Washington state- COVID-19 Practice Update for Emergent Providers

From WA-ACEP Board Member Gregg Miller, MD, FACEP:

Every ED in the Puget Sound region has experienced an increase in respiratory cases, with multiple COVID19 positive cases each week if not daily in the ED. We have seen a concomitant decline in other issues. Some sites report up to a 20% decline in overall ED volume, thanks to aggressive messaging from organizations such as the Washington State Hospital Association and public media to stay out of the ED and likely the fear potential patients have of catching the disease in the ED. Offerings for telehealth visits from multiple health systems are also helping. While our inpatient capacity is stretched, we have not yet run out of vents or ICUs at about 2-3 weeks into the epidemic. However things are very tight. One major hospital system just announced today that starting tomorrow, all elective OR cases are canceled due to dwindling beds, blood supply, and hospital staff. We are concerned this is the "calm before the storm" and anticipate this could rapidly worsen as the epidemic evolves.

TRIAGE

Triage processes vary from ED to ED, but all have set up separate waiting areas for potential respiratory isolation. Patients are typically greeted by a staff member in PPE (which varies by institution, some in mask and gloves, some adding full gown and goggles) and triaged based on the presence of respiratory complaints. At least one ED has set up a tent for RTI surge capacity, and most EDs are creatively isolating using lobby space or evaluating stable patients in their cars. Some are advancing screening for EMS patients outside as well. In some cases, only a limited in-person exam is performed and much of the history is via telephone. To our knowledge no one has implemented a 100% telemedicine process for patients who present on hospital grounds, and everyone gets at least a focused in-person assessment as part of their EMTALA medical screening exam.

PPE

Our PPE usage follows WHO guidelines, using contact and droplet but not airborne precautions. We wear surgical masks (not N95) for standard H&Ps, in addition to face shields, gowns, and gloves. If aerosolizing procedures are being performed then staff wears an N95 instead of a surgical mask. During nasal swab collection, some hospitals are requiring N95s, others are requiring surgical masks. Most patients are treated in closed rooms, but not AIIR/negative pressure rooms. We are experiencing shortages of PPE, for example, rationing N95 masks and reusing disposable face shields after cleaning. Staff burnout on PPE remains an issue. Confusion about when to discontinue droplet and contact precautions for non-COVID rule out patients exists (i.e. dialysis patient who comes in with SOB).

TESTING

Testing is determined at the site and no longer involves calling the Department of Health prior to ordering. Workflows resemble that of STD tests – we send out labs with delayed results, and we are responsible for calling back positive cases and notifying the Department of Health. Turn-around times now are a day or two, using a combination of University of Washington (UW) laboratories and commercial laboratories. Because of the concern and potential lost work time around this illness, some of our EDs are also calling back negatives, some are not. The workflow around this differs in the hospitals, with some utilizing the ED for callbacks and others for example using Infection Control or nursing supervisors.

UW reports that about 5-10% of specimens are testing positive for COVID19, one ED reports numbers closer to 15%. We still don't understand the epidemiology and actual community prevalence. Anecdotally, when calling back the discharged 'positive patients,' all seem to be doing better and some with reported near resolution of symptoms. Unfortunately this is not the case for many admitted patients.

TREATMENT

While the vast majority of these patients are managed in the outpatient setting, we have admitted many sick individuals. We limit non-invasive ventilation given the risk of aerosolization. Intubations are done typically using PAPR/CAPR and ideally in a negative pressure room. 30 people have died, typically older with comorbidities. However there have been individuals in their 30-40s who have been intubated and who don't have significant underlying illness other than mild obesity. In some cases we are using remdesivir on a compassionate use protocol, though it's rumored this protocol will be canceled in favor of clinical trials. Some facilities are participating in the trial, enrolling all qualified, consenting admissions into a 5-day and 10-day arm trial of remdesivir (no placebo.) We are not starting patients in the ED on chloroquine or antiretrovirals.

WORK RESTRICTIONS

At least one ED physician has been infected (unclear if work or community acquired), but is recovering and several more have been placed on work restrictions after exposure. Once these clinicians tested negative, they were allowed to come back to work while wearing a mask and did not need to take the full 14 days off work.

WHAT'S NEXT

Based on the experience in Italy, we are concerned about what might happen in the next week or two. Our inpatient capacity is tight and elective surgical cases are being canceled, some chemotherapy treatments requiring hospitalization are postponed. One hospital has done a quick construction job to install fans in windows and convert a unit to negative pressure. While we are not to the point of rationing ventilators yet, we are having conversations around such protocols. A regional coalition is working on scarce resource utilization and crisis standards of care algorithms. Many sites actively are engaging their palliative care teams.

The community is beginning to finally realize the seriousness of the situation, with school closures and cancellations of large gatherings. Our workforce has consequently been impacted by childcare challenges. Some hospitals are implementing or expanding their own childcare service programs for staff. We hope that this more aggressive response helps blunt the spread locally, but our concern is that enough patients have been recently infected that when they decompensate in a few days to weeks, our capacity will be overwhelmed.

We do know we will get through this. The collaboration amongst medical staff and across disciplines is encouraging and should be noted. While we have certainly seen fear in our staff and patients, we have also seen tremendous resolve and courage. We are proud to call each other colleagues and to represent you in the front lines of medical care.