1. Member, Work Group, Minimum Technical Standards And Recommendations For Rehabilitation For Emergency Medical Teams' Guidance Document, World Health Organization, Geneva/Switzerland
2. Lead, Work Group, 'minimum Technical Standards And Recommendations For Rehabilitation For Emergency Medical Teams' Guidance Document, World Health Organization, Geneva/Switzerland

Study/Objective: To disseminate the development and use to date, of the WHO 'Minimum Technical Standards and Recommendations for Rehabilitation for Emergency Medical Teams' guidance document (e-publication expected December 2016).
Background: The World Health Organization (WHO) Emergency Medical Team (EMT) initiative, supports populations severely impacted by large-scale catastrophic disasters by ensuring a rapid, professional, coordinated medical response by national and international teams. Physical rehabilitation has become increasingly recognized as an essential health component of the medical response in disasters, due to the humanitarian imperative to limit long-term disability, and optimize functional outcomes in persons sustaining severe traumatic injuries (and infectious disease outbreak sequelae). The WHO 'Minimum Technical Standards and Recommendations for Rehabilitation for Emergency Medical Teams' was developed to provide guidance for integrating rehabilitation capacity into EMTs, and hence the global humanitarian medical response.
Methods: Guidance document development was a highly consultative process hosted by WHO involving global experts from the rehabilitation field, including operational rehabilitation from International Non-Governmental Organizations (INGOs), international professional rehabilitation societies, and individuals.
Results: The WHO 'Minimum Technical Standards and Recommendations for Rehabilitation for Emergency Medical Teams' guidance document draft, is available on the WHO EMT Initiative extranet, with the official e-publication anticipated in December 2016. The minimal technical standards for rehabilitation have been incorporated into the verification process undergone by EMTs, to qualify for global classification. It is expected that use of the minimum standards and recommendations will result in expanded, quicker access of patients to rehabilitation services (and equipment) in disasters, as well as improved referrals between EMTs and local health facilities for ongoing rehabilitation service provision - translating to increased near-term functional outcomes and reduced long-term disability for affected persons.
Conclusion: In conclusion, the WHO 'Minimum Technical Standards and Recommendations for Rehabilitation for Emergency Medical Teams' guidance document establishes minimum standards for rehabilitation to increase the rehabilitation capacity of EMTs in disasters (and outbreaks).
Prehosp Disaster Med 2017;32(Suppl. 1):s91-s92
doi:10.1017/S1049023X17002370

International Emergency Medical Teams in the Russian Federation

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Study/Objective: To show the tools and tasks of Emergency medical teams in the Russian Federation.
Background: International experience of a national Mobile Field Hospital in the Russian Federation (RF) is very large (Columbia, Turkey, Iran, China, Afghanistan, Chile, etc). The Task of this presentation is not to show the procedures of WHO in step-by-step certification of International Emergency Medical Teams, but rather how this processing was created in the Russian Federation.
Methods: Procedure analysis.
Results: 1. In Civil Law Code there is a special legislative article, supported by some part of the state budget, for humanitarians, free of charge assistance delivery for the injured in emergencies anywhere. 2. Medical emergency relief in all aspects is never connected to policy, politics, confession, economical status of patient, etc. Protocols and Standards are the same to everyone injured independently upon his social position. 3. Every central hospital or specialized clinic has bed reserves (5%) if any emergency occurs. 4. All the system of Emergency Medical Care in RF has its satellite network, and taking it into account, could connect all the medical facilities and register of specialists into one competent and powerful telemedicine framework. 5. The system has mobile field hospitals, portable modern equipment, and staff prepared who are regularly educated and trained. 6. The system is strictly organized, centralized vertically, and is under the management of the RF Health Ministry, 7. The system is strictly territorially organized and has more than 80 territorial and regional units (centers). In such a way, all Russian Disaster Medicine Centers 'Zaschita' (Protection) have become one of the first in the great number of medical facilities amidst many WHO member-countries who satisfies the requirements of WHO procedures of certification.
Conclusion: Tasks of the internal emergency medical teams of RF, Disaster Medicine Centre 'Zaschita', as a collaborating WHO disaster medicine center, are presented and discussed.
Prehosp Disaster Med 2017;32(Suppl. 1):s92
doi:10.1017/S1049023X17002382

Learning from Canadian Red Cross International Health Team Deployments: Understanding Individual and Institutional Competencies that would be Beneficial to a Canadian Domestic Response

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Study/Objective: To determine the types of individual/institutional competencies/skills that are obtained from working with the Canadian Red Cross (CRC) International

Emergency Response Unit (ERU) that can be applied to a domestic context in Canada.
Background: The Canadian Red Cross has extensive experience working in international settings, both in disaster and development. The ERU of the CRC is a health emergency unit that can respond to international humanitarian disasters, either in the form of basic primary care health services or as a field hospital. Much institutional and individual knowledge and skills have been obtained over years of working in these contexts. We hypothesize that there is a large amount of knowledge and skills that have been learned, that could easily be applied to the Canadian domestic context, but this has never formally been studied.
Methods: Qualitative methodology: Key informant and semi-structured in-depth interviews. Aim for a diversity of perspectives and in-depth accounts. Sampling and recruitment: Purposive/snowball sampling strategies. Participants will include a diversity of professional backgrounds, ERU HCPs (nurses, physicians, mental health, surgeons, anesthetists), ERU team/deputy leaders, logisticians, technicians, security managers, and other CRC managers/directors involved in the deployment of health ERU. Data collection: Experienced research assistants will conduct the interviews by Skype, telephone, or in person. Interviews will be audio-recorded (with consent) and are expected to last 30-45 minutes. All interviews will be transcribed. Demographic information: age range, gender, number of years working in humanitarian settings, role collected.
Results: Analysis: Three team members will independently code the interviews based on a pre-developed code sheet. Key overarching themes developed. Results: Will be discussed in terms of themes/lessons learned. Discussion will include next steps for integrating this knowledge at the domestic level.
Conclusion: Hypothesis: Individual and institutional skills/knowledge/capacities that are acquired through international ERU deployment have application in the Canadian domestic realm.

Prehosp Disaster Med 2017;32(Suppl. 1):s92-s93
doi:10.1017/S1049023X17002394

Psychological Fitness for Deployment: Personality as a Predictor of Performance

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Study/Objective: To predict peer-evaluated performance of deployed AusMAT members from personality and psychological well-being.
Background: Disaster response personnel are typically selected on the basis of professional training and qualifications. These criteria contribute to the 'can do' component of performance. The 'will do' component incorporating performance quality and interpersonal effectiveness is generally assessed subjectively. Australian Medical Assistance Team (AusMAT) examined the role of the Five-Factor Model (FFM) personality factors and psychological wellbeing in predicting performance of medical and logistics personnel as measured by peer evaluation.
Methods: During the annual Tour de Timor event in 2016, twenty-three AUSMAT personnel completed the NEO Personality Inventory – 3 (Costa & McCrae, 2010) and the MH30 Mental Health Screen (Response Psychological Services, 2008). Performance criteria were obtained through peer evaluations submitted during deployment, via the online PES50 Peer Evaluation Schedule (Response Psychological Services, 2010). Anonymous data was used to explore the relationship between personality factors and peer-evaluated performance.
Results: Low scores on the personality facet Tender-mindedness and high scores on the facet Order were valid predictors of peer-evaluated performance. Order predicted almost 90% of the variance in the performance criterion, while tender-mindedness predicted almost 50%. Many other directional relationships were observed between both personality and mental well-being with the performance criterion.
Conclusion: AusMAT personnel who demonstrated a realistic, rational and in some ways very clinical approach were rated more favorably by their peers across multiple criteria of deployment performance. AusMAT Logisticians who maintain flexibility while adhering to standards and process more so than their peers are rated very favorably. Establishing a performance baseline measure using peer evaluation enabled improved self-other awareness during the deployment, and provided participants with detailed feedback for self-development. The proportion of variance explained, suggests significant potential for the use of personality measures in AusMAT selection.

Prehosp Disaster Med 2017;32(Suppl. 1):s93
doi:10.1017/S1049023X17002400

Emergency Medical Services during Mass Casualty Incidents (MCIs) - Challenges and Proposed Policies

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Study/Objective: To identify consensus-based policies that could be adopted by world-wide Emergency Medical Services' (EMS) to manage mass-casualty incidents (MCIs).
Background: Medical management in MCIs is often characterized by challenges, such as lack of available resources, insufficient cooperation between first responders, inability to protect personnel, etc. As such challenges are common to EMS services world-wide, there is a need to identify policies applicable to the varied entities.
Methods: Twenty-one challenges concerning EMS' operation during MCIs were identified. Potential policies to effectively address challenges were disseminated to 38 experts from ten countries. Two cycles of a modified e-Delphi process were conducted; participants were requested to agree/disagree to endorse the policies based on a five-point Likert scale. Policies endorsed by ≥80% of participants were adopted for EMS use during MCIs. Policies that did not achieve consensus were reviewed to identify differences according to experts' country of origin.
Results: Seventy-six percent (16/21) of proposed policies were endorsed in the first e-Delphi cycle. Four were endorsed by