**Conclusion**: In Lebanon, burn care appears to be fragmented and heterogeneous. This is in addition to the fact, that the different parties (Army, EMT responders, physicians, etc.), that should sequentially be involved in addressing burn care, seem unsure of their role in the chain of command. Centralization of burn care by means of a national catastrophe burn plan would allow for a multi-disciplinary and coordinated approach, which is the only effective way of treating a burn victim.

*Prehosp Disaster Med* 2017;32(Suppl. 1):s22–s23
doi:10.1017/S1049023X17000796

## Patient and Family Reunification During Disasters - Hospital Perspectives and Process Improvements, Boston, MA

*David Reisman, Alison Parmar, Paul Biddinger*
Center For Disaster Medicine, Massachusetts General Hospital, Boston/MA/United States of America

**Study/Objective**: Patient and family reunification during and after disasters requires thoughtful, innovative planning by hospitals. A clear and practiced Family Response Protocol ensures that in addition to providing clinical care for patients injured in disasters, hospitals are prepared to rapidly and effectively reunite patients with their loved ones.
**Background**: The Massachusetts General Hospital (MGH) Family Response Protocol is informed by our experience responding to multiple mass casualty events, including the Station Nightclub Fire in 2003 and the Boston Marathon Bombings in 2013. Our experience in these events identified the need to quickly mobilize trained patient/family support teams as part of our mass casualty disaster response, and to implement mechanisms to support patients and families at our hospital, as well as those looking for loved ones located at other hospitals in the area. The key tenant of the protocol is to connect patients, family members and friends of victims with the most appropriate resources to meet their needs. Multidisciplinary in nature, the Family Response Protocol leverages the expertise of leaders in psychiatric care, social services and emergency management as well as hospital security and support personnel.
**Methods**: Our strategy and protocol for patient/family reunification is based on our experiences responding to several mass casualty events, and internal review of event data from other responses.
**Results**: A well exercised Family Response Protocol focused on supporting patients and families post disaster, is a critical component of the hospital Emergency Operations Plan.
**Conclusion**: Our presentation will discuss best practices in hospital patient/family reunification post disaster. Using case studies from our experiences responding to the 2003 Station Nightclub Fire and the 2013 Boston Marathon Bombings. We will explain how key aspects of the plan were used in each event, and identify critical improvements implemented based on lessons learned.

*Prehosp Disaster Med* 2017;32(Suppl. 1):s23
doi:10.1017/S1049023X17000802

## Communication: The Antidote to Chaos during a Mass Casualty Event

*Alison Parmar, David Reisman, Paul D. Biddinger*
Center For Disaster Medicine, Massachusetts General Hospital, Boston/MA/United States of America

**Study/Objective**: Mass Casualty Incidents (MCI) typically occur without warning, unfold rapidly and unpredictably, creating a chaotic environment. The lack of advanced notice and the nearly-ubiquitous lack of good situational awareness regarding the early event details, creates major challenges for hospitals and health systems in their response, often resulting in suboptimal mobilization and/or use of resources.
**Background**: The initial development of the MGH MCI Protocol in 2010, was formed by lessons learned from terrorist, and other mass casualty events, in Israel, London, Madrid, Mumbai, and others. The MGH MCI protocol has been updated and refined following critical evaluation of our own response to the 2013 Boston Marathon bombing, and other less severe events. Our experiences have confirmed the importance of setting clear expectations for a large number of hospital departments outside of the Emergency Department upon identification of an MCI. Setting clear and actionable responsibilities for the operating rooms, ICUs, blood bank, radiology, and even internal medicine services in the hospital, has helped us ensure a rapid, coordinated response to no notice events that supports the safe and efficient movement of patients through the hospital.
**Methods**: Our findings are based on a review of published, and informally shared event data, as well as on our own experience in the Boston Marathon bombing of 2013.
**Results**: We believe that a comprehensive and detailed hospital-wide protocol to proscribe the initial hospital MCI response actions is a required component of an optimal response.
**Conclusion**: We will present an overview of the collaborative process that we used to develop our MCI Protocol and discuss examples of its use. We will also give session participants a template to create their own MCI Response Protocol for their Emergency Operations Plan, and present strategies for use when developing such a protocol that is appropriate for the capabilities of their hospital and setting.

*Prehosp Disaster Med* 2017;32(Suppl. 1):s23
doi:10.1017/S1049023X17000814

## Airport Aviation Disaster Patient Transfer Point Lifesaving Enhancement

*Eli Jaffe, Itamar Abramovich, Sassi Mohadeb, Roman Sonkin*
Community Outreach, Magen David Adom in Israel, Tel Aviv Jaffo/Israel

**Study/Objective**: Comparison between the means of voice reporting messaging apps and a dedicated app for counting, tracking, and decision-making in the transfer point out during aviation airport disasters.
**Background**: In Israel, the medical preparedness and response to aviation disaster events is the responsibility of Magen David Adom (MDA), the Israeli national EMS organization.

Preparedness is comprised of a response plan which is taught in basic EMS training and practiced a few times each year. The response is based on shift ambulances, Mobile Intensive Care Units (MICU), and volunteer first responders. This article proposes to study the phase which occurs after authorization by the fire department, extraction of the patients, and first triage and treatment that includes secondary triage and allocation of the patient to the appropriate transporting vehicle, with the appropriate medical team for transportation to the hospital, with consideration of injury types and severity. The departure site facilitators conduct secondary triage, ensure the proper medical team and vehicle, and report quantity of injured and severity to the receiving destination hospital.

**Methods**: MDA is using a departure dispatch site to make secondary triage and transportation decisions. MDA conducted a drill to compare the efficiency between the use of a dedicated app for report and decision making and the use of a smartphone messaging app that allows recording of times and voice recording.

**Results**: Data were extracted from both apps and compared as to time intervals, report quality, apprehension of the dispatch center, and decisions made by the dispatch center. The data were compared with consideration of data from the records of MDA representative in the receiving hospitals which records arrival of ambulances, number of injured, and injury types.

**Conclusion**: The messaging app allowed for quicker apprehension by the dispatch, higher quality of report, and quicker and better decisions as to the destination hospital.

*Prehosp Disaster Med* 2017;32(Suppl. 1):s23–s24
doi:10.1017/S1049023X17000826

## Pediatrics for the Non-Pediatric Provider: Kids are Just Small Adults

*Vicki L. Sakata*
Senior Medical Advisor, Northwest Healthcare Response Network, Tukwila/WA/United States of America

**Study/Objective**: 1. Provide an overview of pediatric emergency care in the US, emphasizing the fact that most children are seen in non-pediatric facilities. 2. Describe various tools available to reduce cognitive load and error when caring for children. 3. Describe the Northwest Healthcare Response Network's (NWHRN) regional Hospital Toolkit for Managing Pediatric Patients in Disaster, and the statewide trainings developed as a result.

**Background**: Children under the age of 18 represent approximately 25% of the total US population. Many metropolitan areas have specialized Children's Hospitals. However, studies show that the majority of pediatric ER visits are made to non-pediatric hospitals[1]. Therefore, pediatric specialists must continue training and engaging their non-pediatric colleagues. Initial stabilization of a child can be done by *any* non-pediatric emergency provider. The NWHRN has developed tools and trainings for non-pediatricians, and over the past 3 years has taught throughout Washington state.

**Methods**: The NWHRN is a healthcare coalition representing the 2 largest counties in Washington state. We developed a regional Hospital Pediatric Toolkit specifically for non-pediatric hospitals.[2] We then created half-day workshops incorporating hands-on skills sessions. Participant evaluations are reviewed and used to improve and develop new trainings.

**Results**: The NWHRN Pediatric Toolkit received the 2010 NACCHO Model Practice Award (National Association of County and City Health Officials (NACCHO)). Since then eleven different hands-on pediatric training sessions have been developed. Participant evaluations have "strongly agreed" that these sessions are "valuable" and "useful learning aids". The demand for trainings continues. We have also shared these products with our colleagues in Oregon through a "Train the Trainer" Workshop. Oregon has successfully completed 2 workshops in their state.

**Conclusion**: Pediatric emergency care and disaster preparedness should be an everyday priority in all healthcare facilities. There are several tools available to help non-pediatric providers plan and train for the pediatric patient. Hands-on sessions have been a valuable training tool. [1]Gausche-Hill, M, et al, JAMA Pediatr. 2015;169(6): 527-534. doi:10.1001/jamapediatrics.2015.138 [2]www.nwhrn.org/all-documents/hospital-guidelines-for-managing-pediatric-patients-in-a-disaster/

*Prehosp Disaster Med* 2017;32(Suppl. 1):s24
doi:10.1017/S1049023X17000838

## Development and Application of an Educational Program for Medical Disaster Health Coordinators in an Earthquake and Tsunami Prone Area of Japan

*Taichi Takeda*
Center For Disaster Medicine, Mie University Hospital, Tsu-city, Mie/Japan

**Study/Objective**: We have developed and implemented an educational program for medical professionals in an earthquake and tsunami prone area of Japan, in order to provide training on the competencies needed by medical and disaster health coordinators to run a cluster meeting.

**Background**: Major earthquakes with a magnitude of 8.0-9.0 are anticipated to occur on the southern coast of Japan. Most part of Mie Prefecture would likely be damaged severely by tsunami and landslides. We need to foster medical and disaster health coordinators who could serve the area's Health Emergency Management Service.

**Methods**: We have developed a 4-hour program for the coordinators, that includes 2-hour didactic lectures and 2-hour tabletop exercises, which will be organized by the local government. The educational contents include practical procedures necessary to function as a disaster health and medical coordinator; ie, registering and dispatching medical teams and public health teams, analyzing and assessing situations in order to plan further response to a disaster, and organizing health cluster meetings. The tabletop exercise simulates disaster response in the area where the program is conducted. It requires participants to utilize the cluster meetings to share information and dispatch each team to rescue sites, shelters and/or facilities for medical and health support. The program evaluation by the participants was anonymously conducted using a questionnaire.