Criteria One: Risk for Harm to the Consumer

1. Provide a description of the typical functions performed and services provided by members of this occupational group.
   - Split between administrative and clinical duties. **Administrative du**ties may include: patient registration and data entry, medical records, mail processing, billing/collections, enter data in EMR, following up with insurance companies regarding claims, preauthorizations/precertifications relating to testing/procedures. **Clinical duties** may include: patient care and treatments, lab testing (urinalysis, pregnancy testing, glucose/cholesterol, etc.), injections, EKG, venipuncture, handling phone calls, scheduling patients for appointments, tests, surgery, etc. **General duties**: may include coaching patients (i.e., diabetes and weight loss, etc.) and serving as a liaison between the patient and the provider.

2. Describe the relationship between the professional and the general public.
   - An important team member working in the Patient Centered Medical Home with the health care delivery team.

   What is the nature of the interaction?
   - touching, talking, listening

   Does the interaction involve personal contact?
   - YES

   Does the regulated individual provide a product or a personal service?
   - YES - Patient care and/or administrative functions that impact the patient

3. Has there been evidence of specific public harm due to the activity of unregulated providers or by providers who are regulated in other states? If so, what is the frequency of deaths, serious injuries, or other harm; and how is the evidence of harm documented (i.e. court case or disciplinary or other administrative action)? What was the nature of the harm; physical, emotional, mental, social, economic, or financial? Can the relative harm be qualified? If not specific evidence of actual harm is available, what aspects of the groups' practice constitute a potential for harm?
   - There is anecdotal evidence but the committee has come across nothing specific to document evidence of public harm.

4. Specific public harm is attributed to which of the following? Elaborate as necessary
   a. Lack of skills (untrained person or on-the job trained (OJT) person)
   b. **Lack of knowledge** (untrained person or OJT person)
   c. Lack of ethics (breach of confidentiality, HIPAA violations); comes from lack of training.
   d. **Lack of supervision** –some people need supervision because they say they know how to perform tasks or have been trained, but really don't know how or cannot prove education/training in this field

e. **Practices inherent in the occupation** (invasive procedures – ie, venipuncture, assisting with procedures, etc.)
f. **Characteristics of the client/public being served** – clients seeking medical care, treatments or procedures in the ambulatory care setting
g. **Characteristics of the practice setting or work environment** – ambulatory care settings
h. Other (specify)

5. Does a potential for fraud exist because of the inability of the public to make an informed choice in selecting a competent individual?
   Yes –
   - the public doesn't choose who is their medical assistant – the physician employer (or human resources people) hires these people;
   - the physician isn't knowledgeable enough as to the education/training differences to select a qualified, competent medical assistant
   - Advertising on television make it sound like all medical assisting education is equal when it is not and the public doesn't know the difference any more than the physician does
   - Educational programs for medical assistants can range from 6 months to 2-3 years (associate degree)
   - There are numerous credentials for medical assistants available – those from professional organizations and those from for-profit organizations

6. Is the public seeking regulation or greater accountability of this group?
   No. MSMA is on their behalf. Regulation leads to greater accountability.

7. What is the harm to the general public if occupation/profession remains unregulated?
   - compromise of patient safety
   - injury, possible death due to lack of training standards /skills
   - Without credentialing, to what standard is the OJT or untrained person held?

Criterion Two: Specialized Skills and Training

1. What are the educational or training requirements for entry into this occupation?
   A CMA (AAMA) must pass a credentialing exam upon completion of a training program accredited by CAAHEP or ABHES and then re-credential every 5 years while employed (including CPR). The accreditation standards are reviewed/revised every five years and curriculum changes made related to cognitive objectives and psychomotor and affective domain competencies. The accreditation changes made are based upon a role-delineation analysis performed by random selection of practitioners in medical assisting. The CMA (AAMA) exam is a comprehensive exam covering the theory components of the CAAHEP Core Curriculum; it is jointly

developed by the AAMA (American Association of Medical Assistants) Certifying Board in conjunction with the National Board of Medical Examiners.

2. Are there training programs in Michigan?
   - YES

   Who accredits programs?
   - CAAHEP (MAERB) and ABHES (AMT)

   What are the standards for accreditation?
   - Will attach them

   Are sample curricula available?
   - YES

3. If no programs exist in Michigan, what information is available on programs elsewhere which prepare individuals for practice in Michigan? What are the minimum competencies (knowledge, skills and abilities) required for entry into the progression? How were they derived?
   - N/A

4. Are there requirements and mechanisms for ensuring continuing competence?
   - YES

   For example, are there mandatory education requirements, re-examination, peer review, practice audits, institutional review, practice simulations, or self-assessment models?
   - See attached: AAMA Certifying Board requirements and Disciplinary Standards

5. Why does the public require state assurance of initial and/or continuing competence?
   - To maintain a high level of standards for the education/training of medical assistants in an attempt to assure quality care for our patients/clients

   What assurances does the public have already through private credentialing or certification or institutional standards?
   - Accreditation is voluntary and demonstrates that the institution/program desires to offer quality education and training.
   - Credentialing is voluntary and shows that the person has taken it upon themselves to obtain education and skills training.

6. Are there currently recognized or emerging specialties (or levels of classifications within the occupational grouping? If so
   - What are these specialties? How are they recognized? (By whom and through what mechanisms – e.g. specialty certification by a national academy, society or other organization)?
     - CMA (AAMA)
     - RMA (AMT)

- CCMA (NHA)
- NCMA (NCCT)

- What are the various levels of specialties in terms of the functions or services performed by each?
- How can the public differentiate among these levels or specialties for classification of practitioners?
  The public cannot differentiate as each credential says the person is a medical assistant. The educational requirements differ and the training also differs dependent upon which credential is sought by a person and which accreditation body surveyed and accredited the program.
- Is a "generic" regulatory program appropriate, or should classifications (specialties/levels) be regulated separately (e.g., basic licensure with specialty certification)?
  - Possibly a basic regulatory/licensure with classifications due to credential?

Criterion Three: Autonomous Practice

1. What is the nature of the judgments and decisions made in the work environment?
   Changing environment due to the Patient-Centered Medical Home, team-based care situations, Health Care Reform and the increasing number of patients being seen in ambulatory care settings.

   For Health Professions:
   - Is the practitioner responsible for making diagnoses?
     - No - Not diagnosis as much as phone triage/screening work requiring judgment calls (critical thinking) which is part of the educational process
   - Does the practitioner design or approve treatment plans?
     - No
   - Does the practitioner direct or supervise patient care?
     - Supervision within parameters/protocols set by the physician
     - Lab results, EKGs, x-rays, billing/collections, medical records, etc.
     - Monitoring of patients related to treatment plan changes, medication changes, etc.
   - Does the practitioner use dangerous equipment or substances in performing services?
     - YES – injections, x-rays, phlebotomy equipment, scalpels, cautery, diathermy, chemicals, sterilization equipment, etc.
   - If the practitioner is not responsible for diagnosis, treatment, design, or approval, or directing patient care, who is responsible for these functions?
     Physicians , NP, PAs
   - Does this practitioner operate under the authority of another regulated health professional? Identify the health professional authorizing practice.
     Physician

2. Which functions, typically performed by this group, are unsupervised?
   This is dependent upon the type of practice and protocols within the practice. It may include: phone calls, documentation, administrative procedures (mail, billing/coding, etc.) appointment/test scheduling, EKGs, blood draws, injections, vital signs, billing/collections, phone screen/triage, calling in RXs, pulmonary function, nebulizer treatments, NSTs, chest x-rays, first aid, CPR, suture removal, etc.
   - What proportion of the individual's time is spent in unsupervised activity?
     ≥ 50% of time?
   - Who is legally accountable/liable for acts performed with no supervision?
     physician, administrator, medical assistant

3. Which functions are performed only under direct supervision?
   - Urinary catheterization, IV (if trained to do so)
   - Is the supervision direct or general? General or direct
     Who provides the supervision? Physician
     How frequently? PRN
     Where? On site (ambulatory care)
     For what purpose? Patient safety –the medical assistant functions as their agent
     - Is the supervisor a member of a regulated profession (please elaborate)?
       Yes - physician
     - What are the parameters contained in a typical supervision arrangement?
       - Order (standing or verbal) given by the physician and carried out by the medical assistant

4. Does the practitioner of this occupation supervise others? Describe the nature of this supervision.
   - The medical assistant or a "lead" medical assistant could supervise others (co-workers) and externship students. This would be done for training purposes, to keep the office running smoothly, to monitor for patent safety and liability considerations (confidentiality, etc.)

5. What is a typical work setting like, including supervisory arrangements and interaction of the individual with other regulated/unregulated occupations and professions?
   - In physician offices there is usually a manager/administrator who oversees operations and personnel. There may be an administrative supervisor and a clinical supervisor who oversee the daily activities in those specific areas. In many settings, regardless of training or credentialing, all employees perform the same duties, providing patient care. In some offices, the administrative supervisor or the clinical supervisor are medical assistants.

6. Does this occupational group treat or serve a specific consumer/client/patient population?
   - The population served is whoever is seeking care whether they are ill or seeking routine care/treatment.

7. Are clients/consumers/patients referred to this occupational group for care of services? If so, by whom?
   - No. Patients may be referred to the employer's practice by other medical providers, other patients or family members; this is depending upon the type of practice and the type of care needed by the patient.

   Describe a typical referral mechanism N/A

8. Are clients/consumers/patients referred from this occupational group for care of services?
   - NO – the physician, provider (or NP, PA) would initiate the referral and the medical assistant would carry out the remaining functions.

   If so, to what individuals are such referrals made? Describe a typical referral mechanism. How and on what basis are decisions to refer made? N/A

Criterion Four: Distinguishable scope of practice

1. Which functions of this occupation are similar to those performed by other occupational groups?
   a. Which groups - nursing, phlebotomy technicians, x-rays techs, lab techs, EKG tech, medical coders/billers, medical record people (HIT/HIM), respiratory therapists
   b. Are the other groups regulated by the state? Most - not all
   c. If so, why might the applicant group be considered different?
      We are trained to do all of these skills, services are performed in an outpatient (ambulatory) care setting

2. Which functions of this occupation are distinguishable from other similar occupational groups?
   Medical Assistants are educated and trained to perform BOTH administrative skills AND clinical skills
   a. Which groups?
      - nursing, respiratory therapy, phlebotomy, lab, x-ray
   b. Are the other groups regulated by the state?
      - most, not all

3. How will the regulation of this occupational group affect the scope of practice, marketability, and economic and social status of the other, similar groups (whether regulated or unregulated)?

- Should not have an appreciable impact on any other group; we are already performing these functions in this setting

Criterion Five: Economic Impact

1. What are the range and average incomes of members of this occupational group in Michigan? In adjoining states? Nationally? In states where the group is regulated?
   - See attached AAMA Salary Survey (most recent)

2. What are the average fees for services provided by this group in Michigan?
   - Medical assistants do not charge separately for services provided

   In adjoining states? Nationally? In states where the group is regulated?
   - Billing for this group of practitioners is included in the fee billed by the physician.

3. Is there any evidence that cost for services provided by this occupational group will increase or decrease if the group becomes regulated? In other states, have there been any effects on fees/salaries attributed to state regulation?
   - No documented evidence available.

4. Would state regulation of this occupation restrict other groups from providing services? No

   Are any of the other groups able to provide similar services at lower costs? No
   How is it that this lower cost is possible? N/A

5. Is there a current shortage or oversupply of practitioners in Michigan? In the region? Nationally?
   - Yes, there is currently an under supply – it has been clearly documented that medical assisting is one of the fastest growing professions (National Labor Board)

6. Is occupation/profession aware that costs of regulation will be borne by them? Are the members of the group; willing to accept the costs associated with regulation and enforcement? Yes

7. If continuing education is one of the proposed provisions, how does this proposed continuing education contribute to the goal of assuring continuing competence? Continuing education requirements are already required for the CMA (AAMA)

   Is the profession willing to accept the additional costs associated with continuing competence verification? Yes

8. Are third-party payers in Michigan currently reimbursing services of the occupational group? By whom? For what? No
   a. If not in Michigan, elsewhere in the country? No

b. Does another occupational group reimbursed by third-party payers in Michigan provide similar services? Elsewhere? Elaborate. N/A
c. If third-party payment does not currently exist, will the occupation seek it subsequent to state regulation? No

9. How will the proposed regulation affect the public's interaction with providers? How will access to providers be changed?
   - There should be no change in access or interaction as these types of services are currently being provided.

10. How will the proposed regulation affect the quality of care?
    - Quality of care should improve because standards would be in place requiring education, training and credentialing.

11. Approximately how many individuals are currently performing the same or similar functions in the work place?
    - It is impossible to estimate how many individuals are currently performing the same or similar functions in the workplace. Part of the reason for this is that many of these individuals function without a credential or have been on-the-job trained.
    - With the implementation of the CMS Rule in 2012 requiring credentialing of anyone entering orders in the medical record, credentialing of medical assistant has become even more important to employers.

    How many of these practitioners would meet the proposed new regulation criteria and how many would not?
    - Again, it would be impossible to estimate these numbers. Medical assistant who have already obtained their CMA (AAMA) or RMA (AMT) certification status have met this criteria.

    What are the economic implications to individuals currently doing such work?

    Will any of these individuals lose their jobs?
    - Possibly/possibly not – see above comment relating to the CMS Rule. Also, the AMT is allowing medical assistants to obtain certification (by exam), if not previously certified. These are people with no formal training except on-the-job training or longevity (again with no formal training).

12. How can costs to the state to regulate this profession be minimized?
    - Creation and maintenance of a medical assisting board

    Do the revenues anticipated from fees pay for the cost of regulating this profession? What specific benefits does regulation provide to the consumer?
    - Assurance that quality of care is tied to educational standards and credentialing

Criterion Six: Alternative to State Regulation

1. What laws or regulations currently exist to govern facilities or environments in which practitioners practice or is employed?
   - JCAHO, Rural Health, Health Department, Regional Hospital Organizations, CMS

2. What laws or regulations currently exist to govern equipment, devices, chemicals, and other substances used in the practice or work environment?
   - OSHA, MIOSHA. JCAHO, Rural Health, Health Department, Regional Hospital Organizations, CMS

3. What laws or regulations currently exist to govern standards or practice?
   - See #1 and #2 above

4. Does the institution or organization where the practitioners practice set and enforce occupational standards? YES

5. Does the occupational group participate in a non-governmental credentialing program, either through a national certifying agency or professional association?
   - YES – many but not all practitioners are credentialed.

   How are the standards set and enforced in the program?
   The credentialing organization each have differing criteria for credentialing and maintaining their credentials. These can vary from none to requiring recertification every 5 years. The AAMA also has requirements for certification, recertification and have instituted Disciplinary Standards for those CMAs (AAMA) not complying.

   What is the extent of participation of the occupational group in the program?
   - Many practitioners become credentialed but many fail to renew their credential when it expires.

6. Does a Code of Ethics exist for this profession? YES
   What is it? Attached
   Who established the code? AAMA
   How is it enforced? Other CMAs
   Is adherence mandatory? No

7. Does any peer group evaluation mechanism exist in Michigan or elsewhere? Elaborate.
   - We are unable to find any peer group evaluation mechanism that exists in Michigan or anywhere else.

8. How is a practitioner disciplined and for what causes? Violation of professional standards? Unprofessional conduct? Other causes?

- See attached AAMA Disciplinary Standards

9. Are there specific legal offenses, which, upon conviction, preclude an individual from working?

10. Does any other means exist within the occupational group to protect the consumer from negligence or incompetence? NO
    How are challenges to an individual's competency currently handled?
    - Employer would handle these situations in house

Criteria 7: Applicable State and National Standards of the occupation or profession is consistent with regulatory practices in other states and with established national standards.

1. Provide documentation of applicable national or other state:
    a. Legislation applicable to the occupation or profession
    b. Standards that exist for occupation or profession
    c. Scope of practice
    d. National job analyses that identify entry level competencies

2. Are there national, state, and/or regional examinations available to assess entry-level competency? YES
    a. Who develops and administers the examination?
        - American Association of Medical Assistants (CMA exam)
        - American Medical Technologists (RMA exam)
        - National Health Career Assoc. (CCMA exam)
        - National Center for Competency Testing (NCMA exam)
    b. What content domains are tested?
        Cognitive only. An assumption is made that psychomotor and affective competencies are assessed during an educational program prior to graduation.
    c. Are the examinations psychometrically sound – in keeping with the Standards for Educational and Psychological Testing?
        CMA (AAMA) exam is developed in conjunction with the NBME and their psychometricians. We are not aware that any of the other examinations conform to this standard.

3. How many other states currently regulate the occupation? None
    Which ones?
    What is the level of regulation for the occupation/profession – licensure, registration or certification – in each state where regulated?

4. Have any states deregulated this occupation? Why? When? NO

APPENDICES

Criteria One

#1 Documentation to help with this:

- Content outline
- Occupational Analysis
- Advance Practice document
- CMA Rise Above the Crowd
- Disciplinary Standards
- Protecting Your Right to Practice
- How the CMA Stands Apart

#3 Attach documentation Rena found on lawsuits

Criteria Two:

#2 CAAHEP Standards and Guidelines; sample curricula from several programs

#4 Attach Certifying Board requirements and Disciplinary Standards

Criteria Five:

#1 Attach AAMA Salary Survey (most recent)

#5 Attach stats documenting that medical assisting is one of fastest growing professions

Criteria Six:

#6 and #8 Attach AAMA Disciplinary Standards