Attachment H

2/22/2021

To: Colorado Legislators,

I am a (family practice) physician at New West Physicians*** in (Golden) Colorado. I am writing to support Bill HB21-1184, (Reps. Lontine and Will & Sen. Winter). “HB21-1184 updates the term used to describe the PA-physician relationship from “supervision” to “collaboration.” It also eliminates the legal requirement that an experienced PA be supervised by a physician after their first three years of clinically practicing as a PA, and after an additional year of supervised clinical practice when changing specialties. Employers will retain the ability to require additional supervision (PA bill fact sheet).”

After working with experienced PAs for many years, I believe that they are qualified to provide safe, quality patient care in collaboration with their physician colleagues, and that they do not require direct physician supervision.

Sincerely,

Julia Atkins MD

***This letter is not intended to represent the views of my employer, New West Physicians, but rather my own personal views.

Ann Chevalier
Certified Nurse Midwife
19129 w 53rd loop
Golden, Co
80403

November 11, 2020

Dear Colorado Legislators,

This letter is to request that the supervisory requirement be removed from the Colorado practice laws for physician assistants. We are all well aware that there is a problem in Colorado with lack of access to quality medical care, especially in rural areas. PAs are poised and ready to provide this care if restrictive laws can be removed. There is ample evidence that PAs and NPs provide excellent care and their outcomes are similar, in many cases better than physicians. While laws have changed recently that have removed vicarious liability for physicians who supervise PAs, there has been no corresponding acknowledgement that this implies that PAs are *already* working independently.

As with physicians, PAs and NPs are well trained to perform their duties within their scope of practice. It is the professional responsibility of the practitioner to know their limits and refer appropriately. Allowing PAs to practice using their full scope will improve access to safe care. Removing the supervisory language is the safe and responsible choice to improve health care and to reduce unnecessary burdens on physicians who are already facing a crisis in burnout.

Thank you for your consideration on this issue, and for being part of the solution for Colorado citizens who need medical care.

Sincerely,

Ann Chevalier, Certified Nurse Midwife

3/17/21

To Whom it May Concern regarding Bill HB21-1184,

I am writing about the issue of Physician Assistant professional privileges. I write as a retired orthopedic surgeon and I am mentioning this only to suggest a relevancy to the subject. I think it is necessary that medical professionals are not prevented from practicing to the limits of their training and their credentialing. PA's have had a long time now to demonstrate their abilities to contribute to our medical care delivery system. Most physicians were skeptical at first as to the competency that PAs could achieve. Now it is rather universally agreed upon that PAs are extremely valuable professionals after they have spent an adequate time gaining experience working under the preceptorship of a physician. Physicians get their practical experience in residency programs to prepare themselves to competently deliver care. PAs get their "residencies" by precepting with physicians in the actual practice in the area of their interest. These professionals need to be allowed by law to practice to the limits of their credentials.

Thanks,

Paul Phillips MD (retired)

Colorado
Radiological
Society

4582 S. Ulster Street #201
Denver, CO 80237
(303) 770-6048

March 19, 2021

To the Representatives of the Health and Insurance Committee,

The Colorado Radiological Society (CRS) is the state chapter of the American College of Radiology representing physician-trained radiologists with over 38,000 members, including over 600 radiologists providing imaging interpretation services to patients throughout the state of Colorado. CRS respectfully submits its comments in OPPOSITION to HB21-1184 Physician Assistant Collaboration and Reimbursement.

Physician Assistants (PA) are welcome and important members of the healthcare team, however their educational model was never meant for independent practice without physician supervision. Physicians are required to have a 4 year undergraduate degree, 4 years of medical school including 2+ years of SUPERVISED training, and 3-7+ years of SUPERVISED post-graduate training in their specialty. This is well over 10,000 hours of supervision prior to independent practice. Additionally, physicians are required to take 3 standardized national exams, called the USMLE exams. In the latter half or after the completion of post-graduate specialty training, they are required to take an additional 1-2 standardized national specialty exams, commonly known as the board exam, to achieve to board certification.

The PA educational and certification requirements are less rigorous than a physician. Furthermore, this bill allows each PA to have an even further truncated education with fewer required hours and "collaboration" instead of supervision.

The American Medical Association (AMA) published a survey that was conducted nationally from 2008-2018 asking random US citizens about transparency in healthcare. 91% of respondents said a provider's year of medical education and training are VITAL to optimal patient care. Similar high percentages of survey respondents said they prefer a physician to have primary responsibility of the management of the health. [1]

While improving access to care in rural areas is paramount to improve our health care system, there is no guarantee or evidence this law will address that concern. In fact, the AMA workforce tracker tool and other studies published in the medical literature show that PAs often concentrate in urban environments. Arizona instituted Nurse Practitioner independence in 2001— the workforce report from 2017 showed after 17 years of independent practice, only 11% of Arizona Nurse Practitioners practice in rural areas while serving only 15% of the state's rural population. The same study indicated only 13% of physician assistants practice in rural areas. [2]

There is no evidence this law will lead to healthcare cost savings. There are several studies showing non-physician providers drive up the cost of health care by ordering more costly unnecessary tests, such as blood work or imaging studies. Additionally, non-physicians drive up costs via unnecessary sub-specialty referrals often because they lack the comprehensive education of a primary care physician to manage patients themselves. [3, 4]

Radiologists share the same concern as our other physician colleagues about the impact this bill will have on patient safety. A physician with 10-14 years of training is more capable of appropriately handling emergent and complex imaging results than a provider with only three years of experience. CRS values the role our PA colleagues play in facilitating the care of patients, but when a test result demonstrates complex or emergent findings, we often seek out the supervising physician to ensure the most appropriate and safe care is provided in a timely fashion. It is the job of the practitioner ordering a test to know how to manage the results. It's a danger to patient care when they don't know… and don't have the appropriate supervising physician to ask.

Please oppose this bill.

Sincerely,

Aaron Kirkpatick, MD

President, Colorado Radiological Society

REFERENCES:

1. https://www.ama-assn.org/sites/default/files/media-browser/premium/arc/tia-survey_0.pdf
2. https://crh.arizona.edu/sites/default/files/pdf/publications/PA_NP_CNM_workforce_report.pdf
3. Lohr, Robert H., et al. "Comparison of the quality of patient referrals from physicians, physician assistants, and nurse practitioners." *Mayo Clinic Proceedings*. Vol. 88. No. 11. Elsevier, 2013.
4. Hughes, Danny R., Miao Jiang, and Richard Duszak. "A comparison of diagnostic imaging ordering patterns between advanced practice clinicians and primary care physicians following office-based evaluation and management visits." *JAMA internal medicine* 175.1 (2015): 101-107.

Colorado State Legislature
Committee on Health and Insurance
Hearing Testimony March 24th, 2021
re: HB 21-1184

Committee members,

I urge a NO vote on HB 21-1184 which would allow for the independent practice of physician assistants (PAs) in Colorado. As a resident of Colorado (HD-7, SD-33) and graduating medical student I believe I have a unique perspective and interest in the provision of medical care in Colorado.

For more than 100 years, the minimum standard for an independently practicing physician has been the completion of an accredited medical school (4 years) and residency training (3-7 years). While it is easy to focus on the years of training (or hours required in this bill) it is also important to understand the rigor of training. Simply put, experience does not equal qualification. I do not believe anyone would doubt me when I say the education a physician receives during medical school is more rigorous in every way when compared to a physician assistant. Likewise, residency training is not equivalent to "on the job experience," as residents must meet didactic and national benchmarks, including case exposures, to progress though training.

I will be graduating from the University of Colorado School of Medicine this year. By the provisions of this bill, I have met or exceeded the hours required. Why then am I not allowed to practice independently? How would you respond if I introduced myself as a medical student, who was managing the care of your loved one without supervision? Would you allow me to move to rural colorado and set up a practice?

The job of a PA and a physician are different. Does 5,760 hours (3 years) of supervised practice of minor complaints or follow-up visits prepare the PA to see an undifferentiated patient? Diagnose a cancer patient? Oversee the care of a hospitalized patient? Interpret imaging? Similarly, would you allow a flight attendant who has been on the job for 5,000 hours to pilot a plane? When I investigated the hours required for other professions, I found Colorado requires 4 years or 8000 hours of experience to obtain master licensure as a plumber or electrician.[1] If this bill were to pass, it would be easier to practice medicine independently in Colorado than plumbing.

Your committee will no doubt hear from proponents of this legislation that allowing PAs to practice independently will improve access and costs for Colorado residents, particularly in rural locations. Similar claims were made by nurse practitioners (NPs) who won independent practice in Colorado in 2010. However, the promises of rural NP practice have not materialized. Only half of nurse practitioners enter primary care and less than 11% work in "rural settings."[2] We still face a primary care shortage today. Similarly, only 36.8% of Colorado PAs work in primary care[3] and again only 11% work in rural

[1] CRS 12-155-110; CRS 12-155-110
[2] A Profile of Colorado's Advanced Practice Nurse Workforce, Colorado Health Institute, 2012
[3] 2017 Statistical Profile of Certified Physician Assistants, National Commission on Certification of Physician Assistants (NCCPA)

settings.[4] The simple fact is, PAs and NPs practice where physicians practice. Most PAs work in highly urban and specialized settings. If improved access to care in rural communities is the primary motivation, why not limit independent practice to rural areas only?

In fact, access to poor care may be worse than no care at all. Do rural residents deserve a lesser standard of medical care? Numerous studies have shown that physician assistants order more tests and imaging.[5,6,7] Order more antibiotics.[8] Refer patients to more specialists.[9] There is strong evidence that expanding prescriptive authority for physician assistants has resulted in more prescribing of opioids. A 2020 study published in the Journal of General Internal Medicine found 8.4 percent of physician assistants prescribed opioids to more than 50 percent of their patients, compared to just 1.3 percent of physicians. They also found nurse practitioners and physician assistants in states with independent prescription authority for schedule II opioids were 20 times more likely to overprescribe opioids compared to nurse practitioners and physician assistants in states with restricted prescription programs. It is important to note that the study also found from 2013 to 2017 almost every other medical specialty decreased opioid prescribing while nurse practitioners and physician assistants increased opioid prescribing.[10]

There are real harms to independent practice. Emmalyn Nguyen was a Colorado teen who underwent a routine surgery with anesthesia provided by a non-physician. Unfortunately, she suffered a brain injury from a lack of oxygen and ultimately died.[11] Her case is still being litigated. It is up to the proponents of PA independent practice to supply evidence that their practice is safe. To date, **there has been no single scientific study that compared the safety of independent PAs to physicians.** All the currently available studies have looked at physician assistants who work under the supervision of a physician, with a specific protocol or had additional training.

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[4] Profile of Colorado's Physician Assistant Workforce 2017, Colorado Health Institute

[5] Anderson AM, Matsumoto M, Saul MI, Secrest AM, Ferris LK. Accuracy of Skin Cancer Diagnosis by Physician Assistants Compared With Dermatologists in a Large Health Care System. JAMA Dermatol. 2018 May 1;154(5):569-573. doi: 10.1001/jamadermatol.2018.0212. Erratum in: JAMA Dermatol. 2018 Jun 1;154(6):739. PMID: 29710082; PMCID: PMC6128496.

[6] Hughes DR, Jiang M, Duszak R. A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. *JAMA Intern Med.* 2015;175(1):101–107. doi:10.1001/jamainternmed.2014.6349

[7] Roumie CL, Halasa NB, Edwards KM, Zhu Y, Dittus RS, Griffin MR. Differences in antibiotic prescribing among physicians, residents, and nonphysician clinicians. Am J Med. 2005 Jun;118(6):641-8. doi: 10.1016/j.amjmed.2005.02.013. PMID: 15922696.

[8] Sanchez GV, Hersh AL, Shapiro DJ, Cawley JF, Hicks LA. Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. *Open Forum Infect Dis*. 2016;3(3):ofw168. Published 2016 Aug 10. doi:10.1093/ofid/ofw168

[9] Diabetes Mellitus Care Provided by Nurse Practitioners vs Primary Care Physicians, *J Am Geriatr Soc* 63: 1980–1988, 2015.

[10] Lozada MJ, Raji MA, Goodwin JS, Kuo YF. Opioid Prescribing by Primary Care Providers: a Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns. J Gen Intern Med. 2020 Sep;35(9):2584-2592. doi: 10.1007/s11606-020-05823-0. Epub 2020 Apr 24. PMID: 32333312; PMCID: PMC7459076.

[11] https://denver.cbslocal.com/2020/10/12/emmalyn-nguyen-dies-breast-augmentation-surgery-medical-complications/

PA independent practice will create a two-tiered system of medical care in Colorado. The rural, poor, and people who have no choice will be seen by physician assistants. Many do not know the training and educational differences between PAs and physicians. For example, my mother sees anyone wearing a white coat as a physician. She would not be able to advocate for herself should she need to see a physician or need a higher level of care.

Often, I see lobbyists for large insurance and hospital corporations pushing for non-physician independent practice. Is this an attempt to make profit by bypassing physicians in care? If PAs cost less, why are they reimbursed at the same rates as physicians? What incentive would a business have to employ a physician if they can employ a PA and make the same margin?

If not PA independent practice, then what can Colorado do to increase access to care for rural Colorado? First, we can increase incentives for physicians to practice in rural Colorado. As a graduating medical student, I have over $350,000 of educational debt. The Colorado Health Service Corps would grant me $90,000 for 3 years of rural service.[12] That is approximately 25% of my debt. This would also require I waive other incentives or bonuses. This simply does not make it financially advantageous for me to work in a rural setting. Second, we can increase physician residencies in Colorado. The most likely thing to determine where a physician practices is where they go to residency. Fundamentally, if we have a shortage, we need to train more physicians, not physician replacements. Third, we need to make the job of a doctor easier. Reduce administrative burden and increase reimbursements for Colorado Medicaid. Many doctors do not want to practice in settings with high Medicaid populations due to the low pay and high regulatory burden. I am sure Colorado physicians and medical associations would be happy to work with legislators to craft these improvements.

Again, I urge the committee members to vote NO on HB 21-1184.

Thank you for your consideration,

Casey Dolen
Denver, CO

[12] https://cdphe.stg.colorado.gov/prevention-and-wellness/health-access/colorado-health-service-corps/colorado-health-service-corps-0

March 22, 2021

The Honorable Susan Lontine
Chair, Colorado House Health and Insurance Committee
Colorado General Assembly
200 E. Colfax Avenue
Denver, CO 80203
Delivered electronically: susan.lontine.house@state.co.us

RE: Oppose CO HB 21-1184: Physician Assistant Collaboration And Reimbursement

Dear Chairwoman Lontine:

On behalf of the undersigned organizations, we are writing to express our opposition to HB 21-1184, which would reimburse physician assistants (PAs) at the same level as physicians while removing the requirement for PAs to be under the supervision of a physician with a collaborative agreement that would no longer be needed after 5,760 hours of practice, Using PAs as primary care providers or specialists is in no way equal to the intense years of training physicians undergo to be proficient in their specialty. Our organizations support retaining physician-led team-based care and working together with PAs as important members of that team; however, physician assistants are not primary care providers and classifying them as such is misleading and will confuse the public.[i]

Physicians Are Uniquely Qualified to Lead the Health Care Team

There are substantial differences in the education of physician assistants and physicians, both in depth of knowledge and length of training. After finishing a rigorous undergraduate academic curriculum, physicians receive an additional four years of education in medical school. This is followed by 3 – 7 years of residency and 12,000-16,000 hours of patient care training.

Medical students who attend schools accredited by the Liaison Committee on Medical Education are required to care for patients in both inpatient and outpatient settings in the following clinical rotations: family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery.[ii] Similarly, students at colleges of osteopathic medicine that are accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation must receive education in the following clinical disciplines: internal medicine, family medicine, pediatrics, geriatrics, obstetrics and gynecology, preventive medicine and public health, psychiatry, surgery, radiology, and basic knowledge of the components of research.[iii] All medical students must also select a number of specialty elective rotations to

round out their exposure to the branches of medicine, ensuring a broad and comprehensive medical knowledge base upon which they build by choosing an area of practice specialization for graduate medical education, commonly known as residency.

In stark contrast, physician assistants complete a 26-month physician assistant program followed by 2,000 hours of clinical rotations, which emphasize primary care in ambulatory clinics, physician offices and acute or long-term care facilities.[iv] Rotations could also include family medicine**,** internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry.[v] Unlike physicians, physician assistants are not required to complete a residency program. Physician assistants who elect to practice in dermatology are trained in the clinic by dermatologists.[vi]

By any measure, the differences in training are significant. Given the wide array of challenges that confront the independent practitioner, particularly as the population ages, physicians' additional training and expertise allows them to substantively reduce the incidence of complications and to recognize and treat complications appropriately should it occur. **Reimbursing these two professions are the same amount makes no sense when considering the extensive training physicians go through to become board-certified dermatologists.**

There is a wide spectrum of training and expertise among health care professionals. In a clinical setting, it is often impossible for patients to know whether the person providing their care is a physician, nurse, physician assistant, pharmacist, dentist, or dental hygienist. This creates a great deal of confusion for individuals receiving health care. Our patients have the right to know the credentials and the level of training of that person making the important medical diagnosis, pushing medications into an intravenous line, using a scalpel, or pointing a laser at their face, torso, arms, or legs.

Quality patient care includes evaluating a patient's needs and current condition, selecting an appropriate course of treatment and providing adequate information and follow-up care. Any physician performing a cosmetic medical procedure should be qualified by residency training and a fellowship or other post-graduate training that includes an extensive understanding of cutaneous medicine and surgery, the indications for each procedure, and the pre- and post-operative care involved in treatment. When non-physician practitioners are given legal authority to perform the same procedures physicians spend years in medical and surgical training to perform, patient safety is seriously compromised. ***Short term, basic training is in no way equivalent to a physician's training and understanding of a medical procedure and its implications for each patient.***

As physicians, our number one priority is the health and welfare of our patients. Our organizations appreciate the opportunity to provide written comments on this important public health issue. We respectfully urge you to carefully consider the ramifications of HB 21-1184, which suggests physician and physician assistants are equivalent in training and education. We remain committed to providing high quality care and serving the best interests of our patients in a collaborative way with physician assistants through physician-led team-based care. If you have any questions, please contact Emily Besser, ASDSA Manager of Advocacy and Practice Affairs, at *ebesser@asds.net* or (847) 956-9121.

Sincerely,

American Society for Dermatologic Surgery Association
Colorado Dermatologic Society

cc: Colorado House Health and Insurance Committee

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[i] ASDSA *Position Statement on Delegation.* https://www.asds.net/Portals/0/PDF/asdsa/asdsa-position-statement-delegation.pdf

[ii] Liaison Committee on Medical Education (LCME). LCME Accreditation Standards with annotations. www.lcme.org.

[iii] American Osteopathic Association (AOA). College of Medicine Accreditation Standards and Procedures. https://osteopathic.org/accreditation/standards/

[iv] How are PAs Educated and Trained? https://www.aapa.org/what-is-a-pa/#tabs-2-how-are-pas-educated-and-trained

[v] Ibid.

[vi] The Society of Dermatology Physician Assistants, http://hireadermpa.com/dermpa-training/

March 22, 2021

The Honorable Susan Lontine
Chair, Colorado House Health and Insurance Committee
Colorado General Assembly
200 E. Colfax Avenue
Denver, CO 80203
Delivered electronically: susan.lontine.house@state.co.us

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round out their exposure to the branches of medicine, ensuring a broad and comprehensive medical knowledge base upon which they build by choosing an area of practice specialization for graduate medical education, commonly known as residency.

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Sincerely,

American Society for Dermatologic Surgery Association
Colorado Dermatologic Society

cc: Colorado House Health and Insurance Committee

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[ii] Liaison Committee on Medical Education (LCME). LCME Accreditation Standards with annotations. www.lcme.org.

[iii] American Osteopathic Association (AOA). College of Medicine Accreditation Standards and Procedures. https://osteopathic.org/accreditation/standards/

[iv] How are PAs Educated and Trained? https://www.aapa.org/what-is-a-pa/#tabs-2-how-are-pas-educated-and-trained

[v] Ibid.

[vi] The Society of Dermatology Physician Assistants, http://hireadermpa.com/dermpa-training/

3/21/21

To Whom It May Concern:

I am writing in strong support of support HB21-1184.

I am a certified PA, practicing psychiatry for the past 12 years, the entire length of my professional career. Two years ago, I also obtained an additional Certification of Added Qualifications in Psychiatry from the NCCPA. I am currently with Centura Health, practicing in an outpatient hospital-based clinic associated with Porter Hospital. I have been with Centura for nearly 4 years, previously working with their integrated behavioral health program, where I was able to provide psychiatric care within primary care clinics in the Denver metro area as well as virtually for our underserved mountain areas. I would love to be able to live in the Colorado mountains and serve our rural, underserved areas, however as these areas are have very few psychiatrists, under our current supervision laws, I am unable to provide my needed services to these patients. It is disappointing to think that patients in metro areas are able to access care whereas others are not; location should not make one patient more deserving of care than another.

I have held a few PA positions over the years, both here in Colorado and previously in North Carolina. I trained under a board-certified psychiatrist, my supervising physician (SP), working in tandem with him over the course of a year, before I began to see patients of my own, with continued close supervision for the next two years before transitioning to another practice. I felt competent to practice within the specialty over the course of two to three years, and feel that supervision should be required for new graduate PAs or PAs changing their area of practice. I have worked fairly independently after that, in a second private practice, later practicing psychiatry in an 8 bed psychiatric emergency room within a 36-bed level-1 trauma ER, transitioning to being the primary provider in a crisis stabilization unit prior to joining Centura Health in 2017. Although I have had close, professional relationships with all my supervising physicians, and have discussed cases when clinically appropriate, I am certainly at a place in my career where I have the education, training and experience as well as the resources to treat my patients well, using evidence-based medicine without much of a need to consult others. That being said, I enjoy practicing within a health care team, discussing cases, continue learning, getting support and having collegial relationships.

Should “supervision” change to “collaboration,” as I strongly support, there is little that would change regarding the way I practice. I have my own panel of patients, booked solid most days, participate in a clinic-wide provider meeting monthly as well as a clinic-wide meeting monthly. I have lunch meetings with my SP regularly, provided as support for the APPs on my team. The other APPs, who are NPs, have been in practice for only a few years and require more support than I do, though I gladly participate in the meeting and provide recommendations and support for my colleagues. Every once in a great while, I will have a challenging case, or a patient I cannot seem to get through to, and I ask questions of the group, and of my SP, just as they do.

I am fortunate that my current SP is board certified in child, adolescent and adult psychiatry, which is the scope that I was initially trained in and practiced for the first 5-6 years of my career. Prior to transitioning to my current position, my SP was only board-certified to treat adults. Therefore, an entire population of children and adolescents had to be referred out of their family medical practice to other psychiatric providers in the community (a limited pool to pull from) in order to be in accordance with the law, when I could have provided care for them, there, in a familiar and comfortable environment should I of not been constrained by his medical degree to determine my scope of care. It is difficult to get patients to establish with psychiatry in the first place, especially parents of children middle school-aged and below, but this barrier also increased time to establish with the care that they often need right then and there. A situation like this should not be acceptable.

As noted above, I continue to be very interested in continuing to practice team-based care. However, I would also like to be able to provide my services on a PRN basis, or at some point in the future, move into a more rural area and provide desperately needed psychiatric care to those communities. It is a great hassle for me to moonlight or provide as needed care, even around Denver metro, because of the administrative burdens associated with requiring "supervision." It often feels that it is not worth the time for these organizations to partner with a strong provider such as myself, given that "red tape," if you will. Moving into an underserved area will likely not be an option for me, for similar reasons. Given that it is underserved, there will likely not be an MD or a DO to supervise me, in spite of being completely capable of managing my own caseload, given my training and experience, but also because I fully understand the limitations of my training and when to seek help or send a patient to a higher level of care.

Per the Colorado Health Institute, "Colorado has a higher prevalence of mental health issues and lower rates of access to care, according to Mental Health America's 2021 State of Mental Health in America report. Colorado has an overall ranking of 47 out of 50 states and the District of Columbia, based on account 15 measures of mental health and substance use prevalence among adults and youth as well as access to care…More than one in 10 Coloradans reported not getting needed treatment for mental health issues in 2019, according to the Colorado Health Access Survey. The number of suicide deaths where a current diagnosed mental health problem was reported has increased over time, but gaps in treatment persist." Help me, as a well-trained and competent psychiatric provider, help Coloradans with improved access to care by removing outdated and unnecessary administrative burdens and reliance on physicians to provide such care. Again, I fully support signing support HB21-1184 into law.

Sincerely,

Brandy Frazao, MCMS, PA-C, CAQ-PSYCH
The Centre for Behavioral Health, Porter Hospital
Centura Heath

March 22, 2021

Eric Niemeyer
Chief Executive Officer
High Plains Community
Health Center

To: Members of the Committee on Health and Insurance

RE: Support for HB 21-1184 – Physician Assistant Collaboration & Reimbursement

Dear Members of the Committee on Health and Insurance:

I come to you as a Chief Executive Officer of a community health center in Lamar (rural) Colorado.

I give you this brief written testimony for the purpose of asking your support of for HB 21-1184, Physician Assistant Collaboration & Reimbursement, where you consider broadening the scope of authority and expanding the independence of the Physician's Assistants (PA's) here in Colorado. Since I know that you will be hearing testimony from a wide range of perspectives, I will confine my testimony to that of a healthcare administrator.

Here I give you a "quick scan" format of bullet points and justification for each point:

- My health center and generally, rural Colorado, struggles to attract, recruit, and retain qualified healthcare providers. This means that we need as many available providers with the least amount practice supervision restrictions as possible. Current PA supervision requirements – by physicians - limit my recruiting choices.

- We thank the Colorado legislature for recently expanding the supervision ratio of a physician that oversees PA's. Though this was a wonderful step in the right direction, for struggling rural provider organizations, it may still be cost prohibitive to demand a certain number of physicians be employed to oversee one or more PA's.

- In my thirteen years of experience as a healthcare administrator I have not seen any difference between nurse practitioners – who can practice with complete autonomy – and PA's. If there has been any notable difference the average quality of PA healthcare delivery has exceeded the average nurse practitioner.

- Over the years I have noted a competitive attitude amongst physicians towards PA's. I believe that this is so because PA's operate within the same "scope of practice" as do family practice physicians (this does not include physicians with specialized training), or physicians utilized in a scope of care outside the standard "family medicine" scope. This competitive attitude fosters the physician's lobby to keep the physician oversight over PA's. It certainly is not a quality-of-care issue, as I have noted, as PA's on average deliver equal or greater quality of services than do their physician colleagues. Many physicians would argue their own broader training, but such is irrelevant if both the physician and the PA are operating within the same scope of practice – family medicine.

- Ultimately, the question is about patient provider access and patient choice. Granting the PA greater practice autonomy and expanded practice independence would increase the patient's choices. Many physicians would like to limit this PA freedom to the patient, but PA's in general want to expand this freedom of choice to the patient.

- Physicians, on average, cost twice to three times more than the cost of a PA to a health center but deliver equal quality of service. This means that a health center can provide greater patient choice and do so more cost effectively than with a physician. For struggling – and especially for rural – health centers, a few physicians are needed but more PA's and nurse practitioners are needed.

- The departure of physicians from a health center can disrupt the current "supervision ratio" – and in some cases – cause severe limitations or an absolute bar to a practicing PA. A PA and his/her patients should not be subject to this risk.

I ask that you please vote to support HB 21-1184 - Physician Assistant Collaboration & Reimbursement.

I thank you for your consideration of this important matter.

Eric Niemeyer, CEO

High Plains Community Health Center

Lamar, CO 81052

March 21, 2021

Respected Committee Members,

It is my pleasure to write this letter in support of the passage of H.B. 21-1184. I believe it is very important to update legislation to give Colorado's PAs the ability to practice the profession that they were trained to do without the added burden of administrative constrictions.

I currently serve as the chairperson for the High Plains Community Health Center in Lamar, Colorado. I have been a director on the board since 2011. Within that time, I have seen our small clinic struggle to bring in providers to our area. We are very fortunate in that we currently have a very knowledgeable and capable team of PAs and MDs working to care for over 8000 patients in Prowers County and surrounding areas.

I have reviewed the bill and I believe that our PAs can do everything that they are trained to do and able to comply with the new updated requirements of the bill. This new legislation if passed will enable our clinic to continue to attract qualified medical providers and help us move to the future with strong teams and qualified staff.

The majority of our HPCHC providers are PAs, they are the very educated, and continue to learn in collaboration with physicians and other professionals. New PAs have had hands-on patient care prior to their graduation, they have spent more than 2,000 hours prior to coming to our practice and complete the required hours at the center in collaboration with our MD providers.

Our clinic has an onboarding plan for all new providers including PAs, H.B. 21-1184 does not change the requirements for oversight for new PAs, after 3 years PAs will be able to continue a collaboration with physicians. Additionally, with the new bill any PA who intends to change their specialty will enter a formal collaboration for an additional 2 years.

PAs complete 100 hours of CME courses every 2 years and must recertify every 10 years. 16 other states have already adopted this updated PA regulation and there have not been any adverse effects such as malpractice suits or board action.

H.B. 21-1184 would allow PAs with more than three years of experience to practice without a specific agreement with a physician, the collaboration with physicians will continue always keeping in mind the best interest of the patient.

Lamar, Colorado, and most of eastern Colorado is rural and H.B. 21-1184 will allow PAs to practice in places where they are needed most. I humbly ask you to support this very important bill.

Respectfully,

Cecilia Dowell
HPCHC – Board Chair
719.688.8880
Cecilia4hpchc@gmail.com

March 22, 2021

Eric Niemeyer
Chief Executive Officer
High Plains Community
Health Center

To: Members of the Committee on Health and Insurance

RE: Support for HB 21-1184 – Physician Assistant Collaboration & Reimbursement

Dear Members of the Committee on Health and Insurance:

I come to you as a Chief Executive Officer of a community health center in Lamar (rural) Colorado.

I give you this brief written testimony for the purpose of asking your support of for HB 21-1184, Physician Assistant Collaboration & Reimbursement, where you consider broadening the scope of authority and expanding the independence of the Physician's Assistants (PA's) here in Colorado. Since I know that you will be hearing testimony from a wide range of perspectives, I will confine my testimony to that of a healthcare administrator.

Here I give you a "quick scan" format of bullet points and justification for each point:

- My health center and generally, rural Colorado, struggles to attract, recruit, and retain qualified healthcare providers. This means that we need as many available providers with the least amount practice supervision restrictions as possible. Current PA supervision requirements – by physicians - limit my recruiting choices.

- We thank the Colorado legislature for recently expanding the supervision ratio of a physician that oversees PA's. Though this was a wonderful step in the right direction, for struggling rural provider organizations, it may still be cost prohibitive to demand a certain number of physicians be employed to oversee one or more PA's.

- In my thirteen years of experience as a healthcare administrator I have not seen any difference between nurse practitioners – who can practice with complete autonomy – and PA's. If there has been any notable difference the average quality of PA healthcare delivery has exceeded the average nurse practitioner.

- Over the years I have noted a competitive attitude amongst physicians towards PA's. I believe that this is so because PA's operate within the same "scope of practice" as do family practice physicians (this does not include physicians with specialized training), or physicians utilized in a scope of care outside the standard "family medicine" scope. This competitive attitude fosters the physician's lobby to keep the physician oversight over PA's. It certainly is not a quality-of-care issue, as I have noted, as PA's on average deliver equal or greater quality of services than do their physician colleagues. Many physicians would argue their own broader training, but such is irrelevant if both the physician and the PA are operating within the same scope of practice – family medicine.

- Ultimately, the question is about patient provider access and patient choice. Granting the PA greater practice autonomy and expanded practice independence would increase the patient's choices. Many physicians would like to limit this PA freedom to the patient, but PA's in general want to expand this freedom of choice to the patient.

- Physicians, on average, cost twice to three times more than the cost of a PA to a health center but deliver equal quality of service. This means that a health center can provide greater patient choice and do so more cost effectively than with a physician. For struggling – and especially for rural – health centers, a few physicians are needed but more PA's and nurse practitioners are needed.

- The departure of physicians from a health center can disrupt the current "supervision ratio" – and in some cases – cause severe limitations or an absolute bar to a practicing PA. A PA and his/her patients should not be subject to this risk.

I ask that you please vote to support HB 21-1184 - Physician Assistant Collaboration & Reimbursement.

I thank you for your consideration of this important matter.

Eric Niemeyer, CEO

High Plains Community Health Center

Lamar, CO 81052

To the Legislators of the State of Colorado,

Thank you for taking the time to read and hear my testimony opposing HB21-1184 PA Collaboration and Reimbursement. I am the director of the Fort Collins Family Residency Program, a Board Member of the Northern Colorado Medical Society, and a member of the Colorado Medical Society. I have practiced as a primary care provider and taught residents in full scope family medicine for the last 15 plus years in Fort Collins. During that time, I have also worked extensively with Advanced Practice Providers in both the outpatient and inpatient setting.

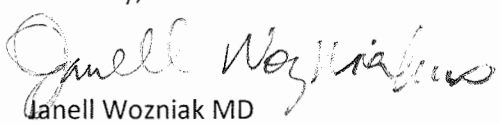
In the 8 years I have served as Program Director, I have closely supervised resident physicians working tirelessly to become properly trained to do what they do each day. Of course, we value all work in health care and my intent in this letter is to not diminish the work of Physician Assistants, rather I want to urge you to better understand the level of training physicians undergo in order to properly care for patients **unsupervised**. This proposed legislation, as outlined, creates the risk that Physician Assistants will not have adequate time in training and with supervision, thus putting our Colorado community members at risk.

Residents on average work 60 hours each week, and frequently closer to 80 hours each week, for a minimum of three years and at times up to six years. Many of them then move on to fellowship training which can mean a total training time of up to 9 years. Within one day, a resident physician or fellow may move from the clinic to the operating room to the intensive care unit – caring for 30-40 patients in a day under the supervision of more experienced physicians within their areas of expertise. Training such as this, with most days mirroring this intensity, allows a physician to be ready to practice medicine independently following the completion of residency and applicable fellowships. 5760 hours (equal to 40-hour work weeks for three years), is nowhere close to equivalent to the training that physicians must go through to practice medicine unsupervised. Additionally, I have great concern about a Physician Assistant who might want to switch specialties, this bill only calls for a PA to do an extra 960 hours of training in this new specialty before they can become unsupervised, whereas a physician or resident would have to go through their **entire residency** all over again if they were to switch specialties.

It is hard to fathom a resident physician being ready to work without supervision if they were to only be allowed to train forty hours/wk for three years. We find that it usually takes 2-3 years at 60-80 hrs/wk for resident physicians to know what they DON'T KNOW. Something that is critical in the transition to independent practice. Not much is more dangerous than a healthcare provider who doesn't know when they are in over their head.

Thank you for your diligence on this critical issue.

Sincerely,



Janell Wozniak MD

Residency Program Director, Fort Collins Family Medicine Residency Program
1025 Pennock Place
Fort Collins, CO 80524
O (970) 495-8855 **F** (970) 495-8891
Janell.Wozniak@uchealth.org

COLORADO
SOCIETY OF OSTEOPATHIC MEDICINE

Members of the House Health & Insurance Committee,

I am a Board Certified Osteopathic Family Physician since 1994. I earned my medical degree from Nova Southeastern University College of Osteopathic Medicine in 1991 and completed a residency in Family Medicine in 1994. I have worked in clinical practice and academic medicine since completing my Family Medicine Residency Training. During my career I have had the opportunity to work with many members of the health care team such as nurses, physician assistants and other healthcare technicians.

Prior to attending medical school, I attended a Physician's Assistant training program at Emory University from 1978 to 1980 and the worked in a Primary Care Practice for 7 years before returning to medical school in 1987.

As a Physicians Assistant the training was two years, one year in the classroom and one year of clinical rotations. As a Family Physician, the training consisted of four years of medical school, two years in the classroom and two years of clinical rotations and three years of residency training. At the end of this training I was eligible to independently practice medicine as a Family Physician.

In my opinion, the depth and breadth of my training as a physician was much deeper than my training as a Physician's Assistant. Returning to physician training after working as a Physician's Assistant, I realized "I did not know what I did not know". Comparing the training of a Physician's Assistant to the training of a residency trained physician is comparing "apples to oranges".

I must oppose HB21-1184 allowing Physician's Assistants to be independent practitioners. The creation of the Physician's Assistant profession at least 40 years ago was not intended to be an independent practitioner but be an extension of the supervising physician. Today, the training of a Physician's Assistant has not significantly changed.

Finally, the most important issue that must be addressed is patient safety. Can a provider with two years of training deliver the same level care as a provider with at least seven years of training acting independently? I would be concerned of uncommon or complicated diagnoses being missed or mistreated.

For the safety of our patients in Colorado, please vote to oppose HB21-1184.

Thank you.

Joseph Stasio, D.O., FACOFP

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

March 23, 2021

Members of the Health & Insurance Committee
Colorado General Assembly
200 E Colfax Avenue
Denver, CO 80203

Re: Opposition to H.B. 1184

Dear Members of the Heath & Insurance Committee:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I am writing to express our **strong opposition to House Bill (H.B.) 1184**. This bill would allow physician assistants to practice medicine without any physician involvement, including the ability to diagnose and treat patients. As drafted, H.B. 1184 replaces physician supervision with a weakened definition of collaboration and only requires such collaboration for 5,760 hours of practice experience. These parameters are woefully inadequate to maintain patient safety, sets Colorado apart from other states, and is not what patients want. In a recent AMA survey, 68% of U.S. voters agreed. Specifically, when it comes to receiving high quality health care, patients believe that physicians should be involved in medical diagnoses and treatment. Patients also are increasingly concerned about the cost and quality of health care and removing physicians from the care team is a step in the wrong direction. As such, we strongly encourage you to oppose H.B. 1184.

The AMA has long valued the commitment of physician assistants to the team-based model of care, and greatly respects the contributions physician assistants make to the health care team. It is our long-held belief that health care professionals' **scope of practice should be based on standardized, adequate training, and demonstrated competence in patient care**. This is imperative in protecting the health and safety of our patients. While all health care professionals share an important role in providing care to patients, their skillsets are not interchangeable with those of a fully trained physician. Patients want and expect a physician to be involved in their medical diagnoses and treatment decisions. Health care is about fixing a problem. Patients expect the most qualified person—physician experts with unmatched training, education and experience—to deal with the unexpected. That is why the AMA has long supported physician-led health care teams, with the members drawing on their specific strengths, working together, and sharing information and decision-making for the benefit of the patient. Just as teams do in business, government, sports, and schools, health care teams require leadership. With seven or more years of postgraduate education and more than 10,000 hours of clinical experience, physicians are uniquely qualified to lead the health care team.

The AMA is deeply concerned that H.B. 1184 eliminates physician-led teams and ultimately, allows physician assistants to practice medicine without any physician oversight. First, H.B. 1184 would set Colorado apart from the 40 states that currently require physician supervision of physician assistants by

replacing the "supervision" definition in current statute with "collaboration." Not only does this weaken the relationship between a physician and physician assistant, but it actually goes much further and in effect, eliminates such a relationship after 5,760 hours of "practice experience," a fraction of the more

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AMA
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than 10,000 hours physicians complete. It is important to note, "practice experience" is not defined in the legislation and there is no standardization in how this experience must occur or requirements to demonstrate competence upon completion. In addition, any physician assistant currently licensed in Colorado or licensed in another state may attest they have met this requirement simply by submitting an affidavit as such to the Board of Medicine. This means, upon passage of H.B. 1184, any physician assistant currently licensed in Colorado can practice medicine without any physician involvement after submitting an affidavit to the Board of Medicine that they have met said requirements. This back door approach to practicing medicine should give legislators great concern.

Scope of practice should be based on standardized, adequate training, and demonstrated competence in patient care. The well-proven pathways of education and training for physicians to obtain a license to practice medicine include medical school and residency, and years of caring for patients under the expert guidance of medical faculty. As stated above, physicians complete more than 10,000 hours of clinical education and training during their four years of medical school and three-to-seven years of residency training. By sharp contrast, the current physician assistant education model is two years in length with 2,000 hours of clinical care—and includes no residency requirement. Adding 5,760 hours of patient experience is woefully inadequate for the independent practice of medicine. This is alarming and should give legislators great pause when considering the appropriateness of creating essentially two separate paths for obtaining a license to practice medicine.

The AMA agrees with the conclusion of physician assistant educators that physician assistant education is inadequate for independent practice. The Physician Assistant Education Association (PAEA) recently surveyed physician assistant educators—program directors, past presidents, and medical directors—about independent physician assistant practice. (PAEA. Optimal Team Practice: The Right Prescription for New PA Graduates? Available at http://paeaonline.org/wp-content/uploads/2017/05/PAEA-OTP-Task-Force-Report_2017_2.pdf.) Overwhelmingly, respondents concluded that the current physician assistant school curriculum does not adequately prepare physician assistants to practice without physician supervision, collaboration, or oversight. Rather, the current education system trains physician assistants under a model created with the intention to prepare physician assistants to practice in a mutually beneficial team-based care model under the supervision of or in collaboration with physicians.

Specifically, in the PAEA survey, first, all respondents were asked, "[D]oes your program's current curriculum already prepare your graduates to practice without a supervisory, collaborating, or other specific relationship with a physician in order to practice?" **Eighty-six percent of physician assistant program directors and 100 percent of PAEA past presidents responded, "no."**

Next, particular concern was expressed by physician assistant educators about the implications of proposals to remove physician supervision or collaboration for new physician assistant school graduates, who "may have an incomplete understanding of their own limitations and knowledge and/or are practicing in settings where there are geographic or other barriers to consultation." According to the PAEA, this could lead to the negative consequences of compromising physician assistants' success and confidence and pose a potential risk to patient safety.

Moreover, many physician assistant students are under the impression that upon graduation they will be practicing under a high degree of physician collaboration, which may decrease as they gain experience. **PAEA data indicates that 91 percent of physician assistant students nearing graduation described the collaborating physician relationship as "essential" or "very important."** The AMA agrees, and as such, encourages members of the House Health and Insurance Committee to oppose H.B. 1184.

As the provision of health care in this country becomes more complex, a fully coordinated, quality-focused and patient-centered health care team will be the optimal means by which Americans will receive their health care. In the physician-led team approach, each member of the team plays a critical role in delivering efficient, accurate, and cost-effective care to patients. The AMA is committed to helping all members of the health care team work together in a coordinated, efficient manner to achieve the triple aim in health care: ensure that Colorado's patients receive the highest quality of health care, at the lowest cost, resulting in the most optimal clinical outcomes. **Simply put, H.B. 1184 is contrary to this goal**.

Finally, the AMA is concerned with language in H.B. 1184 that would allow physician assistants to prescribe controlled substances without physician supervision. There is strong evidence that expanding prescriptive authority for physician assistants has resulted in more prescribing of addictive opioids. A 2020 study published in the *Journal of General Internal Medicine* found that 8.4 percent of physician assistants prescribed opioids to more than 50 percent of their patients, compared to just 1.3 percent of physicians. They also found nurse practitioners and physician assistants in states with independent prescription authority for schedule II opioids were 20 times more likely to overprescribe opioids compared to nurse practitioners and physician assistants in states with restricted prescription programs. It is important to note that the study also found that from 2013 to 2017 almost every other medical specialty decreased opioid prescribing while nurse practitioners and physician assistants increased opioid prescribing. We believe you will agree that these results are startling, yet they are indicative of the significant risk patients in Colorado will face if H.B. 1184 becomes law.

For all of the reasons stated above, the AMA stands in strong opposition to H.B. 1184 as written. We urge you to oppose H.B. 1184, as well.

Thank you for your consideration. If you have any questions, please contact Kimberly Horvath, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at kimberly.horvath@ama-assn.org.

Sincerely,

James L. Madara, MD

cc: Colorado Medical Society

I am writing in support of HB21-1184.

The current supervisory requirements for Physician Assistants have created many barriers to providing efficient care in Occupational Medicine in the State of Colorado. The requirement for physician co-signatures on the majority of all patient charts is an administrative burden and an unnecessary task that does not contribute to the quality of care provided. The inability of Physician Assistants to assist with basic patient care duties, such as completing and signing task-letters for injured workers or addressing legal inquiries on patients is an archaic approach. The requirement that a physician personally see the patient within the first 3 visits is also a requirement that does not add much value to the over-all quality of care that the patient receives.

I have worked with many Physician Assistants during my 23 years in the practice of medicine. First alongside them in the Emergency Department, and more recently for the past 4 years in the 26 Occupational Medicine and urgent care clinics that I oversee here in the State of Colorado. I have found that experienced Physician Assistants are very capable and provide safe, high quality medical care to their patients. The majority of Physician Assistants with experience in their chosen fields have developed a high level of expertise and I have found them to be highly qualified and able to work independently. It is important that any health care provider have an awareness of their own limitations and the need to utilize their resources for guidance on management of complicated or difficult cases. A collaborative relationship between a Physician and Physician Assistant is an essential part of providing high-quality patient care. This type of relationship should foster a partnership that is designed to elevate patient care through professional mutual respect, collaboration, and the efficient delivery of that care. Collaborative partnerships such as these will help us to leverage the valuable knowledge and skill of Colorado's Physician Assistants and will help to create a care team that excels in providing high quality and efficient care to patients.

In the world of Occupational Medicine, we must find a way to better utilize our clinicians. The reality is that physicians are in short supply in this arena of medicine. The Scope of practice for Physician Assistants should be tied to their level of education, years of experience, specialized training, and certifications. Physician Assistants with adequate experience and training can participate in collaborative relationships with physicians and other health care team members and effectively work independently. Ultimately, the scope of practice of Physician Assistants should allow for organizations to tailor the utilization of these highly capable individuals to the needs of the healthcare delivery team and our patients. This approach can allow for a more flexible and customized health care team while empowering experienced Physicians Assistants to continue to provide excellent high quality care to the Colorado community. HB21-1184 will provide employers with needed flexibility in customizing their health care teams, while ensuring high quality care. I ask for your support of this important legislation.

Sincerely,

Trina Bogart, MD
Director of Medical Operations-Colorado
Concentra
970-443-0521 (m)
620 S. Lemay Avenue
Fort Collins, CO 80524
www.Concentra.com

Valley-Wide
Health Systems, Inc.

03/23/2021

House Committee of Reference: Health and Insurance
Colorado General Assembly
State Capital Building
200 E. Colfax Avenue
Denver, CO 80203

RE:
HB21-1184

Dear Madam Chair, members of the committee,

I am a Board Certified Family Medicine physician and Regional Medical Director at Valley-Wide Health Systems in Canon City, CO, serving the rural community of Fremont County in southern Colorado.

This letter is my request for your support of House Bill HB21-1184, Physician Assistant Collaboration.

I believe it is my civil duty as a healthcare professional to advocate for my patients, and this bill will ultimately be of benefit for them.

As I understand, this bill will increase access to affordable, quality care – *especially* for our most vulnerable population by removing the outdated and unnecessary legal requirement for a physician to directly supervise a PA after the first 3 years in practice.

Our current healthcare system needs a collaborative team practice where all providers are able to work within their full scope.

HB21-1184 will improve a licensed PA's ability to practice to the full extent of their education, training, and experience by removing outdated administrative barriers like supervision agreements and chart review between a PA and physician. The bill will also ensure that experienced PAs will continue to informally collaborate with other members of the health care team, including physicians.

I currently practice with three outstanding PA colleagues. As a team, we provide high quality, affordable, accessible primary care to meet the medical needs of the citizens of Fremont County on a daily basis. The administrative burden of chart review and supervisory agreements for experienced PAs is outdated and cumbersome.

To my knowledge, PAs have always been held to strict clinical and safety standards of care. They are held to the same standards for physicians in the state of Colorado because both physicians and PAs are regulated by the Colorado Medical Board. I have full confidence in PA training and education since I have been personally working with these professionals on a daily basis.

This bill will increase access to care and affordability of care by removing the outdated and unnecessary legal tether between one physician and one PA.

Today's healthcare providers at all levels of training, work in teams and hopefully always will. The outdated "independent practice" is a thing of the past and will not be the standard going forward.

In my opinion, removing supervision and replacing it with a period of collaboration will not affect how PAs practice in the real world. This bill will allow PAs and their practices greater adaptability to provide on-going comprehensive services to patients, especially in rural areas like Fremont County.

Thank you for your time and attention to this matter, it is greatly appreciated.

Sincerely,

Phyllis Pennington, DO
Regional Medical Director
Valley-Wide Health Systems, Inc.
121 N 6th St.
Canon City, CO 81212

Thank you to the Representatives of the Committee on Health & Insurance for your time.

My name is Taj Kattapuram, MD and I am a physician in the specialty of radiology. I am testifying on behalf of the entire house of medicine in strong opposition to HB-1184.

PAs are integral and valued members of a physician-led team. The key words being physician-led. Their educational model is significantly truncated in comparison to physicians, where we have 10s of thousands of hours of supervised care and 4-6+ standardized national exams prior to independent practice. We can't even get into medical without doing well on the MCAT entrance exam.

The physician assistant education was never meant for independent practice. The word assistant is paramount because to assist by the very definition means to NOT be independent. There is no other industry I'm aware where the assistant can be independent without the completion of a rigorously tested/certified educational program.

Vet techs can't be veterinarians without the DVM degree and passing a national exam. Paralegals who want to be attorneys must take the LSAT to get into law school and take the BAR exam before practice. Teachers' aides must get educated and certified before becoming professors, and the list goes on.

There are some major myths and half-truths given as reasons for pushing this bill.

1. *PAs provide just as good of care as physicians.* In a statement by the American Academy of PAs (AAPA) to the American Medical Association (AMA) November 2020, they claim PAs have similar health outcomes as physicians. However, every study cited to support this claim includes PAs who were supervised by physicians or used consultation services of physicians. Furthermore, most studies focused on a SINGLE diagnosis when many patients have multiple concurrent chronic diseases. These studies support PAs as members of a physician-led team, not as independent providers. [1]
2. *Increased access to rural care.* The Graduate Nurse Education (GNE) Demonstration was published recently in 2019, and it showed only 9% of Nurse Practitioners (NPs) went to rural areas. [2] A study from Arizona in 2017 showed 17 years after granting NPs independence, only 15% of them serve the state's rural population. In that same study, only 13% of PAs practiced in rural AZ. [3] The AMA has a healthcare workforce tracker tool. Searching 2020 data specifically for PAs in Colorado shows they concentrate in urban areas. There is no specific language in the bill to encourage or drive PAs to rural CO. Plus, our rural constituents tend to have multiple and more chronic medical concerns. They deserve access to physicians.
3. *Increased primary care practitioners*. The GNE Demonstration showed only 12% of NPs practiced primary care. [2] In HB1184, there is language for how PAs need to collaborate if they switch specialties. There is nothing in this bill that guarantees PAs will increase primary care services. Isn't that the access most of your constituents need?
4. *Healthcare cost savings*. There are multiple studies published in the medical literature that non-physicians increase healthcare costs, whether it's unnecessary or inappropriate lab work, imaging studies, specialty referrals, or medications. For example, a study published in the

Journal of the American College of Radiology in 2018 showed skeletal x-ray ordering increased by 441% among non-physician providers, primarily NPs and PAs. [4]

I'll end with two important, anonymous true stories shared with me.

1. The first anecdote is regarding the change of wording from supervision to collaboration. This is a big deal. Under supervision, physicians are ultimately responsible for the patient. With collaboration, there is no guarantee a physician would ever be involved, or if involved that they'd be heard. Here is true story #1 "I manage a cardiac surgical icu, the hospital hired NPs to cover nights we can't. The hospital hired a new, but "experienced" NP. Last week, this NP ordered a head CT, EEG and called for a neurology referral/inpatient consultation because he thought a patient was having a seizure. It was clonus, an involuntary non-seizure related movement, and this NP had no clue about this basic physical exam finding. This NP texted me for collaboration to ask how to order an eeg. When I asked why, he described clonus and I told him to call Neuro if he was really concerned, but the other studies weren't necessary. He didn't listen. He ordered the cat scan and the electroencephalogram anyway… and then called Neuro."
2. The second true story is from a patient experience by a hospital c-suite administrator "my loved one was in the hospital. We were not given the option to see a physician. We were seen the entire time by an NP who ordered a bunch of tests and couldn't tell us why or what the results meant. It's a great way to drive up costs. I know this because as a retired hospital CEO I'm inclined to hire these mid-levels to drive up my profits. They have cheaper salaries. They order a lot of tests. They make a lot of referrals we can bill within our system. I had no reason to keep physicians until I experienced the replacement care first hand and feared for my loved one's safety. Unfortunately it's too late to reverse these decisions because I'm retired, but I'm hopeful legislators will hear this story and not exacerbate the problem."

In conclusion, please vote no on HB1184. PAs provide the best care as part of a supervised team. This bill gives no guarantee for increased rural access, no guarantee for increased primary care services, no guarantee of healthcare cost savings. In fact, all data points against these ideas.

What might be guaranteed… a high likelihood when you, your loved one, or your constituents need or want to see a physician… we won't be available.

Please oppose this bill. Vote Nay.

Thank you for your time.

Sincerely,

Taj Kattapuram, MD

REFERENCES:

1. https://www.aapa.org/news-central/2020/01/aapa-response-to-amas-stopscopecreep-campaign/
2. https://innovation.cms.gov/files/reports/gne-final-eval-rpt.pdf
3. https://crh.arizona.edu/sites/default/files/pdf/publications/PA_NP_CNM_workforce_report.pdf
4. Mizrahi, DJ et al. National Trends in the Utilization of Skeletal Radiography From 2003 to 2015. Journal of the American College of Radiology, Volume 15, Issue 10, 1408 - 1414

Colorado Chapter

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

March 24, 2021

To: Members of the House Health & Insurance Committee
RE: **Testimony on HB 21-1184, Physician Assistant Collaboration and Reimbursement**

My name is Megan Stinar, and I am a pediatrician practicing both outpatient and inpatient pediatrics in Grand Junction and for the Western Slope. Please accept this written testimony on behalf of the American Academy of Pediatrics, Colorado Chapter on House Bill HB21-1184. AAP-CO is respectfully opposed to the bill.

In my career I have worked with all levels of providers and advanced practitioners on many different teams. I currently work with physician assistants both in my office and at the local regional hospital. Every medical provider in healthcare is important and needed. And it is my belief that a medical team with diverse training backgrounds is essential to offering the best medical care possible. However, the members of the medical team are not equal in depth of knowledge, and they are not interchangeable.

I would like to take a moment to explain my medical training as a physician. Every physician has attended a four-year medical school, which was undoubtedly competitive and difficult to be accepted to. Due to the rigorous requirements of medical school, not every student graduates. Once a medical student graduates, they have officially earned a medical degree and the title "doctor." However, despite the title, doctors apply to and attend residency programs where they will get an additional 3 to 6 or more years of medical training in their chosen specialty as resident physicians. During these years of residency training, most resident physicians spend an average of 80 hours a week working in the hospital for hands-on training. For me, to become a pediatrician after medical school I attended a pediatric residency program where I gained over 11,000 hours of training. If a physician wishes to switch specialties, they must apply for and go to a residency program in that specialty, again getting 3 to 6 or more years of training before working in that new specialty independently.

With this background, you can understand why allowing physician assistants to practice independently and without formal physician supervision after a few years of experience causes me justified hesitation to support this bill. Additionally, being able to switch specialties with as little as 960 hours of supervision is unreasonable and unsafe. Furthermore, physicians are trained to read, appraise, and act on academic medical studies. After a year of COVID and COVID related studies being shared on the nightly news, I would imagine you can understand the complexities that come with continuing medical education and staying up to date on the best medical care. For these reasons, physicians and physician assistants should not be considered equals in their knowledge or training. This bill proposes that insurance reimbursement for physician assistants should be equal to that of physicians, which greatly concerns me as we do not have the same training background or knowledge depth.

My other concern is that this bill has been brought to the house as a solution for access to healthcare in the rural parts of Colorado. While I agree there are some areas of Colorado that do not have adequate

healthcare access, offering physician assistants without physician support would be ill-informed and unsafe. As a pediatrician in Grand Junction, I provide care for many children that come to me from the small towns of the Western I-70 corridor, around the Uncompahgre plateau area, and into the far northwest corner of the state.

I understand these families may have hours to drive before they can reach reliable 24-hour access medical care. However, I also know that these remote clinics can have anything from seasonal allergies to a life-threatening injury that will need critical care for several hours while waiting for safe transport. And while I do not mean to catastrophize the healthcare needs of rural towns, I want to be clear that expecting a physician assistant without physician-level 24-7 support to be able to manage a rural clinic, urgent care or emergency room is troublesome and unsettling. I believe Colorado can support physician assistants working more in the rural regions of the state, but only with at least phone access to physician support. I also am worried that this bill offers no guarantee that physician assistants would work in rural areas if this bill were passed. While I am committed to increasing healthcare access to rural Colorado, this bill does not accomplish that goal.

Thank you for the consideration of the AAP-CO's input on this bill. We urge you to vote no on HB 21-1194. Please do not hesitate to reach out to me by phone or email if you have any questions.

With Respect,

Megan Stinar MD FAAP
719-351-8713
mstinarmd@gmail.com
Grand Junction Colorado, Mesa County

RE: BILL HB21-1184

Members of the House Health & Insurance Committee
200 E Colfax Ave
Denver, CO 80203

March 23, 2021

Dear Members of the House Health & Insurance Committee,

I am a full-time practicing Physician Assistant at Rose Medical Center and I have been in clinical practice for just shy of fifteen years. I have spent all of those years working in Orthopedics, Spine, and Neurosurgery in the same acute care facility. I am writing today to ask you to support HB21-1184, Physician Assistant Collaboration. This bill brings forth necessary change in the supervision of physician assistants in Colorado to be more in line with current times in the practice of medicine and the functionality of healthcare team models.

HB21-1184 will eliminate outdated administrative barriers that can negatively impact the employability of physician assistants because many physicians that are already overstretched for time do not always have the ability to accommodate the added burden of signing all the clinical notes of their PAs. This is especially burdensome and unnecessary when they have a long standing relationship with their PAs and trust their medical knowledge and skill sets. I have personally seen nurse practitioners offered positions over physician assistants because of the onerous administrative regulations that come with employing a PA. The current regulations that govern PA practice in Colorado do not necessarily improve the quality of patient care or prevent bad outcomes. The twenty physicians that I work with directly do not even review the PA notes they are cosigning to ensure sound clinical judgment or check the appropriateness of the treatment plans. In my opinion, my experience is likely not unique and many

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physicians are not utilizing the PA regulations as they were designed. These career long regulations are more burdensome than helpful for the healthcare team, especially several years into a PA-Supervising Physician relationship. I agree that oversight is essential in the beginning of a PA's career, but as the years of experience continue to increase, the utility of a physician's daily oversight on all patient encounters dwindles. Updating PA practice regulations will allow years of experience to have more meaning and determine the amount of proper oversight each individual PA requires. Collaboration with a supervising physician as needed should replace chart cosigning to be more efficient and meaningful to the physician, the PA, the rest of the healthcare team, and the patients.

Bill HB21-1184 will improve access and quality of care to patients across Colorado, regardless of geographic region, age, race or socioeconomic status. Under this bill, PAs will continue to be regulated and held to the safety standards set by the Colorado Medical Board just as they always have been. Physician assistants have been proven to provide sound, high quality healthcare to patients in research studies without increased malpractice claims or poor clinical outcomes when compared to physicians or nurse practitioners. The covid pandemic quickly provided a real life example of the effectiveness and quality of care provided by PAs across the country in all regions and practice settings when we did not have enough physicians to handle the massive amount of patients. I am aware of quite a bit of negative attention lately from physician groups regarding the quality of care PAs provide. When utilized and trained appropriately, PAs can be an integral part of the healthcare team that can use their experience and education to the furthest extent possible to improve patient care and outcomes. Every profession has incompetent or ineffective members, including physicians, physician assistants, teachers, engineers, police officers, etc. To make generalized statements about a profession is unfair and misleading. I am dedicated to every patient I treat and each physician I work with by keeping myself educated on the latest evidence based medicine and collaborating when needed to ensure patients are receiving optimal care from our healthcare team. Every PA I work with closely holds themselves to the same standards and moral code. The professional title does not bestow the competence on a healthcare provider; the individual's level of dedication to the practice of medicine determines the safety, effectiveness, and capability of that provider. The outdated PA practice regulations do not play a role in a PA's drive to

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provide excellent patient care and updating the regulations through Bill HB21-1184 will not decrease the quality of care PAs provide.

Sincerely,

Kimberly Houkal MS, PA-C
Rose Medical Center
Orthopedic and Spine Center
Supervising Physician Assistant

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I agree with the above letter. I am also a full time practicing PA in Orthopedics, Spine and Neurosurgery and have been working for almost sixteen years. Please consider how limiting PA care will affect the citizens of Colorado as you vote on this bill.

Sincerely,

Sarah Tilly MS, PA-C
Rose Medical Center
Orthopedic and Spine Center

I agree with the above letter. I am also a full time practicing PA in Orthopedics, Spine and Neurosurgery and have been working for almost five years. Please consider how limiting PA care will affect the citizens of Colorado as you vote on this bill.

Sincerely,

Renee Charest MSPAS, PA-C
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Orthopedic and Spine Center

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House Health & Insurance

Testimony - HB21-1184 Physician Assistant Collaboration & Reimbursement

First Name	Last Name	Position	Representing	Text of Testimony
Carolyn	Dacres	For	Self	I am writing in support of HB 21-1184, Physician Assistant Collaboration and Reimbursement. We are living in a time where affordable health care is difficult to access. Any means we can develop to ease availability of, and access to, quality health care by easing restrictions in a safe manner can only help this situation. Outcome studies have shown that care provided by Physician Assistants is comparable to care provided by medical doctors. A VA study (https://www.eurekalert.org/pub_releases/2019-06/varc-vsb060719.php) concluded that “The fact that PAs and NPs had similar results for quality of care without sharing care with a physician suggests that using these providers in primary care may improve the efficiency of health care.” A similar study (https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00014) concluded “In a large national sample of medically complex people with diabetes, when we controlled for important patient- and facility-level factors, we found greater rates of hospitalizations and ED visits and higher health care expenditures among primary care patients of physicians compared to those of NPs or PAs. These findings are notable particularly because we studied NPs and PAs in relatively expansive primary care provider roles analogous to those of physicians in the same system and because we analyzed the total cost of care over a one-year period.” There are a number of other outcome studies with similar conclusions. Easing the supervisory restrictions by establishing a collaborative practice model will increase the availability of Physician Assistants, who are in short supply in Colorado, and will have a positive impact on health care access and cost without compromising quality of care and outcomes. Sincerely, Carolyn Dacres, RXN, CNS Psychiatric Clinical Nurse Specialist with Prescriptive Privileges
Bridget	Carbiener	For	Self	I am writing in support of the physician assistant role moving from a supervised position by physicians to a collaborative position with physicians. Physician Assistants are highly trained and qualified providers supporting our medical practices in a variety of areas. One area with the most urgent need is Behavioral Health. This specialty has seen an exponential increase in need of services. Colorado currently has the sixth highest suicide rate in the nation. It is an extremely underserved population with lack of funding, support, and specialized providers. It is overloaded and burdened with needs and is disproportionately balanced with providers to carry the load. By allowing the physician assistant role to move from a supervisory role to a collaborative role, this would open doors for access to highly sought and needed care in this vulnerable population. It allows the providers to practice at the highest level of their scope and thereby allow for unhindered, unencumbered care to populations who need the care most urgently. We have already supported Nurse Practitioners in this role and have had overwhelming success. Please make the right decision and pass this bill to help our patients.
Emily	Zanardo	For	Self	This letter is in support of bill HB21-1184. As a nurse practitioner who has practiced and collaborated professionally with many physician's assistants, I recognize the invaluable role that PAs play in our healthcare system. This bill will help improve access to healthcare and entitle PAs to the professional growth and independence that they deserve. Sincerely, Emily Zanardo PMHNP-BC

Mark	Wallace	For	Sunrise Community Health	My written testimony as a family physician with 33 years' experience, and the Chief Clinical Officer of Sunrise Community Health (SCH), an FQHC providing physical, behavioral, and oral health services to residents of northern Colorado out of 11 clinical locations, is submitted representing our organization's position, in association with the Colorado Community Health Network, in favor of HB21-1184 (Physician Assistant Collaboration & Reimbursement). SCH employs 46 are physicians, advanced practice nurses (including certified nurse midwives), and physician assistants (PAs) practicing within the scope of family medicine, pediatrics, and women's health (including maternity care). We also employ an optometrist providing vision services and have 6 family medicine residents and 6 podiatry residents in training in our organization. Physician assistants make up 19 (40.4%) of the 47 clinicians on our team. PAs outnumber all categories of clinicians on our team and create the backbone of our ambulatory primary care system. SCH would not have been able to provide 159,934 visits in 2020 to 41,033 unduplicated patients without our highly trained and competent PA workforce. Our system ensures clinical on-boarding of all providers. Sunrise also dedicates a physician preceptor who is available for consultation by our non-physician providers. As a physician, and a chief clinical officer, I find the ongoing administrative burden of supervising PAs of low value add in ensuring quality care. This burden interferes with providing care in an efficient and effective manner. HB21-1184 won't change the current autonomous practice of PAs unless it's outside of their scope. PAs are highly educated, well trained clinicians who provide safe, quality care. The three-year formal collaboration period outlined in the bill is adequate time to safely assimilate PAs into our practice. If I, or SCH, feel a PA would benefit from more training or supervision, we will require it as this bill doesn't prohibit us from requiring more formal collaboration. PAs are a critical component of today's health care workforce. Their autonomous but collaborative patient care should be like other non-physician providers in Colorado. Reducing the administrative burden on our physicians as proposed in HB21-1184 will not reduce the quality of care delivered by SCH or our PAs. I ask Members of the House Committee on Health & Insurance to support HB21-1184.
Leslie	Eber	For	Self	I support HB21-1184. Physician Assistants are essential to geriatric and primary care medicine. I work in 4 Long Term Care Facilities and Physician Assistants not only add phenomenal expertise and elevate the quality of care for our fragile residents in nursing homes but they have additional time to invest in personal and meaningful connections with our patients. I have note on numerous occasions that due to their dedication and educational expertise, it has been the physician assistant that has discovered an additional diagnosis, eliminated an unneeded medication or initiated a non pharmacological intervention for pain that has made a significant difference in our patients lives. We need to honor the work, education and expertise of physician assistants and acknowledge the value they bring to patient care. Thank you for your consideration. Leslie Eber MD CMD
Caroline	Fernandez	For	Self	I am an APRN in psychiatry. I work with a fantastically driven and brilliant psychiatric PA who I believe should be viewed equally within our system and all others in healthcare.
Eliza	Schlutz	For	Home Care and Hospice Association of Colorado	The Home Care and Hospice Association of Colorado is very excited about this bill. Our industry employs PA's regularly to care for our fragile clients and keep them at home. During the pandemic, the federal government allowed PA's to order home health for their patients. We work closely with these PA's to establish and continue care. This change has made a significant difference in the wait time for clients to get care. For example, they are not waiting in the hospital longer than necessary to get the appropriate paperwork done to discharge and get care at home. PA's are a critical component of the home health system. Not only does this bill recognize the skills and training of a PA, but allows home health agencies to further partner with these essential providers so our patients can get the care they need, when they need it. We hope you'll support this great bill.

Witness Signup List

Pauline	Morrow	For	Self	My name is Pauli Morrow physician assistant who has a masters degree in medical science and over 22 years of clinical PA experience. I am writing today to ask you to vote “yes” in support of HB21-1184, Physician Assistant Collaboration. I am in strong support of this bill because physician assistants are integral in a healthcare team to continue to give quality medical care, better access to medical care and reduce overall healthcare costs. On the issue of updating the model of the PA-physician relationship from “supervision” to “collaboration.”: I am in support of changing the model of physician assistants supervised by a single physician. This would take away the burden on physicians and move to a more current model. In the distant past, it was one physician and one physician assistant. Now the climate has changed where multiple physicians and physician assistants (along with other APPs) are under one umbrella of a company. I feel that PAs should work within the parameters of a collaborative agreement and similar practice guidelines of the physician and nurse practitioners, where the guidelines of how one practices medicine is determined by the medical group or umbrella organization. In many cases, physicians do not want the liability and responsibility of supervising a PA. medical groups (including Boulder Medical Center in Boulder, a large network of 80 providers and 22 medical specialties) are changing their model to only hire nurse practitioners as APPs instead of PAs because of physicians within the group not wanting the liability of PAs. PAs are losing job opportunities. Updating “supervision” to “collaboration” will allow more job opportunities for PAs and modernize the PA/physician model allowing PAs to continue to decrease the cost of healthcare. In addition, allowing PAs to be eligible for direct payment by all public and private insurers will expand the number of available providers through the use of healthcare staffing companies and other business arrangements that require PAs to reassign insurance payments. Please consider voting “yes” to bill HB21-1184 (Physician Assistant Collaboration And Reimbursement) so that physician assistants can continue to give quality medical care, while moving forward in a more current model that would allow PAs to contribute in decreasing healthcare cost and increasing access to medical care.