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The Role and Inclusion of General Practitioners in Evacuation Centres

Contents

The Role and Inclusion of General Practitioners in Evacuation Centres 1
Contents 1
Acknowledgement 2
Definitions 2
Introduction 5

1. This resource 6
2. Key principles in establishing/setting up evacuation centres 6
3. Chain of command in evacuation centres 7
4. Evacuation centre assessment 7
5. Evacuation centre activation 7
6. Guiding principles 9

Guiding Principle 1: Keeping local general practices operational 9
Guiding Principle 2: Employing General Practitioners in evacuation centres 9
LHD communication with PHNs 9
Guiding Principle 3: Maintaining a GP volunteer register 9
Activating the Register 10
Guiding Principle 5: Coordinated messaging during an emergency 11
Communicating with General Practitioners and team members providing healthcare at evacuation centres 11
Communicating with General Practitioners, general practices and other community health services 11
Communicating with the public in affected communities 12
Maintaining a contact list of emergency service providers 12
Guiding Principle 6: Scope of practice for GPs in evacuation centres 12
Services that should be provided: 13
Healthcare services that are inappropriate for General Practice healthcare provision within an evacuation centre: 15
Managing medical emergencies in evacuation centers 15
Medicines management in evacuation centers 16
Documentation of clinical consultations at evacuation centres 16
Guiding Principle 4: GP training and credentialling preparedness for evacuation settings 16
Credentialling 16
Training 17
Major Incident Medical Management and Support (MIMMS) training 17
Abbreviated training 17
Guiding Principle 7: Supplies and resources for GPs working in evacuation centres 18
PHN 'Supplementary kit': 18
Supports for GPs in evacuation centres 19
Principle 8: Ensuring safe working conditions in evacuation centres 20
Support services 21

6. Considerations and information for GPs working in emergency settings 21

6.1 Provider number considerations 21
6.1.1 Provider number mobility for GPs in disaster affected areas 21

6.1.2 Emergency provider numbers for GPs coming into disaster affected areas 21
6.2 Ensuring medicolegal coverage for GPs working in evacuation centres 22
6.3 Requirements for paper scripts 22
6.4 Authority PBS prescriptions 22
6.5 Emergency access to prescription medicines in disaster-affected areas 23
6.6 Providing care via telehealth 23
Exemptions to the “12-month rule” in areas of natural disaster 23
7. Policy considerations for general practice involvement in responding to disasters 24
7.1 Current state 24
7.2 GP inclusion on disaster planning and management committees 24
7.3 Remuneration for general practice participation 25
8. Conclusion 25
9. ACRONYMs 26
10. Further resources 26
11. Support services for GPs 27
12. References 28

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Definitions

Emergency	An event, actual or imminent, which endangers or threatens to endanger life, property or the environment, and which requires a significant and coordinated response. The scale of the event is such that can be managed within capacity and resources of local authorities. Note, there are jurisdictional legislative variations[1].
Disaster	A serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human,

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	material, economic and environmental losses and impacts. The scale of **the event is characterised by impacts that overwhelm local capacity and resources and requires external assistance**. Note, there are jurisdictional legislative variations[1].
Evacuation centre	Physical site providing emergency shelter for people, and sometimes animals, displaced by a hazard. The aim is to provide basic human needs of safety, shelter, warmth, light, food, water, sanitation, and to address immediate healthcare needs. The full range of activities in any evacuation centre will vary according to local community context including availability of local healthcare services, personnel and resources; the particular hazard and disaster(s); the length of operation of the evacuation centre; and political and socioeconomic issues.
General Practitioner (GP)	A medical doctor who has undertaken specialist training in general practice. GPs are trained to treat a range of medical conditions, focusing on the whole person, ranging from emergency medicine through to chronic disease management.
Local Health Districts/Networks (LHDs/LHNs)	LHDs/LHNs are established to operate public hospital services and institutions and provide health services to communities within geographical areas or a defined patient population, as determined by the **state or territory government.** In a disaster, LHD/LHNs are responsible for preparation and response to local disasters including producing the Local Health District Health Services Functional Area Supporting Plan (LHD HEALTHPLAN) where PHNs can be incorporated.

Primary Health Networks (PHNs)	PHNs are independent organisations that are funded by the **Australian Government** Department of Health and Aged Care to coordinate primary health care in their region. PHNs assess the needs of their community and commission and support health services so that people in their region can get coordinated health care where and when they need it. In a disaster, PHNs form the linkage between the LHD and GPs and other primary care health professionals in disasters. They are the path to an integrated inclusion of GPs into disasters. PHNs will usually have a 'lead' with the role of disaster and emergency management.
PHN Disaster and Emergency Operations Manager (or equivalent)	The PHN officer responsible for disaster management within the PHN.
All hazards approach	A consistent management approach to all types of emergencies and disasters and civil defence regardless of the hazard type[1].
Command	The internal direction of the members and resources of an agency in the performance of the organisation's roles and tasks. Command operates vertically within an organisation[1].
State/Territory Emergency Management Plans	All states and territories have their own emergency management plan which is comprehensive plan detailing how states/territories will plan for, respond to and recover from disasters and emergencies as well as the roles and responsibilities of various agencies and organisations. **NSW:** State Emergency Management Plan (EMPLAN) **QLD:** Queensland State Disaster Management Plan (QSDMP) **VIC:** State Emergency Management Plan (SEMP) **WA:** State Emergency Management Plan **SA:** State Emergency Management Plan (SEMP) **TAS:** Tasmanian Emergency Management arrangements (TEMA) **NT:** Territory Emergency Plan (TEP) **ACT:** ACT Emergency Plan

State/Territory Health Services Functional Area Supporting Plan (HEALTHPLAN)	The State/Territory Health Services Functional Area Supporting Plans support the State/Territory Emergency Management Plans.
Health Services Functional Area Coordinator (HSFAC)	The HSFAC is a local district or state level coordinator of the functional area of Health. Under emergency management arrangements, the local HSFAC is responsible for providing health support in a disaster to the local health district in support of the local emergency plan. There is a corresponding role at state/territory level. Functional Area Coordinators also exist for other services such as Welfare.

For the purposes of this document the following terms may be used interchangeably:

- 'emergency' and 'disaster'
- 'LHD' and 'LHN'

Introduction

Emergencies and disasters have a significant impact on the health and well-being of people and communities[2]. GPs are essential healthcare providers playing a crucial role in supporting individuals and communities before, during and in the aftermath of such events. The rehabilitation and recovery of an affected community extends well beyond initial first responder activity, often lasting months, or years, with GP involvement integral to effective healing.

Primary Health Networks (PHNs) are the organisation that is responsible for connecting GPs to the broader disaster health management (DHM) response. The 31 PHNs in Australia are linked to corresponding LHDs that are part of the local public health system and therefore to local and state/territory DHM.

The evidence suggests that efficient utilisation of GP services in areas affected by disasters and emergencies is crucial to the health and welfare of the community[3]. While the key site for GP involvement will always be the usual local general practice, on some occasions GPs and their teams may need to be deployed to evacuation centres to assist in provision of healthcare.

Early in a disaster, a decision will be made on whether optimising the safety of those in the path of the disaster requires evacuation or whether local community members will be just as safe, or safer, if they shelter in place. The need for an alternative safe location may be for several hours for a single family, to up to many weeks for hundreds of thousands of people. Preference will be to encourage evacuees to shelter with family or friends, and to minimise the time period an evacuation centre is open. Evacuation centres will differ according to their location, the premises chosen, the disaster type and severity, the human impact, the local context, and the preparedness of the local authorities.

1. This resource

The purpose of this resource is to provide guidelines to assist with the integration of general practice healthcare provision in evacuation centres and to ensure the principles and concepts of evacuation planning for general practice are consistent nationally. These guidelines include recommendations on the roles and responsibilities for PHNs coordinating, supporting and administering these services.

These guiding principles take an all-hazards approach and are designed to inform and assist agencies involved in community evacuation planning. They aim to support effective engagement and utilisation of GPs (predominantly through PHNs) to support the comprehensive biopsychosocial healthcare needs of people seeking emergency shelter following an event. They aim to ensure GPs can operate in a safe environment, within their professional scope, as an integrated part of the healthcare team, and with the resources they require.

2. Key principles in establishing/setting up evacuation centres

These guidelines recognise there are variations in arrangements and processes for establishment and management of evacuation centres across jurisdictions and local regions. Best practice for establishment of an evacuation centre(s) is based on advance planning and preparedness by local authorities who work with emergency responders to ensure potential local evacuation sites are evaluated thoroughly for suitability well prior to any event.

Each state or territory will have an established and documented emergency management plan aimed at minimising the impact of the emergency and ensuring there is a co-ordinated response bringing together the correct resources needed to support a community during an emergency. Part of the response plan will include relief activities to meet the immediate needs of communities during and in the aftermath of an emergency and the activation of evacuation centres will occur, as required, as part of the response plan.

Key principles in the evacuation planning process, as per Australian Disaster Resilience Handbook 4: Evacuation Planning, include:

- ongoing communication and consultation with all key stakeholders
- identifying and establishing an evacuation planning committee with the authority and scope to plan for evacuation
- conducting an emergency risk management study to clarify risks within the local region and community including local capabilities
- identifying responsibilities so all agencies have clear roles and responsibilities
- identifying the resources and services needed, with each agency aware of their capacity, availability, and resource requirements
- developing arrangements and systems
- documenting the evacuation plan, and making it available to all agencies contributing
- exercising the evacuation plan with stakeholders to identify any gaps
- monitoring and reviewing the plan.

To date, inclusion of health in this exercise has meant the involvement of disaster managers from LHDs working with the local authorities and other emergency responders. However little to no inclusion of general practitioners or PHNs in this planning and preparedness has occurred in the vast majority of LHDs until recently. This has resulted in little to no planned involvement of GPs as health care professionals in evacuation centres. Their involvement has tended to be in an ad hoc manner during the chaos of the response[4]. A safer and more effective inclusion would involve general practitioners and PHNs from the initial planning in collaboration with other key stakeholders until the after action review following the closure of the evacuation centre.

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3. Chain of command in evacuation centres

While there are coordinated and well-resourced response procedures and chains of command in place for emergency services and LHDs, PHNs and GPs are not consistently integrated into these plans. If they are not integrated into plans, then they do not form part of the official chain of command outlined in the Australian Inter-Service Incident Management System (AIMMS) chain of command for emergency management. This creates risk for organisations and individuals mobilised to support emergency response and this needs to be considered as part of the decision making process when offers of assistance and requested or made.

Specific structures for the establishment and organisation of evacuation centre operation and engagement are not consistent nationally and differ even within, and between, states and territories. Appropriately, there is a significant element of local context to the operation of an evacuation centre, for example, while the principles for the establishment of centres may be similar nationally, the needs of disaster-affected communities vary significantly according to many factors including rurality, the pre-existing health of the local community, type and severity of disaster, and duration of need for the centre.

While LHDs may leverage PHNs and their ability to muster a GP volunteer workforce for evacuation centres, there is no state/territory or federal body that "owns" or manages the GP workforce and can direct GPs to where they are needed in an emergency. PHNs are an effective marshalling point for GPs who are willing and able to provide services at an evacuation centre. Therefore, it is essential PHNs and GPs are integrated into these planning and response procedures and chains of command, both for efficiency of activation of a GP workforce in the event of a disaster, and for their effective utilisation through streamlined communications and clear chain of command through the PHN.

In an evacuation centre where provision of medical care is principally provided by GPs, a primary care command and control structure must be implemented as a principle of safety. This would include roles such as regional GP disaster coordinator, shift 'in-charge', triage, case allocation and nursing integration.

4. Evacuation centre assessment

Evacuation centres are facilities established outside the area at risk that can meet the immediate needs of disaster affected people during evacuation including local residents, local workers and travellers. It may or may not include overnight accommodation. Premises will be assessed for animal shelter as well.

Local Emergency Management Committees (LEMCs) are usually responsible for collectively identifying and evaluating potential evacuation premises in close consultation with combat agencies and with Health?[5].

Facilities are considered as potential evacuation centres if they meet minimum requirements. Essential considerations in assessing sites as suitable evacuation centres include:

- Security with the perimeter maintained to restrict access to members of the public.
- Shelter providing safety, protection from the climate, and from diseases. It should aim to accommodate family and community life as possible.
- Minimum requirements need to be met for provision of food, water, sanitation, personal space and if possible, sleeping facilities[5].

5. Evacuation centre activation

Evacuations vary depending on many factors. Some evacuations are immediate whereby the impact of the hazard does not allow time for any warning and requires immediate reaction, such as an earthquake or flash flood. Some are pre-warned or managed evacuations where a planned evacuation occurs ahead of a potential hazard such as a bushfire, or flood. Some are self-managed evacuations or relocations where local residents are asked to leave early during dangerous conditions such as catastrophic bushfire conditions.

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Agencies with legislative authority to order an evacuation are the Police Force and combat agencies with appropriate legislation such as fire services, or State Emergency Services. The decision to evacuate is usually made in consultation with various agencies including the emergency services and the Functional Areas, including Welfare Services, Transport, Health and Animal & Agricultural Services. The police usually enforce any order for evacuation.

Once an evacuation is activated the establishment and management of the evacuation centres is the responsibility of the Welfare Services Functional Area (WSFA) [5].

An evacuation centre is considered a place of work and needs to comply with the Work, Health and Safety Act 2011. This falls under the responsibility of the Welfare Services Functional Area and includes restrictions on types of activities permissible on site.

Disaster Victim Registration (DVR) is a process of documenting displaced persons, including those with injuries. The Police Force is usually the responsible agency however other agencies can assist. Therefore evacuees attending an evacuation centre will be registered as they arrive. Those self-evacuating to family and friends can often self-register.

A full list of requirements for evacuation centres can be found in the National Emergency Management Agency Evacuation Handbook.

The challenge for GPs is that plans to establish evacuation centres do not yet routinely include local GPs. The governance structures in the emergency response plan do not consistently include GPs as part of the system. However, the current best practice method of GP participation in an evacuation centre as part of the health service is through the local PHN in collaboration with the local LHD.

The final step in the evacuation process is the safe return of evacuees to their homes and/or to the affected site, and again this requires planning and coordination. This may be done in a staged or restricted fashion depending on the hazards remaining in the area. In some situations, it may be years before evacuees can return to the affected area and various forms of alternative accommodation may be needed.

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6. Guiding principles

Guiding Principle 1: Keeping local general practices operational

In the event of a disaster, supporting the ability and capacity of existing general practices to provide health services to the community must be the priority and the GP workforce should not be removed from one setting to fill a need in another.

Ideally local general practices should be supported to remain open and operating where possible. This allows continuity of GP healthcare services to the local community and management of lower acuity disaster healthcare presentations. PHNs are key organisations that may be able to provide assistance to general practices to support this. In some situations this may be through extended hours of operation, or through expanded patient loads supported by PHN financial payments.

Local PHNs have a role in communicating the up-to-date status of general practice healthcare service capacity in a disaster. This requires a real time understanding of which practices are impacted, and equally which practices are fully operational. This can be accomplished through regular contact with general practices in the area to determine impacts on the practice and staff from the disaster, their ability for the practice to scale up service provision through extended hours or increased capacity for patient load, and whether they have capacity to provide clinical and administrative space to clinicians and staff from other practices that may be unable to provide services from their usual location. Some PHNs have developed a mapping tool that can be activated during a disaster which identifies practices according to a green-orange-red traffic light system corresponding with fully operational-partially operational-closed.

Guiding Principle 2: Employing General Practitioners in evacuation centres

One of the key ways of working for General Practice is in General Practice teams. General Practice teams can include GPs, Practice Managers (PMs), Practice Nurses (PNs), and receptionists. While it is usually GPs who might be called on/considered to provide direct assistance in evacuation centres, depending upon the need, availability, completion of training/suitability of GP staff, and funding, in some circumstances it may be valuable to deploy a small General Practice team such as a GP, a PM, and a receptionist.

Renumeration of GPs (and their teams) for provision of direct assistance at evacuation centres should be incorporated into the PHN evacuation planning. There may be situations where remuneration is not possible however best practice would be to attempt to make some arrangement to pay for time provided.

PHNs are the key organisations that can link local general practitioners and their teams to the corresponding LHD and thereby to the broader disaster management response network during a disaster. During activation of evacuation centres requiring assistance of General Practice healthcare services, PHNs have a key role to play in communication and information exchange between frontline GPs and the local HSFAC. They have roles in activating, rostering, supporting and managing GP services to evacuation centre(s).

LHD communication with PHNs

Communication channels between PHNs and LHDs and agreed modes of deployment of GPs in the event of a disaster, should be part of localised disaster planning activities prior to a disaster event, and written into the Local Health District/Network Health Services Functional Area Supporting Plan (LHD HEALTHPLAN).

Guiding Principle 3: Maintaining a GP volunteer register

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Before GPs or their teams can be employed in an evacuation centre, adequate preparation including training and certification is required. PHNs are the key organisations in provision of this preparedness. A register of trained certified GPs who have indicated a willingness to assist in evacuation centres is required. PHNs can achieve this through:

1. **Distribution of an annual expression of interest (EOI):**
    - to all GPs and general practices in the region, to identify those who are willing to assist in local disaster incidents. For practices where a GP qualifies for involvement then other practice staff including practice managers, practice nurses, and administrative staff can also be trained and registered. (Those axillary General Practice staff who don't have a GP qualified to be involved should not at this time be deployed, although as systems improve this may change.)
    - to identify and engage those who are willing to assist but require further training and preparedness so this can occur before the next disaster season.
    - to maintain an up-to-date register in regard to training, qualifications, vaccinations, interest/availability and for targeted communications in the time preceding high risk disaster periods, during any disaster actualisation, and in recovery.
    - to identify General Practices with capacity and willingness to:
        - scale up service provision in the event of a disaster where their premises have not been impacted
        - provide clinical and administrative space to other General Practice clinicians and staff whose practices have been disrupted.

2. **Maintenance of an up-to-date Register:**
    - managing, training, communicating with and coordinating an up-to-date register of GPs who have expressed an interest in working in evacuation centres
    - ongoing engagement of this group of practitioners could be achieved by a quarterly newsletter on disaster health management (DHM) reporting on local disaster events, preparedness activities etc, or on non-local disaster events of interest.

Activating the Register

GP engagement in evacuation centres will be via PHNs. The trigger for GP engagement in an evacuation centre(s) will be determined by the LHD HSFAC who will communicate a request for GP assistance through to the PHN contact (potentially a PHN disaster and emergency operations manager or equivalent) with close ongoing communication with the LHD Counter Disaster Unit (CDU) Disaster Manager (DM).

A disaster and emergency operations manager (or equivalent) within the PHN will contact GPs on the GP volunteer register to determine their willingness and ability to assist at an evacuation centre and establish a roster. If multiple evacuation centres are being established, GPs may be able to nominate the centre which they wish to be rostered for, however this may not always be possible.

PHN's will need to coordinate a roster of GPs, nursing and administrative staff as appropriate, supported by a PHN coordinator. Depending on the local community context, the ongoing effects of the hazards, the range of other medical health services available in the community, and the availability of GP staff, each shift could involve a small General Practice team rather than an individual clinician, and could include medical, nursing and administrative staff,

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Guiding Principle 4: Coordinated messaging during an emergency

A key role of the PHN is coordinating timely, up-to-date health related messaging to different stakeholders during an emergency. PHNs are ideally placed to act as a communication conduit between frontline GPs and the LHD which is linked to the broader health and emergency response in disasters.

Communicating with General Practitioners and team members providing healthcare at evacuation centres

The PHN Disaster and Emergency Manager and a lead senior General Practitioner should be the key initial contact points for those working in the evacuation centre.

The preference is to communicate through established pre-disaster media. This might include emails, texting, phone calls, Facebook messenger, or Zoom or other video platforms.

PHNs may wish to utilise group messaging, for example through WhatsApp, to provide rapid communication amongst the evacuation response team members.

Several printed laminated up-to-date contact lists will be a requisite of any GP Evacuation Resource Kit as rapid clear communication is a key resource for disaster response.

The PHN will have responsibility for communicating and following up with those clinicians who were deployed and those who were registered but were not deployed to an evacuation centre.

Communicating with General Practitioners, general practices and other community health services

While PHNs have ongoing communication with their local GPs and general practices year-round, emergency communications systems should be established in advance of any incident. Active communications regarding an impending event should commence, as early as possible, to allow preparedness in advance of any call for response. Different streams of communication protocols may be needed, i.e., one for those GPs on the volunteer evacuation centre list, one for all GPs in the PHN area, and for all primary healthcare providers within the PHN area.

As information comes to hand, communications should include up to date details of:

- details of general practices in the area that are fully or partially operational, including changes to operating hours or service availability
- details of general practices that are non-operational
- as available details of the operational status of other local health services (including hospitals, pharmacies, allied health, and the PHN itself), including changes to operating hours or service availability
- referral suggestions on where to direct patients with specific needs arising from the event
- GPs should prioritise providing services from their usual practice rather than from an evacuation centre
- details of activated evacuation centres (as applicable)
- notice of activation of the GP volunteer register
- details as they emerge on how to access resources to support patients
- details of available funding to increase practice capacity or return to operation if physically impacted
- links to external sites for updates on the disaster e.g., Fire Service, SES, Police, Local Councils etc.

DRAFT

Communicating with the public in affected communities

PHNs may communicate directly with the public via their usual methods including social media or their website.

PHNs will work closely with LHDs to share the same up-to-date information and messaging as relevant to the local community. Both PHN and LHD can disseminate this information through their usual channels. Information may include:

- where to seek healthcare, including which health services (including general practices, hospitals, pharmacy, allied health) in the area are operating, including changes to operating hours or service availability
- Note that only evacuees should access health services provided in an evacuation centre.

Maintaining a contact list of emergency service providers

PHNs should maintain a list of emergency advice provider contacts for distribution to GPs and other service providers during an emergency event, including:

- hospital/local pharmacies
- mental health contact
- alcohol and other drugs service
- PHN-run GP telehealth service number
- relevant specialties for clinical advice (for example, infectious diseases, respiratory, burns unit etc.)

Guiding Principle 5: Scope of practice for GPs in evacuation centres

An evacuation centre is a ‘home-like’ setting and should not be treated as a temporary emergency department. Patients presenting with health issues that cannot be appropriately cared for in an evacuation centre setting should be safely transferred to the nearest appropriate facility e.g., hospital emergency department or acute care facility.

Similarly, an evacuation centre is not a makeshift general practice designed to respond to low acuity issues which could be managed by the patients’ usual GP, face-to-face or via telehealth, as this has the potential to overwhelm resources. However, if time and resources allow, and access to the usual GP is difficult then an appropriate consultation can be provided.

Healthcare provision in evacuation centres by GPs should ideally be reserved for evacuees taking shelter in the centre. However, patient safety and support during a disaster is important, and those who genuinely cannot access care elsewhere should be supported to find suitable services or receive care at the evacuation centre as a last resort.

Substantial literature exists on the epidemiology of health effects of disasters over the days, months and years post-disaster. The majority of these effects fall within the realm of General Practice. Information on these effects is available to GPs through online resources as noted in Resources below in Guiding Principles 7.

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> I attended the evacuation centre in Bega during the 2019 Black Summer bushfires and the majority of clinical presentations were straightforward and involved such things as script replacements, psychological first aid, asthma exacerbations and eye problems. There were also several logistical challenges such as accessing incontinence pads for a disabled child or formula for an infant. I felt the main benefit of my visit was the calm instilled in the evacuees knowing there was a GP on hand.
>
> \- Dr Louise McDonnell

Services that should be provided:

The role of the GP in an evacuation centre is to undertake a broad range of medical assessments for evacuees across mental, physical, and social health as required while maintaining an understanding of the likely health effects of disasters during the relevant time period post-disaster. There will be considerable variation in healthcare needs at different evacuation centres based on the disaster type and severity and the health status of the local community and their exposure to the disaster.

GPs provide holistic comprehensive healthcare for patients and most patients present with a combination of healthcare needs across physical and mental health, however for simplicity these are separated in the lists of conditions below.

Acute health care activities

- triage of evacuees may be required, especially in larger mass casualty evacuation centres.
- surveillance and early recognition of emerging health care needs including:
    - Infectious or communicable diseases - for example, COVID-19, influenza, gastroenteritis, scabies, wound infections, etc. These would variously require early notification and discussion with the Public Health Unit and PHN.
- acute injuries: wounds, animal and insect bites, lacerations, soft tissue injuries, eye irritations, inflammatory skin conditions and rashes
- acute infections: cellulitis, upper respiratory conditions including otitis media/externa and tonsillitis, lower respiratory conditions including croup, bronchiolitis, acuity community acquired pneumonia and infective exacerbations of asthma and chronic obstructive pulmonary disease, gastroenteritis, urinary tract infections, urolithiasis
- chronic wound management
- arthralgias and myalgias including gout.

Mental Health

- management of distress including provision of Psychological First Aid (PFA)
- Mental Health First Aid (MHFA) for deterioration of pre-existing mental health conditions such as anxiety or depression
- Trauma Informed Care (TIC) as evacuees have experienced a traumatic event
- Referral to an on-site mental health team, or their local GP or other local community psychologists, as applicable/available.

Pregnant women and young children

DRAFT

- antenatal care and conditions
- breast feeding and bottle feeding issues
- review and management and referral of babies, infants and young children.

Chronic conditions

- management of people with exacerbations or deterioration of chronic or pre-existing medical conditions, particularly those at higher risk, for example people with:
    - diabetes especially those with poor glycaemic control, gestational diabetes, insulin dependent diabetes mellitus, those who have been more traumatised
    - hypertension especially those with an increased risk of myocardial infarction or cerebrovascular accident
    - respiratory conditions exposed to increased aerosolised particulate matter
    - older age especially if any heat hazard, risk of cognitive impairment, risk of falls, etc.

Vaccinations

Consider the following vaccines where appropriate and vaccines are available:

- diphtheria-tetanus combination (ADT) vaccine in those not up to date or with recent injuries, especially where patients may be involved in clean-up activities
- influenza and covid vaccinations
- pneumococcal and herpes zoster vaccinations in those at risk
- boostrix, influenza and covid in pregnant women
- locally relevant vaccine preventable conditions such as measles.

These activities may be better conducted at a local General Practice due to cold-chain considerations.

Prescriptions and dispensing

- provision and review of prescription medication for continuity of routine chronic disease management as appropriate. This may have been disrupted due to:
    - poor adherence to medications due to either evacuating without them, destruction in the disaster, or due to distraction from the disaster.
    - poor access to usual medications and medical supplies, particularly those that require special authorisation.
    - deterioration or exacerbations of chronic disease such as increased blood pressure in those with hypertension, deterioration in glycaemic control in those with diabetes, and deterioration of respiratory conditions particularly due to increased particulate matter from fire smoke.
- occasionally in certain circumstances administration of medication may occur where pharmacy services are unavailable, due to inaccessibility or disruption, or when safe storage of a particular patient's medicines on-site is necessary (see *Medicines management in evacuations centre)*.
- note limitations to prescribing as per *Services that should not be provided*

DRAFT

Referrals

- referral to other services including:
  - services operating within the evacuation centre e.g., St John, Mental Health, Welfare etc
  - the patient's usual GP (possibly via telehealth)
  - another local general practice (which is operational)
  - a local hospital Emergency Department for higher acuity care or
  - a relevant specialist or allied health provider (local face-to-face or non-local via telehealth) including pharmacists, physiotherapists, psychologists, community nursing, occupational therapists, etc.

High acuity injuries resulting from an emergency event should not be transferred to an evacuation centre for management by a GP. However, evacuation centres may be housing evacuees with high acuity injuries that then require triage and transfer for specialist care in a timely fashion.

Healthcare services that are inappropriate for General Practice healthcare provision within an evacuation centre:

GPs have a variety of skills with some GPs specialising in anesthetics, obstetrics, palliative care, family planning, etc. This guideline is written in consideration of GPs without that specialist training, however in some situations where specialist GPs are available the services able to be provided safely in an evacuation centre by GPs may vary. On some occasions phone consultation with a specialist may enable further safe management in an evacuation centre. However, services that are generally not appropriate, and therefore should not generally be provided by GPs in an evacuation centre include:

- provision of high-acuity acute care that would normally require emergency department referral or tertiary healthcare services
- management of alcohol and other drug withdrawal, including providing replacement prescriptions for methadone
- provision of routine non-urgent routine care of a chronic condition that is able to be, and usually is, attended to by the usual local GP or usual local outpatients department.
- delivery of babies (unless it is unplanned, within the scope of the GP, and unavoidable in the situation)
- fracture management that requires plastering or specialist intervention
- any service outside the scope or comfort of the attending general practitioner. As mentioned there will be variation in skills between General Practitioners.
- management of patients with severe chronic conditions including those that might sometimes be managed at home, but with particular specialised equipment e.g., respiratory ventilatory support at night. These patients should be relocated to an appropriate tertiary healthcare facility healthcare facility.

In general patients requiring additional health care that cannot be provided safely in an evacuation centre (or that is outside the scope of practice in an evacuation centre) should be transferred to the relevant hospital or health service for assessment and management. GPs attending evacuation centres should be able to inform these decisions.

Managing medical emergencies in evacuation centers

As can happen in any setting, medical emergencies such as cardiac arrest, seizures, acute drug withdrawal, may occur within an evacuation centre.

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While GPs can provide initial basic life support, these medical emergencies require greater resources and access to tertiary healthcare and therefore should be escalated urgently via emergency services for transport to the nearest, or most appropriate emergency department.

Medicines management in evacuation centers

The storage and taking of personal medicines in an evacuation centre is ultimately the responsibility of the evacuee, however GPs and nurses may be called upon to provide assistance (for example where there are risks to storage of some medicines such as drugs of dependence (for example, S8s) or medicines that require special storage such as refrigeration (for example, insulin) and medicines that the evacuation centre may supply and store on-site such as Ventolin puffers, rehydration solutions, basic antibiotics etc.).

In the rare circumstances where medicines might need to be stored by GPs in an evacuation centre, and only when there is capacity to do safely do so, the medicines should be:

- kept within their original packaging or a pharmacy webster/blister pack
- marked clearly with the person's name and date of birth
- added to a register of stored medicines

Access to the medicines should be restricted to medically trained persons only and provided to the patient only after their identify has been confirmed.

A lockable storage area should be provided to enable this storage.

Documentation of clinical consultations at evacuation centres

Consultations should be recorded on appropriate forms provided by the PHN. A minimum of two copies are required (using photocopier, carbon paper or other method as available); one copy to be held by the consulting GP and included in their usual practice records; one copy provided (when possible) to the patient's regular GP via the patient themselves (or via other means). In some circumstance, it may be possible to include the encounter as an event summary on the patient's My Health Record. The latter will be very subject to workload demands, capacity and internet access.

The PHNs will provide a sheet to maintain a de-identified list of each patient for tracking and administrative purposes.

Some jurisdictions will require a copy be provided to the local health authority (either as a complete record or as part of a summary list of patients consulted in the evacuation centre) for recording in the Emergency Medical System as a record of events.

A brief end-of-shift patient list form may be utilised to handover to incoming clinicians.

Guiding Principle 4: GP training and credentialling preparedness for evacuation settings

Credentialling

There is no current required certification for GPs to contribute health services in an evacuation centre however an understanding of basic disaster concepts and systems, as well as local processes of communication, command and control in the local PHN/LHD is fundamental to working in this environment. While standardisation of GP training for disaster healthcare provision at evacuation centres is being discussed and considered, specific credentialing for volunteer GPs in evacuation centres should not act as a barrier to participation. Any Australian Health Practitioner Regulation Agency (AHPRA) registered general practitioner (or nurse actively working in general practice) (without

relevant conditions, restrictions or supervision requirements) should be eligible to provide services in these settings. Practice managers and receptionists actively working in general practice should be eligible to accompany GPs they work with to the evacuation centre to assist.

Training

As part of disaster preparedness activities PHNs have a role in provision of initial and regular ongoing training in disaster health management to interested GPs and practice staff. All GPs who have expressed an ongoing interest in working/volunteering in evacuation centres (such as through addition to a register of practitioners) should be offered training via the PHN. This may include training with the LHD. The degree of training may be commensurate to the role the GP is likely to take. Training has not yet been standardised for GPs, however there are a number of options available.

Major Incident Medical Management and Support (MIMMS) training

Major Incident Medical Management and Support (MIMMS) is an internationally recognised qualification and is a pre-requisite for Australian Medical Assistance Teams (AUSMAT) personnel who are deployed to provide life-saving medical care following international disasters. MIMMS courses teach a systematic approach to disaster medical management with a focus on disaster management principles, not specific medical interventions.

While MIMMS training is not required for most GPs working/volunteering in an evacuation centre, it would be useful for GPs likely to play a leadership role in this space. This may be applicable to permanent PHN roles for a regional GP disaster coordinator or GP who will take an 'in-charge' role in an evacuation centre.

MIMMS training can take one or three days and can be facilitated through the PHN via the LHD, noting that there are a limited number of positions in these courses. GP involvement should be supported through salary backfilling.

Abbreviated training

Until standardised training for GPs contributing to DHM is developed, all GPs on the GP volunteer register should be provided with abbreviated disaster health management training, including:

- basic disaster management terminology, concepts and systems.
- chain of command and control for GPs in evacuation centres
- local emergency management coordination procedures and protocols (from PHN/LHD)
- communication lines and processes between GPs, PHNs and other relevant parties
- localised relevant information which could be provided through HealthPathways
- expected role, responsibilities and scope of practice in an evacuation centre
- orientation to medical resources provided in an evacuation centre
- navigating processes under non-traditional circumstances (for example, when no power, technology, or phone reception is available)
- documentation processes and clinical handover
- disaster triage
- psychological first aid
- management of medicines
- responding to media queries

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This training is best facilitated by PHNs as the local operationalising body and tailored to the local context.

Guiding Principle 7: Supplies and resources for GPs working in evacuation centres

When standing up GPs to work in an evacuation centre, PHNs should provide standard operating procedures (SOPs) and local contextualised information on the local disaster situation, contact numbers and details of the particular evacuation centre as available. This will include:

- command and communication lines
- orientation to the evacuation centre
- the expected role and scope of the GP
- information and relevant contact details of organisations involved in the disaster response
- what to bring to the evacuation centre
- available resources provided by the PHN and others at the evacuation centre
- where and how to access mental health support (team leader, Employee Assistance Programs (EAP) etc)
- available training to ensure competency and readiness for deployment

These SOPs and information should have been provided and explained as part of preparedness and training activities well before any disaster struck. When evacuation centres are activated, and GPs invited to contribute, provision of GP access to the following provided/considered by the PHN, as appropriate and available:

- a GP station with a table(s) and minimum two chairs in a location with visual and auditory privacy
- a computer and printer (preferably with internet access)
- a phone
- a PHN stocked and managed 'supplementary kit' complementary to the GP's own 'Prescriber/Doctor's bag'*
- a defibrillator (if available)
- clinical waste bins
- easily accessible hand washing facilities
- a lockable storage cupboard for the housing of medical resources and supplies

** GPs should bring their own 'Prescriber/Doctor's bag'*

PHN 'Supplementary kit':

The medical pack is designed to supplement a GPs own *Prescriber/Doctor's bag'* and should include:

- identifying vest (fluorescent / reflective tabard with preferably GENERAL PRACTITIONER or DOCTOR emblazoned)
- personal protective equipment (PPE) – gloves, masks (surgical and P2/N95), gowns, eye protection
- stethoscope
- sphygmomanometer
- pulse oximeter

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- torch
- pen torch
- auroscope/ ophthalmoscope
- blood glucose monitor and testing strips
- alcohol based hand sanitiser
- alcohol cleaning wipes
- basic dressing packs, sterile water, steri-strips, dressings, disposable suture sets and sutures, cotton buds, needles, syringes, bandages, slings
- basic First Aid pack
- blank prescription pads (ideally triplicate carbon copy)
- blank note pads
- pens
- spare batteries for all battery-operated devices
- relevant forms (for example, disaster medical assessment forms, clinical notes forms, end-of-shift patient list form, deidentified patient list, copies of consultation notes)
- referral forms to local radiology and pathology providers
- list of relevant contact numbers, including GP Liaison Officer (where applicable), PHN contact person, hospital emergency department, local pharmacies, other health services such as mental health, community health, alcohol and other drug services
- local area map with resources including accessible healthcare services – this should be marked up to understand road closures, hazards etc
- kit checklist
- bottled water and snacks.

The medical pack could include:

- defibrillator
- clinical waste containers/bags
- sharps container

Supports for GPs in evacuation centres

To support GPs effectively carry out their role in evacuation centres, PHNs should consider the need for:

- rostering GP support staff as available/needed to ensure skill mix, inclusive of nursing and administration team members
- further administrative support
- technology support
- up-to-date information on access to pharmacies and other medical services in the region
- clear communication regarding command and control, reporting lines, check in/out process, escalation process
- referral pathways including HealthPathways Disaster Management Pathway
- access to a translation service

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- confirmed medicolegal coverage (See *Medicolegal for more)*
- resources: provide links to disaster resources for local GPs in collaboration with the RACGP and other professional GP groups (See *Helpful resources* for more).

Principle 8: Ensuring safe working conditions in evacuation centres

GPs working and volunteering in evacuation centre have the right to a safe work environment and be covered under relevant Work Health and Safety (WHS) / Occupational Health and Safety (OHS) regulations.

All evacuation centres should be deemed safe prior to being set up with basic facilities, and generally include:

- being located at a suitable distance from the emergency/disaster
- access to power
- access to sanitation (for example, bathrooms, hand washing facilities, routine cleaning)
- adequate workspace for the provision of essential services
- being free from hazards
- security presence inside the centre.

To prevent and control communicable disease, the evacuation centre should:

- ensure all workers and volunteers are vaccinated against relevant communicable diseases where a risk is present
- maintain infection prevention and control guidelines
- be adequately ventilated (in clinical and non-clinical areas)
- allow for physical distancing (as appropriate)
- include a separate safe space to manage people with known infectious illnesses (for example COVID-19, influenza) that provides safety, while maintaining patient dignity.

To ensure the safety of workers and volunteers in accessing the evacuation centre:

- consideration should be given to the safest means of accessing the centre, considering that the disaster event may lead to a rapid change in access routes or changes to infrastructure.
- security escorts to vehicles should be available for those completing a shift at night.

To support the mental and emotional health and wellbeing of GPs in evacuation centres:

- maximum hours, and consecutive days of work should be established* to prevent GP burnout. The RACGP suggests:
  - standard 8 hr shifts, maximum 10 hour
  - standard 5 consecutive shifts, maximum 7 consecutive shifts

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- minimum 10 hours off between each shift.

  **As an evacuation centre is not an acute care facility, overnight attendance by a GP is generally not required and should not be expected. In many cases a GP "round" or attendance for 1-2 hours a day may be most appropriate. This will enable GPs to continue to provide services in their usual General Practice as well.*

- it must be recognised that in many cases GP volunteers have also been personally impacted by the disaster
- access arrangements should be in place for an EAP, or details of other available support services be provided to all GP staff working or volunteering (see Support services)
- inclusion in any post disaster *after action review* or *operational debriefing* should be facilitated by the PHN/LHD - this should include all members of the GP evacuation centre medical response team (for example, GPs, administrative, nursing and PHN personnel)
- PHNs should consider establishing peer support networks for GP volunteers in different evacuation centres for exchange of learnings and support.

Support services

Support services should be shared with GPs, in addition to any other local support services (see *Support Services for GPs).*

6. Considerations and information for GPs working in emergency settings

6.1 Provider number considerations

Normally practitioners need a provider number for each location they work from. Arrangements are in place to support GPs working in disaster-affected areas.

6.1.1 Provider number mobility for GPs in disaster affected areas

In an emergency or disaster affected area, it is more than likely that provider numbers will become transferable to allow GPs registered at a location in a disaster affected area (provided they are an unrestricted provider (not working under a 3GA training placement and/or 19AB exemption), to work in evacuation centres or other locations (such as an alternate practice) if they are displaced from their practice.

The numbers become transferable once a disaster has been declared and can be used in other locations as required. If Services Australia do not implement temporary provider number mobility, GPs working at different locations will need to apply for a temporary provider number via the Services Australia website.

6.1.2 Emergency provider numbers for GPs coming into disaster affected areas

Arrangements are in place to expedite access to provider numbers for GPs who are registered at locations outside of disaster-affected areas, who wish to support provision of care in a disaster-affected area (including at an evacuation centre or an existing medical practice).

Expedited process:

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- The medical practitioner completes, signs and emails the application form to provider.registration@servicesaustralia.gov.au.
- The medical practitioner calls **132 150** and advises they will be working in a disaster-affected area and require their application to be processed as a priority.
- A Services Australia Service Officer will locate their application and arrange for its urgent assessment. The Service Officer will also call the medical practitioner back to advise the outcome/provider number.

6.2 Ensuring medicolegal coverage for GPs working in evacuation centres

Provided GPs work within their normal scope of practice when providing services (paid or voluntary) in an evacuation centre, they should be covered by their individual medical indemnity insurance policy (subject to the terms, conditions, and exclusions in the policies). GPs providing services in an evacuation centre will be doing so independent from the practice they typically work from (even if that practice provides support for such) and therefore the GP would not be covered under the practice's policy.

It would be prudent for all GPs providing services in an evacuation centre to confirm the details of their medical indemnity insurance policy, including coverage when considering providing services in an evacuation centre/emergency setting.

PHNs should check this requirement when registering GPs to their GP volunteer register and GPs should notify their PHN of any changes.

6.3 Requirements for paper scripts

Noting that online prescribing software may not be available in the evacuation centre, GPs can provide paper prescriptions. Ideally paper prescriptions would be made on triple pads for record keeping, however remain valid if written on single blank paper, provided all mandatory information is required and details are record in clinical notes.

The prescription, must include:

- prescribers name, practice address (or address of evacuation centre), and prescriber number
- patient's name and address
- whether the prescription is for a PBS or RPBS medicine
- the name, strength and form of medicine
- the dose and instructions for use
- the quantity and number of repeats
- prescriber signature
- the date the prescription is written
- patient's Medicare number and any entitlement details, including Commonwealth concession, pension or health care card details or veterans' entitlement number.

6.4 Authority PBS prescriptions

For 'Authority Required (STREAMLINED) Benefits PBS prescriptions' prescribers need to add the 4 or 5 digit streamlined authority code from the schedule. These prescriptions do not require prior authority from Services Australia or the Department of Veterans Affairs.

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For ‘Authority required Benefits PBS Prescriptions’ GP prescribers will need to obtain an authority approval number by calling Services Australia Telephone Authority Applications service on **1800 888 333** or online via HPOS (further information available here).

It should be noted that this line experiences frequent delays and requires GPs to be on hold. At times when prescribers call the hotline, they may hear an emergency message. In such cases emergency provision arrangements are in place to prescribe an Authority required item. These arrangements are outlined by Services Australia here.

All Authority PBS prescriptions must be written on an Authority PBS/RPBS prescription form, one item per form.

6.5 Emergency access to prescription medicines in disaster-affected areas

Federal and state/territory arrangements are in place to allow patients continued access to their essential PBS/RPBS medicines if affected by a natural disaster or emergency.

This may vary between disasters but usual arrangements include:

- that in most states and territories, patients can access a 3-day supply of medicine without a prescription, supplied by a pharmacist for most medicines
- ‘Owing prescriptions’ whereby a pharmacist can dispense a medicine on confirmation from the prescribing GP, noting that the prescription must be received by the pharmacy within 7 days
- ‘Continued dispensing’ of previously dispensed medicines where there is an immediate need for the medicine and the PBS prescriber is not contactable.

Further information on these arrangement is available online.

6.6 Providing care via telehealth

Exemptions to the “12-month rule” in areas of natural disaster

Patients in disaster-affected areas are exempt from the existing relationship ("12-month rule") requirement for telehealth. This means patients' do not need to have had a face-to-face consult with a GP in the last 12 months to access MBS subsidised telehealth services.

A person is exempt from the 12-month rule” if, at the time of accessing a telehealth service, they are living in a local government area that is declared by a State or Territory Government to be a natural disaster area.

As GPs in evacuation centres should only be providing care from centres for evacuees in the centre, all telehealth services required by non-evacuation centre patients would be provided by their usual GP or other service provider. PHNs should consider promoting GP telehealth services provided by the PHN for where a person’s regular GP is not accessible physically or via telehealth.

7. Policy considerations for general practice involvement in responding to disasters

7.1 Current state

Establishment and operation of evacuation centres, and emergency response more broadly, is a responsibility of state/territory governments with support from local jurisdictions. General practice is governed through federal structures and therefore works outside the state/territory structures which establish and run evacuation centres. While in many localities, there are coordinated and well-resourced response mechanisms at the ready from local emergency services and the LHD, general practice is variably included and not integrated.

General practice is not currently represented consistently in federal, state/territory or local disaster management planning or response, including in evacuation centres. A growing number of local jurisdictions provide the exception; however, arrangements are in many cases based on informal relationships. This lack of integration and formalisation results in inconsistent and under-utilisation of GP skill sets, and poor communication with general practice in times of disaster.

The lack of formal structure for the inclusion of GPs is compounded by a lack of systematic training of GPs in disaster preparedness, response and recovery, no systematic communication channels between GPs and the formal disaster response systems in most regions in Australia and therefore under, ad hoc and/or inconsistent utilisation of GPs in evacuation centres.

While many PHNs have prioritised disaster planning, considering many years of tragic natural disaster nationwide, they are not currently funded to play an active, integrated or coordinated role in disaster planning and response and are therefore not currently well resourced to proactively engage GPs and local practices in disaster planning and response, including integrating formal processes for utilising GPs in evacuation centres.

7.2 GP inclusion on disaster planning and management committees

The role of GPs as frontline health providers must be formally recognised in any national disaster arrangements in Australia across planning, mitigation, preparation, response and recovery. GPs have continuous relationships with their communities before, during and after disasters and are met with extraordinarily high demand for their services during and after a disaster. To support this healthcare, and integrate it with other disaster healthcare provision, general practice needs to be firmly embedded in emergency plans across the country.

Sustained formal, funded GP representation on state/territory disaster management committees is essential to ensure GP-led plans, responses and solutions are embedded and that GPs are involved at governance and strategic levels for state-wide responses and appropriate inclusion of GPs in plans.

In 2020 the RACGP made a submission to the Royal Commission into National Natural Disaster Arrangements advocating for formal general practice representation on national and state/territory-based planning groups and committees and greater coordination and inclusion of GPs involved in frontline responses. This position was supported in the Royal Commission's report under recommendation 15.2 (Inclusion of primary care in disaster management) which stated "A*ustralian, state and territory governments should develop arrangements that facilitate greater inclusion of primary healthcare providers in disaster management, including: representation on relevant disaster committees and plans and providing training, education and other supports.*"

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7.3 Remuneration for general practice participation

Services provided by GPs in evacuation centres are not billed through Medicare and GPs are not remunerated. Utilisation of GPs in evacuation centres is in most cases voluntarily and reliant on philanthropic will. While many GPs are happy to volunteer their services to assist their communities, it must be acknowledged that in doing so they may be missing out on paid work via their usual place of practice, the impact of which will be dependent on the length of disaster event and operation of the evacuation centre.

PHNs should be funded to scale up disaster planning and response to include formal, renumerated GP involvement for specific managerial and leadership roles taken on by GPs that might include a regional GP disaster coordinator or a GP who will take an 'in-charge' role in an evacuation centre.

Where evacuation centres have extended periods of operations, payment should be available to rostered GPs (via the PHN) and be commensurate to the payments provided for the delivery of other GP services to the PHN (for example, participation on working groups) to reflect the cost of not practising from their usual place of practice.

Formal employment or contracting of GPs for the provision of services provides surety around WHS/OHS, access to workers compensation and professional indemnity insurance. It also provides surety of up-to-date registration, vaccinations and any other necessary credentialling of GPs working in evacuation centres.

Where a GP would prefer to remain a volunteer, their decision not to be paid should not prevent them from continuing to provide voluntary services at an evacuation centre.

Other appropriate funding for general practices (facilitated via PHNs) may include:

- Practice Incentive Payments to support practices to bulk-bill patients in disaster-affected areas
- incentives for practices to extend operating hours (for practices not physically impacted and capable of providing services) during and in the aftermath of a disaster

8. Conclusion

While this resource has been developed to outline guiding principles on the role and integration of general practitioners providing services in evacuation centres and includes recommended roles and responsibilities for PHNs coordinating, supporting and administering these services, PHNs also play a strong role in supporting general practices to continue operating, increase capacity and support other practitioners who may be displaced from their premises.

Clarity and implementation of a process for disaster preparedness across all levels of government will enable a more proactive and coordinated approach to local emergency management with a distinct role for both PHNs and GPs when responding to a disaster.

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9. ACRONYMs

AIMMS	Australian Inter-Service Incident Management System
AUSMAT	Australian Medical Assistance Teams
CDU	Counter Disaster Unit
DHM	Disaster Health Management
DM	Disaster Manager
DVR	Disaster Victim Registration
EAP	Employee Assistance Program
EOI	Expression of Interest
HSFAC	Health Services Functional Area Coordinator
LEMCs	Local Emergency Management Committees
MIMMS	Major Incident Medical Management and Support
MHFA	Mental Health First Aid
NBMLHD	Nepean Blue Mountains Local Health District
NSLHD	Northern Sydney Local Health District
PFA	Psychological First Aid
PHN	Primary Health Network
SES	State Emergency Service
SOPs	Standard Operating Procedures
TIC	Trauma-Informed Care
WSFA	Welfare Services Functional Area

10. Further resources

- HealthPathways
- Phoenix Australia – Disaster Mental Health Hub
- Australian Disaster Resilience Evacuation Planning Handbook
- Australian Disaster Resilience Glossary
- Australian Inter-Service Incident Management System
- Major Incident Medical Management Support
- RACGP Managing Emergencies in general practice
- RACGP Emergency planning and response factsheets

- RACGP 'Providing care and support during disasters' webpage
- Emergency Response Planning Tool (ERPT)

11. Support services for GPs

RACGP GP support program

The RACGP GP Support Program offers free, confidential specialist support to GPs to assist them in coping with professional and personal stressors impacting their mental health and wellbeing.

The service is available to all RACGP members who are registered medical practitioners at locations across Australia, including in regional and remote areas.

Appointments for face-to-face or telephone counselling during business hours can be made by calling **1300 361 008** (office hours 8.30 am – 6.00 pm, Monday to Friday) and via the same number for 24-hour/7-day-a-week crisis counselling.

DRS4DRS

DRS4DRS is an independent program providing free and confidential support and resources to doctors and medical students across Australia, by doctors.

Confidential phone advice is available 24/7 for any doctor or medical student in Australia via each state/territory helpline and referral service.

Australian Capital Territory	02 9437 6552
New South Wales	02 9437 6552
Northern Territory	08 8366 0250
Queensland	07 3833 4352
South Australia	08 8366 0250
Tasmania	1800 991 997
Victoria	03 9280 8712

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Western Australia	08 9321 3098

The Essential Network (TEN) for Health Professionals

The TEN online e-mental health hub, developed by the Black Dog Institute, connects frontline healthcare workers with services to help manage burnout and maintain good mental health.

CRANAplus Bush Support Service

CRANAplus' Bush Support Services provides a free and confidential 24-hour/7-day-a-week telephone counselling service for rural and remote health practitioners. The service is staffed by psychologists, including two Aboriginal psychologists. CRANAplus membership is not required to access the service. Phone **1800 805 391**.

Community support services

Other support services available include:

Lifeline	13 11 14
beyondblue	1300 224 636
Mensline	1300 789 978

12. References

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