

(P2-77) The Unique Role of Emergency Medical Services (EMS) in an Earthquake – A Community Based Approach*E. Jaffe,¹ S. Ben-zvi²*

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Introduction: Timely actions can facilitate the efficacy of Emergency Medical Services (EMS) response in disaster by understanding the scale of event and shifting of traditional tasks. A simple scaling system of earthquakes/disasters by ABC is proposed: Level A treated by the local EMS. One or more Multi Casualty Incident's (MCI) in a defined geographical area that can easily be Level B hours, by reinforcement of regional and national aid coordinated by automatic autonomic response. An earthquake/disaster where the EMS and medical community can complete their task within 48 Level C - An earthquake/disaster that even joint national forces cannot eliminate within 48 hours.

Methods: Information from medical systems around the world was gathered to help develop strategies to minimize the weaknesses whilst achieving the objectives of the EMS via adapting to shifting conditions.

Results: EMS goal is to provide treatment to those in need of urgent medical care and arrange for timely transfer of the patient to definitive care. EMS are not qualified or equipped to delay victims in the field for hours or days. However, many patients in earthquakes do not require definitive treatment or have an immediate lifethreatening.

Conclusion: By scaling the event by the ABC - a timely coordinated autonomic regional / national response can begin immediately. An area defined as level A will automatically back-up a level B/C area, in an event that the standard communication and activation systems collapse. Moreover, a clear shift in EMS roles will take place in a level B or C events. Available-Hours Busy-48-Hours Catastrophe-weeks Types of Levels area for delaying evacuation. Prioritizing, sorting and sending patients that require immediate attention to definitive care whilst considering availability of destination facilities and transportation resources. Patients that do not require immediate attention or cannot be saved shall await evacuation.

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(P2-78) Creating Alternate Care Sites and Community-Based Care Centers for the Delivery of Medical Care During Public Health Emergencies*M. Reilly*

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Introduction: Developing alternative systems to deliver emergency health services during a pandemic or public health emergency is essential to preserving the operation of acute care hospitals and the overall health care infrastructure. Alternate care sites or community-based care centers which can serve as areas for primary screening and triage or short-term medical treatment can assist in diverting non-acute patients from hospital emergency departments and manage non-life threatening illnesses in a systematic and efficient manner. Additionally, if planned for correctly these facilities can also be used to decant

less critical patients from inpatient wards thereby increasing the surge capacity of acute care hospitals.

Methods: A model concept of operations plan for alternate care sites to be used during pandemics and large-scale public health emergencies was developed over a 3 year period, 2007–2010. Subject matter experts were convened and best-practice methods were used to design operational plans, clinical protocols, modified standards of care, and checklists for facilities appropriate to locate such a facility. This model plan was designed to allow the mild to moderately ill patient to be managed in a non-acute care hospital or community-based care setting and then ultimately return to their homes for convalescence, following a public health emergency where regional surge capacity had been exceeded.

Results: Over three years of interagency, comprehensive planning, training and review was conducted to create the model alternate care site/community-based care center concept of operations plan. Accomplishments and milestones included: Creating stakeholders, engaging community partners, site selection, staffing issues, detailed medical protocols and clinical pathways, functional role development, equipment and supplies, site security, media and communications plans, designing training programs and conducting drills and exercises.

Conclusion: The key tenets of the concept, planning, operation and demobilization of an alternate care site or community-based care center will be discussed in this session. Participants will learn what has worked based on our planning experience. Lessons learned and best-practices developed in our program will be presented to assist attendees in beginning or continuing the process of creating surge capacity in the out-of-hospital setting, by planning to operate alternate care sites in their local areas.

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(P2-78a) Feasibility and Safety of Ultrasonography-Guided Nerve Blocks Performed by Emergency Physicians in the Emergency Department*S. Bhoi,¹ T.P. Sinha,² M. Rodha,² A. Bhasin³*

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Background: Emergency physicians often encounter patients who require procedural sedation and analgesia (PSA) for the treatment of acute traumatic injuries like fracture reduction, joint dislocation reduction, wound care, and pain relief. Its complications include airway or circulatory compromise. Ultrasound (US) guided peripheral nerve block is a safe alternative that utilizes minimal amounts of local anesthetic and does not require hemodynamic monitoring or prolonged post-procedure observation.

Objective: The objective of this study is to determine the feasibility and safety of ultrasonography-guided nerve blocks, performed by emergency physicians.

Methods: A prospective study involving 28 patients > 12 years of age presenting to an emergency department (ED) were recruited after informed consent. Ultrasonography-guided nerve blocks were performed by emergency physicians who underwent a