

Results: Study results will inform prehospital service configuration to ensure safe and equitable patient management.

Conclusion: The data arising from this study will capture the full trauma patient journey. This data is essential to inform policy and practice for trauma care in Ireland.

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The Public Health Emergency Response Model of COVID-19 Pandemic in North-eastern Part of Thailand

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Introduction: The pandemic of COVID-19 in the northeastern part of Thailand established the response mechanism to COVID-19.

Method: This study aimed to explore the PHER model of the COVID-19 pandemic in three provinces located in northeastern Thailand. The target group was 78 people who were responsible for COVID-19 response from the sub-district, district, and provincial levels. The data was collected through in-depth and group interviews following the non-structure interview guide and data was analyzed by content analysis.

Results: Two levels of the PHER model were: 1) The response of the provincial level related to national and global situations. The provincial's measure of the COVID-19 response was run by the Provincial Communicable Disease Committee (PCDC) and followed by the COVID-19 Epidemic Administrative Center (CEAC). The core team was a public health subcommittee who ran the Emergency Operation Center (EOC) and COVID-19 pandemic. The PCDC launched the provincial measure, risk communication response to COVID-19, and issues of the pandemic from CEAC and EOC. 2) The response inside the provincial level two components of the structure were the PCDC and the PEOC and the district EOC. They composed the Situation Analysis Team (SAT) and Joint Investigation Team (JIT), which was an operation to surveillance, investigation, real-time situation and reported to PEOC and PCDC as the issues of measures decision. Thailand's identity of the PHER model was the village and sub-district on behalf of the Communicable Disease Control Unit (CDCU) and Community COVID-19 Respond Teams (CCRTs) in which members were Health Volunteer (HV), Village's leader, and Local organization. Core activities were screening the risky group and surveillance: Home or Local quarantine and Home isolation (HI) or community isolation (CI) of rehabilitation from Covid-19 post treatment.

Conclusion: The strengthening of PHER depended on the CCRTs and CDCU which supported the PEOC and PCDC to prevent and control Covid-19.

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Media Mortality Surveillance during Winter Storm Uri, United States – 2021

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Introduction: On February 13, 2021, Winter Storm Uri hit the United States beginning in the Pacific Northwest, heading across the central US, and eventually exiting on the East coast. By February 16, roughly 73% of the continental United States had snow coverage leading to ten million households without power. To understand the disaster-related causes and circumstances of death for Winter Storm Uri, we activated media mortality surveillance to help inform preparedness and response efforts.

Method: We searched the internet for key terms related to the winter storm, including storm name and type (e.g., winter storm), location-specific terms (e.g., state, county, city), mortality-related terms (e.g., death, mortality), cause of death (e.g., exposure, motor vehicle collision, carbon monoxide), along with other information learned from previous days (e.g., name of individual). We compiled and coded data into a standardized media mortality surveillance database and conducted descriptive statistics.

Results: Between February 13 and March 2, 2021, the media reported 136 storm-related deaths from nine states. The winter storm had the largest impact in Texas (n=91). Of decedents with sex data available (n=91), the majority (58%) were male. For decedents with age data available (n=93), the majority (91%) were adults. Exposure to extreme temperatures (47%) was the most common cause of death, followed by blunt force trauma (15%), CO poisoning (7%), and fire (7%). Roughly one-third of deaths (34%) were indirectly related to the winter storm with motor vehicle collision (13%) representing the top indirect circumstance. Twenty-six deaths (19%) have an unknown circumstance and cause of death.

Conclusion: This was the first time we activated media mortality surveillance for a winter storm providing timely data for public health action. Media mortality surveillance continues to be a useful tool in assessing the impact of a disaster and guiding response efforts.

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Improving Hazardous Material Incident Preparedness for Emergency Medicine Physician Trainees: A Quality Improvement Project

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Introduction: Hazardous materials (HazMat) training is not a requirement for accreditation of US Emergency Medicine (EM) residencies, nor for EM board certification by the American Board of Emergency Medicine (ABEM). However, the US Occupational Safety and Health Administration (OSHA) requires hospitals train all personnel expected to deal with contaminated patients. This QI project aimed to develop an EM physician-specific HazMat course and evaluate the physician comfort level with HazMat personal protective equipment (PPE) donning and doffing, triage, procedural skills, and decontamination.

Method: A four-hour “HazMat for Docs” course was designed at a large urban academic trauma center and offered to second-year EM residents. Additionally, we performed a quantitative survey of a cohort of 72 current and recently graduated EM residents (classes 2019–2024), some of whom had taken the course in person. Our primary outcome was to measure improvement in comfort level with essential HazMat tasks after completing the course. Our secondary outcome was to evaluate the current or recently graduated EM physician's overall comfort levels with managing a HazMat incident, as well as HazMat skills and knowledge retention.

Results: A total of 53 responses (73.6%) were obtained. 45.3% of the respondents were male and 54.7% female. 37.8% of the respondents were recent EM graduates, with 20.8% PGY-4, 13.2% PGY-3, 15.1% PGY-2, 13.2% PGY-1. 16/53 (30.2%) had prior EMS experience. EM Physicians were most comfortable with donning and doffing PPE (4.92 on a 7-point scale) and least comfortable with decontamination procedures (2.98/7). After completing the HazMat course, EM physicians increased their comfort level with HazMat decontamination procedures by 8.6% and with organizing a multi-disciplinary ED HazMat response by 10.5%.

Conclusion: EM Physician comfort levels with HazMat procedures are low. Increased training aimed at improving physician knowledge, preparedness, and comfort level for such events is necessary and can be accomplished through a short course.

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“Is Resilience Useful, Usable, and Used? Outlining the Social Characteristics of a Resilient System”

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Introduction: The COVID-19 pandemic has underlined the international priority to systemically operationalise resilience in the face of increasing prevalence of complex and cascading hazards. This concept paper identifies the components of a resilient society, establishing the usefulness and usability of

the application of ‘resilience’, and proposes the characteristics used by a resilient system.

Method: Through the review of case-based examples and previously published concept papers, this paper underwent a concept analysis to understand and qualify the characteristics of a resilient community. Through extensive research and critical analysis of disaster risk responses both effective and not, the authors condensed the literature to identify the key components of a resilient society.

Results: To respond to this evolving landscape of disaster risk, community and governmental responses should be collaborative in order to be successful and sustainable to increase resilience across communities, societies and networks. To unpick the complexity of how communities and governments might promote resilience effectively, we explore whether community and social capital are useful resources to create and sustain resilient approaches to disaster risk reduction and management. We consider that by exploring how social capital links, bridges and bonds actors within a system are qualitative key facets of a resilient community. A resilient system is the product of trust and collaboration between asset-based networks of bonded and bridged communities and risk and support-based networks of bonded and bridged organizations.

Conclusion: By evaluating the usefulness and usability of the concept, we consider that a resilient system is an iterative learning process, asset based, trusting across power and resource gradients and is best built before or even if essential during a crisis. Noting that resilience is a dynamic process which requires integrated collaboration and continual adjustment to develop a sustainable framework, we consider that social characteristics of a resilient system are useful, useable and should be used.

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Mass Hospital Evacuation During COVID-19 Pandemic: Experience of Hospital Cluster Infection in Taiwan

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Introduction: A mass hospital evacuation occurred in Taiwan in 2021 due to the clustered COVID-19 infection in Hospitals. To maintain essential services with limited manpower, 74 patients are triaged and evacuated to 12 hospitals in 6 cities in 16 hrs for further treatment.

Method: All patients were evaluated by physicians for discharge. The patients who still needed hospitalization were classified into three groups according to the risk of infection¹. The high-risk group of patients were cared for by infected staff directly; the moderate-risk group were patients admitted to the same ward but didn't receive care from infected staff. The low-risk group were patients avoiding infection outbreak. Only the low-risk group patients were transferred, excluding patients with unstable vital signs, hospice, and prison. Command Center of HICS of TGH set up a transfer execution team to handle this task.