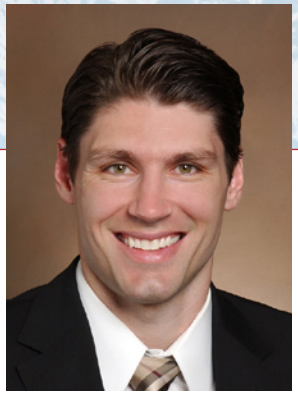
EPIC

March 2017

COLORADO CHAPTER
American College of Emergency Physicians®

FROM THE PRESIDENT

The Challenges Facing Emergency Medicine



by Andrew French, MD, FACEP

I am incredibly excited and honored as I think about the coming year as the President of our chapter. 2017 has already brought us new board members, each of whom is incredibly well equipped to help lead our chapter and provide guidance on the legislative and patient care issues facing our state. We are joined this year by Jennifer Bellows, MD, MPH Anna Engein, MD and Erik Verzemnieks, MD.

In the approaching months we will be attempting to look proactively at issues facing our specialty and using a data driven approach to formulate positions on the crucial topics requiring our leadership and expertise. As I reflect on what is to come is no doubt that change and its associated uncertainty are ahead.

I am naturally biased, but I truly believe no other group of physicians has the ability to innovate, adapt and overcome change and ambiguity like emergency physicians.

William Osler once said "Medicine is a science of uncertainty and an art of probability." While my career has not been as long as others, the uncertainty of healthcare, maybe not medicine per se, feels greater than ever. We are seeing seemingly exponential advances in biotech, healthcare technology, and artificial intelligence juxtaposed with continued growth and concern of national healthcare expenditure, not to mention potential substantial shifts at the state and national level in healthcare policy, the sand beneath our feet seems to become ever more unsteady.

As emergency physicians, these elements can create concern for us all. However, I would encourage every member of our chapter and national college to embrace what we are experiencing as a challenge and opportunity. I am naturally biased, but I truly believe no other group of physicians has the ability to innovate, adapt and overcome change and ambiguity like emergency physicians. After all, what group of providers operates at a higher level with less information than we do? What doctors balance more critical information and make sound decisions in times of stress than we do?

There are none other who understand and master uncertainty like physicians and no other physicians who can operate with uncertainty and the unknown like we can. Because of that, we as emergency physicians each have a responsibility to lead change in healthcare in our city, our state, and country not only now, but in all times of change. Then if it is true what Greek philosopher Heraclitus said "nothing endures but change" (and uncertainty), then the very nature of our profession and specialty carries with it an unending call to lead.

Lastly for those of you attending the upcoming ACEP Leadership and Advocacy conference, I look forward to standing with you as we guide the future of healthcare and shape the landscape of emergency medicine.

INSIDE:

EPIC

Colorado Chapter
American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

"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."

CHAPTER OFFICE

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JOIN US

UPCOMING COLORADO ACEP MEETINGS

- March 22, 2017
- May 17, 2017
- July 19, 2017
- September 20, 2017
- November 15, 2017

CO ACEP Meetings will be held at
COPIC/CMS Headquarters
7351 Lowry Blvd.
Meetings begin at 12:00 Noon
Lunch provided

Please Welcome Denver Health Residency in Emergency Medicine's Colorado ACEP Representative:

Sarah Krajicek, MD

By Cara Bergamo, MD

Dr. Krajicek has been an active member of the Denver Health Residency in Emergency Medicine (DHREM) program over the past 3 years. Her activities and interests led her to be chosen as the Colorado ACEP representative for DHREM. Here she reveals a little more about herself.

Where are you from?
Tulsa, Oklahoma

Where did you go to College?
Fort Lewis College, Durango, Colorado

Where did you go to Medical School?
University of Oklahoma School of Medicine, Oklahoma City

What persuaded you to choose Denver for residency?
The reputation of the program was one main reason. Dr. Michael Breyer and Dr. Jeff Druck really sold me at the second look dinner.

What do you enjoy most about being an emergency medicine physician?
I really enjoy connecting with people from all walks of life.

What made you want to be involved in Colorado ACEP?
I wanted to be a part of ACEP to be on the front edge of policy and to work with the people who protect our specialty and our rights.

Do you have any plans for your year as the DHREM Colorado ACEP Representative?
I just hope to represent us well.

> "I wanted to be a part of ACEP to be on the front edge of policy and to work with the people who protect our specialty and our rights."

What are you most proud of?
I am most proud of my growth through residency and, of course, my Pomeranians.

What do you like to do in your spare time?
I like to cook and to dance.

If you would like to reach out to Dr. Krajicek with any projects or ideas for resident involvement in Colorado ACEP, she can be contacted at sarah.krajicek@denverem.org.

Colorado ACEP Annual Meeting 2017 Summary

The Colorado ACEP Annual Meeting was held January 18, 2017 at the Denver Chop House.

We had a great turnout and members enjoyed lectures from Dr. Kevin McGarvey on *"The Virtual Emergency Physician"*. Dr. Don Stader gave an update on the *"Colorado Opioid Guidelines"*.

The 2017 CO ACEP Award Recipients were:

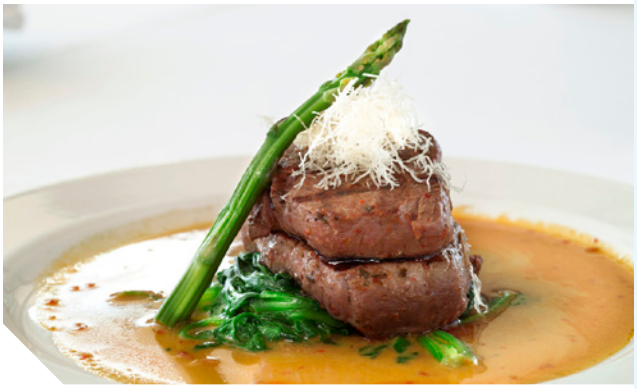
- Jean Abbott, MD, FACEP – *Legacy Award*
- Don Lefkowits, MD, FACEP – *Meritorious Service Award*
- Maria Moreira, MD – *John Marx Education Award*

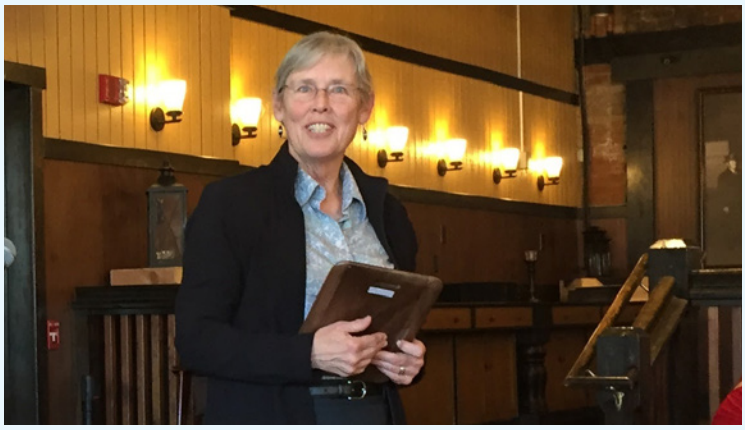
Legislative Update

- Susanne Hamilton reviewed *"2017 – What to Expect"*
- Dave Friedenson, MD, FACEP reviewed *Out of Network legislative implications.*
- *Free Standing ED Update* was presented by Drs. Nathaniel Hibbs, and Paul Price.

This year will be an active year at the State Capital. We need your involvement in legislative issues facing emergency medicine. You can access the Weekly Legislative Report at our website www.coacep.org. It is under the Legislative Tab.

Contact Barb Burgess to get more information on how to be involved on our Legislative and Advocacy Committee.



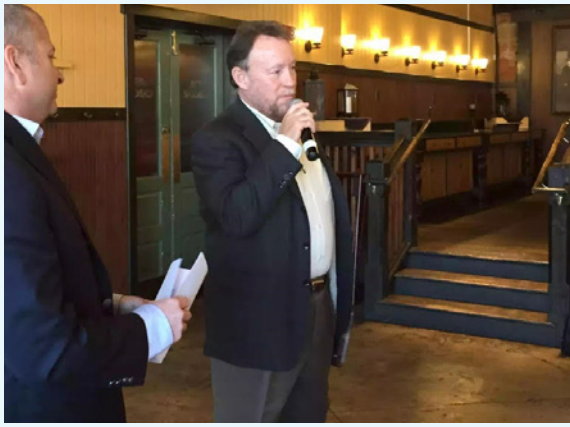


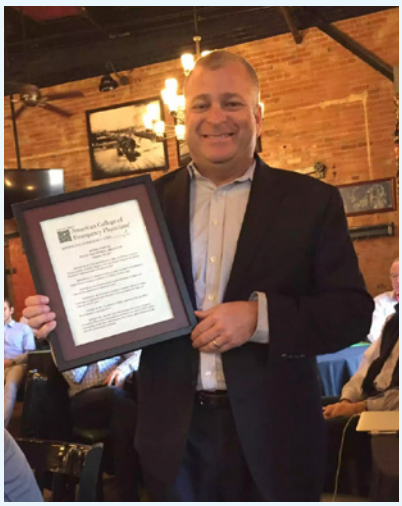
Top: Jean Abbott, MD, FACEP

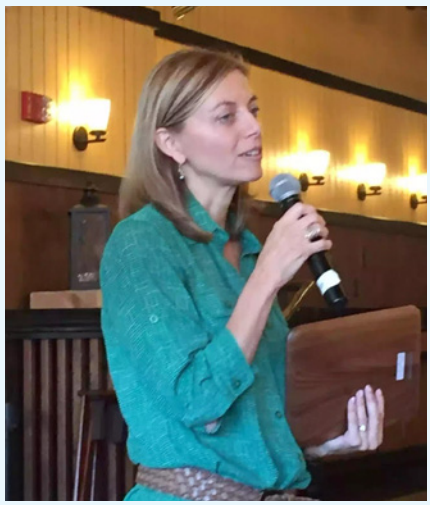
Right: Don Lefkowits, MD, FACEP

Bottom Right: Maria Moreira, MD

Bottom Left: Dave Friedenson, MD, FACEP







To Colorado ACEP Membership:

Bylaws Approval Required

In order for Colorado ACEP Bylaws to be in compliance with National ACEP we have made the required changes and they are posted on our website at www.coacep.org, Click Membership Tab to access. The bylaws will be approved by the membership at our May meeting. Please take a moment to review the bylaws and contact Barb Burgess if you have any questions. The explanation for the bylaws change is described below:

"At the 2014 ACEP Council meeting, Resolution 9(14) was passed and subsequently, at their October 30, 2014 meeting, the Board of Directors ratified that resolution. Resolution 9 (14), titled "Membership Classification Restructure" amended Articles IV - Membership, V – Fellowship, and Article VIII – Council, of the ACEP Bylaws by changing the language for increased flexibility and readability without changes to the criteria for current members, as well as closing potential loopholes for non-EM subspecialists to join. Life membership was changed to 30 years, irrespective of membership class. Additional housekeeping changes and a correction to an unintended problem for candidate members in the EM fellowship programs created by prior Bylaws amendments were also included. Chapters will be required to amend their bylaws within a two year time period to be in concert with the new language in the ACEP Bylaws IF there is a conflict between the two documents (Article VI, S 6 of the ACEP Bylaws).

"The Article of the chapter bylaws which may need amendment is regarding the eligibility of nominees to that chapter's Board of Directors. This is Article VI, Section 4A regarding the nomination and election of candidates to the Board of Directors. The specific language revised is: "Nominees shall be active, eligible honorary, or life regular or (if eligible) candidate members in good standing."

CO ACEP Members on National ACEP Committees

CLINICAL DATA REGISTRY COMMITTEE
Kerry B Broderick, MD, FACEP
Stephen V Cantrill, MD, FACEP
Jennifer L Wiler, MD, MBA, FACEP

ACADEMIC AFFAIRS COMMITTEE
Todd A Guth, MD, FACEP

AWARDS COMMITTEES
Benjamin Clark Murphy, MD

CRITICAL CARE COMMITTEE
Mariana Guerrero, MD

EDUCATION COMMITTEE
Kerry B Broderick, MD, FACEP
James Michael Cusick, MD, FACEP
David Brent Richards, MD, FACEP

EMS COMMITTEE
Sheaffer Gilliam, MD
Kristin M Schmid

FINANCE COMMITTEE
Brooks F Bock, MD, FACEP

FEDERAL GOV'T AFFAIRS COMMITTEE
Thomas R Eckler, II, MD
Nathaniel T Hibbs, DO, FACEP
Stephen V Sherick, MD, FACEP

QUALITY & PATIENT SAFETY COMMITTEE
Daniel Bickley, MD
Stephen V Cantrill, MD, FACEP
Jennifer L Wiler, MD, MBA, FACEP

MEMBERSHIP COMMITTEE
Zachary Joseph Jarou, MD
Eric B Olsen, MD, FACEP

EMERGENCY MEDICINE PRACTICE COMMITTEE
Elizabeth Hamilton Arrington, MD
Benjamin David Easter, MD
Andrew J French, MD, FACEP
Carla Elizabeth Murphy, DO, FACEP

RESEARCH COMMITTEE
Jason A Hoppe, DO, FACEP
Jody A Vogel, MD

NATIONAL/CHAPTER RELATIONS COMMITTEE
Eric B Olsen, MD, FACEP

CLINICAL POLICY COMMITTEE
Richard Byyny, MD, MSc, FACEP
Stephen V Cantrill, MD, FACEP
Benjamin W Hatten, MD, MPH
Jason Scott Haukoos, MD MSc, FACEP
Graham Stephen Ingalsbe, MD
Molly E W Thiessen, **MD**

CODING & NOMENCLATURE ADVISORY COMMITTEE
David G Friedenson, MD, FACEP

ETHICS COMMITTEE
Kelly Bookman, MD, FACEP

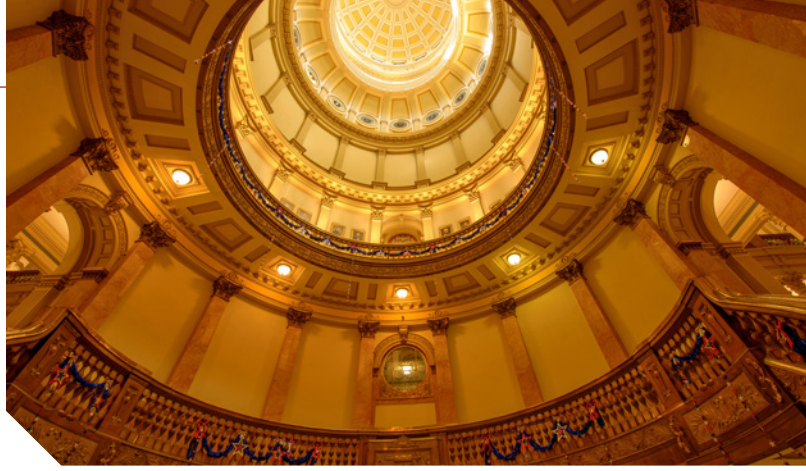
REIMBURSEMENT COMMITTEE
David G Friedenson, MD, FACEP
Michael Roshon, MD, PhD, FACEP
James D Thompson, MD, FACEP
David P Wiebe, MD, FACEP
Jennifer L Wiler, MD, MBA, FACEP

STATE LEGISLATIVE/ REGULATORY COMMITTEE
Nathaniel T Hibbs, DO, FACEP
Stephen V Sherick, MD, FACEP

AUDIT COMMITTEE
Brooks F Bock, MD, FACEP

DISASTER PREPAREDNESS & RESPONSE COMMITTEE
Charles M Little, DO, FACEP
David S Markenson, MD, MBA, FACEP

Mid-Point Session Update



By Suzanne Hamilton

This month marks the half way point of the 2017 legislative session. After fifty-five days, the legislature has introduced 426 bills. The Colorado Chapter of the American College of Emergency is involved in 46 of those with many more anticipated. To see what has been introduced and identified as important to ACEP members, please see the website. Several issues have not yet been introduced, but are expected. These include a Free Standing Emergency Department bill coming from the administration.

A group of domestic violence advocates want to continue a trend here is Colorado that has been moving across the country. Colorado has had mandatory reporting by physicians of serious bodily injuries resulting from domestic violence. The advocates believe that there are circumstances in which it would be safer for the patient if the police were not notified. Therefore, they are seeking legislation to allow the reporting of domestic violence injuries to be discretionary at the patient's request. Immunity from civil, criminal and regulatory liability must accompany this change in requirements for physician reporting. This bill should be introduced within the next week.

Numerous insurance reform bills have already been introduced and appear on the legislative update on the ACEP website. One very important to bill to ACEP members is SB17-206. Introduced late Friday, March 3 and assigned to the Senate Business Affairs and Labor Committee, this bill is the result of months of work by impacted physician groups pulled together by the Colorado Medical Society. The non-partisan Colorado Department of Legislative Legal Services describes the situation and bill as follows:

Under current law, when a health care provider who is not under a contract with a health insurer (out-of-network provider) renders health care services to a person covered under a health benefit plan at a facility that is part of the provider network under the plan (in-network facility), the health insurer is required to cover the services of the out-of-network provider at the in-network benefit level and at no greater cost to the covered person than if the services were provided by an in-network provider.

The bill outlines the method for a health insurer to use in determining the amount it must pay an out-of-network provider that rendered covered services to a covered person at an in-network facility and requires the health insurer to pay the out-of-network provider directly. The bill also establishes an independent dispute resolution process by which an out-of-network provider may obtain review of a payment from a health insurer.

Additionally, the bill requires an in-network facility where a covered person will receive a health care procedure or treatment, the health insurer, and an out-of-network provider who provides health care services to a covered person at an in-network facility to provide specified disclosures to the covered person, explaining that:

- *An out-of-network provider may provide health care services to the covered person as part of the procedure or treatment provided at the in-network facility;*
- *If the covered person's plan is governed by state law, the services rendered by an out-of-network provider are covered under the plan at the in-network benefit level;*
- *The out-of-network provider will submit a bill to the covered person's health insurer, and if the covered person receives a bill from the out-of-network provider, he or she should contact the health insurer's customer service to resolve the bill; and*
- *The covered person is only responsible for paying the applicable in-network cost-sharing amount, and the carrier is responsible for paying any remaining balance owed the out-of-network provider.*

A health insurer that fails to reimburse out-of-network providers as required by the bill and under current law or fails to provide the required notice to the covered person engages in an unfair or deceptive act or practice in the business of insurance and is subject to monetary penalties and other penalties authorized by law.

For additional behind-the-scenes information and strategy, please join us on our legislative conference calls on Thursdays from 12:30 to 1:00 PM. To view text of the bill, **CLICK HERE.**

Colorado ACEP Addresses the Opioid Epidemic

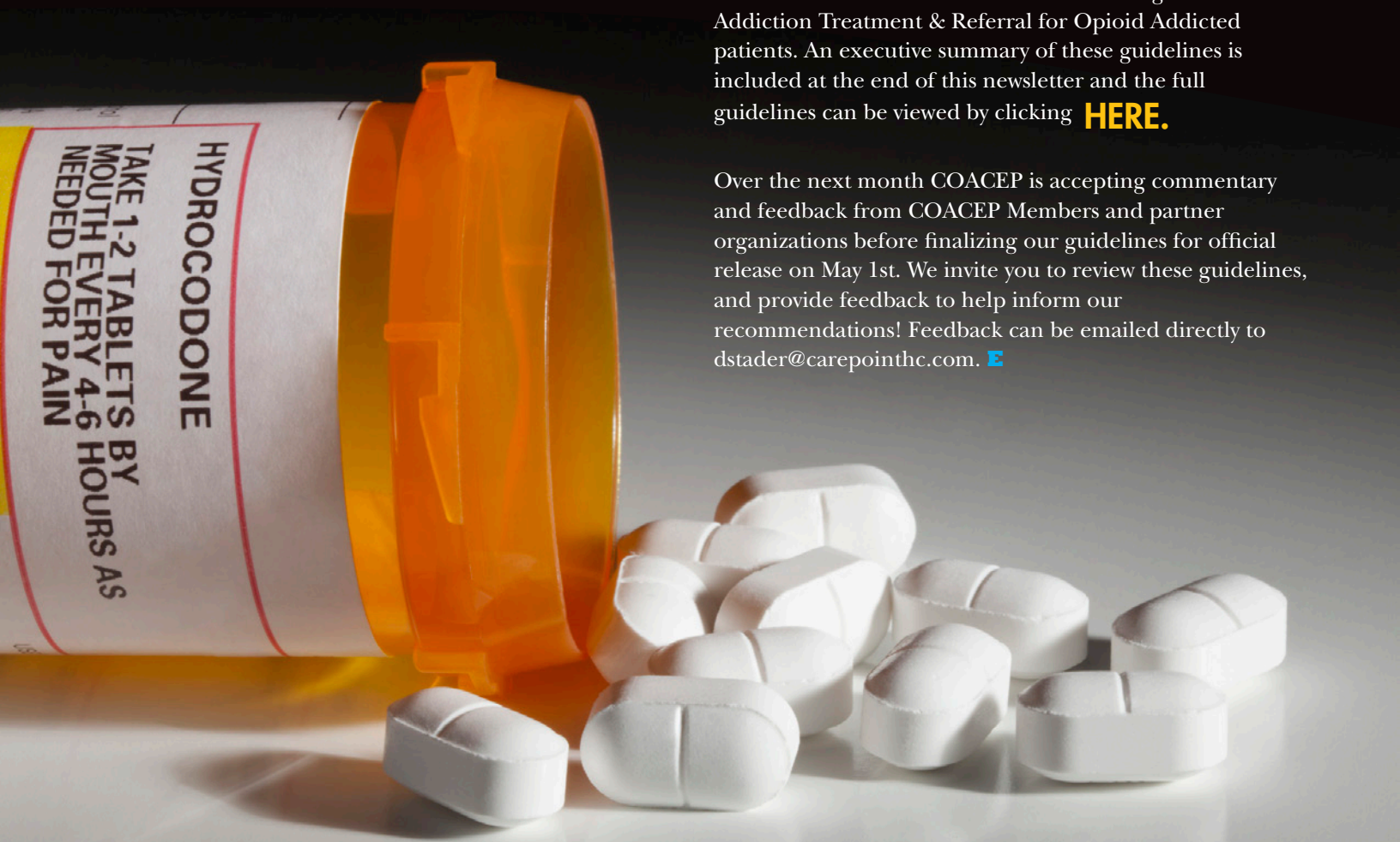
By Don Stader, MD, FACEP

Emergency providers across Colorado and our nation are facing one of the greatest public health crises of our generation. Opioids, both prescription and illicit, have become the leading cause of accidental death in the United States. Correspondingly, hospital visits for opioid overdose, drug-related complications, and "doctor shopping" have become an increasingly common part of emergency medicine practice. The number of lives impacted by this epidemic is astonishing. The Centers for Disease Control and Prevention (CDC) reports that opioid overdose killed nearly half a million Americans between 2000 and 2014, and another 78 are dying every day. What makes this crisis especially tragic is that organized medicine and the practice patterns of physicians have played a prominent role in creating it.

Colorado ACEP has over the past year has established a taskforce to address the Opioid epidemic here in Colorado and is proud to present its *Colorado Emergency Department Opioid Prescribing and treatment Guidelines*. Among the most comprehensive ever published, these recommendations were developed by a panel of more than 20 experts, including emergency physicians, addiction and harm reduction specialists, pharmacologists, paramedics, emergency department nurses, and medical students. The guidelines provide both practice & policy recommendations which can help clinicians address the opioid epidemic in their ED's and with policy makers.

The guidelines stand on 4 pillars - Limiting Opioids in the ED, Alternative Treatments to Opioids for pain, Harm Reduction for Addicted Patients and IV Drug Users and Addiction Treatment & Referral for Opioid Addicted patients. An executive summary of these guidelines is included at the end of this newsletter and the full guidelines can be viewed by clicking **HERE.**

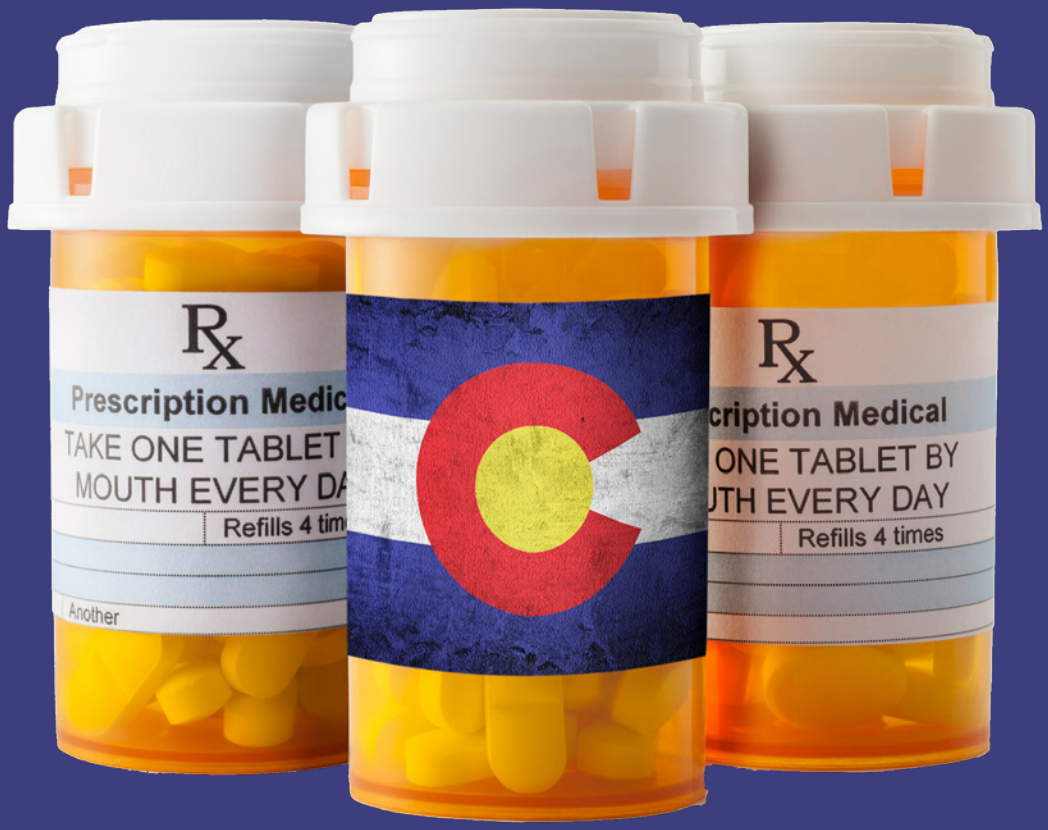
Over the next month COACEP is accepting commentary and feedback from COACEP Members and partner organizations before finalizing our guidelines for official release on May 1st. We invite you to review these guidelines, and provide feedback to help inform our recommendations! Feedback can be emailed directly to dstader@carepointhc.com.



COLORADO ACEP

2017 Opioid Prescribing & Treatment Guidelines

EXECUTIVE SUMMARY



Confronting the Opioid Epidemic in Colorado's Emergency Departments

The Opioid Epidemic in Colorado

It's no secret that the United States has been gripped by opioid addiction. This public health crisis has been magnified by the frequency with which these potent drugs are prescribed, a rate that has quadrupled since 1999. These prescriptions also are the principal culprit behind our nation's escalating heroin addiction; Colorado alone has seen a 170% increase in heroin-related felony arrests since 2011, a 205% increase in non-heroin narcotic deaths, and a 250% rise in heroin-related fatalities since 2000.

Many factors have contributed to this epidemic, including inaccurate (but widely accepted) reporting on the safety of opioid analgesics, deception by profit-driven pharmaceutical companies, and a misguided emphasis on national pain and patient satisfaction policies by regulatory agencies such as the Joint Commission (JC) and the Center for Medicare and Medicaid Services (CMS). As emergency clinicians, we are obliged to provide appropriate pain relief to our patients, but we also bear a growing responsibility to help stem the tide of addiction.

The Colorado Emergency Department Opioid Prescribing and Treatment Guidelines offer an approach to pain management aimed at decreasing the morbidity and mortality associated with narcotic use and abuse. This protocol provides concrete recommendations about when and how opioids can be avoided, describes an array of alternative treatments for addressing pain in the acute setting, empowers emergency providers to become champions of harm reduction, and explains best practices and resources for the treatment of drug-addicted patients.

The Colorado Chapter of the American College of Emergency Physicians strives to build a community of clinicians dedicated to ending this national epidemic with resolve and innovation. If adopted, these guidelines will help combat the tremendous burdens of drug addiction and enable Colorado emergency departments to serve as a model for the nation.

Limiting Opioids in the ED

PRACTICE RECOMMENDATIONS

1. Opioids are inherently dangerous, highly addictive drugs with significant abuse potential, numerous side effects, lethality in overdose, rapid development of tolerance, and debilitating withdrawal symptoms. They should be avoided whenever possible and, in most cases, initiated only after other modalities of pain control have been trialed.

2. Prior to prescribing an opioid, physicians should perform a rapid risk assessment to screen for abuse potential and medical comorbidities. Alternative methods of pain control should be sought for patients at increased risk for abuse, addiction, or adverse reactions.

3. Emergency physicians should frequently consult Colorado's prescription drug monitoring program (PDMP) to assess a patient's history of prescription drug abuse, misuse, or diversion.

4. Alternative medications and nonpharmacological therapies should be used to manage patients with acute low back pain, for whom opioids are particularly detrimental. Opioids should be prescribed only after other treatments have failed.

5. Potential drug interactions must be evaluated, and opioids should be avoided in patients already taking benzodiazepines, barbiturates, or other narcotics.

6. Patients with chronic pain should receive controlled medications from one practice, preferably their primary care provider or pain specialist. Opioids should be avoided in the acute treatment of most chronic conditions. Emergency physicians should coordinate care with a patient's primary care or pain specialist whenever possible, and previous patient-physician contracts regarding opioid use should be honored.

7. Clinicians should abstain from adjusting opioid dosing regimens for chronic conditions and avoid routinely prescribing narcotics for acute exacerbations of chronic non-cancer pain.
8. Long-acting or extended-release opioid products should be avoided for the relief of acute pain.
9. Patients receiving prescriptions for controlled medications should be able to show proof of their personal identity.
10. Patients who receive opioids should be educated about their side effects and potential for addiction, particularly when being discharged with a prescription.
11. When considering opioids, clinicians should prescribe the lowest possible effective dose in the shortest appropriate duration (<3 days).
12. Emergency departments should refuse to refill lost or stolen opioid prescriptions.

POLICY RECOMMENDATIONS

1. As has been done in other states, the Colorado PDMP should develop an automated query system that can be more readily integrated into electronic health records (EHRs) and accessed by emergency clinicians.
2. Pain control should be removed from patient satisfaction surveys, as these questions may unfairly penalize physicians for exercising proper medical judgement
3. Opioid prepacks should be eliminated from the emergency department if 24-hour pharmacy support is available.
4. Pain should be removed as the "fifth vital sign."

Alternative Treatments

PRACTICE RECOMMENDATIONS

1. All emergency medicine providers should be proficient in Alternatives to Opioids (ALTO) by learning new skills such as trigger-point injections, nerve blocks, and the appropriate administration of medications such as ketamine, haloperidol, lidocaine (IV and topical), gabapentin, and NSAIDs.
2. Low-dose, subdissociative ketamine (0.1-0.3 mg) is an effective analgesic that can be opioid-sparing for many acute pain syndromes. Institutional guidelines and policies should be in place to protect clinicians and nurses who administer this agent for analgesia.
3. For musculoskeletal pain, consider a multimodal treatment approach using acetaminophen, NSAIDs, steroids, topical medications, and low-dose ketamine. Trigger-point injections also can be considered.
4. For headache and migraine, consider a multimodal treatment approach that includes the administration of antiemetics, valproic acid, steroids, and triptans. Strongly consider preparing a cervical or trapezius trigger-point injection.
5. For pain with a neuropathic component, consider gabapentin.
6. For pain with a tension component, consider a muscle relaxant.
7. For pain caused by renal colic, consider an NSAID, lidocaine infusion and DDAVP nasal spray.

8. For chronic abdominal pain, consider low doses of haloperidol and lidocaine infusion.
9. For extremity fracture or joint dislocation, consider the immediate use of nitrous oxide and low-dose ketamine while setting up for ultrasound-guided regional anesthesia.
10. For arthritic or tendinitis pain, consider an intra-articular steroid/anesthetic injection.

POLICY RECOMMENDATIONS

1. All emergency departments should implement ALTO programs and prepare narcotic-free pain pathways for managing the following conditions: acute on chronic opioid-tolerant radicular lower back pain, opioid-naive musculoskeletal pain, migraine or recurrent primary headache, extremity fracture or joint dislocation, gastroparesis-associated or chronic functional abdominal pain, and renal colic.
2. Emergency departments are encouraged to assemble an interdisciplinary pain management team that includes clinicians, nurses, pharmacists, physical therapists, social workers, and case managers.
3. Reimbursement should be available for any service directly correlated to pain management, the reduction of opioid use, and treatment of drug-addicted patients.

Harm Reduction

PRACTICE RECOMMENDATIONS

1. Patients who abuse opioids should be managed without judgement; addiction is a medical condition and not a moral failing. Caregivers should endeavor to meet patients "where they are," infusing empathy and understanding into the patient/medical provider relationship.
2. Every emergency clinician should be well-versed in the safe injection of heroin and other IV drugs, and understand the practical steps for minimizing the dangers of overdose, infection, and other complications. When treating patients with complications of IV drug use, injection habits should be discussed and instruction should be given about safe practices.
3. Emergency department patients who inject drugs should be referred to a local syringe access program, where they can obtain sterile injection materials and support services such as counseling and HIV/hepatitis testing.
4. Emergency departments should provide naloxone to high-risk patients at discharge. If the drug is unavailable at the time of release, patients should be given a prescription and informed about the drug's over-the-counter availability in most Colorado pharmacies.
5. Emergency departments should share information about their own overdose prevention initiatives to offer reassurance about the legality of providing and prescribing naloxone.
6. Patients who receive prescriptions for opioids should be educated on risks, safe storage methods, and the proper disposal of leftover medications.

POLICY RECOMMENDATIONS

1. Harm reduction agencies and community programs that provide resources for people who inject drugs (PWID) should be made readily available.
2. When local resources are unavailable, emergency departments should establish their own programs to provide harm-reduction services such as safe syringe exchanges.

Treatment and Referral

PRACTICE RECOMMENDATIONS

1. The use of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol and SBIRT-trained health educators in the acute setting is associated with a significant decrease in continued drug abuse and an increase in patient follow up for treatment programs. Every Colorado emergency department should consider implementing such a program.
2. The use of alpha$_2$-agonists, antihistamines, antiemetics, and NSAIDs should be used to ameliorate withdrawal symptoms.
3. Any patient willing to consider treatment and recovery should be directed to a nearby Medication Assisted Treatment (MAT) program.
4. The initiation of Suboxone® is among the most effective methods for transitioning patients into treatment and recovery. Emergency departments with a high prevalence of opioid-addicted patients should strongly consider implementing a coordinated program that allows those suffering from drug withdrawal to receive the medication and expeditiously transferred to a MAT program.

Call to Action

The opioid epidemic belongs to the medical community and we must help extinguish it. To this end, Colorado ACEP is collaborating with the Colorado Hospital Association on a pilot program to implement ALTO protocols in five hospitals across the state. The initiative aims to quantify the benefits of implementing guidelines and gauge their effects on opioid usage and patient satisfaction scores. Swedish Medical Center, which implemented ALTO guidelines and staff training in 2016, already has reported a 33% reduction in prescriptions for hydromorphone and opioids in the emergency department without significant detriment to patient satisfaction scores.

Finally and perhaps most importantly, we must reject the status quo, revolutionize our own practices, and endeavor to stem the tide of opioid addiction. We challenge you to join us in becoming an agent for change. We in Colorado can make a profound difference by setting the standard for every emergency department in the country, and together we can bring this deadly epidemic to an end.

WHAT CAN YOU DO?

- ✓ Work with your emergency department medical director, physician group, pharmacists, and hospital administrators to fully integrate as many of these recommendations into your clinical practice as possible.
- ✓ Share these guidelines with the clinicians and medical staff in your emergency department.
- ✓ Sign the pledge to abide by these guidelines and challenge your fellow clinicians to do the same. Your emergency department will be recognized by COACEP when 60% of its care providers sign and submit their pledges.