tion (cardiopulmonary resuscitation (CPR), thrombolytics, transfusion, intravenous medication).

Results: Category definitions of the developed DCS and the mean upper tolerance of AE risks were to develop a prognostic tool for real-time patient classification. Specific clinical variables (current vital signs, working diagnoses, co-morbidities, key laboratory results, functional status) were weighted and rank ordered by EPs for likelihood of predicting an AE within 72 hours of disposition. Details of these rankings will be presented.

Conclusion: The DCS, based on risk tolerance of AEs, allows conceptual classification of inpatients for safe disposition, allowing hospital capacity to be used for acutely ill or injured patients in a disaster.

Rank	Definition	Mean Upper Risk Tolerance of AE
1	*Minimal Risk of AE*: Suitable for Discharge Home	<4%
2	*Low Risk of AE*: Transfer to Low Acuity Facility	4–12%
3	*Moderate Risk of AE*: Transfer to Facility to Moderate Capabilities	13–33%
4	*Significant Risk of AE*: Transfer to Major Acute Care Facility Only	34–60%
5	*High Risk of AE*: Keep or Transfer to ICU Setting Only	>61%

Table 1—Category definitions of the Disposition of Classification System (DCS) developed by the expert panels (AE = adverse event; ICU = intensive care unit)

Keywords: adverse event; definition; disposition of classification system (DCS); expert panels; hospital; triage
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The Australian Capital Territory (ACT) General Practice Biothreat Preparedness Survey

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In 2003, an outbreak of severe acute respiratory syndrome (SARS), a newly emerged infectious disease, caused a global public health emergency. In Australia, the response to SARS included specific guidelines for general practitioners (GPs). These guidelines covered patient screening, infection control procedures, and specifications regarding equipment availability.

In late 2003 and early 2004, the ACT Division of General Practice and the ACT Health (the Territory's Health Authority) conducted two concurrent, anonymous, self-completion, postal surveys of all ACT GPs. The surveys were designed to identify knowledge, attitudes, and practices of GPs around SARS and biothreat preparedness. One survey asked individual GPs questions about: (1) how they gathered information on SARS in 2003; (2) how they prefer to receive information; (3) their current practices; and (4) how they perceived the threat of SARS and other infectious agents. The second survey asked practice principals: (1) how they organized their general practice to respond to the SARS threat in 2003; (2) about any difficulties they had while implementing this response; (3) about the use of guidelines; and (4) about their current policies.

The response rate for the GP survey was 48% (184 of 381), and the response rate for the practice survey was 54% (74 of 136). Some issues raised by the survey will be discussed, as well as the ensuing recommendations. These issues included rapid communication with GPs in a public health emergency, application of guidelines in the general practice setting, occupational health and safety, continuing professional development, and GP involvement in planning for future outbreaks or public health emergencies. It is hoped that information obtained through these surveys will help the ACT and other parts of Australia improve future responses to emerging infectious disease threats.

Keywords: Australia; biothreat; general practitioners (GPs); guidelines; preparedness; severe acute respiratory syndrome (SARS); survey
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A Public Health and Disaster Mitigation Model: Case Studies from Ecuador

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Based on five years of multidisciplinary health and social science research, the following model of Chronic Exposures Health and Hazards (CEHH) was developed. The CEHH model is a schematic presentation of multifactorial variables important to the design of health disaster mitigation strategies. Using this model, public health policies and programs can be designed to reduce health consequences of acute and chronic disasters. Disasters have long-term debilitating impacts on society, which can be manifested in higher levels of contagious/communicable diseases, increased vulnerability, early death, decreased social capital, and economic stress. Mitigating such impacts will limit human vulnerability and enhance various social, economic, and political characteristics, such as personal relationships, social contacts, shared interest groups, and other community-building and public health activities.

Since 1999, an international team composed of physicians, epidemiologists, public health professionals, and applied social scientists, collaborated to investigate the effects of ongoing exposure to volcanic risk. Research was undertaken in communities located on Mount Tungurahua, Ecuador, an active volcano that has been depositing ash over the surrounding landscape for the last five years. The research used a multi-dimensional, integrated model of relationships among different health outcome measures, as assessed through structured questionnaires and in-depth ethnographic studies of local residents, interviews with public health officials and political leaders, and evaluations of regional epidemiological and clinical records.

The results of the CEHH model suggest public health interventions in four areas: (1) integrated disaster planning to include a locally-based focus, extensive local community