American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

COVID-19 ED Medical Directors Survey

American College of Emergency Physicians – COVID-19 Taskforce

December 4, 2020

Participation

Survey of emergency department (ED) medical directors during the first week of November 2020. See the map of survey respondents below (Figure 1). Directors of EDs across 40 of 50 states responded.

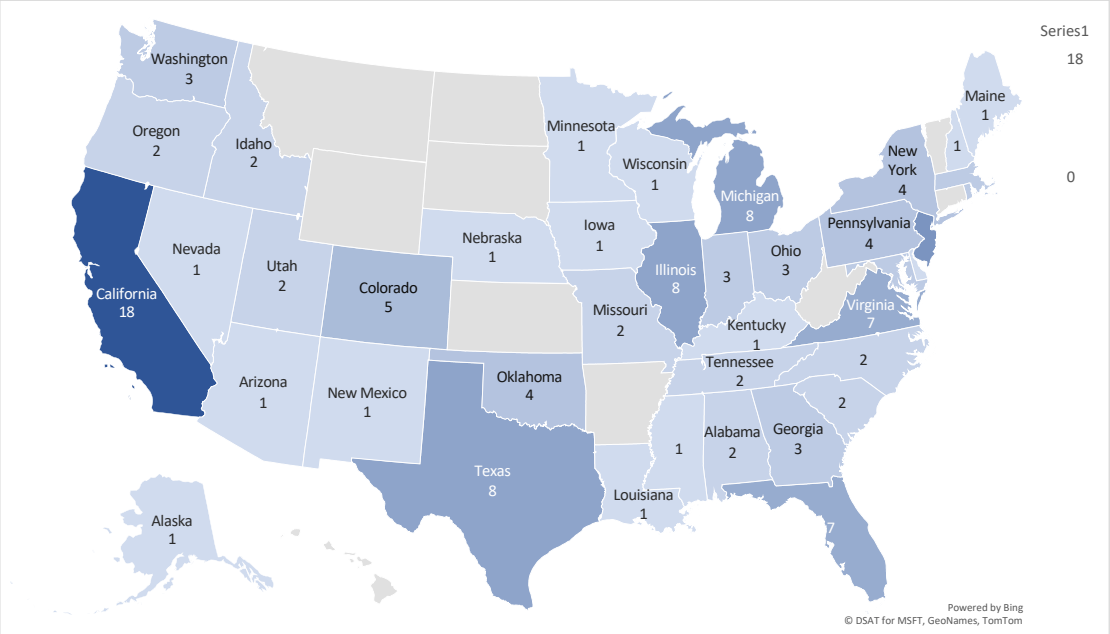

Figure 1. Map of COVID-19 ED Medical Directors Survey respondents.

ED Characteristics

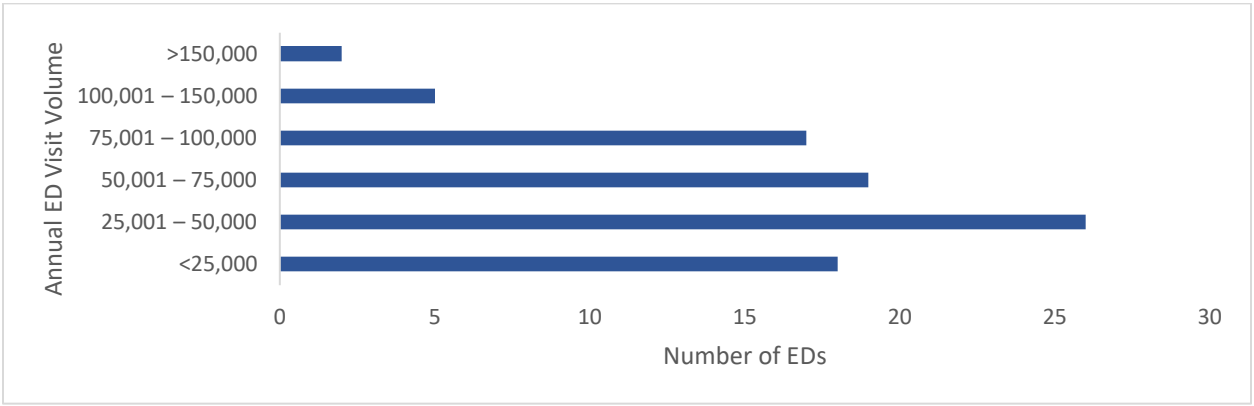

Figure 2. Annual ED Visit Volumes.

Figure 3. ED Descriptions. Top Left/Right – ED/Hospital Type. Bottom – Classification of area with ED serves.

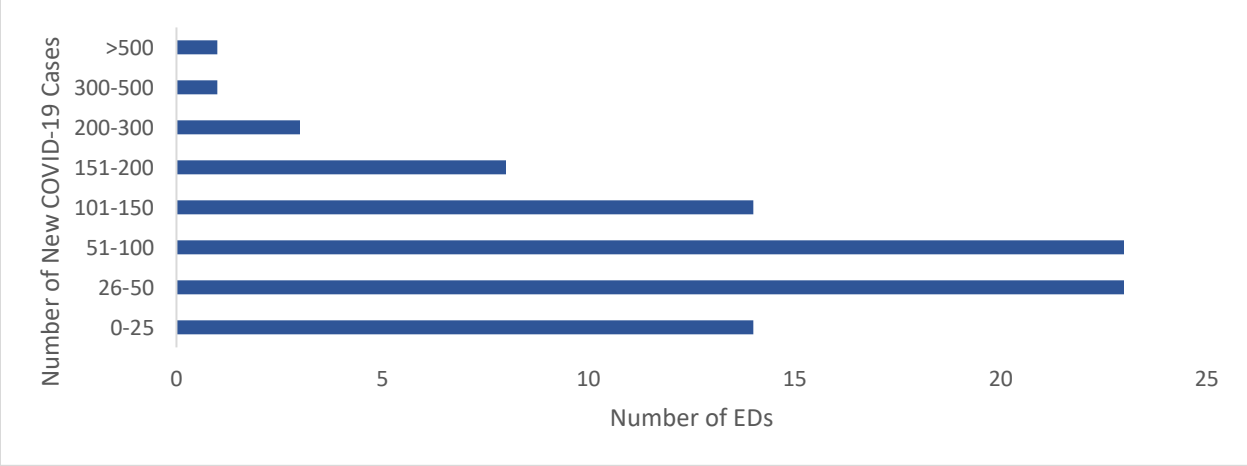

Figure 4. New COVID-19 Cases during the first week of November 2020.

ED Shortages

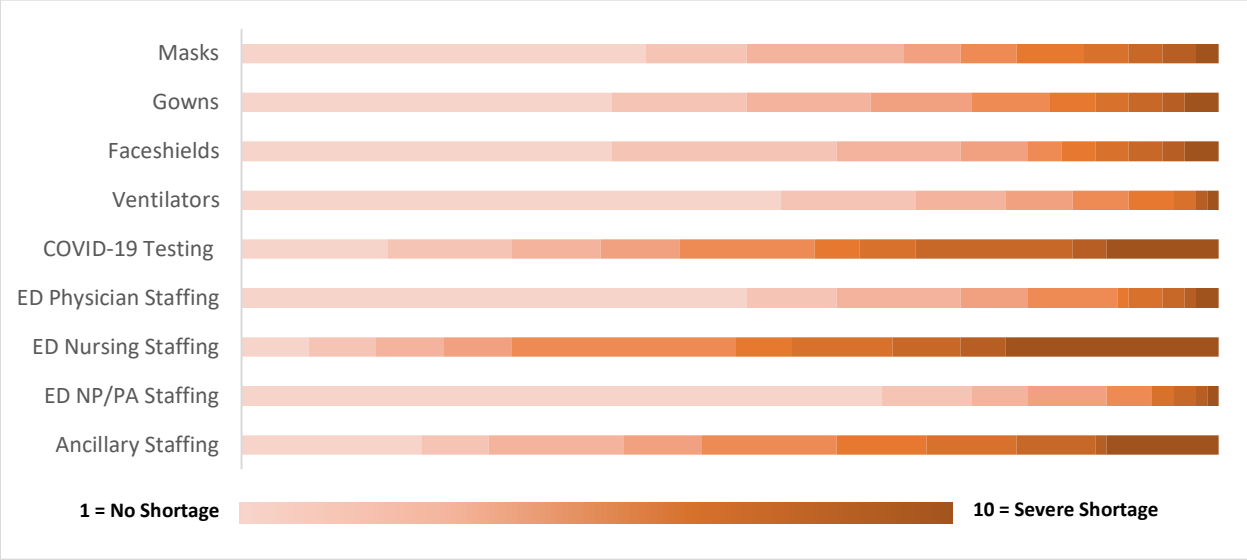

Figure 5. ED equipment and staff shortages. Darker colors indicate greater severity of the shortage.

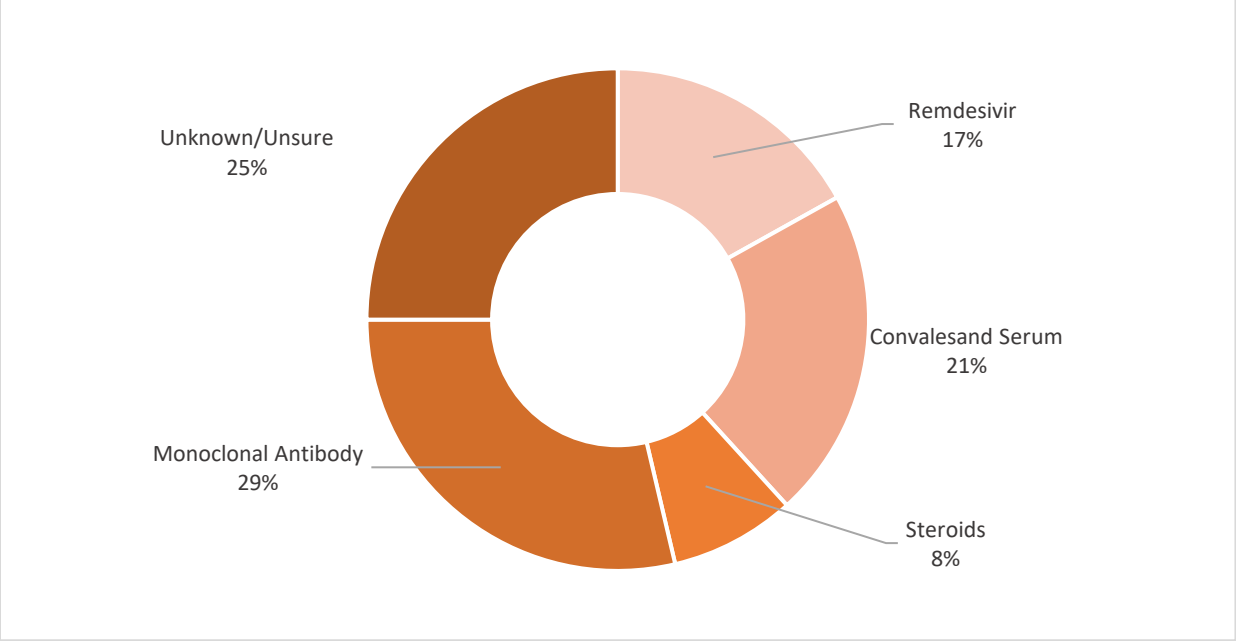

Figure 6. ED COVID-19 medicine shortages.

ED Capacity

Many EDs have reported being crowded. A primary cause of crowding in EDs is the holding (boarding) of inpatients while waiting for a bed in the hospital. Since isolation beds in the hospital and in the ED are limited, patients who need admission and an isolation room may be held in the ED until an isolation room becomes available on a hospital floor. This potentially leads to a back up of infected patients in the ED, where there may be limited options for isolation.

Table 1. ED Capacity Descriptors during the first of November

	Value	Max Value	n-Value
Percentage of EDs Boarding Inpatients	51%	-	150
Mean No. of Boarded Inpatients	40 Patients	450 Patients	75
Mean Hours Spent/Patient	12.4 Hours	48 Hours	76
Percentage of EDs in which Patient Wait Time is 1+ Hours	49%	-	150
If yes, No. of confirmed COVID-19 or PUIs	85%	-	74
Mean Patient Wait Time with Suspected/Confirmed COVID-19	2.7 Hours	>6 Hours	87
Mean Hours until COVID-19 Test for Admitted Patients	2.4 Hours	10 Hours	87
Percentage of ED in which Patients are Held until COVID-19 Test Administered	29%	-	150

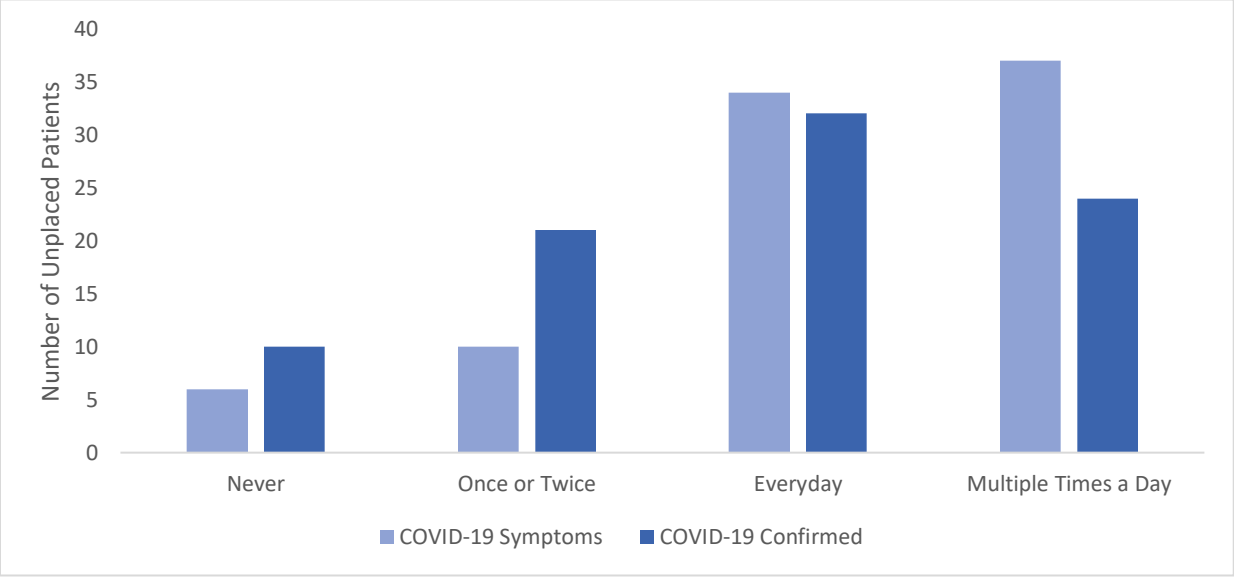

Figure 7. Patients unable to be placed in isolation. The bars indicated as COVID-19 Symptoms represent patients presenting with COVID-19 symptoms and unable to be immediately placed in an isolation room in the ED. The bars indicated as COVID-19 Confirmed represent patients with a confirmed COVID-19 diagnosis and unable to be immediately placed in an isolation room in the ED.

ED Staff Exhaustion

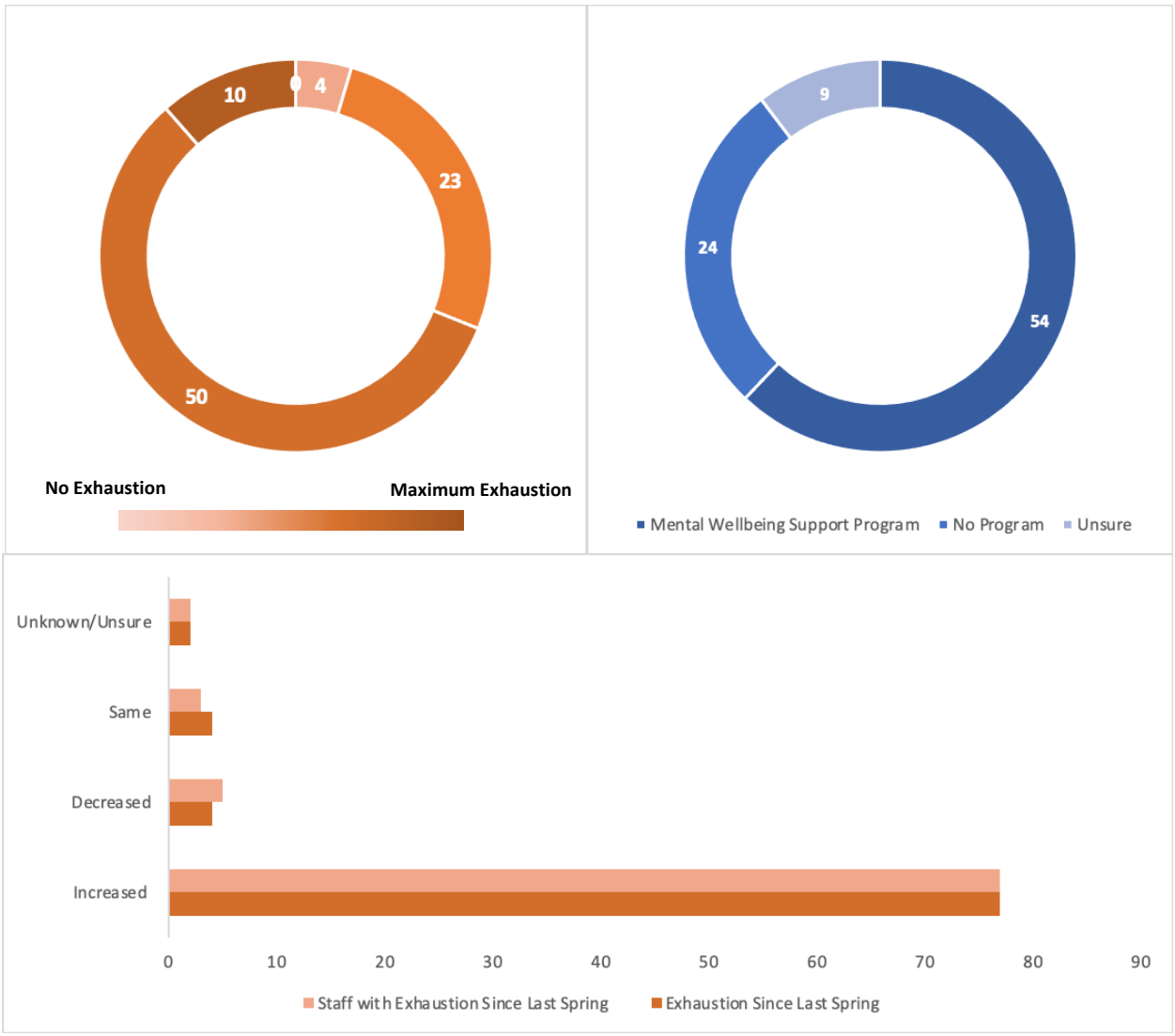

Figure 8. Staff Emotional Exhaustion Across EDs. Top Left – Current level of staff exhaustion, with darker colors indication increasing exhaustion. Top Right – Existence of programs to support the mental wellbeing of staff as it relates to their work during the COVID-19 pandemic. Bottom – Classification of area with ED serves.

Public Health Measures utilizing the ED

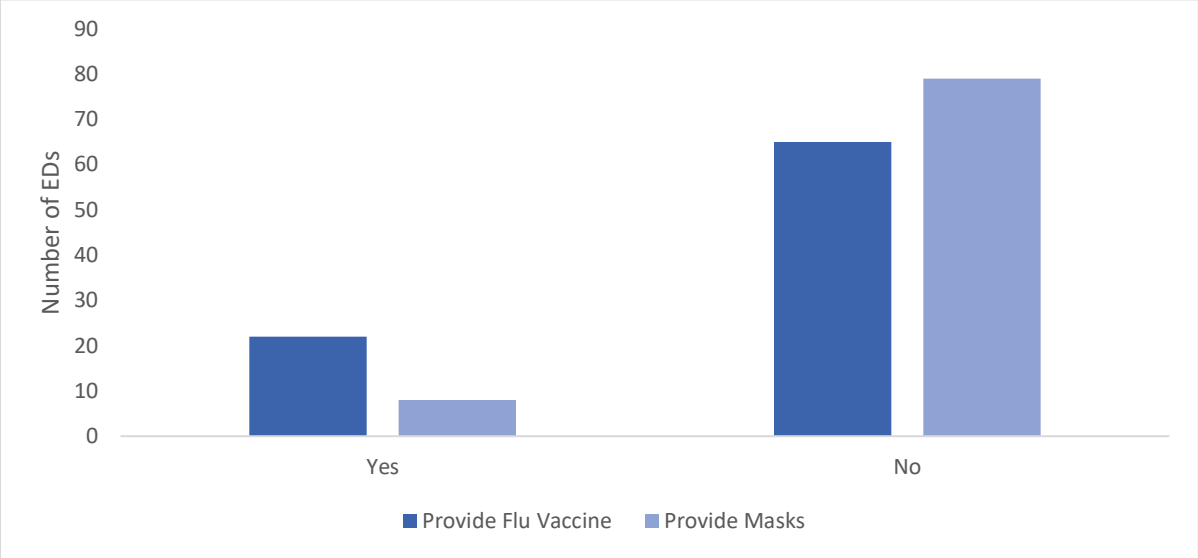

Figure 9. Current public health measures. The bars indicated as Provide Flu Vaccine represent the number of EDs responding Yes or No to providing the flu vaccine to patients in their ED. The bars indicated as Provide Masks represent the number of EDs responding Yes or No to providing providing masks to patients at discharge from the ED to take home, beyond the mask that they are given on entry to the ED?

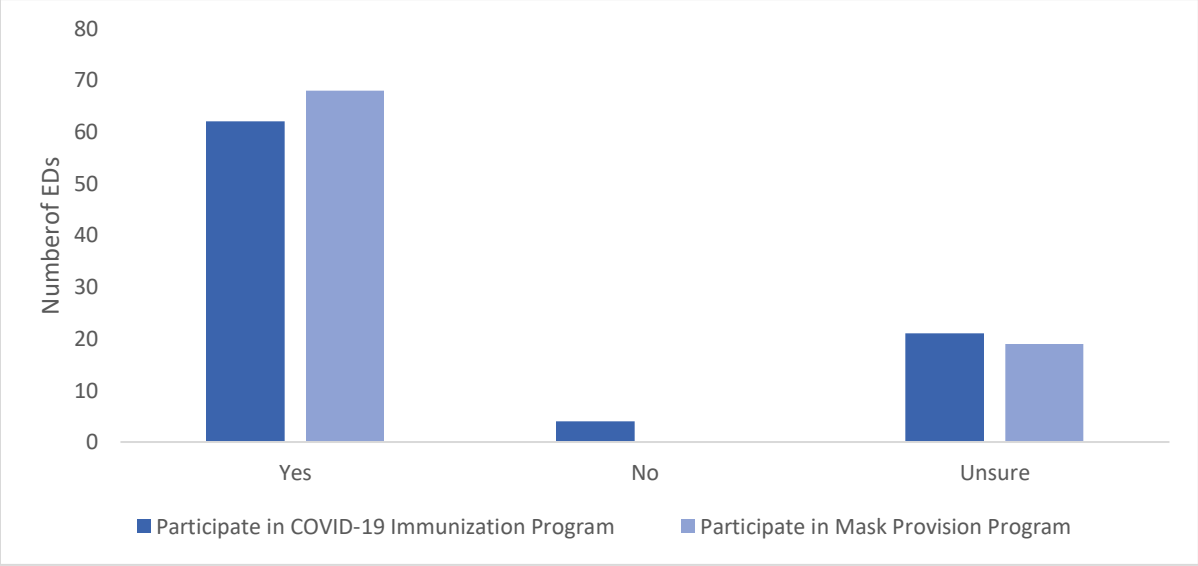

Figure 10. Interest in participation in future programs. The bars indicated as Participate in COVID-19 Immunization Program represent the number of EDs responding Yes or No to participating in a federally funded ED-based COVID-19 immunization program. The bars indicated as Participate in Mask Provision Program represent the number of EDs responding Yes or No to participating in a federally funded ED-based mask provision program.

Appendix A – COVID-19 Tests in Use

Respondents shared current used COVID-19 tests and additional comments captured in unedited form below:

Current COVID-19 Test(s) In Use
4-Plex test
Abbot ID now
Abbot rapid tests and Mayo send out tests
Abbott
ABBOTT & LABCORP
Abbott ID Now
Abbott ID Now in house for rapid (restricted use); otherwise LabCorp PCT NAAT
Abbott ID now, antigen send out tests
Abbott ID Now, Aptima
Abbott ID Rapid, Cepheid Resp Panel, E-plex Resp Panel, Hologic Panther
Abbott Rapid Antigen and a PCR test not sure of the name
Abbott rna
Abbott, BD Max
Abbott, Cephid, Solaris
Abbott, Roche, Cepheid
alere
BD Max
Biofire and abbott
Biofire and send out
Biofire resp panel 2.1
Biofire respiratory panel (pcr)
both
Cepheid
Cepheid and Diasorin
cepheid PCR
Cepheid, BD max, Roche/liat. Have Abbot units but no supplies
Cepheid/Abbott ID now/Roche
Cephelid Mutliplex PCR
Cephid for rapid testing and PCR for routine testing screening and discharged patients
cephid, Diasorin
Cephid, Roche
Cephied
COVID PCR standard (I think this is on Abbott platform), we have bio fire rapid but no supplies currently
COVID19 PCR, Respiratory pathogen panel that includes covid19, starting to use antigen testing
Disarno as well as PCR rapid
FLOVID PCR and Sophia antigen
Gene-Expert, BD Max
Gilead RA
In-house developed
LIAT, CEPHEID, BRL
Many: BioFire RP2.1, Cepheid, Roche 6800, Amplitude, Thermo Fisher, and an LDT
Microgen PCR and Sofia 2 antigen
Multiple
Multiple -- cepheid "fluvid", cepheid combo RVP/Covid, hologic panther, send out to UW
multiple pcr platforms
Numerous
our hospital has Rapid POC test Abbot, as well as 4 different in-house PCR platforms
PCR
PCR NAAT
PCR send outs + Abbott
PCR Test
PCR test and Abbott Antigen
PCR testing only. Not sure current brand names as they change frequently.
PCR, rapid and 48 hr.
Pcr, sofia
Primarily cepheid pcr. When out biofire multi virus assay including covid

Rapid
Rapid Abbott, Cepheid PCR
Rapid and nasopharyngeal (unsure of brand)
Rapid test
SARS antigen and PCR
Sars Antigen as a screen, PCR as confirmatory
sars-Cov-2 RNA, NAAT (Quest)
Sephia
Several. In-house PCR, Quest, others.
Sofia
Sofia 2, Cepheid and routine sendoff PCR
SOFIA and PCR
Sofia antigen and uncertain of the maker of the PCR test
Sofia rapid antigen, labcorp per, rheonix PCs (unreliable)
Sophia Ag test for screening admissions, if negative Cephia(sp?)PCR...Diathrix discharge PCR
Unknown
We currently use 8 different testing platforms and have a complex algo to determine what test the patient receives
We do not test in our ER
We have several testing platforms that we use based on supply and need for turn around

Appendix B – Shared Suggestions

Respondents were asked several open-ended questions captured in unedited form below:

Shared Concerns about your Emergency Department as they relate to the COVID-19 pandemic:
Air flow in the ED waiting rooms and non negative pressure/positive pressure rooms is not being evaluated well. Short staffing of the ED especially on the nursing side leads to more emotional exhaustion and burn out. IF and when there is another PPE shortage this will cause tremendous pressure/tension with staff. Reductions in staffing, pay, benefits with ED staff risking a lot to be on the front line causes more staff turnover, emotional exhaustion and burnout. Hospitals can free up a lot of capacity by balancing elective surgeries with inpatient staffing, capacity. Leaders need to do a better job managing the balance.
As cases are rising exponentially the health system is making zero effort to reduce elective surgeries and admissions. We have issues discharging patients to SNF as many have reduced capacity and/or are requesting negative COVID testing prior to acceptance; this has exacerbated what was already brittle hospital crowding
Availability of testing kits and reagent has been the biggest challenge.
Burnout of staff Boarding ED always relief valve for system even when we have nothing left to give.
Community buy in and education are needed
Cummuluative Tool of 9 months of continued vigilance is really taking a tool. Especially when we see a federal government that doesn't take the disease seriously. People can out in the public do what they want with the support of the Supreme Court and Federal Government and we are mandated to be there for them. Our total census is down, so hospital is cutting resource to make their budget neutral, but we have to also try and staff rapid for surges such as we are seeing now. The two can't really be balanced. Our hospital has put a stop on hiring, but nursing are leaving, going out on leave. They have put a hold on capital spending when we need more PAPR's.
EMTALA mandates evaluations without any funding. SIGNIFICANT disparity in patients being seen in ED due to lack of insurance is creating unsustainable financial strain on Emergency Departments in addition to the ongoing physical and emotion burn-out
General testing and immunization needs to be away from Ed and hospital. This is a govt Function
Great measures have been taken to manage the increased COVID-19 patient volume. We have been able to adapt and feel supported by the hospital as much as they can. However, staff and physicians/providers are beginning to fatigue and there is no end in sight. I am concerned that as volumes continue to increase there will come a point where providers simply say they've had enough and decide to take time off, thus leaving the rest behind to continue the fight.
I am concerned about the financial support needed for the providers when they have to be on quarantine due to exposure or illness. Why aren't there any federal programs/dollars for people while out of work for quarantine or testing? What little is there is insufficient. Using vacation time is inappropriate. The limited capped amounts provided by FFCRA are not adequate.
I need nurses. Sweet holy moses, I need nurses. My system pays $3/hr less than our competitor across the street, so we have created this problem ourselves. Still, I need nurses.
I'm concerned about the mental & physical exhaustion of my staff.

Lack of adequate workforce as more & more of us become ill and have to be out-of-work for 10-14+ days. Lack of compassion by administrators & patients for the difficult work we do, that we're constantly exposed to Covid-19 & trying to protect ourselves yet there is sense that we have to be resilient. Massive increase in mental health problems d/t covid-19 and lack of accepting facilities willing to take psychiatric patients needing psych hospitalization. Lack of public awareness of the impact on how hospitals are being flooded by covid patients, staff becoming sick, supplies being strained, healthcare resilience at the breaking point.
N 95s are desperately needed, wearing the same ones since March and April
Need federal support to ensure covid testing remains covered by insurances of all types. Need federal support to not cut emergency physician pay.
need more high flow oxygen machines, ventilators and nursing staff for both the ED and inpatient units
Need to get patients pulse o instead at discharge for mild cases to help guide them on returning to ER. Insurances do not cover.
Needs nurses, tests, staffed beds, PPE.
Not enough ICU nurses or ICU docs. Beds are tight too.
Our biggest issue is testing reagent. We need more reagent.
Our hospital thinks the "KN95" masks are ok. They are not. We all have been buying our own PPE off Amazon and Ebay.
Our tertiary hospitals are reaching capacity and have intermittently had to go on diversion or closed to our transfers including stemi patients
Overwhelmed ED with boarders taking up sometimes 75% of my ED capacity. This has led to increased LWS rates
Pt volume, funding for decreased visits, department staffing, better masks
Rapid molecular testing would be very helpful. Better communication with local contact tracing teams would be great.
Right now, cannot order more gloves. Have enough for 4 weeks and have another 4 weeks in county storage, but unable to source reliably after that.
SEVERE lack of Inpatient staff.
Shortages in nursing and ancillary services due to illness, child care issues, or quarantine are resulting in long wait times in the ED and boarding due to staffing on the units. We are still converting more rooms to negative airflow and carefully monitoring ventilator usage daily. ICU and pulmonary critical care staff are particularly exhausted.
Simply need more beds in the ED, even more so inpatient beds to prevent ED boarding and allow us to care for our community.
Small ED. 1/4 to 1/2 beds with psych holding. Same or more for admit or transfer holds. Transfering to 2 other states, up to 4.5 hours away. No PCU, ICU, COVID beds.
Staffing resources are very stressed. difficult to hire up staff as current volume is low.
Staffing shortages 2/2 Covid LEAVE is severely impacting our staffing and throughput
Testing remains problematic. We need a safe easy place for walk in testing of asymptomatic people who have exposures. Our state has an excellent program but it still takes too long. This leads to individuals NOT getting testing, NOT isolating as they should for fear that they miss work or school and do not have the disease.
The duration of the pandemic is emotionally exhausting More staff (MDs, PAs, RN, techs, hospital ancillary staff) are getting covid or need quarantine which is taxing our staffing. Holding pts in ED at record numbers for record periods of time
The inpatient service has become very efficient due to changes in protocol there including all private rooms for patients. This has led to more ED boarding than we have ever seen in the past. We have been lucky that Covid prevelence remains low in our community and also in the sense that ED volumes are 20% lower than usual so we can absorb the inefficiencies without too much added risk to patients or staff. But if volumes rise, we may have trouble.
The provider exhaustion is very real and we are also concerned about income with the recent bills looking at 6% provider cut
There is no distinction being made with regard to dying OF Covid vs dying WITH Covid. It sure would be helpful to all of us, especially the community at large, to know how many people actually are truly affected by Covid, not just a generic infection rate.
Unable to test for Covid unless the patient is admitted Follow up is hit and miss
Unreliable PPE supply. Pressure to give logistically difficult but limited utility treatment (bamlivimab) Staff fatigue. Floor nursing shortages resulting in ED holds.
We are a critical care access hospital. Patients with severe COVID related illness and other pathology are waiting excessive periods for transfer to higher level facilities. In some cases they have been on ventilators in our facility that does not have the resources for periods that are too long. In one case a patient from the floor had to be transferred back to the ED because they had to be on a ventilator and there was no where to transfer this patient. It seems to me that the COVID problem is becoming what we feared in March/April where we are getting to a point where we will have to say there is nothing more we can do for you, go home. In addition, we are inundated with patients

that are positive for COVID with mild illness. We need to conserve the resources we do have for patients that clearly will benefit from ED assessment and treatment. There is no reason we cannot do more of this in the patient's home...the resources are just not there.
We are in need of additional nursing and ancillary support
We are running out of space and ventilators. Multiple pts being housed in most of the ED's in the Network.
We are seeing steep increases in patients with Covid at the same time as seasonal increases. At least in spring our overall volumes were down. Not sure we have safe waiting areas
We are the only trauma center 125 miles around designated level 3 work as level 1 with 2 physicians 24/7... between traumas and covid we have been running at capacity for 7 mo the straight.....
We have adequate supply of N95s...as long as we keep re-using the same ones. Ideally we would be able to use them as they were intended: once.
We have ED MDs and PAs and we provide scribes. Hospitals have a hard time flexing up nursing/beds when surges hit.
We have limited negative pressure rooms. Recommendations to infuse monoclonal antibodies in the ED ties up valuable bed capacity. We need greater community resources for testing to minimize the number of well patients coming to the ED for Covid testing. Boarding issues impede efficient ED throughput. Better access to critical care beds on a regional level their appears to be a lack of ICU beds to meet demand during this pandemic and during bad flu seasons.
We have masks but very limited N95 masks. Many of the gowns do not fit people over about 6 feet tall (forearms are not covered).
We need nurses for inpatient beds every hospital in the area is getting overwhelmed on the inpatient side
We need nursing staff, both for in our ED but also for the inpatient setting to help decrease our holds. We have a significant problem with both nursing recruitment and retention.
We see 30,000 patients per year so we are a smaller ER. However, we are treating patients from all over our state as well as neighboring states. I accepted a transfer from a facility 4.5 hours away last week. We are on the Texas border. Texas has appropriately utilized money and raised nursing pay. 12 of our nurses have resigned over the past 10 days and accepted jobs in TX. Meanwhile, I work for a "for profit" company who refuses to raise their rates and is allowing hemorrhaging of nursing and all ancillary staff yet expecting the same high yield results with Skelton crews.
We would like more testing immediately available.
We're a children's hospital. Have seen 60% drop in volume. Main concern is we are over staffed.

Shared Suggestions on how your ED could be more supported:
Less mid level staffing and supporting more staffing of ED by physicians with significant EM experience even if their training wasn't in EM. Much safer than an mid level provider. We can't risk safety and quality of care by having midlevels during covid if we can staff with physicians.
ability to test all admitted patients in the system
We need more rapid tests so we can test all pts quickly
Change payment structure to hospitals. Less dependence on elective procedures.
Better access to testing and quicker turnaround of testing results.
It would be better if goals and outcomes were measured, issues quantified by overseeing bodies and then have each institution develop there own standards and processes to achieve those goals, standards.
We need more rapid test availability. We need to be able to use them more widely in the entire healthcare landscape. Patients/the public comes to the ED for rapid tests once they know we have them. It is a misuse of our department which is a critical and limited resource.
More community awareness of when to come and when not to come to EC. Home pulse ox monitoring, home testing for close contacts would be great.
Dedicated funding for staffing and staff recruiting. remove HIPPA constraints regarding COVID status and COVID testing.
My suggestion is that we need teams that can assess patients in their homes and advise regarding ED visits. We need more follow up at homes with patients that are COVID positive. We need more monitoring regarding compliance with isolation. We need to consider paying individuals a stipend to stay home when they are COVID positive.
More rapid COVID testing, especially for discharged patients.
Nursing staff are done. Big system but employees treated differently at different facilities. 50% loss of nursing staff. Hard time competing for travelers. Small hospital capacity capped at 2/3 med surg and 1/4 ICU.
improved staffing, improved airflow and air filtering, identification of overflow areas, crowd control, not reducing pay and benefits to staff, taking measures to reduce staff turnover, assure appropriate PPE, limit boarding in the ED of admitted patients, having reasonable surge plans hospitals can execute and held accountable on executing. Incentives should be given to hospitals that are deploying extra resources to manage COVID well.
More ventilators, more space

Decreased overall volumes has lead to significant cuts in nurse, tech, APC and physician hours. The acuity of those presenting is higher and not accounted for in these cuts. On top of the extra work and processes we have to go through to handle patients and ourselves in this pandemic which are not accounted for in productivity metrics. This has contributed to nurse, physician and APC stress and burnout as we work harder and harder in crazy conditions with less staff.
We need the capability to test anyone who wants a test, any day of the week with rapid (less than 24 hour) turnaround
Shorter provider shifts. We do 12 hr. shifts currently which are already too long, but now are much more intolerable given the volume and acuity of patients. We have a plan in place to change, but it won't be happening until July because of budget issues which may be too late.
staff support for the inpatient units will really our ED
More nursing support, as volume is down, they get flexed home and then we work short staffed and heightened fear of overload.
Change CON so hospitals can add more inpatient beds, or an emergency provision that extends beyond the pandemic to eliminate ED boarding.
Access to sufficient testing materials.
Improved access to rapid testing
Severely short of nurses, techs and secretaries
The limitations on supply chain or testing kits (regardless of manufacturer) is extremely problematic. We have daily allocations of test kits available which is often exceeded. This leads to practicing medicine with a crystal ball, truly unsure if any particular patient is Covid infected our not.
Support from the hospital for system-wide flow.
Financial support to keep our nurses and doctors would be great. We keep hearing of money being released but I can assure you, those of us in the trenches haven't seen a dime of it.
Unsure patients do not hold in the ED.
N-95's
Move boarded patients to other locations to allow ED staff to take care of new patients
Hospitals must be giving funding so that administrators are cutting everything to the bone. Care is hard enough to provide.
Better PPE. Hospital support for ER docs to retain them.
Decrease funding during pandemic if hospitals board patients to incentivize not boarding.
We are being crushed under the weight of boarding psych patients. We recently had 3 COVID positive psych patients waiting for placement for up to 8 days. There were no facilities that would accept these patients. State DMH no help in placement. Behavioral health volume skyrocketing and no help in sight. Psych staff and providers are afraid to come to work to see patients, beds are closed d/t staffing. Psych boarding has been out of control for years and our psychiatric infrastructure is crumbling under the pressure of the pandemic. Our EDs had 27 psych boarders today, Monday, Nov 23, 2020 with no hope of placement in sight. THIS IS A MAJOR PROBLEM for our health system and our society!
need to have the ability to transfer the most critical patients to tertiary care centers.
AS above - staffing
I have two chief concerns: We are still reprocessing N 95 masks. This leads to improper fit and concern for exposure. No excuse at this time as we should be able to produce enough to meet the demand and keep everyone safe. Due to boarding our LWBS continues to increase and we are not able to effectively evaluate all patients presenting for emergency services. Need nursing and ancillary services staff to offload the boarders.
Hospital support, funding for visits, appropriate staffing, better PPE supplies
Secure funding AND personnel for dedicated transport units that does not draw from the EMS system. Most rural facilities have a single company to serve both roles. This is a huge factor in transferring patients out to a higher level of care.
We have no infection control specialist, b/c we drove the old one off. She didn't want to take phone calls, and insisted we leave messages on her voicemail. Insert eyeroll.
GRants for durable PPE, FDA approval for meds that actually have a significant patient centered effect.
Better community resources such as more telemedicine; better understanding that many covid patients do not require ED evaluation when outpatient visits with outpatient monitoring capabilities would be extremely helpful; disallow ED boarding
We need more rapid ABBOTT tests and more gowns.
More nursing staff is our biggest hurdle
After medications such as monoclonal antibodies are distributed by government would be good to have a guideline on how to set up. Our facility was allotted 20 doses and have to develop all the work on how to give and where to give and also who will get, for a supply that we project to last less than 3 days.
Ancillary staff help is the most important my techs and nurses left are exahusted emotionally and physically. There is zero support for all My staff we keep working as if covid is just another disease and many are very young 1-2 years experience most of the staff because turn over is humongous.
When the local health department receives PPE, it would help if they would consult clinical personnel at the hospital before deciding how to dispense it.
Federal Funding for EMTAL directed care

Shared Suggestions for an ED-based COVID-19 immunization program:

In order to have a community based immunization program all local hospitals must share and HIE or EHR so that we can keep track of who has gotten a vaccine, who has only been partially vaccinated. We have 4 local hospital systems, but patients go from ED to ED. We have a

large homeless population. In order to keep track of who is being vaccinated we need to share and HIE so we can know who needs to be vaccinated and who already was. Also if yearly boosters are needed this will allow us to know when someone is due for their booster
I think it should target those that are higher risk and are willing to get the vaccine and are not in hospital for COvID or other illness that would prevent administration of the vacccine.
Depending on any required monitoring after administration of the vaccine, I'd recommend a drive through setup and keep them out of the actual department.
Currently, we don't have the staff to support this. We would have to coordinate with health department or another agency to supply staffing but otherwise, whatever we need to do to get this under control we will do.
Need an effective and easily stored vaccine.
Immunize health care workers. It should be mandatory. Many of my colleagues have contracted COVID and have been off work for extended periods. We have taken enough risk and for the sake of preserving resources for treatment of this disease we need to vaccinate health care workers first.
Disagree with this. Ed's are busy enough.
More research on the vaccine
I am concerned about our overwhelmed EDs being crushed with hordes of people seeking immunization. How can we help if we are busy caring for psych boarders?
It should be done in parallel to the normal ED flow, with EMS units available to immunize those most vulnerable patients at home
The ED's are being asked to do everything. What about the rest of the facility?
Make vaccinations available through other resources. EDs are already overcrowded and many are understaffed making an ED immunization program a major challenge.
Vaccine availability at no cost.
Would have to be vaccine that doesn't require ultra cold storage
We should not be immunizing in the ED. OMG. Are you insane? We're already crushed. You want us to have folks coming in for immunization?
Could offer free vaccine for all patients and families outside of need to provide full medical screening exam u set emtala.
I understand this is anticipated to start as a hospital-based endeavor due to cold storage, etc, and vaccine may be given to eligible/willing patients who seek care in the ED for the usual reasons, but the ED should notbe the site of care for those only seeking vaccination.
Simple... Have a huge stock on hand. Anyone that comes through the ED should be offered covid vaccination. Just as we do for influenza. Department directors should make this a standing order. Nurses simply need to recommend to the patient and administer when they are agreeable.
Offer it in big bold letters on the road sign that advertises the 30 minute service pledge, 'Rona vaccines given here.
We do not have the very low-temperature freezers required for the storage of the vaccine. If we could be notified a week or two before the vaccine arrives, we could arrange the administration of our entire supply during the limited time the vaccine can be at warmer temperatures.
Education and suppression of the fear of the vaccine must be priority
In theory the immunization of ED patients sounds like a noble cause. However, most patients presenting to the ED have an acute illness and are not necessarily optimized for vaccination at that time. The logistics of reporting and ensuring the second vaccination from the same manufacturer are also cumbersome. Drawing patients to the ED for immunization may also present challenges. A mass immunization effort outside of the ED for well patients will probably be more efficient and effective.
yes- all and REQUIRED
Good intent, no staff to perform function. EMS same fix, staff leaving or out with C19 or isolation.
None
Give to ED providers and hospitalists/hospital based physicians first then add the urgent care and PCP's offices to dispense.
We can do this if we are given the manpower resources, supplies and space. We can add this on and manage the current surge at the same time. Many hospitals run the ED lean especially taking into account all the boarding.
Start with true front line providers, ED nurses, techs, docs, then move to primary MD offices.
While additional work is just that, more work for already-overburdened EDs, the better option would be for such immunization programs to be set up AWAY and SEPARATE from the ED. ED patients who might benefit from immunization and agree to it could then be sent there after their ED visit. And, patients who seek immunization BUT, have no need for ED services, would be appropriately kept OUT OF THE ED! Shoving more patients into the ED is detrimental to everyone. Please pay special attention to keeping our EDs OPEN and do not jam more services into our EDs! Please.
DO NOT DO IT. We CANNOT handle any more patients. Needs to be done in conjunction with health departments. That is their mission. We MUST decide what is emergency care and support and fund that. ADDING public health measures to ED care makes running an ED IMPOSSIBLE - unless MASSIVE FUNDING accompanies these "great ideas". ACEP/Nation must clearly define and limit what the role of the ED is and should be.
This would need to be separate from any flow of ED patients. It could be located in or near the ED, but would have to have separate staffing to be able to not add burden to the already overburdened patient flow.
Make it free. Offer it to everyone.
My staff would love to offer vaccine program for the ED, even as a drive up.
Have access to tent space in parking lot that we could implement a drive through vaccination program easily