

ANSWERING THE BELL

*by Don Stader,
MD, FACEP*



On May 3rd, 2019 the Seventy-second General Assembly of the Colorado Legislature adjourned. It has been a busy and grueling session, with medicine being the primary focus of many lawmakers. Many bills were authored that presented both opportunities and threats to our practices and patients.

During the session, one bill in particular captured the attention of our board and membership - House Bill 1174 on Out-of-Network billing. The bill set unfair rates for out-of-network care that threaten our ability to negotiate with insurers. We reached out to you, our members, to advocate for fair payment and fair benchmarks for out-of-network billing and you answered the bell. Many made phone calls, sent emails and came in person to legislative hearings.

Our organization published op-eds in the Pueblo Chieftain and Daily Camera, to educate the public. Emergency physicians advocated passionately for our patients and practices - and while we ultimately lost, and House Bill 1174 was passed, I could not be more proud of our organization and our members. On the senate and house floors, many lawmakers brought up emergency physicians, emergency patients and our practices stating their appreciation for what we do and promising to readdress out-of-network billing if our practices are harmed. Many of our colleagues from across medicine took note and expressed admiration of our organization and our engagement - we fought a great fight.

The most recent legislative session represents the first round in what will be a drawn out battle to protect patients from predatory billing practices, while also ensuring fair physician coverage and access to emergency care. Beyond the actions taken by our state legislature, out-of-network billing is receiving significant federal attention and we anticipate further action from Washington DC in the coming year. Your board, acknowledging the potential negative effects of House Bill 1174 and the potential for federal legislation, has formed a task force on Out-of-Network billing, has reached out to stakeholder organizations across Colorado and will continue to closely monitor the effects of both state and upcoming federal legislation.

Beyond out-of-network billing, your board continues to work to advance the practice of emergency medicine. We are excited to host ACEP19 in our state and welcome our colleagues from across the nation. The board is making plans for an education and social event in Colorado Springs and our opioid task force has joined, and is leading, a multispecialty group to write practice guidelines to address Colorado's Opioid Epidemic. The project named - The Colorado Opioid Solution: Clinicians United to Resolve the Epidemic (CO's : CURE) promises to publish the first joint multispecialty guidelines in the nation. As part of this effort COACEP will be updating our 2017 COACEP Opioid Prescribing & Treatment guidelines.

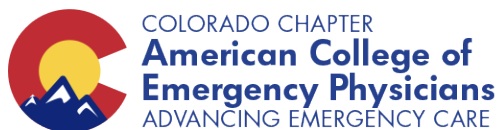
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EPIC



"The mission of the Colorado Chapter, American College of Emergency Physicians is to serve as the primary organization in the State of Colorado representing the specialty of Emergency Medicine, promoting the interests and values of emergency physicians and patients by giving physicians the tools to support the highest quality of emergency medical care."

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If you are interested in joining the opioid task force please reach out to either **Dr. Erik Verzemnieks** (our task force chair) or **me**.

On behalf of your board and our organization - thank you for answering the bell. For your involvement over the past few months of our legislative calendar. Thank you for your commitment to our specialty. Most of all, thank you for what you do in caring for your patients in their times of need. Your board is proud to represent you and will continue its work to advance and improve emergency care in our state. **E**

NEW POLICY STATEMENTS, PREP AND INFORMATION PAPER

During their April 2019 meeting, the ACEP Board of Directors approved the following new or revised policy statements/PREP/information paper (click on **RED** text to open link in your browser):

New Policy Statements:

- Salary and Benefits Considerations for Emergency Medical Services Professionals
- Small Motorized Recreational Vehicles
- Violence Prevention and Intervention in Emergency Medical Services Systems

Revised Policy Statements:

- Crowding
- Domestic Family Violence
- Patient Support Services
- Violence-Free Society

Revised Policy Resource and Education Papers (PREPs):

- Resource Utilization in the Emergency Department: The Duty of Stewardship

New Information Paper:

- Influenza Emergency Department Best Practices

POINT-OF-CARE TOOLS

(click on the logo below to open link in your browser):



Confusion and Agitation in the Elderly ED Patient



A tool to guide the management of ED patients with atrial fibrillation



Bariatric Examination Assessment, and Management



Buprenorphine use in the Emergency Department tool



Recognition and Treatment of Sepsis and Septic Shock



Identifying Suicidal Patients in the Emergency Department



Managing Acute Pain in the Emergency Department



Copy and paste these into your hospital's EHR system



Determine Ischemic Stroke Risk with Atrial Fibrillation

2019 LEGISLATIVE SESSION: The good, the bad, and the ugly

To say this was a tough legislative session in an understatement. 598 bills were introduced with 462 being sent to the Governor. Approximately one thirds of those dealt with health care. There is both good news and bad news to report from the Capitol as the 2019 Legislative Session has come to a close.

Let's highlight a few of the most troublesome pieces of legislation that passed. The out-of-network bill was a disaster for physicians. Patients were taken out of the middle of the situation, a desperately needed step which Colorado ACEP has long supported. The problem comes with the payment benchmark set in statute.

Although there is a significant drafting error in the bill as it was signed by the Governor, the reimbursement is set at the greater of the 60th percentile of commercial rates in the All Payers Claims Database or 100% of the carrier median in-network reimbursement for similar services by an equally qualified medical



professional in a similar geographic area. We fought hard to amend the bill with strong support of numerous senators including: Senator John Cooke, Weld County; Senator Chris Holbert, Douglas County; Senator Jack Tate, Arapahoe County; Senator Jim Smallwood, Douglass County; Senator Rhonda Fields, Arapahoe County and Senator Rachael Zenzinger, Jefferson County.

Public sentiment and politics were not on our side this year. With certain facilities and non-physician health care professionals misusing Colorado's existing statute as a business model, our ability to stop the political tsunami of HB19-1168 was nullified. Colorado ACEP and its members did an outstanding job in warning legislators of the devastating consequences this bill could have on access to care in Colorado. We need to carefully monitor insurers behavior over the next year. We anticipate that, as have happened in other states, insurers may terminate contracts and renegotiate contracts. We need to collect data regarding these actions along without ability to recruit and retain physicians in Colorado. Physician shortages can result in long wait times in the emergency department and an inadequate panel of specialists to whom patients need referred.

It became very clear early on in the process that HB19-1168 was part of the Governor's agenda. Politics were at an all-time high around this issue. There was simply no willingness to discuss the bill much less to accept amend to the bill.

Due to the drafting error referenced above, it will be necessary for the

By Suzanne Hamilton



legislature to pass a "Revisor's Bill" early in the 2020 session. The Office of Legislative Legal Services has already reached out to the insurance commissioner alerting him to the drafting error in hopes that rules and regulations necessary to implement the bill will be drafted pursuant to legislative intent and pending the clarification.

On another note, SB19-079 was also adopted which will mandate that controlled substances be prescribed electronically beginning July 1, 2021. The Colorado Hospital Association believes that they will have the technology in place in order for hospital-based physicians to meet this deadline. There are numerous exceptions to this requirement, and though we worked to get an exemption for emergency departments since they serve patients outside of normal business hours, the proponents of the bill were unwilling to allow such an amendment.

THE GOOD NEWS INCLUDES:

We were able to extend the sunset date of the medical practice act with SB19-193 as well as peer review in SB-234. These were big wins for physicians. HB19-1033 & HB19-1076 increased regulation of nicotine products in an attempt to cut back on underaged use of e-cigarettes. Statewide (SB19-073) and psychiatric (HB19-1044) advanced directives both passed and will help patients communicate their health care wishes. In addition, advances in battling the opioid crisis were adopted. We will use the website and future newsletters to dig deeper into those issues. **E**

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States Find Tool for Quick Legislative Response

By Harry J. Monroe, Jr.
Director, ACEP State and Chapter Relations

Those of us that work on state legislation often struggle with the pace of activity, particularly as deadlines approach for bills to get out of committee or as the end of the session nears. Lots of bills pass into law out of state assemblies, for both good and for ill, and taking advantage of the opportunity to impact them at a time that will make a difference frequently presents a challenge, particularly as regards mobilizing members to take action on key legislation having a significant impact on the practice of emergency medicine.

When ACEP rolled out engagED as a new social media platform for member communication and collaboration, I am not sure that it was really thought of as a new tool for advocacy efforts, but its value has been shown by at least a couple of chapters. In Indiana, an NP independent practice bill quickly made its way out of the state senate and appeared to be fast tracked for quick

passage, with many of those groups that might be expected to be opposed either sitting on the sideline or actually deciding to favor the bill. Indiana ACEP President Chris Ross used engagED to mobilize members. Over the course of the session, he and others used the platform to share talking points, urge emails and calls to state legislators, and mobilize members to show up at the capitol for hearings. The chapter effectively created a buzz that there were reasons for concern about the impact of this legislation on emergency departments, thus showing legislators opposition on an issue where they had been led to believe that there was none. The result was that the legislation could not make it out of the House. Victory was clutched out of the jaws of defeat.

Similarly, in Texas, legislation threatened to dismantle successful liability reforms that have been in place for more than a decade. Chapter

leaders used engagED to get information out, with the result that, according to TCEP's Immediate Past President, Gerad Troutman, many members reported reaching out to state legislators to oppose, and ultimately defeat, the legislation.

These examples from a medium and a large chapter point toward the potential of engagED as an advocacy tool for chapters of all sizes. engagED can be a tool that provides a mechanism for getting out information that in turn gives members what they need to reach their legislators with personalized communications in support of positions that promote the specialty.

If your chapter does not have a means for encouraging advocacy in a way that allows for communication of information with a quick turnaround, I would encourage looking at this example. **E**



ACEP19
Scientific Assembly
Denver, CO • October 27-30, 2019



Colorado ACEP Meeting Dates > **July 17, 2019 • Sept. 18, 2019 • Nov. 20, 2019**

All meetings begin at 12 noon and are held at the CMS/COPIC office located at 7351 E. Lowry Blvd. Denver, CO 80230

Josh Poles, DO, FACEP

Where did you train?

Bachelors: University of Arizona

Medical School: Kansas City University of Medicine and Biosciences

Residency: John Peter Smith, Fort Worth, Texas

Where do you practice in Colorado?

I joined the TeamHealth Northern Colorado practice. Our group covers four Banner Health facilities. My primary hospital is Sterling Regional MedCenter. This is a level III rural hospital that serves northeast Colorado. I also work at North Colorado Medical Center in Greeley, a Level II trauma center which hosts the Western States Burn Center. Beyond my clinical time I serve as Medical Director for Greeley Fire Department, Banner Health Paramedics and several other fire departments in Weld County.

Why did you choose to practice where you do?

I grew up in Arizona where I learned to love the outdoors. I was lucky enough to complete most of my fourth year medical school rotations in Colorado and I felt that I belonged in the Rocky Mountains. I joined our practice for a combination of reasons. Our group is relatively small and we have great cohesion among our doctors and APCs, as well as support from hospital administration. I am able to contribute in a meaningful way. I've received great leadership training and opportunities to expand my career beyond my clinical practice. I get to work in a busy tertiary hospital and a high-acuity rural hospital where I have come to appreciate rural medicine in ways I never imagined.

Favorite part of emergency medicine?

I love being an investigator and problem-solver for patients that need the most help. To help a patient go through a true emergency and make the emergency turn out as well as possible is what keeps me going.

Hobbies outside of medicine?

Outside of my clinical practice, I put a lot of time towards my EMS work. Beyond all of that, my most important hobby is being a great husband to my wife, Jessica. I am a novice dog trainer of our German Shepherd and we do tracking ("scent") work to keep her satiated. At my core, I am a ski-bum-turned-physician, so I find snow whenever I can. When there's no snow, I supplement with my bike,



skateboard and running shoes. And finally, food; Any good restaurant has my immediate attention.

Favorite place to visit in Colorado?

On a powder-day, Telluride. Otherwise, I have a fondness for Minturn.

Anything else you would like us to know about you? Or interesting fact about yourself.

After college I earned a music degree despite the fact that my childhood dream was to become a surgeon. As a kid, I would cut open all of my sisters dolls in an attempt to heal them. Immediately after college, I taught Spanish and worked a handful of other jobs. With music degree in-hand, I eventually went back to college to complete pre-medical curriculum before finally being accepted to medical school. The Spanish comes in very handy. The music degree does not. I am glad I chose emergency medicine over surgery. **E**

911 Network Member of the Year **Donald E. Stader, MD, FACEP**

Dr. Donald Stader, MD, FACEP has received 911 Network Member of the Year for his outstanding efforts to educate members in Colorado about ACEP-led legislative efforts to combat the opioid crisis. Dr. Stader conducted meetings and represented ACEP at district roundtables, convincing members of the Colorado congressional delegation to promote and include emergency department-specific provisions in the 2018 federal opioids legislative package. These proposals included expanding the Alternatives to Opioids (ALTO) program, which had proven its success in New Jersey and Colorado, and allowing emergency physicians to initiate medication-assisted treatment (MAT) for patients with an opioid use disorder. **E**



Leadership and Advocacy Meeting Report

The ACEP Leadership and Advocacy meeting was well attended by Colorado ACEP members with 8 Emergency Physicians in attendance. Conference activities focused on federal legislation on Out of Network billing and Psychiatric boarding in the Emergency Department.

Several days of lectures by both Emergency Physicians and politicos was followed by visits with our Senators and Representatives. We were able to meet with most of our legislators aides and a few Congressman as well. Representative Perlmutter was quite engaged with the legis-

lative proposals we were pushing. As a result of the ongoing lobbying efforts by our national ACEP chapter, NEMPAC, and our efforts going to Capitol Hill to engage our politicians, we have seen two very reasonable bills introduced in both the House and the Senate. **E**



Annals of Emergency Medicine Spring 2019

By Sam Shahid, MBBS, MPH

Practice Management Manager, ACEP

ACEP would like to provide you with very brief synopses of the latest articles and articles coming soon to Annals of Emergency Medicine. Some of these have not appeared in print. These synopses are not meant to be thorough analyses of the articles, simply brief introductions. Before incorporating into your practice, you should read the entire articles and interpret them for your specific patient population.

Andolfatto G, Innes K, Dick W, Jenneson S, Willman E, Stenstrom R, Zed PJ4, Benoit G.
Prehospital Analgesia With Intranasal Ketamine (PAIN-K): A Randomized Double-Blind Trial in Adults.

This randomized double-blind study compared use of intranasal ketamine with intranasal placebo in providing pain reduction at 30 minutes when added to usual paramedic care with nitrous oxide, for out-of-hospital patients with acute pain who reported a verbal numeric rating scale (VNRS) pain score greater than or equal to 5. The primary outcome was the proportion of patients with VNRS score reduction greater than or equal to 2 at 30 minutes. One hundred twenty subjects were enrolled and seventy-six percent of intranasal ketamine patients versus 41% of placebo patients reported a greater than or equal to 2-point VNRS reduction at 30 minutes (difference 35%; 95% confidence interval 17% to 51%). Median VNRS reduction at 15 minutes was 2.0 and 1.0 and at 30 minutes was 3.0 and 1.0 for ketamine and placebo, respectively. The study concluded that added to nitrous oxide, intranasal ketamine provides clinically significant pain reduction and improved comfort compared with intranasal placebo, with more minor adverse events. Full text available [HERE](#).

Sampson FC, Goodacre SW, O’Cathain A.
The Reality of Pain Scoring in the Emergency Department: Findings From a Multiple Case Study Design.

In this study, the authors utilized naturalistic, qualitative methods to understand how pain scores are used in practice and the mechanisms by which pain scoring may influence pain management. They undertook a multiple case study design, using qualitative research in 3 EDs in England (the cases) and incorporated 143 hours of nonparticipant observation, documentary analysis, and semi structured interviews with 36 staff and 19 patients. The analysis identified that ED staff used the pain score for 2 conflicting purposes: as an auditable tool for guiding patient management and as a tool for monitoring patient experience. This led to ED staff’s facing conflict between reporting their own judgment of what the pain score ought to be and what the patient said it was. The authors found that in practice, pain scoring may not accurately reflect patient experience and that using pain scoring to determine the appropriateness of triage and treatment decisions reduces its validity as a measure of patient experience. They concluded that pain scoring should not be central to audit and systems of accountability for pain management. Full text available [HERE](#).



Probst MA, Su E, Weiss RE, Yagapen AN, Malveau SE, Adler DH, Bastani A, Christopher W, Baugh CW, Caterino JM, Clark CL, Diercks DB, Hollander JE, Bret A, Nicks BA, Nishijima DK, MD, Shah MN, Stiffler KA, Storrow AB, Wilber ST, Sun BC.

Clinical Benefit of Hospitalization for Older Adults with Unexplained Syncope: A Propensity-Matched Analysis.

In order to determine whether hospitalization versus outpatient management for older adults with unexplained syncope was associated with a reduction in post-disposition serious adverse events at 30 days, the authors performed a propensity score analysis using data from a prospective, observational study of older adults with unexplained syncope/near-syncope who presented to 11 emergency departments (ED). The study enrolled 2,492 adults (≥ 60 years) who presented with syncope/near-syncope and no serious ED diagnosis from April, 2013 to September, 2016. Mean age was 73 years and 51% were female. The incidence of serious adverse events within 30 days after the index visit was 7.4% for hospitalized patients and 3.19% for discharged patients. After propensity score matching on risk of hospitalization, there was no statistically significant difference in serious adverse events at 30 days between the hospitalized group and the discharged group and the authors concluded that hospitalization was not associated with improvement in 30-day serious adverse event rates.

Berg LM, Ehrenberg A, Florin J, Östergren J, Discacciati A, Göransson KE.

Associations between crowding and 10-day mortality among patients allocated lower triage acuity levels without need of acute hospital care upon departure from the emergency department.

In order to describe the association between emergency department (ED) crowding and 10-day mortality for patients triaged to lower triage acuity levels at ED arrival and without need of acute hospital care upon ED departure, the authors conducted a registry study based on ED visits with all patients ≥ 18 years with triage acuity levels 3–5 and without need of acute hospital care upon ED departure during 2009–2016 ($n=705,699$). The sample was divided into patients surviving ($n=705,076$) or dying ($n=623$) within 10 days. The results of the study showed that the 10-day mortality rate was 0.09 % ($n=623$). The event group had larger proportions of patients ≥ 80 years (51.4% vs. 7.7%), triaged with acuity level 3 (63.3% vs. 35.6%), and greater co-morbidity (ACCI median IQR 6 vs. 0). They also observed an increased 10-day mortality for patients with a mean ED LOS ≥ 8 vs. < 2 hours. The authors concluded that patients triaged to lower triage acuity levels when arriving to the ED and

without need of acute hospital care upon departure from the ED had higher 10-day mortality when the mean ED LOS exceeded 8 hours and when ED occupancy ratio increased.

Weiner SG, Olesya B, Bernson D, Schuur JD.

One Year Mortality of Patients after Emergency Department Treatment for Nonfatal Opioid Overdose

In order to determine the one-year mortality of patients who were treated for a non-fatal opioid overdose in Massachusetts emergency departments the authors of this study conducted a retrospective observational study of patients from three linked statewide Massachusetts datasets: a master demographics list, an acute care hospital case mix database, and death records. Patients discharged from the emergency department (ED) with a final diagnosis of opioid overdose were included and the primary outcome measure was death from any cause within one year of overdose treatment. During the study period, 17,241 patients treated for opioid overdose. Of the 11,557 who met study criteria, 635 (5.5%) died within one year, 130 (1.1%) died within one month and 29 (0.25%) died within 2 days. The authors concluded that the short-term and one-year mortality of patients treated in the ED for non-fatal opioid overdose is high, with the first month, and particularly the first two days after overdose, being the highest risk period. They added that patients who survive opioid overdose should be considered high risk and receive interventions such as offering buprenorphine, counseling and referral to treatment prior to ED discharge. **E**

