

(CDC) and RTI International designed a study to mitigate these issues by surveying within weeks of a natural disaster to examine associations of preparedness to peri-event exposures, emergency services, and health.

Method: Given the unpredictability of natural disasters, a significant challenge for the team was to plan a rigorous study design applicable to several types of severe weather events. This presentation will review our forethought, planning, and resulting strategy, including important considerations related to IRB and OMB applications with unspecified disaster/location details. We will share decision-making on sampling, instrumentation, communication materials, and multi-mode data collection procedures. The impact of delays due to COVID-19 and waiting to select a disaster that met a prior disaster inclusion/exclusion criteria will also be presented.

Results: Results are forthcoming. We will present details on RTP's 2022 survey implementation in the Fort Myers area of Florida within weeks of Hurricane Ian landfall including information on our final sampling strategy, field period, and outcome rates among key community groups and exposures.

Conclusion: Conclusions will be presented. Pragmatic lessons learned related to timeline, labor, and other resources will be used to compare our strategy to rapid needs assessment methodology as well as more typical self-report surveys with later post-disaster data collection periods. Researchers working in emergency preparedness/response and disaster epidemiology will have gained a solid understanding of the advantages and disadvantages to planning studies for the immediate aftermath of undefined disasters.

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Quarantine Facility Model of Care Toolbox

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Introduction: The COVID-19 pandemic public health strategy to reduce community transmission in Australia included unprecedented use of quarantine facilities to separate those at risk and those with the infection from the rest of the community. No standardized approach to quarantine facilities existed resulting in different models of care emerging across the country. The Northern Territory Howard Springs Quarantine Facility was a large-scale quarantine and isolation operation which hosted over 33,000 domestic and international arrivals with zero COVID-19 transmission recorded from residents to staff for the duration of its operation. The facility was deemed the gold standard model of care and the aim of this project was to distill the important elements of that model of care into an evidence-based tool kit for future use as an open access, online resource. The toolkit was a result of intense data and information analysis including resident, staff and leadership surveys, policies and procedures and results of audits of the facility during its operation.

Method: This project to develop an online, open access evidence-based toolkit forms part of the Translational Research to Improve Health Outcomes project funded by the Australian Government's Medical Research Future Fund. The methodology included mixed methods with an underpinning grounded theory approach to analyze de-identified audit data and information from the quarantine and isolation facility operational period. Staff and leadership team surveys were conducted to explore experiences of site functions and infrastructure. A (non-experimental) descriptive design allowed collation and statistical analysis of information recognizing the variables in the data and information.

Results: The toolbox includes a resident centered quarantine care model, infection, prevention and control strategies for health professionals and non-health staff, quarantine communication model and presentation of core challenges (rapid recruitment, environmental factors, workforce resilience).

Conclusion: The resulting online web resource presents evidence-based core strategies and resources for implementation in future pandemics.

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A Characterization of the Burden from Mandated COVID-19 Public Health Reporting on a Small Independent Hospital in New York City

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Introduction: Public health agencies' ability to monitor outbreaks requires government mandated reporting from health-care institutions, with consequences for noncompliance. This study aims to characterize the burden on acute care hospitals from government reporting requirements during COVID-19 pandemic.

Method: A retrospective study over a 14-month period (April 27th, 2020 to June 10th, 2021) during the COVID-19 pandemic examining the log of changes and requirements of the Health and Human Services (HHS) Teletracking, an online system for hospital reporting. We interviewed 33 individuals including hospital leadership, clinical directors, and infection control personnel in a New York City (NYC) small independent hospital (SIH).

Results: During the study period, reporting requirements increased from five daily reports to 29 daily reports across eleven different agencies, all with separate reporting systems. Reporting schedules varied from several times a day to intermittently. Typically, new reporting requirements were conveyed to institutional contacts at 8 AM with a required deadline of 1 PM the same day. The continuous changes reportedly made it difficult to develop stable data gathering and workflow processes. There was a reported lack of clarity around new data elements' definitions and different agencies employed different variables for the same measure. There were hospital penalties for missing

