year residency is 100% ($p = 0.014$).There was not a statistically significant difference among these three groups considering the complications but the success rate should a difference between level 1 and 3 ($p = 0.936$). Multiple attempts did not increase the rate of complications. Mortality were dependent to hypotension ($p = 0.019$) and age ($p = 0.001$).

Conclusion: In our study we did not find the results of RSI to be operator dependent as long as it was done by emergency residents. It is recommended to compare the results of RSI and non- RSI methods in a future.

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(A181) Process Improvement in Disaster Relief: Implementation of a Fast Track in a Haitian Tent Hospital

C. Bloem, R. Gore, B. Arquilla, T. Naik, J. Schechter
Emergency Medicine, Brooklyn, United States of America

Study Objective: To determine if instituting an Emergency Department (ED) fast-track area would increase efficiency in patient flow, improve utilization of limited resources, and identify critical versus non-critical patients during disaster relief in Port au Prince, Haiti.

Methods: A survey was conducted at L'Hôpital de l'Université d'Etat d'Haïti (HUEH) in Port au Prince, Haiti by Emergency physicians and nurses from SUNY Downstate Medical Center on a disaster relief mission following the 2010 earthquake. The following variables were obtained to assess ED effectiveness: number of patients, acuity level, chief complaints, critical interventions, waiting times, length of stay, specialty service coverage and physical plant space. Additionally, existing practitioners were surveyed regarding existing ED practices. ED operation flow maps were created.

Results: The assessment revealed a large volume of low-acuity patients mixed with high-acuity patients without identification of acuity level, time of arrival, or designated area for treatment. Although literature reports routine use of START triage, this was not being implemented in this setting. Results of implementing a fast track area included: (1) Improved identification of patients needing immediate treatment. (2) Increased flow of low acuity patients in designated fast track areas. (3) Improved triage protocols maximized appropriate use of resources, and expedited subspecialty consultation.

Conclusion: By instituting well-accepted, validated patient flow systems and reinforcing communication regarding resources available and the use of geographic space, better management of incoming emergency patients was achieved.

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(A182) Model to Assess Geo-Temporal Spread of Disease by Air Travel from Major World Cities to the United States

G.M. Hwang,[1] T. Wilson[2]
1. Office of the Chief Engineers, Mclean, United States of America
2. Division of Global Migration and Quarantine, Atlanta, United States of America

With increasing numbers of international flights and air travelers arriving in the US annually, the rapid spread of communicable diseases has grown. Epidemics of novel infectious diseases have emerged and rapidly spread globally in association with air travel, including the severe acute respiratory syndrome (SARS) outbreak in 2003 and H1N1 in 2009. In order to anticipate and mitigate the consequences of future rapid disease spread, the MITRE Corporation, in collaboration with the (US) Centers for Disease Control and Prevention, developed a risk assessment tool using a Susceptible-Exposed-Infectious-Recovered model and detailed flight and population data. The emergence and spread of prototypic pandemic influenza was simulated based on a theoretical geographical point of origin and its communicability. More than 50 international metropolitan areas were analyzed as potential points of origin to simulate the rapidity of spread to the US. The basic reproduction number (Ro), defined as the average number of persons to whom one infected individual transmits disease in an immune naive population, was varied from 1.4 to 1.9. The starting numbers of infectious persons at each origin also were varied (100 or 500 persons, 5% infectious may travel). Waves were computed as aggregate across metropolitan areas modeled in the US. The visualization of the first pandemic wave was most apparent in simulations of Ro = 1.9, resulting from 500 infectious persons at each origin. More than 50% of origins indicated that aggregate waves peaked around Day 125, while 30% of origins peaked around Day 90. Additionally, the time, in days, from its origin in six continents into the US was compared, and a two-week delay was found from South America compared with other continents. This simulation tool better equips policy makers and public health officials to quickly assess risk and leverage resources efficiently via targeted and scalable border mitigation measures during a rapid global outbreak.

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(A183) Umbrella" in a Small, Developing Country - A Case Report on Pandemic Influenza Preparedness in Bosnia and Herzegovina

S. Cornwell,[1] N. Fejzic[2]
1. College of Public Health, Department of Global Health, Tampa, United States of America
2. Animal Health Economics, Sarajevo, Bosnia and Herzegovina

Cooperation between veterinary and public health authorities in Bosnia and Herzegovina and their respective field services has historically been weak and inefficient. As is the case in many countries, animal health and public health fall under separate ministries with animal health the responsibility of the ministry of agriculture and public health the ministry of health. This model has promoted interagency competition for funding for disease surveillance and control. It has also resulted in poor information exchange, lack of efficient utilization of diagnostic resources, and poor harmonization of policies. Political decentralization, established in Bosnia after the Dayton peace agreement, resulted in the lack of a national-level responsibility for animal or public health. This was instead placed at mid-governmental levels. A state (national) veterinary office was created in 2000, but there still remains no national public health agency. The H5N1 Avian Influenza (AI) outbreak which began in Southeast Asia in 2003 and reached Europe in 2005 raised concerns about Bosnia and Herzegovina's (BiH) preparedness to combat pandemic disease.