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.

Table 2. PTSD of all Participants

PTSD	Current Position			P-Value
	Attending Physician (n=68)	Mid-level Practitioner (n=84)	Resident or Fellow Physician (n=24)	
PTSD-PCL-5^ (Use 31 as the cutoff point), n (%) *	8 (13.6)	20 (25.0)	2 (3.5)	0.14
PTSD-PCL-5 total severity score (continuous)				0.01*
Mean (SD)	13.9 (12.6)	20.4 (14.9)	15.4 (18.2)	
Range	0 - 55	0 - 58	0 - 63	
Median [Q1, Q3]	10 [3, 22]	16 [9, 30.5]	9 [2, 22]	
PTSD-DSM-5, n (%)	5 (8.5)	20 (25.0)	2 (9.5)	0.02
Sub-threshold DSM-5 PTSD				
DF1: Three of the four Criterion B-E, n (%)	7 (11.9)	5 (6.3)	3 (14.3)	0.36
DF2: Two of the four Criterion B-E, n (%)	10 (17.0)	13 (16.3)	2 (9.5)	0.79
DSM-5 Each Criterion B-E				
Cluster B [re-experiencing]**, n (%)**	19 (32.2)	39 (48.6)	6 (28.6)	0.08
Cluster C [avoidance]**, n (%)**	16 (27.1)	25 (31.3)	6 (28.6)	0.91
Cluster D [negative alteration in mood] **, n (%)**	15 (25.4)	40 (50.0)	7 (33.3)	0.01
Cluster E [hyper-arousal]**, n (%)**	14 (23.7)	29 (36.3)	4 (19.1)	0.17

Notes: 1. 16 missing values. 2. All p-values were generated using Fisher's Exact test except p = 0.01 which was tested using a Kruskal-Wallis test. 3. n (%) *: represents the number and percentage of people who meet the criteria for PTSD.*

^ The PCL-5 is a 20-item self-report measure that assesses the 20 *DSM-5* symptoms of PTSD with a rating scale of 0-4 for each symptom. Research indicates that a PCL-5 cutoff score between 31-33 is indicative of probable PTSD.

48 Management and Disposition of Patients with Venous Thromboembolism In Academic Vs. Rural Hospital Populations During the COVID-19 Pandemic

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Study Objective: While being supported by national societies, management of low-risk venous thromboembolisms (VTEs) in the outpatient setting with direct oral anticoagulant medications (DOACs), has yet to become standard of care. We sought to determine the differences between rural and academic hospitals in VTE management and disposition of patients during the COVID pandemic.

Methods: This retrospective study used data from a quality improvement database to evaluate the management and treatment of patients diagnosed with VTE in our emergency departments during the COVID pandemic between 9/1/2020 and 2/28/2021 in any one of our 6 network locations across NE PA. Three of these sites have affiliations and are considered teaching/academic hospitals, while the other 3 are located in rural settings.

Results: Of 454 patients diagnosed with VTE, 291 patients were at our academic hospitals and 163 in our rural hospitals. Data include 235 males and 219 females, with an average age of 58 and 61, respectively. Patients treated for VTE in the rural hospitals had an on average shorter length of stay (LOS) prior to disposition (372 min. rural vs. 404 min. academic, p= 0.204). Further, patients seen in rural settings were less likely to be admitted than in academic settings (45.4% (N=74) rural vs. 59.8% (N=174) academic admit rate). The 30-day return rate for 'all causes' following an ED visit was almost 2x greater in the rural setting vs. academic (30.7% (N=50) vs. 17.5% (N=51), respectively). Despite this, the 30-day return rates attributable to VTE were similar (24% (N=12) rural, 23.5% (N=12) academic). At the 6-month mark, return rates attributable to VTE at rural locations were low but had an almost 1.6x higher rate of return (7.7% (N=2) rural vs 4.8% (N=3) academic). Rural locations utilized different rates of DOACs, with rural hospitals using rivaroxaban at a 2x higher rate than academic settings (45.3% (N=34) rural vs 20.2% (N=36) academic). Apixaban was more frequently used at academic vs rural settings (64.0% (N=114) academic vs. 41.3% (N=31) rural). Rural vs academic settings had similar rates of PCP follow-up (89.7% (N=261) vs 81.6% (N=133), respectively). Academic settings had an almost 2x higher rate of coagulation clinic follow up vs. rural settings (6.9% (N=20) vs 3.7% (N=6), respectively).

Conclusions: The findings in this single network study show substantial differences in the management of VTE during the COVID pandemic in rural versus academic settings. Future research involving a more detailed understanding of these differences between rural vs. academic hospital settings is indicated.

49 911 Call Diversion to Telemedicine During the COVID-19 Pandemic in New York City: Call Characteristics, Outcomes and 48-Hour Follow-Up at a Single Academic Center

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Study Objective: The COVID19 pandemic saw unprecedented increases in call volume to the New York City (NYC) 911 system. Several large health systems collaborated with the NYC Fire Department to transfer low-acuity 911 caller to hospital-based telemedicine services in to ease the burden on EMS. We describe the results of a single center participating in this program, and the results of a nurse follow-up program for diverted calls.

Methods: Emergency dispatchers screened 911 calls using a computerized algorithm. Eligible calls were then transferred to hospital-based hotlines for further triage by a registered nurse (RN) or physician assistant (PA). An ambulance was dispatched for calls deemed not appropriate for telemedicine. Otherwise, medical information was given by the RN/PA or a telehealth visit was initiated. Data on demographics, clinical presentation and call outcomes were entered into a REDCap database during initial call. A RN attempted follow-up calls on all patients within 48 hours of initial during the first three months of the program.

Results: Between 4/3/20 and 10/2/20, 459 calls were diverted to the triage line, averaging 6 to 10 calls per day. Calls originated from all five boroughs: Brooklyn (26.2%), Bronx (30.2%), Manhattan (23.5%), Queens (17.3%), and Staten Island (2.7%). The median age was 58 (range 4-85 years), and half were female. Shortness of breath (29%), nausea/vomiting (29%) and myalgias/malaise (23%) were the most common symptoms. Approximately 21.5% of calls were related to COVID-19. Among completed calls, 55% resulted in subsequent ambulance dispatch, most commonly due to medical necessity or patient preference. The proportion of calls resulting ambulance response after transfer increased as pandemic levels decreased largely due to patient preference. Among appropriate transfers, 35% were referred to telemedicine while 39% received medical advice from the triage RN/PA. However, only 15 patients were able to complete a telemedicine call, mostly due to technical issues accessing the telemedicine platform. Among the 320 attempted follow-ups, 144 patients (45%) were contacted. Many patients (60%) called 911 again after triage; none of the 15 patients completing a telemedicine visit sought additional care. Thirty-three patients had been admitted to the hospital since the initial call, with one patient in the ICU.

Conclusion: Our institution successfully participated in a NYC-wide pilot to divert selected 911 calls to hospital-based telemedicine resulting in fewer ambulance dispatches and more appropriate allocation of EMS resources during the pandemic. However, many callers sought subsequent care after diversion with some requiring hospitalization, and patient acceptance of diversion decreased as pandemic conditions improved. More specific initial screening algorithms, public education campaigns and streamlined IT workflows could significantly increase the volume and effectiveness of similar 911 diversion programs.