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Study Objectives: Podcasts have become increasingly popular platforms for knowledge synthesis and translation. Trainees now report spending more time with podcasts than any other educational resource, including textbooks and journals. Though almost two thirds of residents report podcast listening changes their clinical practice, there is uncertainty over the quality and influence of podcasts. Given the broad use of podcasts among emergency medicine (EM) trainees, there is a need to better understand the processes by which they sort, interpret, and judge information as they learn. What is not known is how EM residents make credibility judgements about podcast content, how their judgements compare to the judgements of attending physicians, and how those credibility decisions relate to other learning modalities.

The objective was to explore the processes by which podcasts are weighed, valued, and judged relative to one another, and relative to other learning modalities.

Methods: We performed a multi-center qualitative thematic analysis based on a constructivist grounded theory approach by conducting 11 semi-structured interviews with resident and attending physicians from three North American teaching institutions from January 2020 to June 2020. Narrative transcripts were coded line-by-line using constant comparative analysis to organize transcripts into focused codes, key conceptual categories, and then major themes. Three authors met regularly during the analysis to develop the coding schema, resolve discrepancies, and discuss themes.

Results: We identified four broad themes related to credibility judgements and educational podcasts: trust in source, congruence of content, triangulation of references, and application context. Participants had a baseline level of trust in a podcast resource based on popularity, recommendations from colleagues, format, Web site, and speaker credentials. When listening to podcast content, participants’ levels of scrutiny varied based on the type of material (core content vs. cutting-edge) and level of agreement of the content with their existing knowledge. When considering incongruent or cutting-edge information, participants triangulated the podcast content with their experience, understanding of physiology, content of other podcasts and online resources, reading the primary literature, and conversations with attending physicians. When applying information gleaned from podcasts, participants yielded to local practice contexts and, for residents, their attendings’ judgments.

Conclusion: When listening to educational podcasts, resident and attending physicians made a series of complex credibility judgements that weighed trust in the source, congruence of the content, triangulation of references, and the context of application.
(Shaman, 2020) and 70% of CCBs in each county were assumed to be occupied by non-COVID-19 patients. For each county, three potential constraints on increasing capacity were estimated: the number of nurses, the number of physicians (including APPs), and the number of CCBs. One or more constraints could be active at any time.

Results: Prior to optimization, 91% of counties were able to meet the demand for projected case counts. In contrast, 8.4% were limited by nursing resources, 0.09% by physicians, and 0.8% by the number of CCBs. After optimization, 16.9% of counties sent nurses to a different county(s) (median 6 nurses sent, IQR 13.75) compared with 5.9% counties receiving them (median 23, IQR 43.5). Fewer physicians were relocated (0.09% sent, median 1, IQR 1; 0.06% received, median 2.5, IQR 1.5) (Figure). Using baseline staffing ratios and availability, these redistributions led to a reduction in total unmet demand from 24,155 to 19,957. In order to fully meet demand across the US under these conditions, an additional 1,225 physicians, 41,939 nurses and 13,905 CCBs would have been needed.

Conclusion: This work shows that with the redeployment of resources even within state boundaries may provide relief to areas of need without causing strain in other locations. While validation with actual redeployment during the pandemic can improve estimates, these models can provide decision support to stakeholders by suggesting optimal reallocation or the ability of existing resources to support additional capacity.

### Impact of the SARS-CoV-2 Pandemic on Emergency Department Presentations in an Integrated Health System

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Study Objectives: We aimed to quantify the impact of the SARS-CoV-2 pandemic on emergency department (ED) volumes and patient presentations, and to evaluate changes in community mortality for the purpose of characterizing new patterns of emergency care utilization.

Methods: This is an observational cross-sectional study using electronic health records for ED visits in an integrated, multi-hospital system with academic and community practices across four states for visits between March 17 to April 21, 2019, and February 9 to April 21, 2020. We compared quantity and proportion of common and critical chief complaints and diagnoses, stays, transfers, admissions, trauma activations, throughput, disposition, and hospital length-of-stay for selected diagnoses, and out-of-hospital deaths. Academic and community hospitals were evaluated separately and in combination for an overall picture of emergency department utilization.

Results: Compared to both the preceding four weeks (n=37,670), and the prior year (n=35,037), ED visits from March 17 to April 21, 2020 (n=18,646) decreased 49% and 53.2% respectively. The total numbers of patients diagnosed with myocardial infarctions (STEMI and Non-STEMI), stroke, appendicitis and cholecystitis all decreased by a similar percentage. While there were fewer visits for mental health (n=1,104 in preceding weeks, n=1,032 for year prior, n=752 during pandemic), they made up a larger proportion of ED visits - 2.9% for both baselines and 4% during period of interest (p<0.001 for both). Compared to both baselines, the percentages of trauma were similar; however, the absolute number of red (n=35 during COVID; n=72, p<0.001 peri-COVID; n=67, p=0.002 pre-COVID) and yellow (p=0.004 pre-COVID; p<0.004 peri-COVID) declined overall, driven by a drop at academic centers by nearly 60% for red trauma and 50% for yellow. Mortality was considered a surrogate for delayed/deferred emergency care. Southern Minnesota Regional Medical Examiner’s Office data showed an increase in natural deaths during the COVID period (n=250 versus pre-COVID (n=294) baseline (p=0.037). Out-of-hospital mortality for natural (non-COVID-related) and non-natural deaths increased from 73 pre-COVID to 128 during the COVID period (p<0.001). The significant increase in out-of-hospital mortality drives the overall mortality increase. There was an increase in deaths, driven by out-of-hospital mortality.

Conclusion: Fewer patients presenting with acute and time-sensitive diagnoses suggests that patients are deferring care, this may be further supported by an increase in out-of-hospital mortality as well as a lower number of patients presenting with complaints and diagnoses that would be expected to remain stable for a given population during the periods studied. Understanding which patients are deferring care...