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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>65 years. We also included an additional group of all patients who had blood testing (complete blood count or electrolyte panel). Linear regression analysis was used to adjust for age, sex, presence of fever, and completion of CT imaging when appropriate. Chief complaint groups and confounder variables were pre-specified.

Results: ED length of stay was found to be significantly longer in patients who had urine testing completed than in those who did not, across all subgroups analyzed. In all discharged patients (n=228,494 visits), patients who had urine testing had a mean LOS which was 78 minutes longer (unadjusted) than patients who did not have urine testing. In all patients who had labs done (n=111,082 visits), the mean LOS difference was 21 minutes after adjusting for age, sex, fever, and CT A/P. In all chief complaint groups analyzed, patients who had urine testing had longer LOS, with adjusted mean differences ranging from 22 to 37 minutes. All comparisons were statistically significant.

Conclusion: In this multicenter retrospective cohort study, urine testing was associated with an increased LOS that was both statistically significant and appears clinically meaningful. This was found in all pre-specified patient groups examined. If this finding is replicated in other settings with prospective data, decreasing unnecessary urine testing might help to decrease ED LOS.

### Table 1. Association of urine testing with length of stay in discharged ED patients.

| Chief Complaint Group | Mean LOS (minutes) | Mean LOS (minutes) | Mean Difference | P-Value |
|-----------------------|--------------------|--------------------|----------------|---------|
|                       | Completed (95% CI) | Not Completed (95% CI) | (minutes) (95% CI) |         |
| Chest pain¹(n=12,724)| 270 (263, 278)     | 233 (228, 238)      | 37 (35, 40)     | P < .001|
| Vaginal bleeding in pregnancy²(n=1,990)| 346 (323, 369) | 314 (304, 324) | 32 (19, 45) | P < .001|
| Abdominal pain³(n=21,665)| 381 (367, 395) | 349 (346, 352) | 32 (21, 43) | P < .001|
| Weakness, altered mental status, confusion, female > 65 years old⁴(n=896)| 416 (331, 501) | 381 (365, 396) | 35 (35, 105) | P < .001|
| Received CBC and/or blood chemistry⁵(n=111,082) | 374 (369, 379) | 354 (353, 355) | 21 (17, 24) | P < .001|

LOS=length of stay, UTI=urinary tract infection, CBC=complete blood count.
1: Adjusted for age, sex, presence of fever, and completion of CT abdomen/pelvis.
2: Adjusted for age.
3: Adjusted for age, presence of fever, and completion of CT abdomen/pelvis

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### 207 Virtual Powers of Observation: A Telemedicine Pathway for the Suspected COVID-19 Patient

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Study Objectives: Prior to COVID-19, telemedicine and its applications to the emergency department (ED) had made significant inroads towards remote evaluation and care. During the local peak of the COVID-19 pandemic in NYC, telemedicine patient encounters for suspected COVID-19 symptoms dramatically increased. In response, pathways were developed to promote a standardized telemedicine approach to remote evaluation and assessment of suspected COVID-19 patients.

Methods: A pathway was developed and implemented at two academic emergency departments in New York City that collectively had approximately 8300 telemedicine visits for suspected COVID-19 from March 2020- June 2020. Protocol was developed via an expert consensus panel of 4 board certified emergency physicians and 2 pediatric emergency physicians, all with telemedicine training/administrative roles.

Results: The pathway was initiated for any telehealth patient with suspected COVID-19 symptoms (cough, fever, shortness of breath, bodyaches). A standardized history solicited known or suspected risk factors for worse prognosis including: age>50, cardiovascular or lung disease, obesity, immunosuppression, living alone) as well as a focused assessment of symptom severity and exercise tolerance. An exam at rest included visual counting of breaths along with instruction on palpation of radial pulse. Saturation was included if pulse oximetry was available. If exam at rest was reassuring, providers were instructed to repeat the respiratory assessment on exertion by having the patient walk in place briskly for one minute. Patients with severe illness, defined by resting or exertional respiratory rate greater than 30 and/or oxygen saturation less than 90% were instructed to go to the ED. Patients with moderate illness defined by exertional metrics of respiratory rate less than 22, oxygen saturation greater than 94 percent and heart rate less than 125 were discharged from the virtual urgent care visit with a repeat telehealth follow up call at either 12 or 24 hours depending on the number of risk factors. Patients without risk factors and with reassuring respiratory assessment were discharged from the telemedicine encounter with reassurance and standard discharge precautions for escalation of care.

Conclusion: Designing and disseminating a standardized pathway helped provide a framework to approach patients suspected of COVID-19 over telemedicine. Future work focusing on patient outcome data, will help guide and refine any standardized telehealth approach to the COVID-19 suspected patient.

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### 208 Sleep Time and Characteristics Measured Using Fitbit Devices in Emergency Medicine Residents

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Study Objectives: Sleep is an integral part of both physical and mental well-being, and has been long revered as a delicacy during medical residency training. We sought to quantify and characterize the sleep of emergency medicine (EM) residents training at a level one trauma center in eastern PA.

Methods: This study was an IRB-approved, prospective, observational study that assessed EM residents’ objective sleep data obtained from a Fitbit. EM residents gave consent to participate in the study. A Fitbit Charge 3 device was given to each resident and they were asked to wear the Fitbit at all times, except for a brief period required for weekly charging of the device. The Fitbit automatically tracks time in bed, total sleep time, and time spent in light, deep and REM sleep. The study was conducted over a three-month period. The data from each Fitbit was automatically synced to a database, Fitabase. Each resident was identified by a subject number and their identity was hidden from investigators. Data was interpreted using descriptive statistics, first taking the median time for each subject and then the mean for the group. Median times overall for female and male subjects were compared using a two-tailed t-test.