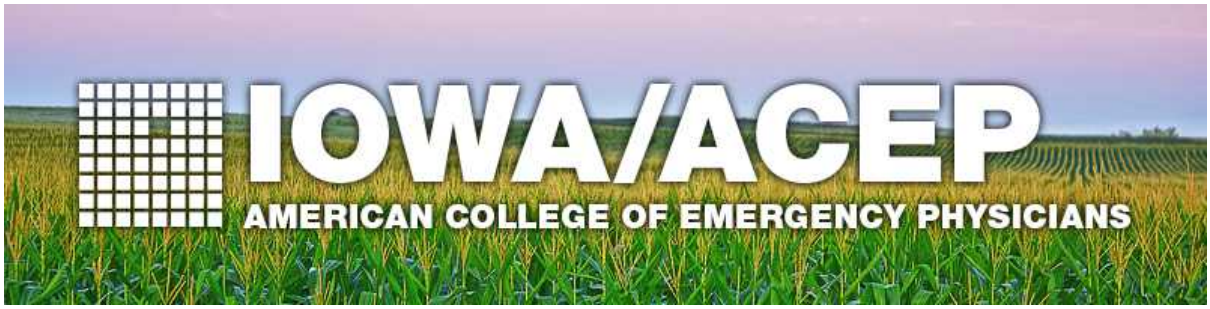
A Newsletter for the Members of the Iowa Chapter - Spring 2020



Kathryn K. Dierks, DO, FACEP
President

Adriana Alvarez
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President's Message

Iowa ACEP Members,

As winter has transitioned from the bleak cold, barren landscape to colorful blossoming trees and perennials, one term comes to mind and that is changing landscape.By far, spring has always been my favorite time of year, however this spring has felt immensely different.

While our physical landscape is changing around us, perhaps the most striking change is what has occurred in healthcare during the past three months since the COVID pandemic has affected our nation. Changing landscape indeed. The landscape of healthcare has drastically changed in just a snip of time. With one fell swoop, a virus has uprooted our delivery of healthcare and overwhelmed a system that we believed to be somewhat indestructible. We have changed the way we don our PPE. We have adapted to new health care delivery systems with rapid implementation of telemedicine. We have adapted to lack of supplies by creatively adjusting ventilators to multi-patient systems. We have implemented novel treatments for uncommon disease states such as giving tPA to COVID induced ARDS patients. This virus is unlike anything we have ever seen and as time progresses, we continue to see new surprising pathophysiology. This pandemic has, however, demonstrated that we healthcare workers are resilient and can adapt to whatever challenges we face. Not only are we resilient, we are leaders in our communities and hospitals at the forefront of managing this crisis. If there is something that emergency physicians are equipped to handle, it is unpredictable disasters.

These past several months have been some of the most anxiety provoking I have ever experienced in my career. In March, I felt an ever-increasing wave of anxiety building as the incidence of disease started to increase in the community. But at the same time, I

have felt an overwhelming sense of guilt and mourning for healthcare providers in states like New York, Louisiana, and Washington as they faced the most tragic consequences of the pandemic. The unimaginable horror of having an emergency department with 200+ patients, many of whom are actively dying from COVID, without enough staff or supplies to take care of them are some of my worst nightmares. I have the utmost respect for everyone who has worked in the epicenter of disease.

Throughout the entire nation we continue to observe many unforeseen consequences of this pandemic in all aspects of healthcare. Patients in all communities fear they will contract COVID by coming to the emergency room and in many cases have been avoiding healthcare altogether. Patients are now delaying care for their medical emergencies and they are arriving to the hospital in critical condition. Patient volumes in clinics, emergency departments and hospitals are low as patients continue to avoid the healthcare. Healthcare system across the state are facing difficult financial decisions that will impact our already challenged physician work force across Iowa. Furthermore, medical students have been unable to attend assigned clinical rotations for several months stifling their ability to learn clinical medicine. What will this mean for our next generation of physicians, patients and hospitals?

Within the past week our governor has lifted social distancing restrictions. And as cases throughout Iowa continue to rise, we may see a resurgence of severe disease throughout our communities. There is so much uncertainty and only time will tell what the next chapter of this pandemic holds. I applaud all of you for your continued patience, leadership and resilience through this pandemic. I encourage everyone to continue to contact your local state representatives to share your clinical knowledge that will help shape the way our government responds to the pandemic. We play a crucial role in keeping our state safe.

I hope to see you all next month, via Zoom, for our upcoming annual chapter meeting!

Upcoming Chapter Events
Annual Iowa ACEP Chapter meeting - For your safety and the safety of your patients and family members, the chapter annual meeting will be held virtually on **Tuesday, June 16th at 6:30 PM CST**.

Special guest speaker will be John T. Finnell, MD, FACEP, FACMI who will present a National ACEP Update and the topic on Well-being: Work/Life Balance.

An election will be held during the annual meeting. The positions that are open are the following: President-Elect, Treasurer, Elected Councillor, Resident Representative (UICCM), Resident Representative (DMU), Medical Student Representative (UICCM), and Medical Student Representative (DMU). If you would like to run for any of these positions, please send an email with your bio, a head shot and an explanation as to why you think you would be a good candidate for the position. **The deadline is Friday, May 29th**.

Resident Corner
The Ventilator Compact: Scarce Resource Allocation during COVID
Brooke A. Dugdale, MD

I spent the last month in the Surgical ICU at the University. This was a distinctive SICU experience as, like across the rest of Iowa, all non-emergent surgeries were cancelled, and we became MICU overflow while they filled with COVID patients. We too, watched as our census grew over the month. Thankfully, the wave of COVID

cases has not yet crested above our hospital capacity. Working closely and proactively with palliative care over the month was enlightening and I found one of our ICU team's discussions was particularly gripping as we together considered the ethics of ventilator allocation should we face limitation.

Ventilators are a keystone within scarce resource allocation as uniquely their apportionment or withdrawal can confer imminent life or death. Typical ethical principles around resource allocation fall flat in reference to ventilators. Equality has little meaning, as apportioning each patient for example, an equal time period, say four days on a ventilator has little clinical meaning. Equity too, is problematic as the structural disparities from which health inequities arise cannot be ameliorated at the point of ventilator need--the situation is too acute and would result in an increased number of deaths. First come, first served would likewise lead to more deaths and is not a sophisticated way to maximize resources to do the most good for the greatest number of people. To step outside the world of medicine and into that of sociologic theory, John Rawls proposes a "justice of fairness", wherein he challenges us to operate under the presupposition of ignorance; were we to not know our own stratified position within the circumstance, how may one create the most fair system for all positions. This is perhaps the most analogous to actual policies in place.

A colleague from the SICU who had traveled to Detroit to aid with treatment of COVID patients, shared his hospital's triaging system. Like NY guidelines, there were hard-stop exclusionary criteria such as terminal cancer or other illness with poor prognoses and short life expectancies. Next, each patient was assigned to a point system dependent on their SOFA score and regular reassessments were built in even during ventilator use to ensure the greatest benefit for the most patients. The *NEJM* article by Emanuel et al. on this topic contributes additional ideas worth contemplation. For example, it introduces the nuance of triaging to gain the most life years versus the most lives (1). Along those lines, in *JAMA* White and Lo propose incorporation of equal opportunity to pass through the stages of life, biasing ventilatory decisions toward youth (2). More controversial is the argument that some prioritization should go to front-line healthcare workers, as they have instrumental value "essential to pandemic response." The premise is that a healthcare worker's training is difficult to replace, and that individual has the potential to save numerous other lives; several sources in fact, advocate for this controversial triaging consideration (1, 2). Finally, a crucial point for most is that those already on ventilators be re-triaged and that ventilatory support be considered a dynamic process instead a of static endpoint. Withdrawal of care to re-apportion the scarce resource is a prospect wrought with moral consequence. There is accord that such decisions deserve deep contemplation and discussion, and that these be established, not undertaken by those directly providing care.

Due to COVID many aspects of our lives have experienced upheaval and have subsequently settled out to look a little bit different than before. So too in medicine, may we continually engage with these difficult questions, to reshape our practice and best serve our patients.

1. Emanuel, E.J., Persad, J.D., Upshut, R., Thome, B., Parker, M., Glickman, A., Zhang, C., Boyle, C., Smith, M., and Phillips, J.P. "Fair Allocation of Scarce Medical Resources in the Time of Covid-19". New England Journal of Medicine. March 23, 2020. [Epub ahead of print].

2. White, D.B. and Lo, B. "A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic". JAMA. March 27, 2020. [Epub ahead of print].

3. Truog, R.D., Mitchell, C., and Daley, G.Q. "The Toughest Triage- Allocating Ventilators in a Pandemic". New England Journal of Medicine. May 12, 2020. [Epub ahead of print].

Virtual Hill Visits
Thomas E. Benzoni, DO, FACEP

Overview
Virtual Hill Visits were held with Representatives Axne, Finkenauer and Loebsack, and Senators Ernst and Grassley. Personal appearances were made by Finkenauer, Grassley and Loebsack. Representatives Finkenauer and Loebsack were extremely engaged. Senator Grassley left partway through.

Malpractice Reform
What was done?
In general, I followed the PPE discussion. I used the PPE reuse discussion to segue into malpractice reform. I noted that the person reusing the PPE could later be held liable for spreading infection from person A to person B, even though they were following the directives of the hospital. I also noted that under the presidential declaration, section 3103, companies were given blanket permanent immunity. I offered the solution that EMTALA made emergency physicians' federal agents; this may make them eligible for federal tort claims act. Additionally, noted was that many states had moved the standard of proof to gross negligence for medical malpractice related to COVID.

What I learned that was new?
There were few questions and little engagement.

What I think this means going forward?
There seemed to be little interest in this topic from other legislators. Without certainty, I think the problem is that we have made this, in the past, a financial issue. Physicians talking about being impoverished, especially when they are insured, makes for a very poor argument. A more potent argument would be finding a just solution for the injured patient and ways to keep the injury from reoccurring, leaving the money as a trailing rather than a leading indicator. I think ACEP has a lot more groundwork to lay. I think we need to clearly show forward what happens with filing of a malpractice suit using the felony concept of "check the box." I think the defense attorneys, more than the plaintiff attorneys, are concerned about the immunity provisions. We need to be aware of who are our allies; It may not be who we think. This will require a different way of thinking and very rigid conflict of interest actions by ACEP.

Read the positive response from Senator Ernst below:

Dear Dr. Benzoni,

Thank you for contacting me about the Novel Coronavirus (COVID-19). It's important for me to hear from folks in Iowa, and I know that this issue is of concern for our communities right now.

In response to this public health and economic crisis, I have supported multiple legislative packages to deliver relief and critical resources for Iowans. Most recently, I supported the bipartisan CARES Act (S.3548), which passed Congress and was signed into law by President Trump on March 27, 2020. This relief package builds on the Phase 1 package that provided resources for federal, state and local

response efforts, and the Phase 2 package to provide paid sick leave, free COVID-19 diagnostic testing, and increased support for nutrition for seniors and children.

As this Phase 3 package continues to be implemented, my Senate colleagues and I have turned our attention to negotiating a Phase 4 package to provide further relief and resources to families, businesses, and hospitals, among others. As negotiations have begun, I have already began advocating for a number of important provisions to be a part of the Phase 4 package, including rewarding our essential workers with a tax holiday, providing assistance to our nonprofits, investing in infrastructure and broadband, and supporting our frontline hospitals and health care providers as they continue to fight the spread of this virus and provide care for our communities and loved ones.

Thank you again for contacting my office. For more information about resources available, please visit my website. You can be assured that I will continue to closely monitor this issue and its impact on individuals and communities in Iowa. Please do not hesitate to contact me with any future questions or concerns.

Sincerely,
Joni K. Ernst
United States Senator

Virtual Hill Visits
Karl E. Anderson, DO

On Tuesday, April 28, a few members of the Iowa Chapter of the American College of emergency physicians took part in the Leadership and Advocacy Conference Virtual Hill Day.

We took the opportunity to speak with the staff and/or congresspersons from the state of Iowa. We were able to speak directly with Sen. Chuck Grassley, representative Abbie Finkenauer, and representative Dave Loebsac. We also spoke with staff of Sen. Joni Ernst and representative Cindy Axne.

I spoke with the Senators regarding hazard pay as well as insurance coverage for COVID-19 related billing. We spoke with them briefly about providing some type of hazard pay for emergency physicians who are on the front line in this battle with COVID-19 coronavirus. ACEP's position is to advocate for hazard pay up to $25,000 per physician for serving on the front lines in this battle. We also spoke with the congresspersons about the possibility of providing tax exempt pay while serving during this national emergency. As some of you may know, when a member of the US military serves in a combat zone, they receive specialty pay for serving in a combat zone and, that pay is exempt from income tax. This has been suggested as one possible means compensation as well. Sen. Ernst representative stated that she had a draft of a bill for such tax exemption for frontline workers. Sen. Ernst's representative as well as Sen. Grassley will seemed receptive to the idea of hazard pay for emergency physicians as part of a national relief bill such as the CARES Act. Representative Finkenauer and Rep. Loebsac also seemed interested in such compensation for frontline workers.

I also addressed with the Congress persons concern for insurance coverage of COVID-19 related testing. The current bill requires insurance companies to pay for

COVID-19 testing. However, as many of you are aware, COVID-19 testing remains limited by the Iowa Department of public health. Therefore, we requested legislation that would compel insurance companies to pay for all testing related to evaluation for COVID-19 infection. The Congress persons seemed receptive to this concern. Quite frankly, I feel all of them seemed more interested in providing some sort of hazard pay/compensation for frontline workers. What would constitute frontline worker was not discussed but obviously, this would include emergency physicians and emergency care.

We briefly discussed loss of revenue due to decreased volumes during this pandemic. We mentioned the need for income protection for providers a critical access hospital specifically as well as all emergency physicians during this time.

Financial support may be the only thing Congress can do. Entities may be able to keep the funds even though it's directed to physicians.Click here to read more about how funds for employed physician are the property of their employer.

At the national level, ACEP continues to advocate with Congress for sufficient PPE, hazard pay, liability protections, and insurance coverage reform to protect patients.

ACEP has taken steps to help emergency physicians cover unexpected costs for providing care right now, such as temporary housing to isolate away from our families to keep them safe, child care costs due to school or daycare closures, or costs incurred when we become ill or test positive and are unable to work, among others.

During our modified LAC this year, emergency physicians in Iowa and across the country conducted “virtual visits” with Congress and staff to outline our priorities while our legislative staff in DC continues to evaluate a number of proposals. Emergency physicians detailed steps Congress can take to enhance protections for those of us on the frontlines:

- Congress and the Administration should employ a proactive, coordinated federal effort to ensure emergency physicians have sufficient PPE, and emergency physicians should have the right to wear and use their own personally-provided PPE.
- Mandate that health plans cover all COVID-19 related care, including testing and treatment, without patient cost-sharing and with appropriate reimbursement for all services rendered.
- Congress should provide up to $25,000 of “hazard pay” to acknowledge the risks of providing COVID-19 related care and support emergency physicians and others on the front lines of this pandemic.
- Given the broad range of employment types that emergency physicians practice in, ACEP has specified that individual physicians should receive payment directly. Under our proposal, emergency physicians would apply to the fund using their National Provider Identifier (NPI)
- Establish broad civil immunity to physicians for any alleged injury or death while providing medical care in response to the COVID-19 pandemic.

I hope you can join the 2021 Hill Visits. This is a great opportunity for you to voice your opinion.

Virtual Hill Visits
Jackie E. Kitchen, MD

During the virtual hill visits on Tuesday, April 28, I was privileged to speak about personal protective equipment (PPE) with Representatives Abby Finkenauer and Dave Loebsack, as well as Senator Chuck Grassley. I was also able to speak with the legislative assistants of Senator Joni Ernst and Representative Cindy Axne. The discussion centered around the lack of appropriate PPE in our state, as well as the mixed message of what constitutes "appropriate" PPE. I explained how many frontline workers are being asked to use items, such as N95 masks, surgical masks and isolation gowns, multiple times, despite the fact that these were always considered single-use items prior to this pandemic. I emphasized how the reuse of these items may prove to be dangerous not just to frontline workers, but also to the patients we are treating, due to the risk of cross-contamination between patient rooms.

ACEP supports utilization of the Defense Production Act to mobilize US factories to produce more PPE. I discussed this with our representatives and senators, and they were quite receptive. Abby Finkenauer actually even suggested this before I did! We also discussed ACEP's support of depleting the national stockpile of PPE during this crisis. Lastly, we touched a bit on federalizing the distribution of PPE, as the current arrangement of states having to bid against each other for PPE has led to significant inequities between states, with Iowa in particular having a difficult time competing with larger and more populous states for PPE allocation.
In all, the representatives and senators were very receptive to this discussion. Abby Finkenauer in particular was very enthusiastic in her support. She noted that her sister-in-law is a nurse, so this issue is especially important to her. Everyone we talked to agreed that they would do whatever they could to improve our access to appropriate PPE.

On a personal note, I have been to several ACEP Leadership and Advocacy Conferences in Washington, DC, in the past, and, as a result, I have had the privilege of being able to speak with many of our Iowa representatives and senators in person over the past few years, and I must say that I have never seen such overwhelming support and enthusiasm by our Iowa congress members and their assistants as I did during the discussions this year. It was very gratifying to see that our congress members seem engaged and invested in protecting their Iowa hospitals and frontline workers.

Crisis Standards of Care
Nicholas Kluesner, MD, FACEP

These days, all our healthcare organizations are dusting off their crisis management and mass-casualty procedures in a new way. In the emergency department we are more comfortable than most departments with the drilling for an MCI and the chronic readiness for chaos. This can also, however, uncover deep seated anxieties and biases in the way we deliver healthcare. As such, I encourage all of us with emergency medicine training to be a steady voice of reason in this storm.

Nowhere is this more apparent and more important than in adhering to the ethical principles to which we have historically subscribed. This does include the responsibility to respond to our current public health crisis in a different way. Crisis Standards of Care is a paradigm shift in the goals and methods for delivering health care that are adopted in a public health crisis where society seeks to achieve the most good for the population. This can come at a consequence to respecting individual liberties (e.g. quarantine or visitor restrictions) and even individual patient's needs (e.g. rationing ventilator resources). It is obvious to us that, "this goal is different from the traditional focus of medical ethics, which is centered on promoting the well-being of individual patients." We have seen our colleagues and organization readily embrace this reality.

It is important to note that these crisis standards of care, which should remind all of us of the triage priorities in a mass casualty event, have some important limitations. They are only applied in the crisis. (for example, we cannot be rationing ventilators prior to the need to do so arising in real-time). We must use the least restrictive means necessary to achieve the public health and common good goals. (for example, while a comprehensive visitor moratorium is appropriate to limit global infection spread, restricting a loved one from seeing their family member at the end-of-life doesn't seem to achieve that goal in a meaningful way). We must be vigilant that even in crisis standards of care we do not introduce unjust, discriminatory biases. (for example, while the elderly certainly experiences a worse prognosis with COVID-19, we should not categorically exclude any patient from consideration for critical care based exclusively on an age cut-off).

As we see medical practices changing in response to this pandemic (e.g. hospital and departmental policies, guidelines considering IV lytics for STEMI, hospitalization to avoid nursing home exposure, aerosol-generating procedures being avoided by those two may need them), we should be championing the right degree of crisis standards of care at the right time in our organizations.

For the quote references and to read more about a validated model for implementing crisis standards of care in critical care resource allocation click here.

Author Brief Bio: *Nicholas Kluesner, MD, FACEP is the associated medical director at UnityPoint Health Des Moines. Dr. Kluesner sits on the Iowa Medical Society Law and Ethics Committee and ACEP's Ethics Committee.*

Travel to Iowa
Hans R. House, MD, FACEP

Brief Report: Less Patients Planned Trips to Asia Since the Onset of the COVID-19 Pandemic

The Novel Coronavirus (SARS-CoV-2) has spread worldwide, exacerbated by rapid, international transportation. International travel may have played a role in the introduction of COVID-19 disease into Iowa. Additionally, we would expect that patients' travel plans have changed significantly since the advent of the pandemic.

This study documented the intended travel destination for all patients presenting between October 2019 and March 2020 to a travel medicine clinic in Bettendorf, Iowa, United States. During this time four hundred and twelve (n = 412) patients ranging in age from one to eighty-two (mean = 41.54) presented for pre-trip guidance, vaccines, and prophylactic medications. Intended destinations of the patients were recorded and the countries were categorized into each of the six World Health Organization (WHO) regions (Africa, Americas, Europe, Eastern

Mediterranean, Western Pacific, and South-East Asia). Patients had planned travel throughout all six regions of the with an average of 22% of patients planning travel to multiple WHO regions in a given month (Figure 1). In October 2019, 26 patients intended to travel to the Western Pacific region (i.e. China, Japan, Korea, etc.) while in March 2020, 0 patients planned on visiting this region. Furthermore, before January 2020, 11 patients planned travel to China, while in January 2020, only 3 patients planned to travel to China. In February and March 2020, no patients planned travel to China. This change in planned travel preferences is likely attributable to the news of the emerging COVID-19 epidemic and the imposition of a level 4 travel warning ("Do Not Travel") to China on February 2, 2020 by the U.S. Department of State. From October 2019 to February 2020, travel to all other WHO regions remained constant with an abrupt reduction in March 2020. Notably, on March 11, 2020, COVID-19 was officially declared a pandemic by the World Health Organization (WHO), and most travel bans were implemented during this month.

In closing, it is apparent that little effort was devoted to mitigating the disease prior to its establishment as a pandemic. Until March 2020, almost all travel behavior remained constant despite the first US case arising in mid-January. It is indiscernible whether social factors such as media and press are efficacious in discouraging travel since the disease was originally confronted with skepticism instead of concern. It is evident that strict travel bans represent an effective means of halting travel and possible disease spread. In the future, it will be essential to institute travel restrictions in an expedient and proactive manner.

Written in collaboration with Pooja Patel, BS.

Figure 1. Total Patient Trips to Various WHO Regions

Adriana's Corner

A special thank you to all of you for your continued support of your patients during this pandemic. These are unprecedented times and many of you have made many sacrifices and have continued to risk your lives for others. Wishing you all the best during this crisis. Stay safe and healthy!

Take advantage of the useful resources that are posted on the chapter website:

COVID-19
Mental Health

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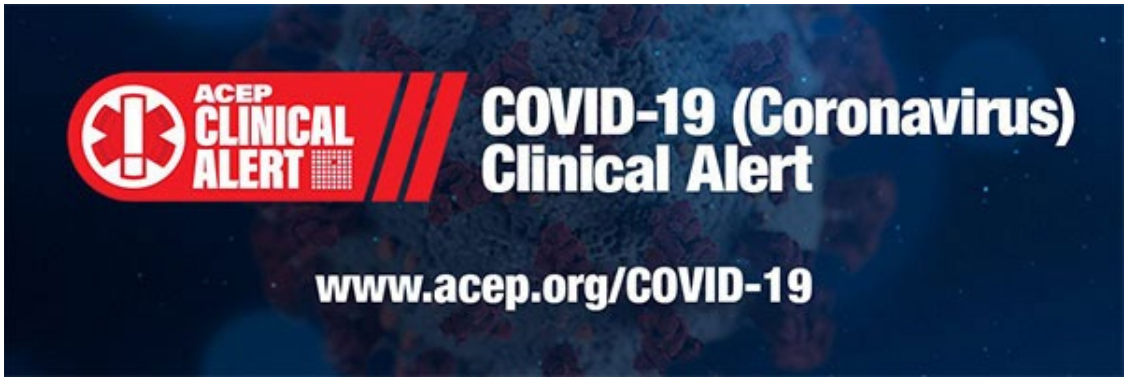


New COVID-19 Website, Plus Updates to COVID-19 Field Guide
Featuring more than 400 resources, our revamped COVID-19 website will help you find what you need, when you need it. Our most popular resource, the ACEP Field Guide for Managing COVID-19 in the ED, has grown to more than 230 pages and been translated to 5 additional languages. The following sections are newly updated: decontamination/cleaning, HCW checklist, HFNO, treatment and management.

Public Poll: Emergency Care Concerns Amidst COVID-19
There is a worrisome trend across ERs of people who are avoiding getting the medical care they need. While it's important to stay home and follow social distancing guidelines, it's critical to always know when to go to the emergency department. Read more.

TJC Statement, COVID 4.0 Package and More in this Week's Capital Minute
Tune into the reimagined ACEP Capital (30) Minutes every other Thursday at 3 p.m. ET to get federal advocacy updates and answers to your questions in real-time. In the latest edition, we're covering the most recent regulatory changes and funding updates, The Joint Commission statement on mental health that came out earlier this week and what you need to know about the COVID 4.0 package. Watch this week's ACEP Capital Minute here and register for the next edition here.

Medicare Telehealth Flexibilities…Are They Here to Stay?
We are seeing an expansion of telehealth that we have never seen before, and it is hard to imagine ever going back to where we were before. However, for us to keep up the momentum and not return to the pre-pandemic telehealth world, a few things need to happen---read this week's Regs & Eggs blog to find out what.

COVID-19 Financial Survival Guide: What You Need to Know
ACEP is standing up for our members who, despite serving on the frontlines of the COVID-19 pandemic, are having their livelihoods threatened. Cutting benefits, reducing shifts or canceling contracts in today's environment is akin to signing a 'Do Not Resuscitate' order for many emergency departments and the physicians who care for patients, especially those in rural or underserved areas. Access the guide.

TJC Statement Supports Removing Barriers to Mental Health Care for Clinicians and Health Care Staff
ACEP recently met with The Joint Commission to discuss physicians being penalized by state licensing boards and other entities for seeking mental health support. On May 12, TJC released a statement that supports "the removal of any barriers that inhibit clinicians and health care staff from accessing mental health care services, including eliminating policies that reinforce stigma and fear about the professional consequences of seeking mental health treatment." View more wellness and crisis support resources.

Upcoming Virtual Grand Rounds Focused on Physician Wellness
Join us May 27 for our Virtual Grand Rounds! From 10 a.m. – 2:45 p.m. CT, we'll cover physician wellness, second victim syndrome in COVID times, emergency

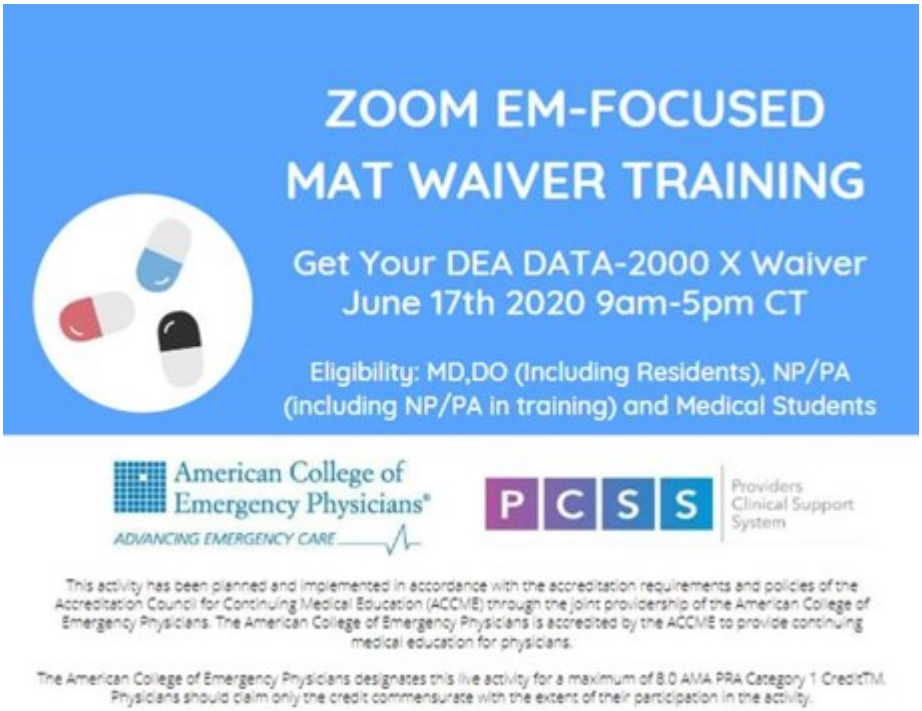
mindfulness, overcoming self-judgment with self-compassion, and how to support your team during times of crisis. Register by 8 a.m. CT on May 27.

Related Resources:

- Physician Crisis Support: ACEP collaborated with the American Association of Emergency Psychiatry on a webinar and podcast related to physician wellness and mental health during COVID-19.
- ACEP Member Benefit: Free Counseling and Support

Did You See This Broadway Tribute to Emergency Medicine?
ACEP and ENA were asked to join the "Resilient Project," featuring more than 60 Broadway theatre artists to virtually perform "Resilient" as a thank you to emergency healthcare professionals worldwide. Watch for cameos from several EM physicians and nurses in the video, which also aims to raise money for COVID-19 research through EMF.

Member Benefits: COVID-19 No Cost, Discount & Other Offers
You are risking your lives to care for patients from this unprecedented pandemic, and we all appreciate the additional stress on you and your families. We want to help. And, so do a lot of companies out there. So, thanks to you and thanks to the companies willing to support our healthcare heroes. View the benefits.



Opioid Updates

- More than 800 participated in a Zoom version of waiver training hosted by ACEP, Get Waivered, and ED Bridge on May 20. Missed it? Sign up for our next EM-specific MAT waiver training via Zoom on **June 17**.
- ACEP's PACED accreditation program is the nation's only specialty-specific program that allows EDs to improve pain and addiction care.
- In January, ACEP convened a summit, Addressing the Opioid Stigma in the ED, and a powerful 11-minute video from that event is now available. Be part of the solution!
- The COVID-19 Field Guide has a section focused on the management of patients with substance use disorders.
- Read the latest Regs & Eggs blog post discussing the Ongoing Efforts to Reduce Barriers to Opioid Use Disorder Treatment.

COVID-19 Special Edition of Critical Decisions in EM
Our newest CDEM features lifesaving lessons focused on the ED evaluation and management of COVID-19, including timely information on risk factors, common examination findings, valuable diagnostic tests, and the safe use of pharmacological treatments. The issue also takes a deep dive into PPE, the provision of respiratory support, and what interventions should be avoided when managing these vulnerable patients. Learn more.

EM Research during a Pandemic + Call for Research Forum Abstracts

- Our latest podcast discusses conducting EM research during a pandemic.
- Submit your abstracts to ACEP's Research Forum 2020 by June 11. Abstracts will be peer reviewed for presentation at the 2020 Research Forum during ACEP's Scientific Assembly. See abstract requirements.

Be Accredited to Provide Pain & Addiction Care in the ED
Show your community that your ED is part of the solution. ACEP is now accepting applications for the Pain & Addiction Care in the ED (PACED) Accreditation Program, developed for EM physicians by EM physicians.

PACED, the nation's only specialty-specific accreditation program, will provide the education, tools & resources you need to provide better care for patients in pain & those with substance misuse.

Elevate the quality of patient care with innovative treatments, alternative modalities, and impactful risk reduction strategies in a collaborative team setting, resulting in positive outcomes for your patients, families, providers, and communities. Learn more at www.acep.org/PACED or contact us at paced@acep.org.

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