Special Protocol Advisory

Celebrating the First Police ACE

Unforgettable: Florida’s Jaime Melser Stays Cool and Saves an Infant

The National Academies of Emergency Dispatch

Spring 2007

National Center for Missing and Exploited Children

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“A missing child’s life often depends on how quickly information is given to the people who can do something with it... At the heart of this whole effort is the public safety communications professional.”

— Ernie Allen, president and CEO of NCMEC
Q&A with the President.

Nearly two decades...but who’s counting

You've been in the field of emergency care for 17 years, which is shy about two years of when Dr. Jeff Clawson and several other EMD pioneers began exploring the formation of a national organization specifically for EMD. What made you aware of the work the NAED was doing when you started in the profession?

When I became an EMT in 1987, there was nothing that resembles today's EMD or dispatching. We were dispatched by an answering service. When someone dialed 9-1-1, the police department answered the phone, and if the call was medical, it was transferred to the hospital. An operator at the hospital would dispatch the paramedics and then call the answering service to have the ambulance dispatched. A typical dispatch was “respond to [an address] for a sick person.” There were no Pre-Arrival Instructions or Dispatch Life Support.

It wasn't until I began working for the Salt Lake City Fire Department that I became familiar with the NAED, Priority Dispatch, and MDPS®. My first introduction came by way of Brian Dale, who was the fire department’s dispatch Quality Improvement (QI) officer. He was developing the department's QI process and protocol compliance, separating police and fire dispatch, and medical accreditation.

Interestingly, my hometown in Jackson, Ill., began using MDPS® protocols when I was there for Christmas a few years back. It was New Year’s Eve and my uncle had taken a fall and, because he was in so much pain, we took him to the ER for an evaluation. When we got there, I noticed some of my former colleagues huddled around the nurse’s station and they seemed to be staring at something. Naturally, I asked, “What’s everyone looking at?” They showed me their brand new medical card-set that was going into effect at midnight, January 1. I couldn’t believe the coincidence! What were the chances that my hometown was using the NAED Medical Protocols for the first time the very night that I was there in the hospital?

It was about 10 p.m. when they finished x-raying and examining my uncle, but there were at least two more hours before the dispatcher would be using the protocol. What could I do? I told my uncle that, although he had already been there for a couple of hours, he’d have to stay with me until they took their first call using the protocol. He wasn’t too happy.

The first call came in around 12:20 a.m. It was a “heart problem” call. The dispatcher was so nervous. There must have been 20 people standing around the desk when the call came in. She did a great job. What an exciting night!

Are the reasons you joined the NAED the same you would give today for someone interested in the organization?

There are many reasons. The first and foremost is certification as an EMD, EFD, and/or EPD, which is an automatic qualifier for membership in the NAED. Others are members because they are instructors, quality-assurance officers, communications center directors, or otherwise associated with the NAED. We have more than 40,000 members worldwide and we are recognized as the leading voice on protocol dispatching for all three disciplines.

Membership in the NAED not only recognizes dispatch and communications professionals, but it supports the important work of the National Academies in its research and development of protocols, curricula, standards, and its forwarding of the profession. The Academy is involved in many dispatch-related projects, including NG 9-1-1, call processing, state and federal legal recognition, missing and exploited children, CBRN, disaster-awareness recognition, Department of Transportation EMD development, technology, fire and police dispatch standards, and automatic vehicle-crash notification technology and protocols.

This column is published in the issue that members will be reading at Navigator. What do you look forward to above anything else at this premier gathering of EMDs?

Navigator lets me reconnect with all of the wonderful people associated with the Academy and this profession. This is the crème of the crop. I also look forward to hearing from so many talented people that present timely and important topics at the conference. I leave Navigator a better person and dispatch professional. It really is a rewarding and reaffirming experience.

Editor’s Note: It's good to get to know the people you work with, look up to, as well as those who write columns published in your professional journal. That’s why this edition features our conversation with NAED President Scott Freitag. A most of you know, Scott is the Director of the Salt Lake City Fire Department’s communications center. Read on, and you'll see an engaging side that sometimes, because of the seriousness of dispatch, escapes the printed copy.

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Protocol 23 Overdose/ Poisoning.  
"I coded this call as a 23-C-8 and our EMD QA Supervisor scored me down"

Jeff Clawson, M.D.

Alaina writes

I'M AN EMD CERTIFIED DISPATCHER for the Idaho Statewide Communications Center. I received a call from the frantic mother of a 2-year-old child found with an almost empty bottle of Nyquil about 10 minutes prior to the call. Nyquil was spilled on the floor near the child and the mother was not certain whether the child had ingested anything but wanted transportation to the hospital, just in case. The child was acting age appropriate, completely awake, breathing normally. I coded this call as a 23-C-8 and our EMD QA supervisor scored me down and advised that it should have been coded 23-B-1. I don't think either code is accurate since one is signifying that the status is unknown/3rd party and the other is signifying that there had been an ingestion/ overdose when actually we did not know that. It seems we could use a “possible ingestion” as a Determinant Descriptor. What do you think? How would you have coded this call?

Dear Ms. Nudell:

THANK YOU FOR YOUR QUESTION.

Actually, in this case, neither you nor your QA supervisor coded it correctly. The correct code is 23-01-1. It is not an unknown problem, a third party caller, or an overdose (intentional act to harm one's self). This is the exact call that the Poison Control Center referral was designed for 30 years ago. The fact that your EMS system doesn't utilize it, or it is not available, is not the issue here. The code is the code. What is referred or sent on that code is a local system's predetermined decision. It might be a helicopter in some places (although we wouldn't recommend it).

Pediatric ingestions happen by the bushel barrel full, and they are the main reason for the PCC's existence. If after they evaluate the situation (a two-minute process), and an ER visit is needed, they will either advise the parents to come in, or reconnect with the 9-1-1 center for a transport. When that happens, the code officially becomes 23-C-9. In most cases, they home manage the patient, and follow up with them at half-hour, one-hour, four-hours, eight-hours, and 24-hour periods. They are the experts at this. If we (EMS) are needed at any time, they will notify us.

If the mother wanted to have the child transported and declined a PCC referral, an override response code is used. Using ProQA, that would be a 23-B-0 or 23-C-0, whichever your policy is for an asymptomatic accidental poisoning transport. Using cards, it is a change in response, not in the code—which is what it clinically is—regardless of an altered response.

Changing codes without the patient changing condition is not correct. We call this "code surfing." Remember, the patient didn't change, only the response you desired for them did.

I would refer you to read the section in the Principles of EMD textbook titled, “9-1-1 Transfers to the Utah Poison Control Center — 1994” located in the Appendix A.42. As you can see in the chart “Age Category by Management Site,” 75 percent of 2 year olds are managed at home. Of all patients (any age) referred to a health care facility, 79 percent are treated and released. As you can see, for these patients mobile and ER care is usually an excess (resource commitment and health care dollar-wise). If there is an Idaho (or regional) PCC, I encourage your communications center/EMS system to utilizing it for correct care of these patients. We can provide additional information and help facilitate this. Many State PCC and local EMS/FDs have worked together to established a trusted link between them, you can too.

Hope this helps.

Onward through the fog... Doc.

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Editors Message.
There’s something special about this issue of the Journal

This issue of the NAED Journal contains important news about our colleagues and the Academy, including a first look at a Canadian call center making history as the first Police Accredited Center of Excellence (ACE), some comments on protocol, a story about the Medical dispatcher Shawn Smith guiding a roadside baby delivery, and columns by your favorite support crew, NAED founder Dr. Jeff Clawson, and NAED President Scott Freitag.

There’s something else that’s special about this issue… it marks our new magazine format. We recognize just how busy you are, so we’ve packaged the news, columns, and features into departments you can find easily and consistently. We hope you will find the editorial, organization, and layout more engaging. Let us know what you think.

New in this publication, we’re introducing the IndustryInsider column that will keep you ahead of what’s happening in public safety dispatching. We’ve roped off Academy opinions and perspectives in a department we’re calling ViewFinder. The ACE and other fine examples of the dispatch profession will be highlighted in the BestPractices pages.

Finally, we’re really excited to tell you more stories about you. And the new department we’ve labeled YourSpace does just that. We hope you’ll share your opinions, what motivates you, what worries you, what inspires you, and much more. In return we’ll give you a view of what others are doing and how they are responding in the ever-changing space of a communications center. We encourage you to email us at editor@emergencydispatch.org and share your story.

And not to worry. The popular CDE articles and quizzes are headlined under OnTrack (no trick to how we came up with that name).

We’re pleased that our membership is climbing, which means our message is reaching more and more communications centers round the world. And in the year ahead, you can look forward to an even greater membership benefit from your Journal as we move ahead with six, rather than four, issues. We will also be stepping-up our reporting on the Navigator educational conferences, both the national and international events.

Enjoy the issue, and as always, we welcome your feedback, suggestions about topics to cover and articles for publication in the NEW Journal. Our e-mail addresses are listed in the masthead, and you can always reach me at editor@emergencydispatch.org.

— Audrey Fraizer
Managing Editor

THE JOURNAL
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THE JOURNAL
National Journal of Emergency Dispatch is the official quarterly publication of the National Academies of Emergency Dispatch (NAED), a non-profit, standard-setting organization promoting safe and effective emergency dispatch services worldwide. Comprised of three sister academies for medical, fire, and police dispatching, the NAED supports first-responder-related research, unified protocol application, legislation for emergency call-center regulation, and strengthens the emergency dispatch community through education, certification, and accreditation.

General NAED membership, which includes a) journal subscription, is available for $25 annually, $35 for two years, or $60 for three years. Non-member subscriptions are available for $35 annually. By meeting certain requirements certified membership is provided for qualified individual applicants. Accredited Center of Excellence status is also available to dispatch agencies that comply with academy standards. © 2007 NAED All rights reserved.
AN OUTSPOKEN PHYSICIAN WHO is often critical of EMD recently commented about a study out of Toronto, Canada, that attempted to compare the Medical Priority Dispatch System® (MPDS®) with a standardized patient-acuity scale. He said that, although MPDS is widely used, it is unproven. He then attempted to use the results of the Toronto study to support his contention.

Interestingly, when I researched the Canadian Triage and Acuity Scale (CTAS)—which the Toronto study used as a benchmark for MPDS—I found that it was also widely used, and yet also unproven. CTAS studies I encountered all involved inter-rater reliability: the comparison of a score obtained by one party (for instance, a paramedic or doctor) with one obtained by another (such as an EMT or nurse). While I can see how such studies might help to validate the objectivity of a triage tool, they do not determine how well that tool predicts acuity.

Commons sense and responsible analysis of the evidence
IN MY EXPERIENCE, MPDS ALSO HAS excellent inter-rater reliability. In the late 1990s I conducted a study using a 100 percent sample of protocol-compliant calls that compared the dispatch codes derived from the original caller interrogation to those derived by a second EMD’s interrogation of the first arriving paramedic.

The result?
AGREEMENT WAS JUST OVER 93 percent. While this shows that the scale is consistent among users, it doesn’t validate that the scale accurately measures what it was designed to measure. The trouble is that acuity is so ambiguous and subjective with regard to a patient’s immediate needs, at least in the field, that EMS professionals can’t agree on a standard scale. What is clear is that measuring prehospital acuity is difficult at best because clinicians often disagree about a given patient’s needs except in the clearest of circumstances.

Fortunately, EMD has rapidly evolved despite the difficulties associated with studying it. This is because well-intentioned people have combined common sense, expert consensus, anecdotal evidence, and responsible interpretation of Advanced and Basic Life Support science to create what we know today as Dispatch Life Support. Success stories abound in the thousands of communications centers worldwide that use MPDS. Resources are prioritized and reserved for the sickest patients and callers are given experts instruction about how to care for the sick and injured until field responders can take over in person.

Tales from two Florida cities
NOT LONG AFTER MPDS WAS updated to include the American Heart Association’s 2005 CPR guidelines, a young mother called 9-1-1 in Manatee County, Fla., and told Academy-certified EMD Jaime Melser that her six-month-old baby wasn’t breathing. Six minutes later, after the mother had calmly performed several rounds of perfectly instructed 30:2 CPR, the once-limp, breathless, and cyanotic infant resumed breathing—and that healthy baby continues to breathe today.

Irrefutable scientific evidence may not prove Jaime was responsible for the successful resuscitation of this infant, but it is not difficult to draw meaningful conclusions about what likely would have happened had an EMD with proven protocols not been at the caller’s disposal. Consider a similar case that happened years ago in another Florida community where prearrival instructions (PAIs) were not standard. Brooke Hauser, a 14-month-old twin, was plucked from the family swim-
ming pool by her 13-year-old sister, Ivonne. As Ivonne called 9-1-1 to report her sister’s accident, she was horrified to find that the dispatchers had no heroic advice or instructions of the sort that her favorite TV show, “Rescue 9-1-1,” had brought her to expect from emergency professionals. For what seemed like an eternal five minutes, Ivonne watched her motionless sister turn blue, then purple. All she could ask was “What should we do?” Each time I hear the recording of that call, the silence on the other end is more painful; it doesn’t take a rocket scientist—or a fancy study—to understand that PAIs were exactly what Ivonne needed. The proof is in the pudding.

Brooke was resuscitated and lived in a vegetative state until her death 15 months later. Thanks to the tireless efforts of Brooke’s mother since then, however, similar tragedies have since been averted. Brooke’s mother, Ivette, went on to form Parents Against Negligent Dispatch Agencies (PANDA), which helped shape public expectations for the pre-arrival instructions that most PSAPs use today. Ivette understood, without the benefit of a controlled, clinical study, that pre-arrival instructions simply make sense.

More converts every day
TODAY, AS MPDS FILLS NORTH America, the U.K., Australia, New Zealand, and the Caribbean Islands, only a few skeptics remain. EMDS worldwide remain proud of their accomplishments and confidently take part in the evolution of their profession. To the EM D — and the callers and patients they serve — the success of dispatching protocols is self-evident. From the subtle dissipation of anxiety in a frightened caller’s voice to a second chance at life for an infant, the influence of today’s EM DSs is felt somewhere every day.

Does the MPDS make a difference? Fargo, N.D., proves it does with its own study

By Wade Mitzel

AS THE CLINICAL SUPERVISOR for F-M (Fargo-Moorhead) Ambulance at Red River Regional Dispatch Center (RRRDC) in Fargo, N.D., a call center with 30 dispatchers fielding police, fire, and medical calls from 175,000 urban and rural residents in Cass County, N.D., and Clay County, Minn.—it’s my job to study outcomes and determine the best protocols, procedures, and equipment for our service. Not long ago, one of our dispatchers asked me if MPDS really makes a difference in patient care.

“Of course,” I said. “Absolutely.”

As we debated MPDS merits, the dispatcher admitted that Dispatch Life Support helps callers and provides live-saving instruction.

“But what about all the other calls?” she persisted. “Does it really make any difference in how the patient does if her life isn’t in immediate danger? And can you prove it makes a difference in our area—not just in some big metropolitan setting?”

I set out to answer her question.

Collecting data
TO ANSWER THE BIG QUESTION ABOUT MPDS’s effectiveness, I obtained patient outcome data from one of the two major hospitals in RRRDC’s area and tracked each patient from the time of their 9-1-1 call until discharge. I worked with the hospital’s trauma committee and decided to focus on patients with major and minor trauma injuries.

As the graph below shows, I compared RRRDC’s EM D codes with the Injury Severity Scores (ISSs) assigned by the hospital. ISS is virtually the only anatomical scoring system used and it correlates linearly with mortality, morbidity, hospital stay, and other measures of severity. The higher the ISS (between 0 and 75), the greater the injuries.

Vertical lines in the graph show the ISS range for each category, while circles indicate the average. Looking at trauma cases, you can see that our DELTA responses had the largest range of ISS scores. This seems to be a normal variant due to third-party callers and different mechanisms of injury. As you
can see, the protocol did a great job of classifying the most injured patients with the highest level of response.

Police calls are the next category that inconsistently receive a Chief Complaint code, although local authorities have started to use the “SEND Protocol” supplied by the NAED.

I also took into consideration that we are a smaller agency and this reflects very small data set of 62 responses for trauma. Of those 62 responses, we recorded only two CHARLIE responses. The study is in the beginning stages, but after sharing the information with the different entities involved, we look forward to using the data more specifically.

**Preliminary results**

The data showed an interesting relationship between the ISS to the Determinate Code. As each call was given a code based on the protocol, the patient’s ISS score increased as the code progressed from ALPHA to DELTA determinant levels.

The fact that the information has really helped change a perception held by our dispatch team is an important result of this study. Using MPDS dispatchers really can make a difference in the community and people’s lives. Even though dispatchers are taught from the beginning that they have an impact throughout the health care system, their perception often mimics the chart at the left. They are skeptical about their effect beyond how an ambulance responds, emergent or non-emergent. Without following our patients and gathering the data, it was difficult to see how using MPDS enables the best and most specific response to each caller and emergency (see chart perceptions of dispatching left).

The study provides a chart (shown at left—MPDS “Reality”) that more accurately portrays how an EMD using the MPDS touches each part of the health care system. Based on the information from this study, more work is going to be done to look at the way EMD protocols can lead to a more positive outcome for the people we serve.

**What’s next?**

This information has sparked interest in looking at the outcomes even further:

1. The hospital trauma committee wants to see how the M PDS Codes could give indications to the injury severity score and how it could help in emergency room (ER) response. Committee members discussed the possibility of calling a trauma code in the ER based only on the M PDS Code assigned by dispatch.
2. EMS is interested in using the protocols and research to take a more in-depth look at how it responds to and intercepts with BLS agencies within the two large counties.
3. Community groups are interested in the information to show how our health care system is viewing patient outcomes and making a difference in the care we give our citizens.

**Conclusion**

Communications centers do make a difference by using the Medical Protocol Dispatch System. A direct correlation exists between the determinate code they assign and how the patient fared throughout the health care system. Because EMD touches every link in the chain of survival using M PDS gives each patient the best opportunity for a good medical outcome. After showing the dispatcher this information, she decided her job really does make a difference. EMD works!
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JUNE 9 - 14, 2007   CHARLOTTE, NORTH CAROLINA   www.nena.org   1-800-332-3911
Do you want to be in on a secret? ProQA has its own report program.

ProQA Reports lets you access a wealth of statistical information about the calls your center processes. The reports are not limited to one format. There are many.

Some of the useful reports that can be created in ProQA are:
- Comparative histories for the operator (dispatch level and/or dispatch codes)
- Master dispatch analysis (summary of all dispatch codes and frequencies).

For those agencies that report Medi-aid/Medicare billing, the Incident Conditional Code and Summary Reports are specific to medical analysis.

To unlock the secrets of using these ProQA Reports, follow the steps outlined in this article.

Steps to follow:

**STEP 1:** Create A User ID and Password created in the Operator Maintenance for the version of the protocol you want to use; police fire or medical.

You can refer to the ProQA User's Guide on how to create your user ID.

**STEP 2:** Click the Windows Start button (at the lower left, on the Taskbar).

**STEP 3:** Select Programs.

**STEP 4:** Locate the Priority Dispatch file and select the appropriate reporting module (ProQA EMD, EFD, or EPD Reports).

Note: Here we will use EMD Reports to demonstrate ProQA's reporting functionality.

**STEP 5:** When the ProQA login dialog opens, enter your username and password. Click OK.

**STEP 6:** From the Menu bar, select Database, then Data manager (see Figure 1, Step 6).

**STEP 7:** When the Data Manager window opens, select the Create new database button (see Figure 2, Step 7).

**STEP 8:** In the Create Database window, select the local or network location at which you wish to store the database.

Note: For easier file management, we suggest storing the database in a folder named "Reports" in the ProQA.win Directory (see Figure 3, Step 8).

**STEP 9:** Assign the report a unique file name (something like "Medical_Reports"). Click Save .

**STEP 10:** On the Data Manager window (see Figure 4, Step 10), specify your preferences for the following criteria:
- Empty database (checkbox) - Causes data to be removed from the existing database the next time it is reloaded
- Include Key Questions (checkbox) - Causes KQs to be displayed within the final report
- Start /End date (dropdown arrow which displays a calendar) - Determines the time period from which report data is gathered; if you leave this field blank it will bring in all records in the ProQA database.

**STEP 11:** In the Update window that appears choose OK to Update the report.

**STEP 12:** When it finishes, the window will display various information such as:
- Operator Summary records verified and inserted as well as Cases Summary records verified and inserted (see Figure 5, Step 12).

Click Done .

**STEP 13:** On the left side of the ProQA Reports window, click on the icon with the name of the report you would like to create.

**STEP 14:** From the list of employees that is displayed, select the employees you wish to include in the report. Important tips:
- The default is all employees
- You can choose only one by clicking on that employee's name
- You can hold down the CTRL key and click on multiple employees
- You can hold down the Shift key to select a block of employees
- There is also a button on the lower right of the screen that says "Select All"
Figure 1, step 6

Figure 2, step 7

Figure 3, step 8

Figure 4, step 10

Figure 5, step 12

Figure 6, step 15
Click \textit{Next}.

\textbf{STEP 15:} In this window (see Figure 6, Step 15), select your preferences for:
- **Case number** – Enter in the specific case number you want in the report.
- **Date range** – Using the drop down arrow, select the beginning and end date for the report; if left blank, the report will be on all data in the database.
- **Dispatch level(s)** – You can run the report for All levels, one level, or any combination needed.
- **Chief Complaint(s)** – Leave blank and the report will include all Chief Complaints in the database; select a single Chief Complaint if that's all you need.
- **Exclusions** – e.g., cases completed by supervisory logins, incomplete cases, or aborted calls.
- **Reset Filter** – Choosing this option will reset all previous fields selected on this screen.

Click \textit{Next}.

\textbf{STEP 16:} Now you will select the cases you want to run the report on, as in Step 15 you can choose one, multiple or all. Click \textit{Next}.

\textbf{STEP 17:} When the report window opens, use the available buttons to vary viewing, navigation, and other options, including:
- The three buttons at top left yield different views of the report.
- These icons aid in navigating through the reports.
- The arrows with the lines will jump you to the first or last page.
- The arrows without the lines will move you page by page forward or back (You can also use your keyboard’s Page Up and Page Down keys or click on the thumbnails in the navigation pane a left).
- The Go To Page button allows you to quickly jump to a specific page you choose.
- The binocular icon enables text searches to help you find specific info on a report.

Results display in the Search Results Tab.

These two icons govern printing and printer setup:
- The diskette icon allows you to save reports for viewing. Caution: Reports saved in ProQA Reports can only be opened and viewed in ProQA Reports. The folder icon allows you to open a saved report for viewing or printing.

Available reports are:
- **Incident Case History** – Details individual case occurrences, including:
  - Case Entry (CE)
  - Key Questions (KQ)
  - Dispatch Coding (DC) Information
  - Time stamps
- **Incident Case Summary** – Reveals all information from Incident Case History and prints entire case summary.
- **Operator Comparative History** – Compares a calltaker’s statistics against agency averages for case times in CE, KQ, Send, and Total Evaluation, compliance with ProQA’s recommended Dispatch Level, shunts, and reconfigurations.
- **Dispatch Level Comparative History** – Summarizes agency statistics for each dispatch level and compares them with those for all dispatch levels (including percentage of calls in each dispatch level, average time to dispatch, average time in CE and KQ, DC overrides, and reconfigurations).
- **Dispatch Code Comparative History** – Shows agency stats for each Chief Complaint and compares them with average stats for all dispatch codes (including average time in CE and KQ, shunts, reconfigurations and time to dispatch).
- **Master Dispatch Analysis** – Reveals a detailed summary of all dispatch codes and the frequency with which they occur.

ProQA EMD also offers the following two reports:
- **Incident Condition Code** – Offers a detailed history for an individual case; this is often useful for justifying Medicare billing (including average time in CE and KQ, shunts, reconfigurations and time to dispatch).
- **Incident Condition Code Summary** – Shows the condition and dispatch codes for all selected cases.
They’re counting on you to get them on-scene fast. That’s why you should count on RescueNet CommCAD. Its map-based interface provides a birds-eye view of the incident scene so you can get your fire and EMS crews on their way in record time. With RescueNet CommCAD they get a dispatch solution that’s tailored specifically to the unique needs of fire and EMS. And it’s backed by ZOLL Data Systems, a company with years of experience in dispatch systems and hundreds of installations nationwide. Our team of experts is here to answer your questions, provide training, help with system integration, and continually develop new and better ways to get accurate information to those who need it. Which means everyone—dispatchers, fire/EMS crews, the entire community—can count on RescueNet CommCAD today, and for years to come.

To get your FREE white paper “The Top 10 Things to Consider when Buying a Computer-Aided Dispatch System”, call 800.474.4489 or visit www.zolldata.com/CADwhitepaper4.
Choking is not only a critical prehospital emergency, but it is also one of the most time-sensitive situations emergency medical dispatchers (EMDs) encounter.

Stark reality
THE BRAIN IS SO DEPENDENT UPON oxygen that a choking patient will die if his airway isn’t cleared in a matter of minutes. If the patient survives but goes too many minutes without immediate intervention, brain damage is very likely. Because patients with complete airway obstruction typically lose consciousness within three to five minutes, you can see how prompt sharing of the Medical Priority Dispatch System’s (MPDS) Dispatch Life Support (DSL) instructions can literally be the difference between life and death.

Choking is one of the leading causes of death for kids under age 4 and it is also a top killer in every other age group. Choking is the most likely cause of unexplained cardiac arrest for children and young adults, which explains why, in the dispatch environment, a healthy child or young adult found in cardiac arrest is considered to have a foreign-body airway obstruction until proven otherwise (see-rules below).

What qualifies as choking?
FOR MEDICAL PURPOSES, CHOKING is a partial or total blockage of the airway by an object. It is usually caused by inadequately chewed food, especially meat (see the Choking Definition below). In adults, choking often results from eating too quickly, while talking or laughing, or with improperly fitted dentures. Drinking alcohol during or prior to a meal also increases choking risk because it numbs the nerves used in swallowing, reducing the gag reflex.

Children often choke on small, round foods such as nuts, hot dogs, grapes, hard candy, and popcorn. Other than food, balloons are the leading cause of choking in children—although children can also choke on small toys, buttons, coins, and watch batteries.

Gagging: Disconcerting but not dire
TRUE CHOKING RARELY OCCURS with liquids. Gagging—the choking-like phenomenon that sometimes occurs with the improper swallowing of liquids (for example, a baby inhaling formula), and which may be accompanied by coughing and vomiting—is a contraction of the back of the throat that actually helps prevent choking. Gagging is rarely a prehospital emer-

### Protocol 11-Airway Obstruction At-a-Glance

#### Rules
1. A healthy child (or young adult) found in cardiac arrest is considered to have a foreign body airway obstruction until proven otherwise.
2. Only if the victim of a PARTIAL obstruction begins to faint (pass out) should the EMD instruct the caller to try an obstructed airway maneuver, since the patient can no longer make efforts to clear his own airway.
3. Before ALPHA-response selection, the caller needs to verify that the patient is not choking now (can talk or cry, is alert and breathing normally).
4. Back slaps are not recommended in the DSL environment due to the increased risk of injury from overly forceful or misplaced blows from an untrained caller.

#### Choking
Choking occurs when the airway is **partially or totally blocked** by an object. While most choking involves food (at restaurants, barbecues, and in the home), small children can choke on toys or other objects they put in their mouths, and many people choke on chewing gum.

#### PARTIAL Obstruction
Complaints may include but are not limited to:
- Forceful coughs
- Wheezing sounds between coughs
- Abnormal breathing
- Difficulty speaking normally

#### Axioms
1. **PARTIAL obstruction**—life-threatening intervention in.
   The best approach to a partial obstruction is to try to clear their airway.
2. As choking occurs, liquids, gagging—choking-like phenomenon with baby formula.
   Gagging is rare emergency.

#### KEY QUESTIONS
- **Choking verified**
  1. Is s/he complete
  2. Is s/he breathing
  3. (Alert & breathing)
  4. What did s/he eat?
gery (see Axiom 2 below). Conscious gagging patients should not be given back slaps, chest compressions, or the Heimlich maneuver. In most cases, these patients can clear their own airway without help.

**Partially or totally obstructed? That’s dire**

A patient with partial airway obstruction often experiences forceful coughs, wheezing, abnormal breathing, and difficulty speaking normally—but he can still move air in and out of his lungs (see Partial Obstruction definition below). Even so, partial obstruction can be a serious prehospital emergency. But it can be made even more life threatening by attempted intervention. The best approach is to let the patient try to clear his airway with reflexive coughing (see Axiom 1 below). An EMD should instruct a caller to help only if the victim begins to faint and can no longer try to breath on his own (see Rule 2 below).

Complete airway obstruction is always a time-sensitive prehospital emergency. A patient with a complete airway obstruction cannot breathe, talk, cough, or cry—at all—and his airway must be cleared quickly or he will die. He often instinctively clutches his throat, and panic typically ensues as he realizes the gravity of his situation. He may turn blue or purple, especially around the lips and fingernail beds, and if his airway isn’t cleared right away, he will usually lose consciousness in three to five minutes. Without immediate intervention, brain damage and death are imminent.

To clear the victim’s airway, the caller should be advised to administer the Heimlich maneuver or chest compressions immediately. Back slaps are not recommended due to the increased risk that an untrained caller might cause injury with excessive force or misplaced blows (see Rule 4 below).

**Airway obstruction = CC 11**

**THE CHOKING CHIEF COMPLAINT in MPDS 11.3 (number 11) is designed for foreign-body airway obstructions, whether caused by gagging, partial obstruction, or complete obstruction. Absent scene safety issues, dispatchers should select this complaint whenever a caller says the patient is (or was) choking on food or a foreign object. It is also appropriate when the caller reports that the patient was but is no longer choking (see Key Question below). If a patient was choking but seems to have recovered, he should always be evaluated by a trained medical professional—even if he believes the foreign body has been expelled. Serious complications can occur when even a small portion of the object is forced into the lungs or windpipe. Delayed complications can also arise from administered first-aid maneuvers.**

Not always what it seems

**OTHER MEDICAL PROBLEMS CAN cause choking symptoms. Some infections, such as severe cases of croup or epiglottitis, can inflame and block (or partially block) tissues surrounding the airway, possibly leading to suffocation or death. Severe allergic reactions also can cause choking-like symptoms. A naphylactic shock is a rare but potentially life-threatening allergic reaction with symptoms such as severe shortness of breath, shallow breathing, mouth and throat swelling, and unconsciousness. A naphylactic shock can result in a dramatic loss of blood pressure through vascular dilatation. Without adequate blood pressure, oxygen cannot be delivered to tissues, and the patient will become less alert and eventually may lose consciousness.**

**Not always what it seems**
prompt treatment, a severe reaction can rapidly become fatal.

Although other medical conditions can produce symptoms similar to choking, breathing problems caused by illness should be handled with the Breathing Problems Chief Complaint (number 6). Breathing problems associated with allergies or envenomations should be handled with the Allergies (Reactions)/Envenomations (Stings, Bites) Chief Complaint (number 2)—unless the caller reports that the patient choked on a foreign object, in which case Breathing Problems is appropriate. The Key Questions, Post-Dispatch Instructions (PDIs), and DLSs on Chief Complaints 2 and 6 are better suited to patients with medical-related, choking-like symptoms.

Key Questions not necessary for ECHOs

Because Choking Is a Critical, time-sensitive prehospital emergency, it clearly warrants an ECHO-level response. The dispatcher must verify that the patient is still choking and not breathing effectively before sending an 11-E-1 response. Failure to verify this critical information may put responders and the public at risk from an unnecessary HOT run.

Key Questions for Chief Complaint 11 are not necessary when choking has been verified and an 11-E-1 response has been sent. Notice how MPDS immediately directs you to PDIs, then DLS links in such cases (see Q line 1 on the previous page). For choking calls that are not ECHO level, the key questions help determine the appropriate Determinant Descriptor:

- An 11-D-1 response is appropriate whenever the patient is not alert
- An 11-D-2 response is appropriate whenever the patient is experiencing abnormal breathing that likely resulted from a partial airway obstruction
- The 11-A-1 Determinant Descriptor is appropriate only when the patient is not choking now, can talk or cry, is alert, and is breathing normally

Calm callers with repetitive persistence

Calls reporting choking incidents will likely be very emotional—especially if the patient is panicking or the victim is a child. That's why the Additional Information for Chief Complaint 11 (Choking) contains repetitive persistence and reassurance examples, phrases that help calm the patient and speed the response.

When using repetitive persistence, always combine a command (such as "calm down") with a reason ("so we can help your daughter"). Pick an appropriate phrase and repeat it verbatim whenever necessary. Examples of appropriate phrases include: "M'am, you're going to have to calm down in order to help your baby"; "Sir, please calm down and listen to me carefully so that we're sure to do it right"; and "Your son needs you to calm down so that you can help him." (See examples on page 17).

Research puts heimlich in the back seat

Timely, Appropriate Pre-Arrival Instructions (PAIs) can save lives in many emergency situations, but they're especially crucial in choking cases. Users of previous MPDS versions may notice significant changes to PAIs in version 11.3. DLS Links on Chief Complaint 11 now direct you to ABC-1 for unconscious choking patients (see DLS links on the page 17). This change was recommended by various international resuscitation councils—including the American Heart Association, the International Liaison Committee on Resuscitation, and the Canadian Heart and Stroke Foundation—based on evidence that chest compressions are an effective obstructed-airway maneuver. These organizations say that lay rescuers should begin cardiopulmonary resuscitation (CPR) immediately for unconscious choking patients, rather than first attempting the Heimlich maneuver. In accordance with these recommendations, DLS instructions have been redesigned to better handle unconscious choking patients. EM Ds should use the new Airway/Airway/Choking (Unconscious) instructions on DLS instructions A, B, and C whenever a caller reports an unconscious choking patient.

Previous MP Ds versions had distinct PAI protocols for conscious choking victims: one for infants and children, and one for adults. Due to more recent research, however, MP Ds 11.3 advises EM Ds to use DLS instruction D, Choking (Conscious)—Adult/Child/Infant, regardless of the victim's age. (Infant-specific instructions appear in pink highlighting.)

Complexity reduced to simplicity

Choking is a time-sensitive, prehospital emergency for which prompt intervention—including, when appropriate, the Heimlich maneuver, chest thrusts, or chest compressions—can be the difference between life and death. Providing callers with instructions for how to administer these procedures is not without risk. A conscious patient who can breathe, talk, cough, or cry—even just a little—should be allowed to try to clear his own airway. For the rest, thankfully we have MP Ds to offer the most appropriate guidance available. Case after case has proven that strict compliance to the NAED's Medical Priority Dispatch System ensures the best possible hope of saving a life in danger from choking. ■
Answers to the CDE quiz are found in the article "A Breath of Fresh Air" which starts on page 16.

1. Patients with a complete airway obstruction cannot breathe, talk, cough, or cry at all.
   a. True
   b. False

2. A caller says his 6-month-old baby is choking on a watch battery. The baby is conscious and crying, but making wheezing noises when he breathes. Which is the correct Chief Complaint?
   a. Allergies (Reactions)/Envenomations (Stings, Bites)
   b. Breathing Problems
   c. Choking

3. A caller reports that her 2-year-old daughter has been sick and coughing all night. She reports that the girl’s throat is all swollen and she seems to be having difficulty breathing. Which is the correct Chief Complaint?
   a. Allergies (Reactions)/Envenomations (Stings, Bites)
   b. Breathing Problems
   c. Choking

4. Previously choking patients who are not choking now, can talk or cry, are alert, and are breathing normally generally don’t need to be evaluated by a medical professional.
   a. True
   b. False

5. You must ask all of the Key Questions on Chief Complaint 11, even when an ECHO determinant is selected.
   a. True
   b. False

6. A caller reports that his 74-year-old wife choked on a piece of meat and is now unconscious. Which Pre-Arrival Instruction (PAI) is appropriate?
   a. Airway/Arrest/Choking (Unconscious) – Infant < 1 yr
   b. Airway/Arrest/Choking (Unconscious) – Child 1 - 7 yrs
   c. Airway/Arrest/Choking (Unconscious) – Adult > 8 yrs
   d. Choking (Conscious) – Adult/Child/Infant

7. A caller says her 6-year-old son is choking on food. The boy is conscious, but cannot breathe. Which PAI is appropriate?
   a. Airway/Arrest/Choking (Unconscious) – Infant < 1 yr
   b. Airway/Arrest/Choking (Unconscious) – Child 1 - 7 yrs
   c. Airway/Arrest/Choking (Unconscious) – Adult > 8 yrs
   d. Choking (Conscious) – Adult/Child/Infant

8. The Heimlich maneuver is the preferred airway-obstruction maneuver for conscious adult and child patients over the age of 1.
   a. True
   b. False

9. Infant-specific instructions and links, on PAI D, are marked with the color:
   a. Blue
   b. Pink
   c. Purple
   d. Green

10. When using repetitive persistence, you should always combine a command with:
    a. The caller’s name
    b. A reassuring phrase
    c. A reason
    d. A question

To be considered for CDE credit, this answer sheet must be received no later than 5/30/08. A passing score is worth 1.0 CDE unit toward fulfillment of the academy’s CDE requirements (up to 4 hours per year). Please mark your responses on the answer sheet located at right and mail it in along with the $5 processing fee to: The National Academies of Emergency Dispatch 139 East South Temple, Suite 200 Salt Lake City, UT 84111 USA (800) 960-6236 US; (801) 359-6916 Intl. Attn: CDE Processing
Equal but different. Although dispatchers handled calls differently, using the PPD S® helps them give the same degree of attentive care regardless of the type

By Eric Parry

It makes a great deal of sense for a police department to focus its resources on dealing with the most dangerous crimes and serious problems in our neighborhoods. But did you know that, although handled in different ways, dispatchers give the same degree of attentive care regardless of the type of call received in the basic three-level system?

Police calls are separated into three basic levels:

- In-progress
- Just-occurred
- Past-event

In-progress calls pose immediate threat IN-PROGRESS CALLS RECEIVE THE highest priority and require immediate attention due to the immediate danger to people or property.

In this type of situation, a higher probability of arrest exists if the police respond quickly with suspect and vehicle information that has been collected and disseminated accurately and efficiently. The chances of apprehension increase dramatically if the responding officers know who and what they are looking for enroute to the scene.

The caller may be able to provide up-to-the-minute information, describe what is happening, provide descriptions of suspects and their vehicles, and help the police identify and apprehend the suspects. For most in-progress calls, emergency police dispatchers (EPDs) try to stay on the phone with the caller until the police arrive.

In-progress calls usually require a multiple-unit response. Police respond quickly and assess the situation based on the information relayed by the EPD.

The importance of current and accurate information cannot be overemphasized; the safety of the responding officers, victims, and bystanders depends on it.

Just-occurred calls could net fleeing suspects POLICE ALSO RESPOND TO CALLS for events that have already occurred; those involved have generally left the scene.

The caller notifies police of the incident, describes the suspects and/or vehicles, and provides other pertinent information. Police officers move to the area and, as they approach, they use the information provided to look for the fleeing suspects.

In some situations, the police supervisor may station officers at major highways or intersections to watch for the suspect vehicle leaving the area. This technique, known as setting up a perimeter, depends upon an accurate estimation of the amount of time that has passed since the suspects left the scene in addition to how they left.

The time delay must be accurate, and descriptive information must be relayed to responding officers as soon as possible. For example, a car leaving the scene at 30 miles per hour will cover a mile every two minutes, increasing the size of the perimeter proportionately.

Vehicle descriptions and direction of travel are vital to locating the suspects. In some cases, the caller may know the identity of the suspects so the EPD must follow the protocol and get solid descriptions of the people and vehicles involved. The information must be relayed to the responding officers as soon as it is received.

These calls typically require immediate action, similar to in-progress calls, although the field response may be much different.

Past-event calls often may mean few leads THE PAST-EVENT CALL REPORTS AN incident that occurred at some time in the past. That means limited information is available and the suspects have left the scene and are no longer in the area. For example, a family returning from a vacation may find their home broken into and the television and PlayStation missing. The caller needs the police to respond to take a report and process the scene for evidence.

These calls are generally low priority for response because the victim is not in immediate danger and no suspects are readily available. This seemingly safe state, however, can change because the perpetrators may return to the scene at any time.

Ask the right questions AGENCY POLICY, PROCEDURE, AND protocol provide the direction needed to process these calls properly, but it is the EPD who must ask the right questions to determine the proper call classification. For example, is it a barking dog complaint or a possible prowler in the area? The barking dog is a low-priority call, while a prowler call would rate a higher priority.

The use of NAED’s structured police Protocol to classify Chief Complaint call types ensures that all calls are classified correctly, and that they receive the appropriate level of response.

Law enforcement calls for service AS PREVIOUSLY STATED, LAW ENFORCEMENT CALLS FOR SERVICE may or may not be actual emergencies. The nature of the call may be administrative, informational, non-emergency, or a true emergency. How the call is eventually processed depends on the quality, quantity, and accuracy of information that the EPD obtains.
Answers to the CDE quiz are found in the article “Equal But Different,” which starts on page 20.

1. Police calls are separated into three basic levels.
   a. True
   b. False

2. The type of call that receives the highest level of response is:
   a. In progress
   b. Just occurred
   c. Past event
   d. Cold call

3. A call should not be dispatched until the calltaker has received suspect and suspect
   vehicle information.
   a. True
   b. False

4. In progress calls usually require a multiple-unit response.
   a. True
   b. False

5. For most in progress calls, the EPD should try to stay on the phone with the caller until the
   police arrive.
   a. True
   b. False

6. The technique used by law enforcement to contain a geographic is known as:
   a. Setting up a roadblock
   b. Establishing a perimeter
   c. BOLF
   d. BOLO

7. If the caller knows the identity of the suspects, the EDP must get solid descriptions of the \ people involved and their vehicles.
   a. True
   b. False

8. The type of call that receives the lowest level of response is:
   a. In progress
   b. Just occurred
   c. Past event
   d. Cold call

9. A report of a barking dog in the middle of the night is considered a:
   a. High priority call
   b. Medium priority call
   c. Low priority call
   d. Cold call

10. Offenders often:
    a. Never return to the scene
    b. May return to the scene
    c. Turn themselves in the next day
    d. Never turn themselves in

To be considered for CDE credit, this answer sheet must be received no later than 5/30/08. A passing score is worth 1.0 CDE unit toward fulfillment of the academy’s CDE requirements (up to 4 hours per year). Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE certificate to be submitted to the academy with your application when you recertify.
Cooperating for Kids’ Sake
The National Center for Missing and Exploited Children partners with NAED and other industry leaders in a landmark effort to improve emergency responses to reports of missing kids

BY SHAWN HAMMOND

Although NAED’s industry-leading Police Protocol has long provided emergency communications professionals with thoroughly vetted call-handling instructions for child abductions, a significant number of Public Service Access Points (PSAPs) in the United States do not have similarly proven standards in place. Consequently, policies and procedures are surprisingly inconsistent at both call centers and law-enforcement agencies across the country.

According to Ernie Allen, president and CEO of the National Center for Missing and Exploited Children (NCMEC), even after the 1990 National Child Search Assistance Act required law enforcement to enter missing-child information in the FBI’s National Crime Information Computer (NCIC) immediately, agencies across the country interpreted “immediately” differently. For many, it meant sometime within 24 hours. “The problem with that,” says Allen, “is that U.S. Justice Department research shows that in the most serious cases, those in which children are abducted and murdered, in 74 percent of those incidents the child is dead within the first three hours. So time is the enemy.” Despite such frustrations, major strides have been made, both at the local and federal levels, over the last two decades. And the NCMEC—which operates its own 24/7 call center and maintains extensive databases on missing children, predators, resources, and statistics—has been at the forefront of the effort to standardize emergency response since the organization was founded in 1984.

Even so, approximately 800,000 children are reported missing each year, and there is still plenty of room for improvement in emergency response. That’s why NCMEC is now working with NAED, the Association of Public-Safety Communications Officials (APCO), the National Emergency Number Association (NENA), the U.S. Department of Justice’s AMBER Alert division, the National Sheriffs Association, and the International Association of Chiefs of Police in a partnership that promotes best practices in the emergency communications system. The efforts of this syndicate are bound to help save thousands of children each year. We recently spoke with Allen via phone to find out more about the consortium’s efforts, and Allen subsequently made a keynote appearance at the NAED’s April 2007 Navigator conference in Las Vegas, Nev., to emphasize the urgency of the group’s mission.

What was the impetus for this new partnership between NCMEC, NAED, NENA, APCO, and others?

We originally began discussions about this with Bill Munn, president of NENA, and one of the things we were interested in was quicker notification. That evolved into this consortium effort. We basically laid out a concern, and the leaders of the public safety communications community said let’s gather, let’s think through it—let’s look at what we do and how we do it, and come up with the best possible response. The fact that these organizations are coming together in this joint effort is, I think, extraordinary and historic.

This issue of missing and exploited children has been misunderstood for a long time. For example, it hasn’t been many

“A missing child’s life often depends on how quickly information is given to the people who can do something with it. At the heart of this whole effort is the public safety communications professional.”

—Ernie Allen
Ernie Allen, president and CEO of NCMEC
Two thousand kids are reported missing every day. That’s a lot of kids and families who will potentially be affected by this every year.

Or “You’re just not a responsible parent and you don’t know where they are.”

Exactly. Now, congress, in 1990, changed the law with the National Child Search Assistance Act, which mandated immediate report and entry into NCIC. But “immediate” was interpreted differently in different places. In much of the country it still meant 24 hours. The problem with that is that U.S. Justice Department research shows that in the most serious cases, those in which children are abducted and murdered, in 74 percent of those incidents the child is dead within the first three hours. So time is the enemy. Secondly, the information initially reported alone makes it difficult to determine which cases are likely to become a homicide. Child-homicide research reveals that only 10 percent were originally reported as abductions. Over 60 percent were just missing-child reports. So, our view—and the consortium’s—is that information is power. The rapid, appropriate handling of information is key to saving lives.

Was there ever any research that supported the old rule of waiting 24 hours or more before responding?

No. And it was individual cases that changed America’s attitudes and awareness on this. The Adam Walsh case is an example. Adam, the son of “America’s Most Wanted” host [and NCMEC cofounder] John Walsh, disappeared from a shopping mall in south Florida in 1981, and the FBI didn’t get involved because under the Lindbergh Law [the Federal Kidnapping Act] there had to be a ransom note and tangible evidence that he was transported interstate. For most purposes, you couldn’t enter missing-child information into NCIC back then. You could enter information about stolen cars and stolen guns, but not stolen children. So, in 1982, John Walsh and oth-
ers, including myself, worked to get Congress to pass the Missing Children Act, which made it possible to use NCIC. However, most police departments still had these waiting periods. So, in 1990 Congress passed the National Child Search Assistance Act that said, basically, “Do it now.” It required immediate entry into NCIC. And the Adam Walsh Act requires that they be entered within two hours. I’m sure it will take time to be fully implemented, but there has been a gradual change in law and, simultaneously, a recognition that a child’s life often depends on how quickly information is captured, how thorough the information is, and how rapidly it is given to the people who can do something with it. And, under the AMBER Alert and similar concepts, that means mobilizing the eyes and ears of the public. So, at the heart of this whole effort is the public safety communications professional.

So centers no longer operate under the assumption that the missing child is a runaway until at least 24 hours have passed? Well, I hope so. A recent series of articles in a newspaper chain found that, although laws have changed, in some places attitudes and policies haven’t. Simply because Congress passes a new law doesn’t mean it’s instantly communicated and implemented. So this requires a comprehensive, coordinated effort.

How will the consortium work to change that— it seems like a mammoth task?

One of the things we’ve been doing for a number of years is bringing police chiefs and sheriffs into the NCMEC headquarters [in Alexandria, Va.] for free, all-expenses-paid “CEO training,” and the focus of that is departmental policy. You know, “Has your policy been updated? Do you know what to do when a child is reported missing? Have you identified the necessary resources? Are protocols in place to determine which cases meet AMBER Alert criteria? Are you capturing the information necessary to respond effectively?” And with this new push, we’re now including 9-1-1 center leaders with police chiefs and sheriffs in that training, because your world is key to saving these children’s lives. We are absolutely convinced that effective response to these cases is predicated on rapid distribution of high-quality images and information. To help with that, we’ve created a first response call intake checklist to identify all the information that needs to be obtained.

What are the consortium’s primary goals?

There are five parts. One is to create a memorandum of understanding among all these organizations that defines commitment to the effort. Secondly, we’re developing and endorsing best practices, including minimum performance levels for evaluating effectiveness. Third, we’re setting out to improve awareness in the public safety communications field so that there is greater standardization and better handling of these incidents. Fourth, we’ve got to develop and disseminate tools to help call centers respond more effectively. And fifth, we’re developing training so that communications staff at all levels know what’s required for optimal response.

So the main drive of your appearance at Navigator—as well as subsequent nationwide efforts—is to get all the involved organizations to comply with the laws and show them how best to do it.

If you built a tower of 2,000 kids backpacks, the tower would be twice the height of the Empire State Building. That’s how many kids are reported missing each day.
AMBER Alerts makes a difference, one child at a time

*January 29, 2007
Reno, Nev.

An 8-month-old girl was violently taken from her custodial grandparent’s home by her biological parents. Because the child may have been injured during the abduction, an AMBER Alert was issued. A local resident who had heard the Alert saw the vehicle described and contacted authorities. Law enforcement apprehended the suspects and safely recovered the child.

*January 13, 2007
West Point, Neb.

An 11-year-old girl was taken from her bedroom in the early morning by a family acquaintance. Because it was believed the suspect may be dangerous, an AMBER Alert was issued. A citizen later recognized the vehicle from the AMBER Alert and notified law enforcement. Authorities were quickly dispatched to the area, where a chase ensued. The suspect soon disabled the vehicle and was apprehended. The child was safely recovered.

*January 9, 2007
Franklin County, Mo.

A 13-year-old boy disappeared while walking home from his school bus stop. A friend who had seen the boy start to walk home noticed a vehicle speeding away from the direction he had gone. An AMBER Alert was issued. A few days later authorities spotted a vehicle fitting the description in the AMBER Alert. The child was located inside the apartment of the vehicle’s owner, as was a 15-year-old boy who had disappeared while riding his bicycle more than four years ago. The suspect was apprehended, and both children were safely recovered and reunited with their families.

*January 1, 2007
Burtonsville, Md.

Three siblings, ages 4, 6, and 8, were abducted by their estranged father after he allegedly murdered their mother. An AMBER Alert was issued, including a description of the suspect, children and vehicle. However, a license plate number for the vehicle was not available. A citizen recognized the vehicle with the children inside after hearing the AMBER Alert and notified law enforcement. That citizen was able to provide a license plate number to authorities, which was verified by law enforcement as correct. An officer later came upon the vehicle and recognized it from the AMBER Alert with the correct license number, at which point a chase ensued. The suspect vehicle struck a police vehicle and became disabled. The suspect was arrested and the three children were recovered safely.

*Used with permission from the NCMEC website.
fessionals already. We just want to build their sensitivity and awareness to these unique problems and fill some gaps that inadvertently put kids at greater risk. I think it’s particularly powerful because it has been mutually produced—it’s not being forced from above. There is a genuine joining of hands between all sides, and the effort is to produce something not only that will be implemented but that will work.

What have been the biggest hurdles so far?

This is a nation of 50 states that sometimes act like 50 separate countries. There are 18,000 police departments, and I’m confident that public safety communication centers number in the thousands. The biggest problem is figuring out how to bring about greater consistency and uniformity in a system that is so diverse, with so many actors trying to do so many things in a high-stress, high-demand setting. We aren’t saying this should be done at the expense of other things. What we’re saying is that this is something you’re dealing with already, so let’s figure out how to develop protocols and procedures that impact these problems not just in Tacoma and Kansas City, but nationally. That’s why the participation of NAED and these others was so vital—because you represent that broad constituency. Your involvement brings this message home to the people who do the real work.

How will the consortium go about getting as many public safety communications departments as possible to participate?

I think Navigator is really the beginning of that. We’re nearing the conclusion of the planning and consulting phase, and now it’s time to communicate and execute. We’re going to have to work together and get this information out and into the hands and hearts of as many people as possible, and then provide support and follow-up.

So you will be contacting management at all the PSAPs across the country?

Absolutely.

How will you do that?

In cooperation with NAED, APCO, and NENA. We want to work through the recognized organizations.

How many children and families do you estimate this new effort will affect per year?

In this country, two thousand kids are reported missing every day. Those are the kids that are going to be impacted by this. The impact is not going to be measured in lives that you could count on one or two hands. We’re talking about potentially thousands of kids who will be affected by this every year. Every hour, every day that a child is missing, the statistical probability of safe recovery decreases. The period when there’s the greatest likelihood of safe recovery is immediately following that child’s abduction, when the abductor is still on the run and most visible. It’s the power of the AMBER Alert—mobilizing the eyes and the ears of the public. The nexus of all of that is the capture of information by PSAPs. This exercise is not about some arcane academic procedure. It’s about the capture and use of lifesaving information at the most vital time—when it can save a human life.

More At

emergencydispatch.org/journal
or missedkids.com

You can download the OID paper for handling calls regarding missing children. And read more about the Center for Missing and Exploited Children and NAED.

Ernie Allen was the keynote speaker on Tuesday, April 25, at the Navigator 2007 educational conference in Las Vegas, Nev. The next issue of the Journal is a special “Navigator 2007” issue and we will give you an update on this very important joint project.

These organizations are coming together in what I think, extraordinary and historic.”

— Ernie Allen, president and CEO of NCMEC
In anticipation of resource response configuration worries, NAED put a disclaimer at the bottom of the Response Determinant matrices that reads: “All actual response assignments and emergency modes are decided by local Medical Control and EMS Administration.”

By Jim Lanier

As we brainstormed ideas for the redesigned Journal you’re holding, we got to talking about the incredible array of misconceptions and “urban legends” out there about gaining (and retaining) Accredited Center of Excellence status, as well as NAED protocols in general. So we decided to create this regularly occurring “Utter Nonsense” department to help dispel some of those myths. (In this issue, Jim Lanier obliterates the notion that locally modified response configurations adversely affect a center’s chance of becoming an ACE.)

You’ve likely heard some of the bogus claims we’ll address in this space each issue, but if you’ve heard other doozies you’d like us to clarify, please send them to us at editor@emergencydispatch.org.

As the Priority Dispatch System (PDS)—the Police, Fire, and Medical Protocols—evolves, we at the NAED are keenly aware of your needs and the dynamic environment in which you serve. There’s no way around it—we wouldn’t be successful and relevant if it weren’t for your invaluable insights and recommendations, which help us continually improve the protocols and other resources we make available to you.

But we know you’re always trying to improve, too. And for the vast majority of you, attaining Accredited Center of Excellence (ACE) status is the “gold standard” for improvement. However, some agencies are reluctant to begin the ACE process because they believe they are somehow disqualified from ACE distinction because they’ve tweaked protocols to meet local needs. In their eyes, initiating the ACE process could reveal their closeted skeletons to the NAED. But guess what? We at the NAED want you to make those skeletons dance!

One “skeleton” that call centers often wish to keep out of sight is the fact that they’ve modified resource deployment options—that is, which units they send, and how they send them. Why? Because each NAED protocol has an associated Response Determinant Methodology matrix that some agencies mistakenly conclude is our directive on which units should be dispatched (e.g., Advanced Life
Support vs. Basic Life Support, or single vs. multiple apparatuses) and whether they should respond cold or hot.

For example, from the MPDS matrix one could conclude that a BRAVO response requires a single BLS unit running hot. But what if your center doesn’t have BLS? On the FPD S matrix, an ALPHA equates to a single unit running cold. However, what if your fire chief believes some ALPHA calls require a full alarm? Do these situations put you in conflict with the PDS?

In a word, no. The matrixes are only meant to offer minimal recommendations for each level. However, if your center doesn’t have BLS units to send to a medical incident, we aren’t going to penalize you for sending ALS. If you want to send ALS to an ALPHA incident, go ahead. Heck, send the Blue Angels, the local Red Hat club, and the Fantastic Four, if you like!

Matrixes also help because they provide response-configuration options for agencies with multiple resource and capability layers, aiding administrators in planning how to mix and match resources to maximize availability for competing incidents. Consider an agency with ALS fire engines that respond on medical and fire incidents. These resources might be able to handle calls at all response levels because of the manpower and capacity, whereas an ALS rescue might have a more focused response capacity.

In summary, comprehensive response plans should be established before PDS implementation, and they should be re-evaluated as needed. Deciding which apparatuses to send—and how—should be a cooperative effort with fire, law-enforcement, and EMS experts, as well as communications center management, medical directors, agency executives, field responders, and other stakeholders. Feel free to call us, too. The NAED is an excellent resource for assistance and industry contacts to help you through the process. There’s no sense reinventing the proverbial wheel if you can avoid it!

Dr. Jeff Clawson’s formation of the NAED in 1988 was driven by the desire to save lives and prevent the escalation of injuries caused by lack of emergency protocols—not by hopes of awards and acclaim. However, when we have as big an impact on an industry and everyday people as Dr. Clawson and his Police, Fire, and Medical Protocols have, it’s hard to avoid the accolades.

However, “Doc” (as we refer to him around the office) recently received recognition that he terms “a highlight of his career” from the U.S. Metropolitan Municipalities EMS Medical Directors Consortium. He has been a member of this collaborative organization of top EMS medical directors from the largest cities in the U.S. (as well as FBI and U.S. Secret Service experts) since the group’s inception in 1998. But when the consortium asked Dr. Clawson to speak at its annual EMS State of the Sciences Conference—or “Gathering of Eagles”—this February in Irving, Texas, he had no idea it was a ruse. He was actually the guest of honor.

“A bout two weeks before, Paul [Pepe, the consortium’s founder] called and said one of the speakers, a guy from the secret service, had cancelled,” recalls Dr. Clawson. “But then at the beginning of the conference, I saw the agenda and didn’t see my name on it. Paul said, ‘You’re tomorrow, in the morning. Don’t worry about it.’”

Moments later, Dallas EMS medical director, Dr. Marshal Isaacs, came to the podium to act as master of ceremonies for bestowal of the organization’s annual Paul E. Pepe Award. “So he got up and started talking about this award and its background,” says Dr. Clawson. “He named some of the other people who have received it, and I’m just kind of listening—and then I heard my name. I put my head down on the table. A couple of people said ‘You didn’t know, did you?’ It moved me to tears. They faked me out!”

The Paul E. Pepe Award itself features a bald eagle figurine on a stained-wood pedestal with an engraved quote from noted French aviator and author Antoine de Saint-Exupéry’s book “Wind, Sand and Stars.” The first portion of the quote particularly struck Dr. Clawson: “‘You didn’t know, did you?’ It moved me to tears. They faked me out!”

The Paul E. Pepe Award is a fellowship, that it binds humans together and fashions for them a common language.”

“That’s how I’ve seen our [the academies'] efforts,” said Dr. Clawson.

A sked what the award meant to him, the famously shy Dr. Clawson said, “It’s sort of like winning the Nobel Peace Prize. It’s a reaffirmation that you’re on the right track—that’s how I take it, personally. And I understand that these awards are often
given to recognize an entire movement or idea. It's not necessarily all the recipient's doing. It's like somebody on a basketball team getting MVP."

Vonage tops 94 percent for VoIP E911 capability

The industry's leading Internet telephony provider, Vonage—which has more than 2.2 million subscriber lines—recently announced it had equipped more than 94 percent of its Voice over Internet Protocol lines with Enhanced 911 capabilities. This means the majority of its customers now have physical addresses associated with their VoIP phone numbers, which makes it much easier to deal efficiently and successfully with 9-1-1 calls that originate from these lines.

Thanks to the company's nomadic E911 solution, 9-1-1 callers using Vonage phone services are routed automatically to the appropriate PSAP for their location. In keeping with the increasing pace of VoIP adoption, Vonage now offers its customers E911 access at more than 6,600 call centers nationwide.

Said Vonage CEO Mike Snyder, "Vonage will continue to work with the FCC, regulators, Congress, and public safety officials until PSAPs across the nation are equipped with E911."

Massachusetts's city council pushing for hi-tech solutions

According to a recent article in the West Roxbury/Roslindale Transcript in Needham, M ass., local city councilor Rob Consalvo is sponsoring legislation that would bring "incident-linked multimedia" to 9-1-1 communications centers in the Boston area. In layman's terms, this would help emergency call centers keep up with rapidly advancing technologies that are so ubiquitous in today's culture by giving them the ability to receive video images, cell-phone pictures, and text messages. Other metropolitan areas, including New York City, Chicago, and Philadelphia are already undertaking similar measures.

"I feel it's time for Boston to make that step technologically and bring that technology to the city," Consalvo told the Transcript. "Many people are using cell phones and many people, both young and old, are text messaging. We should upgrade to meet the growing technology that's available to help the public."

Consalvo said that, besides providing emergency dispatchers with invaluable information that otherwise may be unobtainable, incident-linked multimedia could help distressed callers in extraordinary ways. "If you're alone at home, what if you were able to text message if there's an intruder in your house?"

Sounds like a pretty handy tool to us.

London's emergency operations climbs to new high

Accolades were coming in all directions when Dr. Jeff Clawson presented a Certificate of Re-accreditation to the London Ambulance Service (LAS) Emergency Operations Centre (EOC) at a recent presentation held in London.

"London performs at a high standard of excellence," said the Dr. Clawson at the March 23 event where John Hopson, Assistant Director of Operations, Control Systems, accepted the Certificate given on behalf of the International Academy of Emergency Dispatch (IAED). "The influence of what London Ambulance Service has done in creating a centre of excellence is remarkable." Said Dr. Clawson. "I hope you understand the height to which you have climbed."

Hopson, a 27-year veteran of the LAS, was every bit appreciative of the award and the chance to accept it.

"This is a terrific achievement for the service, and we are delighted to have Jeff here in person to officially present our Re-accreditation," he said. "Over the last few years, EOC staff have risen to the challenge of increased call demand and an ever more challenging environment to work in. This honor is well deserved for all staff."

Sheer numbers show the LAS EOC as one of the biggest emergency dispatchers in the business anywhere. Centre dispatchers handle more than 3,000 calls a day for an estimated one million calls each year.

This is not the first time IAED has recognized the EMD work of London Ambulance Service Communications Centre. In May 2005, IAED honoured the Emergency Communications Centre for a European first–Advanced EMD status. And one year before that, in October 2004, Dr. Clawson presented the IAED Dispatcher of the Year award in Liverpool to LAS's EMD Jeanine Antonio, in recognition of the way she handled a 999 call (London's equivalent to our 9-1-1 system) about a shooting. According to press releases at the time, Hopson said Jeanine did a tremendous job handling one of the most difficult situations. "Her actions are a credit to the Service," he said. And, without a doubt, the Centre is a credit to the IAED.
Brian Dale adds to list of accomplishments

When asked about his accomplishments for a story about a recent promotion, Brian Dale sent along a bulleted list of certifications and job dates. There was barely enough information to fill a text space the size of his mug shot.

Don’t let that fool you, was the advice we got from NAED President Scott Freitag, who also happens to be the Director of the Salt Lake Fire Department Communications Center where Dale was recently promoted to Battalion Chief.

“He has a colorful, extensive, and thorough background,” said Freitag.

It seems that in addition to the certifications—his EMT in August 1980 and his Paramedic in April 1984—Dale has worked with the Salt Lake Fire Department since October 1986. During the past decade, he has risen through the ranks, from Captain (September 1996) to his recent promotion to Battalion Chief in February 2007. The new job makes him the battalion chief over emergency medical services and he also serves as the Department’s Safety Officer. The dual job description alone would intimidate most, let alone the test that it takes for consideration.

There’s also one other major achievement and that’s Dale’s first as the recipient of the prestigious Jeff Clawson Leadership award, given each year by the NAED to an individual who has made a significant contribution to the emergency dispatch profession; someone who exhibits courage and determination in the face of adversity; someone who represents the highest standards and pursuit of excellence in research, education, management or operations; someone who by example has inspired others to become the best that they can be.

To say Dale is modest about his achievements is an understatement.

In his spare time (if he gets any), Dale is devoted to the NAED and Priority Dispatch Corp. He has been a PDC instructor for about 30 years, making him a well-known communications expert among at least 10,000 dispatchers nationally.
EVEN IF MEDICINE HAT, LOCATED in the Canadian Badlands of southeastern Alberta, Canada, wasn’t known as the Great White North’s sunniest city, the crew at the Medicine Hat Regional 9-1-1 Communication Centre would still have good reason to feel particularly sunny right now: They just made their center the first to ever become an Accredited Center of Excellence (ACE) in use of the NAED’s Police Priority Dispatch System® (PPDS).

The Medicine Hat 9-1-1 center is a primary PSAP that handles call taking and dispatching for an array of public safety responder agencies, including the city police, 25 fire departments scattered throughout the region, and six emergency medical services (EMS) sites—in addition to handling calls for public utilities. The center dispatches 30,000 police calls annually.

“We were originally motivated to be accredited years ago when we first began attending the Navigator conferences,” says Ronda Grant, the center’s director. “The pride and excitement exuded by those receiving their accreditation was contagious.”

Colleen Bachewich, Medicine Hat’s operations and quality assurance coordinator, recalls the keynote address on the first day of Navigator 2006 as her initial moment of motivation. Eric Ferrari, manager of Reedy Creek Improvement District at Disney World in Orlando, Fla., spoke about his own center’s accreditation achievement.

“He was so excited and had such a sense of accomplishment. It was truly inspiring.”

By Ben Rose
QA: First things first

**Medicine Hat 9-1-1** had been using PPDS for more than three years before serious steps toward accreditation were finally underway.

“We often have competing priorities,” says Grant, “While the goal of accreditation remained on department business plans since that first conference, we had difficulty finding the resources to attain some of these lofty goals.”

Specifically, Bachewich says, Medicine Hat lacked the personnel to begin quality assurance in earnest. “When you look at the breakdown of each point [in the Twenty Points of Accreditation], and see all the information required, it seems very overwhelming at first,” says Bachewich.

Motivating calltakers to set and achieve higher goals was another major obstacle for protocol compliance. “They needed to understand that the Protocols are not about us—they are about who we serve,” said Bachewich. “If their mother called 9-1-1, they would want to get 100 percent compliance on her call.”

Enforcing exactness

**After beginning quality assurance for police, fire, and medical protocols in January 2006**, the team found that one problem existed across the board.

“In all three protocols, the biggest challenge was getting dispatchers to say, ‘Tell me exactly what happened,’” said Bachewich.

Because all of Medicine Hat’s dispatchers also rotate as calltakers, it took time for them to narrow down what happened rather than simply accepting the caller’s initial complaint.

“We would think like a dispatcher and just get the caller’s complaint instead of getting the story behind the call. A lot of times the story is different from the complaint,” she said.

For example, the caller’s initial complaint could be “My boyfriend refuses to leave,” which equates to Chief Complaint 133, “Trespassing/Unwanted.” But when asked the specifics, the caller may say, “We had an argument and he punched me in the face. Now he won’t leave.” The added information reveals a much more serious situation, making “Domestic Disturbance/Violence” (number 114) the more appropriate chief complaint.

Early versions of the Police Priority Dispatch System—requiring lengthy interrogation, even for cold calls, was one of the biggest obstacles to achieving Accredited Center of Excellence (ACE) status for the Medicine Hat Regional 9-1-1 Communication Centre.

Frustrated calltakers became more lax in following the protocol—and some quit using it altogether, said Eric Parry, a Priority Dispatch Corp. (PDC) consultant who has worked extensively with the center.

What finally resolved the problem, Parry says, was the release of PPDS v3.0, as well as implementation of ProQA®. When Medicine Hat managers were ready to put the necessary quality-assurance personnel in place, they were able to pursue accreditation in a speedy, effective manner. In the process, they also aided every other call center using the Police Protocol.

“They’ve made a significant contribution to development of PPDS,” says Parry. “By using it—and using it correctly—they have facilitated fine-tuning of the protocol. Their many proposals for change have had a positive impact on the evolution of both PPDS and ProQA. Medicine Hat has proven beyond any doubt that they have conquered the police protocol.”

The potentially significant delay caused by ProQA waiting until the end of Key Question interrogation to pass description information to computer-aided dispatcher (CAD) was the most significant issue facing Medicine Hat at the time. The upcoming version release of the police ProQA software will pass descriptions of persons and vehicles to CAD immediately after they are entered.

“This new functionality provides a safer, more effective response,” Parry said. “This is the biggest thing to happen to ProQA Police for a long time.”

The staff’s goal this year is to become the first center in the world to receive accreditation in all of the NAED’s protocols... We’re rooting for them.
Feedback and CDE

WHAT WAS THE KEY TO OVERCOMING these obstacles and achieving accreditation-level compliance scores?

Bachewich said consistent feedback and education throughout the quality-assurance process, and feedback in writing.

“I also meet with every member of the staff every month to go over problem areas or trends—and to celebrate successes!” said Bachewich. “Those face-to-face meetings seem to have been the thing that made a world of difference with compliance.”

According to Grant, all these methods helped make the accreditation process “a positive interaction rather than a punitive measure.”

Bachewich cited continued dispatch education as a second key to their success.

“If there’s a problem with a pathway, education can consist of something as simple as navigating through ProQA,” says Bachewich.

She also holds monthly “Brain Buster” sessions in which she quizzes calltakers about scenarios such as, “There’s a male throwing knives into a tree. Which Chief complaint do you choose—and why?”

Making sure everyone is on the same page is Bachewich’s goal and, in that sense, the ideal is every participant giving the same answer for every situation.

“Regular feedback and education nips bad habits in the bud and gives calltakers the tools to do their jobs to the best of their ability,” she says. “If they understand why, they are more apt to remember and do it correctly—and consistently.”

Pride and confidence

THE NAED’S ANNUAL NAVIGATOR conference introduced Medicine Hat management to the sense of accomplishment that accompanies accreditation. Now they’re ready to talk about their success.

“It’s a real achievement and certainly something we’re proud about,” Bachewich says. “The entire department feels the same way.”

Grant can’t say enough about the department’s accomplishment.

“I am incredibly proud of the hard work Colleen has put into the accreditation process, as well all the dispatchers who have made it possible for us to achieve this level of compliance. It speaks highly of the importance we place on those we serve,” says Grant.

The increased self-assurance that accreditation has brought is every bit as critical as the newfound pride.

“Young and, just in case Police Protocol ACE status isn’t enough to keep the Medicine H at 9-1-1 folks feeling sunny, Bachewich says that since attaining Police Protocol accreditation in February the center also has completed an entire month with accreditation-level compliance scores for the Medical and Fire Protocols. She says the staff’s goal this year is to become the first center in the world to receive accreditation in all of the NAED’s protocols.

If they pull it off—and we’re betting they do—it looks like the folks in Medicine H will need to stock up on sunscreen, because the sunshine quotient is about to shoot off the charts.”

Salt Lake City, we have liftoff

BACHEWICH HAS ONE SIMPLE PIECE of advice for employees at other centers considering accreditation:

“It’s not as hard as you think,” she insists. “After you break down each of the 20 Points of Accreditation, check off what needs to be done, and get things organized, it just seems to fall into place.”

Once the Medicine H at team started working on quality assurance consistently, Bachewich says, “everything skyrocketed from there.”

Around town Left to right—top to bottom: Medicine Hat City Hall, Police Station, Court House, and communications tower
Special Medical Protocol Alternative Care Advisory.
17-Ω-1 may entail high-acuity and scene cardiac arrest risks

This Advisory is made to provide you with the latest information on what could be an issue in your method of response for a few patient situations you process. The OMEGA codes within the NAED’s Medical Protocol allow a special exception to the normal response practice of always sending an EMS mobile response to a patient. Whether this is done in any system is decided locally by creating alternative response and care plans. Various potential alternative care exceptions to direct EMS response have been carefully incorporated into the protocol by the Academy over the last 28 years.

Queue referrals require extra care

IN APPLYING ALTERNATIVE CARE for low-acuity patients, there exists heavy reliance on high compliance to protocol to assure that such evaluations are accurate and safe. It is essential that quality assurance be an ongoing and vibrant part of systems creating alternate referral choices for 9-1-1/9-9-9/0-0-0 patients.

Especially worrisome, however, are referral choices that allow for a delayed next evaluation of the patient by the receiving agency. In the case of Poison Control Center (PCC) referrals, this process is nearly immediate because there is a direct hand over of the caller to the PCC experts. However, where cases may be placed in a queue, a potential time-delay factor may prove dangerous, if not fatal, to some patients.

Calls that are referred out of the system, especially to a system that may have a time delay, must be of the highest quality to ensure minimum patient care. Good, continuous quality-assurance reviews of any such cases— as well as feedback to the evaluating EMD — goes a long way to ensuring acceptable patient outcomes. The NAED, in conjunction with PDC, has developed computer-based CDE training to stress the importance of this to the calltaker.

Queue referrals require extra care

NAED HAS RIGOROUSLY STUDIED OMEGA codes—and it will continue to do so. As a “higher risk” group with possible alternative or delayed response, these codes must have the data, science, and quality behind them. In some recent studies we have found some areas of concern.

A review of a very large ProQA database (599,107 patients) shared by an Accredited Center of Excellence, as well as two audio case reports, reveals the possibility of cases resulting in high acuity and scene cardiac arrest being present, albeit at low frequen-

cy, in an OMEGA-level MPDS code: 17-Ω-1 Falls, PUBLIC ASSIST (no injuries, no priority symptoms).

In the case of 17-Ω-1, some agencies may utilize fire responders, aid cars, or fall teams to provide assistance as requested by the caller. This variation in standard response methods is based on the absolute premise that these individuals have NO injuries and NO priority symptoms. Obviously, many of these patients are already sick or infirm, which prevents them, on their own, from getting back into bed. This provides a patient group that may contain certain instabilities in their pre-existing underlying condition.

Compliance, compliance, compliance

THE LARGE DATABASE OF PROQA MPDS determinant codes lists the number of cardiac-arrest-at-scene outcomes, as well as paramedic high-acuity findings. Out of 1,397 17-Ω-1 encounters, a finding of 5 (0.36%) scene arrests and 36 (2.6%) high-acuityprehospital alerts was observed. While these percentages are low, they appear not to be devoid of untoward findings.

The calls will be reviewed to help determine the level of compliance to the Medical Protocol and whether there should be a change to or further evaluation of these particular OMEGA codes. But this data and study does show that the NAED must reiterate the need for high levels of protocol compliance in the use of OMEGA codes, especially in systems that defer or delay the next patient evaluation or response.

The NAED, in this advisory, reinforces its advice that compliance to protocol should be strictly monitored in all OMEGA cases that result in any delay in “next step” evaluation and care. Post Dispatch Instructions should always be given, even though a referral is being made. Such follow-up callback advice should be clearly and completely provided.

As mentioned previously, the NAED will continue to monitor and study these types of situations in order to make necessary recommendations. If you have questions on this subject, please feel free to contact me via phone at (801) 746-5693.

— Jeff Clawson, MD
Medical Director
National Academies of Emergency Dispatch
Salt Lake City Fire Department 9-1-1 dispatcher Shawna Smith has answered all kinds of emergency calls during her 18 years as an EMD, but her skills were put to the test this past fall when she found herself helping to deliver a baby—over the phone to a couple trying to get to the hospital before the baby arrived.

Time was not on their side. Natasha Bell's labor came on quickly. Only five miles away from their home and heading south on the Utah Interstate toward LDS hospital, her water broke. The dad-to-be, Jamon Bell, called 9-1-1. Shawna answered and her first instruction, once she heard the agonized cries of a female in the background, was to take the nearest exit. "It's coming. The baby is coming," Shawna heard Natasha saying loudly. Natasha was in the middle of a contraction and the baby's head was nearly out by the time Jamon was able to pull the Honda over to the side of the road.

Using MPDS ProQA v11.3 protocol software, Shawna calmly talked the father through the entire delivery. Less than six minutes after the call came in, Shawna had helped the Bells deliver a healthy baby girl. "I kept thinking that the squad would get there soon and take over, but it happened so fast, I just ended up walking them through the whole thing. If wasn’t for ProQA I wouldn’t have known what to do. It guided me all the way through..."
Shawna told Jamon to remove his shirt to clean and warm the newborn, and then gave him instructions about tying off the umbilical cord. "It came down to him actually using the lace from his tennis shoe to tie off the cord," she added.

EMS personnel arrived at the roadside shortly after the delivery and took over the scene, transporting mom and her healthy baby to the hospital.

Although delivering the baby in tight quarters and under less than ideal conditions was no easy feat, everything worked out fine.

The baby, mother and honorary doctor/father got through wonderfully. The baby weighed 6 pounds and measured 19 1/2 inches long, according to news reports published near the time of delivery on September 14, 2006.

The same happy ending goes for Shawna. "It was nice to have such a good outcome since that’s not what happens," said Shawna. "Everyone [at Dispatch] was really excited about it."

A letter from local media were all over the story. Interviewed at the hospital, the parents had nothing but rave reviews for Shawna.

And, the same high marks go to the MPDS ProQA. "If it wasn’t for ProQA I wouldn’t have known what to do," said Shawna. "It guided me all the way through."

Shawna received a thank you note from the Bells, and recalls an irony from the evening delivery. "Jamon’s brother is a pediatrician and yet he was the first in his family to deliver a baby," she said.

A sis in a roadside delivery is all but common, according to NAED President Scott Freitag, public information officer for the Salt Lake City Fire Department’s communications center.

The center’s statistics show between 2001 and 2007, the fire department dispatched EMS to 274 reports of an imminent delivery (or related type of pregnancy problem), which represents 0.02 percent of the call volume of 108,000 calls during those six years. Of the average 45 incidents each year, dispatchers actually participate in the delivery of about 6 to 10 of those. "So yes, it is a pretty rare occasion in a city the size of Salt Lake City," said Freitag.

Headed Home.

Florida’s Jaime Melser stays cool and saves an infant

**Name:** Jaime Melser
**Hometown:** Bradenton, Fla.
**Comms Center:** Manatee County 9-1-1
**Years dispatching:** 6

I’m not much of an emotional person—a lot of people would probably be hit harder by a call like this than I was. I mean, I don’t have kids or anything. Anyway, when I had my “unforgettable” dispatching experience it was about 10 or 15 minutes before the end of the shift, and I was thinking it would be a regular call. My relief dispatcher was right there and I was ready to get out the door.

The call was from a mom, and she was really calm so I thought it was a law enforcement call or something simple. She called on a cell phone, so we didn’t get her address automatically. I had to ask her twice for her address, but she still didn’t get upset at me. I asked for her phone number, and then, firmly, she said—really calmly—"My baby’s not breathing." I was, like, "Oh, crap!" My heart sank. I’d had calls like that before, but none that had a positive outcome. I mean, you hope for the best, but...

So I went through ProQA, and we started CPR. We’d gone through a few rounds of the new national CPR standards—the 30:2—and halfway through the call, after chest compressions, she said, "It’s starting to move." I asked her what he was doing, and she said that he was looking at her and taking really deep breaths.

I got to meet the mother and baby the next week. It was really neat, just to see him alive, you know? It was a big press thing, which helps build good rapport with the public, I guess. We had two news stations and three newspapers. People were making a big deal over it, but I was just doing my job, you know? I don’t like attention, so I didn’t like having all the cameras in my face. I didn’t know what to say when they asked me all these questions—don’t want to toot my own horn, I guess.

When I think about the call, though, I remember feeling really good when the boy’s mom said he was breathing. I jumped up from my chair. Part of my shift was leaving, and I just remember looking at whoever was sitting next to me and mouthing the words, "He’s breathing!" I was really excited. It makes you feel like you were put here for a reason.

Headed Home.

My husband is still down there and I haven’t heard his voice

**Name:** Cindy Sluys
**Hometown:** Bellingham, WA
**Comms Center:** Prospect Comm. Center, Bellingham Fire Department
**Years dispatching:** 23+ (am I still sane?)

Our consolidated comm. center had officially split, however we were still physically in the same building. There were two Fire/EMS dispatchers on (myself and a 2-week new dispatcher, completely green to the industry), and four law enforcement dispatchers/call receivers on duty. Other than myself, person with the highest seniority in the room had only 2 years.

My partner and I were talking and enjoying the last few hours of our shift, when an outside odor investigation call came in. It was reported as a smell near a
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fire ball rolling towards them, houses on
fire, the creek on fire. “Get crews out of
the way, get citizens out of the way, people
hurt, people in the way, mass confusion”. A
gas pipeline running through our city had
just exploded. My heart jumped and start-
ed racing. My husband was down there.
Aid calls were pouring in, one of them
about two children badly burned. IN the
back of my mind I know my husband is
there somewhere, was he safe? Everyone in
the comms. center was yelling and trying to
answer all the flood of ringing lines. The
ALI screen is just rolling, not even stopping
to lock on an address - completely worthless.

Other aid calls are coming in from all
over the county. A heart attack up north,
structure fire in the east of the county.
Wait, now there are two houses on fire
down by the creek, and my husband is still
down there.

We kept going like this for over two
and a half hours. It was close to three
hours before I could talk to my husband. I
knew within 20 minutes that no respon-
ders were injured, so logically I knew he
was OK, but my heart!

My partner is no longer a dispatcher.
I’ve thought about it a lot, but this is where
I belong, where I can make a difference.

This is my call from Hell...may it rest
there.

For a chance to have your “Unforgettable
Call” or “Call from Hell” featured in the Journal
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dispatch story (in 500 words or less, and
with “Unforgettable” or “Hell” in the
subject line) to editor@emergencydispatch.org. Tell us
your full name, your call center, your
hometown, and the number of years
you’ve been dispatching. We will con-
tact you if your submission is selected.

SHAWN HAMMOND is the outgoing Journal edi-
tor. Shawn Hammond is a full-time freelance writer/editor
(www.stormbrain.net) with more than ten years of expe-
rience working for industry-leading newspapers, interna-
tional magazines, and Fortune 500 firms. He lives with his wife
and three nutty boys just outside of Salt Lake City, Utah.

FEATURE STORY PAGE 22

TAMMY HAISLIP makes her debut in the Jou-
rnal this month with her ar-
ticle that demystifies the
ProQA report system. Tammy
travels frequently for Priority
Dispatch Corp. in her role as
a trainer on both the ProQA
and AQUA emergency dispatch soft-
ware systems and in the past
year, her teaching schedule
put her in the classrooms of
at least a thousand dispatch-
ers. Tammy can be reached at tama-
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et.

SOFTWARE TIPS PAGE 12

GREG SPENCER is a member of the NAED
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member of the Police Dis-
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spent 24 years in the Royal
Canadian Mounted Police.

MEDICAL CDE PAGE 16

JIM LANIER is Division Chief of Communications for the
Emergency Medical Services Alliances that
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Florida and the Director of
Communications for the
Pinellas County’s Sunstar
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to the Journal and frequent
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David? Or Goliath? Who do you want on your team?

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