

# Colorado Chapter Update

A Newsletter for the Members of Colorado ACEP



Summer 2010 Issue

## Emergency Medicine in Network with CO ACEP Stephen Wolf, MD, FACEP President, Colorado ACEP

One of the main goals of Colorado ACEP is to provide value to you as a member. In my last EPIC article, I focused on how we as an organization advocate for emergency medicine and our members both on the state and national levels. With this letter I would like to highlight the value of networking opportunities that we offer.

Everyone knows that Emergency Medicine in Colorado is still a small community. In fact, most of us not only know who works in our hometown but also across the state. Unfortunately, our busy schedules do not often allow for the valuable time to share ideas and generate solutions outside of our own institutions. Given this, CO ACEP works to provide opportunities to network, socialize and learn both with and from peers in hopes of improving patient care across the state. We truly hope you will consider attending these events.

On July 28, we will be taking our quarterly meeting on the road again as part of our continued attempts to bring your college and chapter to you. Last year our travels to Redstone, Colorado were a great success. This year we are heading to the [Armstrong Hotel](#), one of the last remaining historic hotels in Old Town Fort Collins. At this dinner meeting, we will be honored by Colorado Senate Majority Leader John Morse talking about "Past Successes in Colorado Legislative Healthcare Initiatives and a Vision for the Future." A former paramedic, Senator Morse is a significant supporter of the medical community and specifically a strong advocate of emergency medicine. Colorado ACEP hopes to work closely with him in the near future on EMTALA Provider Protection legislation. Additionally, Kennon Heard, MD, Director of the Rocky Mountain Poison and Drug Center's Medical Toxicology Fellowship, will present "Toxicology Tips for Emergency Physicians." Please come share in the evening festivities and dynamic agenda.

On November 17th, the 2nd Annual CO ACEP Symposium on Emergency Medicine will be held at the Brown Palace Hotel in downtown Denver. This year's conference will focus on neurologic emergencies with former National ACEP president Greg Henry, MD, FACEP, a very well known keynote speaker! A board-certified emergency physician, Dr. Henry is formally trained in neurology and an expert in risk management strategies. Similar to last year, 25-minute lectures will be used to target relevant, critical topics in emergency medicine. CO ACEP will also be working with COPIC to present a mock trial event in hopes of giving emergency physicians greater insight into the medical-legal process. The conference is a wonderful way to obtain CME and an incredible opportunity to network with emergency physicians from across the state. Please save the date - Nov. 17, 2010!

## Colorado Chapter ACEP

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President



Barb Burgess,  
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day event, our goals will be encouraging communication and networking across the state. We believe this annual event over time will facilitate creative problem solving and improve patient care.

CO ACEP and I hope to see you at these educational, networking events!



## A New Tool for Health Care Decision Making in Colorado

During the spring of 2010, a new tool was added to the the health care decision making toolbox in Colorado: a bill passed by the Colorado Delegate Assembly established the Medical Orders for Scope of Treatment (MOST) process. The MOST bill was put forward by the Colorado Advance Directives Consortium and sponsored by Representatives Ellen Roberts and Mike Merrifield and Senators Williams and Morse, among others.

The 1-page, 2-sided MOST form summarizes patient preferences in four areas of medical treatment which might be relevant to an emergency or end-of-life situation: CPR, scope of treatment, artificial nutrition/hydration, and antibiotics. Check-box choices are offered by which persons may refuse treatment, request full treatment, or specify limitations.

The MOST is intended for use by individuals who are in frequent contact with health care providers due to a chronic, serious, advanced, or terminal illness.

When signed by a physician, advanced practice nurse, or physician's assistant, this summary form of patient preferences becomes "portable" medical orders which "travel" with the patient and are honored by any provider in any health care setting: by EMS at home, in the community or a nursing facility; in the ER; in the hospital; in rehab or long-term care.

The portability of the form allows seamless documentation of treatment preferences and closes gaps as patients transfer from setting to setting or experience delays in access to providers. The latitude of authorized signers (physician/APN/PA) allows prompt documentation of preferences in rural regions or areas where physicians and health care services are scant.

The original is brightly colored for easy identification, but photocopies, faxes, and electronic scans are also valid. A section on the back prompts patients and providers to regularly review, confirm, or update choices based on changing conditions.

The MOST does not replace advance directives; Living Wills or Medical Durable Powers of Attorney may contain instructions on issues not addressed in the MOST. The MOST form should be completed and updated to be consistent with any other advance directives. In case of any conflict between a person's MOST form and his or her Living Will, for instance, the most recent document prevails. The MOST may be revoked at any time by the person or, if the person lacks capacity to make decisions, by his or her agent.

The form provides clarity and a certain amount of rigidity for EMS personnel, who can easily scan the form and know what treatments to offer to what degree, in confidence that the treatment preferences are recent, appropriate, and ordered by a medical professional. However, the MOST also provides clarity and a certain amount of flexibility for receiving physicians and facilities who may consult with patients or their health care agents to recommend revisions to the orders.

No individual will be obliged to complete a MOST. If a provider or facility objects to the MOST program or individual provisions on individual forms on moral or religious grounds, they must inform the patient of their objections, provide support and comfort care, and arrange for transfer to another facility or provider who will comply with the orders.

The MOST is based on the POLST, or Physician's Orders for Life-Sustaining Treatment, which was pioneered in Oregon in the early 1990s, and in several varieties is now in use in 14 other states and in development in 24 more. Extensive research indicates that the Medical Orders for Scope of Treatment program greatly improves the incidence of advance care planning and adherence to expressed wishes. (See [the POLST Web site](#) , for references and research findings.)

The MOST statute goes into effect on August 11, 2010. However, a great deal of work must be done to educate the provider community—EMS, Emergency departments, hospitals, nursing facilities to start—before the program can really get underway. The Colorado Advance Directives Consortium is working with a number of other statewide organizations to coordinate an education campaign about the MOST. By the end of the summer 2010, the Consortium hopes to have downloadable MOST forms, instruction booklets, self-paced training tools, and train-the-trainer programs available. It is essential that this education campaign be well underway before the MOST form is widely distributed or put into practice. For information on how the campaign is progressing or to offer assistance in the project, please contact the Consortium co-chairs: [Dr. David Koets](#), or [Jennifer Ballentine](#).

## By Jason Hoppe, D.O. University of Colorado

Did you know opioid analgesics have surpassed cocaine and heroin as the number one cause of unintentional drug overdose deaths? Were you aware that 1 in 5 U.S. teens has abused prescription drugs without a prescription? Did you know that emergency department (ED) visits for non-medical use of prescription painkillers doubled between 2004 and 2008? The stats don't lie; prescription drug abuse is an increasing public health problem across the United States. Colorado has not been spared by this epidemic and our EDs are a common destination for doctor shopping in search of narcotics and sedatives. ED physicians are put in a difficult position as we must balance the need for appropriate analgesia with the risk of misuse, abuse and diversion in a population of patients with whom we have no established relationship.

Fortunately help is just a mouse click away. Colorado is one of 34 states with an operational Prescription Drug Monitoring Program (PDMP). Implemented in 2008, the CO PDMP is a secure database of controlled substance prescriptions dispensed by CO pharmacies and from non-resident pharmacies that ship prescriptions into CO. This tool is available to help prescribers receive objective information of a patient's prescription history and to identify possible abuse.

Is it worth your time? According to a recent survey of CO physicians (ED, Family Practice, Internal Medicine, and Pain management) the CO PDMP has been a rousing success. Of the 460 respondents, 97% have found the system helpful and 96% found that the search results affected their decision to prescribe opiates or sedatives to a patient. Clearly physicians using the system feel it changes practice and is worth the additional effort.

Like any good tool there is always room for improvement. The PDMP is undergoing its sunset review and the Colorado Medical Society recently met to address areas for improvement. Increasing the frequency of pharmacies uploading data and enforcing pharmacy compliance is a priority. Allowing access to the database for opiate abuse research to help our communities is crucial as well. Making the site more user friendly, time efficient, and available to residents should increase the use of the site. Finally, working with surrounding states to get access for physicians practicing near our borders would be ideal for physicians in those communities on both sides of the state lines. Hopefully the system will continue to improve and will remain an important tool as ED physicians help prevent prescription opiate and sedative abuse, misuse, and diversion.

How do I access the system? Log on to [coloradodmp.org](http://coloradodmp.org) and click on portal login and registration.

What if I haven't used it in a long time and I'm locked out? Contact the CO PDMP help desk 303-894-5957 or [pdmpinqr@dora.state.co.us](mailto:pdmpinqr@dora.state.co.us)

How do I report a patient who I am concerned about forging prescriptions or illegal activities? Contact the DEA at 303-705-7300 or fax 303-705-7400.

What can I do to help? Increase your familiarity and use of the system and use the information appropriately. Watch for opportunities to help support improving the CO PDMP.

### References:

CDC report on [Unintentional Drug Poisonings in the United States](#).  
[Youth Risk Behavior Survey](#).

CDC Emergency department visits involving nonmedical use of selected prescription drugs—United States, 2004-2008. MMWR 2010; 59: 705-09  
Colorado Prescription Drug Monitoring Survey. Unpublished data. Contact: [jason.hoppe@ucdenver.edu](mailto:jason.hoppe@ucdenver.edu)

## The Cycle of Residency Training By Maria Moreira, MD

In June, the Denver Health Residency in Emergency Medicine celebrated the graduation of its 35th residency class and the start of the Class of 2014.

The thirteen board eligible physicians of the Class of 2010 join the already 371 graduates across Colorado and the country advancing the field of emergency medicine. Nine of them will be venturing out of state, with one traveling to New Zealand to practice for a year. The remaining four will be staying in Colorado. Colorado ACEP would like to congratulate them on their completion of residency.

### **Class of 2010 - Location of Employment:**

Susan Brion, MD – Denver, CO  
Jessica Brooks, MD – Dorchester, MA  
Nathan Cleveland, MD – Las Vegas, NV

Todd Guth, MD – Denver, CO  
 Benjamin Hatten, MD – Denver, CO  
 Cameron Klug, MD – Portland, OR  
 Matthew Ledges, MD – Rock Springs, WY  
 Matthew Mendenhall, MD, MPH – New Zealand  
 Jeremy Seelinger Devey, MD, MPH – Long Island, New York  
 Brad Talley, MD – Seattle, WA  
 Zach Tebb, MD – St. Louis, MO

Denver Health's 14 new EM residents come from across the country, with a great diversity of interests. Their accomplishments and success in their medical education careers to date are to be commended. Colorado ACEP provides dues waivers for all emergency medicine residents and would like to welcome them to the specialty.

**Class of 2014 – Medical School:**

John Anderson, MD - University of Colorado SOM  
 Peter Emiley, MD – University of Michigan Medical School  
 Elena Ewert, MD – Stanford University SOM  
 Nir Harish, MD, MBA – Harvard Medical School  
 Michael Austin Johnson, MD, PhD - University of Wisconsin SOM  
 Christopher Johnston, MD – Saint Louis University SOM  
 Douglas Melzer, MD – University of Colorado SOM  
 Ashley Menne, MD – University of Wisconsin SOM  
 Michael Miller, MD – University of Colorado SOM  
 Kristi Rahimi, MD, MS – University of Colorado SOM  
 Omeed Saghafi, MD – UC San Diego SOM  
 Maegan Sauvageau, MD – Oregon Health Sciences University SOM  
 Matthew Taecker, MD – Creighton University SOM  
 Lina Tran, MD – Medical College of Georgia SOM

**Leadership Fellow Report  
 By Adam Barkin, MD**

I am currently serving as the first CO ACEP Leadership Development Fellow. One of the opportunities I have had during this fellowship was to attend the ACEP Leadership and Advocacy Conference in Washington DC in May. This conference is unlike most EM conferences that focus on the clinical practice of EM and technical skills such as ultrasound or the latest equipment for intubation. Instead, this conference takes a broader look at issues such as healthcare policy and access along with a focus on leadership skills essential to our practice. We heard from economists and the president of the AMA on health care reform. A professor from West Point lectured on leadership during crisis. The interesting take-away message from this lecture was – this is what we do almost everyday in the ED –whether it is the true disaster or the “ordinary” 4 critical patients that arrive simultaneously. Perhaps, the most memorable hour of the entire conference was hearing from an EP who worked the day of the Fort Hood shootings. She had the audience’s rapt attention as she described her team and department’s reactions to the immense challenge of many unstable patients while also dealing with their intense emotions.

The advocacy portion of the conference focused on meeting with our Colorado legislative delegation. In one afternoon, we met with representatives from Senator Udall and Bennett’s office as well as office staff associated with our congressional representatives. We emphasized the need to prioritize emergency and trauma care during implementation of the new health care reform bill.



Dr. Doug Hill, Dr. Erica Douglass, Dr. Stephen Wolf, Dr. Adam Barkin, Dr. Chris Miller, & Dr. Todd Guth

We also discussed the sustained growth rate (SGR). So, what is the SGR? That was the question I had before I went to the L&A conference. The SGR went into law in 1997 and essentially tied reimbursement for Medicare to this growth rate. Unfortunately, for the last decade, actual expenditures have far exceeded targeted expenditures – thus, the law would require a decrease in physician payment. Since 2003, Congress has passed “patches” to reverse these cuts in our reimbursement. As of June 1, 2010, the law required a



## 21.3 % cut. On June 18, 2010, the Senate approved legislation to again temporarily reverse the cut and raise payments by 2.2% until November 30, 2010.

Unfortunately, in November, the whole process will likely start again. Until there is a true fix for this problem (i.e. permanent change in the legislation), we will be facing drastic cuts in our reimbursement when the temporary legislation expires.

Dr. Erica Douglass, Dr. Nathan Watkins, Dr. Dennis Beck, Dr. Doug Hill, Dr. Adam Barkin, Dr. James Cusick & Dr. Chris Miller

I highly recommend this conference to any EP whether you are interested in the politics and policy of healthcare, or not. The attendees span the range of emergency physicians from residents to some of the true thought leaders in our field. These leaders, including ACEP Presidents, Past-Presidents and Board members are accessible, open to conversations and certainly willing to provide their insight. This is a different kind of medical conference, but essential to having a better understanding of our health care system, the politics involved and what ACEP fights for on our behalf.

### Scientific Assembly - September 28-October 1, 2010

Excitement is growing with the approach of this year's [Scientific Assembly](#), September 28 - October 1, in spectacular Las Vegas. Beat the rush and reserve the classes that you want, today!

Our program will include over 300 hours of world-class education, more than 300 industry-leading companies in our exhibit program, and many social events to enjoy with your colleagues. Join us and see for yourself why *Scientific Assembly* is the best in emergency medicine education!

### Clinical News

#### CME Article on Reversal of Anticoagulation Now Available

Originally printed in ACEP News, the "Focus On" series of articles brings the latest literature and best practices to help the busy emergency physician provide the best care possible.

This issue's topic, Reversal of Anticoagulation, will help the physician understand the indications for reversal of warfarin, identify the side effects of protamine in heparin reversal, and recognize the advantages and disadvantages of fresh frozen plasma (FFP) vs. prothrombin complex concentrates (PCC) in the treatment of warfarin reversal.

[Read the article online and then take the CME quiz.](#)

#### Perspective EHR Report: What's Missing From the Meaningful Use Criteria

Since the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act in February of 2009, there has been a tremendous amount of discussion about the idea of "meaningful use." And now that the full set of rules for meaningful use is available, it might surprise some to know what has actually been excluded from the criteria.

The first and most fascinating exclusion is any requirement for encounter note generation. The criteria specifically state that it will not be necessary for providers to document their encounter notes using the EHR. In other words, while most EHR products emphasize electronic note generation, the authors feel this does not provide a significant benefit over handwritten charting in meeting the goals of HITECH.

[Read the full article](#)

#### Diffuse Nature of MRSA Abscesses Contribute to High Treatment Failures

Methicillin-resistant *Staphylococcus aureus* abscesses, when compared by ultrasound with those caused by other pathogens, are smaller and more likely to lack a defined edge. They are also more likely to have edema in surrounding tissue planes as well as pus divided into multiple pockets within the abscess, according to an abscess ultrasound study presented at the Society for Academic Emergency Medicine's annual meeting. The characteristics could make it more likely that an abscess is caused by methicillin-resistant *Staphylococcus aureus* (MRSA), helping guide antibiotic selection pending culture and sensitivity reports, according to the study's author.

### Shared Strategies for Homeland Security Conference in Denver

[Shared Strategies for Homeland Security](#) is a multidisciplinary conference in Denver scheduled for December 13-16, 2010. A group of experts from Israel and the United States will provide information about preparedness and response to terrorism and bombings. This is hosted by the Denver Urban Area Security Initiative. The tracks include: medical, EMS, first responders, bomb squad, SWAT, critical infrastructure and public health. More information is at the conference [website](#).

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## Colorado ACEP Calendar of Events

**July 28, 2010** -Colorado ACEP Membership Meeting - Armstrong Hotel  
Ft. Collins, CO - Mantz Hall

**September 2010** -Colorado ACEP Membership Meeting - COPIC/CMS 12:00 Noon  
Denver, CO

**November 17, 2010** – 2nd Annual Colorado ACEP Symposium on Emergency Medicine  
Brown Palace Hotel, Denver, CO

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## Positions Available- Colorado Springs, Colorado

Royal Gorge Emergency Specialists has one position opening for the summer of 2010.

- Local group of board-certified emergency physicians with Partnership opportunity.
- Excellent compensation.
- The level 4 trauma, 15-bed ED has 16,500 annual visits.
- Local backup specialties include: Family Practice, Internal Medicine, OB/GYN, Pediatrics Surgery, Orthopedics, Urology, Anesthesia, and Radiology.
- CT and Ultrasound tech support is available 24/7.
- Sister-hospitals with fixed wing and helicopter transport provide for easy transfers if needed.
- Mid-levels (NPs) provide fast-track coverage 8-10 hours every day.
- ED recently expanded and renovated.
- Cutting edge clinical care including:
  - ED ultrasound.
  - Goal-Directed Therapy for Sepsis.
  - ED driven Therapeutic Hypothermia program.
- Beautiful, affordable mountain community perfect for families.
- Nestled in the Sangre de Cristo mountains alongside the Arkansas river this outdoor paradise provides easy access to mountain biking, hiking, skiing, fishing, climbing, whitewater rafting and more.
- Close to 14,000 foot Pikes Peak, beautiful Garden of the Gods, Manitou Springs, Salida, Buena Vista and historic Cripple Creek.

Please contact [Ruby Gallegos](#) at (719) 475-0299 Fax: (719) 475-0414.

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## Emergency Medicine Foundation Announces Emphasis Area in 2011-12 Grant Funding

The Emergency Medicine Foundation (EMF) is pleased to announce an area of special emphasis for its fully funded grant categories in the 2011-2012 grant cycle. To better improve emergency patient care, illustrate value in emergency medicine research, and assist the practice of emergency physicians in a changing health care environment, the EMF Board of Trustees is emphasizing innovative health services and health policy research.

EMF has been committed to supporting emergency medicine research by helping young investigators. Grants currently fully funded by EMF are the EMF Health Policy Grant (\$50,000), the EMF Fellowship (\$150,000 over two years), and the EMF Career Development Grant (\$50,000). For this grant cycle, EMF encourages applications with a focus on health services research, including but not limited to, health policy, practice, medical liability, regionalization, patient safety, and hospital utilization. However, it is important to note that EMF welcomes all applications, including research that is not health services-based.

"The Emergency Medicine Foundation has committed to supporting actionable research that directly impacts the care of our patients," said EMF Board Chair Alexander Rosenau, DO, FACEP. "EMF will continue to underwrite a wide variety of research. The EMF Board of Trustees believes that this new era in health care reform is not only momentous, but pivotal. It demands serious investigation by the best that emergency medicine researchers have to offer in health services and health policy research."

EMF/SAEM Medical Student (\$2,400 each, two available).  
EMF/EMRA Resident Research (\$5,000 each, three available).  
EMF/ENAF Team Grant (\$50,000, one available).

The EMF is pleased to announce two new co-sponsored partnerships:  
EMF/Medical Toxicology Foundation Resident Research (\$5,000, one available).  
EMF/Emergency Medicine Patient Safety Foundation (\$10,000, one available).

Also new this year will be one directed research grant underwritten by Baxter in sub-cutaneous infusion (\$50,000, one available).

Grant applications will be available [online](#) in August 2010. Grant deadline is January 5, 2011.



## ACEP Artistic Expressions 2010 Application Instructions

ACEP Artistic Expressions provides a unique opportunity for ACEP members to share their creative side with their colleagues. The purpose of the gallery is to encourage creative expression among members and to provide an area for reflection. The ACEP Artistic Expressions gallery will be located in the exhibit hall, in the ACEP Resource Center, during the conference and will remain on display from September 28-30, 2010.

Please submit no more than two (2) pieces of art or literature for display in the gallery. A separate application must be submitted for each piece. Articles must not have been accepted for past galleries. If accepted, you must ship your artwork to ACEP headquarters no later than August 23, 2010, to be included in the shipment to the meeting. If artwork is not received by this date, you will be responsible for all mailing/shipping costs, including insurance, and delivery to the exhibit. Work must be delivered to the Convention Center on Monday, September 27, 2010.

Security will be provided for the gallery area but ACEP cannot guarantee safety of all art and creative displays. You MUST commit to the availability of your work during the entire Scientific Assembly. You are responsible for pick up of your artwork, unless you agree to donate it to EMF (see application). If you do not arrange for pick up of your artwork by the end of the exhibit, it will be discarded or donated to EMF for auction.

If you wish to display your works, please complete the [application](#) and submit this application and all required supporting materials no later than August 2, 2010 to:

American College of Emergency Physicians  
Attn: Tracy Napper  
P.O. Box 619911  
Dallas, TX 75261-9911

Or via e-mail to [tnapper@acep.org](mailto:tnapper@acep.org)

Supporting materials for rejected submissions will not be returned so please submit copies or digital images rather than original pieces.



## Physician Assistants in the ED By: Cary Stratford PA-C DFAAPA

Since the mid-60s, physician assistants (PAs) have been practicing in emergency medicine (EM). Today, nearly 10 percent of the estimated 74,000 clinically practicing PAs work in EM. In fact, EM is the second largest specialty in which PAs practice – equal to all surgical specialties and sub-specialties combined. And, given the increase of ED volume in the past few years, the number of EMPAs is likely to only increase.

PAs practice medicine with the supervision of licensed physician and, although by law PAs are dependent practitioners, they typically exercise considerable autonomy in clinical decision-making.

The relationship between the physician and PA is one of mutual trust and reliance. The physician trusts the PA to provide physician-quality care to patients and to consult with the physician on those cases that are outside the PA's expertise or scope of practice. The PA trusts the physician to be available for supervision, provide learned advice, and accept the care of patients with serious or complex problems.



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