

Title 64 Series 60
Department of Health and Human Resources
Office of Inspector General
Office of Health Facility Licensure and Certification
DELEGATION OF MEDICATION ADMINISTRATION AND HEALTH MAINTENANCE TASKS TO
APPROVED MEDICATION ASSISTIVE PERSONNEL

Summary of Public Comments

Comment

§64-60-3.7. Training for non-nursing home AMAPs is inarguably more involved than the training for nursing home AMAPs, as non-nursing home AMAPs may perform health maintenance tasks, administer injections, pass opioids and other divertible medications, etc.

It is understandable that a nursing home AMAP should not work in a non-nursing home facility without the proper retraining. However, a non-nursing home AMAP receives additional training that a nursing home AMAP does not. As long as the permissible tasks are clearly defined, a non-nursing home AMAP should not have to undergo retraining to work in a nursing home.

We therefore suggest the following language change:

3.7. AMAPs who have successfully trained and tested in the nursing home AMAP program may not transfer to the AMAP program of a non-nursing home without prior training and testing in accordance with W. Va. Code §§16-50-1, et seq.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

LATE COMMENT §64-60-3.7. Recommend clarifying whether the reverse is permitted. If an AMAP is trained in a nursing home, can they come to a group home and pass meds without prior training and testing?

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

§64-60-4.1.3. Subsection 4.1.3. delineates testing opportunities for a registered nurse training to be an authorized registered professional nurse in the AMAPs program. Paragraph 4.1.3.d. states that a fourth test will not be given if the nurse does not pass on his or her first three attempts. However, paragraph 4.1.3.e. states that the nurse may wait six months after the third failed test to begin retesting. For the sake of clarity, we suggest that paragraph 4.1.3.d. be stricken, as 4.1.3.e. sufficiently explains the retesting protocols for a nurse that failed the test three times.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

§64-60-4.3. A resident's primary care provider may see a resident monthly, while the authorized registered professional nurse, especially in a nursing home setting, will likely have contact with a resident multiple times per week. Due to this more frequent interaction and availability, the authorized registered professional nurse is in a better position to determine a resident's stability than the primary care provider. We therefore request that the language requiring collaboration with a primary care provider be stricken, as the primary care provider may not always be readily available to determine a resident's stability, causing an unnecessary delay in the administration of medications to a resident.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

LATE COMMENT §64-60-4.3. Some PCPs will not sign the collaboration because they did not train the AMAP. Recommend the regs permit providers to utilize other physicians working with the client (i.e., psychiatrist)?

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

LATE COMMENT §64-60-4.4. This is new and would require us to send a list of AMAPs to the authorizing agency at least annually. This seems cumbersome, and would recommend the requirement be modified to provide the list only upon the request.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

LATE COMMENT §64-60-4.6.1.c. Recommend clarifying the definition of “qualified instructor”.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

§64-60-5. In recognition of the new curriculum and exam that will be implemented upon the passage of this rule, we request language be added to clarify that current AMAPs will not be required to retrain and retest under the new curriculum and exam. In other words, we ask that a “grandfather” clause be added for current AMAPs.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

§64-60-5.2. As the owner of Professional Healthcare Development, LLC A Small WV Business, we have had the opportunity every three years to bid on the AMAP certification exam through the WV Purchasing Department. Professional Healthcare Development, LLC has been awarded the contract for AMAP certification exam in West Virginia since November 2001. Because of the competitive bidding process, the current price of an AMAP certification in WV is \$35.00.

Per the new AMAP law, the National Council of State Boards of Nursing is the only entity able to provide the AMAP certification exam through Pearson VUE, a global company. According to Pearson VUE’s web site, they only offer the Medication Aide Certification Examination, MACE, in the following states:

1. Illinois, Utah cost of MACE test is \$120.00 If same price point in WV would increase cost of AMAP test by 243%
2. New York, Vermont, Washington, Wyoming cost of MACE test is \$80.00 If same price point in WV would increase cost of AMAP test by 129%

This new AMAP law not only eliminates the competitive bidding process for any WV business and has the potential to greatly increase the cost to WV facilities for AMAP testing.

1. AMAP tests administered by Professional Healthcare Development, LLC in 2019 was 769 cost \$35.00 per test WV facilities paid \$26,915.00.

2. If Pearson VUE charges \$120 per test, it would cost WV facilities \$92,280.00. A potential increase of \$65,365.00 to WV facilities.

3. If Pearson VUE charges \$80 per test, it would cost WV facilities \$61,520.00. A potential increase of \$34,605 to WV facilities.

As Governor Jim Justice has said, “Small businesses are the backbone of our state’s economy”. By passing this law as written, you have eliminated the competitive bidding process for small WV businesses, have given the AMAP testing to a large global corporation, and potentially increase the cost of AMAP testing for WV health care facilities. No global corporation knows the needs of the residents of West Virginia better than a West Virginia based company.

Response

The Department has reviewed this comment and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment

LATE COMMENT §64-60-5.2.1. From a review of the NCSBN and Pearson VUE websites, it appears the state must contract with Pearson VUE so that they will administer the MACE to prospective AMAPs in WV. If that does occur, we recommend the exams be online, rather than requiring employees to travel to a testing site. Also, what would be the provider’s cost related to this exam?

Response

The Department has reviewed this comment. This comment is general in nature and offers no specific areas for amendment.

Comment

LATE COMMENT §64-60-5.2.3. Recommend clarifying the language here. Is the competency evaluation here referring to the same testing mentioned in 5.2.1.? If not, can this additional competency testing be done by the provider staff?

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

§64-60-5.3.2. The requirement that the AMAP retraining course be four hours is unnecessarily specific. A facility may have an exceptional AMAP who may only require three hours of instruction. On the other hand, an AMAP may require additional instruction in certain areas and may need six hours of retraining. The authorized registered professional nurse is in the best position to determine the retraining needs of an AMAP and should not be constrained to an arbitrary number of hours. We therefore suggest that the four-hour requirement be removed.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

LATE COMMENT §64-60-5.3.2. Is this training to be developed by the nurse? Why must it be a four hour training? This will be very costly to providers.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

LATE COMMENT §64-60-7.3.1.c. Some providers have electronic MARs, which may not contain printed name, initials and/or signatures. Are electronic MARs acceptable?

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

§64-60-7.3.1.h. It is currently within the scope of practice of all licensed nurses to take verbal orders. Requiring verbal orders to only be taken by the authorized registered professional nurse devalues the abilities of other licensed nurses.

Further, a licensed nurse cannot take verbal orders when off site. Therefore, should the authorized registered professional nurse be on-call but out of town, a resident would have to wait until the authorized registered professional nurse returns to transcribe the order before a resident receives necessary medications.

Permitting any licensed nurse to take a verbal order acknowledges the training and capabilities of those nurses and eliminates any unnecessary delays in the administration of medications. We therefore request the second sentence of this paragraph be revised to read:

Verbal orders may only be taken by a licensed nurse and must be countersigned by the physician or authorized health care professional within the designated timeframe not to exceed 14 days; and

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

LATE COMMENT §64-60-7.3.h. Often doctors no longer give written orders. They come from the pharmacy via an e-scribe system and may not have a physician signature.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

§64-60-7.4.1. Requiring an individual, regardless of profession, to be on site or on-call every minute of every day is simply unprecedented. Even doctors, police officers, firemen, and other first responders are afforded vacation and medical leave. Though it is preferable that the authorized registered professional nurse be available to an AMAP who has questions or concerns, any registered nurse is capable of assisting an AMAP when necessary.

Should this requirement remain in place, an AMAP would not be able to administer medications when the authorized registered professional nurse is unavailable. This may not be as significant a hardship in a nursing home setting where nurses are always on site and can assist in medication administration. However, in a non-nursing home setting, the AMAP is likely the only individual available who is permitted to administer medications. Therefore, the unavailability of the authorized registered professional nurse could mean that residents would not receive their medications timely.

Because we feel that this is an unrealistic regulation and that any registered nurse can assist an AMAP in need, we ask that “authorized registered professional nurse” be replaced with “registered nurse” in this subsection. This would allow the authorized registered professional nurse the leave benefits afforded to any other professional while ensuring a registered nurse is always available to assist an AMAP.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

§64-60-7.4.5. In some care settings, the authorized registered professional nurse may not be on site regularly to observe and supervise an AMAP. However, that is not the case in nursing homes, where the authorized registered professional nurse will have regular shifts and will therefore have frequent interactions with the AMAP.

Additionally, in a nursing home setting, competency verifications occur annually, regardless of position, unless there is a quality of care issue that must be addressed. Requiring a quarterly review of AMAPs, when all other staff members receive an annual review, is unnecessary and excessive.

For these reasons, we request that “quarterly” be replaced with “annually” in this subdivision.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

LATE COMMENT §64-60-7.4.5.d. Given the increased use of videoconferencing as a result of the COVID-19 pandemic, recommend lessening the restriction and permitting the use of videoconferencing for these observations/reviews.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

§64-60-9.3. There is some question as to the intent of this section and the medications contemplated to be included in the category of “debriding agents.” Because AMAPs are permitted to administer some topical medications, and “debriding agents” is undefined, we request that this section be revised to simply state, “No wound care shall be administered.” We believe this will eliminate any confusion as to what is considered to be a “debriding agent,” thus providing needed clarification.

Response

The Department has reviewed this comment and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment

§64-60-9.4. The first sentence of section 9.4. contradicts paragraph 7.3.1.h. and should be stricken.

Also, while we agree that first dosages of medication should not be administered by AMAPs in a nursing home setting, we do not believe that to be the case in other care settings.

Nursing home residents are typically more fragile than the residents in other care facilities. An adverse reaction to a medication is likely to be more severe for a nursing home resident. Having a nurse present for the critical first dose in a nursing home is a necessary safety precaution.

On the other hand, residents in other care settings typically do not have the health complications that require more skilled care. Also, AMAPs have been administering the first dose of medication in non-nursing home settings without issue since the inception of the AMAPs program. Finally, nurses are not regularly available in other care settings like they are in nursing homes. Requiring a nurse to administer the first dose would likely delay the delivery of necessary medication.

We therefore request the sentence relating to first dosages read as follows:

“In nursing homes, no first dosages of medication shall be administered.”

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

LATE COMMENT §64-60-9.4. This is cumbersome. There are constantly new medications being prescribed, which the registered nurse would have to be available to give at all times. Additionally, because the IDD Waiver program has relied on the AMAP program and reduced funding for nursing services, providers may not even have enough nurses to comply with this requirement.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

3.7	<p>AMAPs who have successfully trained and tested in the non-nursing home AMAP program may not transfer to the AMAP program of a nursing home without prior training and testing in accordance with W. Va. Code §§16-5AA-1, <i>et seq.</i></p>	<p>Recommend clarifying whether the reverse is permitted. If an AMAP is trained in a nursing home, can they come to a group home and pass meds without prior training and testing?</p>
4.3	<p>The authorized registered professional nurse, in collaboration with the resident's primary care provider, will determine whether the resident is in stable condition relative to the tasks proposed to be delegated to the AMAP.</p>	<p>Some PCPs will not sign the collaboration because they did not train the AMAP. Recommend the regs permit providers to utilize other physicians working with the client (i.e. psychiatrist)?</p>
4.4	<p>Any facility with an approved AMAP program shall provide the authorizing agency a list of the AMAPs, upon request, but not less than annually.</p>	<p>This is new and would require us to send a list of AMAPs to the authorizing agency at least annually. This seems cumbersome, and would recommend the requirement be modified to provide the list only upon request.</p>
4.6.1 c	<p>Staff must receive training on the administration of lifesaving medication and treatment by a qualified instructor.</p>	<p>Recommend clarifying the definition of "qualified instructor"</p>
5.2.1	<p>The prospective AMAP must pass a national Medication Aide Certification Examination offered by the National Council of State Boards of Nurses.</p>	<p>From a review of the NCSBN and Pearson VUE websites, it appears the state must contract with Pearson VUE so that they will administer the MACE to prospective AMAPs in WV. If that does occur, we recommend the exams be online, rather than requiring employees to travel to a testing site. Also, what will be the provider's cost related to this exam?</p>

5.2.3	The authorizing agency may contract with an entity to provide the competency evaluation to the prospective AMAP. The facility utilizing services shall pay any fees for competency evaluation testing.	Recommend clarifying the language here. Is the competency evaluation here referring to the same testing mentioned in 5.2.1? If not, can this additional competency testing be done by provider staff?
5.3.2	Retraining of the AMAP must consist of a four-hour course developed by the authorized registered professional nurse to includes areas identified through required monitoring and supervision activities, and best practices.	Is this training to be developed by the nurse? Why must it be a four hour training? This will be very costly to providers.
7.3.1.c	The printed name, the initials, and the signature of the individual who administered the medication.	Some providers have electronic MARs, which may not contain printed name, initials and/or signatures. Are electronic MARs acceptable?

7.3.1.h	Written, signed, and dated orders by the physician or authorized health care professional shall be present in the medical record for each medication to be administered, including over-the-counter medications. Verbal orders may only be taken by the authorized registered professional nurse and must be countersigned by the physician or authorized health care professional within the designated timeframe not to exceed 14 days; and	Often doctors no longer give written orders. They come from the pharmacy via an e-scribe system and may not have a physician signature.
7.4.5.d	Video conferencing should be limited to emergency situations, including inclement weather and other emergencies	Given the increased use of videoconferencing as a result of the COVID-19 pandemic, recommend lessening the restriction and permitting the use of videoconferencing for these observations/reviews.
9.4	No verbal medication orders shall be accepted,. No new medication or treatment orders shall be transcribed. No first dosages of medication shall be administered and No drug medication dosages shall be converted or calculated.	This is cumbersome. There are constantly new medications being prescribed, which the registered nurse would have to be available to give at all times. Additionally, because the IDD Waiver program has relied on the AMAP program and reduced funding for nursing services, providers may not even have enough nurses to comply with this requirement.

Whitmore, Jessica Y

From: Robertson, April L
Sent: Friday, July 31, 2020 1:23 PM
To: Whitmore, Jessica Y; Maher, Tina E; Marra, Jolynn
Subject: FW: [External] Title Series: 64-60 Statutory Authority 16-50-11, 16-5AA-6, and 16-1-7 AMAP

Follow Up Flag: Flag for follow up
Flag Status: Flagged

From: info@profhd.com <info@profhd.com>
Sent: Friday, July 31, 2020 1:20 PM
To: Robertson, April L <April.L.Robertson@wv.gov>
Subject: [External] Title Series: 64-60 Statutory Authority 16-50-11, 16-5AA-6, and 16-1-7 AMAP

CAUTION: External email. Do not click links or open attachments unless you verify sender.

April L. Robertson

As a small West Virginia business owner, I would like to make you aware of issues I have with the new AMAP law.

As written in the new AMAP law, “5.2 Competency Evaluation The prospective AMAP must pass a national Medication Aide Certification Examination offered by the National Council of State Boards of Nurses.”

As the owner of Professional Healthcare Development, LLC A Small WV Business, we have had the opportunity every three years to bid on the AMAP certification exam through the WV Purchasing Department. Professional Healthcare Development, LLC has been awarded the contract for AMAP certification exam in West Virginia since November 2001. Because of the competitive bidding process, the current price of an AMAP certification exam in WV is \$35.00.

Per the new AMAP law, The Nation Council of State Boards of Nursing is the only entity able to provide the AMAP certification exam through Pearson VUE, a global company. According to Pearson VUE’s web site, they only offer the Medication Aide Certification Examination, MACE, in the following states:

1. Illinois, Utah cost of MACE test is \$120.00 If same price point in WV would increase cost of AMAP test by 243%
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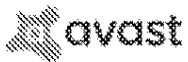
This new AMAP law not only eliminates the competitive bidding process for any WV business and has the potential to greatly increase the cost to WV facilities for AMAP testing.

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2. If Pearson VUE charges \$120 per test, it would cost WV facilities \$92,280.00. A potential increase of \$65,365.00 to WV facilities.
3. If Pearson VUE charges \$80 per test, it would cost WV facilities \$61,520.00. A potential increase of \$34,605 to WV facilities.

As Governor Jim Justice has said, "Small businesses are the backbone of our state's economy". By passing this law as written, you have eliminated the competitive bidding process for small WV businesses, have given the AMAP testing to a large global corporation, and potentially increase the cost of AMAP testing for WV health care facilities. No global corporation knows the needs of the residents of West Virginia better than a West Virginia based company.

Mark Cihy owner
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www.avast.com



July 31, 2020

Ms. April Robertson
General Counsel, WV Department of Health & Human Resources
One Davis Square
Suite 100, East
Charleston, West Virginia 25301

SENT VIA U.S. MAIL AND ELECTRONIC MAIL TO APRIL.L.ROBERTSON@WV.GOV

RE: WVHCA Comments to Proposed Changes to 64CSR60, Delegation of Medication Administration and Health Maintenance Tasks to Approved Medication Assistive Personnel

Dear Ms. Robertson:

On behalf of the West Virginia Health Care Association (WVHCA), which represents nearly all nursing homes and several assisted living facilities in our state, I am writing to offer comments to the proposed revisions to the Delegation of Medication Administration and Health Maintenance Tasks to Approved Medication Assistive Personnel rule (64CSR60) that have been published for public comment.

The WVHCA's comments are as follows:

3.7. AMAPs who have successfully trained and tested in the non-nursing home AMAP program may not transfer to the AMAP program of a nursing home without prior training and testing in accordance with W. Va. Code §§16-5AA-1, et seq.

Training for non-nursing home AMAPS is inarguably more involved than the training for nursing home AMAPS, as non-nursing home AMAPS may perform health maintenance tasks, administer injections, pass opioids and other divertible medications, etc.

It is understandable that a nursing home AMAP should not work in a non-nursing home facility without the proper retraining. However, a non-nursing home AMAP receives additional training that a nursing home AMAP does not. As long as the permissible tasks are clearly defined, a non-nursing home AMAP should not have to undergo retraining to work in a nursing home.

We therefore suggest the following language change:

3.7. AMAPs who have successfully trained and tested in the nursing home AMAP program may not transfer to the AMAP program of a non-nursing home without prior training and testing in accordance with W. Va. Code §§16-5O-1, et seq.

4.1.3. Number of testing opportunities.

4.1.3.d. If the prospective authorized registered professional nurse does not pass the third testing opportunity, a fourth opportunity will not be given.

4.1.3.e. If the prospective authorized registered professional nurse does not pass the third testing opportunity, he or she must wait six months to gain more training and experience prior to being able to start the competency testing process a second and final time.

Subsection 4.1.3 delineates testing opportunities for a registered nurse training to be an authorized registered professional nurse in the AMAPS program. Paragraph 4.1.3.d states that a fourth test will not be given if the nurse does not pass on his or her first three attempts. However, paragraph 4.1.3.e states that the nurse may wait six months after the third failed test to begin retesting. For the sake of clarity, we suggest that paragraph 4.1.3.d be stricken, as 4.1.3.e sufficiently explains the retesting protocols for a nurse that failed the test three times.

~~4.3. After having assessed the health status of an individual resident, the authorized registered professional nurse, in collaboration with the resident's primary health care professional and the approved medication assistive personnel, may recommend that the administration of medications or performance of health maintenance tasks, or both, be provided by an approved medication assistive personnel~~ The authorized registered professional nurse, in collaboration

with the resident's primary care provider, will determine whether the resident is in stable condition relative to the tasks proposed to be delegated to the AMAP.

A resident's primary care provider may see a resident monthly, while the authorized registered professional nurse, especially in a nursing home setting, will likely have contact with a resident multiple times per week. Due to this more frequent interaction and availability, the authorized registered professional nurse is in a better position to determine a resident's stability than the primary care provider. We therefore request that the language requiring collaboration with a primary care provider be stricken, as the primary care provider may not always be readily available to determine a resident's stability, causing an unnecessary delay in the administration of medications to a resident.

§ 64-60-5. Instruction and Training Curriculum and Competency Evaluation.

In recognition of the new curriculum and exam that will be implemented upon the passage of this rule, we request language be added to clarify that current AMAPS will not be required to retrain and retest under the new curriculum and exam. In other words, we ask that a "grandfather" clause be added for current AMAPS.

~~5.3.b. 5.3.2. The retraining shall include the curriculum and documentation of the required AMAP observation by the authorized registered professional nurse of medication administration or performance of health maintenance tasks or both~~ Retraining of the AMAP must consist of a four-hour course developed by the authorized registered professional nurse to includes areas identified through required monitoring and supervision activities, and best practices.

The requirement that the AMAP retraining course be four hours is unnecessarily specific. A facility may have an exceptional AMAP who may only require three hours of instruction. On the other hand, an AMAP may require additional instruction in certain areas and may need six hours of retraining. The authorized registered professional nurse is in the best position to determine the retraining needs of an AMAP and should

not be constrained to an arbitrary number of hours. We therefore suggest that the four-hour requirement be removed.

7.3.1.h. Written, signed, and dated orders by the physician or authorized health care professional shall be present in the medical record for each medication to be administered, including over-the-counter medications. Verbal orders may only be taken by the authorized registered professional nurse and must be countersigned by the physician or authorized health care professional within the designated timeframe not to exceed 14 days; and

It is currently within the scope of practice of all licensed nurses to take verbal orders. Requiring verbal orders to only be taken by the authorized registered professional nurse devalues the abilities of other licensed nurses.

Further, a licensed nurse cannot take verbal orders when off site. Therefore, should the authorized registered professional nurse be on-call but out of town, a resident would have to wait until the authorized registered professional nurse returns to transcribe the order before a resident receives necessary medications.

Permitting any licensed nurse to take a verbal order acknowledges the training and capabilities of those nurses and eliminates any unnecessary delays in the administration of medications. We therefore request the second sentence of this paragraph be revised to read:

Verbal orders may only be taken by a licensed nurse and must be countersigned by the physician or authorized health care professional within the designated timeframe not to exceed 14 days; and

7.4.1. The authorized registered professional nurse must be available onsite or on-call 24-hours per day, seven days per week, to respond to questions or concerns related to any aspect of the delegation process from the AMAP;

Requiring any individual, regardless of profession, to be on site or on-call every minute of every day is simply unprecedented. Even doctors, police officers, firemen, and other first responders are afforded vacation and medical leave. Though it is preferable that the authorized registered professional nurse be available to an AMAP

who has questions or concerns, any registered nurse is capable of assisting an AMAP when necessary.

Should this requirement remain in place, an AMAP would not be able to administer medications when the authorized registered professional nurse is unavailable. This may not be as significant a hardship in a nursing home setting where nurses are always on site and can assist in medication administration. However, in a non-nursing home setting, the AMAP is likely the only individual available who is permitted to administer medications. Therefore, the unavailability of the authorized registered professional nurse could mean that residents would not receive their medications timely.

Because we feel that this is an unrealistic regulation and that any registered nurse can assist an AMAP in need, we ask that “authorized registered professional nurse” be replaced with “registered nurse” in this subsection. This would allow the authorized registered professional nurse the leave benefits afforded to any other professional while ensuring a registered nurse is always available to assist an AMAP.

7.4.5. Periodic and ongoing observation and supervision, to verify competencies, not less frequently than quarterly, of the AMAP performing delegated tasks. In-person and face-to-face observation and supervision between the AMAP and the authorized registered professional nurse under the following conditions:

In some care settings, the authorized registered professional nurse may not be on site regularly to observe and supervise an AMAP. However, that is not the case in nursing homes, where the authorized registered professional nurse will have regular shifts and will therefore have frequent interactions with the AMAP.

Additionally, in a nursing home setting, competency verifications occur annually, regardless of position, unless there is a quality of care issue that must be addressed. Requiring a quarterly review of AMAPS, when all other staff members receive an annual review, is unnecessary and excessive.

For these reasons, we request that “quarterly” be replaced with “annually” in this subdivision.

9.3. No irrigations nor debriding agents used in the treatment of a skin condition or minor abrasions shall be administered.

There is some question as to the intent of this section and the medications contemplated to be included in the category of “debriding agents.” Because AMAPS are permitted to administer some topical medications, and “debriding agents” is undefined, we request that this section be revised to simply state, “No wound care shall be administered.” We believe this will eliminate any confusion as to what is considered to be a “debriding agent,” thus providing needed clarification.

9.4. No verbal medication orders shall be accepted, ~~and~~ No new medication or treatment orders or health maintenance task orders, or both, shall be transcribed, No first dosages of medication shall be administered. ~~and~~ No drug medication dosages shall be converted or calculated.

The first sentence of section 9.4 contradicts paragraph 7.3.1.h and should be stricken.

Also, while we agree that first dosages of medication should not be administered by AMAPS in a nursing home setting, we do not believe that to be the case in other care settings.

Nursing home residents are typically more fragile than the residents in other care facilities. An adverse reaction to a medication is likely to be more severe for a nursing home resident. Having a nurse present for the critical first dose in a nursing home is a necessary safety precaution.

On the other hand, residents in other care settings typically do not have the health complications that require more skilled care. Also, AMAPS have been administering the first dose of medication in non-nursing home settings without issue since the inception of the AMAPS program. Finally, nurses are not regularly available in other care settings like they are in nursing homes. Requiring a nurse to administer the first dose would likely delay the delivery of necessary medication.

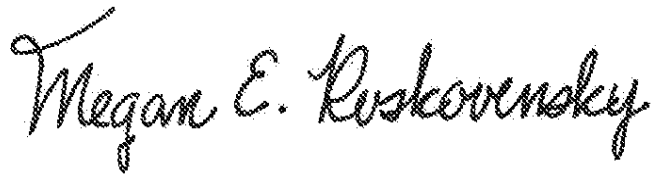
We therefore request the sentence relating to first dosages read as follows:

“In nursing homes, no first dosages of medication shall be administered.”

This concludes the WVHCA comments regarding proposed changes to the Delegation of Medication Administration and Health Maintenance Tasks to Approved Medication Assistive Personnel rule (64CSR60). We appreciate your consideration of our comments and suggestions. Should there be additional amendments adopted from outside sources, we request notification and an opportunity to address any further changes.

Please feel free to contact me with any questions or to seek further clarification as to these comments.

Respectfully submitted,

A handwritten signature in black ink that reads "Megan E. Roskovensky". The signature is written in a cursive, flowing style.

Megan E. Roskovensky
Director of Government Relations