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BRIEF19

A daily review of covid-19 research and policy.

RESEARCH BRIEFING

Emergency room visit trends during the pandemic. Fewer patients. Sicker patients.

Previously in *Brief19,* we reported that Emergency Department (ED) visits declined during the early covid-19 pandemic period, as reported by the Centers for Disease Control. A new study published in *JAMA Internal Medicine* provides far more granular insight regarding these aforementioned trends from five large healthcare systems spread across the United States (Connecticut, Massachusetts, New York, North Carolina and Colorado). The researchers included data from 24 EDs between January 1 and April 30, 2020. The primary outcomes of the study were daily counts of ED visits, hospital admissions, and covid-19 cases over time. A rapid decline in ED visits started around the week of March 11th, which corresponded to reports of accelerated counts of covid-19 cases in the United States. President Trump announced the national state of emergency on March 13th, which also is thought to have contributed to the decrease in ED visits, as Americans became more fearful of interacting with the healthcare system out of fears of being exposed to patients or even medical teams who might have contracted SARS-CoV-2.

While the number of ED visits decreased, hospitalization rates increased as covid-19 case rates increased in each state. The largest relative increase in hospitalization rates during the pandemic occurred in New York (a 149 percent increase), followed by Massachusetts (51.7 percent), Connecticut (36.2 percent), Colorado (29.4 percent), and North Carolina (22.0 percent). In essence, as ED visits decreased during the pandemic, hospital admission rates among patients diagnosed and treated in EDs increased, suggesting that the acuity (severity of illness) of patients presenting to EDs during the pandemic was much greater than usual, so as to overcome the expected rate of hospital admission that would normally accompany lower patient counts. This translated into increased resource utilization of those hospitals despite generally low ED volumes. Busy hospital wards (and especially intensive care units) are likely to contribute to PPE and medication shortages, which have been reported all over the country.

What is unclear is exactly why ED visits went down during the pandemic. There are important possibilities to consider. It may be that medical emergencies still occurred, but that fearful patients did not seek out medical care. This possibility has been a concern to health officials who have tried to counter this with messaging reminding the public that EDs are generally still safe places—and that the consequences of foregoing emergency treatment is often worse than the small risk of SARS-CoV-2 exposure. But it might also be the case that ED volume went down because fewer emergencies occurred. For example, fewer accidents occurred during the shutdown. Fewer heart attacks and strokes were also reported early in the pandemic. In those cases however, it is unknown whether those emergencies continued to occur (but patients were afraid to call 911 and so they went untreated) or whether lifestyle modifications (such as more healthy diets, decreased stress) or environmental factors (less pollution) led to fewer cardiac and other vascular emergencies. Researchers are now assessing those questions.

—Joshua Niforatos, MD

POLICY BRIEFING

Tests results are taking too long. Six states tired of waiting band together.

Months into the covid-19 pandemic the reported average turnaround time for the results of SARS-CoV-2 tests has not improved since April. Individuals are reporting waiting an average of four days to receive test results. Delayed results are consequential to any reopening plan that relies on testing, as patients are at risk of contracting the virus in the time between test and result, potentially nullifying test results. For months, public health experts have been advocating for large-scale access to rapid covid-19 testing in order to successfully control the spread of this disease. Despite these calls, the federal government has failed to roll out such any such plan.

Now, six governors from both sides of the aisle have taken the issue into their own hands. Louisiana, Maryland, Massachusetts, Michigan, Ohio and Virginia have worked together to secure access to 3 million tests from the manufacturers of rapid tests. These six states have collectively performed just over 100,000 tests to date and the newly acquired rapid tests will last approximately a month at the current rate of usage.

While well intentioned, rapid tests are also fraught with high false negatives, making the plan slightly less airtight. The tests are reported to have false negative rates of up to 15-20 percent. Ultimately, it is not clear if these rapid false negatives will undermine the intention behind speeding up testing turnaround times. *New York Times.* *—Kimi Chernoby, MD, JD*

The medical liability protection update: Congress still mulling it over.

As hospitals were overwhelmed during the height of the pandemic, many stakeholders wondered if medical providers would be held to normal legal standards of care given the uncertainty and stress of caring for covid-19 patients. While the topic of employer liability protections has been quite visible, with the latest Senate-authored stimulus package granting broad immunity, a quieter struggle has been waged between the medical community and a coalition of trial lawyers over H.R. 7059, the Coronavirus Provider Protection Act. Introduced by Phil Roe (R-TN) and Lou Correa (D-CA), a new bill aims to protect medical providers from frivolous and unfair lawsuits derived from direct care related to the novel coronavirus, and has received bipartisan support. While opposing groups have expressed concern that the wording of the bill is overly broad, possibly creating unnecessary protections for insurance providers and healthcare providers who create an unsafe work environment, a group of 130 medical organizations, led by the American Medical Association (AMA), argues that this is not the case. In a letter to Congressional leaders and in their advocacy efforts, these organizations argue that protections enacted by this legislation would be limited to situations where decisions are dictated by external forces, such as supply shortages, delayed elective procedures and to providers acting in good faith. Harm done as a result of decisions like practicing outside of one's scope or gross negligence would not be subject to protections proposed by the bill. *Various.*

—Joshua Lesko, MD