American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved June 2017

Emergency Department Utilization During Outbreaks of Influenza

Revised June 2017 and April 2011

Originally approved November 2004

The American College of Emergency Physicians (ACEP) recommends close coordination between emergency physicians, health care facilities, and public health entities to educate the public regarding appropriate physician referrals and emergency department (ED) utilization for presumptive influenza.

To meet this goal, the following steps are recommended to minimize the impact of community wide influenza.

1. Ensure that emergency care and critical care providers [emergency medical services (EMS) personnel, nurses, physicians, and ancillary staff involved in direct patient care] are current in their influenza immunization.

2. Implement rapid screening and appropriate respiratory infection control interventions for all individuals arriving in the ED.

3. End the practice of boarding admitted patients in the ED when no inpatient beds are available, which will allow the ED to respond to increased patient volumes and maintain appropriate respiratory precautions. Hospitals operating at full capacity may be required to distribute boarded patients who do not require respiratory isolation to inpatient hallways, solariums, admission units, and other spaces outside the ED.

4. Develop robust communication methods with the Centers for Disease Control and Prevention (CDC) as well as state and local health departments that provide real-time, surveillance-derived guidance specific for ED care (triage, testing, treatment, and disposition) for both seasonal influenza epidemics and pandemics.

5. Engage emergency physician participation in city, state, and national public health response planning.

6. Develop hospital-based and regional emergency response plans to appropriately manage increased patient volumes and containment precautions in the event of an epidemic. Such response plans may include alternate venues of care for low acuity patients and postponement of elective admissions.

7. Create regional command centers to monitor ambulance diversion status and local inpatient and ED capacity, and to coordinate regional ED response.