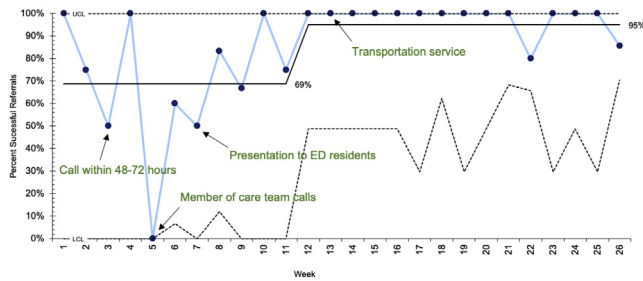




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Figure 1. Successful Referrals Each Week (P Chart)



365 Emergency Department Visits for Ovarian and Testicular Torsion After the Arrival of COVID-19

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Study Objective: To evaluate whether the decrease in visits for ovarian and testicular torsion was less than the overall decrease in ED visits following the arrival of COVID-19 in the New York metropolitan area. There was a marked decrease in ED visits after COVID-19 arrived in the New York metropolitan area in the United States in early March 2020. This was likely due to public health mandates and fear of exposure to the virus. Because torsion of the ovaries or testes is usually heralded by sudden onset of severe pain, patients with these conditions may have overcome this general reluctance to go to the ED. We hypothesized that, following the arrival of COVID-19 in the New York metropolitan area, the decrease in torsion visits was less than the decrease in ED visits overall.

Methods: Design: Retrospective cohort. Setting: EDs of 28 hospitals within 150 miles of New York City. Hospitals were teaching or non-teaching and rural, suburban or urban. Annual ED volumes were from 12,000 to 122,000. Population: Consecutive ED patients from March through November in 2019 and 2020. Data analysis: We tallied the number of patients diagnosed with ovarian or testicular torsion using the International Classification of Disease codes (version 10). We calculated the difference in the decrease in total visits compared to the decrease in torsion visits from 2019 to 2020, along with the 95% CI.

Results: The database contained a total of 1,587,246 visits, 898,850 in 2019 and 688,396 in 2020 (a 23% decrease from 2019 to 2020). The number of patients diagnosed with torsion was 203 in 2019 and 185 in 2020 (a 9% decrease from 2019 to 2020). The median ages [IQRs] for ovarian and testicular torsion were: 28 [18-37] and 15 [13-19] years, respectively. The difference in the decrease in total visits compared to the decrease in torsion visits was 14% (95% CI:10% to 18%).

Conclusions: Consistent with our hypothesis, we found that following the arrival of COVID-19 in the New York metropolitan area, the decrease in torsion visits was less than the overall decrease in ED visits. We speculate this difference was because of the sudden onset of severe pain associated with torsion. Additional studies are needed to determine if patients who have sudden onset of severe pain from other conditions had less of a decrease in visits than overall ED visits.

366 Detroit City Mass Vaccination Site Template

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Study Objective: In 2020, the city of Detroit was impacted by the COVID-19 pandemic, with over 162,000 reported diagnosed cases and 4,800 deaths. In response to anticipated availability of a vaccine, the Detroit Health Department developed plans for a drive-through mass vaccination site to help distribute the vaccine to the city's population. We describe the Detroit City Mass Vaccination Site and its methods of recruitment, enrollment, site selection, and logistics.

Discussion: Initial recruitment for vaccination was through traditional media means as well as the city of Detroit's website. Interested individuals were instructed to call a dedicated scheduling line in addition to separate numbers for general inquiries and SMS based inquiries for vaccination sites. Individuals were provided appointments on the hour for both doses at the appropriate interval during the initial conversation.

Methods: The TCF Conference Center was selected due to its central location, vicinity to the city's vaccine storage site, capacity for large number of vehicles, protection from the elements, and availability. As vehicles arrived for appointments, they went through multiple checkpoints for confirmation of appointment and consent for treatment. Detroit police traffic control units aided with traffic-flow and vehicles were queued into two floors with a total of 27 lanes. On-site pharmacy was responsible for drawing, preparation, and delivery of vaccine doses to each lane. Once vehicles were confirmed for appointment and consent reviewed the vaccine was administered and vehicles remained in line for an observation period. Vaccine administration was documented on a CDC Vaccination Card and consent form was delivered to data entry workers from the Detroit Health Department for entry into the Michigan Care Improvement Registry (MCIR). On-site EMS supervisor, EMS teams, and an on-site physician and were available for medical response. After observation, vehicles were directed by security for egress.

Results: To date, the TCF Center Mass Vaccination site accounts for over 220,000 doses administered with 62.0% of those doses given to individuals identifying as Black/African American, 31.9% identify as White and 6.0% identifying as another race.

Conclusion: As vaccination studies showed promise for efficacy, the City of Detroit developed and implemented a mass vaccination site to help to mitigate the impact of COVID-19 on the city. Multiple public and private partners assisted in the effort. While only a piece of the necessary response, to date we have provided in excess of 250,000 doses of vaccine and this model has proven effective at providing mass vaccination while the population remains vaccine limited.

367 Rural Rates of Hepatitis C Within an Emergency Department-Based Universal Screening Program

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Study Objective: As a consequence of the opioid epidemic, overall Hepatitis C (HCV) infections have increased in the United States. HCV mortality now surpasses more than 60 other infections (eg, HIV, and TB). The CDC now recommends universal HCV screening, for all adults aged ≥ 18 years. Several reports highlight the success of large urban EDs to provide screening and linkage to care for HCV but the ability to utilize rural EDs has not been explored. Our objective was to highlight results of an electronic health record (EHR) driven "opt-out," universal HCV screening program in a small rural community ED that serves the economically disadvantaged, rural/mountainous area of SC, including parts of Appalachia.

Methods: An IRB approved, retrospective study (September 2019 to September 2020) on the HCV seroprevalence and active HCV infection (RNA positive) rates as part of a universal HCV screening program in a rural Seneca, SC ED. Patients aged 18 yrs and older with: 1) no reported history of HCV infection, and 2) no reported testing for HCV in the last 12 months were reported using an Abbott Architect anti-HCV serum assay (Abbott Diagnostics) with reflex HCV RNA testing. Cumulative HCV testing outcomes with recorded demographic information were obtained using de identified data abstracted from our EHR (EPIC Madison WI). All anti-HCV antibody and RNA results were stratified by birth year for separation into two groups, those patients born between the years of 1945-1965 as part of the "birth cohort" and everyone else born after 1965. Results were also stratified by race/ethnicity, sex, and initial recoded insurance status at time of service. Patient characteristics and prevalence estimates for overall seropositivity and active infection (presence of RNA) are reported with 95% confidence intervals. Alpha was set at 0.05. All analyses were performed using SAS Enterprise Guide 7.1.

Results: EHR driven "opt-out" HCV screening programs instituted within a small 20 bed (~44K patients a year) rural ED in SC. The total number of unique adult patients eligible for HCV screening was 16,287. Overall population, 19.2% insured, 28.9% Medicare, 19.8% Medicaid, and 28.1% self-pay/uninsured. A total of 3294 HCV screening tests were obtained, with 1317 patients screened within the birth cohort and 1692 screened outside the cohort. A total of 161 (4.9%) were HCV ab positive with 72 (2.1%) and 89 (2.7%) positive patients within and outside the birth cohort respectively. A total of 133 reflex RNA tests (~83% of total) were obtained. There were 58 (1.8%) positives with 23 (.7%) vs 35 (1.1%) from within and outside the birth cohort respectively. Specific demographic differences show an increased prevalence (95% CIs) of 4.06 (1.6, 6.51) for males, 5.57 (1.33, 9.82) for White Non-Hispanics, and 5.92 (0.73, 11.10) for self-pay/uninsured.