Ohio Legislative Service Commission

Bill Analysis

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Sen. Hite

BILL SUMMARY

Physician assistant scope of practice

- Modifies the list of services that a physician assistant may provide under a physician supervisory plan, and without approval by the State Medical Board as special services, relating to the removal of birth control devices, insertion and removal of chest tubes, and authorization to prescribe physical or occupational therapy.

- Authorizes a physician assistant to issue a do-not-resuscitate (DNR) order and to take any other action that may be taken by an attending physician under the law governing DNR orders.

- Authorizes a physician assistant to determine and pronounce death in specified locations and circumstances, but prohibits the physician assistant from signing any portion of a death certificate.

Prescriptive authority

- Eliminates the requirement that the State Medical Board adopt and modify through rulemaking procedures the formulary that identifies the drugs that a physician assistant may be authorized to prescribe.

- Authorizes the Board to make changes to the physician assistant formulary every six (as opposed to every 12) months.

- Generally permits a physician assistant who either practiced in another state or who was credentialed or employed by the federal government to obtain a certificate to prescribe in Ohio without participating in a provisional period of physician-delegated prescriptive authority.

- Eliminates a prohibition on physician assistants prescribing to patients schedule II controlled substances, but limits the locations from which such substances may be prescribed without restrictions.

- Prohibits a physician assistant from prescribing any schedule II controlled substance to a patient in a convenience care clinic.

Medicaid reimbursement rates

- Requires the Medicaid program to reimburse a physician assistant for providing a service in an amount that is 100% (as opposed to 85%) of the amount established as the "Medicaid maximum" for the service.

Patient Centered Medical Home Education Advisory Group

- Requires that the Patient Centered Medical Home Education Advisory Group include in its membership one individual appointed by the governing board of the Ohio Association of Physician Assistants.

- Requires the Advisory Group, when selecting physician practices to participate in the Patient Centered Medical Home Pilot Project, to strive to select practices that utilize physician assistants as part of the healthcare delivery system.

Emergency medical services

- Adds physician assistants to the list of health care professionals from which emergency medical service (EMS) personnel may obtain required authorization through a direct communication device to perform certain services or to perform emergency services in a hospital.

- Extends the existing immunity from civil liability that applies with regard to a student enrolled in an EMS training program to those occasions when the student is under the direct supervision and in the immediate presence of a physician assistant.

- Specifies that nothing in the law governing EMS personnel prevents or restricts the practice, services, or activities of any physician assistant.

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CONTENT AND OPERATION

Physician assistant scope of practice

The bill modifies the list of services that a physician assistant may provide under a physician supervisory plan and without approval by the State Medical Board as special services, as follows:[1]

- Replaces the authority to remove intrauterine devices and Norplant capsules with the broader authority to remove any birth control device;
- Adds the authority to insert or remove chest tubes;
- Adds the authority to order or refer a patient for occupational therapy;
- Adds the authority to prescribe or refer a patient for physical therapy. In conjunction with this provision, the bill permits a physical therapist to practice physical therapy pursuant to a physician assistant's prescription or referral.[2]

Do-not-resuscitate (DNR) orders

The bill authorizes a physician assistant to issue a do-not-resuscitate (DNR) order and take any other action that may be taken by an attending physician under the law governing DNR orders. The physician assistant's action may be performed pursuant to either (1) a physician supervisory plan (without the need for the Board's approval as a special service) or (2) the policies of a health care facility in which the physician assistant is practicing.[3] A DNR order is a directive that identifies a person and specifies

[1] R.C. 4730.09(A).

[2] R.C. 4755.48; conforming changes in R.C. 4755.481.

[3] R.C. 2133.211 and 4730.09(A)(40).

that CPR (cardiopulmonary resuscitation) should not be administered to that person. Currently, DNR orders may be issued only by a physician, certified nurse practitioner, or clinical nurse specialist. The nurse's action must be performed pursuant to a standard care arrangement with a collaborating physician.[4]

The bill extends to physician assistants immunity from criminal prosecution, civil liability, or professional disciplinary action arising out of, or relating to, the withholding or withdrawal of CPR from a person pursuant to a DNR order. The immunity also applies when CPR is provided to a person who requests to receive CPR even though the person earlier had executed a DNR order. Presently, these immunities apply to (1) physicians, (2) persons under the direction, or operating with the authorization, of a physician, (3) emergency medical services personnel, (4) certain health care facilities, health care facility administrators, or other persons at the facility working under the direction of a physician, and (5) certified nurse practitioners and clinical nurse specialists.[5]

Determination and pronouncement of death

The bill permits a physician assistant to determine and pronounce death if an individual's respiratory and circulatory functions are not being artificially sustained and, at the time of the determination and pronouncement, either or both of the following conditions are met:

(1) The individual was receiving care at a nursing home, residential care facility, home for the aging, a county home or district home, or a residential facility licensed by the Department of Developmental Disabilities;

(2) The physician assistant is providing or supervising the individual's care through a licensed hospice care program or any other entity that provides palliative care.

If a physician assistant determines and pronounces an individual's death, the bill requires the assistant to notify the individual's attending physician of the determination and pronouncement in order for the physician to complete and sign the individual's medical certificate of death within 48 hours in accordance with current law. The notification must occur within a reasonable time period following the determination and pronouncement of the individual's death.

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[4] R.C. 2133.211, 2133.22 (not in the bill), and 2133.25 (not in the bill).

[5] R.C. 2133.211 and 2133.22 (not in the bill).

The bill specifies that a physician assistant is not permitted to complete any portion of an individual's death certificate.[6]

Express authorization for a physician to determine and pronounce death

To correspond with the bill's provisions permitting a physician assistant to determine and pronounce death, the bill expressly authorizes physicians to engage in those activities. Current law does not expressly authorize a physician to make a determination of death – rather, the authority is assumed in the law describing when a person is considered to be dead. Similarly, current law does not expressly authorize any individual to pronounce death.[7]

Under current law, which the bill applies to physician assistants, an individual is considered dead if a determination is made, in accordance with accepted medical standards, that the individual meets either of the following conditions:

(1) The individual has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the brain, including the brain stem;

(2) The respiratory and circulatory functions of the individual are being artificially sustained and a physician *determines* that the irreversible cessation of all functions of the brain has occurred. The determination is to be made by observing and testing the individual.

Immunity from liability

A physician who makes a determination of death in accordance with current law and accepted medical standards is immune from liability for damages in any civil action, and is not subject to prosecution in any criminal proceeding, for the physician's acts or the acts of others based on the determination. The bill adds that a physician is not subject to professional disciplinary action for such acts. The bill extends these protections to a physician's pronouncement of death and specifies that the protections apply when there is a determination *and* pronouncement of death.[8]

In a manner similar to the immunity that is established for physicians, the bill provides immunity from civil liability, criminal prosecution, and professional disciplinary action to a physician assistant who makes a determination and

[6] R.C. 2108.40(B), (C), and (D).

[7] R.C. 2108.40(A) and (B).

[8] R.C. 2108.40(E)(1).

pronouncement of death in accordance with the bill's provisions and accepted medical standards. The immunity applies to the physician assistant's acts or the acts of others based on the assistant's determination and pronouncement of death. The bill also extends immunity to a physician for the acts of a physician assistant who makes a determination and pronouncement of death.[9]

With respect to other persons, current law provides immunity from civil liability and criminal prosecution to any person who acts in good faith in reliance on the determination of death made by a physician. The bill specifies that this immunity also applies to a pronouncement of death by a physician (rather than applying only to the physician's determination of death). Similarly, the bill grants immunity from civil liability and criminal prosecution to a person who acts in good faith in reliance on a determination and pronouncement of death that has been made by a physician assistant.[10]

Prescriptive authority

Physician assistant formulary

Administrative rulemaking – no longer required

The bill eliminates the requirement that the State Medical Board adopt and modify the physician assistant formulary through administrative rulemaking.[11] This means that the Board may add or remove drugs and therapeutic devices from the formulary without giving public notice of its intention to make changes and without convening a public hearing.

Under current law, the Board must adopt rules in accordance with the Administrative Procedure Act (R.C. Chapter 119.) governing physician-delegated prescriptive authority for physician assistants who hold a certificate to prescribe. The rules must establish, among other things, a formulary listing drugs and therapeutic devices by class and specific generic nomenclature that a physician may include in the physician-delegated prescriptive authority granted to a physician assistant.[12] The Board must review the formulary and make any necessary modifications to it through administrative rulemaking.[13] Before doing so, the Board must consider

[9] R.C. 2108.40(E)(1) and (2).

[10] R.C. 2105.35 and 2108.40(E)(3).

[11] R.C. 4730.39(A)(1).

[12] R.C. 4730.39(A)(1).

[13] R.C. 4730.39(B).

recommendations made by the Board's Physician Assistant Policy Committee, which is required to submit recommendations regarding the formulary to the Board on an annual basis.[14]

Frequency of changes to the formulary

The bill permits the Board to consider modifications to the formulary every six (as opposed to every 12) months. Pursuant to law unchanged by the bill, the Board must approve or disapprove a recommendation made by the Physician Assistant Policy Committee not later than 90 days after receiving it.[15] The bill requires the Committee to review the formulary not less than every six months beginning on the first day of June following the bill's effective date (as opposed to annually) and, to the extent it determines to be necessary, submit recommendations to the Board proposing changes to the formulary.[16]

Elimination of obsolete provisions

The bill repeals an obsolete provision requiring the Board, if it has adopted all rules necessary to issue certificates to prescribe to physician assistants other than the formulary, to begin issuing the certificates to prescribe. It also repeals a related provision specifying that the formulary established by the Board of Nursing for advanced practice nurses would constitute, with the exclusion of schedule II controlled substances, the formulary for physician assistants.[17] These provisions are no longer needed because the physician assistant formulary has been established.[18]

The bill repeals obsolete laws regarding the adoption of the initial formulary. Under those laws, with the exception of schedule II controlled substances, the initial formulary had to include all drugs and therapeutic devices that could be prescribed by advanced practice nurses.[19]

Out-of-state and federal government physician assistants

The bill permits certain individuals to obtain a certificate to prescribe without participating in the provisional period of physician-delegated prescriptive authority

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[14] R.C. 4730.38(B) and 4730.39(C).

[15] R.C. 4730.06(C).

[16] R.C. 4730.06(A)(3) and 4730.38(B).

[17] R.C. 4730.401.

[18] *See* Ohio Administrative Code (O.A.C.) 4730-2-6.

[19] R.C. 4730.40(C).

that is normally required before a physician assistant attains the regular certificate to prescribe.

The provisional period generally lasts not longer than one year, and must be conducted by one or more supervising physicians in accordance with rules the State Medical Board is required to adopt.[20]

Under the bill, an individual is exempt from the provisional period requirement if the individual (1) practiced in another state as a physician assistant or was credentialed or employed as a physician assistant by the federal government, (2) held a master's degree or higher that was obtained from a program accredited by the Accreditation Review Commission on Education for the Physician Assistant or a predecessor or successor organization recognized by the State Medical Board, and (3) held valid authority issued by the other state or the federal government to prescribe therapeutic devices and drugs, including at least some controlled substances.[21] The individual must produce an affidavit from the appropriate agency or office of the other state or the federal government attesting to the fact that the individual held the prescriptive authority issued by the other jurisdiction.[22]

Related to this exemption, the bill specifies that the initial certificate to prescribe issued to the individuals who are exempt is a regular "certificate to prescribe." This is in contrast to the initial certificate issued to an individual seeking to participate in a provisional period, which is issued as a "provisional certificate to prescribe."[23]

Schedule II controlled substances

The bill eliminates a prohibition on physician assistants prescribing to patients schedule II controlled substances.[24] Related to this change, the bill permits the Board to include schedule II controlled substances on the physician assistant formulary.[25]

A schedule II controlled substance is a drug or other substance that (1) has a high potential for abuse, (2) has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions, and (3) may lead to

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[20] R.C. 4730.45.

[21] R.C. 4730.44(A)(3)(c).

[22] *Id.*

[23] R.C. 4730.44(C) and 4730.45(A).

[24] R.C. 3719.06(A)(3).

[25] R.C. 4730.40(A)(1).

severe psychological or physical dependence if abused.[26] Examples include hydrocodone, oxycodone, morphine, and methamphetamine.[27]

The bill imposes three restrictions that generally apply to a physician assistant's ability to prescribe schedule II controlled substances. The three restrictions are that (1) the patient must have a terminal condition, (2) the physician assistant's supervising physician initially prescribed the substance for the patient, and (3) the prescription must be for an amount that does not exceed the amount necessary for the patient's use in a single, 24-hour period.[28] The three restrictions do not apply when the physician assistant issues the prescription from the following locations:[29]

(1) A hospital registered with the Department of Health;

(2) A health care facility operated by the Department of Mental Health or the Department of Developmental Disabilities;

(3) A nursing home licensed by the Department of Health or a political subdivision;

(4) A county home or district home that participates in Medicare or Medicaid;

(5) A hospice care program;

(6) A community mental health facility;

(7) An ambulatory surgical facility;

(8) A freestanding birthing center;

(9) A federally qualified health care center;

(10) A health care office or facility operated by a board of health of a city or general health district or an authority having those duties.

The practical effect of this change is that the bill, except as discussed below (see "**Convenience care clinics**"), authorizes a physician assistant to prescribe a schedule II controlled substance from the locations specified above as long as the physician assistant is (1) prescribing a schedule II controlled substance that is on the drug

[26] 21 United States Code § 812(b).

[27] 21 Code of Federal Regulations § 1308.12.

[28] R.C. 4730.411(A).

[29] R.C. 4730.411(B).

formulary for physician assistants, (2) acting in accordance with the physician assistant's supervisory plan or the policies of the health care facility in which the physician assistant practices, and (3) the physician assistant's prescriptive authority does not exceed the prescriptive authority of the physician assistant's supervising physician.

Convenience care clinics

The bill prohibits a physician assistant from prescribing any schedule II controlled substance to a patient in a convenience care clinic. The bill specifies that this prohibition applies even if the convenience care clinic is owned or operated by an entity that is one of the locations from which a physician, under the bill, may prescribe schedule II controlled substances without being subject to the three restrictions that otherwise apply when a physician assistant prescribes a schedule II controlled substance.[30]

Medicaid reimbursement rates

The bill requires the Medicaid program, for any service a physician assistant provides to a Medicaid recipient, to reimburse the physician assistant in an amount that is 100% of the amount established as the "Medicaid maximum" for the service as contained in the Medicaid fee schedule.[31] (The Medicaid fee schedule is adopted by ODJFS in an administrative rule.[32]) Generally, a physician assistant currently receives only 85% of the Medicaid maximum.[33]

Am. Sub. H.B. 153 (the biennial budget) addressed the topic of Medicaid reimbursement for physician assistants, but in a manner that may be in conflict with the bill. Under H.B. 153, Medicaid reimbursement rates for services provided during fiscal year 2013 cannot be greater than the Medicaid reimbursement rates for services provided on June 30, 2012.[34]

Patient Centered Medical Home Education Advisory Group

The bill requires that the Patient Centered Medical Home Education Advisory Group, created to implement and administer the Patient Centered Medical Home Pilot

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[30] R.C. 4730.411(C).

[31] R.C. 5111.0216.

[32] O.A.C. 5101:3-4-03(C)(5).

[33] Telephone interview with ODJFS representative (July 25, 2011).

[34] Section 309.37.53(B) of Am. Sub. H.B. 153 of the 129th General Assembly.

Project, include in its membership one individual appointed by the governing board of the Ohio Association of Physician Assistants.[35] The Pilot Project was created to advance medical education in the patient centered medical home model of care – an enhanced model of primary care in which care teams attend to the multifaceted needs of patients, providing whole person comprehensive and coordinated patient centered care.[36]

The bill also requires the Advisory Group, when selecting physician practices with educational affiliations to participate in the Pilot Project, to strive to select practices that utilize physician assistants as part of the healthcare delivery system.[37]

Emergency medical services (EMS) authorized by physician assistants

The bill adds physician assistants to the list of health care professionals from which emergency medical service (EMS) personnel may obtain required authorization through a direct communication device to perform certain services. However, the physician assistant must be designated by a physician. Currently, EMS personnel may obtain prior authorization through a direct communication device from either a physician or physician-designated registered nurse.[38]

The bill extends to physician assistants the existing immunity from civil liability that applies when physicians and physician-designated registered nurses advise or assist in the provision of emergency medical services by means of any communication device or telemetering system. As under the existing immunity provisions, the immunity extends to physician assistants from states that border Ohio when the physician assistants advise or assist EMS personnel from those states who are providing services in Ohio. The bill retains the qualification specifying that the immunity does not apply if the communication or assistance is provided in a manner that constitutes willful or wanton misconduct.[39]

Emergency medical services in a hospital

The bill adds physician-designated physician assistants to the list of health care professionals from which direction and supervision must be obtained in order for EMS personnel to be authorized to perform emergency medical services in a hospital emergency department or while moving a patient from the emergency department to

[35] R.C. 185.01 and 185.03.

[36] R.C. 185.02 (not in the bill).

[37] R.C. 185.05.

[38] R.C. 4765.35, 4765.37, 4765.38, and 4765.39.

[39] R.C. 4765.49(A) and (F).

another part of the hospital. Currently, EMS personnel may do so under the direction and supervision of either a physician or physician-designated registered nurse.[40]

Each of these EMS personnel provisions applies in the case of first responders and the three types of emergency medical technicians (EMTs) – basic, intermediate, and paramedic.

EMS training program students supervised by physician assistants

The bill extends the existing immunity from civil liability that applies with regard to a student enrolled in an emergency medical services training program accredited by the State Board of Emergency Medical Services, or a Board-accredited continuing education program, to those occasions when the student is under the direct supervision and in the immediate presence of a physician assistant. Currently, the immunity applies when the student is under the direct supervision and in the immediate presence of an EMT-basic, EMT-intermediate, EMT-paramedic, registered nurse, or physician. The bill retains the qualification specifying that the immunity does not apply if the services, care, or treatment is provided in a manner that constitutes willful or wanton misconduct.[41]

EMS law not applicable to physician assistants

The bill specifies that nothing in the law governing EMS personnel prevents or restricts the practice, services, or activities of any physician assistant practicing within the scope of the physician assistant's physician supervisory plan or the policies of the health care facility in which the physician assistant is practicing.[42]

HISTORY

ACTION	DATE
Introduced	01-03-12

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[40] R.C. 4765.36.

[41] R.C. 4765.49(C)(1).

[42] R.C. 4765.51.