

EPIC

February 2010

From the President: Colorado ACEP 2009 in Review

by David Ross, DO FACEP

This will be my final column as Chapter President.

At the general membership meeting on January 20, 2010, I officially turned over the reins to Stephen Wolf. I handed him the briefcase with all of the nuclear (medicine) codes and the Secret Service dumped me like a hot potato. No more flights on CO ACEP One. I felt the weight of the world lifted off my shoulders.

Ok, maybe I haven't been taking my medications like I should be over the past year. In an occasional rational moment, I realize my delusions have lately been becoming much more vivid. So the transition was probably not quite that dramatic.

But what has been dramatic is the year we have had at Colorado ACEP – and the future ahead. I have already described a lot of the activities in 2009 in previous newsletters, so I won't belabor the point on some of the earlier events.

First, I must thank Dr. David Seaberg, a member of the national ACEP Board of Directors, for coming to our membership meeting last month. He gave us an excellent presentation on what is happening at the national level and how that will impact ACEP and our practices.

It is important to summarize the success of our CME offering, the Colorado Symposium on Emergency Medicine, held on November 11th at the Brown Palace Hotel in Denver. We had 75 attendees and a host of excellent speakers. Our presenters essentially donated their time in an effort to hold costs to the minimum. Additionally,



Dr. Dave Ross and Dr. Stephen Wolf

Dr. Steve Lowenstein received CO ACEP's first Meritorious Service Award and Dr. Vince Markovchik was presented CO ACEP's first Legacy Award.

The evaluations and post conference comments were, generally, very positive. As a result the Board of Directors is very encouraged that members, and other providers, found this conference suited their needs. We will plan to host another Symposium this coming fall. Be sure to look for coming announcements as the details take shape.

Building on the concept established at the Western Slope Board Meeting last July at Redstone, we have decided that one Board meeting, annually, will be held away from Denver. This will occur every July and we will be at different sites. At least every other year, the site will be somewhere on the Western Slope.

On July 28 we will have our meeting in Fort Collins. These are not "typical" Board meetings. We will include some type of clinical educational

component along with important updates from our leaders that impact everyone's emergency medical practices. Additionally, we will provide ample opportunity for attendees to socialize and network. Watch for announcements of the specific time and venue for this upcoming Ft. Collins meeting. We encourage any emergency physician to attend.



Dr. Seaberg with Dr. Wolf

Leadership Development Fellow program. Along with our Board member election information that was sent to members

In 2009, we established a

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Colorado Chapter

 American College of
Emergency Physicians®

ADVANCING EMERGENCY CARE 

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EPIC

COLORADO CHAPTER



American College of
Emergency Physicians®

ADVANCING EMERGENCY CARE 

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around the Christmas holidays, we included a document that outlined the benefits and responsibilities of this new Fellowship. Essentially, CO ACEP will reimburse the Fellow for a majority of their costs in exchange for participation in CO ACEP leadership activities. 2010 Fellowship Award will be announced in early March.

Also in 2009, we began work on the CO ACEP tort reform proposal. The concept of this proposal is that physicians and extenders providing EMTALA mandated healthcare be subject to a higher standard malpractice standard. The current standard in Colorado to demonstrate malpractice in a legal action against any physician is a "preponderance of the evidence," or 51% likely to the jury that malpractice occurred.

The CO ACEP tort reform proposal would require a standard of "clear and convincing evidence," or approximately 75% likely to the jury that malpractice occurred. Again this standard would not be just reserved for emergency physicians, but extended to all providers of EMTALA mandated care.

The tort reform proposal has been presented to a variety of groups within the house of medicine and has met with mixed opinions. As a result, several challenges have been presented to CO ACEP. One of these is to solicit information from patient groups regarding their opinions as to how the tort reform proposal could affect access to emergency medical care. We hope to meet this challenge later this year by conducting a formal survey of patient advocacy groups.

A second challenge extended to CO ACEP is an assessment of how the tort reform proposal might impact our members, the practice of emergency medicine in our state and how it might impact the availability of on-call specialists to our EDs. To address this, we are in the planning stages of a survey that will go to our members, some other specialty societies that typically represent physicians commonly associated with ED on-call panels, and non-member physicians practicing emergency medicine in our state. We will, of course, advise you when this survey is ready to be completed. I ask that you complete the survey when it comes out, as it will be very important in giving us a read as to whether the tort reform proposal would have a positive impact on our practices, or not.

In regard to the issue of tort reform for EMTALA mandated healthcare providers, any anecdotes you may have as to how this tort reform might help your practice would be very welcome. So if you think you have an incident, or story, that might lend support to our tort reform effort, please email it to me at DRDR0682@aol.com.

In the space I have left, I would like to briefly mention a few current legislative issues that will be high on the radar screen for the CO ACEP Board, and our membership, this year.

In Colorado, emergency physicians and other hospital-based specialists

enjoy legislative protection to be reimbursed at least at in-network rates for patients they care for that might be out of network. There is a provision in this statute that mandates a repeal of a portion of it in 2010. A change or removal of this portion of the statute could negatively affect payment to emergency physicians. CO ACEP will be watching this very closely as we may need to quickly develop legislation during this session of the legislature to limit, or prevent, this repeal.

The Colorado Medical Society has just introduced its legislative response to the trial lawyers' two prior attempts to raise non-economic damage caps in medical malpractice suits. Entitled "The Patient Safety Act" this is an innovative bill that has several potential up sides. It will be interesting to see how this legislation



Suzanne Hamilton giving Legislative Report

progresses. Along similar unique lines, another organization is proposing a bill that would create a pilot program for a no-fault malpractice system for families of babies born with neonatal encephalopathy, or cerebral palsy.

The MOST Bill has also been presented this year. This effort attempts to clarify patient wishes for certain aspects of healthcare they may, or may not, want. This could range from CPR directives to certain types medications or procedures. The CO ACEP Board has not taken a position yet on this legislation, but will be discussing it soon.

We continue to represent emergency physicians on the Colorado Medical Society's Systems of Care/Patient Centered Medical Home Committee. This group is evaluating ways to improve communications between the Patient Centered Medical Home concept and other healthcare providers and entities. While this does not have a direct bearing on emergency medical practice today, it is important the CO ACEP be a part of these discussions. Jim Cusick and Dennis Beck represent us there.

Many other things are happening both at the state and national level but I think what I have highlighted are the most

pressing. All of this information in greater detail can be found on our web site, www.coacep.org.

And speaking of our web site, make sure to check it out. Its new and much improved and more user friendly. Thanks to Barb Burgess and Greg Maloney for the major facelift.

In order for us to do the best job to respond to important issues affecting all emergency physicians, we need membership. During the past year, we have increased from just under 500 members to 530. We are trying to make CO ACEP as relative to our emergency medical practices as possible. So, if there are physicians in your group who are not members, encourage them to join. We need them.

In conclusion, this year has gone very quickly for me. It has been both a pleasure and a challenge to serve as the chapter president. I would like to thank all of our board members for their efforts over the past 12 months and especially Barb, our Executive Director, and Suzanne Hamilton, our lobbyist.

I wish Stephen all the best during his upcoming term as president and I know he will do a great job. ■



Colorado ACEP Board Members with Dr. Seaberg. From Left to right: Drs. Adit Ginde, Dave Ross, Stephen Wolf, David Seaberg, Neal O'Connor, Kevin Weber, Sean Bender, Carla Murphy. Front Row: Drs. Eric Olsen and Chris Miller

2010 Leadership and Advocacy Conference

May 16-19, 2010 / Washington, DC



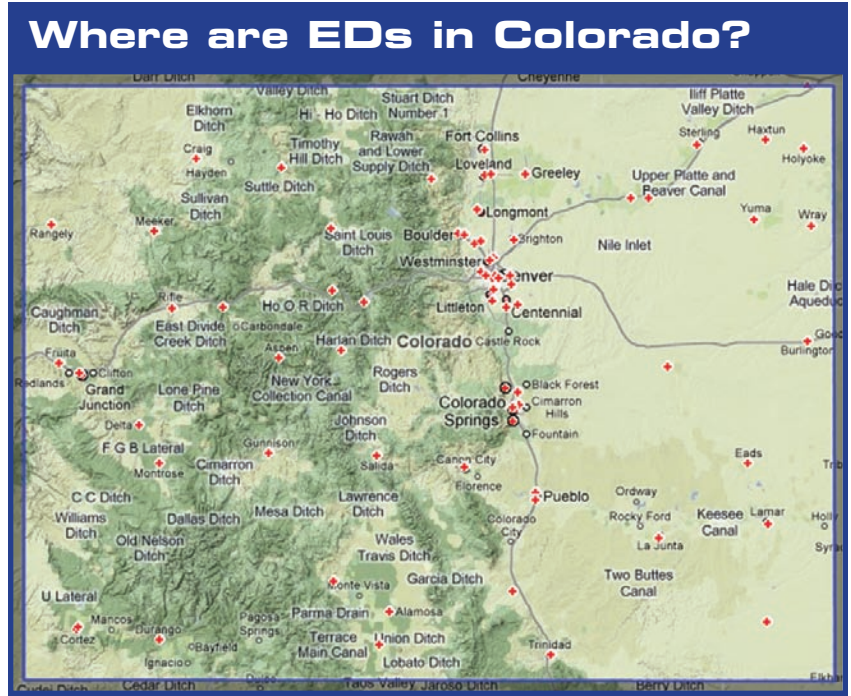
You have a critical role to play in health care reform. Join emergency medicine leaders from throughout the country in shaping that future at ACEP's 2010 Leadership and Advocacy conference. Visit www.acep.org/LAC for details.

2009 Summary of Colorado Emergency Department Survey

by Adit Ginde, MD, MPH

Colorado has a wide variety of communities and landscapes, and its Emergency Departments are equally diverse. The patients, staffing, and resources of EDs from the Front Range to the Eastern Plains to the Western Slope are different, which create unique challenges. To improve the quality of emergency care throughout the state, we first need to describe the similarities and differences among Colorado EDs.

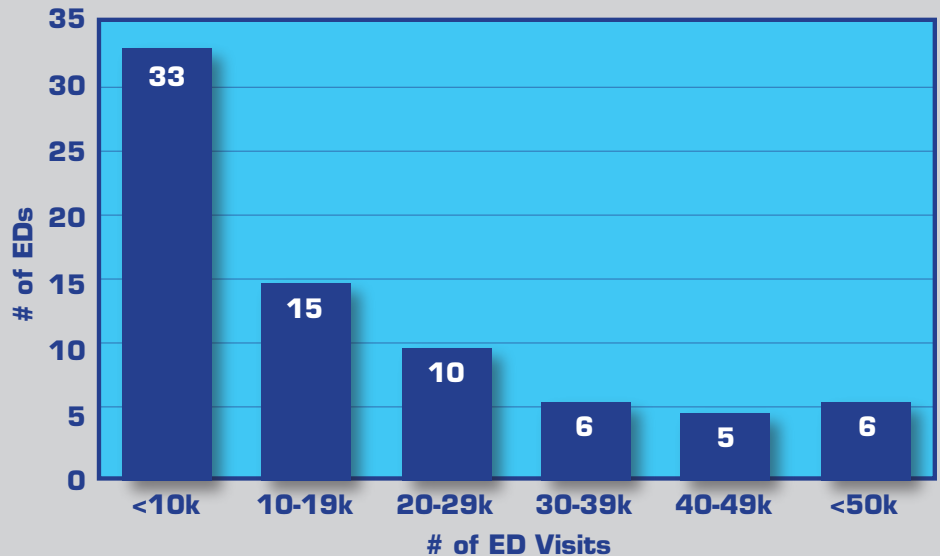
With the endorsement of Colorado ACEP, two Denver Health residents (Drs. Brad Talley and Stacy Trent) and I led an effort to describe EDs across the state. Thanks to many ED directors, we received responses from 63 (83%) of the 76 EDs statewide. We have learned a tremendous amount that will help Colorado ACEP serve the needs of its EDs. Coordinated by the Emergency Medicine Network (www.emnet-usa.org), similar data were also collected in three other states (Georgia, Massachusetts, and Oregon), with five other states slated for data collection in 2010. This will provide the ability to compare and contrast Colorado to other states and to learn from the collective experiences.



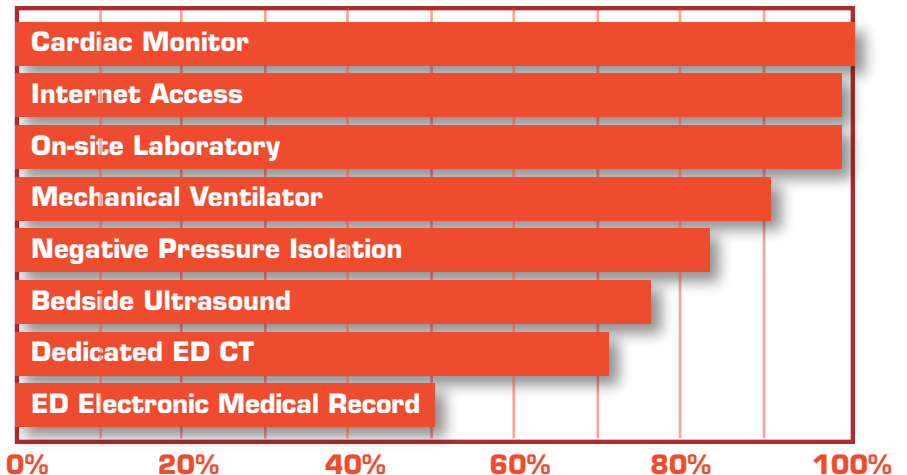
We would like to share some results of the database that you helped create. Thank you for your help!

What are the visit volumes of EDs in Colorado?

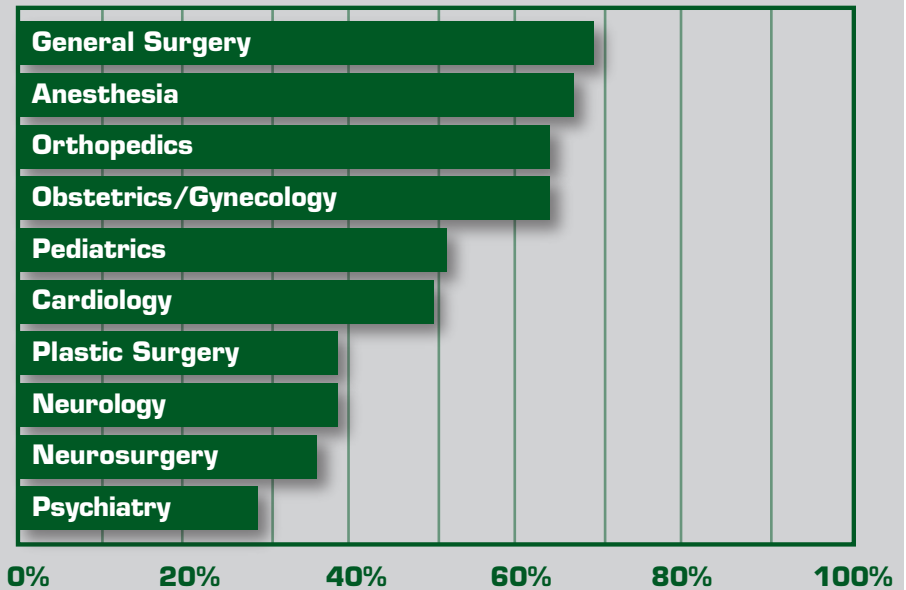
Like much of the country, there are many small EDs in Colorado. Overall the median volume was 12,240 visits per year (range 266 to 97,154).



Summary of Access to Resources and Equipment in Colorado EDs



Onsite Availability of Consultants



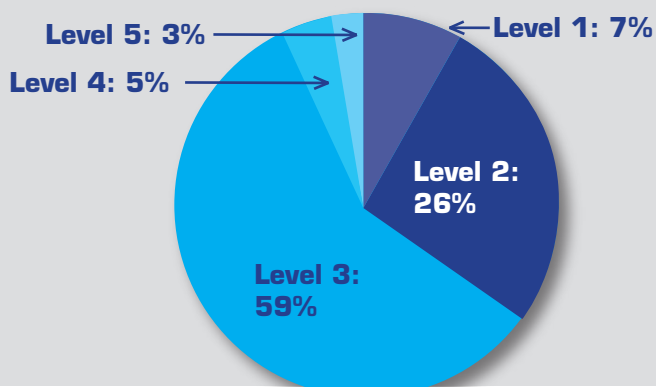
Proposed EMNet Categorization System

In the 2006 Institute of Medicine report on the “Future of Emergency Care” recommended the development of capabilities-based categorization of EDs. The purpose of this effort is to improve regionalization of care and integration of

resources and staffing throughout the spectrum of EDs. One of the major goals of this multi-state effort was to develop a system of categorizing EDs to improve overall access to emergency care.

ED Level	Definition *
Level 1	<ul style="list-style-type: none"> Attending physician on duty in the ED 24/7. Specialty consultations for anesthesia, OB/GYN,† orthopedics, pediatrics (including neonatology), and surgery are available in-person in <30 minutes (i.e., in-hospital coverage) In-person consults for cardiology, neurology, and neurosurgery are available in-person in <1 hour, but are not required to be in-hospital 24/7.
Level 2	<ul style="list-style-type: none"> Attending physician on duty in the ED 24/7. Specialty consultations for anesthesia, OB/GYN, orthopedics, pediatrics (including neonatology), and surgery are available in-person in <1 hour, but they are not required to be in-hospital 24/7.
Level 3	<ul style="list-style-type: none"> Attending physician on duty in the ED 24/7. Specialty consultations for anesthesia, OB/GYN, orthopedics, pediatrics (including neonatology), and surgery are not available in-person in <1 hour.
Level 4	<ul style="list-style-type: none"> Physician available to the ED 24/7 from within the hospital, but is not on duty in the ED.‡ Availability of specialty consultations varies.
Level 5	<ul style="list-style-type: none"> Physician available 24/7, but from diverse locations, including at least some shifts from outside the hospital.
Level 6	<ul style="list-style-type: none"> Physician not available 24/7.

In Colorado, most EDs were classified as Levels 2 and 3, but included EDs from Levels 1 through 5.



* Availability in <30 minutes is taken as a crude measure of in-hospital physician coverage.

† Children’s hospitals must have an OB/GYN consultant available in-person in <30 minutes to be a Level 1 ED.

‡ If a physician does not show up for a hospital shift (and thereby leaves the ED without an attending physician from within the hospital), but as a matter of policy/scheduling the ED has 24/7 coverage from within the hospital, the ED would continue to be classified as a level 4 ED.

For more information, please contact:

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The Par/Non-par Debate, 2010 Version

In 1997 the legislature adopted 10-16-704 "Consumer Protection Standards Act for the Operation of Managed care Plans." Section (3) protects a consumer from balanced billing when they receive out-of-network services at an in-network facility. As interpreted by the Division of Insurance (DOI), if an insured patient goes to an in-network facility and receives services from an out-of-network provider the patient is not responsible for any charges above their in-network deductible, co pay or co-insurance. Because the patient must be held harmless, it is the onus of the health plan to either negotiate an acceptable rate with the out-of-network provider or pay billed charges.

This section of legislation was amended in 2001, 2002, 2003, and again in 2006. The most recent legislation, SB06-213 clarified, "... the General Assembly finds, determines and declares that the purpose of Senate Bill 06- 213 is to codify the interpretation of the Division of Insurance that holds consumers harmless for charges over and above the in-network rates for services rendered in a network facility."

Health plans object to this section and interpretation and offer alternatives that shift the financial exposure to the out-of-network provider. This solution would force providers to contract with plans without any leverage to negotiate not only fees, but objectionable contract provisions. This is often referred to as the participating/non-participating provider (Par/Non-Par) debate.

As part of the 2006 legislation, Subsection (3) is automatically repealed on July 1, 2010 unless continued by legislative action in the 2010 session of the Colorado General Assembly. Further, the DOI was charged to conduct an evaluation of the effects of this statute on network adequacy (the concern has been raised that hospital based providers will be incentivized to refuse to contract or terminate contracts with health plans), the costs to health plans, and the impact on consumers. That evaluation was submitted to the legislature on January 21, 2010.

Highlights of the Division of Insurance Findings:

- The total number of processed claims dropped for both in-network processed claims (-33.7%) out-of-network (-32.82%) claims.
- The ratio for processed claims between in-network and out-of-network providers held steady.
- The gap in billed charges made between in-network and out-of network providers decreased years from nine percent to three and one half percent.
- The percent of billed charges paid to out-of-network providers also decreased by almost six percent.
- Consumer complaints have decreased from 43 in 2003 to nine in 2009.

Marcy Morrison, Commissioner of Insurance, stated in this January 21 report, "... the consumer protections against

balance billing currently in place should remain. Repealing Subsection (3) will harm consumers in situations where they have followed the rules of their managed care health plans and expect to pay in-network rates for services provided at in-network facilities." Unfortunately, the Commissioner's recommendation was not accompanied by legislation removing the July 2010 repeal date.

Therefore, Colorado ACEP and Pediatrix have taken the lead on legislation to "repeal the repealer." The bill will to be introduced early in March by State Senator John Morse. Colorado ACEP members will be receiving additional information regarding this legislative proposal. The Colorado ACEP webpage will also guide members through this process. It is very important all Colorado ACEP members be an active participant in preserving this statute. While the DOI recommendation is clear, physicians will be battling the health plans over comments like these made during the DOI survey:

"Although this law protects consumers from balance billing by non-contracted providers when they receive covered services at an in-network facility, it has created incentives for many surgical and technical assistants to either terminate their contracts with carriers or to refuse to contract. Without a contract, and with the law requiring all services at an in-network facility to be paid, such surgical and technical assistants are free to bill amounts that are unreasonable and beyond usual and customary rates."

"Non-contracted ambulance companies, anesthesiologists, ER doctors, radiologists and pathologists often are paid significantly above market rates for their services. Certain groups appear to have a general business policy to refuse to participate in health plan networks to ensure payment of billed charges."

"Out-of network surgical assistants and certain technicians charge excessive amounts and demand full payment of billed charges which causes inequities in payment."

"Clear disincentives for providers not to contract with carriers have been institutionalized by the statute and the Division's enforcement (of this statute.)"

This statute is working. It protects the patient. It protects the providers' freedom to contract and keeps the financial risk with the only party in this debate in the business of assuming risk.

Be prepared for a battle. The Par/Non-par debate is never an easy one!

To read the January 21, 2010 Report of the Commissioner of Insurance, please refer to the Colorado ACEP webpage at: www.coacep.org.

Emergency Physician Ultrasound-Guided Central Line Placement in Colorado

by Brandon H. Backlund, MD, FACEP

In the fall of 2008, many of you participated in a joint effort between Colorado ACEP and the Department of Emergency Medicine at Denver Health Medical Center to survey the membership about training and practice patterns for the use of ultrasound guidance to place central venous catheters (CVC). Presented here is a brief summary of the results of that survey.

The survey was deployed electronically via Zoomerang.com, and was sent to all CO ACEP members with a listed email address. 116 responses were received out of 330 invitations, for a response rate of 35%. According to Zoomerang, the average response rate for online surveys is 20-30%.

Of the respondents, 85% were board-certified or board-eligible in emergency medicine. The average number of

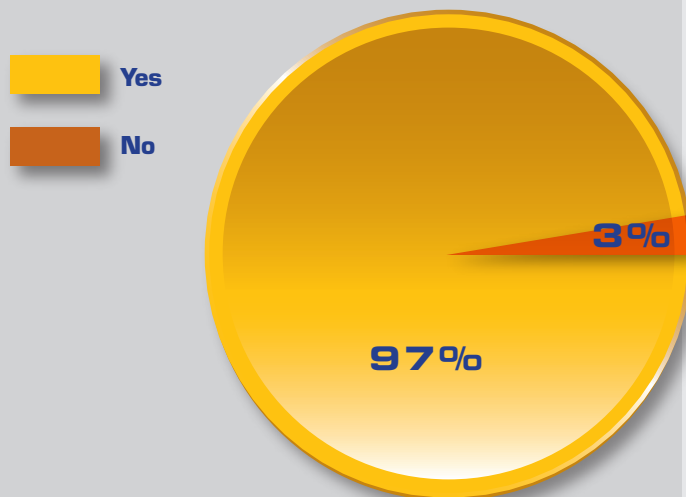
years in practice was 13 years (median 11 years). 5% had been in practice for less than 1 year, and 12% were still in residency. 97% indicated that they do have an ultrasound machine immediately available in the ED.

Overall, 22% of those responding indicated that they do not use ultrasound guidance to place CVC. Interestingly, a similar percentage (23%) of respondents also stated that they had not received specific training in US-guided CVC placement.

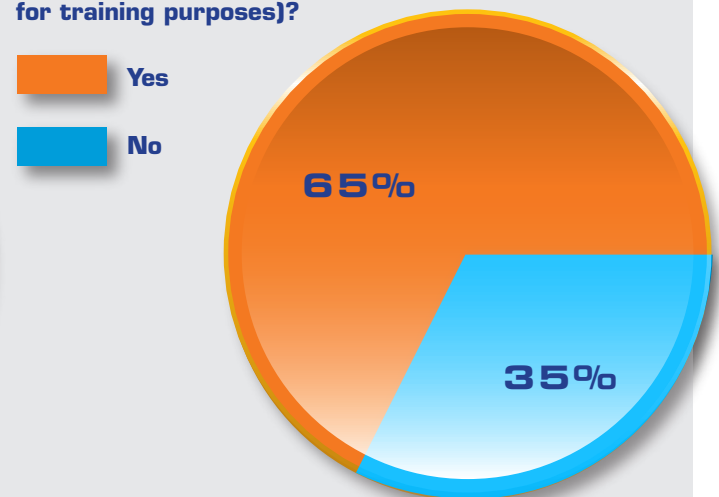
Additional data from the survey is being analyzed, and the authors anticipate the submission of a manuscript for publication in the medical literature in 2010.

The investigators would like to thank Colorado ACEP for their cooperation and assistance with this project.

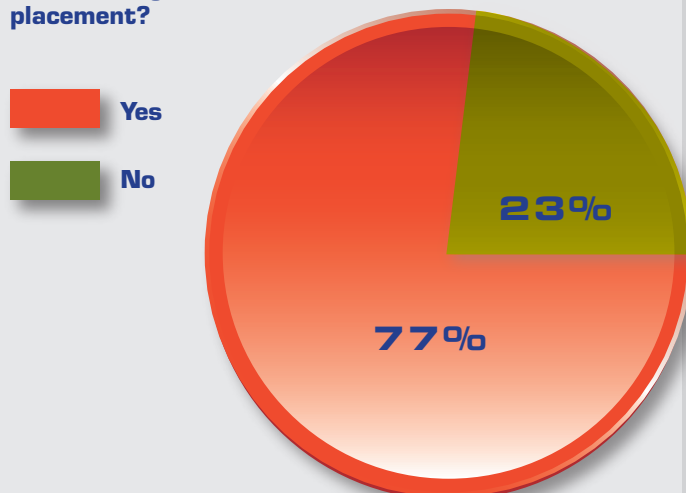
Do you have immediate access to an ultrasound machine in your emergency department?



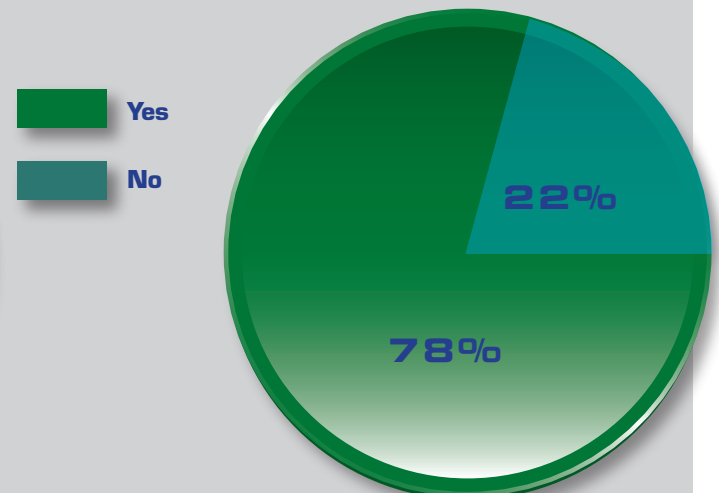
Is your emergency department affiliated with an emergency medicine residency program (i.e., do emergency medicine residents work in your department for training purposes)?



Have you received specific training in ultrasound-guided venous catheter placement?



Do you ever use ultrasound guidance to place central venous catheters?



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COLORADO ACEP CALENDAR OF EVENTS



March 24, 2010 – COPIC/CMS
Lunch 12:00 Meeting 12:30 – 2:30 PM

May 26, 2010 – COPIC/CMS
Lunch 12:00 Meeting 12:30 – 2:30 PM

July 28, 2010 – Fort Collins, CO
To be announced

September 22, 2010 - COPIC/CMS
Lunch 12:00 Meeting 12:30 – 2:30 PM

November 17, 2010 – COPIC/CMS
Lunch 12:00 Meeting 12:30 – 2:30

Meetings will be held at COPIC/CMS Offices
– 7351 Lowry Blvd., Denver, CO unless noted.