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Study/Objective: To examine the role of Primary Health Care (PHC) doctors in disasters.

Background: Research shows that primary health care strengthens population health outcomes across developing/developed nations and disparate health groups. Life expectancy is increased, infant mortality decreased, and access to health care more equitable; a strong element of this is continuity-of-care. However, in disasters, this care can be disrupted as PHC doctors are not linked into disaster response, with potential adverse effects on population and individual health in the months to years following the aftermath. Existing disaster management systems currently focus on local capabilities. PHC doctors are locals; part of the local community and health care with a unique contribution to offer to patient care during any adversity.

Methods: The epidemiology of health consequences of disasters was reviewed. A temporal pattern of the prevalence and incidence of health effects and health deterioration over time emerges. Interviews were conducted with PHC doctors and disaster management experts involved in the November 2010 E.Australian floods, the 2010–2011 Christchurch earthquakes, 2013 NSW bushfires, and the 2014 Sydney Siege, exploring the diversity of roles played by PHC doctors across the PPRR of disasters.

Results: Roles that the PHC doctors undertake in disasters varies considerably. Many are spontaneous and unsupported, with few involving planning or preparedness. Key messages from the PHC doctors involved in disasters are consistent across the different disasters.

Conclusion: In order to improve the health of people affected by disaster, there is an urgent need to define the role of primary care in existing disaster management systems, using evidence from the literature and experience from the field. Pre-disaster involvement on local disaster planning committees, as well as patient and practice preparedness; during-disaster continuity-of-care for the local population; and post-disaster involvement in health surveillance for emerging disease and deterioration of existing health conditions are crucial to strengthen and optimize community health outcomes following disasters.

Prehosp Disaster Med 2017;32(Suppl. 1):s70–s71

doi:10.1017/S1049023X17001893

Analysis of Disaster Related International Frameworks

2015–2016: Implications for WADEM

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Study/Objective: To analyze disaster related International Frameworks 2015 - 2016, and identify implications for WADEM

Background: In the period 2015 - 2016, a number of influential international disaster-related Frameworks evolved, including the: Sendai Framework for Disaster Risk Reduction

2015 - 2030; Sustainable Development Goals–2030 Agenda; Paris Climate Change Conference; World Humanitarian Summit; Rockefeller Foundation’s 100 Resilient Cities Project; WADEM’s Disaster Research and Evaluation Frameworks; and, ALNAP’s Evaluation of Humanitarian Action Guide. Our research question asked if there were commonalities and potential interactions between these Frameworks and if there were possible implications for WADEM?

Methods: A desktop review and thematic analysis of the definitive documents from these Frameworks was undertaken.

Results: These international Frameworks all had substantial theoretical and / or evidence based underpinnings, and evolved from structured processes over a period of time. The Sendai Framework, Sustainable Development Goals (SDG), Paris Climate Change Conference and World Humanitarian Summit all had major political and government influences, while the Rockefeller, WADEM and ALNAP Frameworks were led by applied, professional influences. A number of the SDGs include targets specifically related to natural disasters. Common themes included: the desire to improve the quantum and quality of the science, evidence-base and accountability in this domain; the use of ‘Resilience’ as a concept and as a framework to consider interventions; commonalities and interactions between the new generation ‘humanitarian and development’ concepts and traditional ‘disaster’ concepts, particularly in the global trend towards greater urbanization; and, new paradigms, eg the international influence of Rockefeller’s ‘Acute Shocks’; and ‘Chronic Stressors’ concept, which shares commonalities with the SDG’s.

Conclusion: The Rockefeller, WADEM and ALNAP Frameworks provide useful guidelines on how the objectives of Sendai Framework, Sustainable Development Goals, Paris Climate Change Conference and World Humanitarian Summit may be achieved and measured. All Frameworks have implications for the direction of WADEM and for WADEM to globally influence.

Prehosp Disaster Med 2017;32(Suppl. 1):s71

doi:10.1017/S1049023X1700190X

Facilitating Decision-Making and Provision of Medical Care during Disasters through Utilization of a Comprehensive Computerized Information System

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Study/Objective: To present contributions of a comprehensive computerized information system to decision-making and provision of medical care during disasters.

Background: During disasters the healthcare systems are required to ensure provision of medical services to vulnerable populations. In order to monitor vulnerable patients and ensure efficient management of resources, information systems are needed.

Methods: “Meuhedet”, an HMO which insures 1,200,000 patients, developed a comprehensive information system which

includes a database concerning patients, infrastructure and personnel, as a unique management tool. The GIS-based system enables to identify the location and current status of patients and providers at all times. During large-scale fires that occurred in Israel between November 22–27, 2016, which necessitated mass evacuation of populations, the information system was used to locate vulnerable patients and plan provision of needed services.

Results: Following the decree of mass evacuation of all populations from the risk zones due to the fires, the information system enabled the HMO to locate all vulnerable patients within minutes, and plan provision of specifically needed services: 2 patients from a nursing home and 1 home-care ventilated patient were located and evacuated within 2 hours. Specific medications were supplied within two hours to patients who were evacuated to absorption centers or hotels, based on their personal files available through the information system. One terminally ill patient was tracked and treated by the home-care unit within 3 hours, based on the data provided by the information system.

Conclusion: The comprehensive information system facilitated decision-making and improved ability of primary health care workers, to provide efficient and continuous medical care in the community during the disaster. During the recent fires in Israel, vulnerable patients were located within minutes and provided with individually-needed medical care within 2–3 hours, due to the availability of the information system that provided vital data concerning each patient.

Prehosp Disaster Med 2017;32(Suppl. 1):s71–s72

doi:10.1017/S1049023X17001911

The Introduction of Hospital MIMMS, A United Kingdom Based Hospital Mass Casualty Response Course to Australia: Needs, Issues and Solutions

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Study/Objective: An outline of the introduction of a standardised, national, mass-casualty response course to Australian hospitals, including review of obstacles and issues experienced together with adopted solutions.

Background: Although the Advanced Life Support Group (ALSG) Major Incident Medical Management and Support Course (MIMMS) has been well established in Australia for several years, there was no corresponding, nationally consistent course providing hospital care providers with a similar framework for response. Several jurisdictions utilized locally applicable education, but an overall consistent national approach was absent.

Methods: Since a nationally consistent approach to hospital-based mass-casualty response had been identified as desirable by the National MIMMS Working Group (NMWG), efforts were made to identify an appropriate, credible, and internationally recognized course. Funding was sought from the National Critical Care & Trauma Response Center (NCCTRC), and

negotiations with the UK based Advanced Life Support group ensued. In October 2014, two UK-based instructors traveled to Australia to provide an introductory course, and to train an initial cadre of Australian instructors with subsequent local roll out.

Results: The course was subjected to a process of iterative improvement based on participant feedback and instructor review. Many initial perceived issues revolved around definitions and terminology, which differed between the two nations. Significant attention was paid to the requirement for a course with a national remit, but which remained sufficiently flexible to adapt to the varying systems, processes, and procedures of the various Australian jurisdictions. HMIMMS has subsequently been adopted by four of six participating Australian jurisdictions, with 18 courses being run nationally between October 2014 and October 2016.

Conclusion: HMIMMS was successfully adapted to the Australian context, and adopted by four of the six participating jurisdictions. The remaining two may adopt HMIMMS at a later date. Australian implementation of HMIMMS demonstrates a successful collaboration of jurisdictions within a federated system.

Prehosp Disaster Med 2017;32(Suppl. 1):s72

doi:10.1017/S1049023X17001923

Maintaining Continuity of Care in the Recovery Phase With Family Medicine

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Study/Objective: The recovery period of a disaster often requires re-establishing health care and maintaining continuity of care for a large number of victims. This means recruiting primary care physicians who are preferably trained to provide healthcare to all ages, as well as having the ability to provide treatment covering a wide range of specialties. The specialty of Family Medicine is well-positioned to lead the healthcare recovery phase of disasters, prevent breach of medical care, manage chronic care issues, and provide urgent care treatment, thus alleviating the burden on the local emergency departments.

Background: The medical recovery phase of a disaster is a chaotic period where re-establishing health care, and re-connecting the affected population to their primary care physicians becomes a complex challenge. This is partially due to displacement of the affected population, including the local physician force, as well as destruction of local clinics, both which are a necessity in resuming healthcare to full capacity.

Methods: Analysis of the recovery periods of multiple disasters over the past decade, and in different geographical locations for loss of primary care capacity.

Results: Deficit of primary care providers during the recovery period, breach in continuity of care for many patients, and lack of clinic guidelines were all identified in varying degrees in each disaster examined.

Conclusion: Activating specialists in Family Medicine to assume the lead during the disaster recovery phase will preserve