Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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obtain medical insurance and establish long-term primary care. To our knowledge, this program is novel in emergency medicine.

Methods: At the time of discharge, the ED physician, at their discretion, can schedule a patient for a ProPEr care clinic visit within the next 7-14 days. An EM or EM-IM trained physician provides the virtual follow-up visit using the Doximity™ platform with video or phone call only options. The goal is to provide a bridge while the patient is in the process of establishing a PCP. We contacted patients via a phone call at least 30 days after their ProPEr care clinic visit and asked a series of 10 follow-up questions. Survey questions were developed based on similar studies from other medical specialties. Data was collected and stored in Microsoft Excel™. Basic demographic data was reported from Tableau™, and survey results were calculated in Microsoft Excel™.

Results: The majority of our patients felt they were seen quickly (88%) and that the virtual visit was more convenient than a traditional in-person visit (94%). 72% felt that ProPEr care prevented them from coming back to the ED for the same reason. The ProPEr care clinic was able to arrange referrals for all the patients who needed specialty care (100%) and provided electronic prescriptions for all of the patients who needed refills for their long-term medications (100%).

Conclusion: A post ED discharge virtual clinic visit provided by an EM or dual trained EM-IM physicians ensures rapid follow-up care, facilitates specialty referrals and potentially reduces return ED visits. It can also help establish long-term primary care. Future studies should evaluate the cost and benefits of a ProPEr care clinic and its impact on hospital readmissions, and health system utilization.

105 Piloting a Novel Medical Student Virtual Discharge Counseling Process in the Time of COVID

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Study Objectives: During the COVID-19 pandemic, there was a gap in adequate discharge counseling for COVID-19 patients from the emergency department due to high patient volumes and constantly changing guidelines. Medical students were also restricted from clinical areas for safety, compromising their clinical experience. We piloted a novel program in which medical students served as virtual discharge counselors for COVID-19 patients via teleconference. This program allowed patients to receive dedicated counseling on their COVID-19 diagnosis. Students had a safe clinical experience while clinical staff could simultaneously provide direct patient care and increase ED efficiency.

Methods: Students were trained with a standardized protocol and a discharge script. Counseling included diagnosis, supportive care with medication dosing, quarantine instructions, return precautions, follow-up, and the ability to ask questions. Counseling was provided via secure video conference integrated in the electronic health record (EHR), in the patient’s preferred language.

Results: Over an 18-week period, 45 patients were counseled for a median of 20 minutes (range, 7 to 39 min). 58% of patients spoke English; 35% spoke Spanish; and 7% additional languages. Median times for discharge counseling were 16 minutes, 23 minutes, and 18 minutes, respectively (p = 0.015). The 72-hour ED revisit rate was 0%, versus 4.2% in similarly-matched, not counseled COVID-19 patients. Medical students (n = 16) believed this project increased their confidence when speaking with patients (90% strongly agreed or agreed) and that it was a worthwhile experience (100% strongly agreed or agreed). Lastly, 80% strongly agreed that they would volunteer again, and similarly, 80% indicated that this was their first telemedicine experience.

Conclusion: Our novel discharge program provided patients extensive counseling in that preferred language that would not otherwise be possible in an urban ED setting amidst a pandemic (or even routine ED operations). Medical students received a safe clinical experience that improved their communication skills. Due to its success, this program was scaled across three additional ED sites, and ten additional counseling diagnoses were added. The program has now accrued over 100 medical and nursing student participants. This project has proven to be sustainable and is currently ongoing as part of the emergency medicine medical student curriculum.

104 Barriers and Facilitators to Implementation of a Regional Disaster Teleconsultation System for New England Hospitals and Emergency Departments

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Study Objectives: The Region 1 Disaster Health Response System (RDHRS) Project is developing a novel teleconsultation system to expand regional access to clinical experts in disasters. Our objectives were to identify barriers and facilitators to implementation, and determine willingness to use a regional disaster teleconsultation system at a hospital-level in New England.

Methods: In Spring 2021, we conducted a telephone survey of all New England hospitals and freestanding EDs using the National ED Inventory-USA database. Key respondents were emergency managers.

We collected hospital/ED information about: notification systems for large no-notice emergency events; access to disaster specialists (toxicology, radiation/nuclear medicine, trauma, burn care, high-consequence infectious disease, critical care); disaster credentialing/privileging requirements of teleconsultants before system use; reliability and redundancy of internet/cellular service; and willingness to use a disaster teleconsultation system to access specialists (primary outcome). We report descriptive statistics as preliminary analysis, and plan to test association of willingness to use with hospital/ED characteristics, access to non-disaster telehealth services, and interstate differences with logistic regression models once ≥80% data collection is complete (by ACEP Research Forum).

Results: To date, 121 (64%) of 189 New England hospitals/EDs have responded. Most (89%) are notified of large no-notice events via hospital network emergency notification systems activated at the state level. One in four hospitals/EDs lacked any access to burn and toxicology specialists; ≥80% had in-person, telephone or telehealth access to other disaster specialists. Overall, 76 (63%) hospitals/EDs would require disaster credentialing/privileging of teleconsultants prior to system use where 12 (16%) expected to complete this process in <4 hours, 14 (19%) in 4-24 hours, and 38 (51%) in >24 hours. However, 52 (68%) would use a third-party verification system for disaster privileging. Most hospital/EDs can reliably stream video in clinical spaces (110, 91%) and maintain cellular service despite internet disruption (83, 75%). Overall, 92 (76%) hospitals/ED were somewhat or very likely to use the RDHRS system to access specialists if a no-notice event affected their hospital. Among the 21 hospitals/EDs somewhat or very unlikely to use the system, leading barriers were sufficient access to specialists (33%) and reluctance to use new technology during a disaster (24%); potential time delays (14%), liability (14%), privacy (10%), and hospital information system security restrictions (10%) were infrequent concerns.

Conclusion: Most New England hospitals/EDs have the necessary emergency notification systems, telecommunication infrastructure, and willingness to use a regional disaster teleconsultation system, but policies and procedures to speed disaster privileging are needed for implementation.