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vomiting, patients with history or family history of chronic disease, disorders of lipid metabolism, and myocardial infarction presentations in 2020 compared to 2019. Dispositions also significantly differed in 2020 compared to 2019 with more patients receiving admission or dying in the ED (p < 0.001). Patients who presented to the ED often presented with more severe illness in 2020 as reflected in increased length of stay in 2020 (p = 0.01) and increased case-medical-index (p < 0.001).

Conclusion: The COVID-19 pandemic significantly reduced the total number of ED visits to HMC in Flint, Michigan in 2020, when compared to the same time period in 2019. Notably, patients were more likely to have a longer length-of-stay, present with more severe illness, and more likely to be admitted or pass away in the ED when compared to the same time period in 2019. Analysis also revealed that visits for respiratory diagnoses and other life-threatening conditions like myocardial infarction increased, whereas less life-threatening/acute conditions like sprains, urinary tract infections, and sexually transmitted infections decreased. Interestingly as well, the pandemic drove statistically significant increased visits for mental health and socioeconomic factors.

Limitations include analyzing 6 months of data as opposed to the whole calendar year and the use of broad ICD-10 code categories. It is also important to note that diagnosis codes were analyzed versus what the patient subjectively presented for, so there is a gray area between being able to elucidate what motivated the patient to come to the ED and versus what was analyzed in this project as patient’s ICD-10 diagnoses.

Table 1: Comparison of Emergency Department Values in 2019 vs 2020

| Year | # of ED Visits |
|------|----------------|
| 2019 | 33,648         |
| 2020 | 25,697         |
| Study Total | 59,345         |

Table 2: Comparison of Patient Demographics in 2019 vs 2020

| Year | 2019 (n=33,646) | 2020 (n=56,971) | P-value |
|------|-----------------|-----------------|---------|
| Sex  |                 |                 |         |
| Male | 14,687          | 12,067          | <0.001 |
| Female | 18,959         | 13,630          |         |
| Race |                 |                 |         |
| White | 15025          | 11,559          |        |
| Black | 17,175         | 12,899          | 0.025  |
| Hispanic | 752             | 660             |         |
| American Indian & Alaskan Native | 114  | 90  | 0.071  |
| Native Hawaiian & Other Pacific Islander | 8  | 9  | 0.035  |
| Asian | 46              | 33              | 0.1    |
| Other | 363             | 298             |         |
| Unknown | 165            | 149             | 0.8    |

Table 3: Comparison of Severity Markers in 2019 vs 2020

| Length of Stay (Hours) | 2019 | 2020 | p-value |
|------------------------|------|------|---------|
|                          | 6.81 | 6.97 | 0.01   |
| Case medical index (CMI) | 1.65 | 1.93 | <0.01  |

Table 4: Comparison of Disposition in 2019 vs 2020

| Disposition | 2019 | 2020 | P-value |
|-------------|------|------|---------|
| Discharge   | 23140 | 17,721 | 69 |
| Admit       | 7116 | 5870 | 22.8 |
| SNF         | 884  | 535  | 2.1 |
| Death       | 230  | 255  | 1 |

Table 5: Comparison of Diagnoses in 2019 vs 2020

| Year | 2019 | 2020 | P-value |
|------|------|------|---------|
| Infectious Disease | 2662 | 2181 | 11 | <0.001 |
| COVID-19 | 0 | 462 | 1.8 | <0.001 |
| General Signs/Symptoms | 1089 | 942 | 3.7 | <0.01 |
| Pneumonia | 532 | 747 | 2.9 | <0.001 |
| Lower Respiratory Disease | 137 | 115 | 0.4 | 0.454 |
| Respiratory Failure/Insufficiency/Air | 989 | 1035 | 4 | <0.001 |
| Cardiac Arrest | 166 | 125 | 0.5 | 0.905 |
| Socioeconomic Factors | 542 | 437 | 1.8 | <0.05 |
| Mental Health | 1376 | 416 | 116 | 4.5 | <0.05 |
| Abdominal | 4162 | 3210 | 12.5 | 0.654 |
| Musculoskeletal | 3036 | 2238 | 8.7 | 0.183 |
| Essential Hypertension | 7733 | 19779 | 23 | 0.891 |
| Nausea or Vomiting | 2320 | 2107 | 8.2 | <0.01 |
| Upper Respiratory Infection | 1322 | 1030 | 4 | 0.624 |
| Sprain | 789 | 452 | 1.8 | <0.001 |
| Superficial Injury/Contusion | 1893 | 1496 | 5.8 | 0.308 |
| Personal/Family History of Disease | 7691 | 6373 | 24.8 | <0.001 |
| Headache | 2021 | 1481 | 5.8 | 0.213 |
| Unspecified Injury | 567 | 378 | 1.5 | <0.05 |
| Nonspecific Chest Pain | 2934 | 2266 | 8.8 | 0.674 |
| Tobacco-Related Disorders | 13167 | 10258 | 39.9 | 0.052 |
| Urinary Tract Infection | 1491 | 995 | 3.9 | <0.01 |
| Sexually Transmitted Infection | 195 | 114 | 0.4 | <0.05 |
| Asthma | 1542 | 1158 | 4.5 | 0.658 |
| Disorders of Lipid Metabolism | 1941 | 1660 | 6.5 | <0.01 |
| Skin/Subcutaneous Infection | 1146 | 836 | 3.3 | 0.305 |
| COPD or Bronchiectasis | 2494 | 1823 | 7.1 | 0.14 |
| Myocardial Infarction | 457 | 414 | 1.6 | <0.05 |
| Cerebral Infarction | 175 | 153 | 0.8 | 0.22 |

Sexually Transmitted Infection Testing and Prevalence at a Large, Urban Hospital Before and After the SARS-CoV-19 Pandemic
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Study Objectives: To determine whether behavior changes made during the SARS-CoV-19 pandemic impacted the number of patients being tested and the positivity rate of sexually transmitted infections (STI) at a large, urban hospital in the Bronx to identify how to improve the sexual health services available to our patients.

Methods: A retrospective, cross-sectional study using data from the EMR at a public hospital in the Bronx, New York. Included patients were aged 13 and over that had STI testing from Aug. 1, 2019 to Feb. 1, 2020 (Period 1) and Aug. 1, 2020 to Feb. 1, 2021 (Period 2) in any hospital setting. Periods 1 and 2 are 6 month periods before and after the SARS-CoV-19 pandemic in NYC, respectively. Counts and percents were used to quantity STI tests (HIV point of care, HIV 4th generation serum, Gonorrhea Amplification, Chlamydia Amplification, and Treponema Pallidum Ab screen) and
positive results during Period 1 vs. Period 2. A chi-squared test of independence determined significance of positivity rates in Period 1 vs. Period 2 with a p-value of .05.

Results: In Period 1, there were 11,752 distinct patients, 33,183 total STI tests, and a mean age of 38 years (S.D. ± 16). They were 58% female, 18% male, and 23% unknown or other self-identified sex. Period 2 had 10,313 distinct patients, 29,797 total STI tests, and a mean age of 37 years (S.D. ± 16). They were 51% female, 18% male, and 31% unknown or other self-identified sex. As described in Table 1, fewer tests were done in Period 2 than Period 1 for all STI categories at our hospital. Gonorrhea had a significantly increased positivity rate in Period 2 than Period 1. There were no significant differences in positivity rates for other STIs between the two time periods.

Conclusion: A lower number of STI tests was done at our hospital in Period 2 vs. Period 1. This may be due to a fear of using healthcare resources during the pandemic. Gonorrhea positivity rates were higher in Period 2 than Period 1, with no difference for other STIs. A stable or increased positivity rate could imply that despite new SARS-CoV-19 guidelines on social behavior, patients in our population continued to engage in condomless sexual relations. The pandemic may lead to an increase in undiagnosed STIs in the community due to decreased testing; therefore, a special focus should be placed on increasing testing availability. The emergency department is an ideal environment given readily available testing and treatment.

|             | Period 1 | Period 2 | Period 1 vs. Period 2 |
|-------------|----------|----------|-----------------------|
| STI         | Tests [n]| Positive results [n] | Percent positive | Tests [n]| Positive results [n] | Percent positive | Percent difference of number of tests performed | Percent positive, prior |
| HIV         | 7964     | 31%       | 7964                 | 72 | 3.0%   | 7968                 | 0.83 |
| Chlamydia   | 9882     | 3.5%      | 9882                 | 311 | 3.9%   | 9827                 | 0.20 |
| Gonorrhea   | 8950     | 33%       | 8950                 | 156 | 2.0%   | 8011                 | 0.02 |
| Syphilis    | 7487     | 4.7%      | 7487                 | 414 | 5.7%   | 7067                 | 0.65 |

88 How Did Emergency Physician Fathers Prepare and Cope at the Beginning of the COVID-19 Pandemic?

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Study Objectives: Emergency physicians (EPs) are always on the frontlines and many EPs thrive on the unpredictable. Despite this, the COVID-19 pandemic posed unprecedented challenges to all EPs, including the challenge of how to prepare for and cope with a pandemic. This subset analysis aimed to evaluate the impact of the COVID-19 pandemic specifically on the lives of EP fathers.

Methods: From May 2 through June 16, 2020, a convenience sample of physician fathers was surveyed on their personal and professional preparedness for COVID-19. Surveys were distributed via the Physician Dads Group (PDG), an international Facebook group covering all medical specialties, LinkedIn, via personal contacts and professional organizations.

Results: 260 surveys were completed by EP fathers (Table 1). Of the respondents, 77% were between 30–49 years, 84% were White, 9% Asian, 1% Black; 31 U.S. states were represented. 98% reported they had a partner. At the time of the survey, 63% felt they were in a high-density area with 88% having cared for a COVID+ patient. About half had taken steps to prepare personally or professionally for the local impact of COVID-19 (46% and 67%, respectively). EP fathers top two concerns were exposing their partner or their child(ren) to COVID-19, followed by personally acquiring COVID-19. 44% of fathers didn’t have to change their schedule to care for children, while 37% did; other fathers did not have school-aged children or already had care in the home. In terms of preparation, about 67% made sure they had adequate food, 60% made sure they were financially prepared, while 46% and 41% obtained PPE for self or family, respectively. To prepare professionally, almost all (97%) educated themselves about COVID-19, 68% self-educated about pandemics, and 72% reviewed critical care literature. The three biggest professional concerns were morale of staff (48%), financial challenges (45%), and health of staff (43%). 37% of fathers felt that the balance between their professional and personal responsibilities worsened, while 17% felt the balance improved. When EP fathers were asked if they wished they had not gone into medicine, 67% disagreed/strongly disagreed. When asked if they wished they had not gone into their specialty, 89% disagreed/strongly disagreed.

Conclusions: EP fathers felt more prepared professionally than personally for the pandemic. The findings suggest an increase in patient transport staff will improve CT TAT when pandemic redeployment ends.