

were deductively analyzed and categorized based on the practical elements necessary in disaster and emergency management.

Results: The obtained data could be categorized into the seven collaborative elements of the major incident medical management and support model. The command-and-control category demonstrated four subcategories: 1) coordination and collaboration, 2) staff engagement, 3) responsibility clarification, and 4) sustainability. Safety presented two subcategories: 1) patients' information privacy and treatment, and 2) personnel safety and privacy. Communication showed internal and external communications subcategories. Assessment, triage, treatment, and transport followed the processes of the COVID-19 treatment protocols according to the World Health Organization guidelines and hospital operations. Several supplies and patient-related challenges were identified and managed during center development.

Conclusion: The use of community resources, based on the flexible surge capacity concept, was feasible under restricted circumstances and enabled the relief of hospitals during the pandemic. Continuous education among multidisciplinary volunteer teams facilitated their full participation and engagement. The concept of flexible surge capacity may promote an alternative community-based care opportunity, irrespective of the emergencies' etiology.

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Assessing Trends and Severity of Emergency Department Access Block by Measuring Median ED Length of Stay for Admitted Patients

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Introduction: The Emergency Department (ED) is the hospital's main gateway, as well as the initial site for diagnosis and emergency medical care. In recent years, ED overcrowding is worsening in Israel and world-wide. Overcrowding has been shown to adversely affect patient service and care, fostering patient and caregiver dissatisfaction, as well as lowering quality of care and even increasing mortality. A main driver of ED overcrowding is ED patient boarding due to limited inpatient bed availability in conjunction with hospital policy. Measuring median length of ED stay (LOS) for admitted vs. discharged patients can serve as a simple indicator for the severity of the access block over time and between facilities.

Method: ED operational data from the computerized system of four hospitals in Israel were collected over a year and analyzed. In parallel data was collected regarding hospital capacity and ED volumes. Data were analyzed using SPSS.

Results: The Mean ED LOS was significantly higher for ED patients needing admission in all hospitals. Mean ED LOS for admitted vs. discharged patients was 227 min vs. 431 in hospital A, 215 min vs. 222 in hospital B, 198 min vs. 440 in hospital C and 167 min vs. 190 in hospital D. The discrepancy in LOS for admitted patients was not related to the total hospital bed capacity or the hospital ED patient volume.

Conclusion: ED boarding is a major challenge for ED's and hospitals worldwide and a significant contributor to ED overcrowding. A tool to assess boarding is proposed. The tool calculates the ratio of median ED LOS between patients admitted to the hospital and those discharged. Slightly higher LOS among those admitted is to be expected, considering the fact that they usually present with more complex medical problems. In this study the LOS ratios were 1.03, 1.12, 1.90 and 2.22.

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