MICHIGAN ACADEMY
of PHYSICIAN ASSISTANTS

The physician Assistant (PA) profession was created in the mid-1960s as a result of a nationwide shortage of medical providers. PAs practice medicine. The master-level curriculum was initially approved by the American Medical Association (AMA).

6,000 PAs practice medicine in Michigan and we graduate over three hundred Masters prepared PAs each year. PAs are the fastest growing profession in the United States according to Forbes and the second fastest growing profession according the Federal Bureau of Labor Statistics.

Michigan now has six PA programs including **Western Michigan University**, **University of Detroit/Mercy**, **Central Michigan University**, **Grand Valley State University**, **Wayne State University** and **Eastern Michigan University**. Four more PA programs will be enrolling students by 2021 including **Michigan State University**, **University of Michigan-Flint**, **Concordia University** and **Lawrence Tech University**.

PA programs are an average of 27 months of continuous academic and clinical training and student rotations encompass over 2,000 clinical hours in the disciplines of **internal medicine**, **general surgery**, **pediatrics**, **obstetrics** and **gynecology**, **behavioral** and **mental health**, and **family medicine**.

PAs are one of the three professions licensed to practice medicine in the State of Michigan alongside of Allopathic (MDs) and Osteopathic (DOs) physicians. PAs are trained as generalists and are able to practice in all aspects of medicine and specialties. PAs work in outpatient and inpatient settings along with home care, palliative care and hospice.

One of the most important aspects of PA practice is the period of mentorship that occurs once PAs enter into practice with physicians. This team-based approach to caring for patients is where the physician and PA understand the strengths of their practice together as the PA gains confidence in their ability to care for patients.

For over 40 years Michigan PAs have worked with physicians to provide medical care for patients in Michigan.

Ron Stavale, PA-C, Legislative Chair
Michigan Academy of PAs
MichiganPA.org

Thadd Gormas, Executive Director
Michigan Academy of PAs
ThaddGormas@MichiganPA.org

Scope of Practice History

1976 – The initial PA enabling language stated that the PAs practice of medicine was supervised by physicians and that the prescribing ability of PAs was delegated by supervising physician(s).

1999 - PAs were required to register with the Drug Enforcement Agency (DEA) after physicians were allowed to delegate controlled medications to PAs.

2002 – PAs receive Good Samaritan protection and the ability to provide bus driver physicals and handicap permits.

2005 – PAs allowed to refer to Physical Therapists.

2010 – PAs and Physicians allowed to enter into business/practice together.

2011 – Physician rounding requirements on PA patients was removed, PAs were granted the ability to write for chemical and physical restraints, forms requiring Physician signatures can be signed by PAs.

2017 - The Michigan Legislature eliminated the PA requirement for physician 'supervision' and 'delegation'. PAs are now prescribers required to have a Controlled Substance License like physicians.

PAs enter into practice agreements with physicians which requires the physician to verify the PAs training and credentials. PAs practice up to their training, education and experience.

Because of the awareness of Michigan's legislators, the dedication of our educators and critical need of our residents, PAs will continue to increase access to care throughout Michigan.

B. "Delegation" under MCL 333.16215 does not apply to, or may not be legally available to, prescribers required to establish a bona fide prescriber-patient relationship.

The delegation provisions of MCL 333.16215 predate the bona fide prescriber-patient relationship requirements of MCL 333.7303a. Even if the Draft Rule did not reference delegation under MCL 333.16215, in some situations, it would be legally appropriate for certain prescribers to delegate the tasks necessary to establish a bona fide prescriber- patient relationship to qualified individuals. However, prescribers in many common patient care scenarios will encounter legal issues that prevent them from utilizing delegation under MCL 333.16215 to perform the tasks necessary to establish a bona fide prescriber-patient relationship.

Section 16215 of the Code permits a licensee, other than a subfield licensee, to delegate to another individual who is qualified by education, training or experience, the performance of a task that is within the scope of the delegator's license and is performed under the delegator's "supervision" as defined in the Code. In other words, Section 16215 requires that all delegated tasks be performed under "supervision," which the Code defines as the presence of all of the following conditions:

1. (a) The continuous availability of direct communication in person or by radio, telephone, or telecommunication between the supervised individual and a licensed health professional.
2. (b) The availability of a licensed health professional on a regularly scheduled basis to review the practice of the supervised individual, to provide consultation to the supervised individual, to review records, and to further educate the supervised individual in the performance of the individual's functions.
3. (c) The provision by the licensed supervising health professional of predetermined procedures and drug protocol.[2]

There are many common controlled substance prescribing scenarios in which the supervision requirements of delegation cannot be satisfied. For example, a physician who uses a registered nurse (RN) caring for a patient in a licensed facility (e.g., hospital, nursing home, hospice) to perform tasks necessary to establish a bona fide prescriber- patient relationship is not in a legally-compliant delegation-supervision relationship with that RN because the physician is not supervising the RN in accordance with the Code's definition of supervision above. The same is true for a physician who must write a controlled substance prescription while on call for another physician. An on-call physician is prescribing under the authority of his or her own license, not as a delegated act, and must establish his or her own bona fide prescriber-patient relationship with the patient. The relationship between an on-call physician and the unavailable physician is not a delegation-supervision relationship that satisfies the requirements of Section 16215 of the Code.

Additionally, the authority to delegate tasks pursuant to Section 16215 is not available at all to a prescriber who is a physician's assistant (PA). As a subfield license holder, the text of Section 16215 specifically precludes a PA from delegating any tasks to another practitioner.[3]

Accordingly, a PA prescriber who has established a bona fide prescriber- patient relationship, but who is unavailable, is not permitted to delegate aspects of the bona fide prescriber-patient relationship to the on-call practitioner. Similarly, in the non- call setting, a PA wishing to establish a bona fide prescriber-patient relationship could not use the delegation/supervision provisions of the Code to permit, for example, an RN caring for the patient in a facility to complete the tasks necessary to establish the bona fide prescriber-patient relationship.

Additionally, it is not at all clear that an advanced practice registered nurse (APRN) who is prescribing controlled substances as a delegated act may "subdelegate" or "redelegate" tasks associated with controlled substance prescribing, including establishing a bona fide prescriber-patient relationship. The Code permits an APRN to prescribe controlled substances only pursuant to delegation from a physician.[4] Prescribing controlled substances is not within the legal scope of the APRN's license. Given the requirement in Section 16215 that a delegated task must be within the scope of the delegator's license, it is not clear that it would be appropriate for an APRN to "redelegate" or "subdelegate" any aspect of prescribing controlled substances, including establishing a bona fide prescriber-patient relationship, to another practitioner. Thus, an APRN wishing to establish a bona fide prescriber-patient relationship with a patient could not use the delegation/supervision provisions of the Code to permit another licensee to complete the tasks related to prescribing controlled substances, including the tasks needed to establish a bona fide prescriber-patient relationship. This same would be true for on-call situations involving an APRN.

Prescribers affiliated with the MHA do not view these legal issues raised by the proposed use of delegation under 16215 to establish a bona fide prescriber-patient relationship as merely academic. On the contrary, these prescribers express sincere concern about the risk of professional misconduct and professional discipline should they use the delegation provisions of Section 16215 when establishing a bona fide prescriber-patient relationship. As mentioned above, failure to establish a compliant bona fide prescriber-patient relationship constitutes professional misconduct that could adversely affect their license. A PA who (inappropriately) attempts to delegate tasks necessary to establish a bona fide prescriber-patient relationship will not have actually established the relationship and could be subject to professional discipline for such failure. Further, it is considered professional misconduct subject to adverse licensure action to be involved in negligent delegation to and supervision of another practitioner.[5] Accordingly, a prescriber who uses a facility- employed RN to complete the tasks necessary to establish a bona fide prescriber-patient relationship, and who does not/cannot provide supervision of that RN's performance of the delegated tasks as defined in the Code, risks professional discipline for negligent delegation and supervision.

[1] MCL §§ 333.16221(v) and 333.16226(1).
[2] MCL §333.16109(2).
[3] MCL § 333.16215.
[4] MCL § 333.17211a(1)(b).
[5] MCL §§ 333.16221(a) and 333.16226(1).

May 23, 2018

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing– Boards and Committees Section
Attention: Policy Analyst
P.O. Box 30670
Lansing, MI 48909-8170

Dear Policy Analyst:

The Michigan Healthcare Stakeholders Opioid Stewardship Collaborative, on behalf of fifteen of our member organizations, along with the Health Care Association of Michigan and Michigan County Medical Care Facilities Council respectfully request your consideration of alternative language to that currently proposed in Administrative Rule 338.3161a(3). While well-intentioned, the current language proposed by the Michigan Department of Licensing and Regulatory Affairs (LARA) does not fully address the range of issues created by the new definition of "bona fide prescriber patient relationship" that severely restrict the ability to provide quality care to patients in a variety of common clinical situations.

According to MCL 333.7303a, beginning March 31, 2019, or upon the promulgation of rules if sooner, a licensed prescriber shall not prescribe a controlled substance listed in schedules 2 to 5 unless the prescriber is in a "bona fide prescriber-patient relationship." The statute defines "bona fide prescriber-patient relationship" to mean "a treatment or counseling relationship between a prescriber and a patient in which both of the following are present:

- The prescriber has reviewed the patient's relevant medical or clinical records and completed a full assessment of the patient's medical history and current medical conditions, including a relevant medical evaluation of the patient conducted in person or via telehealth.

- The prescriber has created and maintained records of the patient's condition in accordance with medically accepted standards.

A provision was also included in the law that specifically allows the Department, in consultation with the applicable licensing boards and Physician Assistants Task Force, to promulgate rules identifying situations in which a bona fide prescriber-patient relationship as specifically defined is not necessary or when alternative requirements may be appropriate.

The undersigned organizations believe this new definition of "bona fide prescriber-patient relationship" severely restricts the ability to provide quality care to patients during situations in which a prescriber is providing coverage for an unavailable colleague, another licensed member of the health care team has evaluated the patient, there is a transition of care from one setting to another, or medical emergency.

The language currently in the proposed rule simply states that a prescriber can delegate the performance of the assessment and in-person or telehealth medical evaluation to another person pursuant to existing law. Concerns with this language include:

- Delegation and supervision as defined under MCL 333.1625 does not apply in all situations.
- Delegation can only be made to an individual who is otherwise qualified by education, training, or experience to perform the delegated task.
- Delegated tasks must fall within the scope of practice of the delegating licensee's profession and be performed under the licensee's supervision.
- Physician assistants, as subfield licensees, are precluded from delegating tasks to other licensed or non-licensed individuals.

- Physicians do not delegate to and supervise other physicians when on-call or providing coverage. They act under their own prescribing authority.
- Delegation requires supervision and, in many cases (i.e., cross coverage and shift changes), the statutorily required conditions comprising supervision such as availability for communication, review and consultation, as well as establishing pre-determined procedures and protocols are not within the prescriber's purview.
- Certain tasks like diagnosis cannot be delegated to a person not trained to make diagnoses.

Violation of the delegation and supervision provisions of the Public Health Care can result in disciplinary action that could jeopardize a prescriber's license, credentialing and privileges.

To ensure that this issue is resolved without needlessly interrupting patient care or adversely impacting professional licensing, the language needs to recognize that, in certain scenarios, an in-person/telehealth medical evaluation may be repetitive, impractical or an impediment to the timely delivery of care to a patient. It is during these scenarios that a bona fide relationship, as defined in the statute, should be excepted or the prescriber deemed to be compliance. Examples include:

- On-call, coverage and cross-coverage situations in which the prescriber with the bona fide prescriber-patient relationship is not available.
- Transitions of care from one setting to another such as from hospital to nursing home or hospice.
- Another licensed health professional completes the medical evaluation but is not the one who will be issuing the prescription.
- Medical emergencies in which the patient needs to be stabilized.
- Admissions to nursing care facilities when the accepting prescriber is not available for a face-to-face evaluation at the time of admission.

In proposing amendatory language, it is the intent of our organizations to be inclusive of the above-mentioned scenarios while also ensuring appropriate review of medical records, an assessment of the patient's current medical condition, and proper documentation. Therefore, our organizations urge LARA to replace the current language in proposed Administrative Rule 338.3161a(3) with the following language:

> (3) Notwithstanding Section 7303a of the Act, MCL 333.7303a and subrule (1) of this Rule, and pursuant to Section 16204e, MCL 333.16204e, a prescriber shall be deemed to have a bona fide prescriber-patient relationship under one or more of the following circumstances:
>
> (a)The prescriber has reviewed the patient's relevant medical or clinical records, medical history and any change in medical condition, is acting on behalf of a prescriber described in subrule (2) who is not available, and provides documentation in the patient's medical record in accordance with medically accepted standards of care.
>
> (b) The prescriber is following or modifying the orders of a prescriber who has an established bona fide prescriber-patient relationship described in subrule (2) with a hospital in-patient, hospice patient, or nursing care facility resident and provides documentation in the patient's medical record in accordance with medically accepted standards of care.

(c) The prescriber is prescribing for a patient for whom the tasks listed in subrule (2)(a) and (2)(b) have been performed by an individual licensed under article 15 as authorized by law and documentation is provided in the patient's medical record in accordance with medically accepted standards of care.

(d) The prescriber is treating a patient in an emergency medical situation. For the purposes of this subdivision, "emergency medical situation" means a situation that, in the prescriber's good faith professional judgment, creates an immediate threat of serious risk to life or health of the patient for whom the controlled substance prescription is being prescribed.

(e) The prescriber is prescribing or ordering a schedule 2 to 5 controlled substance for a patient being admitted to a nursing care facility, the tasks identified in subrule (2)(a) and (2)(b) are completed in accordance with R 325.20602, and documentation is provided in the patient's medical record in accordance with medically accepted standards of care.

Prescribers must be able to provide timely, appropriate and non-duplicative care to patients. Failure to do so will result in patients going to emergency departments or suffering needlessly. Our organizations are committed to working with the LARA, the respective licensing boards, the Legislature, and other stakeholders to ensure the proposed rule is appropriately modified.

Thank you for your consideration.

Respectfully submitted,

Health Care Association of Michigan
Michigan Academy of Family Physicians
Michigan Academy of Physician Assistants
Michigan Association of Health Plans
Michigan Chapter-American Academy of Pediatrics
Michigan College of Emergency Physicians
Michigan County Medical Care Facilities Council
Michigan Council of Nurse Practitioners
Michigan Health and Hospital Association
Michigan Pharmacists Association
Michigan Primary Care Association
Michigan Psychiatric Society
Michigan Osteopathic Association
Michigan Society of Addiction Medicine
Michigan Society of Interventional Pain Physicians
Michigan State Medical Society
Michigan Veterinary Medical Association