

ment before and after simulated exercises. The study sample consisted of 45 undergraduate nursing students enrolled in a disaster management course. Content areas included types of disaster agents, nursing roles, and care of victims during a disaster event involving various lethal exposures and the use of appropriate personal protective equipment.

Results: Mean and standard deviation values for pre and post simulation were 77 (4.04) and 86 (3.33) respectively. A one-sample *t*-test showed a statistically significant difference between pre and post simulation mean scores ($p < 0.001$). About 65% of students ($n = 30$) reported increased confidence in prioritizing care and performance of clinical skills after simulated experiences. Improved accuracy in the utilization of personal protective equipment also was reported.

Conclusion: Simulation experiences may enhance learning among undergraduate students in disaster management courses. During simulation, students acquire and improve clinical skills, critical thinking, and decision-making in a safe environment.

Keywords: disaster management; education; nurses; simulation; training

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Strengthening the Survival Chain in Disasters: Development of an Incident Medical Assistance Team

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Introduction: The Vermont Department of Health and Fletcher Allen Health Care have supported the development of an Incident Medical Assistance Team (IMAT) as a locally available, medically trained, incident response team. Within this framework, tactical medical response teams will be mobilized to incidents in which a field medical response unit or advanced medical practice team may augment the overall emergency response.

Objective: This presentation describes the development of an IMAT in Vermont.

Methods: Descriptive information was obtained from observations and records associated with this project.

Results: The IMAT was developed in four stages:

1. the initial idea was drafted, a field operations guide and equipment list were generated, and funding was applied for;
2. upon receipt of the first grant funds, initial equipment was purchased and recruitment of personnel began;
3. the field operations guide was revised, protocols were produced, team training took place, and additional equipment and supplies were purchased with continued grant funding; and
4. the IMAT was readied for deployment and systems and protocols underwent continuous re-evaluation.

Ultimately, three teams were developed with nine members each, including physicians, nurses, and emergency medical technicians at various certification levels. Each team is deployable within 90 minutes of notification.

The teams share a response vehicle, a trailer that stores a tent (inflatable in two minutes), a generator, 10 litters, ventilators, multiparameter monitor, various medical equipment, and medications. The next step is for the IMAT to beta-test its response at a mass casualty incident drill in autumn 2005.

Conclusion: By guaranteeing a physician is available in the field during a disaster, the IMAT provides an important link between emergency medical services and the emergency department and hospital trauma services, which may increase the chance of patient survival.

Keywords: disaster; emergency department; emergency medical services; incident medical assistance team; physician

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Is Our Health Protected? A Connecticut Panel Tells All

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Introduction: The terrorist attacks on 11 September 2001, and the terrorist anthrax letter attacks in October 2001 were critical in reshaping the US approach to emergency preparedness and response capability. To meet this challenge, Connecticut's public health community has changed its readiness capacity and infrastructure significantly. As a result, Connecticut's public health system has been improved and buttressed.

Objectives: This panel presentation will describe: (1) emergency readiness in the public health arena; (2) infrastructure change in Connecticut's public health emergency response system; and (3) how challenges in these processes were addressed in four Connecticut jurisdictions.

Other topics to be discussed include: (1) issues of encompassing health policy, legislation, funding, and government priorities; (2) the impact of the legislature, funding, state/local priorities, bioterrorism, and citizens on the process; (3) key legislation, funding, community priorities, and leadership challenges on this unique process; (4) community-wide priorities during this period and the unique involvement of a statewide professional health organization in the Connecticut experience; (5) planning and preparedness efforts for public health emergency response that have been taken throughout the state; (6) the strengthening of Connecticut's public health infrastructure; (7) competing interests and inter-agency relationships in accordance with this process; and (8) how advocacy, funding, legislation, and the threat of emergency/terrorism can propel public community priority and attention toward public health infrastructure enhancement. In addition, the alteration and reformation that the Connecticut public health system has experienced over the past three years will be reviewed from a community/region/state viewpoint in the context of addressing public health emergencies and threats.