore active status.

If the sponsor has not notified CAAHEP of its intent to re-activate a program by the end of the two-year period, CAAHEP will consider this a "Voluntary Withdrawal of Accreditation."

B. CAAHEP and Committee on Accreditation Responsibilities – Accreditation Recommendation Process

1. After a program has had the opportunity to comment in writing and to correct factual errors on the on-site review report, the MAERB forwards a status of public recognition recommendation to the CAAHEP Board of Directors. The recommendation may be for any of the following statuses: initial accreditation, continuing accreditation, transfer of sponsorship, probationary accreditation, withhold accreditation, or withdraw accreditation.

The decision of the CAAHEP Board of Directors is provided in writing to the sponsor immediately following the CAAHEP meeting at which the program was reviewed and voted upon.

2. Before the MAERB forwards a recommendation to CAAHEP that a program be placed on probationary accreditation, the sponsor must have the opportunity to request reconsideration of that recommendation or to request voluntary withdrawal of accreditation. The MAERB reconsideration of a recommendation for probationary accreditation must be based on conditions existing both when the committee arrived at its recommendation as well as on subsequent documented evidence of corrected deficiencies provided by the sponsor.

   The CAAHEP Board of Directors' decision to confer probationary accreditation is not subject to appeal.

3. Before the MAERB forwards a recommendation to CAAHEP that a program's accreditation be withdrawn or that accreditation be withheld, the sponsor must have the opportunity to request reconsideration of the recommendation, or to request voluntary withdrawal of accreditation or withdrawal of the accreditation application, whichever is applicable. The MAERB reconsideration of a recommendation of withdraw or withhold accreditation must be based on conditions existing both when the MAERB arrived at its recommendation as well as on subsequent documented evidence of corrected deficiencies provided by the sponsor.

   The CAAHEP Board of Directors' decision to withdraw or withhold accreditation may be appealed. A copy of the CAAHEP "Appeal of Adverse Accreditation Actions" is enclosed with the CAAHEP letter notifying the sponsor of either of these actions.

   At the completion of due process, when accreditation is withheld or withdrawn, the sponsor's chief executive officer is provided with a statement of each deficiency. Programs are eligible to re-apply for accreditation once the sponsor believes that the program is in compliance with the accreditation **Standards**.

   Any student who completes a program that was accredited by CAAHEP at any time during his/her matriculation is deemed by CAAHEP to be a graduate of a CAAHEP-accredited program.

Appendix B

Core Curriculum for Medical Assistants
Medical Assisting Education Review Board (MAERB)
2008 Curriculum Plan

Foundations for Clinical Practice

Medical assistants graduating from programs accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) will demonstrate critical thinking based on knowledge of academic subject matter required for competence in the profession. They will incorporate the cognitive knowledge in performance of the psychomotor and affective domains in their practice as medical assistants in providing patient care.

I.C Cognitive (Knowledge Base)	I. P Psychomotor (Skills)	I. A Affective (Behavior)
I. Anatomy & Physiology 1. Describe structural organization of the human body 2. Identify body systems 3. Describe body planes, directional terms, quadrants, and cavities 4. List major organs in each body system 5. Describe the normal function of each body system 6. Identify common pathology related to each body system 7. Analyze pathology as it relates to the interaction of body systems 8. Discuss implications for disease and disability when homeostasis is not maintained 9. Describe implications for treatment related to pathology 10. Compare body structure and function of the human body across the life span 11. Identify the classifications of medications, including desired effects, side effects and adverse reactions 12. Describe the relationship between anatomy and physiology of all body systems and medications used for treatment in each	**I. Anatomy & Physiology** 1. Obtain vital signs 2. Perform venipuncture 3. Perform capillary puncture 4. Perform pulmonary function testing 5. Perform electrocardiography 6. Perform patient screening using established protocols 7. Select proper sites for administering parenteral medication 8. Administer oral medications 9. Administer parenteral (excluding IV) medications 10. Assist physician with patient care 11. Perform quality control measures 12. Perform CLIA waived hematology testing 13. Perform CLIA waived chemistry testing 14. Perform CLIA waived urinalysis 15. Perform CLIA waived immunology testing 16. Screen test results	**I. Anatomy & Physiology** 1. Apply critical thinking skills in performing patient assessment and care 2. Use language/verbal skills that enable patients' understanding 3. Demonstrate respect for diversity in approaching patients and families

II.C Cognitive (Knowledge Base)	II. P Psychomotor (Skills)	II. A Affective (Behavior)
II. Applied Mathematics 1. Demonstrate knowledge of basic math computations 2. Apply mathematical computations to solve equations 3. Identify measurement systems 4. Define basic units of measurement in metric, apothecary and household systems 5. Convert among measurement systems 6. Identify both abbreviations and symbols used in calculating medication dosages 7. Analyze charts, graphs and/or tables in the interpretation of healthcare results	**II. Applied Mathematics** 1. Prepare proper dosages of medication for administration 2. Maintain laboratory test results using flow sheets 3. Maintain growth charts	**II. Applied Mathematics** 1. Verify ordered doses/dosages prior to administration 2. Distinguish between normal and abnormal test results
III.C Cognitive (Knowledge Base)	**III. P Psychomotor (Skills)**	**III. A Affective (Behavior)**
III. Applied Microbiology/Infection Control 1. Describe the infection cycle, including the infectious agent, reservoir, susceptible host, means of transmission, portals of entry, and portals of exit 2. Define asepsis 3. Discuss infection control procedures. 4. Identify personal safety precautions as established by the Occupational Safety and Health Administration (OSHA) 5. List major types of infectious agents 6. Compare different methods of controlling the growth of microorganisms 7. Match types and uses of personal protective equipment (PPE) 8. Differentiate between medical and surgical asepsis used in ambulatory care settings, identifying when each is appropriate 9. Discuss quality control issues related to handling microbiological specimens 10. Identify disease processes that are indications for CLIA waived tests 11. Describe Standard Precautions, including: a. Transmission based precautions b. Purpose c. Activities regulated 12. Discuss the application of Standard Precautions with regard to:	**III. Applied Microbiology/Infection Control** 1. Participate in training on Standard Precautions 2. Practice Standard Precautions. 3. Select appropriate barrier/personal protective equipment (PPE) for potentially infectious situations 4. Perform handwashing 5. Prepare items for autoclaving 6. Perform sterilization procedures 7. Obtain specimens for microbiological testing 8. Perform CLIA waived microbiology testing	**III. Applied Microbiology/Infection Control** 1. Display sensitivity to patient rights and feelings in collecting specimens 2. Explain the rationale for performance of a procedure to the patient 3. Show awareness of patients' concerns regarding their perceptions related to the procedure being performed

a. All body fluids, secretions and excretions b. Blood c. Non intact skin d. Mucous membranes 13. Identify the role of the Center for Disease Control (CDC) regulations in healthcare settings.		

Applied Communications

Medical assistants graduating from programs accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) will demonstrate critical thinking based on knowledge of academic subject matter required for competence in the profession. They will incorporate cognitive knowledge in performance of psychomotor and affective domains in their practice as medical assistants in communicating effectively, both orally and in writing.

IV.C Cognitive (Knowledge Base)	IV. P Psychomotor (Skills)	IV. A Affective (Behavior)
IV. Concepts of Effective Communication 1. Identify styles and types of verbal communication 2. Identify nonverbal communication 3. Recognize communication barriers 4. Identify techniques for overcoming communication barriers 5. Recognize the elements of oral communication using a sender-receiver process 6. Differentiate between subjective and objective information 7. Identify resources and adaptations that are required based on individual needs, i.e., culture and environment, developmental life stage, language, and physical threats to communication 8. Recognize elements of fundamental writing skills 9. Discuss applications of electronic technology in effective communication 10. Diagram medical terms, labeling the word parts 11. Define both medical terms and abbreviations related to all body systems 12. Organize technical information and summaries 13. Identify the role of self boundaries in the health care environment 14. Recognize the role of patient advocacy in the practice of medical assisting 15. Discuss the role of assertiveness in effective professional communication 16. Differentiate between adaptive and non-adaptive coping mechanisms	**IV. Concepts of Effective Communication** 1. Use reflection, restatement and clarification techniques to obtain a patient history 2. Report relevant information to others succinctly and accurately 3. Use medical terminology, pronouncing medical terms correctly, to communicate information, patient history, data and observations 4. Explain general office policies 5. Instruct patients according to their needs to promote health maintenance and disease prevention 6. Prepare a patient for procedures and/or treatments 7. Demonstrate telephone techniques 8. Document patient care 9. Document patient education 10. Compose professional/business letters 11. Respond to nonverbal communication 12. Develop and maintain a current list of community resources related to patients' healthcare needs 13. Advocate on behalf of patients	**IV. Concepts of Effective Communication** 1. Demonstrate empathy in communicating with patients, family and staff 2. Apply active listening skills 3. Use appropriate body language and other nonverbal skills in communicating with patients, family and staff 4. Demonstrate awareness of the territorial boundaries of the person with whom communicating 5. Demonstrate sensitivity appropriate to the message being delivered 6. Demonstrate awareness of how an individual's personal appearance affects anticipated responses 7. Demonstrate recognition of the patient's level of understanding in communications 8. Analyze communications in providing appropriate responses/ feedback 9. Recognize and protect personal boundaries in communicating with others 10. Demonstrate respect for individual diversity, incorporating awareness of one's own biases in areas including gender, race, religion, age and economic status

Medical Business Practices

Medical assistants graduating from programs accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) will demonstrate critical thinking based on knowledge of academic subject matter required for competence in the profession. They will incorporate cognitive knowledge in performance of psychomotor and affective domains in their practice as medical assistants in the performance of medical business practices.

V.C Cognitive (Knowledge Base)	V. P Psychomotor (Skills)	V. A Affective (Behavior)
V. Administrative Functions 1. Discuss pros and cons of various types of appointment management systems 2. Describe scheduling guidelines 3. Recognize office policies and protocols for handling appointments 4. Identify critical information required for scheduling patient admissions and/or procedures 5. Identify systems for organizing medical records 6. Describe various types of content maintained in a patient's medical record 7. Discuss pros and cons of various filing methods 8. Identify both equipment and supplies needed for filing medical records 9. Describe indexing rules 10. Discuss filing procedures 11. Discuss principles of using Electronic Medical Record (EMR) 12. Identify types of records common to the healthcare setting 13. Identify time management principles 14. Discuss the importance of routine maintenance of office equipment	**V. Administrative Functions** 1. Manage appointment schedule, using established priorities 2. Schedule patient admissions and/or procedures 3. Organize a patient's medical record. 4. File medical records 5. Execute data management using electronic healthcare records such as the EMR 6. Use office hardware and software to maintain office systems 7. Use internet to access information related to the medical office 8. Maintain organization by filing 9. Perform routine maintenance of office equipment with documentation 10. Perform an office inventory	**V. Administrative Functions** 1. Consider staff needs and limitations in establishment of a filing system 2. Implement time management principles to maintain effective office function
VI.C Cognitive (Knowledge Base)	**VI. P Psychomotor (Skills)**	**VI. A Affective (Behavior)**
VI. Basic Practice Finances 1. Explain basic bookkeeping computations. 2. Differentiate between bookkeeping and accounting 3. Describe banking procedures 4. Discuss precautions for accepting checks. 5. Compare types of endorsement 6. Differentiate between accounts payable and accounts receivable	**VI. Basic Practice Finances** 1. Prepare a bank deposit 2. Perform accounts receivable procedures, including: a. Post entries on a daysheet b. Perform billing procedures c. Perform collection procedures d. Post adjustments e. Process a credit balance	**VI. Basic Practice Finances** 1. Demonstrate sensitivity and professionalism in handling accounts receivable activities with clients

7. Compare manual and computerized bookkeeping systems used in ambulatory healthcare 8. Describe common periodic financial reports 9. Explain both billing and payment options. 10. Identify procedure for preparing patient accounts 11. Discuss procedures for collecting outstanding accounts 12. Describe the impact of both the Fair Debt Collection Act and the Federal Truth in Lending Act of 1968 as they apply to collections 13. Discuss types of adjustments that may be made to a patient's account	f. Process refunds g. Post non-sufficient fund (NSF) checks. h. Post collection agency payments. 3. Utilize computerized office billing systems	
VII.C Cognitive (Knowledge Base)	**VII. P Psychomotor (Skills)**	**VII. A Affective (Behavior)**
VII. Managed Care/Insurance 1. Identify types of insurance plans 2. Identify models of managed care 3. Discuss workers' compensation as it applies to patients 4. Describe procedures for implementing both managed care and insurance plans 5. Discuss utilization review principles. 6. Discuss referral process for patients in a managed care program 7. Describe how guidelines are used in processing an insurance claim 8. Compare processes for filing insurance claims both manually and electronically 9. Describe guidelines for third-party claims 10. Discuss types of physician fee schedules 11. Describe the concept of RBRVS 12. Define Diagnosis-Related Groups (DRGs)	**VII. Managed Care/Insurance** 1. Apply both managed care policies and procedures 2. Apply third party guidelines 3. Complete insurance claim forms 4. Obtain precertification, including documentation 5. Obtain preauthorization, including documentation 6. Verify eligibility for managed care services	**VII. Managed Care/Insurance** 1. Demonstrate assertive communication with managed care and/or insurance providers 2. Demonstrate sensitivity in communicating with both providers and patients 3. Communicate in language the patient can understand regarding managed care and insurance plans
VIII.C Cognitive (Knowledge Base)	**VIII. P Psychomotor (Skills)**	**VIII. A Affective (Behavior)**
VIII. Procedural and Diagnostic Coding 1. Describe how to use the most current procedural coding system 2. Define upcoding and why it should be avoided 3. Describe how to use the most current diagnostic coding classification system 4. Describe how to use the most current HCPCS coding	**VIII. Procedural and Diagnostic Coding** 1. Perform procedural coding 2. Perform diagnostic coding	**VIII. Procedural and Diagnostic Coding** 1.Work with physician to achieve the maximum reimbursement

Medical Law and Ethics

Medical assistants graduating from programs accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) will demonstrate critical thinking based on knowledge of academic subject matter required for competence in the profession. They will incorporate cognitive knowledge in performance of psychomotor and affective domains in their practice as medical assistants in providing patient care in accordance with regulations, policies, laws and patient rights.

IX.C Cognitive (Knowledge Base)	IX. P Psychomotor (Skills)	IX. A Affective (Behavior)
IX. Legal Implications 1. Discuss legal scope of practice for medical assistants 2. Explore issue of confidentiality as it applies to the medical assistant. 3. Describe the implications of HIPAA for the medical assistant in various medical settings 4. Summarize the Patient Bill of Rights 5. Discuss licensure and certification as it applies to healthcare providers 6. Describe liability, professional, personal injury, and third party insurance 7. Compare and contrast physician and medical assistant roles in terms of standard of care 8. Compare criminal and civil law as it applies to the practicing medical assistant. 9. Provide an example of tort law as it would apply to a medical assistant 10. Explain how the following impact the medical assistant's practice and give examples a. Negligence b. Malpractice c. Statute of Limitations d. Good Samaritan Act(s) e. Uniform Anatomical Gift Act f. Living will/Advanced directives g. Medical durable power of attorney 11. Identify how the Americans with Disabilities Act (ADA) applies to the medical assisting profession 12. List and discuss legal and illegal interview questions 13. Discuss all levels of governmental legislation and regulation as they apply to medical	**IX. Legal Implications** 1. Respond to issues of confidentiality 2. Perform within scope of practice 3. Apply HIPAA rules in regard to privacy/release of information 4. Practice within the standard of care for a medical assistant 5. Incorporate the Patient's Bill of Rights into personal practice and medical office policies and procedures 6. Complete an incident report 7. Document accurately in the patient record 8. Apply local, state and federal health care legislation and regulation appropriate to the medical assisting practice setting	**IX. Legal Implications** 1. Demonstrate sensitivity to patient rights 2. Demonstrate awareness of the consequences of not working within the legal scope of practice 3. Recognize the importance of local, state and federal legislation and regulations in the practice setting

assisting practice, including FDA and DEA regulations 14. Describe the process to follow if an error is made in patient care		
X.C Cognitive (Knowledge Base)	**X. P Psychomotor (Skills)**	**X. A Affective (Behavior)**
X. Ethical Considerations 1. Differentiate between legal, ethical, and moral issues affecting healthcare 2. Compare personal, professional and organizational ethics 3. Discuss the role of cultural, social and ethnic diversity in ethical performance of medical assisting practice 4. Identify where to report illegal and/or unsafe activities and behaviors that affect health, safety and welfare of others. 5. Identify the effect personal ethics may have on professional performance	**X. Ethical Considerations** 1. Report illegal and/or unsafe activities and behaviors that affect health, safety and welfare of others to proper authorities 2. Develop a plan for separation of personal and professional ethics	**X. Ethical Considerations** 1. Apply ethical behaviors, including honesty/integrity in performance of medical assisting practice 2. Examine the impact personal ethics and morals may have on the individual's practice 3. Demonstrate awareness of diversity in providing patient care

Safety and Emergency Practices

Medical assistants graduating from programs accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) will demonstrate critical thinking based on knowledge of academic subject matter required for competence in the profession. They will incorporate cognitive knowledge in performance of psychomotor and affective domains in their practice as medical assistants, applying quality control measures in following health and safety policies and procedures to prevent illness and injury.

X.C Cognitive (Knowledge Base)	X. P Psychomotor (Skills)	X. A Affective (Behavior)
XI. Protective Practices 1. Describe personal protective equipment 2. Identify safety techniques that can be used to prevent accidents and maintain a safe work environment 3. Describe the importance of Materials Safety Data Sheets (MSDS) in a healthcare setting 4. Identify safety signs, symbols and labels 5. State principles and steps of professional/provider CPR 6. Describe basic principles of first aid 7. Describe fundamental principles for evacuation of a healthcare setting 8. Discuss fire safety issues in a healthcare environment 9. Discuss requirements for responding to hazardous material disposal 10. Identify principles of body mechanics and ergonomics. 11. Discuss critical elements of an emergency plan for response to a natural disaster or other emergency 12. Identify emergency preparedness plans in your community 13. Discuss potential role(s) of the medical assistant in emergency preparedness	**XI. Protective Practices** 1. Comply with safety signs, symbols and labels. 2. Evaluate the work environment to identify safe vs. unsafe working conditions. 3. Develop a personal (patient and employee) safety plan. 4. Develop an environmental safety plan. 5. Demonstrate proper use of the following equipment: a. Eyewash b. Fire extinguishers c. Sharps disposal containers 6. Participate in a mock environmental exposure event with documentation of steps taken. 7. Explain an evacuation plan for a physician's office 8. Demonstrate methods of fire prevention in the healthcare setting 9. Maintain provider/professional level CPR certification. 10. Perform first aid procedures 11. Use proper body mechanics 12. Maintain a current list of community resources for emergency preparedness	**XI. Protective Practices** 1. Recognize the effects of stress on all persons involved in emergency situations 2. Demonstrate self awareness in responding to emergency situations

Senate Web Site
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Audio Archives
Deadlines
Rules
Seating
Briefs
Legislative Summary
Confirmations
Weekly Schedule
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Senate Lists
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Members
Live Proceedings
Deadlines
Rules
Seating
Legislative Summary
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State of Arizona

32-1456. Medical assistants; use of title; violation; classification

A. A medical assistant may perform the following medical procedures under the direct supervision of a doctor of medicine, physician assistant or nurse practitioner:

1. Take body fluid specimens.
2. Administer injections.

B. The board by rule may 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:

1. Billing and coding.
2. Verifying insurance.
3. Making patient appointments.
4. Scheduling.
5. Recording a doctor's findings in patient charts and transcribing materials in patient charts and records.
6. Performing visual acuity screening as part of a routine physical.
7. Taking and recording patient vital signs and medical history on medical records.

D. The board by rule shall prescribe medical assistant training requirements.

E. A person who uses the title medical assistant or a related abbreviation is guilty of a class 3 misdemeanor unless that person is working as a medical assistant under the direct supervision of a doctor of medicine, physician assistant or nurse practitioner.

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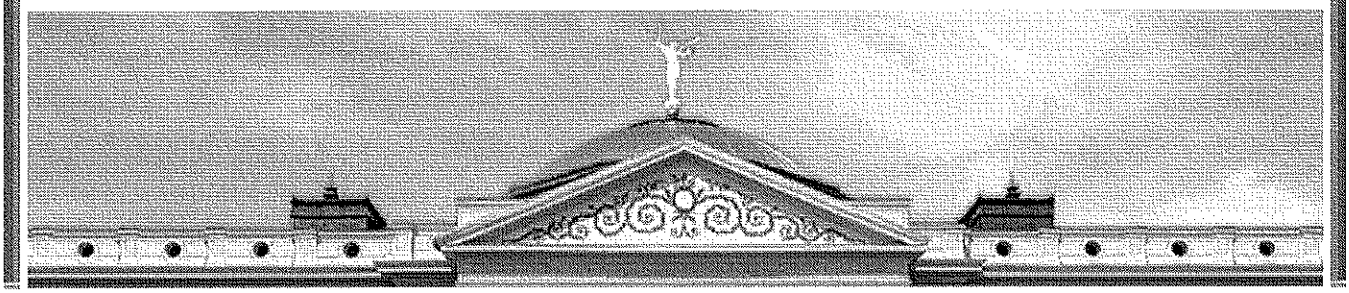

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File #88600-18821
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From the Statutes and Rules of the official website of the Arizona Medical Board (http://www.azmd.gov/):

R4-16-101. Definitions

Unless context otherwise requires, definitions prescribed under A.R.S. § 32-1401 and the following apply to this Chapter:
"Approved medical assistant training program" means a program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP); the Accrediting Bureau of Health Education Schools (ABHES); a medical assisting program accredited by any accrediting agency recognized by the United States Department of Education; or a training program designed and offered by a licensed allopathic physician that meets or exceeds any of the prescribed accrediting programs and verifies the entry-level competencies of a medical assistant prescribed under R4-16-402(A).

ARTICLE 4. MEDICAL ASSISTANTS

R4-16-401. Medical Assistant Training Requirements

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:

1. Completion of an approved medical assistant training program; or

2. 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.

B. This Section does not apply to any person who:

1. Before February 2, 2000:

a. Completed an unapproved medical assistant training program and was employed as a medical assistant after program completion; or

b. Was directly supervised by the same physician, physician group, or physician assistant for a minimum of 2000 hours; or

2. Completes a United States Armed Forces medical services training program.

R4-16-402. Authorized Procedures for Medical Assistants

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, Illinois 60601, www.caahep.org, or the Arizona Medical Board at 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258, www.azmd.gov.

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:

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.

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Medical Assistants - Frequently Asked Questionsn

Define acceptable and appropriate training to practice as a medical assistant.

Prior to performing technical supportive services, a medical assistant shall receive training, as necessary, in the judgment of the supervising physician, podiatrist or instructor to assure the medical assistant's competence in performing that service at the appropriate standard of care.

Such training shall be administered in either of the following settings: 1) Under a licensed physician or podiatrist, or under a registered nurse, licensed vocational nurse, a physician assistant or a qualified medical assistant, or 2) in a secondary, post secondary, or adult education program in a public school authorized by the Department of Education, in a community college program provided for in the Education Code, or a post secondary institution accredited or approved by the Bureau for Private Postsecondary and Vocational Education in the Department of Consumer Affairs.

To administer medications by intramuscular, subcutaneous and intradermal injections, to perform skin tests, or to perform venipuncture or skin puncture for the purposes of withdrawing blood, a medical assistant shall complete the minimum training prescribed in the regulations. Training shall be for the duration required by the medical assistant to demonstrate to the supervising physician, podiatrist, or instructor, as referenced in 16 CCR Section 1366.3 (a)(2), proficiency in the procedures to be performed as authorized by section 2069 or 2070 of the code, where applicable, but shall include no less than:

10 clock hours of training in administering injections and performing skin tests, and/or

10 clock hours of training in venipuncture and skin puncture for the purpose of withdrawing blood, and

Satisfactory performance by the trainee of at least 10 each of intramuscular, subcutaneous, and intradermal injections and 10 skin tests, and/or at least 10 venipuncture and 10 skin punctures.

For those only administering medicine by inhalation, 10 clock hours of training in administering medical by inhalation.

Training in (a) through (d) above, shall include instruction and demonstration in:

pertinent anatomy and physiology appropriate to the procedures;

choice of equipment;

proper technique including sterile technique;

hazards and complications;

patient care following treatment or tests;

emergency procedures; and

California law and regulations for medical assistants

In every instance, prior to administration of medicine by a medical assistant, a licensed physician or podiatrist, or another appropriate licensed person shall verify the correct medication and dosage. The supervising physician or podiatrist must authorize any technical supportive services performed by the medical assistant and that supervising physician or podiatrist must be physically present in the treatment facility when procedures are performed, except as provided in section 2069(a) of the code.

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Are medical assistants required to be licensed or certified by the State of California to perform procedures within their "scope of practice"?

No. Medical assistants are not licensed, certified, or registered by the State of California. However, the medical assistant's employer and/or supervising physician's or podiatrist's malpractice insurance carrier may require that the medical assistant be certified by a national or private association. A medical assistant must be certified by one of the approved certifying organizations in order to train other medical assistants. (Title 16 CCR 1366.3)

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How may medical assistants legally "administer medications"?

The phrase intends to mean the direct application of medication in several ways including simple injections, ingestion and inhalation or pre -measured medications. For our purposes, the phrase "administer medications" when used regarding medical assistants, means to inject, handle, or provide medications to a patient after verification by a physician, podiatrist or another appropriate licensed person.

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Are medical assistants allowed to administer injections of scheduled drugs?

If after receiving the appropriate training as indicated in Item 1, medical assistants are allowed to administer injections of scheduled drugs only if the dosage is verified and the injection is intramuscular, intradermal or subcutaneous. The supervising physician or podiatrist must be on the premises as required in section 2069 of the Business and Professions Code, except as provided in subdivision (a) of that section. However, this does not include the administration of any anesthetic agent.

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Are medical assistants allowed to start or disconnect IV's or administer injections or medication into IV's?

No. Medical assistants may not place the needle or start and disconnect the infusion tube of an IV. These procedures are considered invasive, and therefore, not within the medical assistant's scope of practice. Medical assistants are not allowed to administer medications or injections into the IV line. (Title 16 CCR 1366(b)(1))

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Are medical assistants allowed to perform nasal smears?

Yes. Only if the procedure is limited to the opening of the nasal cavity.

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Are medical assistants permitted to perform "finger sticks"?

Yes. Medical assistants are trained and allowed to draw blood as long as they have received the proper training. The procedure of finger stick is the pricking of the finger in order to collect a sample of blood. This procedure is within the "scope of practice" of a medical assistant.

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Are medical assistants allowed to swab the throat in order to preserve the specimen in a throat culture?

Yes. Medical assistants are allowed to swab throats as long as the medical assistant has received the proper training and a physician or podiatrist is on the premises.

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Are medical assistants allowed to take a patient's blood pressure?

Yes. Medical assistants are allowed to take the necessary information to prepare a patient for the physician's or podiatrist's visit. This information may include taking the patient's height, weight, temperature, blood pressure and noting the information on the patient's chart.

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Are medical assistants allowed to give narcotic injections?

Yes. At this time there are no restrictions as to what type of medications a medical assistant may inject, EXCEPT anesthetic agents, as long as the medication has been pre-verified and the injection is either intradermal, intramuscular, or subcutaneous. (16 CCR 1366 (b) (1)). Both 1366 and Business and Professions Code section 2069 provide that they shall not be construed as authorizing the administration of any anesthetic agent by a medical assistant."

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Are medical assistants allowed to have access to the keys of the narcotic medication cabinet?

This question should be directed to the supervising physician or podiatrist as it is an "in-house" procedure and the decision must be made by the supervising physician or podiatrist.

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Are medical assistants allowed to chart pupillary responses?

No. The charting of pupillary responses is considered an assessment, which is a form of interpretation. Medical assistants are not allowed to read, interpret or diagnose symptoms or test results.

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Are medical assistants allowed to insert urine catheters?

No. Insertion of a urine catheter is considered an invasive procedure and therefore, not within the medical assistant's scope of practice.

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Are medical assistants allowed to perform telephone triage?

No. Medical assistants are not allowed to independently perform telephone triage as they are not legally authorized to interpret data or diagnose symptoms.

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Are medical assistants allowed to inject collagen?

No. The injection of collagen does not fall within the medical assistant's scope of practice. 16 CCR section 1366.4 states that medical assistants may inject "medications".

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Are medical assistants allowed to use lasers to remove hair, wrinkles, scars, moles or other blemishes?

No. Medical assistants are not legally authorized to use lasers to remove hair, wrinkles, scars, moles, or other blemishes.

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Are medical assistants allowed to administer chemotherapy and/or monitor patients?

No. Medical assistants are not legally authorized to administer chemotherapy or make an assessment of the patient as the procedure does not fall within the medical assistant's scope of practice.

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Are medical assistants allowed to apply orthopedic splints in emergency situations, such as splints in a physician's office?

No. Medical assistants are legally authorized only to remove casts, splints and other external devices. Placement of these devices does not fall within the medical assistant's scope of practice. Please reference CCR Section 1366(b)(3).

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Are medical assistants allowed to interpret the results of skin tests?

No. Medical assistants may measure and describe the test reaction and make a record in the patient's chart. For every questionable test result, the result should be immediately brought to the physician's attention. In addition, all results need to be reported to the appropriate provider. Please reference 16 CCR 1366(b)(2).

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Can medical assistants be supervised by a nurse practitioner, nurse midwife, or physicians assistant in the absence of a physician and surgeon?

Per Business and Professions Code section 2069 (a)(1), a supervising physician and surgeon at a "community clinic" licensed under Health and Safety Code section 1204(a) may, at his or her discretion, in consultation with the nurse practitioner, nurse midwife, or physician assistant provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. The written instructions may provide that the supervisory function for the medical assistant in performing these tasks or supportive services may be delegated to the nurse practitioner, nurse midwife, or physician assistant and that those tasks may be performed when the supervising physician and surgeon is not on site.

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Can medical assistants call in refills to a pharmacy?

Yes. Under the direct supervision of the physician or podiatrist, a medical assistant may call in routine refills that are exact and have no changes in the dosage levels. The refill must be documented in the patient's chart as a standing order, patient specific. Medical assistants

may not call in new prescriptions or any prescriptions that have changes. The physician should view carefully his or her decision to allow medical assistants to perform this task, as the authority to prescribe or refill prescriptions is only granted to licensed physicians and surgeons, podiatrists, or those individuals authorized by law to do so.

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Can medical assistants perform hearing tests?

Yes. Medical assistants may perform hearing tests under the direct supervision of a licensed physician and surgeon or podiatrist. This procedure is within the scope of practice of a medical assistant. Per Business and Professions Code section 2530.5(a), "Nothing in this chapter shall be construed as restricting hearing testing conducted by licensed physicians and surgeons or by persons conducting hearing tests under the direct supervision of a physician and surgeon."

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Are medical assistants allowed to administer flu shots?

Yes. After receiving the appropriate training as indicated in the first question, medical assistants are allowed to administer influenza vaccinations in a clinic or physician's office settings. The dosage must be verified and the supervising practitioner must be on the premises as required in section 2069 of the Business and Professions Code, except as provided in subdivision (a) of that section.

However, if the shot is being provided at a local governmental or private, nonprofit agency the vaccine shall be administered only by a physician, a registered nurse, or a licensed vocational nurse acting within the scope of their professional practice acts. The physician under whose direction the registered nurse or a licensed vocational nurse is acting shall require the nurse to satisfactorily demonstrate familiarity with (1) contraindication for the administration of such immunizing agents, (2) treatment of possible anaphylactic reactions, and (3) the administration of treatment, and reactions to such immunizing agents. (Health & Safety section 104900(e))

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Medical Assistant Certifying Agencies Approved by the Medical Board

Laws, Regulations, and Current Information

Business and Professions Code Section 2544 Interpretation

Additional Information Regarding Medical Assistants

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SOUTH DAKOTA BOARD OF NURSING

MEDICAL ASSISTANTS

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.

["Direct supervision" of a medical assistant means supervision of all activities performed by the medical assistant. Should the physician be unable to provide on-site supervision, supervision by a properly supervised physician's assistant, nurse practitioner, or nurse midwife shall satisfy the medical assistant act's direct supervision requirements. SD Joint Boards Definition 06/1994.]

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
    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 medications by unit dosage
7. Performing basic laboratory procedures
8. Performing office procedures including all general administrative duties

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.

36-9B-4 Application for registration--Renewal--Fees. A medical assistant seeking registration under this chapter shall complete an application prescribed by the Board of Medical and Osteopathic Examiners and the Board of Nursing. The application shall be submitted to the Board of Medical and Osteopathic Examiners. A registration fee of ten dollars shall accompany the application and shall be paid to the Board of Medical and Osteopathic Examiners.
The registration shall be renewed biennially by payment of a fee of five dollars. A registration not renewed by December thirty-first of the year of expiration lapses.

36-9B-5 Registration by Board of Medical and Osteopathic Examiners. The Board of Medical and Osteopathic Examiners shall register a medical assistant following the submission of an application by an applicant for registration who has graduated from an accredited school or a school which meets standards similar to an accredited school and has met other qualifications established by the Board of Medical and Osteopathic Examiners and the Board of Nursing.
An applicant for registration is exempt from the requirements of this section if the application is received by the Board of Medical and Osteopathic Examiners by January 1, 1992.

36-9B-6 Out-of-state applicant. The Board of Medical and Osteopathic Examiners may register an applicant from outside the state whose education and training are substantially the same as that received from an approved school in this state and who meets the other qualifications established by the Board of Medical and Osteopathic Examiners and the Board of Nursing.

36-9B-7 Promulgation of rules for application and registration. The Board of Medical and Osteopathic Examiners and the Board of Nursing may adopt rules for medical assistants in the following areas:

1. Contents of applications
2. Qualifications of applicants
3. Approval of schools other than those which are accredited
4. Renewal of registration

[Note: No RULES outside of statute exist as of March 2004.]

36-9B-8 Revocation or suspension of registration--Committee. The registration of a medical assistant may be revoked or suspended upon violation of any section of this chapter. The proceedings for suspension or revocation of a registration may be initiated by a joint committee comprised of two members of the Board of Medical and Osteopathic Examiners and two

members of the Board of Nursing. All proceedings concerning the revocation or suspension of a registration shall conform to contested case procedure set forth in Chapter 1-26.

36-9B-9 Hospital privileges. Nothing in this chapter permits a medical assistant to provide services in a hospital licensed pursuant to chapter 34-12 unless the hospital has specifically granted such privileges.

Questions? Please contact
the South Dakota Board of Medical & Osteopathic Examiners
or the South Dakota Board of Nursing

MA Scope of Practice Determination by Joint Board of Nursing and Medical & Osteopathic Examiners

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:
    1. Does not include injection of insulin;
    2. Does not include arterial withdrawal of blood, but does include venous withdrawal of blood;
    3. 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
    4. Does not include patient education.

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

1. The medical assistant may report diagnostic lab findings to patients only after appropriate interpretation by the physician;
2. The medical assistant may only provide education information to the patient and may not perform health teaching or counseling;
3. The medical assistant may perform EKG's and glucose testing;
4. The medical assistant may not administer medications which require calculation of a dose;
5. [Reversed 9/95]
6. The medical assistant may only distribute pre-printed information to a patient on medications and inhalers;
7. The medical assistant may not administer nebulizer treatments and is only allowed to perform simple oxygen administration, incentive spirometry or chest physiotherapy (as outlined in the Respiratory Care Practitioners law);
8. [Reversed 9/95]
9. The medical assistant may not perform irrigations for ostomy/stoma care;
10. The medical assistant may apply ace bandages and splints to extremities; and
11. The medical assistant may only perform suprapubic catheterizations involving an established fistula.

3. 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:

1. Skin testing performed by intradermal technique.
2. Skin testing performed by the scratch technique.

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

1. 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

Telephoning of Prescriptions

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

1. Medical Assistants are permitted to telephone prescriptions to a pharmacy pursuant to their supervising physician's written or verbal order.

Medical Assistant Registration through South Dakota Board of Medical and Osteopathic Examiners

Definition: Medical assisting is an allied health profession whose practitioners function as members of the health care delivery team and perform administrative and clinical procedures.

The designation Certified Medical Assistant (CMA) indicates that the individual is a graduate of a CAAHEP (Commission on Accreditation of Allied Health Education Programs) accredited medical assisting program, has passed the Certification Examination of the American Association of Medical Assistants (AAMA), and maintains currency of the CMA credential.

Qualifications: A graduate of a CAAHEP accredited medical assisting program with a current CMA credential, not to preclude those CMAs who acquired the credential prior to February 1, 1998, and maintain currency of the CMA credential.

Scope of Practice: CMAs perform delegated clinical and administrative duties within the supervising physician's scope of practice consistent with the CMA's education, training, and experience. Such duties shall not constitute practice of medicine.

Supervision: Physician supervision shall be active and continuous but shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place that services are rendered.

(Approved by the AAMA Board of Trustees at its March 9-12, 2000 meeting.)

Medical Assisting Career

Nature of Work

Medical assistants perform routine administrative and clinical tasks to keep the offices and clinics of physicians, podiatrists, chiropractors, and optometrists running smoothly. They should not be confused with physician assistants who examine, diagnose, and treat patients under the direct supervision of a physician.

Duties of medical assistants vary from office to office, depending on office location, size, and specialty. In small practices, medical assistants are usually "generalists," handling both administrative and clinical duties and reporting directly to an office manager, physician, or other health practitioner. Those in large practices tend to specialize in a particular area under the supervision of department administrators.

Medical assistants perform many administrative duties. They answer telephones, greet patients, update and file patient medical records, fill out insurance form, handle correspondence, schedule appointments, arrange for hospital admission and laboratory services, and handle billing and bookkeeping.

Clinical duties vary according to state law and include taking medical histories and recording vital signs, explaining treatment procedures to patients, preparing patients for examination, and assisting the physician during the examination. Medical assistants collect and prepare laboratory specimens or perform basic laboratory tests on the premises, dispose of contaminated supplies, and sterilize medical instruments. They instruct patients about medication and special diets, prepare and administer medications as directed by a physician, authorize drug refills as directed, telephone prescriptions to a pharmacy, draw blood, prepare patients for x-rays, take electrocardiograms, remove sutures, and change dressings.

Medical assistants may also arrange examining room instruments and equipment, purchase and maintain supplies and equipment, and keep waiting and examining rooms neat and clean.

Assistants who specialize have additional duties. *Podiatric medical assistants* make castings of feet, expose and develop x-rays, and assist podiatrists in surgery. *Ophthalmic medical assistants* help ophthalmologists provide medical eye care. They administer diagnostic tests, measure and record vision, and test eye muscle function. They also show patients how to insert, remove, and care for contact lenses; and they apply eye dressings. Under the direction of a physician, they may administer eye medications. They also maintain optical and surgical instruments and may assist the ophthalmologist in surgery.

Employment

Medical assistants held about 329,000 jobs in 2000. Sixty percent were in physicians' offices, and about 15 percent were in hospitals, including inpatient and outpatient facilities. The rest were in nursing homes, office of other health practitioners, and other health care facilities.

Training and Other Qualifications

Most employers prefer to hire graduates of formal programs in medical assisting, such as are offered in vocational-technical high schools, postsecondary vocational schools, community and junior colleges, and colleges and universities. Postsecondary programs usually last either one year, resulting in a certificate or diploma, or two years, resulting in an associate degree. Courses cover anatomy, physiology, and medical terminology, as well as typing, transcription, record keeping, accounting, and insurance processing. Students learn laboratory techniques, clinical and diagnostic procedures, pharmaceutical principles, medication administration, and first aid. They study office practices, patient relations, medical law, and ethics. Accredited programs include an externship providing practical experience in physicians' offices, hospitals, or other health care facilities.

Formal training in medical assisting, while generally preferred, is not always required. Some medical assistants are trained on the job, although this is less common than in the past. Applicants usually need a high school diploma or the equivalent. Recommended high school courses include mathematics, health, biology, typing, bookkeeping, computers, and office skills. Volunteer experience in the health care field is also helpful.

Two agencies accredit programs in medical assisting: the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Accrediting Bureau of Health Education Schools (ABHES). In 1999, there were about 450 medical assisting programs accredited by CAAHEP and over 140 accredited by ABHES. The Committee on Accreditation for Ophthalmic Medical Personnel accredited 14 programs in ophthalmic medical assisting.

Although there is no licensing for medical assistants, some states require them to take a test or a course before they can perform certain tasks, such as taking x-rays.

Medical assistants may be able to advance to office manager. They may qualify for a variety of administrative support occupations, or may teach medical assisting. Some, with additional education, may enter other health occupations such as nursing and medical technology.

CMA and RMA credentialing

The Certified Medical Assistant (CMA) and Registered Medical Assistant (RMA) are both voluntary, national credentials for the medical assisting profession. The CMA is awarded by the Certifying Board of the American Association of Medical Assistants organization; the RMA is given by the American Medical Technologists.

SOUTH
DAKOTA
SOCIETY OF
MEDICAL
ASSISTANTS
Since 1995

An affiliate of the **American Association of Medical Assistants**

CODE OF ETHICS: The Code of Ethics of the South Dakota Society of Medical Assistants shall set forth the principles of ethical and moral conduct as they relate to the medical profession and the particular practice of medical assisting.

Members of the South Dakota Society of Medical Assistants are dedicated to the conscientious pursuit of their profession, and thus, desiring to merit the high regard of the entire medical profession and the respect of the general public which they serve, do pledge themselves to strive always to:

1. Render service with full respect for the dignity of humanity;
2. Respect confidential information obtained through employment unless legally authorized or required by responsible performance of duty to divulge such information;
3. Uphold the honor and high principles of the profession and accept its disciplines;
4. Seek to continually improve the knowledge and skills of medical assistants for the benefit of patients and professional colleagues;
5. Participate in additional service activities toward improving the health and well-being of the community.

Medical Assistant Training Programs in South Dakota accredited by CAAHEP as of April 2006		
Colorado Technical University Degree: AS	3901 West 59th Street Sioux Falls SD 57108	Program Director Brenda Hartson Phone: (605) 361-0200
Lake Area Technical Institute Degree: AAS	230 11th Street NE Watertown SD 57201	Program Director Audrey Rausch Phone: (605) 882-5284
Mitchell Technical Institute Degree: AAS	821 N Capital Mitchell SD 57301	Program Director Corinne Hoffman Phone: (605) 995-3024
National American University Degree: AAS	2801 S Kiwanis Avenue Sioux Falls SD 57105	Program Director Gale Folsland Phone: (605) 334-5430
Presentation College Degree: AS	1500 North Main Aberdeen SD 57401	Program Director Mary Gjernes Phone: (605) 229-8544

Medical Assistant Program – Sample Curriculum Schedule			
First Year			
1ST Semester	Credit Hours	2ND Semester	Credit Hours
Anatomy & Physiology	4	Anatomy & Physiology	4
College Comp	3	Intro to Literature	3
College Exp	1	Intro to Phleb	1
Psychology Elec	3	Urinalysis	2
WP/dBase	3	Intro to HI Mgt	3
Christian Trad	3	Intro to CMS	3
Semester Total	17	Semester Total	16
Summer Session			
Orient to ML	2		
Med Transcript	3		
Limited Radiol	1		
Session Total	6		
Second Year			
3RD Semester	Credit Hours	4TH Semester	Credit Hours
Med Terminology	2	Med Assisting II	3
Communic Skills	3	MA Externship	12
Med Assisting I	4		
Christian Moral	3		
Soc & Beh Sc El	3		
Semester Total	15	Semester Total	15
Total Credit Hours Required: 69			

CERTIFICATION OF ENROLLMENT

ENGROSSED SUBSTITUTE SENATE BILL 6237

62nd Legislature
2012 Regular Session

Passed by the Senate March 5, 2012
YEAS 43 NAYS 5

President of the Senate

Passed by the House February 29, 2012
YEAS 97 NAYS 1

Speaker of the House of Representatives

Approved

Governor of the State of Washington

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 6237** as passed by the Senate and the House of Representatives on the dates hereon set forth.

Secretary

FILED

Secretary of State
State of Washington

ENGROSSED SUBSTITUTE SENATE BILL 6237

AS AMENDED BY THE HOUSE

Passed Legislature - 2012 Regular Session

State of Washington 62nd Legislature 2012 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Keiser, Conway, Kline, Frockt, and Becker)

READ FIRST TIME 01/26/12.

AN ACT Relating to creating a career pathway for medical assistants; amending RCW 18.79.340, 18.120.020, 18.120.020, 18.130.040, 18.130.040, and 18.135.055; adding a new chapter to Title 18 RCW; creating a new section; repealing RCW 18.135.010, 18.135.020, 18.135.025, 18.135.030, 18.135.035, 18.135.040, 18.135.050, 18.135.055, 18.135.060, 18.135.062, 18.135.065, 18.135.070, 18.135.090, 18.135.100, 18.135.110, and 18.135.120; and providing effective dates.

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

NEW SECTION. **Sec. 1.** The legislature finds that medical assistants are health professionals specifically trained to work in settings such as physicians' offices, clinics, group practices, and other health care facilities. These multiskilled personnel are trained to perform administrative and clinical procedures under the supervision of health care providers. Physicians value this unique versatility more and more because of the skills of medical assistants and their ability to contain costs and manage human resources efficiently. The demand for medical assistants is expanding rapidly. The efficient and effective delivery of health care in Washington will be improved by recognizing the valuable contributions of medical assistants, and

providing statutory support for medical assistants in Washington state. The legislature further finds that rural and small medical practices and clinics may have limited access to formally trained medical assistants. The legislature further intends that the secretary of health develop recommendations for a career ladder that includes medical assistants.

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

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

(2) "Department" means the department of health.

(3) "Health care practitioner" means:

(a) A physician licensed under chapter 18.71 RCW;

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

(c) Acting within the scope of their respective licensure, a podiatric physician and surgeon licensed under chapter 18.22 RCW, a registered nurse or advanced registered nurse practitioner licensed under chapter 18.79 RCW, a naturopath licensed under chapter 18.36A RCW, a physician assistant licensed under chapter 18.71A RCW, an osteopathic physician assistant licensed under chapter 18.57A RCW, or an optometrist licensed under chapter 18.53 RCW.

(4) "Medical assistant-certified" means a person certified under section 5 of this act who assists a health care practitioner with patient care, executes administrative and clinical procedures, and performs functions as provided in section 6 of this act under the supervision of the health care practitioner.

(5) "Medical assistant-hemodialysis technician" means a person certified under section 5 of this act who performs hemodialysis and other functions pursuant to section 6 of this act under the supervision of a health care practitioner.

(6) "Medical assistant-phlebotomist" means a person certified under section 5 of this act who performs capillary, venous, and arterial

invasive procedures for blood withdrawal and other functions pursuant to section 6 of this act under the supervision of a health care practitioner.

(7) "Medical assistant-registered" means a person registered under section 5 of this act who, pursuant to an endorsement by a health care practitioner, clinic, or group practice, assists a health care practitioner with patient care, executes administrative and clinical procedures, and performs functions as provided in section 6 of this act under the supervision of the health care practitioner.

(8) "Secretary" means the secretary of the department of health.

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

NEW SECTION. **Sec. 3.** (1) No person may practice as a medical assistant-certified, medical assistant-hemodialysis technician, or medical assistant-phlebotomist unless he or she is certified under section 5 of this act.

(2) No person may practice as a medical assistant-registered unless he or she is registered under section 5 of this act.

NEW SECTION. **Sec. 4.** (1) The secretary shall adopt rules specifying the minimum qualifications for a medical assistant-certified, medical assistant-hemodialysis technician, and medical assistant-phlebotomist. The qualifications for a medical assistant-hemodialysis technician must be equivalent to the qualifications for hemodialysis technicians regulated pursuant to chapter 18.135 RCW as of January 1, 2012.

(2) The secretary shall adopt rules that establish the minimum requirements necessary for a health care practitioner, clinic, or group practice to endorse a medical assistant as qualified to perform the duties authorized by this chapter and be able to file an attestation of that endorsement with the department.

(3) The medical quality assurance commission, the board of osteopathic medicine and surgery, the podiatric medical board, the nursing care quality assurance commission, the board of naturopathy,

and the optometry board shall each review and identify other specialty assistive personnel not included in this chapter and the tasks they perform. The department of health shall compile the information from each disciplining authority listed in this subsection and submit the compiled information to the legislature no later than December 15, 2012.

NEW SECTION. **Sec. 5.** (1)(a) The secretary shall issue a certification as a medical assistant-certified to any person who has satisfactorily completed a medical assistant training program approved by the secretary, passed an examination approved by the secretary, and met any additional qualifications established under section 4 of this act.

(b) The secretary shall issue an interim certification to any person who has met all of the qualifications in (a) of this subsection, except for the passage of the examination. A person holding an interim permit possesses the full scope of practice of a medical assistant-certified. The interim permit expires upon passage of the examination or after one year, whichever occurs first, and may not be renewed.

(2) The secretary shall issue a certification as a medical assistant-hemodialysis technician to any person who meets the qualifications for a medical assistant-hemodialysis technician established under section 4 of this act.

(3) The secretary shall issue a certification as a medical assistant-phlebotomist to any person who meets the qualifications for a medical assistant-phlebotomist established under section 4 of this act.

(4)(a) The secretary shall issue a registration as a medical assistant-registered to any person who has a current endorsement from a health care practitioner, clinic, or group practice.

(b) In order to be endorsed under this subsection (4), a person must:

(i) Be endorsed by a health care practitioner, clinic, or group practice that meets the qualifications established under section 4 of this act; and

(ii) Have a current attestation of his or her endorsement to perform specific medical tasks signed by a supervising health care

practitioner filed with the department. A medical assistant-registered may only perform the medical tasks listed in his or her current attestation of endorsement.

(c) A registration based on an endorsement by a health care practitioner, clinic, or group practice is not transferrable to another health care practitioner, clinic, or group practice.

(5) A certification issued under subsections (1) through (3) of this section is transferrable between different practice settings.

NEW SECTION. **Sec. 6.** (1) A medical assistant-certified may perform the following duties delegated by, and under the supervision of, a health care practitioner:

(a) Fundamental procedures:

(i) Wrapping items for autoclaving;

(ii) Procedures for sterilizing equipment and instruments;

(iii) Disposing of biohazardous materials; and

(iv) Practicing standard precautions.

(b) Clinical procedures:

(i) Performing aseptic procedures in a setting other than a hospital licensed under chapter 70.41 RCW;

(ii) Preparing of and assisting in sterile procedures in a setting other than a hospital under chapter 70.41 RCW;

(iii) Taking vital signs;

(iv) Preparing patients for examination;

(v) Capillary blood withdrawal, venipuncture, and intradermal, subcutaneous, and intramuscular injections; and

(vi) Observing and reporting patients' signs or symptoms.

(c) Specimen collection:

(i) Capillary puncture and venipuncture;

(ii) Obtaining specimens for microbiological testing; and

(iii) Instructing patients in proper technique to collect urine and fecal specimens.

(d) Diagnostic testing:

(i) Electrocardiography;

(ii) Respiratory testing; and

(iii) Tests waived under the federal clinical laboratory improvement amendments program on the effective date of this section.

The department shall periodically update the tests authorized under this subsection (1)(d) based on changes made by the federal clinical laboratory improvement amendments program.

(e) Patient care:

(i) Telephone and in-person screening limited to intake and gathering of information without requiring the exercise of judgment based on clinical knowledge;

(ii) Obtaining vital signs;

(iii) Obtaining and recording patient history;

(iv) Preparing and maintaining examination and treatment areas;

(v) Preparing patients for, and assisting with, routine and specialty examinations, procedures, treatments, and minor office surgeries;

(vi) Maintaining medication and immunization records; and

(vii) Screening and following up on test results as directed by a health care practitioner.

(f)(i) Administering medications. A medical assistant-certified may only administer medications if the drugs are:

(A) Administered only by unit or single dosage, or by a dosage calculated and verified by a health care practitioner. For purposes of this section, a combination vaccine shall be considered a unit dose;

(B) Limited to legend drugs, vaccines, and Schedule III-V controlled substances as authorized by a health care practitioner under the scope of his or her license and consistent with rules adopted by the secretary under (f)(ii) of this subsection; and

(C) Administered pursuant to a written order from a health care practitioner.

(ii) The secretary may, by rule, limit the drugs that may be administered under this subsection. The rules adopted under this subsection must limit the drugs based on risk, class, or route.

(g) Intravenous injections. A medical assistant-certified may administer intravenous injections for diagnostic or therapeutic agents if he or she meets minimum standards established by the secretary in rule. The minimum standards must be substantially similar to the qualifications for category D and F health care assistants as they exist on the effective date of this section.

(2) A medical assistant-hemodialysis technician may perform hemodialysis when delegated and supervised by a health care

practitioner. A medical assistant-hemodialysis technician may also administer drugs and oxygen to a patient when delegated and supervised by a health care practitioner and pursuant to rules adopted by the secretary.

(3) A medical assistant-phlebotomist may perform capillary, venous, or arterial invasive procedures for blood withdrawal when delegated and supervised by a health care practitioner and pursuant to rules adopted by the secretary.

(4) A medical assistant-registered may perform the following duties delegated by, and under the supervision of, a health care practitioner:

(a) Fundamental procedures:

(i) Wrapping items for autoclaving;

(ii) Procedures for sterilizing equipment and instruments;

(iii) Disposing of biohazardous materials; and

(iv) Practicing standard precautions.

(b) Clinical procedures:

(i) Preparing for sterile procedures;

(ii) Taking vital signs;

(iii) Preparing patients for examination; and

(iv) Observing and reporting patients' signs or symptoms.

(c) Specimen collection:

(i) Obtaining specimens for microbiological testing; and

(ii) Instructing patients in proper technique to collect urine and fecal specimens.

(d) Patient care:

(i) Telephone and in-person screening limited to intake and gathering of information without requiring the exercise of judgment based on clinical knowledge;

(ii) Obtaining vital signs;

(iii) Obtaining and recording patient history;

(iv) Preparing and maintaining examination and treatment areas;

(v) Maintaining medication and immunization records; and

(vi) Screening and following up on test results as directed by a health care practitioner.

(e) Tests waived under the federal clinical laboratory improvement amendments program on the effective date of this section. The department shall periodically update the tests authorized under

subsection (1)(d) of this section based on changes made by the federal clinical laboratory improvement amendments program.

(f) Administering vaccines, including combination vaccines.

NEW SECTION. **Sec. 7.** (1) Prior to delegation of any of the functions in section 6 of this act, a health care practitioner shall determine to the best of his or her ability each of the following:

(a) That the task is within that health care practitioner's scope of licensure or authority;

(b) That the task is indicated for the patient;

(c) The appropriate level of supervision;

(d) That no law prohibits the delegation;

(e) That the person to whom the task will be delegated is competent to perform that task; and

(f) That the task itself is one that should be appropriately delegated when considering the following factors:

(i) That the task can be performed without requiring the exercise of judgment based on clinical knowledge;

(ii) That results of the task are reasonably predictable;

(iii) That the task can be performed without a need for complex observations or critical decisions;

(iv) That the task can be performed without repeated clinical assessments; and

(v) That the task, if performed improperly, would not present life-threatening consequences or the danger of immediate and serious harm to the patient.

(2) Nothing in this section prohibits the use of protocols that do not involve clinical judgment and do not involve the administration of medications, other than vaccines.

NEW SECTION. **Sec. 8.** (1) In addition to any other authority provided by law, the secretary may:

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

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

(c) Establish administrative procedures, administrative requirements, and fees in accordance with RCW 43.70.250 and 43.70.280.

Until July 1, 2016, for purposes of setting fees under this section, the secretary shall consider persons registered or certified under this chapter and health care assistants, certified under chapter 18.135 RCW, as one profession;

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

(e) Maintain the official department of health record of all applicants and credential holders; and

(f) Establish requirements and procedures for an inactive registration or certification.

(2) The uniform disciplinary act, chapter 18.130 RCW, governs unlicensed practice, the issuance and denial of a registration or certification, and the discipline of persons registered or certified under this chapter.

NEW SECTION. **Sec. 9.** (1) The department may not issue new certifications for category C, D, E, or F health care assistants on or after the effective date of this section. The department shall certify a category C, D, E, or F health care assistant who was certified prior to the effective date of this section as a medical assistant-certified when he or she renews his or her certification.

(2) The department may not issue new certifications for category G health care assistants on or after the effective date of this section. The department shall certify a category G health care assistant who was certified prior to the effective date of this section as a medical assistant-hemodialysis technician when he or she renews his or her certification.

(3) The department may not issue new certifications for category A or B health care assistants on or after the effective date of this section. The department shall certify a category A or B health care assistant who was certified prior to the effective date of this section as a medical assistant-phlebotomist when he or she renews his or her certification.

NEW SECTION. **Sec. 10.** Nothing in this chapter prohibits or affects:

(1) A person licensed under this title performing services within his or her scope of practice;

(2) A person performing functions in the discharge of official duties on behalf of the United States government including, but not limited to, the armed forces, coast guard, public health service, veterans' bureau, or bureau of Indian affairs;

(3) A person trained by a federally approved end-stage renal disease facility who performs end-stage renal dialysis in the home setting;

(4) A person registered or certified under this chapter from performing blood-drawing procedures in the residences of research study participants when the procedures have been authorized by the institutional review board of a comprehensive cancer center or nonprofit degree-granting institution of higher education and are conducted under the general supervision of a physician; or

(5) A person participating in an externship as part of an approved medical assistant training program under the direct supervision of an on-site health care provider.

NEW SECTION. **Sec. 11.** Within existing resources, the secretary shall develop recommendations regarding a career path plan for medical assistants. The secretary shall consult with stakeholders, including, but not limited to, health care practitioner professional organizations, organizations representing health care workers, community colleges, career colleges, and technical colleges. The recommendations must include methods for including credit for prior learning. The purpose of the plan is to evaluate and map career paths for medical assistants and entry-level health care workers to transition by means of a career ladder into medical assistants or other health care professions. The recommendations must identify barriers to career advancement and career ladder training initiatives. The department shall report its recommendations to the legislature no later than December 15, 2012.

NEW SECTION. **Sec. 12.** An applicant with military training or experience satisfies the training or experience requirements of this chapter unless the secretary determines that the military training or experience is not substantially equivalent to the standards of this state.

Sec. 13. RCW 18.79.340 and 2003 c 258 s 2 are each amended to read as follows:

(1) "Nursing technician" means a nursing student employed in a hospital licensed under chapter 70.41 RCW, a clinic, or a nursing home licensed under chapter 18.51 RCW, who:

(a) Is currently enrolled in good standing in a nursing program approved by the commission and has not graduated; or

(b) Is a graduate of a nursing program approved by the commission who graduated:

(i) Within the past thirty days; or

(ii) Within the past sixty days and has received a determination from the secretary that there is good cause to continue the registration period, as defined by the secretary in rule.

(2) No person may practice or represent oneself as a nursing technician by use of any title or description of services without being registered under this chapter, unless otherwise exempted by this chapter.

(3) The commission may adopt rules to implement chapter 258, Laws of 2003.

Sec. 14. RCW 18.120.020 and 2010 c 286 s 14 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Applicant group" includes any health professional group or organization, any individual, or any other interested party which proposes that any health professional group not presently regulated be regulated or which proposes to substantially increase the scope of practice of the profession.

(2) "Certificate" and "certification" mean a voluntary process by which a statutory regulatory entity grants recognition to an individual who (a) has met certain prerequisite qualifications specified by that regulatory entity, and (b) may assume or use "certified" in the title or designation to perform prescribed health professional tasks.

(3) "Grandfather clause" means a provision in a regulatory statute applicable to practitioners actively engaged in the regulated health profession prior to the effective date of the regulatory statute which

exempts the practitioners from meeting the prerequisite qualifications set forth in the regulatory statute to perform prescribed occupational tasks.

(4) "Health professions" means and includes the following health and health-related licensed or regulated professions and occupations: Podiatric medicine and surgery under chapter 18.22 RCW; chiropractic under chapter 18.25 RCW; dental hygiene under chapter 18.29 RCW; dentistry under chapter 18.32 RCW; denturism under chapter 18.30 RCW; dispensing opticians under chapter 18.34 RCW; hearing instruments under chapter 18.35 RCW; naturopaths under chapter 18.36A RCW; embalming and funeral directing under chapter 18.39 RCW; midwifery under chapter 18.50 RCW; nursing home administration under chapter 18.52 RCW; optometry under chapters 18.53 and 18.54 RCW; ocularists under chapter 18.55 RCW; osteopathic medicine and surgery under chapters 18.57 and 18.57A RCW; pharmacy under chapters 18.64 and 18.64A RCW; medicine under chapters 18.71 and 18.71A RCW; emergency medicine under chapter 18.73 RCW; physical therapy under chapter 18.74 RCW; practical nurses under chapter 18.79 RCW; psychologists under chapter 18.83 RCW; registered nurses under chapter 18.79 RCW; occupational therapists licensed under chapter 18.59 RCW; respiratory care practitioners licensed under chapter 18.89 RCW; veterinarians and veterinary technicians under chapter 18.92 RCW; health care assistants under chapter 18.135 RCW; massage practitioners under chapter 18.108 RCW; East Asian medicine practitioners licensed under chapter 18.06 RCW; persons registered under chapter 18.19 RCW; persons licensed as mental health counselors, marriage and family therapists, and social workers under chapter 18.225 RCW; dietitians and nutritionists certified by chapter 18.138 RCW; radiologic technicians under chapter 18.84 RCW; ((~~and~~)) nursing assistants registered or certified under chapter 18.88A RCW; and medical assistants-certified, medical assistants-hemodialysis technician, medical assistants-phlebotomist, and medical assistants-registered certified and registered under chapter 18.--- RCW (the new chapter created in section 19 of this act).

(5) "Inspection" means the periodic examination of practitioners by a state agency in order to ascertain whether the practitioners' occupation is being carried out in a fashion consistent with the public health, safety, and welfare.

(6) "Legislative committees of reference" means the standing legislative committees designated by the respective rules committees of the senate and house of representatives to consider proposed legislation to regulate health professions not previously regulated.

(7) "License," "licensing," and "licensure" mean permission to engage in a health profession which would otherwise be unlawful in the state in the absence of the permission. A license is granted to those individuals who meet prerequisite qualifications to perform prescribed health professional tasks and for the use of a particular title.

(8) "Professional license" means an individual, nontransferable authorization to carry on a health activity based on qualifications which include: (a) Graduation from an accredited or approved program, and (b) acceptable performance on a qualifying examination or series of examinations.

(9) "Practitioner" means an individual who (a) has achieved knowledge and skill by practice, and (b) is actively engaged in a specified health profession.

(10) "Public member" means an individual who is not, and never was, a member of the health profession being regulated or the spouse of a member, or an individual who does not have and never has had a material financial interest in either the rendering of the health professional service being regulated or an activity directly related to the profession being regulated.

(11) "Registration" means the formal notification which, prior to rendering services, a practitioner shall submit to a state agency setting forth the name and address of the practitioner; the location, nature and operation of the health activity to be practiced; and, if required by the regulatory entity, a description of the service to be provided.

(12) "Regulatory entity" means any board, commission, agency, division, or other unit or subunit of state government which regulates one or more professions, occupations, industries, businesses, or other endeavors in this state.

(13) "State agency" includes every state office, department, board, commission, regulatory entity, and agency of the state, and, where provided by law, programs and activities involving less than the full responsibility of a state agency.

Sec. 15. RCW 18.120.020 and 2012 c ... s 14 (section 14 of this act) are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Applicant group" includes any health professional group or organization, any individual, or any other interested party which proposes that any health professional group not presently regulated be regulated or which proposes to substantially increase the scope of practice of the profession.

(2) "Certificate" and "certification" mean a voluntary process by which a statutory regulatory entity grants recognition to an individual who (a) has met certain prerequisite qualifications specified by that regulatory entity, and (b) may assume or use "certified" in the title or designation to perform prescribed health professional tasks.

(3) "Grandfather clause" means a provision in a regulatory statute applicable to practitioners actively engaged in the regulated health profession prior to the effective date of the regulatory statute which exempts the practitioners from meeting the prerequisite qualifications set forth in the regulatory statute to perform prescribed occupational tasks.

(4) "Health professions" means and includes the following health and health-related licensed or regulated professions and occupations: Podiatric medicine and surgery under chapter 18.22 RCW; chiropractic under chapter 18.25 RCW; dental hygiene under chapter 18.29 RCW; dentistry under chapter 18.32 RCW; denturism under chapter 18.30 RCW; dispensing opticians under chapter 18.34 RCW; hearing instruments under chapter 18.35 RCW; naturopaths under chapter 18.36A RCW; embalming and funeral directing under chapter 18.39 RCW; midwifery under chapter 18.50 RCW; nursing home administration under chapter 18.52 RCW; optometry under chapters 18.53 and 18.54 RCW; ocularists under chapter 18.55 RCW; osteopathic medicine and surgery under chapters 18.57 and 18.57A RCW; pharmacy under chapters 18.64 and 18.64A RCW; medicine under chapters 18.71 and 18.71A RCW; emergency medicine under chapter 18.73 RCW; physical therapy under chapter 18.74 RCW; practical nurses under chapter 18.79 RCW; psychologists under chapter 18.83 RCW; registered nurses under chapter 18.79 RCW; occupational therapists licensed under chapter 18.59 RCW; respiratory care practitioners licensed under chapter 18.89 RCW; veterinarians and veterinary

technicians under chapter 18.92 RCW; ((~~health care assistants under chapter 18.135 RCW;~~)) massage practitioners under chapter 18.108 RCW; East Asian medicine practitioners licensed under chapter 18.06 RCW; persons registered under chapter 18.19 RCW; persons licensed as mental health counselors, marriage and family therapists, and social workers under chapter 18.225 RCW; dietitians and nutritionists certified by chapter 18.138 RCW; radiologic technicians under chapter 18.84 RCW; nursing assistants registered or certified under chapter 18.88A RCW; and medical assistants-certified, medical assistants-hemodialysis technician, medical assistants-phlebotomist, and medical assistants-registered certified and registered under chapter 18.--- RCW (the new chapter created in section 19 of this act).

(5) "Inspection" means the periodic examination of practitioners by a state agency in order to ascertain whether the practitioners' occupation is being carried out in a fashion consistent with the public health, safety, and welfare.

(6) "Legislative committees of reference" means the standing legislative committees designated by the respective rules committees of the senate and house of representatives to consider proposed legislation to regulate health professions not previously regulated.

(7) "License," "licensing," and "licensure" mean permission to engage in a health profession which would otherwise be unlawful in the state in the absence of the permission. A license is granted to those individuals who meet prerequisite qualifications to perform prescribed health professional tasks and for the use of a particular title.

(8) "Professional license" means an individual, nontransferable authorization to carry on a health activity based on qualifications which include: (a) Graduation from an accredited or approved program, and (b) acceptable performance on a qualifying examination or series of examinations.

(9) "Practitioner" means an individual who (a) has achieved knowledge and skill by practice, and (b) is actively engaged in a specified health profession.

(10) "Public member" means an individual who is not, and never was, a member of the health profession being regulated or the spouse of a member, or an individual who does not have and never has had a material financial interest in either the rendering of the health professional

service being regulated or an activity directly related to the profession being regulated.

(11) "Registration" means the formal notification which, prior to rendering services, a practitioner shall submit to a state agency setting forth the name and address of the practitioner; the location, nature and operation of the health activity to be practiced; and, if required by the regulatory entity, a description of the service to be provided.

(12) "Regulatory entity" means any board, commission, agency, division, or other unit or subunit of state government which regulates one or more professions, occupations, industries, businesses, or other endeavors in this state.

(13) "State agency" includes every state office, department, board, commission, regulatory entity, and agency of the state, and, where provided by law, programs and activities involving less than the full responsibility of a state agency.

Sec. 16. RCW 18.130.040 and 2011 c 41 s 11 are each amended to read as follows:

(1) This chapter applies only to the secretary and the boards and commissions having jurisdiction in relation to the professions licensed under the chapters specified in this section. This chapter does not apply to any business or profession not licensed under the chapters specified in this section.

(2)(a) The secretary has authority under this chapter in relation to the following professions:

(i) Dispensing opticians licensed and designated apprentices under chapter 18.34 RCW;

(ii) Midwives licensed under chapter 18.50 RCW;

(iii) Ocularists licensed under chapter 18.55 RCW;

(iv) Massage operators and businesses licensed under chapter 18.108 RCW;

(v) Dental hygienists licensed under chapter 18.29 RCW;

(vi) East Asian medicine practitioners licensed under chapter 18.06 RCW;

(vii) Radiologic technologists certified and X-ray technicians registered under chapter 18.84 RCW;

(viii) Respiratory care practitioners licensed under chapter 18.89 RCW;

(ix) Hypnotherapists and agency affiliated counselors registered and advisors and counselors certified under chapter 18.19 RCW;

(x) Persons licensed as mental health counselors, mental health counselor associates, marriage and family therapists, marriage and family therapist associates, social workers, social work associates--advanced, and social work associates--independent clinical under chapter 18.225 RCW;

(xi) Persons registered as nursing pool operators under chapter 18.52C RCW;

(xii) Nursing assistants registered or certified under chapter 18.88A RCW;

(xiii) Health care assistants certified under chapter 18.135 RCW;

(xiv) Dietitians and nutritionists certified under chapter 18.138 RCW;

(xv) Chemical dependency professionals and chemical dependency professional trainees certified under chapter 18.205 RCW;

(xvi) Sex offender treatment providers and certified affiliate sex offender treatment providers certified under chapter 18.155 RCW;

(xvii) Persons licensed and certified under chapter 18.73 RCW or RCW 18.71.205;

(xviii) Denturists licensed under chapter 18.30 RCW;

(xix) Orthotists and prosthetists licensed under chapter 18.200 RCW;

(xx) Surgical technologists registered under chapter 18.215 RCW;

(xxi) Recreational therapists ((~~[under chapter 18.230 RCW]~~)) under chapter 18.230 RCW;

(xxii) Animal massage practitioners certified under chapter 18.240 RCW;

(xxiii) Athletic trainers licensed under chapter 18.250 RCW;

(xxiv) Home care aides certified under chapter 18.88B RCW; ((~~and~~))

(xxv) Genetic counselors licensed under chapter 18.290 RCW; and

(xxvi) Medical assistants-certified, medical assistants-hemodialysis technician, medical assistants-phlebotomist, and medical assistants-registered certified and registered under chapter 18.--- RCW (the new chapter created in section 19 of this act).

(b) The boards and commissions having authority under this chapter are as follows:

(i) The podiatric medical board as established in chapter 18.22 RCW;

(ii) The chiropractic quality assurance commission as established in chapter 18.25 RCW;

(iii) The dental quality assurance commission as established in chapter 18.32 RCW governing licenses issued under chapter 18.32 RCW and licenses and registrations issued under chapter 18.260 RCW;

(iv) The board of hearing and speech as established in chapter 18.35 RCW;

(v) The board of examiners for nursing home administrators as established in chapter 18.52 RCW;

(vi) The optometry board as established in chapter 18.54 RCW governing licenses issued under chapter 18.53 RCW;

(vii) The board of osteopathic medicine and surgery as established in chapter 18.57 RCW governing licenses issued under chapters 18.57 and 18.57A RCW;

(viii) The board of pharmacy as established in chapter 18.64 RCW governing licenses issued under chapters 18.64 and 18.64A RCW;

(ix) The medical quality assurance commission as established in chapter 18.71 RCW governing licenses and registrations issued under chapters 18.71 and 18.71A RCW;

(x) The board of physical therapy as established in chapter 18.74 RCW;

(xi) The board of occupational therapy practice as established in chapter 18.59 RCW;

(xii) The nursing care quality assurance commission as established in chapter 18.79 RCW governing licenses and registrations issued under that chapter;

(xiii) The examining board of psychology and its disciplinary committee as established in chapter 18.83 RCW;

(xiv) The veterinary board of governors as established in chapter 18.92 RCW; and

(xv) The board of naturopathy established in chapter 18.36A RCW.

(3) In addition to the authority to discipline license holders, the disciplining authority has the authority to grant or deny licenses.

The disciplining authority may also grant a license subject to conditions.

(4) All disciplining authorities shall adopt procedures to ensure substantially consistent application of this chapter, the Uniform Disciplinary Act, among the disciplining authorities listed in subsection (2) of this section.

Sec. 17. RCW 18.130.040 and 2012 c ... s 16 (section 16 of this act) are each amended to read as follows:

(1) This chapter applies only to the secretary and the boards and commissions having jurisdiction in relation to the professions licensed under the chapters specified in this section. This chapter does not apply to any business or profession not licensed under the chapters specified in this section.

(2)(a) The secretary has authority under this chapter in relation to the following professions:

(i) Dispensing opticians licensed and designated apprentices under chapter 18.34 RCW;

(ii) Midwives licensed under chapter 18.50 RCW;

(iii) Ocularists licensed under chapter 18.55 RCW;

(iv) Massage operators and businesses licensed under chapter 18.108 RCW;

(v) Dental hygienists licensed under chapter 18.29 RCW;

(vi) East Asian medicine practitioners licensed under chapter 18.06 RCW;

(vii) Radiologic technologists certified and X-ray technicians registered under chapter 18.84 RCW;

(viii) Respiratory care practitioners licensed under chapter 18.89 RCW;

(ix) Hypnotherapists and agency affiliated counselors registered and advisors and counselors certified under chapter 18.19 RCW;

(x) Persons licensed as mental health counselors, mental health counselor associates, marriage and family therapists, marriage and family therapist associates, social workers, social work associates--advanced, and social work associates--independent clinical under chapter 18.225 RCW;

(xi) Persons registered as nursing pool operators under chapter 18.52C RCW;

(xii) Nursing assistants registered or certified under chapter 18.88A RCW;

(xiii) ((~~Health care assistants certified under chapter 18.135 RCW;~~ ~~(xiv)~~)) Dietitians and nutritionists certified under chapter 18.138 RCW;

((~~(xv)~~)) (xiv) Chemical dependency professionals and chemical dependency professional trainees certified under chapter 18.205 RCW;

((~~(xvi)~~)) (xv) Sex offender treatment providers and certified affiliate sex offender treatment providers certified under chapter 18.155 RCW;

((~~(xvii)~~)) (xvi) Persons licensed and certified under chapter 18.73 RCW or RCW 18.71.205;

((~~(xviii)~~)) (xvii) Denturists licensed under chapter 18.30 RCW;

((~~(xix)~~)) (xviii) Orthotists and prosthetists licensed under chapter 18.200 RCW;

((~~(xx)~~)) (xix) Surgical technologists registered under chapter 18.215 RCW;

((~~(xxi)~~)) (xx) Recreational therapists under chapter 18.230 RCW;

((~~(xxii)~~)) (xxi) Animal massage practitioners certified under chapter 18.240 RCW;

((~~(xxiii)~~)) (xxii) Athletic trainers licensed under chapter 18.250 RCW;

((~~(xxiv)~~)) (xxiii) Home care aides certified under chapter 18.88B RCW;

((~~(xxv)~~)) (xxiv) Genetic counselors licensed under chapter 18.290 RCW; and

((~~(xxvi)~~)) (xxv) Medical assistants-certified, medical assistants-hemodialysis technician, medical assistants-phlebotomist, and medical assistants-registered certified and registered under chapter 18.--- RCW (the new chapter created in section 19 of this act).

(b) The boards and commissions having authority under this chapter are as follows:

(i) The podiatric medical board as established in chapter 18.22 RCW;

(ii) The chiropractic quality assurance commission as established in chapter 18.25 RCW;

(iii) The dental quality assurance commission as established in

chapter 18.32 RCW governing licenses issued under chapter 18.32 RCW and licenses and registrations issued under chapter 18.260 RCW;

(iv) The board of hearing and speech as established in chapter 18.35 RCW;

(v) The board of examiners for nursing home administrators as established in chapter 18.52 RCW;

(vi) The optometry board as established in chapter 18.54 RCW governing licenses issued under chapter 18.53 RCW;

(vii) The board of osteopathic medicine and surgery as established in chapter 18.57 RCW governing licenses issued under chapters 18.57 and 18.57A RCW;

(viii) The board of pharmacy as established in chapter 18.64 RCW governing licenses issued under chapters 18.64 and 18.64A RCW;

(ix) The medical quality assurance commission as established in chapter 18.71 RCW governing licenses and registrations issued under chapters 18.71 and 18.71A RCW;

(x) The board of physical therapy as established in chapter 18.74 RCW;

(xi) The board of occupational therapy practice as established in chapter 18.59 RCW;

(xii) The nursing care quality assurance commission as established in chapter 18.79 RCW governing licenses and registrations issued under that chapter;

(xiii) The examining board of psychology and its disciplinary committee as established in chapter 18.83 RCW;

(xiv) The veterinary board of governors as established in chapter 18.92 RCW; and

(xv) The board of naturopathy established in chapter 18.36A RCW.

(3) In addition to the authority to discipline license holders, the disciplining authority has the authority to grant or deny licenses. The disciplining authority may also grant a license subject to conditions.

(4) All disciplining authorities shall adopt procedures to ensure substantially consistent application of this chapter, the Uniform Disciplinary Act, among the disciplining authorities listed in subsection (2) of this section.

Sec. 18. RCW 18.135.055 and 1996 c 191 s 83 are each amended to read as follows:

The health care facility or health care practitioner registering an initial or continuing certification pursuant to the provisions of this chapter shall comply with administrative procedures, administrative requirements, and fees determined by the secretary as provided in RCW 43.70.250 and 43.70.280. For the purposes of setting fees under this section, the secretary shall consider health care assistants and persons registered and certified under chapter 18.--- RCW (the new chapter created in section 19 of this act) as one profession.

All fees collected under this section shall be credited to the health professions account as required in RCW 43.70.320.

NEW SECTION. **Sec. 19.** Sections 1 through 12 of this act constitute a new chapter in Title 18 RCW.

NEW SECTION. **Sec. 20.** The following acts or parts of acts, as now existing or hereafter amended, are each repealed, effective July 1, 2016:

(1) RCW 18.135.010 (Practices authorized) and 2009 c 43 s 2, 2008 c 58 s 1, & 1984 c 281 s 1;

(2) RCW 18.135.020 (Definitions) and 2009 c 43 s 4, 2008 c 58 s 2, 2001 c 22 s 2, & 1997 c 133 s 1;

(3) RCW 18.135.025 (Rules--Legislative intent) and 1986 c 216 s 1;

(4) RCW 18.135.030 (Health care assistant profession--Duties--Requirements for certification--Rules) and 1999 c 151 s 201, 1994 sp.s. c 9 s 515, 1991 c 3 s 273, 1986 c 216 s 2, & 1984 c 281 s 4;

(5) RCW 18.135.035 (Requirements for certification--Military training or experience) and 2011 c 32 s 12;

(6) RCW 18.135.040 (Certification of health care assistants) and 2006 c 242 s 3 & 1984 c 281 s 3;

(7) RCW 18.135.050 (Certification by health care facility or practitioner--Roster--Recertification) and 1996 c 191 s 82, 1991 c 3 s 274, & 1984 c 281 s 5;

(8) RCW 18.135.055 (Registering an initial or continuing certification--Fees) and 2012 c ... s 18 (section 18 of this act), 1996 c 191 s 83, 1991 c 3 s 275, & 1985 c 117 s 1;

(9) RCW 18.135.060 (Conditions for performing authorized functions--Renal dialysis) and 2001 c 22 s 3, 2000 c 171 s 30, & 1993 c 13 s 1;

(10) RCW 18.135.062 (Renal dialysis training task force--Development of core competencies) and 2001 c 22 s 4;

(11) RCW 18.135.065 (Delegation--Duties of delegator and delegatee) and 2009 c 43 s 5, 2008 c 58 s 3, 1991 c 3 s 276, & 1986 c 216 s 4;

(12) RCW 18.135.070 (Complaints--Violations--Investigations--Disciplinary action) and 1993 c 367 s 11 & 1984 c 281 s 7;

(13) RCW 18.135.090 (Performance of authorized functions) and 1984 c 281 s 9;

(14) RCW 18.135.100 (Uniform Disciplinary Act) and 1993 c 367 s 12;

(15) RCW 18.135.110 (Blood-drawing procedures--Not prohibited by chapter--Requirements) and 2006 c 242 s 2; and

(16) RCW 18.135.120 (Administration of vaccines--Restrictions) and 2008 c 58 s 4.

NEW SECTION. **Sec. 21.** The secretary of health shall adopt any rules necessary to implement this act.

NEW SECTION. **Sec. 22.** Sections 1 through 12, 14, 16, and 18 of this act take effect July 1, 2013.

NEW SECTION. **Sec. 23.** Sections 15 and 17 of this act take effect July 1, 2016.

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The Lawful Scope of Practice of Medical Assistants — 2012 Update

Michael N. McCarty, Esq.

[Editor's note: The following is a substantially updated and expanded version of an article originally published in March 1996 and previously updated in the March 2003 issue of AMT Events.]

The AMT office frequently receives inquiries from Registered Medical Assistants about the lawful extent of their clinical practice scope. Typical of such inquiries are the following:

- The state nurses' association says that medical assistants aren't allowed to give injections. Is this correct?
- Is a medical assistant permitted to start an IV?
- Am I allowed to perform "scratch tests" for allergies?
- Can medical assistants do pulmonary function testing?
- What types of laboratory testing are medical assistants qualified to perform?

For better or worse, there is no universal answer to these questions. There is no uniform, national definition of a medical assistant's scope of practice. These types of inquiries usually must be answered by reference to the particular laws and customs of the state in which the medical assistant works. With respect to diagnostic lab testing, in addition to any applicable state laws, an MA's qualifications to perform a particular test depends on whether he or she meets the applicable criteria for testing personnel under the CLIA regulations.

In a vast majority of states, medical assistants may perform basic clinical procedures under the direct supervision of a licensed medical practitioner (e.g., physician, osteopath, podiatrist, and in some cases physician assistants or nurse practitioners). However, the legal framework governing the delegation of clinical tasks to unlicensed assistive personnel varies greatly from state to state. While most states still don't have laws or regulations specifically addressing the practice of medical assisting, the number of states with such laws has continued to grow in recent years. Many states that do not address medical assisting by name nevertheless have statutes or rules acknowledging a licensed practitioner's authority to delegate clinical tasks to an unlicensed assistant, as long as certain conditions are met.

State laws affecting the scope of medical assisting practice generally fall into one of three categories:

1. Laws that expressly recognize the practice of medical assisting and list some of the specific clinical functions that properly qualified medical assistants may perform;

2. Provisions in state practice acts that preserve the right of licensed practitioners to delegate basic clinical tasks to unlicensed assistants or exempt such assistants' performance of delegated tasks from legal definitions of unauthorized practice; or

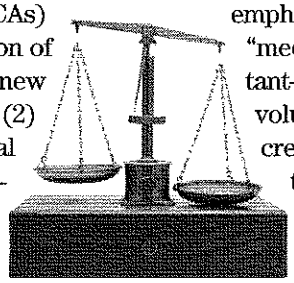
3. Laws governing licensed practitioners of the healing arts that are totally silent as regards the delega-

tion of clinical tasks to unlicensed personnel.

Recent Laws Expressly Recognizing Medical Assisting

When we last published a survey of state laws in 2003, there were just seven states (Arizona, California, Florida, Maryland, New Jersey, South Dakota, and Washington) that had statutes or regulations directly addressing the practice of medical assisting. Since then, four more states have passed laws recognizing a clinical practice scope for medical assistants: Arkansas, Montana, Georgia and Nevada. In addition, earlier this year the State of Washington enacted comprehensive medical assisting legislation that will replace that State's previous, unwieldy scheme for regulating "health care assistants." A brief survey of MA-specific laws follows, starting with the most recent developments.

Washington — On March 29, 2012, Governor Christine Gregoire signed into law Senate Bill 6237, described as an Act creating a career pathway for medical assistants. The new law replaces the prior scheme of registering seven different categories of health care assistants (HCAs) with a new system for certification or registration of four separate levels of medical assistants. The new categories are: (1) medical assistant-certified; (2) medical assistant-phlebotomist; (3) medical assistant-hemodialysis technician; and (4) medical assistant-registered. The Washington Department of Health will administer the program for certifying or registering medical assistants in appropriate categories. Individuals currently registered with the Department as HCAs will be grandfathered into a corresponding category of MA, and the HCA registrations will be discontinued.



To qualify as a **medical assistant-certified,** an individual must complete a medical assisting training program approved by the Health Department, pass a certification exam approved by the Department, and meet any additional requirements imposed by regulations to be developed by the Department. The scope of practice of the medical assistant-certified may encompass a broad range of clinical procedures, including capillary blood withdrawal, venipuncture, intradermal, subcutaneous and intramuscular injections, EKGs, respiratory testing, lab tests classified as "waived" under CLIA, and administering medication only by unit or single dosage, or by a dosage calculated and verified by a health care practitioner. A medical assistant-certified may also administer intravenous injections for diagnostic or therapeutic agents, if he or she meets minimum standards to be established by rule.

A licensed practitioner must certify to the Department the scope of clinical procedures that an individual medical assistant-certified is competent to perform, which may be less inclusive, but not more inclusive, than the list of procedures set forth in the law. The certification is portable from one employer to another.

The **medical assistant-registered** category is for assistive personnel who do not meet all the qualification requirements for the certified category but whose current employer attests the individual is competent to perform basic clinical procedures. The scope of practice for medical assistant-registered is more limited than for medical assistant-certified. It cannot include, for example, venipunctures, capillary blood draws, or injections other than vaccines. An individual's scope of practice is further limited by the endorsement received from his or her current employer. Unlike with the medical assistant-certified, the employer endorsement for a medical assistant-registered is not portable and must be renewed by each new employer.

While the new statute is an improvement over the prior system of registering HCAs, the unfortunate use of the terms "certified" and "registered" to distinguish more highly-trained MAs from those with lesser education and skills is bound to create confusion. It should be emphasized that the legislative distinction between "medical assistant-certified" and "medical assistant-registered" has nothing to do with private, voluntary credentials (e.g., whether someone is credentialed as a Certified Medical Assistant by the AAMA or as a Registered Medical Assistant by AMT). But the public is bound to be misled by the statutory titles, and it is extremely important for RMAs in Washington State to educate employers that, regardless of the title of your credential, you are indeed "certified," and not just "registered." Indeed, most RMAs who have completed a medical assistant education program at an accredited institution should qualify as medical assistant-certified. Those who have previously been registered with the State as a Category C, D, E, or F health care assistant will be grandfathered as medical assistant-certified.

The **medical assistant-phlebotomist** is essentially a phlebotomy technician, who may perform capillary, venous, or arterial invasive procedures for blood withdrawal when delegated and supervised by a licensed health care practitioner. The qualifications for this category will be determined by rulemaking. Individuals holding AMT's Registered Phlebotomy Technician (RPT) credential should qualify, and those currently registered as a Category A or B health care assistant will be grandfathered as MA-phlebotomists. (This article will not discuss the medical assistant-hemodialysis technician category, as it is not part of traditional medical assisting practice and we believe relatively few RMAs will be affected by it.)

The Washington statute includes a broad definition of licensed "health care practitioner" that can delegate tasks

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to medical assistants. Such practitioners can include physicians, doctors of osteopathy, and (to the extent acting within the scope of their respective licensure) podiatrists, registered nurses, or advanced registered nurse practitioners, naturopaths, physician assistants, osteopathic physician assistants, and optometrists.

Georgia — n 2009 the Georgia legislature added a new section to that state's Medical Practice Act for the express purpose of clarifying the role of medical assistants. The new provision makes clear that MAs may perform "medical tasks, including subcutaneous and intramuscular injections; obtaining vital signs; administering nebulizer treatments; or other tasks approved by the board pursuant to rule, if under the supervision by a physician in his or her office." The law also clarifies that "supervision" does not necessarily require on-site supervision at all times. It also provides that MAs may perform medical tasks ordered by a physician assistant or advanced practice registered nurse with authority to delegate such tasks.[1]

The new law authorized the Georgia Composite Medical Board to approve by rule other clinical tasks a medical assistant may perform in addition to those quoted above. To date, the Board has not adopted a regulation expanding the scope of functions MAs may perform. However, the Georgia Medical Practice Act still contains a general provision preserving a physician's right "to delegate to a qualified person any acts, duties, or functions which are otherwise permitted by law or established by custom."[2]

Arkansas — For many years, a cloud existed over the right of physicians to delegate clinical tasks to medical assistants in Arkansas. The state nurses' association periodically claimed that that administering injections fell within the scope of nursing practice, and that unlicensed assistants were therefore prohibited from giving them. The absence of a state law addressing a physician's right to delegate left the State Medical Board with little guidance to go on, leading to frequent disputes.

All of that changed in 2009 when the Arkansas General Assembly enacted an amendment to the Arkansas Medical Practices Act, creating a statutory basis for physician delegation to medical assistants. The amendment directs the Arkansas State Medical Board to adopt rules that "establish standards to be met and procedures to be followed by a physician with respect to the physician's delegation of the performance of medical practices to a qualified and properly trained employee who is not licensed or otherwise specifically authorized by the Arkansas Code to perform the practice."[3] The amendment goes on to set forth a number of parameters the Board is required to follow in adopting regulations with respect to supervision of the unlicensed employee, limits on the types of drugs that can be administered by the assistant, prohibiting delegation of anesthesia administration, and so forth.

The Arkansas State Medical Board responded by adopting Regulation 31 in February 2010. Titled the "Physician Delegation Regulation," Regulation 31 defines "Medical Assistant" as "an employee of a Physician who has been delegated medical practices or tasks, and who has not been licensed by or specifically authorized to perform the practice or task pursuant to other provisions of Arkansas law." Rather than set forth a defined scope of practice for medical assistants, Regulation 31 established mandatory guidelines for physicians to follow in delegating tasks while leaving the physician with substantial discretion to determine what procedures may be delegated to a particular assistant. Among the guidelines that must be observed are:

- The delegating physician remains responsible for the acts of the employee;
- The employee must not be represented to the public as a licensed practitioner;
- The task to be delegated is within the physician's authority to perform;
- The assistant to whom the task is delegated is qualified and properly trained to perform the task;
- The medical assistant cannot re-delegate a task to another unlicensed person, nor can the delegating physician transfer responsibility for supervising the assistant except to another physician who is qualified and has knowingly accepted that responsibility;
- With respect delegating the administration of drugs:
  (a) The physician may delegate only the administration of drugs that do not require substantial, specialized judgment and skill based on knowledge and application of the principles of biological, physical and social sciences;
  (b) Administration of drugs by delegation must occur within the physical boundaries of the delegating physician's offices;
  (c) The physician must evaluate the acuity of the patient, as well as the competency of the person to whom administration of the medication is being delegated.

This is just a partial listing of the more important provisions of the regulation. Arkansas medical assistants and their employers can review the entire text of Regulation 31 and § 17-95-208 of the Medical Practices Act on the State Medical Board's website.[4]

Nevada — In recent years, the ability of Nevada medical assistants to administer injections had been questioned, and even temporarily suspended by the Nevada State Board of Medical Examiners. Controversy had arisen over the widespread use of medical assistants in that

state to administer Botox and other cosmetic "fillers," often in "spa" settings without adequate supervision by a licensed physician. On September 30, 2009, the Nevada Board issued a policy statement declaring that medical assistants may *not* administer *any* prescription drugs, by injection or otherwise. Six days later, in the face of intense political pressure, the Board issued a statement rescinding the September 30 notice, restoring medical assistants' ability to administer medications under certain parameters, and announcing that the Board would undertake a rulemaking to address the use of medical assistants by physicians and physician assistants.

After several abortive attempts by the Board to promulgate medical assisting regulations, the Nevada Legislature took matters into its own hands and passed Senate Bill 294 on the final day of the 2011 session. The bill confirms the authority of medical assistants to possess and administer "dangerous drugs" (i.e., any medication requiring a prescription, other than controlled substances) "at the direction of the prescribing physician and under the supervision of a physician or physician assistant."[6] SB 294 authorized the Board of Medical Examiners and the State Board of Osteopathic Medicine to develop regulations further addressing the delegation of administration of dangerous drugs to MAs (as of this writing, neither board had initiated such rulemaking proceedings). The bill also creates a statutory definition of "Medical assistant": an unlicensed person who performs clinical tasks under the supervision of a physician, an osteopathic physician, or a physician assistant; and does not include a person who performs only administrative, clerical, executive or other nonclinical tasks.[6]

Montana — Prior to 2003, a lack of statutory guidance had muddied the waters in Montana with regard to the functions a physician could delegate to unlicensed assistants. That year the State Legislature enacted an amendment to the Medical Practice Act directing the Board of Medical Examiners to adopt guidelines for "the performance of administrative and clinical tasks by a medical assistant that are allowed to be delegated by a physician or podiatrist, including the administration of medications."[7]

The Montana Board adopted a final rule in March 2006 establishing delegation guidelines as directed by the legislature.[8] The rule contains both general standards for delegation or routine tasks, and specific requirements and limitations with respect to delegation of invasive procedures, drug administration, and allergy testing. As a general matter:

The supervising physician or podiatrist is responsible for determining the competency of a medical assistant to perform the administrative and clinical tasks assigned to the medical assistant. . . . A physician (or podiatrist) may only assign tasks that the physician (or podiatrist) is qualified to perform and tasks that the physician (or podiatrist) has not been legally restricted from performing. Any tasks performed by the medical assistant will be held to the same standard that is applied to the supervising physician or podiatrist.

The Montana rule provides that supervision of tasks assigned to medical assistant must be "active and continuous," but does not require the actual presence of the delegating practitioner, except that the supervising physician or podiatrist must be "onsite" - i.e., "in the facility and quickly available to the person being supervised" - when a MA: (a) performs invasive procedures; (b) administers medicine; or (c) performs allergy testing. In addition, a delegating practitioner must exercise "direct" supervision - defined as being within audible and visible reach of the person being supervised (and not merely "onsite") - when the MA is performing conscious sedation monitoring or administering fluids or medications through an IV.

The Montana regulation prohibits MAs from providing care to an inpatient in an acute care hospital, or administering blood products by IV. The MA is also barred from delegating to another unlicensed person any task assigned to the MA by a licensed practitioner.

Review of "Older" Medical Assisting Practice Laws

Among the first states to enact laws officially recognizing a scope of practice for medical assistants were **South Dakota** and **Florida.** Both states' statutes provide a fairly extensive, non-exclusive list of administrative and clinical duties a MA may perform under supervision of a licensed physician. Among others, the clinical tasks mentioned in both states' laws include performing aseptic procedures; venipunctures and nonintravenous injections; collecting routine laboratory specimens; performing basic laboratory procedures; and administering medications as directed by a physician. The Florida law also lists dialysis procedures, including home dialysis.

The South Dakota statute requires individuals to register with the State Board of Medical and Osteopathic Examiners before practicing as a medical assistant. A modest initial registration fee of $10.00 is assessed, and the registration may be renewed biannually for a fee of $5.00. Qualifications for registration include graduation from an accredited school or a school which meets standards similar to an accredited school, and compliance with such qualifications as may be established by the Board of Medical and Osteopathic Examiners and the Board of Nursing.

A Joint Board committee of the South Dakota medical and nursing boards has issued a series of determinations further defining the medical assistant's scope of practice. Among other clarifications, the committee ruled that MAs may perform skin testing by intradermal or scratch techniques; may perform EKG's and glucose testing; may

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administer medications from either a single or multi-dose vial as along as the supervising physician assures appropriate training and competence, and assumes ultimate responsibility for administration of such drugs. MAs may not administer medications which require calculation of a dose; may not inject insulin; and may not perform arterial withdrawal of blood.[9]

The Florida law does not require medical assists to register with the state nor does it prescribe minimum qualifications, but it expressly recognizes that MAs may be certified as a Registered Medical Assistant by AMT or as a Certified Medical Assistant by the American Association of Medical Assistants (AAMA).[10]

In **New Jersey,** pursuant to regulations of the State Board of Medical Examiners, a "certified medical assistant" may administer subcutaneous and intramuscular injections under the supervision of a physician. The physician must be on premises and within reasonable proximity to the treatment room at all times that a medical assistant is administering injections. The assistant may not inject certain substances, including any substance related to allergenic testing or treatment, local anesthetics, controlled substances, experimental drugs, or any antineoplastic chemotherapeutic agent other than corticosteroids.

To qualify as a "certified medical assistant" in New Jersey, an individual must be a graduate of a post-secondary medical assisting program accredited by the Committee on Accreditation of Allied Health Education Programs (CAAHEP), the Accrediting Bureau of Health Education Schools (ABHES), or other accrediting organization approved by the U.S. Department of Education. Medical assistants also must be currently certified by either AMT, the AAMA, the National Center for Competency Testing (NCCT), or other certifying body recognized by the State Board of Medical Examiners.[11]

In **Arizona,** there are separate laws and regulations governing medical assisting in each of four different fields of medicine: allopathic, osteopathic, homeopathic, and naturopathic. Homeopathic and naturopathic medical assistants must have specialized training in those disciplines and must be either registered or certified by the respective State Boards of Medical Examiners for those disciplines.

Medical assistants working for allopathic (traditional physicians) and osteopathic practitioners in Arizona need not be registered or certified by the applicable Board, but must possess certain qualifications. Under regulations of both the Arizona Medical Board[12] and the Board of Osteopathic Examiners,[13] medical assistants must meet one of the following requirements: (1) complete an education program accredited by ABHES, CAAHEP, or another accrediting agency recognized by the U.S. Department of Education; (2) complete an Armed Forces medical services training program; or (3) hold RMA(AMT) or CMA(AAMA) certification.

Medical assistants may, under the direct supervision of a physician, osteopath, or physician assistant, perform the medical procedures listed in the 2003 revision of CAAHEP's "*Standards and Guidelines for an Accredited Educational Program for the Medical Assistant*, Section (III)(C)(3)(a) through (III)(C)(3)(c)." Besides the tasks listed in the CAAHEP Standards, medical assistants in Arizona may perform the following additional procedures under direct supervision: whirlpool treatments, diathermy treatments, electric galvation stimulation treatments, ultrasound therapy, massage therapy, traction treatments, transcutaneous nerve stimulation unit treatments, and small volume nebulizer treatments.

In **California,** the legislature recognizes a core scope of practice for medical assistants,[14] and the Medical Board has prescribed minimal training requirements for such basic procedures as intramuscular, subcutaneous, or intradermal injections; skin tests; or venipuncture for withdrawing blood. The basic required training includes 10 clock-hours of training in each of administering injections and phlebotomy, as well as successful performance of at least 10 each of intramuscular, subcutaneous and intradermal injections; 10 venipunctures; and 10 skin punctures (finger-sticks).

In addition to these core functions, a medical assistant in California may perform "additional supportive services," provided that the MA has received supplemental training which the employer determines is sufficient for the particular task to be delegated. These additional supportive services may include, among others: administration of medication other than by injection, EKGs, EEGs, plethysmography tests (other than full-body), removal of sutures and staples, applying and removing dressings and bandages, orthopedic appliances, etc., performing ear lavage, collecting and preserving specimens for testing, performing simple laboratory and screening tests, and cutting patients' nails. The supplemental training may be administered in an accredited vocational school or by a medical assistant who is certified by an approved certification organization, including AMT.[15]

In **Maryland,** the state Board of Physicians (formerly the Board of Physician Quality Assurance) administers regulations providing for a broad scope of functions that physicians may delegate to medical assistants under various levels of supervision.[16] The Maryland rules do not establish particular education, training or certification requirements for MAs, leaving it up to the supervising physician to insure that their assistants are properly qual-

ified to perform whatever clinical tasks are delegated. The regulations do, however, contain fairly comprehensive lists of functions that may be delegated under various levels of supervision.

Compared with other states, the Maryland board permits doctors to assign relatively sophisticated clinical tasks to MAs with "on-site" supervision (meaning the physician is "present at the site and able to be immediately available in person during the performance of a delegated act"). Those tasks include, in addition to standard non-intravenous injections, administering small doses of local anesthetics, establishing peripheral intravenous lines, and injecting fluorescein-like dyes for retinal angiography. With "direct" supervision (i.e., the physician is in the immediate presence of the MA and the patient), a medical assistant may also inject IV drugs or contrast materials. These are in addition to a host of more routine, non-invasive tasks that may be delegated without direct or even on-site supervision.

State Laws Permitting General Delegation of Clinical Functions

While the foregoing states have laws or regulations expressly recognizing a role for medical assistants, a greater number of states have statutes that more generally allow physicians (and in many cases, other licensed practitioners) to delegate clinical tasks to unlicensed personnel.

Some states' laws explicitly authorize delegation to assistive personnel under specified conditions. These include: Alaska, Illinois, Massachusetts, Maine, Michigan, Ohio, Pennsylvania, South Carolina, Texas, and Virginia.

Other states effectively allow such delegation by exempting from licensing requirements and unauthorized practice prohibitions the performance of routine clinical duties by unlicensed personnel under the supervision of a licensed practitioner. States with such exemptions include: Colorado, Hawaii, Idaho, Indiana, Kansas, Louisiana, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, and Wisconsin. It should be emphasized that simply because a state is not listed above does not necessarily mean it has no statute or rule allowing physician delegation. There may be others; these are simply the ones that have come to our attention over the years while representing the interests of RMAs.

Ohio has one of the most comprehensive regulations governing the delegation of medical tasks. The State Medical Board rule, which apply to physicians, osteopaths and podiatrists, includes the following stipulations:[17]

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.

The Ohio rule further requires that a physician shall provide onsite supervision when delegating the administration of drugs, with limited exceptions, e.g., the administration of a topical drug such as medicated shampoo. The conditions under which the Ohio rule allows delegation are typical of those adopted in other states, although somewhat more detailed than most. Other states with relatively comprehensive delegation laws include **Illinois,**[18] **Pennsylvania,**[19] **Michigan**[20] and **Texas.**[21]

Typical of jurisdictions that allow delegation through various forms of statutory exemptions is **Indiana,** whose Medical Practice Act includes the following exclusion:[22]

This article, as it relates to the unlawful or unauthorized practice of medicine or osteopathic medicine, does not apply to any of the following:

* * * *

(20) An employee of a physician or group of physicians who performs an act, a duty, or a function that is customarily within the specific area of practice of the employing physician or group of physicians, if the act, duty, or function is performed under the direction and supervision of the employing physician or a physician of the employing group within whose area of practice the act, duty, or function falls. An employee may not make a diagnosis or prescribe a treatment and must report the results of an examination of a patient conducted by the employee to the employing physician or the physician of the employing group under whose supervision the employee is working. An employee may not administer medication without the specific order of

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the employing physician or a physician of the employing group. * * * *

Utah presents a particularly interesting example of a state that authorizes delegation through exemptions. Utah specifically exempts a "medical assistant" from licensure under three separate practice acts: the Medical Practice Act, the Osteopathic Medical Practice Act, and the Physician Assistant Act. The two medical practice laws provide licensing exemptions for "a medical assistant while working under the direct and immediate supervision of a licensed [or osteopathic] physician and surgeon, to the extent the medical assistant is engaged in tasks appropriately delegated by the supervisor in accordance with the standards and ethics of the practice of medicine."[23] The Utah Physician Assistant Act similarly exempts from licensing any medical assistant who is working under the direct supervision of a physician; does not diagnose, advise, independently treat, or prescribe medication to or on behalf of any person; and for whom the supervising physician accepts responsibility.[24] Each act defines "medical assistant" as "an unlicensed individual working under the direct and immediate supervision of a licensed [or osteopathic] physician and surgeon, and engaged in specific tasks assigned by the licensed [or osteopathic] physician and surgeon in accordance with the standards and ethics of the profession."[25]

It should noted that in some states, the legal provision allowing a physician to assign tasks to an unlicensed assistant does not appear in the medical practice act, but in the practice act of another licensed profession such as physician assistant or nursing. For example, the only pertinent statutory reference we can find in **Oregon** is in the Physician Assistant Act, which exempts from licensing "an employee of a person licensed to practice medicine ..., or of a medical clinic or hospital ..., unless the employee is practicing as a physician assistant in which case the individual shall be licensed ...."[26] Similarly, the **Louisiana** Physician Assistant Act provides that: "Nothing herein shall prohibit or limit the authority of physicians to employ auxiliary personnel not recognized under this Part."[27] The **Alabama** nursing practice law includes an exemption for "persons, including nursing aides, orderlies and attendants, carrying out duties necessary for the support of nursing services ...."[28]

Delegation under Nursing Practice Laws

Although the traditional role of a medical assistant is as an auxiliary to a licensed physician who supervises and remains professionally and legally responsible for the actions of the MA, in many jurisdictions MAs may also accept delegated tasks from a registered nurse or nurse practitioner. Delegation of clinical duties in those cases is controlled by state nursing practice laws - and the legal relationship is between MA and nurse, not MA and physician. A number of state nursing boards have developed policies on nurses' delegation of duties to unlicensed assistive personnel, and in January 2012 the American Nurses Association issued draft Principles for Delegation by Registered Nurses to Unlicensed Assistive Personnel. The delegation of nursing functions to MAs is beyond the scope of this article; however, a couple of state regulatory scenarios deserve mention here.

Alaska's regulatory scheme is noteworthy because it not only preserves the physician's right to utilize unlicensed assistants,[29] but also includes provisions in the Nursing Board rules authorizing the delegation of nursing duties to appropriately trained unlicensed personnel. In addition to providing for delegation of routine and specialized nursing duties under specified conditions, the nursing rules permit an advanced nurse practitioner to delegate administration of injectable medication to a certified medical assistant.[30] The term "certified medical assistant" is defined as "a person who is currently nationally certified as a medical assistant by a national body accredited by the National Commission for Certifying Agencies (NCCA) and meets the requirements of this section." (All of AMT's certification programs, including the RMA, are accredited by NCCA.) Besides holding an accepted national certification, a medical assistant to whom the administration of an injectable medication may be delegated must successfully complete a training course in administration of medication approved by the nursing board.

The status of MAs in **North Dakota** is particularly unusual, inasmuch as it appears to be the only state where delegation of injections is within the exclusive purview of the nursing profession. For many years physicians in that state were assumed to have authority to delegate injections to MAs, but they were effectively deprived of that authority in 2004 by an Attorney General's interpretation of the state's medical practice act. Shortly thereafter, largely at the urging of the medical assisting community, the North Dakota Board of Nursing agreed to amend its existing rules regarding the delegation of medication administration to "medication assistants." The rules were supplemented to create a new category known as "Medication Assistant III," the qualifications for which include individuals (1) with two years of nursing education, or (2) who have completed a board-approved medical assistant education program and hold the RMA(AMT) or CMA(AAMA) certification. In addition to a number of routine medication routes, a Medication Assistant III may administer drugs via intramuscular, subcutaneous and intradermal injections, as well as gastronomy and jejunostomy. A complete list of authorized and prohibited med-

ication routes is available on the North Dakota legislature's website.[31]

In 2007, **New Hampshire** nearly became the first state to enact licensure for medical assistants. By the time AMT became aware of the legislation, the licensure bill already had passed the state Senate and was scheduled to be reported by a committee of the New Hampshire House of Representatives within a few days. After reviewing the legislation, AMT determined it should oppose the bill because it would have given the state Board of Nursing total control of the licensing program, including virtually unlimited authority to define the scope of practice, educational prerequisites, and examination requirements for licensed medical assistants. (The AAMA supported the bill, largely because of the recent successful collaboration between medical assistants and the North Dakota nursing board discussed above.) After AMT registered its opposition with each member of the House committee, that body decided not to pass the bill onto the House floor for a vote, and the bill therefore died. Despite the bill's failure, the New Hampshire nursing board has continued to work with the medical assisting community to develop protocols for delegation of clinical duties. The board recently issued a document entitled, *Toolkit: Licensed Nurses, Medical Assistants and Delegation: Safe and Effective Teamwork*, which is accessible on the board's website.[32]

States Without Laws Addressing Delegation to Unlicensed Assistants

While the above survey does not purport to identify each and every state that may have a law addressing physician delegation to unlicensed personnel, the inevitable fact is that a handful of states have no law or regulation either directly or implicitly authorizing such delegation. In most of those cases, it can nevertheless be assumed that common law customs support the physician's right to assign tasks to a medical assistant, provided that: (1) the MA is qualified by education and/or training to perform the delegated tasks; (2) the delegated functions fall within the scope of practice of the licensed practitioner who assigns the tasks; (3) the tasks will be performed under the licensee's supervision; and (4) the performance of the task by an unlicensed individual is not expressly prohibited by law. **Missouri** is a good example of a state whose laws appear to be silent on delegation,[33] but where large numbers of RMAs have enjoyed a comprehensive scope of practice for many years.

Unfortunately, there are several jurisdictions in which this common law presumption is not observed and physicians are denied the right to delegate injections and other clinical functions to MAs. **New York** is a prime example. Medical assistants have long struggled to have a scope of practice recognized in the Empire State that matches their training and skills. In April 2010, the Executive Secretary to the New York State Board for Medicine issued an official Practice Alert and Guidelines reaffirming the board's longstanding position on the limited scope of functions that can be delegated to MAs. Although MAs in New York may take vital signs and obtain laboratory specimens, including venipunctures, the board emphasized that they may not perform any of the following:

- triage,
- administering medications through any route,
- administering contrast dyes or injections of any kind,
- placing or removing sutures,
- taking x-rays or independently positioning patients for x-rays,
- applying casts,
- first assisting in surgical procedures.

In response to a specific inquiry by AMT Board of Directors member Janet Sesser, RMA, on behalf of a New York RMA last October, the medical board's executive secretary further stated that pulmonary function testing and allergy "scratch" testing are outside the lawful scope of a medical assistant's practice in New York.

Connecticut is another state in which physicians' ability to delegate clinical functions to MAs has been limited considerably. As in New York, a cloud has long existed over Connecticut MAs' practice scope, and in 2011 the Connecticut Department of Public Health issued an interpretive memorandum that noted, among other things:

> Section 20-9 of the General Statutes of Connecticut dictate to whom a licensed physician may delegate aspects of care. Medical assistants are not identified in that listing of providers. * * * * Examples of specifically prohibited activities are radiography and medication administration by any route (including oxygen, immunizations, and tuberculin testing). * * * *

Nebraska is an additional jurisdiction where the ability of medical assistants to administer medication, including by injection, has been called into question. Last year, the Director of Public Health in Nebraska's Department of Health and Human Services engaged in correspondence with the program director of an accredited medical assisting education program in that state. The DHHS Director noted that state law prohibits a licensed healthcare provider from allowing an unlicensed individual to perform activities that require a state credential. She took issue with the school administrator's claim that a MA can administer any type of medication, including intravenous chemotherapy and IV moderate sedation. The Director suggested that the provision of medication can only be delegated by a Registered Nurse to a registered Medication Aide under Nebraska's Medication Aide Act. She went on to suggest

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that MAs, under direction of a licensed practitioner, may perform only "auxiliary" tasks such as "measuring vital signs, drawing blood, and assisting individuals with activities of daily living."

However, subsequent correspondence from the legal counsel for the Nebraska Medical Association emphasized that the Director's response was focused primarily on the inability of MAs to administer intravenous medications, which he noted is "a far different issue than whether medical assistants can give injections in a physician's office." The attorney went on to note that, "The NMA is unaware of any physician who has had difficulties with the DHHS concerning use of medical assistants."

During the H1N1 influenza outbreak in 2009, the **District of Columbia** Department of Health issued a memorandum listing various professions and occupations that are and are not legally authorized to administer vaccines in that jurisdiction. Medical assistant was listed as *not* being authorized, with the comment: "Medical assistants are not licensed in the District and no authority exists for them to give immunizations." As of this writing, the memo was still posted on the Department's website.[34] The author is unaware, however, of any chronic issues with recognition of MAs' practice scope in D.C. It is possible that the memorandum was intended to address the administration of vaccines in health-fair or portable clinic settings where a physician is not readily available to supervise those giving the flu shots.

Clinical Laboratory Testing

Many doctors' offices perform laboratory testing onsite. The question often arises as to what types of lab testing a medical assistant is qualified to perform.

The AMT Board of Directors has adopted an official policy that Registered Medical Assistants are qualified, on the basis of their entry-level education and training, to perform only laboratory procedures classified as "waived" under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Waived tests are those which the U.S. Department of Health and Human Services (HHS) has determined are relatively simple to administer, require minimal scientific and technical knowledge to perform, and pose little risk of harm to the patient if performed incorrectly.[35]

This does not necessarily mean, however, that RMAs can never become qualified to perform more complex lab tests. With the requisite additional training and experience, medical assistants may acquire the knowledge and skills needed to perform tests classified as "moderately complex" under CLIA. (Most lab tests performed in physicians' offices are either waived or moderately complex.) An individual may conduct moderately complex test procedures if he or she has the following training and skills, in addition to a high school education:

(A) The skills required for proper specimen collection, including patient preparation, if applicable, labeling, handling, preservation or fixation, processing or preparation, transportation and storage of specimens;

(B) The skills required for implementing all standard laboratory procedures;

Table 1

STATE LAWS AND/OR REGULATIONS EXPRESSLY RECOGNIZING MEDICAL ASSISTING PRACTICE	
Arizona	Ariz.Rev. Stat. § 32-1456 (statute); Az. Admin. Code §§ R4-16-401, R4-16-402 (Medical board rule); Az. Admin. Code §§ R4-22-110, R4-22-111 (Osteopathic medical board rule)
Arkansas	Ark.Code Ann. § 17-95-208 (statute); Regulation 31 (State Medical Board rule)
California	Cal. Bus. & Prof. Code §§ 2069-2071 (statute); 16 C.C.R. §§ 1666-1666.4 (rule)
Florida	Fla. Stat. § 458.3485
Georgia	Ga. Code Ann. § 43-34-44; see also § 43-34-23(f) (preserves physician's right to delegate tasks to UAPs)
New Jersey	N.J. Admin. Code § 13:35-6.4
Maryland	Code of Md. Regs. §§ 10.32.12.01–10.31.12.05
Montana	Mont. Code Ann. § 37-3-104 (statute); A.R.M. § 24.156.640 (rule)
Nevada	Nev. Rev. Stat. § 454.213(22)
North Dakota*	N.D. Admin. Code Ch. 54-07-05 (Nursing board rule)
South Dakota	S.D. Codified Laws §§ 36-9B-1–36-9B-9 (statute); see also: http://doh.sd.gov/boards/Nursing/medasst.aspx (MA practice scope determinations by Joint Board Committee of state medical & nursing boards)
Washington	SB 6237, enrolled as Chapter 153, Laws of 2012 (to be codified as a new chapter in Title 18, R.C.W.)

* North Dakota treats medical assistants as "Medication Assistant IIIs" under Nursing Board rules.

STATE LAWS AND/OR REGULATIONS GENERALLY ALLOWING PHYSICIAN DELGATION TO UNLICENSED ASSISTIVE PERSONNEL (UAPs)	
Alaska	12 Alaska Admin. Code § 40.480(b)
Illinois	225 Ill. Comp. Stat. § 60/54.2 (statute); 68 Ill. Admin. Code § 1285.335(f) (rule).
Massachusetts	243 C.M.R .§ 2.07
Maine	32 Me. Rev. Stat. Ann. § 3270-A
Michigan	Mich. Comp. Laws § 333.16215
Ohio	Ohio Admin. Code § 4731-23-02
Pennsylvania	63 Pa. Cons. Stat. § 422.17 (statute); 49 Pa. Code § 18.402 (rule).
South Carolina	S.C. Code Ann. § 40-47-30
Texas	Tex. Occ. Code § 157.001 (General Authority of Physician to Delegate); § 157.002 (Delegation of Admin. of Dangerous Drugs)
Virginia	Va. Code Ann. § 54.1-2901

STATE LAWS AND/OR REGULATIONS EXEMPTING UAPs' PERFORMANCE OF DELEGATED TASKS FROM LICENSURE REQUIREMENTS OR UNAUTHORIZED PRACTICE PORHOBITIONS	
Colorado	Colo. Rev. Stat. § 12-36-106
Hawaii	Haw. Rev. Stat. § 453-5.3
Idaho	Idaho Code § 54-1804
Indiana	Ind. Code § 25-22.5-1-2(a)
Kansas	Kan. Stat. Ann. § 65-2872
Louisiana	La. Rev. Stat. § 37:1360.38
New Mexico	N.M. Stat. Ann. § 61-6-17
North Carolina	N.C. Gen. Stat. § 90-18(c)(13)
Oklahoma	59 Okla. Stat. § 492
Oregon	Or. Rev. Stat. § 677.505
Rhode Island	R.I. Gen. Laws § 5-54-3(5)
Tennessee	Tenn. Code Ann. § 63-19-110(b)
Utah	Ut. Code §§ 58-67-305(6); 58-68-305(6); 58-70a-305(2)
Wisconsin	Wis. Stat. § 448.03(2)

(C) The skills required for performing each test method and for proper instrument use;

(D) The skills required for performing preventive maintenance, trouble-shooting and calibration procedures related to each test performed;

(E) A working knowledge of reagent stability and storage;

(F) The skills required to implement the quality control policies and procedures of the laboratory;

(G) An awareness of the factors that influence test results; and

(H) The skills required to assess and verify the validity of patient test results through the evaluation of quality control sample values prior to reporting patient test results.[36]

In states that license clinical laboratory personnel, a state license may also be required to perform tests other than those classified as waived under CLIA.[37]

AMT administers a certification program known as the Certified Medical Laboratory Assistant (CMLA), which recently replaced the COLT (Certified Office Laboratory Technician) certification program. As with the COLT credential, with appropriate additional training RMAs can utilize the CMLA as a career-path enhancement tool to help demonstrate they have acquired the necessary knowledge and training to perform moderately complex tests as well as pre- and post-analytical tasks in the laboratory.

Conclusion

The formal recognition of a practice scope that does justice to the training and skills of appropriately credentialed medical assistants continues to expand nationally, as more and more states have enacted laws and regulations allowing licensed medical practitioners to delegate injections and other clinical duties to MAs. Although there are common threads to most of the laws authorizing such delegation, there are many nuances from state to state - e.g., some states expressly permit MAs to perform allergy scratch tests, while others explicitly prohibit them, even when other injections are allowed. Registered Medical Assistants should familiarize themselves with the rules in their respective states so they can help educate their employers to utilize their medical assisting skills to the fullest extent of the law, without over-stepping it. ■

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4. http://www.armedicalboard.org/Professionals/pdf/mpa.pdf (accessed June 18, 2012).
5. Nev. Rev. Stat. § 454.213(22). The authorization also applies to MAs working under direction of osteopathic practitioners.
6. Nev. Rev. Stat. §§ 630.0129; 633.075.
7. Mont. Code Ann. § 37-3-104.
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9. The South Dakota medical assisting statute (S.D. Codified Laws §§ 36-9B-1-36-9B-9) and the Joint Board committee's scope-of-practice determinations can both be viewed on the Nursing Board's website: http://doh.sd.gov/boards/Nursing/medasst.aspx (accessed June 18, 2012).
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24. Utah Code § 58-70a-305(2) (Physician Assistant Act).
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31. N.D. Admin. Code Ch. 54-07-05, http://www.legis.nd.gov/information/acdata/pdf/54-07-05.pdf (accessed June 18, 2012).
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33. The only Missouri law we can find that remotely addresses the performance of medical tasks by unlicensed personnel is that state's Physician Assistant Practice Act, which contains a vague - and, in this author's opinion, confusing - exemption from licensing, as follows: "Nothing in sections 334.735 to 334.749 [the sections requiring licensure of physician assistants] shall be construed as prohibiting any individual whether licensed pursuant to sections 334.735 to 334.749 or not from providing the services of physician assistant."
34. http://dchealth.dc.gov/doh/lib/doh/h1n1/who_can_administer_vaccines_in_dc.pdf (accessed June 18, 2012).
35. A current list of tests classified as waived under CLIA can be viewed on the website HHS's Center for Medicare and Medicaid Services: http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/waivetbl.pdf (accessed June 18, 2012).
36. 42 C.F.R. § 493.1423 (2011).
37. The following states currently require some form of licensing or mandatory certification of clinical laboratory testing personnel: California, Florida, Georgia, Hawaii, Nevada, Louisiana, New York, North Dakota, Montana, Rhode Island, Tennessee, and West Virginia. Some, but not all of these states' licensing laws exempt personnel employed in physician office labs.