

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

Peter Logan<sup>1</sup>, Carissa Oh<sup>2</sup>, Andrew Pearce<sup>3</sup>

1. National Hmimms Co-lead, National MIMMS Working Group, Brisbane/QLD/Australia
2. National Hmimms Co-lead, National MIMMS Working Group, Sydney/NSW/Australia
3. Chair, National MIMMS Working Group, Adelaide/Australia

**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

Sneha Chacko, Md<sup>1</sup>, Ritu R. Sarin<sup>1</sup>, Amalia Voskanyan<sup>1</sup>, Michael S. Molloy<sup>2</sup>, Gregory R. Ciottoni<sup>1</sup>

1. The Bidmc Fellowship In Disaster Medicine, Department of Emergency Medicine BIDMC, Boston/MA/United States of America
2. Department Of Emergency Medicine, BIDMC Fellowship in Disaster Medicine, Boston/MA/United States of America

**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