

assumes an information deficit among the people; ergo, risk communicators operate under the assumption that by increasing awareness of risks, sufficient motivation can be generated for preparedness behavior. Yet, this is far from being true.

A growing body of literature indicates the prevalence of fear-directed preparedness behavior, which is suboptimal in motivating behavioral change. This should come as no surprise, as using fear appeal tactics in risk communication designed to promote health behaviors have been proven to be primarily a failure.

Arguably, the phenomenon of failed risk communication campaigns could be linked to unconscious concerns about death, as proposed in the context of the Terror-Management Theory (TMT). According to TMT, since the experience of death-related thoughts triggers the potential for anxiety, the human psyche responds with motivated avoidance. In other words, the mind utilizes mechanisms that prevent death from becoming salient and remove death-related thoughts from focal attention when they arise. In turn, these defense mechanisms may yield procrastination in adopting protective behavior generated by denial as an adaptive coping mechanism.

Preliminary data suggest that procrastination in preparedness behavior until the threat becomes actual and imminent might be explained by TMT; however, explicit evidence for this association is yet to be provided. Should this understanding of the phenomenon be substantiated, it could significantly contribute to expanding our knowledge of the theoretical model behind public preparedness behavior.

The presentation will discuss the state-of-the-art research currently being done by the author to support the above claims. It will provide preliminary findings and will call the community to reconsider the current paradigm of disaster risk reduction and risk communication.

Method: n/a

Results: n/a

Conclusion: n/a

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Improving Hospital Incident Command Organizational Structures

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Introduction: The current Incident Command System (ICS) was developed to manage wildland fires, then was adopted by general firefighting. It has since been adapted to multiple other sectors and widely used. The Hospital Emergency Incident Command (HICS) was introduced in 1991. An ICS currently is required to be used for hospital incident management in the US.

The overarching structure of traditional HICS consists of Command Staff (Incident Commander, Public Information Officer, Safety Officer, Liaison Officer and Medical/Technical Specialist) and General Staff. The General Staff

has Sections consisting of Operations, Planning, Logistics and Finance/Administration. Multiple and flexible subgroups carry out the processes in these areas.

This HICS structure does not adapt easily to hospital daily functions and alternatives have been proposed. This includes structuring around essential functions and mixed models. Over time hospital systems have become larger, and incidents more complex and sustained. New more expansive and flexible ICS structures are needed for complex responses.

Method: We reviewed both the published and grey literature for examples of different incident management structures and evidence of their effectiveness.

Results: There is very little scientific literature on this topic. Several different descriptive reports exist. Multiple examples of hospital incident command organization structures from the hospital level progressing to hospital (and healthcare) system level and then multistate regional models will be reviewed. This includes the standard HICS model, emergency support function models and modifications following advanced ICS principles such as area command.

Conclusion: Different ICS models exist that may offer individual healthcare systems improved ways to manage disasters.

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NO FEAR–Better Integrating Healthcare Into Crisis Management Structures

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Introduction: Since the beginning of the COVID 19 pandemic, the EU-funded project, NO FEAR collected lessons observed from the response. One of the issues raised in the retrospective “lessons observed” exercise, was the need to better integrate health care into “crisis management structures” (e.g. Civil Protection).

Method: Lessons observed from the COVID-19 response were collected and analyzed by the NO FEAR project, through a questionnaire, discussion with consortium partners, and a large conference in Madrid, with a high-level briefing for policymakers.

Results: During the Madrid conference, different speakers pointed out the lack of training for healthcare professionals in crisis management (processes and procedures)—except those with military training or EMS officers who are part of Fire and Rescue Services. In a same manner, crisis managers have very little (if any) training in health. This was identified as a gap in future preparedness.

Conclusion: Looking into the future, healthcare professionals who will be called to take part in crisis management systems have to be trained in this task, as well as basic awareness of crisis managers to health issues in emergencies.

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