pitalization, and a lack of community-based care.1 To address these concerns, the Southside Medical Homes (SMH) network began linking emergency department-patients with 18 community providers in 2004. The emergency department-based patient navigator is an integral component of this network. This study will illustrate the current and developing role of the emergency department-based patient navigatorr.

Methods: Six navigators at the UCH Emergency Department approached eligible patients flagged by the emergency department electronic tracking system. Patients were offered primary-care referral and treatment at appropriate dental, mental health, and substance abuse facilities. Appointments were scheduled, and pertinent emergency department medical data were faxed to the outlying sites. Navigator roles are expanding with SMH to include: (1) a focus on frequent user/chronic disease populations, such as sickle cell disease where advocates will expedite multidisciplinary clinical referral; (2) training to better inform patients about the specific benefits a "medical home" provides for preventive and psychosocial care; and (3) improvements to navigator and patient knowledge of community resources, such as health-education sites, vocational programs, advocacy agencies, and support groups.

Results: During the first eight months of 2006, 30% (11,612) of the emergency department patients were without a medical home, 2,279 appointments were made, and 816 were kept at the emergency department. The SMH network data demonstrate that patients return to their referred providers (38% of the patients have been seen ≥2 times).

Conclusions: The role of an emergency department-based patient navigatorr is evolving with the expansion of SMH to include: frequent-user population referrals, preventive health education, and utilization of community resources.

Reference:

1. Chicago Department of Public Health: Community Area Health Inventory, Part 1: Demographic and Health Profiles (July 2006). Available at http://egov.cityofchicago.org/webportal/COCWebPortal/COC_EDITORIAL/CAHI_part1.pdf.

Keywords: advocate; Chicago; emergency departments; medical homes; patient navigators

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(217) Health and Welfare for Emergency Personnel in Major Disasters

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This presentation will define the requirements of an aid operation after an analysis of the principal characteristics of disasters. The conditions of emergency personnel and assistance teams will be described through practical experiences (tsunamis, forest fires, and earthquakes). The skills of the personnel and managerial staff will be analyzed, along with problems with security and safety. The physical, psychological, medical, and material aspects of security and safety have declined. In this presentation, the conditions resulting from conserving an operational workforce, action capacity, and mission target will be explained. The responsibilities of the team leader, risk manager, and chief medical officer will be defined. The principal conditions of a successful mission are: (1) sanitation; (2) medical support; (3) housing; (4) restoration and catering; (5) camp hygiene; and (6) lifestyle. The goal of an effective assistance program (physical and psychosocial) and the economic cost of not caring for personnel who provide services during and after disasters will be demonstrated.

Keywords: care programs; disasters; emergency assistance; emergency personnel; safety

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(218) Are Belgian Hospitals Prepared for a H5N1-Pandemic?

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Objective: Virulent airborne diseases can be a real burden to a nation's health system. The most recent threat is that of a mutation-induced H5N1-influenza pandemic. We studied whether Belgian hospitals are able to deal with H5N1-influenza infected patients in the case of a pandemic. Many patients, including children, may require artificial ventilation within 48 hours of admission.

Methods: A survey aimed at determining availability and preparedness was sent by e-mail to the different Belgian Emergency Departments (EDs).

Results and Discussion: Sixty-five hospitals were included. The number of patients being potentially admitted is limited by the reduced number of intensive-care beds equipped with automatic ventilators. Furthermore, the number of available intensive-care beds for children is still lower than for adult patients.

The number of mortuary places, in the case of a catastrophe, also is insufficient. Although most hospitals set up a disaster plan for H5N1, there are only limited stocks of antiviral medication to protect the hospital staff during the acute phase. A separate triage area only is available in a limited number of hospitals.

Conclusions: Belgian hospitals and EDs are not equipped sufficiently to deal with potential pandemic situations.

Keywords: Belgium; pandemic; preparedness; hospitals; emergency department; limitations

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(219) Improving Public Health Emergency Response and Preparedness in India

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This paper discusses some of the strategies and challenges for successfully implementing the public health emergency response plan and preparedness in India. For disasters caused by natural and man-made hazards, the public health emergency response requires an innovative, trained, and committed workforce. Without adequate training, the response capacity of health agencies and communities in India, and their ability to respond effectively to a disaster is