

EMpulse

Official Publication of the Indiana Chapter of American College of Emergency Physicians



**Planning is still
underway for our
2021 INACEP
Emergency Medicine
Conference**

**Date and location will be
listed on our website
www.inacep.org**

**Please check later this
fall or winter for
conference information**

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A View from the Top



Lauren Stanley, MD, FACEP (INACEP Board President)

I begin my year as President of Indiana ACEP during an unprecedented time for our specialty, our communities, and our families. The COVID pandemic has changed our lives in many ways and certainly has altered our day-to-day lives as Emergency Physicians for the foreseeable future.

As with other crises, Emergency Physicians have stepped up to lead the response to the pandemic: on the individual ED, hospital, community, and state levels. This is what all of us do on a daily basis in our individual departments, and this is what several have done on a broader scale: be voices of clarity and leadership in an otherwise chaotic time. I'd like to highlight that EP's hold several key positions at the state level. Dr. Lindsay Weaver is the CMO of the Indiana State Department of Health and has been instrumental since day one in launching and coordinating the state's response, a considerable challenge especially in the earliest days when there was an abundance of confusing and/or conflicting information about the virus, its clinical course, and how we as EP's should treat patients with COVID. Drs. Jen Sullivan and Dan Rusyniak are Emergency Physicians who serve as Secretary and CMO of FSSA (respectively) and have also been instrumental in coordinating the state's efforts.

While these leaders in our specialty have been the public face of the state's response to the pandemic, credit should also be given to each and every one of you, the Emergency Physicians across the state who have unhesitatingly showed up to your ED's and suited up (physically and mentally) to care for patients despite many challenges, from inadequate PPE to rapidly changing treatment guidelines to the mental health toll such circumstances have on front-line docs. In the middle of the uncertainty and fear that have marked this pandemic, you have been beacons of stability, showing up to provide excellent patient care day after day. I am tremendously proud to be part of the EM community in these times.

As we navigate this time of uncertainty, know that your ACEP team "has your back," so to speak. We have engaged with other organizations including ISMA to advocate for Emergency Physicians to have adequate access to PPE, among other efforts. National ACEP has been quite active in swiftly and effectively pushing forward initiatives that support and protect Emergency Physicians. One example is ACEP's support for H.R. 7538 and H.R. 7059 (the latter being the "Coronavirus Provider Protection Act"): these bills would establish liability protections for care provided during the COVID-19 emergency, as well as 60 days following the termination of the emergency declaration. As you are probably aware, on July 23, the U.S. Department of Health and Human Services extended the COVID-19 Public Health Emergency for an additional 90 days.

ACEP has also worked closely with congressional sponsors of the "Dr. Lorna Breen Health Care Provider Protection Act" (S. 4349), which was introduced on July 29. This bill's goal is to take

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Covid Reflections

by Dan Garrison MD, IU Health Bloomington (INACEP Board Member)

In early March, I wrote to my medical director that we should try to find a way to cohort COVID 19 patients. Our department, which sees about 55,000 patients per year in Bloomington, had already started seeing some probable cases, but the state department of health still controlled testing at that time. Each shift included the same conversation. "Yes it is possible that your symptoms are due to coronavirus, but even if we knew you were positive, that result wouldn't change the tools available to treat patients with COVID 19: oxygen, IV fluids and a ventilator. Since you don't need any of those, you need to stay at home and assume you have the virus." When I think back on that time, I'm struck by the question, what if we'd had the resources to test all those people? Would they have continued to spread the disease in the same way?

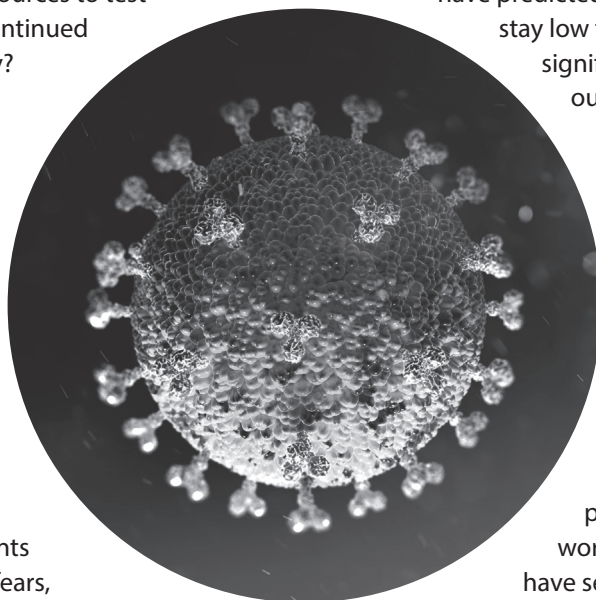
There are so many things about this pandemic that I hope never repeat themselves. The lack of consistent messaging from governmental authorities, the restrictions we faced as providers in ordering tests, the politicization of basic science principles, and the disregard for public safety sadden me. However, this pandemic has brought out some highlights in humanity; the renewed respect our patients have shown us, those moments when our expertise and care calmed fears, and even those times we are called to stand in for patients' loved ones during those darkest moments.

Our department did cohort suspected COVID patients from late-March to late-May, which we termed the "orange zone." Essentially all intubations and aerosol generating procedures happened there. BIPAP became nearly non-existent. One initial and crucial choice was to mask all patients and all staff with surgical masks which undoubtedly prevented some transmissions. I reflect on this zone experiment as having both drawbacks and benefits. One of our aims in implementation was to reduce our PPE burn rate which was largely successful. Sure, we used N95s all day and stored many to dry out and reuse later, but we never ran out or even came that close. Another aim was to try to protect some of our most vulnerable patients, though I'm not sure how effective we

were. It was likely too much to ask a triage RN to distinguish between COVID symptoms and some of the highest risk co-morbidities such as COPD. To this day, I am still not quite sure I could devise better criteria for an "orange zone" patient. This virus has so many manifestations. I believe an unintended consequence of cohorting was to create a false sense of security in the non-COVID side, which we called the "green zone". Even the name seemed to suggest that our staff could provide care without risk of infection. We were not as aware of asymptomatic spread at that time. Thankfully, our department has remained healthy, with only a few nurses testing positive, all of whom recovered well. I never would

have predicted how the volumes would drop and stay low for so long. We found that as the first significant increase in new cases passed, our COVID section took up too much room and impeded flow. It is unclear at this moment if we will resume cohorting, and if we do I'm not sure what will trigger that decision. It seems that Indiana was spared, Monroe County in particular; yet there is an undercurrent of fear that the worst is to come.

As Emergency Medicine physicians, we are reminded daily that this pandemic offers no easy choices. A working economy is needed, and yet we have seen how botched re-openings lead to further economic decline. We need schools to reopen in order to offer safety nets for so many children, but the costs of virtual learning are weighed against the cost of increased exposure and spread. Separating patients from their families in some of their most dire moments has been painful for everyone, including physicians, and yet we have sometimes connected more deeply with patients in these moments that require a new level of presence on our part. I hope we can hold on to the good that the COVID pandemic has brought out in us, and struggle together through the rest. We deserved respect before the pandemic, and we need to continue to earn it. The circumstances of suffering will drain us, but we can still have empathy and compassion for our patients. My takeaway of these five grueling months is that we can persevere, and perhaps be even better at what we do on the other side.





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Excellence in Emergency Medicine: The 2020 Fred Osborn Award Winner is James Jones MD, FACEP

In 2010, the Indiana ACEP board established an annual award in memory of Dr. Fred Osborn who passed away in 2009. Dr. Osborn contributed extensively to the practice of emergency medicine and to his group, hospital, community and the state. As such, an award was established in his memory to be presented annually at the Indiana ACEP Education Conference in the spring.

The recipients of the award to date have been as follows:

2010 - Peter Stevenson MD, FACEP of Evansville, IN

2011 - David VanRyn MD, FACEP of Elkhart, IN

2012 - Thomas Madden MD, FACEP of Bloomington, IN

2013—Thomas Gutwein MD, FACEP of Fort Wayne, IN

2014 - Tom Richardson MD, FACEP of Danville, IN

2015 - Randall Todd MD, FACEP of Indianapolis, IN

2016 - Chris Burke MD, FACEP of Carmel, IN

2017 - John McGoff of Indianapolis, IN

2018 - Thomas Heniff MD, FACEP of Boone CO, IN

2019 - Chris Hartman MD, FACEP of Carmel, IN

2020 – James Jones, MD, FACEP of Zionsville, IN



The Board of Directors of the Indiana Chapter of the American College of Emergency Physicians are thrilled to announce that **James Jones MD, FACEP** is the 2020 recipient of the Fred Osborn Memorial Award for Excellence in Emergency Medicine. This award, presented annually, recognizes leaders in Emergency Medicine who have made extraordinary contributions to the EM community in Indiana in terms of leadership, involvement and contributions to their Emergency Medicine group, hospital, and state. Dr. Jones was nominated by Dr. JT Finnell.

Dr. James Jones' many professional achievements speak for themselves; he has clearly left a legacy of excellence on national, state, and community levels, as demonstrated by his leadership of ABEM, Indiana University's Emergency Medicine Residency Program, the Wishard/Eskenazi ED, and many others. However, equally important is his legacy of service to patients and learners. Dr. Finnell stated it best when he wrote: "He is a man of grace and kindness and a consummate educator. He has helped to train hundreds of physicians over his career. Jamie is a soft and patient teacher who takes his time explaining concepts to students and young physicians."

Typically, the Fred Osborn Award is presented in person during the annual Indiana ACEP conference in April; unfortunately, this was not possible in 2020 due to the conference being canceled in response to the current pandemic. We will be publicly acknowledging James Jones MD, FACEP during our 2021 conference.

From INACEP President Lauren Stanley MD, FACEP – "Thank you for all that you have done to serve the patients, resident physicians, EM faculty, and scores of Emergency Physicians not just in Indiana, but across the country. You have truly made a difference for all of us."

WELCOME NEW INACEP MEMBERS

New Members:

Barbara, Michael DO
Marburger, Erica MD
Matthews, Ryan MD
Nabijohn, Aqeel MD
Piedmonte, Daniel MD
Routh, Matthew DO
Wong, Kenneth MD

Residents:

Curtice, Hanan MD
De Venecia, Bryce MD
Watson, Quinn MD

Medical Students:

Adjei, Stephanie
Baker, Seth
Bode, Nathaniel
Boyes, Daniel
Carroll, Elexus
Crook, David
Gunter, Matthew
Haggard, Benjamin
Johnson, Olivia

Kowalkowski, Ashley
Kyrgic, Zoran
Mohamed, Deena
Peters, Alexander
Phillips, Whitney
Pikus, Angela
Rollison, Nathaniel
Sims, Sara
Valdes, Juan

Case Study: Malaria in Indiana?

by Daniel Elliott MD (INACEP Board Secretary/Treasurer)

Special thanks to Dallas Peak, MD, IU Health Methodist Hospital

Case Presentation

A 48 year-old African female presents to the Emergency Department from the local international airport by EMS with fever and confusion. Upon arrival, the patient is altered and unable to communicate. She was markedly febrile and tachycardic. She was accompanied by her son who states she had mentioned she had not felt well for a day and may have had a headache when she was getting on the flight. She did reportedly visit her doctor a couple days prior for possible fever and not feeling well. She was prescribed medications, but her son is unsure if she had taken them. Upon inspection of patient's belongings with her son, we found that she had been prescribed paracetamol, ciprofloxacin, diclofenac, and Coartem.

On exam, the patient was an African female with a fever to 40.2C and tachycardic. She was moving around the bed but not following commands. She intermittently moaned but was otherwise nonverbal. She had no appreciable rash and no nuchal rigidity. There was no other appreciable tenderness noted. Given the language barrier, her history was limited to the input from medics and her son.

Patient was started on IV fluids and Tylenol. Lab work and blood/urine cultures were obtained. A head CT was obtained due to altered mentation without evidence of acute findings. Broad spectrum antibiotics were started. Initial labwork revealed leukopenia of 3.2, thrombocytopenia of 35, and an elevated total bilirubin of 4.6. Given her recent arrival from Africa, early consultation with Infectious Disease was obtained and led to a stat peripheral smear showing 10.8% parasitemia, *P. falciparum*. IV quinidine was started after consultation and we continued empiric antibiotics until blood cultures resulted. Decision was made to hold off on lumbar puncture given malaria as the likely source of infection per ID recommendations. The patient was admitted to the ICU due to severe malaria for close monitoring and monitoring of airway.

Diagnosis

Severe Malaria with encephalopathy.

Management

The patient was admitted to the ICU with broad spectrum antibiotics, intravenous quinidine, and close monitoring. Infectious disease was consulted and followed throughout the course of patient's stay. Patient continued to show progressive improvement of symptoms. The patient was oriented to person and place on hospital day 2 and transitioned to oral quinine and doxycycline. On day 3, patient was transferred out of the ICU

and peripheral smear showed parasitemia had dropped to <1%. Patient remained in hospital until she was back to her baseline without neurologic deficits and tolerating oral medications. Patient was discharged from hospital on day 8 with completion of 7 day course of oral doxycycline and quinine.

Discussion

Malaria is a common disease affecting over 300 million people each year with over a million deaths related to malarial infections each year. Despite its prevalence worldwide, malaria is a relatively rare disease seen in Indiana and the Midwest in general. In fact, only approximately 1,500 cases were noted in the entire United States yearly with most cases being patients that have travelled to endemic areas. The disease has a wide spectrum of presentation from mild intermittent fever to obtunded comatose patients. The classical presentation involves irregular or cyclic fevers with other common symptoms including nausea, abdominal pain, anemia, chills, lethargy, and URI symptoms. Acute *P. falciparum* infections can manifest with cerebral edema, encephalopathy, metabolic acidosis, hypoglycemia, renal failure, disseminated intravascular coagulation, or death. Obtaining a stat peripheral smear showing an elevated parasitemia and a high index of suspicion is necessary to reach the correct diagnosis and management.

For years, chloroquine phosphate was the treatment of choice for malarial infections, though growing resistance has led to the use of oral quinine and doxycycline for uncomplicated infections from chloroquine-resistant regions. For complicated infections or those with neurologic involvement, such as our patient, intravenous quinine or quinidine is recommended with admission to an intensive care unit. Artemisinin agents can also be effective antimalarial drugs and can also be obtained from the CDC if a severely infected patient is not responding to intravenous quinidine.

Conclusion

Malaria is a common disease prevalent throughout the world and presents with unexplained fever and a myriad of accompanying symptoms. Have a high index of suspicion in patients travelling from endemic areas and obtain a peripheral smear early in the care of the patient to confirm the diagnosis. Consider admission to an intensive care unit if the patient has any accompanied neurologic symptoms as their symptoms may progress over the first 24 hours.

REFERENCES:

Becker, BM and Cahill, JD. *Rosen's Emergency Medicine- Concepts and Clinical Practice*. "Chapter 133 Parasitic Infections". 2014. 1768-1784.e1.



A View from the Top

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major steps to reduce and prevent suicide and burnout, and alleviate other mental health concerns that have been exacerbated by the COVID-19 pandemic. The legislation is named for Dr. Lorna Breen, an emergency physician and ACEP member who died by suicide earlier this year.

Aside from legislative efforts, ACEP has maintained its focus on providing clinical guidance to EP's. If you're looking for a high-quality, up-to-date repository of information about COVID19 (everything from treatment considerations to the financial aspects of billing/coding for COVID care to physician resilience / well-being), bookmark the COVID19 Field Guide on ACEP's website.

ACEP is thinking creatively to adapt to the COVID environment, and the 2020 Scientific Assembly on October 26-29 is no exception. This year's conference will look different, with an entirely online format. There will be multiple live courses to choose from every day, real-time question/answer sessions with course faculty, and of course the networking and social events that make SA a favorite conference every year.

As much as COVID19 is occupying our collective minds, Indiana ACEP is also continuing to address non-COVID-related issues affecting our specialty. For example, Indiana ACEP Board Members have authored 2 resolutions that will be taken to the ACEP Council meetings this year: Dr. Jamie Shoemaker (Elkhart) authored a resolution that calls for ACEP and other national organizations to work together to study and address the often-adverse impact of healthcare insurers on Emergency Medicine reimbursement and patient coverage, while Dr. Sara Brown (Fort Wayne) co-authored a resolution supporting EMS as a vital component of health care delivery (rather than merely a transport mechanism), warranting appropriate reimbursement thereof (among other things). I also look forward to working hard on your behalf at the statehouse during the upcoming legislative session. There will be a number of important bills potentially affecting EM, and we as a chapter will be working hard to have a voice at the table and advocate for our specialty. Stay tuned; your presence at the statehouse in the past couple of years has made a difference on the outcome of key legislation, and we will need to "activate the troops" once again this coming session.

Thank you for the selfless work you have done in these past months. I look forward to serving you as this year's Indiana ACEP President!

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Workplace Violence

by *Lindsay Zimmerman MD (INACEP Board Member)*

A few weeks ago, I was taking care of a patient suffering from acute psychosis from her untreated schizophrenia. She had been off of her medications and over the last couple of days began having auditory hallucinations and paranoia of people coming to “get” her. Her family reported concerns that she was planning to burn the house down. Per our hospital protocols, I performed the usual history and exam, and she was responding to internal hallucinations and refused to give me much history because I was “one of them.” A social worker was able to get placement for her at a psychiatric facility and given her dangerous state and refusal to go voluntarily, I signed an emergency detention for this patient. All seemed normal at the time, but the patient was angry that she was being placed.

At this hospital, sheriff deputies take our emergently detained patients to the inpatient psychiatric facilities. When they arrived, the patient became hostile. After she was placed in the vehicle, she complained that she had to urinate, and the deputies brought her back in through the ambulance bay to use the restroom. At this point, the patient had been discharged from the system, so she was not taken back to her room by the deputies. The patient then locked herself in the bathroom and began loudly screaming to speak with the doctor. I was asked by the sheriff deputies to see what she might need, and when I gained access to the bathroom with the two deputies, she lunged at the deputy to my right and attempted to pull his sidearm. When he yelled, “Get your hands off my gun,” the nursing staff reflexively came running and filled the entryway to the bathroom, effectively cutting off my path of escape. A tussle ensued, during which she continued to attempt to harm me and the two deputies. Ultimately, she was safely restrained and unharmed. None of the staff were injured. This is unfortunately not the first time that I have been under threat of violence, but it was the first time that I was involved in an altercation that included a gun.

In analyzing an incident, a very troubling incident in this case, it is helpful to reflect on the error chain (or chain of events). The patient should not have been brought back in the ED from the ambulance bay. Rather, if she needed to come back into the hospital for any reason, nurses should have been notified and she could have been checked back in before I went to see her. A bedside commode should have been used, as it had been during her ED stay. I could have insisted that she be placed in a room before investigating why the patient was causing a disturbance. Staff had been trained on how

to respond in violent situations and didn’t follow protocols when my route of escape was blocked. Many reasons can be identified as to why these breakdowns in procedure may have occurred. For example, the emergency department was extremely busy that day and expediency of her transport may have become the priority. Her nonviolent behavior for the first few hours of the shift may have induced complacency amongst those caring for her. Situational awareness was certainly lacking as I was unaware of her return into the ED until the screaming started in the bathroom.

Workplace violence in the ED is unfortunately quite common. According to ACEP and ENA surveys, almost half of emergency physicians have reported being physically assaulted on the job, and about 70% of ED nurses have experienced being hit or kicked by patients. Workplace violence in the ED is unacceptable. Scene safety is a crucial part of keeping ourselves safe and in preventing violence in the ED. My patient, suffering from acute psychosis, was able to find an opportunity for violence. In cases of these patients who have acute psychiatric disease or medical causes of psychosis, it is important to remember the possibility of violence and to maintain constant vigilance. With vigilance from all staff, aberrant actions may be recognized, and escalations of violent behaviors may be prevented.

Last week, a colleague of mine had an incident where an alert and oriented, but angry, young woman kicked her and the nurse. There were no signs of psychosis or other medical cause for her behavior. My colleague was unharmed, but there was a prevailing attitude amongst the staff that this is “part of the job.” It is most assuredly not. I am proud that my colleague emphatically quashed this myth on the spot and reported the incident.

Workplace violence anywhere is always unacceptable. We are leaders in the emergency department and must use our voices from a position of power to collectively say that enduring violence is not “part of the job.” Consider getting involved in ACEP’s campaign “No Silence on ED Violence.” Talk about it with your coworkers. Talk about it with administrators. Discuss prevention and de-escalation tactics. Explore opportunities for cross agency training. Familiarize yourself with protocols that law enforcement uses for psychiatric transfers. Encourage your facilities to establish clearly stated, enforceable, zero tolerance policies for aggressive behavior. Maintain vigilance. Safety first, then the ABCs.



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Survival of Independent EM Groups in the Era of Covid-19 and Health Insurance Industry Gluttony

by Bart Brown MD, FACEP (INACEP Board Immediate Past President)

As the Covid 19 pandemic reaches nearly 5,000,000 US cases and 20,000,000 worldwide cases, its deleterious morbidity/mortality is magnified by the economic collapse and unparalleled societal upheaval it has caused. There has been an unparalleled increase in unemployment, including 5.4 million laid-off workers who have become uninsured.

As one of the main groups of “front-line providers”, the difficulties and risks Emergency Physicians faced treating a novel outbreak with inadequate PPE has been well documented. The damaging economic effects of the pandemic have also been widespread for Emergency Medicine, creating many additional challenges, particularly for the numerous Independent Groups in Indiana. Emergency Medicine Groups experienced staggering losses due to radical changes in practice to accommodate for anticipated surges of infected Covid-19 cases and unforeseen decrease in overall patient volume. Many groups were forced to make schedule changes/cuts and furlough providers. Emergency Medicine Groups in Indiana already faced multiple challenges including payments for physician fees that are 22.5% lower than the national average. The long term damage is unclear, some groups are surviving from PPP loans while some face insolvency.

Renewed Insurer Tactics to Deny/Diminish Appropriate Payments

Over the past decade, Insurers have increasing employed numerous tactics (detailed below) to avoid paying providers fairly for care provided to their customers. Shamefully, several Insurers have renewed these tactics during an unprecedented pandemic and recent record profits.

Anthem intends to roll out a new process to review level 4 and 5 visits for providers who they feel bill more level 4 and 5 visits than the average.

Record Profits

The numbers really are quite unbelievable. Record Big Insurer profits during a once in a lifetime pandemic, with its resultant quarantine and economic downturn. Profits doubled year over year. Even more impressive is their record “earnings” over the past decade. For example, United-Health ballooned from \$100 billion to \$200 billion in revenue in just six years, a pace beaten only by Amazon and Apple last decade.

What value are they providing to justify this compensation? Was there a breakthrough in theoretical actuarial mathematics? Did they solve Laplace’s demon?

Common Downcode/Denial Schemes Insurers Have Previously Employed

- 1. Using Limited Autopay Diagnosis Lists --- downcoding claims not on the list**
- 2. Primary Diagnosis Tricks --- in patients with multiple discharge/ admit diagnoses they only look at the primary or 1st listed diagnosis, even if secondary diagnoses are on the autopay list**
- 3. Not paying for procedures when the visit is downcoded**
- 4. Ambiguous processes for reviewing appeals to downcodes — most insurers make you print and send in the entire chart (often nearly or over 100 pages). They often do not have a clear timeframe that they will reply, and it is not uncommon to hear nothing back after an appeal.**
- 5. Retrospective Chart Reviews/Denials**
- 6. Bundling of services or refusal to pay for common services**

Putting Patients in the Middle to Increase Profits

Insurers have pushed high deductible/ high co-pay plans increasingly to shift payment burden to their customers for artificially lowered premiums. This shifts the responsibility to collect these co-payments to the provider. Insurer’s will also send patients an incomplete payment instead of sending it to the provider. This pushes the burden of payment or negotiation to the patient. Finally, there have been campaigns to discourage their patients from seeking care in the ED encroaching on Prudent Layperson.

Disrupting Patient Care

The first issue is that patients get larger bills and have higher out of pocket expenses so the insurer can artificially lower the premium. It is difficult to collect the patient portion, resulting in losses for the provider and possible debt collection for the patient.

Chronic underpayment limits the ability to hire new physicians, find doctors to work at rural locations, and in certain cases can lead to financial loss or closure of smaller hospitals.

Opposing these Tactics

Call the insurer’s representative for your group and oppose these policies. Call Anthem and oppose their current downcode scheme.

- 1. INACEP and multiple groups have reached out and asked insurers to avoid these tactics during the epidemic.**
- 2. Ask them why they are not making fair payments when they are not likely to hit their medical loss ratio.**
- 3. Report to Indiana Dept. of Insurance for Prudent Layperson Violations or other unresolved issues.**



Covid Tools to Share with the Press

Emergency care teams have noticed a worrying trend of people avoiding or delaying seeking medical treatment, which can have life or death implications. A recent poll from the American College of Emergency Physicians (ACEP) found that nearly a third of people have delayed getting care out of concern around COVID-19, and new data from the Centers for Disease Control and Prevention (CDC) show ER visits from stroke and heart attack patients is down at least 20 percent nationwide since the onset of the pandemic.

Despite the uncertainty, you can count on emergency physicians and nurses to be ready and able to care for you anytime. Whether you are concerned you have COVID-19 or are having another medical emergency, it is critical to know when to go to the emergency department.

Here are some of the steps emergency departments across the country are taking to keep everyone as safe as possible.

- **Anyone who comes to the emergency department will be screened on arrival for COVID-19 symptoms.** In addition to the mild or moderate symptoms, emergency warning signs for COVID-19 include trouble breathing, persistent pain or pressure in the chest, confusion or inability to arouse, bluish lips or face.
- **Be prepared to come alone and connect with your loved ones virtually if you get admitted.** To limit the number of people in the emergency department, many are restricting their rules around how many visitors a patient can have.
- **Some emergency departments have created separate entrances and external waiting rooms for patients with known symptoms.** Others will ask you to stay in your car until space becomes available. Once you have been screened, you will go through a triage process to determine how urgently your condition needs to be addressed.
- **Individuals who test positive are kept separated from non-COVID patients.** Some facilities have adopted drive-through testing to prevent potentially contagious individuals from entering the main waiting room. Many emergency departments have separate wings or units, and some have dedicated care teams for patients who have tested positive.
- **Emergency physicians and nurses are trained to prevent the spread of highly contagious illnesses.** They are taught the proper way to put on and take off our protective gear to prevent contamination. In addition to vigorously washing their hands between all patients, emergency physicians will also change clothes after treating a COVID-positive patient.
- **Hospitals are taking extra precautions to keep staff and patients safe.** Emergency departments have set up separate entrances for staff who have their temperatures and symptoms checked before every shift to be sure they are not showing signs of infection. Your physician, nurses and other health care workers may also be wearing more protective equipment than what you would normally experience.
- **Emergency departments have greatly intensified their cleaning and disinfecting efforts.** Staff disinfect the common and private areas, as well as the equipment and shared surfaces multiple times throughout the day. Reusable equipment goes through a meticulous cleansing process between each patient, and some hospitals are using disposable instruments like stethoscopes in rooms with known COVID patients.
- **Hospitals are using enhanced treatments to decontaminate the air and prevent the spread of the virus.** In some cases, patients who test positive may be placed in “negative pressure” rooms, which allow air to flow into the contaminated room and out through designated ventilation, preventing airflow—and potential spread of the virus—back to the rest of the emergency department. Some negative pressure rooms also have an additional UV filtration cycle to remove viral particles and decrease contagions.
- **Emergency departments across the country are continually adapting their procedures as we learn more about the virus and how to treat it.** Many are utilizing new telehealth technology for remote consultations or enabling patients to connect with loved ones while they are admitted. Check with your local hospital or emergency department to see how they are adapting to COVID-19.

UPCOMING 2020 EVENTS

October 24 & 25

ACEP Council Meeting (Virtual)

October 26-29

ACEP Scientific Assembly (Virtual)



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