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His modesty says it all

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The National Academies of Emergency Dispatch

November/December 2007
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All dispatcher wanted to do was reach out and help
Leeds Shows the Way. City presents ideal setting for EuroNavigator conference in the states and abroad provide educational opportunities as well as front row seats to meeting some of the best and brightest people in the industry—your colleagues.

Scott Freitag, NAED President

The city of Leeds, England, was for many reasons the ideal setting for the Seventh Annual EuroNavigator conference held during the third week in September.

For starters, Leeds is a beautiful and vibrant city, making it the perfect place for tourists eager to visit its many national and regional attractions.

Secondly, for the shopper in all of us, Leeds features a massive number of commercial enterprises, from small shops to huge department stores. Even if you’re not a shopper, it’s worth your while to visit the Victoria Quarter, famed for its connecting roof of stained glass in Leeds’ main shopping district.

Last, but certainly not least, is Leeds’ reputation as one of the fastest growing cities in the United Kingdom, in terms of its economy. Research and development is a leading sector in the financial and business services and, in my opinion, this made Leeds just the right setting since R&D basically defines the work behind the Priority Dispatch Corp.” (PDC) protocol now nearly an institution in this part of the world.

Let me step back to explain the importance of the protocol to the UK.

Maybe you’ve heard of the National Enterprise Maintenance Agreement (NEMA). The agreement was mentioned briefly in a previous edition of The Journal in relation to the National Academy of Emergency Dispatch (IAED) office that recently opened in Bristol. The NEMA is a partnership among the Department of Health (DH) of the National Health System (NHS), the Ambulance Trusts, and IAED. NHS measures the performance of each ambulance trust, and one of its targets is reaching category A (life threatening) calls within eight minutes of when the call was received. NHS introduced several initiatives to meet the goal, including the use of the Advanced Medical Priority Dispatch System® (AMPDS) protocol. The agreement, signed on 25 July 2006, establishes the use of the AMPDS as the standard for emergency dispatch in the Emergency Dispatch Centres (EDC) with the ambulance trusts operating across England and Wales. Eleven of the country’s 13 ambulance trusts, along with 24 EDCs are included in the agreement.

Paul Sutton, Chief Executive, South East Coast Ambulance Service NHS Trust, has nothing but praise for the AMPDS and the NEMA. In the DH Emergency Care Bulletin published last year soon after the agreement was signed, he is quoted as saying, “AMPDS has done a good deal to assist ambulance services in delivering high-quality patient care. The national framework should help all services in continuing to improve and encourage application of a national uniform standard when using the system.” Annual data on ambulance response recently published by the Information Centre (IC) for health and social care show ambulance services are performing well despite increased demand.

NEMA is so important to NHS that we set aside a full day of seminars dedicated to discussing its implementation and impact on ambulance services. While I don’t have the exact number of attendees at those sessions, our Conference Coordinator, Claire Colborn, says these were attended of the 75 sessions and workshops offered over the three days. They were packed with great ideas and strategies to try at my center in Salt Lake City, Utah. If you haven’t already, set aside the time to attend next year’s Navigator conference. I’ll look forward to seeing you there.
HIGH RISK Complications.
Patient conditions must match medical director’s approval

Jeff Clawson, M.D.

Question: We are having a problem with 24-D-5 HIGH RISK complications. When the call-taker asks the caller if they have any high-risk complications they give us answers such as “low iron, low blood sugar” or “my last pregnancy was high risk.” I believe that when callers make these types of statements call-takers need to clarify by asking: “Is your current pregnancy high risk?”, or “Has your doctor told you that your current pregnancy is high risk?”

I also think that another response determinant for the high-risk complications “Other” should be added so the agencies can choose between response plans for high-risk complications. Currently, every time the caller tells us that she has a high-risk complication, we respond with an ambulance (emergency response) and a fire engine (emergency response). I believe if we had a second response determinant we would send only an ambulance to these calls. We would not need to send the fire engine.

Melody A. BonAmi
Quality Assurance Officer for
Manatee County Emergency Communications, Bradenton, Fla.

Answer: Thank you for your inquiry about this issue. The initial intent of “Other” is that any “others” must first match the list of conditions (if any) that are approved by the EMS/EMD medical director and listed on the card. This was not clear, so we modified ProQA as the following excerpt from the v11.3 Update Guide explains:

ProQA Only Change: The fourth answer choice for Key Question “Does she have any HIGH RISK complications?” has been modified from “Other:” to “Other (select only if approved by Medical Director).” The same text has been added in the AI section “HIGH RISK complications.” This emphasizes that any additional patient conditions reported by the caller must match those approved by a medical director before they can be selected as “Other” actual HIGH RISK complications.

As you mentioned, we discovered that there was a wide interpretation (often lay-person determined) that caused the callers to give all types of conditions that from a dispatch standpoint are not HIGH RISK. In one system’s case review, we found three dozen highly variable conditions that the EMDs had entered when selecting “Other” without this clarification. The resultant over response was unacceptably high. We are reviewing this list since, in essence, it is our definition, not theirs, that determines what is HIGH RISK in the prehospital setting.

We have also added another answer choice for “Unapproved ‘other’ conditions” that allows the EMD to enter whatever was stated; they do not have to choose “no” as they do now. Obviously, it still functions in logic as a “no.”

Onward through the pregnant fog...
Editor’s Message.

Peace of mind for frantic callers

Audrey Fraizer, Managing Editor

Working in the emergency dispatch profession, at least in my marginal role as the managing editor of The Journal, started me thinking about the times I’ve made calls to 9-1-1. By best recollection, I remember twice pushing the three numbers on the phone pad and both times from our kitchen phone in relation to my daughter, now 18, when she was much younger.

The first time was her first and only febrile seizure, and that call resulted in (what it seemed) the instantaneous arrival of an emergency medical service crew to our front door. The second time was when she doused her spaghetti with the bottle of crystal dechlorinator meant for the fish tank. “Look, Mamma, my tongue is blue.”

The calltaker shunted my call over to the local poison control center.

I don’t think my composure was stellar for either of those calls. In other words, I was probably a wreck. My frame of mind and subsequent behavior was undoubtedly similar to the many 9-1-1 callers I have since heard via audiotapes in the EMD training class and those sent to the NAED offices from the many centers that use the Priority Dispatch Protocols (PDPTM). In my case, I am convinced that it was the protocol and the professionalism of the dispatcher that “saved the day.” I am sure the same applies to others making their calls.

I bring this up in relation to the dispatcher we highlight in this edition of The Journal, Connie Carson, a Sunnyvale Public Safety dispatcher, helps in the safe delivery of a baby in a call that lasts four minutes and 16 seconds. She also assists in restoring the breathing of an infant in a call that lasts six minutes and 38 seconds. Despite the crisis apparent in both situations, Connie brings each caller through to resolution (and they are happy ones, which certainly isn’t always the case) as they wait for the ambulance to arrive. She maintains the same calm voice no matter the emotional state of the parents calling (and there are apparent differences). Connie never loses her cool even when it comes to repeating instructions or continually assuring people that help is on its way.

Once the first responders do arrive, she disconnects, but not before congratulating the callers for their good work. “You’ve done a fantastic job,” Connie tells the new father. “Have a wonderful evening.” Yes, these parents should be recognized for what they did, but it’s also obvious that Connie, like other dispatchers, is the bull behind the phone call. She took control and never let it go.

If that doesn’t give you some semblance of peace of mind when calling a protocol-powered, professional 9-1-1 calltaker, I don’t know what will. Even for wrecks like me.
What could be more important than protecting our children?

Announcing 9-1-1 COMMUNICATION CENTER BEST PRACTICES IN CASES OF MISSING CHILDREN

A missing child is a critically important and high profile event that can rip the fabric of your agency and community if not handled correctly. In terms of urgency, use of resources and potential impact on the community, a missing child requires a level of readiness akin to a disaster. This joint initiative of NAED, APCO, NENA, National AMBER Alert and the National Center for Missing & Exploited Children (NCMEC) was created to:

- Promote awareness of the critical role of the 9-1-1 communication center in handling missing and exploited children calls
- Develop and endorse best practices
- Develop tools for handling incidents of missing and abducted children

Helping to PROTECT OUR CHILDREN is as easy as 1-2-3!

2. **Request** a copy of the Public Safety Telecommunicator Checklist for Missing Children.
3. **Apply** to attend NCMEC’s CEO Overview Course in Alexandria, Virginia.

**CEO Overview Course**

9-1-1 Communication Center Managers and Directors are invited to apply to attend the two-day overview course held at the National Headquarters of NCMEC in Alexandria, VA. Courses are conducted approximately every six weeks at no cost to participants.

For more information, visit www.missingkids.com/ 911 or email 911@ncmec.org
The uses of medically-approved interrogation protocols take the guesswork out of interrogating 9-1-1 EMS callers. Frequently, dispatchers come into an EMD class thinking that the Medical Priority Dispatch System® (MPDS) protocols are a "check your brain at the door and just read what's on the cards" approach to 9-1-1 EMS caller interrogation. Nothing could be further from the truth. The MPDS protocols require thinking, intelligence, and judgment on the part of EMDs. But more than anything else, they require active listening.

The Fourth Law of Medical Dispatch states: "The science of medical dispatch requires non-discretionary compliance to protocol."

Protocol has to be followed. But simply following protocol isn't the issue. Protocol has to be correctly applied to the hundreds of different situations a particular protocol can represent.

There are four particular MPDS protocols that are often misapplied, even by trained and certified EMDs. To use these protocols correctly, EMDs must utilize their intelligence and listening skills. The four protocols are: Protocol 12-Convulsions/Seizures, Protocol 19-Heart Problems/A.I.C.D, Protocol 26-Sick Person (Specific Diagnosis), and Protocol 32-Unknown Problem (Man Down).

Protocol 12 - Convulsions/Seizures
Protocol 12 is the fourth most complex protocol in the MPDS protocol set. It can be applied in four different ways. The most frequent error EMDs make in the use of this protocol is the failure to go straight to Protocol 12 when a convulsion or seizure (fit) is identified as the Chief Complaint during Case Entry interrogation. Ordinarily, if the answer to the Case Entry breathing question is "No" (or "I can't tell" or "I'm not sure.") an ECHO level dispatch is made directly from Case Entry. Seizures are the exception, as stated in Rule 4 in the Additional Information section of the Case Entry Protocol and Rule 3 in the Additional Information section of Protocol 12.

Rules
4. When the initial Chief Complaint appears to be seizure, go to Protocol 12 regardless of consciousness and breathing status.

Additional information section of the Case Entry Protocol and Rule 3 in the Additional Information section of Protocol 12.

The Formidable Four. Correct use of these four protocols takes an extra dash of listening.
There are also two common coding errors related to Protocol 12. If the caller says the seizure is still going on at the end of Key Question interrogation, it is by dis-
patch definition a CONTINUOUS SEIZURE and is coded as a 12-D-2. EMDs often mistakenly code a Continuous Seizure as a 12-D-1. The 12-D-1 descriptor is Not Breathing (after Key Questions). Remember that in an actively seizing patient, breathing status is unknown until after the seizure stops.

Finally, if a patient is breathing irregularly at the end of Key Question interrogation on Protocol 12 the EMD is required to use the Determining Agonal Breathing tool. If the breathing is agonal, the case is coded as a 12-D-1 because IN EFFECTIVE BREATHING has been discovered during Key Question interrogation. If the patient is breathing irregularly the case is coded as a 12-D-3.

Protocol 19-Heart Problems

EMDs are sometimes confused about when to use Protocol 10-Chest Pain (Non-Traumatic) and when to use Protocol 19-H eart Problems/ A.I.C.D. Obviously, Protocol 19 is used anytime a caller is reporting issues involving an Automatic Implanted Cardiac Defibrillator (A.I.C.D.). The confusion arises with the Chief Complaint portion to the protocol.

Here’s the easy way to know when to use Protocol 19: Focus on symptoms, not a caller’s diagnosis. Just because the caller uses the term “heart” in the initial chief complaint doesn’t mean that Protocol 19 is the best choice. For example, if the caller says the patient is having a heart attack (diagnosis—myocardial infarction), the best approach is to immediately clarify the actual event that prompted the call by repeating “tell me exactly what happened?”

Because neither the caller nor the EMD are qualified to diagnose a patient’s immediate problem, signs and symptoms are key to choosing the most appropriate protocol. Protocol 19 is often appropriate when the Chief Complaint appears to be cardi-ac related, i.e., a rapid heart rate, but the caller doesn’t specifically say “chest pain,” or describe any of the Heart Attack Symptoms listed in the Additional Information sections of Protocols 1, 10, and 19.

Chief Complaint Examples:

“W hat’s the problem, tell me exactly what happened?” “M y wife says she’s having palpitations; her heart’s racing.” This is a heart-related complaint, with described symptoms, but the caller has not specifically said the words “chest pain,” or described any of the listed Heart Attack Symptoms.
Interrogate on Protocol 19.

"What's the problem, tell me exactly what happened?" "Grand-dad is in congestive heart failure." This complaint is actually a diagnosis and we are still unclear what the immediate concern is. Asking again, "tell me exactly what happened?" should prompt a more categorizable complaint such as, "He's having a very hard time breathing." In this case, Protocol 6-Breathing Problems—would be most appropriate.

"What's the problem, tell me exactly what happened?" "My son has rheumatic heart disease." This sounds like a heart-related complaint but, once again, the caller has provided a diagnosis rather than a sign or symptom. Simply repeating, "Tell me exactly what happened?" should prompt a sign, symptom, or an event that can be used to choose a Chief Complaint Protocol. In this case, if the caller does not specifically describe any of the listed Heart Attack Symptoms, and the complaint appears to be heart related, interrogate on Protocol 19.

If, during Case Entry interrogation, the caller describes any of the Heart Attack Symptoms listed in the Additional Information section of Protocols 1 (Abdominal Pain/Problems), 10 (Chest Pain), and 19 (Heart Problems/A.I.C.D), the caller should be interrogated on Protocol 10. However, if chest pain or heart attack symptoms are discovered during Key Question interrogation on Protocol 19, the EMD should stay on Protocol 19 because the questioning, prioritization, and instruction on Protocols 10 and 19 are redundant.

Protocol 26-Sick Person (Specific Diagnosis)

This protocol is used to interrogate 1st or 2nd party callers who are calling 9-1-1 about someone with a vague or otherwise non-categorizable Chief Complaint, such as "sick." The caller may also respond to the question, "What's the problem, tell me exactly what happened?" by stating that the patient has a "non-cardiac related previous diagnosis as the Chief Complaint. "What's the problem, tell me exactly what happened?" "Mom's got Bell's Palsy (or leukemia, or Kohn's Disease, or Sickle Cell Anemia, etc.)." As always, when the caller offers a diagnosis other than a diabolic problem or stroke (specific MPDS protocols are available for these very reliable Chief Complaints), you should clarify by repeating "Tell me exactly what happened?" in an effort to solicit categorizable signs or symptoms. It is rare for someone to call 9-1-1 simply because a patient has a particular diagnosis. More often, something has happened to the patient and triggered the call. This "event" is most useful for Chief Complaint selection.

Protocol 26 is also frequently not used when it should be. See Rule 2 in the Additional Information section of Protocol 26. If a 2nd party caller is reporting an Unknown Problem (Man Down), and the patient is conscious and breathing, the EMD should interrogate the caller on Protocol 26. In lieu of a more specific complaint, a 2nd party caller should be able to provide enough information to "rule out" priority symptoms and appropriately care for the patient using the Sick Person Protocol. Protocol 32 (Unknown Problem (Man Down)) is generally for 3rd party callers.

Protocol 32-Unknown Problem (Man Down)

As previously stated, this protocol is used when a 3rd party caller is reporting an Unknown Problem or Man Down. A typical, unknown problem situation might go something like this, "What's the problem, tell me exactly what happened?" "A guy just came into my store and ran off. You'd better send an ambulance over there to check it out." "Do you know if the patient is conscious?" "I don't know." "Do you know if the patient is breathing?" "I don't know." In this case the dispatch would not be made out of Case Entry. This 3rd party caller would be interrogated on Protocol 32.

Protocol 32 cases are frequently mis-coded as 32-D-1 dispatches. The Additional Information section of Protocol 32 contains the dispatch definition of LIFE STATUS QUESTIONABLE. The emphasis in this definition is on the words—the existence of any information. The information regarding Life Status Questionable must come from the caller. It must not be based on what the EMD presumes, second-guesses, or reads into the case. If the caller's response to all the Key Questions on Protocol 32 is "I don't know," the case should be coded as 32-B-3. The descriptor for the 32-B-3 response determinant code is "Unknown status (3rd party caller)."

Less frequently, Protocol 32 may be used when a 1st party caller is unable to speak or understand. Examples include extreme language barriers (virtually no ability to communicate) or a medical problem, such as a stroke, that inhibits the caller's speech. In these cases, it is better to send a timely response, using Protocol 32, than to spend an inordinate amount of time trying to complete interrogation using Protocol 26. Once help has been sent, additional attempts to communicate, such as asking the caller to tap once on the phone for "yes" and twice for "no," may be very helpful in establishing a more specific complaint.

EMDs should frequently review the Additional Information section of the Formidable Four protocols to remind themselves about how and when to use these protocols. Do some practice scenarios to reinforce the reference information contained in the Additional Information section of these protocols.
1. According to the article, what is the most frequent error EMDs make in the use of Protocol 12?
   a. Failure to send an ECHO response when the caller reports that a convulsing patient is not breathing during Case Entry.
   b. Failure to go straight to Protocol 12 when a convulsion or seizure (fit) is identified as the Chief Complaint during Case Entry interrogation.
   c. Failure to check for regular breathing once the seizure (fit) has stopped.
   d. Failure to recognize cardiac arrest as a possible cause of seizure (fitting).

2. What is the best Determinant Code for a patient who is still convulsing at the end of interrogation?
   a. 12-D-1  b. 12-D-2  c. 12-D-3  d. 19-D-4

3. What is the best Determinant Code for a seizure (fitting) patient who is demonstrating AGONAL BREATHING after the seizure has stopped?
   a. 12-D-1  b. 12-D-2  c. 12-D-3  d. 12-D-4

4. In an actively seizing patient, breathing status is unknown until after the seizure stops.
   a. True  b. False

5. What is the most appropriate Chief Complaint Protocol when the caller reports: “My wife says she’s having palpitations; her heart’s racing.”
   a. Protocol 10: Chest Pain (Non-Traumatic)
   b. Protocol 12: Convulsions/Seizures (Fitting)
   d. Protocol 26: Sick Person (Specific Diagnosis)

6. What is the most appropriate Chief Complaint Protocol when the caller reports: “I’m feeling some pressure in my chest. I think it’s just my angina acting up, but it’s not responding to the medicine like it usually does.”
   a. Protocol 10: Chest Pain (Non-Traumatic)
   b. Protocol 12: Convulsions/Seizures (Fitting)
   d. Protocol 26: Sick Person (Specific Diagnosis)

7. According to the article, what should you do when the caller offers a previous, cardiac-related diagnosis, without signs or symptoms?
   a. Assume the current problem is cardiac related and select Protocol 19.
   b. Assume that the current problem is not cardiac related and use Protocol 26.
   c. Ask the caller to tell you more about the patient’s diagnosis.
   d. Clarify the current Chief Complaint by repeating “Tell me exactly what happened?” in an effort to solicit categorizable signs or symptoms.

8. What is the most appropriate Chief Complaint Protocol when the caller reports: “My mom doesn’t look good. I don’t know what the problem is. She’s conscious and breathing, but something is definitely wrong.”
   a. Protocol 10: Chest Pain
   b. Protocol 12: Convulsions/Seizures (Fitting)
   d. Protocol 26: Sick Person (Specific Diagnosis)

9. What is the most appropriate Chief Complaint Protocol when the caller reports: “A guy just came into my store and said an ambulance is needed for someone in the building across the street. Then he ran off. You’d better send an ambulance over there to check it out.”
   a. Protocol 10: Chest Pain
   c. Protocol 26: Sick Person (Specific Diagnosis)
   d. Protocol 32: Unknown Problem (Man Down)

10. A security guard reports that he was asked to call for an ambulance. The caller has not seen the patient and does not know if he is conscious or breathing. The caller answers, “I don’t know” in response to each of the Key Questions on Protocol 32. What is the best Determinant Code?
    a. 32-D-1
    b. 32-B-1
    c. 32-B-2
    d. 32-B-3

Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. (You must answer 8 of the 10 questions correctly to receive credit.) Within six weeks, you will receive notification of your score and an explanation of any wrong answers. Once processed, a CDE acknowledgement will be sent to you. (You must answer 8 of the 10 questions correctly to receive credit.)
Hot Rods in Flames! Protocol helps extinguish this fairly common incident

By Gary Galasso

Like most every boy growing up in Southern California in the ‘60s, I had an inherent love for cars; and I had the plastic hot rod models I built (with flame decals) to prove it. The memories flooded back when I recently visited the Petersen Museum of Automobile History in Los Angeles. Besides displaying vehicles produced throughout the last century, they had a very impressive and informative display on the history of the automobile. With a few decades of emergency services behind me, I was looking at it all from a different viewpoint—and a little dark humor. How did the drivers and inventors of the very first automobiles have the courage to operate these machines with chassis made of flimsy wood, sitting on narrow seats next to the gas tank, with drive chains, metal rods, and the engine surrounding them? Compare what was then to what is now millions of vehicles in the world today, moving around together on a daily basis, each still containing the basic components to initiate and sustain fire: an ignition source (the electrical system), fuel (i.e., gasoline/diesel, upholstery, plastic fixtures, electrical components, etc.), in an environment with plenty of oxygen. What's more amazing is the material that separates these substances is made of metal, plastic, and rubber. Over time, the metal and plastic will wear down and the rubber will crack. Add an event like an incompetent repair or collision and voilà! you have a fire! Oh, but don’t stop there. Let’s enclose the occu-

Semi trucks with saddle tanks, like the one pictured, can carry up to 150 gallons, one for each side of the truck!
pants with sealed glass and doors so that smoke can quickly overcome them. And it’s no challenge to have a stationary fire. Let’s move it along the highway to fan the flames! But wait... there's more! Let's load the cargo areas with additional items that can catch fire and may even explode. Not enough room for all you may want to carry? No problem! We’ll build giant vehicles that can carry thousand of pounds of stuff. But, don’t forget, they'll require huge fuel tanks (saddle tanks like the one pictured on pg. 12, can carry up to 150 gallons; one for each side of the truck!) to power their giant engines to deliver people and goods to their intended destinations, which will “add more fuel to the fire!” (Sorry... I got a little carried away!)

Common Occurrences

Vehicle fires are fairly common incidents. Most of our responses to vehicle fires are on the streets and highways. You may be wondering what causes these fires. (As I’m writing these words, I’m recalling my daughters riding in the car with me singing along to Carrie Underwood’s “Before He Cheats” on the radio; and yes, vehicle fires are sometimes caused by arson!) The fire reports I’ve reviewed have given causes from “underdetermined” to “mechanical failure.” Another common description given by drivers is a burning electrical odor just before smoke started coming out from under the dashboard. After pulling over and getting out, the car would sometimes burst into flames!

Regardless of the cause, firefighters know vehicle fires can be life-threatening not only to the public, but also to them personally. Even with small compact cars, firefighters must approach the scene fully protected by their turnouts and air supply (personnel protective equipment) with charged hose lines in hand. They know, depending on the type of vehicle, additional hazards may not be visible but are no less threatening. And vehicles burn fast! From the time the fire starts to the point the vehicle is totally involved in flames can be but a few minutes in duration. They must act fast, especially if life-safety is at stake. Also, as the fire progresses, tires will explode; and struts (shock-absorber looking devices that hold the hood and trunk open) and the bumper shocks, will launch their parts at a high velocity (there are documented incidents of these parts going through people and buildings). Though fuel tank ruptures are rare, there is potential. All bets are off if a liquid petroleum gas (LPG) tank is on the vehicle.

The Vehicle Fire Protocol

Protocol 71, Vehicle Fires, was developed and continues to evolve to address the challenges of vehicle fires. Reviewing the Additional Information Protocol, the emphasis has been properly placed on type and size of vehicle, type of fuel, presence of dangerous cargo, and location of the vehicle in relation to structures, especially ones that can catch fire.

You'll note that the size of the vehicle can alter the level of dispatch. It is not uncommon for agencies to initially send two engines, a truck, and a Battalion Chief to large vehicles fires (see LARGE FUEL/FIRE LOAD). The larger vehicles may also

Words to Carrie Underwood’s “Before He Cheats”:

That I dug my key into the side of his pretty little souped up 4-wheel drive,

Carved my name into his leather seats...

I took a Louisville slugger to both headlights,

Slashed a hole in all 4 tires...

This is a rear trunk cover of LPG powered vehicle that caught fire. Parts like this trunk cover were found up to 90 feet away from the car after the tank exploded.
In The News.
Putting the protocol to the test

Have you ever taken events from the news to “test” the protocol’s ability to address the issues on the scene? The news can offer many opportunities to put into practice what your agency is responsible for on a daily basis. It provides real life scenarios that you can apply those “seldom used skills” to on incidents that occur only once in a great while.

One such incident occurred recently on Interstate 5 in Southern California. On Oct. 13 at about 10:40 p.m., in a 550-foot-long tunnel, five to six big rigs, along with a number of passenger vehicles, were involved in a major collision that erupted into flames. The fire burned intensely for about four hours. Winds fanned the flames in the tunnel from end to end. The intense heat caused the tunnel’s concrete walls to explode, adding to the debris. There were two known fatalities and 10 injuries, according to initial reports. The fire was not completely extinguished until 5 p.m. the next day.

Let’s say you’re on-duty when the above event takes place. You receive a 9-1-1 call from a passer-by who’s in her car and on a cell phone. You start on Case Entry and obtain and confirm the location and phone number. When you state to her “Tell me exactly what happened,” the driver says she’s about a hundred yards away from a tunnel full of trucks and cars on fire with what looks like people trapped. What would you do at this point? When you continue asking questions on the protocol, here’s the information you obtain: she tells you she’s safe, there are no other structures around, she can’t identify any cargo or containers carried on the trucks, she doesn’t have any information on the number or types of automobiles involved, nor does she know of any injuries. What dispatch determinant would you end up with? What dispatch Life Support instructions would you give?

Answers: Initially dispatch a 71-E-1 on Case Entry and provide CE PDI a and b. Upon completion of KQ’s, upgrade the dispatch to a 71-D-3. Provide PDI a, b, and d. Provide Exit 1, 2.

Protocol 71 also considers the circumstance where the vehicle fire is near enough to a structure to cause it to catch the 71-D-1 determinant.

Parkades or parking garages are the exception. They are typically multi-story buildings of concrete that are not as vulnerable to the heat of a fire.

These structures are a challenge for firefighting because of the limited access by fire engines due to the low height of the ceilings. In most cases, this forces the firefighters to drag hundreds of feet of hose lines into the structure in order to reach the vehicle and put out the fire. A word of caution: many of our cities have buildings that have multiple levels of parking, but also contain businesses and/or apartment units. If it’s not clearly a parking garage, go to Protocol 69.

278,000 vehicle fires occurred in the U.S. during 2006

This is down 4% from 2005 but includes:
- 490 civilian fire deaths
- 1,200 civilian fire injuries
- $1.3 billion in property damage

Take the time to review the rest of the information on Protocol 71/Vehicle Fires. This protocol is designed to appropriately address the questions that need to be asked, provide the most appropriate dispatch to meet the needs of the incident, and provide instructions that will enhance the safety on scene.
Answers to the CDE quiz are found in the article “Hot Rods in Flames” which starts on page 12.

1. Vehicle fires can be life-threatening.
   a. true
   b. false

2. Vehicle fires typically burn very slowly.
   a. true
   b. false

3. As stated in the article, saddle tanks on commercial trucks can carry up to _____ gallons of fuel each.
   a. 50
   b. 100
   c. 150
   d. 200

4. In vehicle fire situations, the size of the vehicle can alter the level of dispatch.
   a. true
   b. false

5. In FPDS terminology, a PARKING GARAGE or PARKADE is defined as:
   a. Any structure that has levels/floors dedicated for parking vehicles.
   b. A freestanding structure constructed specifically for parking vehicles and where fire apparatus access may be limited due to height restrictions.
   c. Any structure where fire apparatus access may be limited due to height restrictions.

6. Which Chief Complaint Protocol is most appropriate when the caller reports that a vehicle is on fire inside a garage that is attached to a house?
   a. Protocol 69: Structure Fire
   b. Protocol 71: Vehicle Fire

7. Which Chief Complaint Protocol is most appropriate when an outside vehicle fire is threatening a structure?
   a. Protocol 69: Structure Fire
   b. Protocol 71: Vehicle Fire

8. Which Chief Complaint Protocol is most appropriate when the caller reports that a vehicle is on fire inside a PARKING GARAGE (PARKADE)?
   a. Protocol 69: Structure Fire
   b. Protocol 71: Vehicle Fire

9. Which Chief Complaint Protocol is most appropriate when the caller reports that a vehicle is on fire inside a parking structure attached to the back of an apartment building?
   a. Protocol 69: Structure Fire
   b. Protocol 71: Vehicle Fire

10. What is the best initial dispatch code for a vehicle fire such as the one described in this article that recently occurred on Interstate 5 in Southern California?
    a. 71-E-1: Vehicle fire (occupants trapped)
    b. 71-D-1: Vehicle fire with THREATENED structure
    c. 71-D-2: Tanker or tractor-trailer (semi) with flammable cargo
    d. 71-D-3: LARGE FUEL/FIRE LOAD vehicle

To be considered for CDE credit, this answer sheet must be received no later than 12/30/08. 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.
Let’s start off with some trivia. Have you ever heard of a bubbler? Unless you’re from Wisconsin or Australia, chances are you haven’t. It’s a drinking fountain. “Bubbler” is the trademarked name of the device originally invented in Kohler, Wis. I don’t know how the term made it to Australia. Language can sure be a funny thing.

How about this one: Ever heard of a cubozoan? This is another one that Australians might know. You might also recognize it if you’ve studied marine biology or watch nature shows on TV. It’s a kind of jellyfish—a particularly deadly type of sea animal that can generate frantic calls to Australia’s emergency services system. The prevalence of jellyfish sting emergencies in Australia—not to mention the pervasiveness of deadly snakes—along with the various language differences, explain...
our unique Australian English version of the Medical Priority Dispatch System® (MPDS).

Killer jellyfish is only one of the facts the Translation and Standards Department staff at Priority Dispatch Corp.™ (PDC) must keep straight while working on protocol products for the National Academies of Emergency Dispatch® (NAED). Thankfully, protocol differences are relatively rare. The NAED’s adherence to a unified protocol model guarantees that.

Translators have the true challenge—ensuring that the conversion from English to their native tongue results in text that is efficient yet eloquent, and accurate yet elegant. The job takes a fine ear for nuance, a solid background in both languages’ cultures, the ability to distinguish between the way we talk and the way we write, and the ability to discriminate among the ways laypersons, dispatchers, doctors, and lawyers talk. And it takes time—up to a year to complete the translation of the protocol and all its related products.

Work on a new language version of the protocol, however, doesn’t stop with the initial translation. Native-speaking subject matter experts—doctors, paramedics, firefighters, or law enforcement officers—must review the text. From there, the text goes to the NAED’s local cultural and language subcommittees for their approval.

Once finalized, graphic artists lay out the translation. To these poor souls falls the bewildering task of styling and formatting text in a language they can’t read. Imagine trying to figure out where to apply italics or text in a language they can’t read. Imagine trying to figure out where to apply italics or colors to a language that uses a completely different alphabet, and you’ll start to get a feel for what our graphic artists go through.

Let’s try not to even think about the nightmares they have trying to cram monstrously long German words into the limited amount of space available in the cardset’s narrow Additional Information columns.

Then comes the proofreading, which is perhaps the most agonizing step in the whole process. The entire translation is combed through for mistakes. We seek out typos that the computer’s spelling checker doesn’t find (for example “form” vs. “from”). We eradicate extra spaces. We manually check everything against the digital database, letter by letter, word by word, line by line. Every little detail has to be perfect. After all, our most frequent readers depend on protocol accuracy. It’s you, the dispatcher, who uses the protocol day in and day out, reciting it over and over again until a new version is released.

So far we’ve only been talking about the protocol itself—the manual cardsets and ProQA®—but along with each protocol version comes a whole suite of products. They are your course manuals and exams, PowerPoint presentations and computer-based training modules, QA Guides and Case Evaluation Records, Update Guides and Field Responder Guides, and more products not specifically related to protocol versions—The Journal, various marketing materials, contracts, and a continuous avalanche of letters and correspondence.

Keep in mind that all this has to be coordinated in 13 different languages. No wonder PDC has an entire department dedicated to this stuff.

So, who are the word wizards behind all this translation work? Check out the following pages featuring members of the Translation and Standards Department.

---

**Nadine Schick**

German Translator

Nadine Schick and her husband Michael picked a straw and the Priority Dispatch Corp.™ (PDC) got lucky. Among the seven states they were considering after Michael’s honorable discharge from military duty, Utah came out the winner for one very good reason.

“He was offered a job,” said Schick. “We decided he should take it.”

Glamorous or not, the decision turned Schick, a native of a small town in southwestern Germany, into a fan of Utah’s outdoors and the PDC emergency service protocol (although not necessarily in that order of priorities). She is the PDC translator for the German versions of the National Academies of Emergency Dispatch® (NAED) Protocols and numerous supporting materials. PDC wasn’t the first job she had in Utah, but it’s the one that has stuck from the days of combing the local classified job listings. “This is one of the only opportunities I have for using my language outside my phone calls to home,” she said.

When not in the office, Schick looks forward to strapping on a backpack for weekend and extended trips that take the couple through the mountains bordering Utah in all directions or the desert environment in the southern and western parts of the state. Her hometown in Germany, St. Julian, is a destination they’ve reached every two years since leaving the country in 1998. “We never thought we would leave Germany but a transfer came through to Texas, so we had little choice,” she said.

And while the “don’t mess with” state was among the seven straws in the stack, it obviously wasn’t fast enough on the draw.
Evan Gibson
Dutch Translator

Six months into the job and Evan Gibson is about to call it quits.

Well, not in the way that might sound, but to the tune of finishing the Dutch translation of the Medical, Police, and Fire Protocols for use in the Netherlands.

It will feel good to get the protocol off his plate, considering the intensity of work over the past several months, he said. But that doesn’t mean he will leave anytime soon. Just look at the list of products needing to be translated and you know Gibson is going to be busy for a long time.

“We were desperate to get him in here,” said Translation and Standards Editor Ben Rose. So desperate, he adds, that they had posted the want ad at the Dutch food pantry and the tiny Dutch credit union in Salt Lake City. “There are not many people that share his expertise.”

Gibson was hired after a prolonged search that ended when he responded to a job listing online. “I couldn’t believe my eyes,” he said. “It sounded like the perfect fit.”

Gibson, a native of Salt Lake City, speaks fluent Dutch from the years he lived in the Netherlands shortly after graduating from high school in Utah. He left the states at age 19 to live with extended family—his mother is native Dutch—and worked there for three years in the software and travel industries. Once his Visa expired, Gibson moved back to the states, earned a bachelor’s degree in psychology, and moved to San Francisco, Calif., to resume his travel career. Family eventually pulled him back home.

Since settling back into the Salt Lake area, Gibson has resumed his interests in hiking, camping, and swimming. He has gone back to the Netherlands to visit, although he doubts a second attempt at becoming a citizen. “At least not for now,” he said.

Veronique Leclerc
French Translator

The puns are almost irresistible.

Veronique Leclerc, a former gymnast, flipped over the chance at working as the French translator for Priority Dispatch Corp. and found balance in her life.

That’s not exactly what happened, as she explains. “I was looking for something that matched and the position here was ideal.”

Leclerc has a long list of abilities to match. The native of Montreal, Canada, and a native French speaker, started in gymnastics at age 4 and went on to achieve one of 10 spots on the Canadian gymnastics team. She came to the states in 2000 for a gymnastics scholarship at the University of Utah and, when not practicing or competing, earned the hours to complete a degree in exercise and sports science and cultural anthropology.

Along the way, Leclerc participated in the World Championships of 1997 and was named gymnastics Athlete of the Year for Canada in 1998. Trophies from her 18 years of competition were once about as common in her home as porcelain salt and pepper shakers for a collector. “I’ve only kept a few,” she said. “I devoted a large part of my life to gymnastics, and I was anxious to move on.”

In other words, Leclerc was ready to go on to other things once receiving her bachelor’s degree in 2004, including marrying a former classmate who is now working toward his medical degree. Their eight-month-old daughter Sunny is growing up in admiration of the outdoors or, at least, maybe so considering early trips into the mountains perched inside a baby-styled Mom and Dad backpack.

While it’s too soon to say where the medical profession will take them, it’s safe to say Leclerc finds Priority Dispatch Corp. a welcome switch from the more competitive and publicity-fueled life. “It’s been a great place for me,” she said.
Giuditta Easthope
Italian Translator

She enjoys time with her husband and kids, loves cooking meals inspired by her culture, and considers it a personal triumph when finding a book at a Salt Lake City bookstore that’s written in her native language (and not a translated version).

And when it comes to every day life, Giuditta Easthope still finds it hard to believe that this is the place where she landed. “I never imagined while growing up that Utah would be my home,” she said. “In all honesty, I had never heard of the state.”

Easthope moved to the states 14 years ago from her native Caserta, a small town in Italy close to Naples. She met her husband Ryan while he was living abroad and she was trying to learn the English language and study sociology at a college in Naples. The rest, as they say, altered her life.

Once married, the couple moved to Utah, close to Ryan’s family and to the University of Utah where he finished a bachelor’s degree in history. Giuditta found the Italian translation job at Priority Dispatch Corp. (PDC) shortly after their first daughter was born. Two more children have since been added to the family, and the once part-time position at PDC has turned into a demanding full-time spot to keep up with the Italian versions of the protocol.

The 10 years Easthope has spent at PDC have been remarkable, she said. Not only has it been a delight to use her native Italian daily, but she has enjoyed the camaraderie of fellow translators (she organizes the daily walks her group takes together) and the opportunity to be part of a growing company.

Translation and Standards Editor Ben Rose calls her the rallying point for the team. “She welcomes everyone,” he said. And, in the meantime, Utah has become a state she is glad to call home. “I really love that in 20 minutes I can be away from the city and completely immersed in nature,” she said.

Creighton Pena
Chinese Translator

He’s the new kid on the block, at least sort of, since he was hired on as software quality assurance a year ago in the PDC Software Development Department and has been on loan in recent months to the Translation and Standards Department. But the acquired position is only logical. Pena speaks several languages fluently, including two dialects and one language of Chinese and two dialects from his native Philippines. He is the chief translator for the Chinese version of ProQA.

Pena calls his ability to learn languages a hobby, something he naturally picked up while growing up as the third of four sons raised by his mother, who is from the Philippines, and his father, who emigrated to the Philippines from his native China. The interest in languages also goes along with his yen for travel, he explained. “I like to go places to learn about different cultures,” said Pena, who earned a bachelor’s degree in computer science in 1999 from the University of San Carlos in the Philippines. “I can adapt to wherever I go.”

His adaptation to Utah, where he has lived almost six years, includes a very active involvement in the local Chinese community, and that means more than the annual celebration of the Chinese New Year. Pena sings in the Chinese choir and plays the Erhu, a two string bowed instrument, in the Chinese Orchestra. He donates his time and talent to the local community in support of the bi-weekly Chinese newspaper.

Travel has taken Pena to more states than most native Westerners can list. Over the past several years he has peered over the edges of the Grand Canyon (Arizona) and Hoover Dam (on the border of Arizona and Nevada), taken pictures of Old Faithful in Yellowstone Park (Wyoming), and marveled at the sights along the strip of Las Vegas (Nevada). His love of travel brought him to the United States. “There’s a lot to see.”
Irena Weight, Translation and Standards Manager

I rena W eight, who directs the department, has been with PDC for six years. D uring that time she has seen the department grow to 13 language versions and from a staff of three people to a staff of eight people. W eight moved to the states nine years ago from Belarus (a country between Russia and Poland) with her A merican-born husband. She speaks fluent English, Russian, Belarusian, and Polish. A s far as her work is concerned, she anticipates additional language translations, including C hinese, A rabic, and a Russian translation she has worked on. "W ith our rapid growth, people are always asking about other language versions, and it’s hard to say which language will come our way next," she said.

"T here’s also a crew of production people that get the translated versions of protocol out the door and into the hands of communications centers.

T here’s also a crew of production people that get the translated versions of protocol out the door and into the hands of communications centers.

Each translation takes time and each is customized in the tradition of the country, she explained. In other words, “It’s not a straight word-for-word conversion. T he translators have to know the best way for the dispatcher to say something, to ask the questions,” she said. “E ach language version must sound eloquent and efficient; it must be as clear and concise as possible.” W ith so many products to be released for each language version, it takes six months to a year to complete one language version.

W eight makes it a priority to find native speaking translators. “W e prefer hiring people whose language is primary to the translation,” she said. T his can take months. For example, it took two months to find a Dutch translator, Evan G ibson.

O nce through the translation process at the PDC offices, a consultant from the country who is in the field of emergency response reviews the document to make sure the translation fits the respective culture of dispatch. O nce that gets the okay, the translation moves through the stages of graphic design and proofreading.

B en Rose is the person everyone at PDC goes to for proofreading and editing. H e is scrupulous on detail and an expert in the application of professional and business trademarks and any reference to the individual protocol. H e doesn’t always read for content, but instead concentrates on the style and formatting of the material before it goes to press. H is work goes beyond protocol, however, and extends to other areas such as testing and setting up the logic pathways for the new ProQA 5. H e is also among the editors of the N AED publication Principles of E MD.

W hile he can’t exactly recite any of the material in the fashion of the book Fahrenheit 451, he does easily recognize a revision that needs to be made. A fter all, he has been through the English versions of the M edical, Police, and Fire protocols at least a dozen times and through the Principles book three times. “I focus on the details but can easily recognize most of the language from the protocols from all of the times I’ve been through them,” he said.

R ose actually came to P DC in hopes of landing a job in graphic design, an area in which he has expertise from his undergraduate days at Utah V alley State College. H is bachelor’s degree in linguistics, however, convinced those hiring that he would be perfect for the position he has held for the past four years. F rom all appearances, PDC and Utah make the perfect professional and personal match for Rose. “I was born and raised here,” he said. “It’s where my family lives and it’s a place I like.”

G raphic designers C hd Iverson and H oly Mills share “sixes” in their careers in the Translation and Standards Department. Iverson has been at his job for six years, while M ills has nearly six months under her belt (at least at the time we talked to her in O ctober).

“T his is great,” said M ills, a recent graduate with a degree in Integrated Studies (art history, ethnic studies, and multi-media) from U tah’s W eber State U niversity. “It’s really fulfilling to apply what I’ve been studying at college.”

H er days in college read like a who’s who among campus volunteers. S he was a member of the student fee recommendation committee that allocated millions to campus clubs and organizations. S he helped in planning an emphasis week while on the Humanities A rea C ouncil and worked as
Looking Ahead.

Your next issue of The Journal will provide stories you surely won’t want to miss. In addition to the valuable CDE articles you rely upon for keeping credentials up-to-date, you can look forward to timely news briefs as well as the latest information about advances in protocol and software.

The January/February issue features stories about your colleagues on the job, including dispatcher Cherri Newhall and the day she helped save a life by providing CPR Pre-Arrival Instructions to a frightened woman who called 9-1-1 because her husband was having trouble breathing. You can also read about dispatcher Linda Boe, who recently passed the 32-year career mark in dispatching and dispatcher Dixie Weatherall reminiscing about days in dispatch that precluded the ease of ever using a foreign language translation.

And, while we’re on the subject of stories, let’s not forget that The Journal needs you! Here are a few ways you can contribute (and see your name in print):

Unforgettable Call, Dispatch in Action
We welcome your touching or hair-raising dispatch story in 500 words or less, and with the word “Action” or “Unforgettable” in the subject line.

Real Life
Submit a story about something you think your peers may want to read about. You can also send us a suggestion and we’ll do the follow-up and story.

Close Call
Our newest column showcases the often unseen talents of those who work in the field of emergency dispatch. If you have written a poem or a prose piece or have an inspired observation, we welcome the chance to showcase your work.

How to Submit
It’s easy. Send us your story and your full name, your call center, your hometown, your contact information (e-mail and phone number) and the number of years you’ve been dispatching to audrey.fraizer@emergencydispatch.org. We look forward to contacting you.
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The Communications Center Manager Course
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— Tom Ling, Johnson County Central Dispatch

Now accepting applications for the 2008 course to be held in Kansas City, MO. Online applications begin August 11, 2007. Go to www.emergencydispatch.org or call 1-800-960-6236 for course curriculum and registration information.

Presented by Fitch & Associates on behalf of NAED

NENA has approved this course as credit toward recertification for the Emergency Number Professional designation.
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### TUESDAY, APRIL 22

**Opening Gala Reception** | **Exhibit Hall**
---|---
6:00 PM - 8:00 PM | 6:00 PM - 8:00 PM

### WEDNESDAY, APRIL 23

**Opening Session** | **Welcome to Navigator 2008 President’s Speech Conference Theme**
---|---
7:30 AM - 8:30 AM |
8:30 AM - 10:30 AM |
10:30 AM - 10:45 AM |
10:45 AM - 12:00 PM |
11:30 AM - 12:30 PM |

**Box Lunch in the Exhibit Hall**

**EXHIBIT HALL**

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Management &amp; Operations</th>
<th>Special Interest</th>
<th>Medical</th>
<th>Fire</th>
<th>Police</th>
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</thead>
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<tr>
<td>Hall Hours</td>
<td>Emotions and Intelligence in Emergency Communications</td>
<td>A 100% Customer Service Standard</td>
<td>Mental Massage</td>
<td>Weird Science</td>
<td>What the Dispatcher Needs to Know about Specialized Rescue, Extrication, Confined Space, and Structural Collapse</td>
</tr>
<tr>
<td>Open</td>
<td>Jim Lanier, Sharon Lanier</td>
<td>J. M. Spafford</td>
<td>Dr. Jeff Clawson</td>
<td>Captain Steve Crandall</td>
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</tr>
</tbody>
</table>
| 10:30 a.m. - 12:30 p.m. | Open Sea Pirate Party
Cruise on The Bay Lady | Coffee Service |
| 1:00 PM - 2:00 PM | Open Sea Pirate Party
Cruise on The Bay Lady | Coffee Service |
| 2:15 PM - 3:30 PM | Open Sea Pirate Party
Cruise on The Bay Lady | Coffee Service |
| 3:30 - 4:30 PM | Open Sea Pirate Party
Cruise on The Bay Lady | Coffee Service |
| 4:30 PM - 5:00 PM | Open Sea Pirate Party
Cruise on The Bay Lady | Coffee Service |
| 5:30 PM - 6:00 PM | Open Sea Pirate Party
Cruise on The Bay Lady | Coffee Service |

**Exclusive Exhibit Hall Hours**

**Children's Program**

**Box Lunch in the Exhibit Hall**

**Attendee Party**

**Bay Lady Sunset Cruise**
6:00 PM - 8:00 PM
Boarding starts at 5:30 PM

### THURSDAY, APRIL 24

**Registration and Continental Breakfast**

**Attendee Party**

**Bay Lady Sunset Cruise**
6:00 PM - 8:00 PM
Boarding starts at 5:30 PM

**Open Sea Pirate Party**

**On The Bay Lady**

**SCHEDULE AT A GLANCE» NAVIGATOR 2008» Baltimore, Maryland» April 22 - 25**

**TOPICS AND SPEAKERS ARE SUBJECT TO CHANGE. VISIT WWW.EMERGENCYDISPATCH.ORG FOR THE LATEST UPDATES**
### Friday, April 25

#### Registration and Continental Breakfast

**7:30 AM - 8:00 AM**

- **LEADERSHIP**
  - Appreciative Supervision
    - David Nelson
  - Maryland — A Statewide Approach to Protocol Implementation
    - Gordon Dams
- **MANAGEMENT & OPERATIONS**
  - Beyond the Incident Action Plan
    - Tim Somers
  - Package Yourself for Promotion
    - Steve Revike
- **SPECIAL INTEREST**
  - Dispatcher Stress Management
    - Alice Vail, Christina Baum
  - Hysteria — Your Fault or the Caller’s
    - Chris Bradford
- **TECHNOLOGY**
  - ProA For Dummies
    - Chip Hlavacek
  - AQUA for Dummies
    - Chip Hlavacek
- **CDE**
  - Modulate and Specialize Your CDE
    - Jerry Charey
  - The Marriage of QIU and CDE
    - Brian Dale
- **QUALITY IMPROVEMENT**
  - Dealing With Your Most Difficult Calls
    - Brian Dale, Scott Freitag
  - Quality Improvement in the Non-Protocol Environment
    - Michael Spath

#### Coffee Service

**8:30 AM - 10:00 AM**

**10:00 AM - 10:15 AM**

**10:15 AM - 11:30 AM**

**11:30 AM - 12:30 PM**

**12:45 PM - 2:00 PM**

**2:15 PM - 3:30 PM**

**3:30 PM - 3:45 PM**

**3:45 PM - 5:00 PM**

#### EXHIBIT HALL

- **LEADERSHIP**
  - Leadership for the Future: Managing a Diverse Workforce
    - Ron Two Bulls, John Ferraro
  - Reach the Summit: Inspire Success Through Appreciative Inquiry
    - David Nelson
  - Call Processing
    - Greg Scott, Brian Dale, Scott Freitag
- **MANAGEMENT & OPERATIONS**
  - Learning From Abroad
    - Guillermo Fuentes
  - Control Charting
    - Jason Shearer
  - The Comm., Center is Gone...
    - Tom Sonnas
- **SPECIAL INTEREST**
  - Research: Dissected
    - Dr. Jeff Clawson, Brett Patterson
  - Going Beyond the Protocol and Being Right
    - Chris Bradford
  - Caler Locator Diagnostics
    - Dr. Jeff Clawson, Brett Patterson
  - Who Wants to be an EMD Millionaire?
    - Ron Two Bulls, John Ferraro
- **MEDICAL**
  - Pandemic Flu
    - Greg Scott, Dr. Jeff Clawson
  - The Santana Row Fire: Lessons Learned for the Emergency Room
    - Gary Galasso, Deanna Mater
  - Pandemic and Preventing Fire Apparatus Accidents
    - Jay Domsel
  - Domestic Violence and the EPD
    - Michael Spath
- **FIRE**
  - The New NENA Protocol Standard
    - Eric Perry, Michael Spath
- **POLICE**
  - Domestic Violence and the EPD
    - Michael Spath

#### Box Lunch in the Exhibit Hall

- **LEADERSHIP**
  - Being Effective: Are YOU, Will YOU?
    - Chip Hlavacek
  - The New NENA Protocol Standard
    - Eric Perry, Michael Spath
  - Being Effective: Are YOU, Will YOU?
    - Chip Hlavacek
- **MANAGEMENT & OPERATIONS**
  - The Call Processing
    - Greg Scott, Brian Dale, Scott Freitag
  - The Comm., Center is Gone...
    - Tom Sonnas
  - Caler Locator Diagnostics
    - Dr. Jeff Clawson, Brett Patterson
  - Who Wants to be an EMD Millionaire?
    - Ron Two Bulls, John Ferraro
- **SPECIAL INTEREST**
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    - Alice Vail, Christina Baum
  - Hysteria — Your Fault or the Caller’s
    - Chris Bradford
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  - Dealing With Your Most Difficult Calls
    - Brian Dale, Scott Freitag
  - The Marriage of QIU and CDE
    - Brian Dale
  - Quality Improvement in the Non-Protocol Environment
    - Michael Spath

#### Summary

- **Hall Hours**
  - Open 10:00 a.m. - 2:00 p.m.
  - Exclusive Hours & Box Lunch 11:30 a.m. - 12:30 p.m.
- **Box Lunch in the Exhibit Hall**
  - Last chance to visit this year’s exhibitors!
- **Coffee Service**
  - 7:30 AM - 8:00 AM
  - 8:00 AM - 9:15 AM
  - 9:30 AM - 10:45 AM
  - 11:00 AM - 12:15 PM
  - 1:00 PM - 2:30 PM
## CONFERENCE REGISTRATION OPTIONS

**APRIL 23-25, 2008 (WEDNESDAY, THURSDAY, FRIDAY)**

Passports INCLUDE admission to all regular conference sessions, the opening reception, the exhibit hall, and two box lunches.

<table>
<thead>
<tr>
<th>Conference Passport</th>
<th>$515</th>
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<tr>
<td>DISCOUNTS (CHECK ONLY ONE, AS ONLY ONE APPLIES)</td>
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<tr>
<td>☐ NENA Membership (ID: ____________)</td>
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<tr>
<td>☐ NAED Membership (ID: ____________)</td>
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<tr>
<td>☐ 1-day (Price per day, Wednesday-Friday, check below)</td>
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<tr>
<td>☐ April 23 ☐ April 24 ☐ April 25</td>
<td>$195</td>
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<tr>
<td>☐ Spouse/Guest Admission (Name: ________________________)</td>
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<tr>
<td>(Admission only to exhibit hall. Includes two box lunches and opening reception.)</td>
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<tr>
<td>☐ Special Event: Bay Lady Cruise, April 23 (Wednesday 6 p.m. - 8 p.m.)</td>
<td>$25</td>
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<tr>
<td>☐ Keynote and Awards Luncheon, April 25 (Friday)</td>
<td>$25</td>
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</tbody>
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### PRECONFERENCE PROGRAM SUMMARY

**APRIL 20-22, 2008 (SUNDAY, MONDAY, TUESDAY)**

### NAED CERTIFICATION COURSES

(Prices as marked. NAED materials and testing fees INCLUDED)

| 3 DAYS, SUN-TUES, APRIL 20-22, 8:30 a.m. - 5:30 p.m. | |
| ☐ EMD: Emergency MEDICAL Dispatch Certification Course (C-13560) | $295 |
| ☐ EMF: Emergency FIRE Dispatch Certification Course (C-13561) | $295 |
| ☐ EPD: Emergency POLICE Dispatch Certification Course (C-13562) | $295 |
| ☐ ETC-I: Emergency Telecommunicator Instructor Course (C-13563) | $475 |

| 2 DAYS, SUN-MON, APRIL 20-21, 8:30 a.m. - 5:30 p.m. | |
| ☐ EMD-Q: MEDICAL Dispatch QI Certification Course (Class 1) (C-13564) | $550 |
| ☐ EPD-Q: POLICE Dispatch QI Certification Course (C-13565) | $550 |

| 2 DAYS, MON-TUES, APRIL 21-22, 8:30 a.m. - 5:30 p.m. | |
| ☐ EMD-Q: MEDICAL Dispatch QI Certification Course (Class 2) (C-13566) | $550 |
| ☐ EPD-Q: FIRE Dispatch QI Certification Course (C-13567) | $550 |

| 1 DAY, MON, APRIL 21, 8:30 a.m. - 5:30 p.m. | |
| ☐ ED-Q: Recertification Course (C-13568) | $250 |

### NAED, NENA, & PSTC SPECIAL TOPIC WORKSHOPS

| 1 DAY, MONDAY, APRIL 21, 8:30 a.m. - 5:30 p.m. | |
| ☐ NENA: Overcoming Negativity in the Communications Center | $190 |
| ☐ NENA: Liability Issues | $190 |

| 1 DAY, TUESDAY, APRIL 22, 8:30 a.m. - 5:30 p.m. | |
| ☐ NENA: Introduction to Next Generation 9-1-1 | $190 |
| ☐ NENA: Missing! | $190 |
| ☐ PSTC: Being the Best | $190 |
| ☐ PSTC: Supervisory Workshop | $190 |

| ½ DAY, TUESDAY, APRIL 22, 8:30 a.m. - 12:30 p.m. | |
| ☐ NAED: Accreditation Workshop | $95 |
| ☐ NAED: Beginning Data Mining: Gaining Access to Your ProQA and AQUA Data | $95 |

| ½ DAY, TUESDAY, APRIL 22, 1:30 p.m. - 5:30 p.m. | |
| ☐ NAED: Executive Workshop | $95 |
| ☐ NAED: Advanced Data Mining: Gaining Access to Your ProQA and AQUA Data | $95 |

### 7th Annual Golf Tournament

Tuesday, April 22, 8:00 a.m. - 1:00 p.m. | $65

## FREE T-SHIRT WITH PRE-PAID REGISTRATION

Prepay your registration fees before the conference using a credit card or check/money order, and you will receive a free, custom-designed Navigator '08 Conference T-shirt at check-in. (See details on the Web.)
I didn’t know what to expect when I got off the plane in Manchester, England, and headed toward Leeds for the 4-day EuroNavigator conference, held September 27-30. I’d never been to England and after a 14-hour plane ride, jostling through customs and tapping my toe while impatiently waiting for my suitcases (yes, suitcases plural) to show up on the luggage carousel, I was feeling a bit surly. But as the rented van, stuffed with seven Americans and even more luggage, left the airport behind, I sat back in my seat and let out a long sigh. Outside my window, green rolling hills were dotted with sheep and an occasional village, farm, or country home. As we got closer to Leeds the traffic picked up and we quickly left the tranquility of the country behind and plunged into the traffic, noise, and exhilarating energy of a vibrant metropolis.

After arriving at the Leeds Marriott and checking in to the lovely old hotel, I found myself pleased with the prospect of interviewing, photographing, and spending time with our members from England, Scotland, Ireland, Wales, and Austria. Academy staff at the international headquarters in Salt Lake City, Utah, USA, and at the new IAED offices in Bristol, England, had been hard at work on EuroNavigator for many months. I knew we had a terrific conference experience prepared for the attendees and I was looking forward to sharing it with them over the next four days.

As is traditional, EuroNavigator is always kicked off

BY KRIS BERG

EuroNavigator: education, certification, networking, and fun

Receiving award. (Left to right) Ing. Christof Chwojka, CEO of LEBIG; Brian Dale, IAED Accreditation Board chair; Stefan Schmidt, IAED Dispatcher of the Year recipient; and LEBIG dispatcher; Beverley Logan, IAED national accreditation officer; Tudy Benson, IAED International Operations director; Scott Freitag, IAED president; and Heinz Novosad, LEBIG quality assurance manager.

Getting acquainted. (Left to right) Alan Fletcher, Priority Dispatch Corp.™ (PDC) president, and Professor Douglas A. Chamberlain, opening session keynote speaker.
Dispatcher Helps Save a Life.
He gives credit to coworkers

Stefan Schmidt, a dispatcher for the LEBIG agency of Lower Austria, was everything but smug about giving instructions credited to saving the life of a five-year-old boy when he accepted the Dispatcher of the Year Award at the recent EuroNavigaotor conference.

The deeply moved EMD told his audience that the award was representative of the job he and fellow dispatchers do on a regular basis, regardless of the attention they may or may not receive. “I hereby accept this award on behalf of my coworkers, who guarantee the safety and well-being of our community day after day!”

But that doesn’t mean the award was any less of an honor for Schmidt, as discovered in an interview that took place several weeks after the conference.

“It was overwhelming, a huge honor. Many of my colleagues at EuroNavigaotor in Leeds (England) were so happy for me and kept congratulating me over and over,” he said. But again in the same breadth he gave another hats off to his colleagues. “It really is an indication that all my colleagues, superiors, and I are doing an excellent job. It demonstrates that we need to continue with our efforts well into the future in order to provide the people of Lower Austria with the best possible help and support with the use of the AMPDS®[Advanced Medical Priority Dispatch System].”

Although the award is based on overall performance, the call that helped clinch the nomination and subsequent award came into the LEBIG agency in January 2007. According to a news release from the agency, a dog pulling on the scarf warn by a five-year-old boy, named Julian, nearly strangled the boy in a game of tug-of-war. Schmidt was on the phone with a family neighbor who relayed Schmidt’s emergency dispatch protocol to Julian’s father. At the same time, another dispatcher sent for emergency crews from the Red Cross and OAMTC. Dad successfully resuscitated his son and when the emergency crews arrived at the scene, Julian was breathing on his own. EMTs and the emergency physician took over his care and transported him to the hospital. A few days later Julian was home without any lasting effects from the accident.

The story for Schmidt doesn’t end there. In addition to the award presented on stage, the dispatcher was rewarded with a visit from Julian and his family and the neighbor who had alerted the family to the impending disaster. It was Julian’s sixth birthday.

“We celebrated by eating cake and drinking lemonade and coffee for the parents,” Schmidt said. “I gave Julian a children’s book about guardian angels for his birthday because I believe that every person has a guardian angel. In this case they were his dad and neighbor. If they wouldn’t have remained as calm as they were, they might not have been able to save his life.”

Schmidt gives a high five to the use of protocol for the job superbly done.

“I can’t even begin to imagine what it would be like if we didn’t use the AMPDS,” Schmidt said. “Not only does it provide the needed help to patients and safety to responders, but as an EMD it keeps me balanced and gives me a sense of peace or calmness, which I need so I can work worry-free.”

The LEBIG agency consists of six different sites within Lower Austria, all of which are connected. There are about 800 emergency vehicles on duty that are dispatched by the appropriate agency (site). On an average day they receive 20,000 calls; of those calls, between 15 to 20 percent are actual emergencies.
Douglas A. Chamberlain, CBE, MD, HonDSc, FRCP, FRCA, FESC, FACC, a professor of Resuscitation Medicine at the School of Medicine, Cardiff University, delivered the keynote address, Improving Resuscitation Results: Compressions Hold the Key. Dr. Chamberlain is a founding member of both the UK and European Resuscitation councils, co-chairman for the past nine years of the International Liaison Committee on Resuscitation (ILCOR), and advisor to the South East Coast Ambulance Service NHS Trust.

Professor Chamberlain enlightened and entertained his audience while illuminating the science, thinking, research, studies, and published papers behind the recent American Heart Association (AHA), European Resuscitation Council (ERC), and ILCOR change in compression recommendations for some types of cardiac arrest. These long awaited recommendations were quickly adopted into the Medical Priority Dispatch System®, version 11.2. Dr. Chamberlain's keynote also reminded us that just as "you" is the action word in the conference theme, "protocol" is the qualifying word that puts the power of science and best practices at the fingertips of calltakers.

Sunday, the final day of the conference, ended with a luncheon closing session. As promised, Dr. Clawson delivered a brief video greeting. Brett Patterson, Academics & Standards Associate and Research chair for the IAED Curriculum Board, admirably delivered the closing keynote address "Weird Science," as a stand-in for Dr. Clawson.

Lunch was full of laughter and stories about the conference. Attendees were asked to vote for one of five selected cities to host the 2008 conference. Take a minute to visit the IAED Web site (emergencydispatch.org) to see which city—Rome, Berlin, Hamburg, London, or Bristol—was voted the winner. I look forward to meeting (and perhaps photographing and interviewing) you next year. EuroNavigator is an experience you won't forget and don't want to miss.
Perhaps a bug in your ear keeps repeating "ACE. ACE. ACE." Maybe you’ve reached a point where ACE is a “must have” because of your own personal convictions for a “gold standard” that brings your communication center to a higher elevation. Or even better yet, ACE status has become a goal that your emergency service dispatchers are pushing to achieve. They work hard. They want the acknowledgement.

So, what’s stopping you?

Several obstacles, you might say. There’s the time element involved or the dreaded anticipation of rejection (what if we don’t get approved on the first review). There’s also the uncertainty of the ACE process and the steps it takes despite the information available from NAED or the ACE network.

Well, toss those fears aside. As the saying goes, no time like the present for—in this case—achieving the ACE objective. The following stories give a glimpse into those involved in the process who lived to share the value of becoming an ACE. These stories offer inspiration, practical direction, and encouragement in anticipation of helping your center achieve the same goal.

Don’t forget the help available from NAED. For more information, contact NAED Associate Director Carlynn Page.
Lyne Degrasse had two things dominating her “to do” list when she signed on as manager of operations to get the Niagara Communication Centre up and running: implementing Priority Dispatch protocol and achieving ACE status.

Of course, she said neither was really optional. Both were “givens” that came with the territory. “I knew what I was getting into when I took the job,” Degrasse said. “But neither was a problem because that was my professional background. I believed in the job ahead.”

Degrasse was already out of the gate when she transferred from Montreal to the Niagara centre in January 2005. Her job: to help get the new centre operating within five months of her arrival. She was among a handful of employees, a skeletal staff to say the least, ultimately responsible for an immense service region (see the stats that accompany this story).

The task was daunting in retrospect, said Degrasse. “We had a dynamic team, and from day one we knew what had to be done and how we were going to do it. We pulled it together—fast.”

According to a story about the Niagara Region Emergency Medical Services Communication Centre in the Spring 2006 issue of *The Journal*, the leadership team made accreditation the priority. For example, they made goals to:

- Train and certify dispatchers in the use of the Medical Priority Dispatch System® (MPDS)
- Teach the MPDS to field paramedics and train all paramedic supervisors as EMDS so that they could better understand the system
- Require EM D-Q certification as part of the quality assurance and quality improvement process
- Dedicate floor supervisor time to administrative and quality oversight

By the time the centre went live on June 1, 2005, 28 dispatchers were EM D certified and eight certified EM D-Qs were set to review nine percent of the cases each month for EM D compliance. Floor supervisors were scheduled to meet biweekly with each of their employees to discuss performance.

The centre also made it a priority to invest in its employees. For example, a dispatcher falling short of compliance goals isn’t put on the chopping block. Instead, the floor supervisor can assign the dispatcher to remedial training and protocol interventions.

“This is certainly not a punishment and we try hard so it’s not viewed that way,” Degrasse said. “Our goal is to give the dispatcher the tools needed to succeed.”

The strategy paid off early into the program when floor supervisors discovered that dispatchers were not quoting protocol word-for-word when gathering Case...
Entry information, and that was resulting in less than perfect compliance scores. A few simple training interventions and the problem was soon solved, she said.

To foster high quality performance and promote teamwork, they post compliance scores by shift “platoon” and the centre’s medical director, Dr. Doug Munkley, attends all Dispatch Review Committee meetings where he’s given the opportunity to coach staff on the clinical aspects of EMD.

As Degrasse says, they’re team-oriented to the extreme and part of that means making sure that everyone is part of the celebrations marking their accomplishments, like the barbecue they held after becoming an ACE in April 2006. In the future, the centre is looking to test pilot new PDS software and they plan to buddy up with the ACE in Nova Scotia for a data exchange to improve their already stellar services.

Degrasse was a Neonatal Intensive Care Unit (NICU) nurse with four years of hospital experience when she decided to try emergency services from a communication centre’s perspective. She had the clinical background—the Ministry of Health and Long-Term Care’s credentialing program requires CPR and first aid training—along with the understated preferred qualifications that come with the job: strong coping skills such as the ability to multitask; solve problems; and work effectively both independently and as part of a team.

“I needed a break from the intensity of NICU to the intensity of emergency services,” she laughs. “Actually, I liked the fast pace and the shift work. It’s been great for me and it’s great working with people who love what they do.”

Niagara Region Ready. On a regular basis the Niagara Region has 14 ambulances staffed 24 hours/seven days a week. In addition, the Niagara Region uses a paramedic response unit in a non-transport vehicle to begin the delivery of services while a transporting ambulance is dispatched.

Statistics:

- Covers 715 square miles and 452,000 permanent residents, plus some 15 million visitors that come to southeastern Ontario, Canada, each year to visit Niagara Falls
- 26 dispatchers (all EMD certified)
- 5 floor supervisors
- 1 training supervisor
- 8 staff members are EMD-Q certified
- Emergency Medical Services has an average response time of six minutes and 20 seconds for all dispatched emergent life threats
- Call volume is in excess of 62,000 calls per year.
- Degrasse credits accreditation with an estimated $2.7 million in cost savings to taxpayers because it ensures the proper prioritizing of calls. The center reduced its HOT responses from 80 percent to 60 percent in the first year of operation and improved critical-call response times by 90 seconds

Call Ready. Niagara Region Emergency Medical Services provides emergency pre-hospital care to the 12 municipalities of Niagara, their call volume is in excess of 62,000 calls per year, with a mix of both urban and rural population.
Editor’s Note: LAS started using version 10.3 of the Medical Priority Dispatch System® (MPDS) cardsets in 1999 and switched to ProQA® the week before Christmas 1999. Incidentally, this was just before the busiest New Year’s Eve in the history of the LAS because it was the millennium. While the LAS receives close to 5,500 calls on New Year’s, the opportunity to watch the century turn in London attracted millions more people to the city and, as a result, added an extra 1,000 calls to the LAS emergency line on that single evening of celebrations that spilled into the next day.

1. Why should a center go for accreditation (ACE)?
   Reaching and maintaining Accredited Center of Excellence standards shows that you have reached, and are publicly recognized as having, an internationally benchmarked, high standard of patient care delivered from your Emergency Operations Centre by your EMDs. The accreditation assures patients that they are receiving the most appropriate care and response no matter their situation.

2. Summarize the process you recommend to achieve accreditation.
   Basically, we kept the documentation for the Twenty Points of Accreditation in a ring binder during the preceding year in order to have the information at hand when it came to the full process.

3. What should you anticipate?
   It is a lot of hard work. Although we had most of the documentation on hand, there was still some that needed to be found. In addition, getting the necessary management to sign off on documentation can be difficult at times so you should work that into your schedule.

4. Could you offer any tips you learned along the way (helpful suggestions to others wanting to earn the same distinction)?
   I would suggest they keep a ring binder with the 20 points as dividers. If you can also store all this electronically, do so. Do whatever you can to save time when it comes to putting the document together. A nother point is, when you print the two copies to send to the Academy don’t use plastic wallets (if you can help it) but instead use high-grade white paper; it feels better and the finished product looks far more professional.

About the London Ambulance Service
The LAS covers an area of 620 square miles and a residential population of seven million people, as well as between one to two million transient workforce and a nightlife population of over two million. With an average of between 3,500 and 4,500 emergency calls each day, of which approximately two-thirds are activated on, 2.5 calls are received every minute in the Emergency Operations Centre each and every day.

The LAS utilizes 395 frontline emergency ambulances (of which 300 will be in use at any one time), 60 response cars, six motorbikes, one helicopter, and bicycles.

Some 2,500 paramedics and Emergency Medical Technicians and 360 Emergency Operations Centre staff are used to operate these resources, operating from any one of 70 ambulance stations or from headquarters.

The area covered by the service includes:
- Four major airports and one heliport
- 10 major rail terminals
- 275 underground tube stations
- 13 professional football clubs
- Approximately 3,700 public houses
- 159 theatres
- More than 230 nightclubs

On top of this, the service has to make contingency arrangements for:
- 28 million tourists and visitors annually
- Some of the largest public gatherings in the world
  - An annual New Year’s Eve party in Trafalgar Square
  - Proms in the park
  - Parties in the park
  - Notting Hill carnival

The LAS receives 20 percent of all emergency calls made in the United Kingdom.
Jim Lanier is an absolute pleasure, a ball of enthusiasm, when it comes to discussing protocol and ACE. When he says, “This is fun stuff,” you don’t doubt for a minute that he means every word of what he’s saying.

But Lanier wasn’t so sold on the whole dispatch idea two decades ago when he got started in the industry. He was a paramedic, a guy trained to give emergency medical assistance in the field, when hauled into the communications center as part of the agency’s promotional process. It’s not like the world had ended, but pretty close to it. “Let’s just say it wasn’t something I was looking forward to,” he said. “I belonged in the field and not on the floor of the comm. center.”

Then came the day Lanier was scheduled to begin orientation. After some “listening in” he was asked to take a call with, of course, the assistance of an experienced dispatcher. Wouldn’t you know? The caller was trying to help someone in cardiac arrest. “I was a deer caught in the headlights,” he said. “I was in a black box and couldn’t see what was going on.” A tap, tap noise to his side caught his attention. “What’s that?” he thought. The sound was from the dispatcher next to him, the trainer, pointing firmly at the “Clawson cards.” “All of a sudden, I refocused,” he said. “I was able to help the caller until help arrived.” Lanier was sold. “I could read instructions that were safe and appropriate,” he said. “It clicked for me. This was cool stuff.”

Lanier’s career took a gradual turn, at least compared to the days of giving medical help in the field. He went from dispatcher to dispatch training officer to eventually become the Director of Communications for the Pinellas County Sun-star Paramedics Communications Center. Along the way Lanier became the project coordinator for the center’s ACE designation, which he and his team of subject matter experts achieved in six months. He later moved on to the Emergency Medical Services Alliance (EMSA) in Marion County, Fla., where he serves as the Division Chief of Communications.

Lanier took his current job two years ago and spent the first five months dusting off the Twenty Points of Accreditation to renew a status that had since lapsed. Lanier, well known for the remarkable analogies he uses to clarify the more complex pictures, compared the process to a smoldering fire. “We needed fresh fuel and oxygen,” he said. “There were a lot of pieces still woven into the framework so it was a matter of getting it started again and to keep it moving on the right track.”
Quality Assurance is vital to the ACE process

“There's no doubt about that,” said Susi Marsan, a QA specialist who teaches the Emergency Dispatch Quality Improvement Specialist (ED-Q™) to centers around the world. “Quality assurance done right means you are making optimal use of protocol.”

The importance of QA in use of the EMD, EFD, of EPD protocol is highlighted through the 20 Points of A creditation. For example, Point 5 requires a full reporting of a center’s quality improvement (QI) committee processes (which assumes, of course, that you have a committee in place) and Point 6 dictates “a complete description of the methods used to evaluate EMD performance in using all elements of the MPDS correctly as outlined in the ED-Q Course Manual.”

Point 7 calls for “consistent case evaluation that meets or exceeds the Academy’s minimum performance expectations.”

In other words, QA is a “must have” for any center trying to achieve the ACE status and keep it. It’s the center’s choice to decide how this done.

Marsan said that in the best-case scenario, the QA is an employee at the center dedicated to the job. “This is a major responsibility,” she said. “You want to make sure your staff is complying to protocol and it takes real dedication to do the job.”

A center may decide to make the position part-time, such as having the supervisor in charge of dispatch devote a certain number of hours to QA each week, or a center may decide to outsource the responsibility.

Whatever they pick, however, the QA must be ED-Q certified to achieve the ACE status, according to Carlynn Page, NAED associate director. First and foremost, the ED-Q randomly reviews the dispatchers’ calls; the number varies according to the call volume, as outlined in Point 7. The QA listens to the entire call— not just a select portion—and scores the call based on standard criteria. The review is the basis for employee reviews and subsequent continuing dispatch education courses and in-house training the QA person develops.

Marsan stresses the non-punitive nature of QA. The process should never strike fear into the hearts of dispatchers.

“The process is meant to make people better at what they do,” she said. “We can look at what each person does really well and help them strengthen those areas that need some attention. This keeps dispatchers on track.”

A CE status means a lot to Lanier. “There’s a great deal of validation,” he said. “You’re telling your internal and external customers that the center is providing the highest degree of patient care that’s possible. We are at the pinnacle of excellence.”

Lanier made the change from the field to the communications center at a pivotal time in the genesis of protocol-based call processing, at a time when some people still considered dispatch the dregs of public service work. In fact, his epiphany—the acknowledgement of the work’s immense value— just about coincided with the evolution of the Medical Priority Dispatch System® (MPDS) into becoming the standard of care in communications centers across the country. “This was a turning point in the industry,” Lanier said. “People were starting to get what protocol was all about.”

The people Lanier now considers for dispatch jobs must be field qualified EMTs or paramedics, and the position of EMD is considered a promotion in their public service careers. The dispatchers must maintain paramedic and/or EMT field requirements and emergency medical dispatch (EMD) and emergency fire dispatch (EFD) certification (the center uses both sets of protocols) and when in the center, “They’re EMDS first when they are using the MPDS,” he said. “Caring for the community and our responders, that’s why we’re here. This has taken them to another skill level of patient care and customer service.”

About the EMS Alliance of Marion County (EMSA)

The EMSA is a nonprofit, government EMS agency created by a partnership between the Marion County, Fla., Board of County Commissioners, the City of Ocala, Ocala Regional Medical Center/ West Marion Community Hospital; and Munroe Regional Medical Center. EMSA provides leadership, field supervision, and medical direction for 9-1-1 based emergency medical services, patient contacts, and ambulance transportation within the 1,653-square-mile service area in North Central Florida. 9-1-1 medical calls answered by the Marion County Sheriff’s Office or the City of Ocala Police Department are transferred to an EM SA calltaker who enters the call into the CAD system. A nother EM SA dispatcher notifies the closest ambulance via radio while the EM SA calltaker gives pre-arrival medical instructions.

Statistics:

- 14 full-time paramedics and EMTs, which include:
  - 4 Communications Lieutenants
  - 2 Communications Training Officers
- 2 Pool Paramedics
- 1 Communications Quality Captain (support staff)
- 1 Communications Division Chief (support staff)
When Ruth McGuire switched back to field services from a management position, she left things the way a successor would like to find them.

“She certainly made my transition easier,” said Tom Anglim, who replaced McGuire as the Quality Assurance (QA) Specialist for San Diego Medical Service Enterprise (SDMSE) dispatch center services. “Everything was in order.”

Anglim was particularly pleased over the hard copy files McGuire had neatly organized to maintain their ACE over the past nine years. The notice of the center’s three-year renewal arrived shortly after Anglim took the position and thanks to McGuire’s meticulous work habits, he believes the process will take less than the hundreds of hours the initial application consumed in 1998.

McGuire was ready to turn the job over and she’s glad it was Anglim who took it.”

Anglim has the background from his intensive experience in creating and maintaining order in a system. Anglim was part of the request for proposal (RFP) building process that brought about the SDMSE and later, their EMS contract for medical transportation services with the city of San Diego. Anglim became a regular fixture of expertise on the plethora of task forces, committees, and working groups created to get the jobs done.

San Diego Medical Service Enterprise, California

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Statistics:

- Largest 9-1-1 paramedic and non-emergency medical transportation provider in San Diego County
- Also serves County Service Area (CSA) 17, which encompasses Del Mar, Solana Beach, Encinitas, Elfin Forrest, 4S Ranch, and the community of Rancho Santa Fe
- Also the non-emergency transportation provider for Sharp Healthcare, Kaiser Permanente, and Palomar/Pomerado Healthcare
- More than 80 medical vehicles
- At least 33 paramedic 9-1-1 vehicles on duty at any given time
- More than 450 employees, including 40 dispatch professionals
- More than 250 calls per day
- Nearly 100,000 emergency medical calls per year
Eleven Tips to achieve accreditation

1. **Take the first step.**
   Lots of things look overwhelming and that makes it easy to say, “This is something that I can start tomorrow when I have a cleaner plate,” Degrasse, of Niagara EMS Communications, suggests breaking the task down into manageable steps and assigning subject matter experts to each phase. A nglim, of the SDM SE, was impressed by his predecessor’s organization and is realistic about the task ahead when the SDM SE goes for reaccreditation. “There’s a commitment and so when I walked in there were already a lot of pieces in place.”

2. **Delegate work and organize the process.**
   Find your subject matter experts and assign them tasks that complement what they know while giving them some new challenges. Once everyone has their task down, encourage the use of ring binders and organize it in a way that everyone recognizes, suggests Gummert of the London Ambulance Service (LAS). “Put in anything you think might be useful as you go along,” he said.

3. **Stick to deadlines.**
   Put someone in charge of scheduling and have that person send out reminders as the deadlines draw near. Degrasse, of Niagara EMS Communications, and her group knew what they had in store from day one. They set schedules, timelines, and charted out what had to be done within the first five months of operations. “We knew what had to be done,” she said. Sometimes, projects can hit a snag and the scheduler can take that into consideration and use that information to revise deadlines or to help seek assistance in getting past the snag.

4. **Look inward (don’t be afraid to reflect on the negatives).**
   Okay, so sometimes things don’t go off exactly as you planned. The Key Question compliance data isn’t turning out like you wanted or the attendance records aren’t coming back completed. Lanier suggests putting the negative into a positive light. “Take these as challenges, as opportunities for positive change rather than personal failings,” he said.

5. **Consider the tortoise, rather than the hare (take things steadily).**
   There’s no need to rush to the finish line. Sure, you want to get the project done in a reasonable amount of time but that doesn’t mean cutting corners or rushing through any of the Twenty Points of Accreditation to set an ACE record. For example, if it looks like protocol compliance requires some extra attention, schedule it in. The end result may be great but, as Lanier warns, the Academy also wants to see how you achieved it.

6. **Seek clarification of the seemingly impossible.**
   Maybe your interpretation of response configurations (number 15 of the Twenty Points of Accreditation) varies from what the Academy intends it to mean to achieve the point. Ask for clarification and, if possible, establish a network of ACE experts to answer questions as you progress through the certification process. Anglim breaks down the barriers of competition that sometimes exist in the world of emergency communications. “I can call an accredited center and there’s always someone there eager to talk about this,” he said. “We’re all trying to dance under the same limbo pole so people want to help out when someone calls.”

7. **Get buy-in.**
   Dispatchers in the business for a longer time than you’ve been alive may not take instantly to the idea of “reading script” or following the rules of compliance. “The big change monster must be taken into consideration,” said Lanier. “Talk to your dispatchers. Find out their fears, the obstacles they think they’ll be facing when learning protocols or going for accreditation. Let them know that this is a process and that you will give them the tools they need to succeed.”

8. **Recognize your employees.**
   And that means more than knowing them on a first and last name basis. Upon achieving ACE status, the Niagara Region Emergency Medical Services Communication Centre held a barbecue and gave out polo shirts embroidered with the agency logo and the IAED logo. In September, they calculate compliance scores and the top dispatchers receive gift certificates and their names are added to the centre’s commemorative plaque. Degrasse said the dispatchers like the recognition. “I’m telling you, they’re proud of what they do. They’re good at what they do and we try hard to let them know their work doesn’t go unnoticed.”

9. **Focus on the benefits of accreditation.**
   Degrasse was well acquainted with the MPDS and the ACE program when she accepted the post in Niagara. “Guillermo [Fuentes, the centre’s associate director] and I had been using MPDS for as long as we could remember. The dispatchers we hired knew that this was something very important to our centre, along with accreditation, and we never lost sight of what we set out to achieve,” she said. The ACE title goes a long way. “Everyone welcomes our services with open arms because they know that every call is answered at the same consistent and effective level of quality,” Degrasse said.

10. **Keep the future in sight.**
    McGuire, the former QA for SDM SE, advises people to look ahead and to consider others taking over the process in the future. “When setting up the process or going through reaccreditation, think about the next time you or someone else will be going through this. You want to make sure the process is coordinated and the information is accessible,” she said. “You want a smooth transition.”

11. **Believe in what you’re doing.**
    ACE status was a given for Degrasse’s group. “We recognized the importance from the start and that’s what we told our dispatchers,” she said.
Despite all that’s going in his favor, however, Anglim still anticipates plenty of challenges in the reaccreditation process.

Reaccreditation takes strict adherence to the Twenty Points of Accreditation. For example, Anglim will document certification and recertification dates among the dispatchers (Point 3) and the EMD certification courses either contracted or taught in-house (Point 4). As part of his job, he will also document the quality assurance activities in line with several of the points listed in the process. That was McGuire’s specialty and something that will take Anglim’s full attention. QA documentation is central to the whole operation, as even a cursory review of the Twenty Points indicates. The importance of keeping accurate and easily retrievable records accumulated over the years cannot be over-emphasized.

“Don’t make it sound too easy,” he said. “Ruth left the files in great order and she’ll be the first person I contact in case of a snag. Yet, it’s still going to be a huge learning experience for me. It’s exciting.”

Similar to the Niagara Region Emergency Medical Services Communication Centre (see accompanying story), the goal of ACE status was a given for SDMSE. The State of California does not require an EMD program, but there are references to EMD activities in the state’s QA/QI plan—perhaps, said Anglim, to remind any QA/QI plan architects to include dispatch in their plans. The contract between SDMSE and the City of San Diego does not require EMD, but it does stipulate varying degrees of dispatch levels, as specified by the city’s Medical Director James Dunford, M.D. In this case, the Medical Priority Dispatch System® (MPDS) is precisely what the doctor ordered.

McGuire cited personal reasons for wanting ACE status. “We wanted to be the best and this showed the world that we have a great program.”

She said the transition to ProQA® from the MPDS cardset when she took over as QA Specialist in 1997 was compounded in difficulty by the simultaneous switch to an advanced computer-aided dispatch (CAD) system. That was on top of their quest for ACE status. “It was a challenging time for everyone, but a lot of positives came out in the long run,” she said. “Dispatchers got comfortable using the protocol; they know they’re helping people by using something that’s proven.”

Anglim started in emergency services 25 years ago after taking a one-credit first aid and CPR course in college to fulfill enrollment requirements. One thing lead to another, and Anglim went from a job as a police officer to jobs as an EMT and a paramedic. He was doing a QI project when the current position opened, so he grabbed it. “I knew the job would be a challenge, which I wanted, and I also like working in quality assurance,” he said. Protocol works. We have the numbers that prove that it does and the dispatchers see the difference.”

H.R. 3403 intends to “promote and enhance public safety by facilitating the rapid deployment of IP-enabled 9-1-1 and E9-1-1 services, encouraging the nation’s transition to a national IP-enabled emergency network and improve 9-1-1 and E9-1-1 access to those with disabilities.” The bill contains provisions similar to S. 428, which has been approved by the Senate Commerce Committee and awaits action by the full Senate.

Rep. Bart Gordon (D-Tenn.) and House E9-1-1 Caucus Co-Chairs Reps. Anna Eshoo (D-Calif.) and John Shimkus (R-Ill.) introduced the legislation.

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Dispatcher Group Reboots

When Michael Wallach was reassigned after his agency civilianized their 9-1-1 center, he thought his involvement with the telecommunications end of the business was over. However, “There is something about being a telecommunicator that just becomes a part of you,” he remarked. Over the years he kept up his involvement, mostly through membership in online groups for dispatchers. When one of those groups began to lose its direction, he found himself back in the fray. “I never expected to get so involved again,” he said. Yet, that’s precisely what happened. “Reading constantly about the real-life concerns of the group’s members, I realized that there was a need for something more,” he recalls. So, with that in mind, Wallach made it his goal to provide the 9-1-1 professional with a place to find quality peer-to-peer support and to promote a positive public awareness of these frequently overlooked, and often-maligned public servants. From that idea, 911Lifeline was born in April of 2006.

As he explains, “In the beginning the group started as a Yahoo forum not too different from several others, though it had a more structured and professional tone than most. But how fast it grew caught me by surprise. We had several hundred members in just the first few months.” The enthusiastic reception, and the feedback the group was receiving, helped him decide to really take the helm and transform the simple forum into a true membership organization. For the past several months, he has done just that. Wallach reached out to create relationships with other public safety support, and educational organizations, as well as the media as he works to position 911Lifeline as the voice and public face of the grassroots 9-1-1 community.

Eventually, Wallach plans to create a nonprofit association to keep the fledgling program alive indefinitely. “This is an organization without a political agenda or an axe to grind,” he said. “Our mission is to be the representative of the dispatcher and the numerous other individuals that make the nation’s lifeline work.”

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the most respected individuals in the 9-1-1 community. He has in-depth knowledge of our people as well as the opportunities and challenges that face NENA as an organization. His leadership will ensure all our programs move ahead while we make this management change,” according to the same release.

Private Funding Might Save Wireless Broadband Network

The government's solution to our inadequate emergency communication system looks like it might depend on the pocketbooks of private investors. The nationwide wireless broadband network plan the Federal Communications Commission (FCC) approved calls for the creation of a network that public safety and commercial users share. According to the plan, a shared national network would combine 10 megahertz of spectrum dedicated to public safety with another 10 megahertz of commercial spectrum. A nonprofit board of members from public safety organizations would manage the public safety portion; the private portion goes up for auction in 2008. One potential downside: If it fails, the delay could result in extending the woes of the deficient national emergency system until another plan is put into place and that could take years.

Medicare Agency Bends Rules for Emergency Transport Claims

The proposal that covers beneficiary signature requirements for ambulance providers and suppliers could be finalized in time for a Jan. 1, 2008, effective date.

At least, that's according to David Walczak, of the Center for Medicare Management, of the Centers for Medicare & Medicaid Services (CMS).

Grant Funds Use of Priority Dispatch System Protocol

What's an optimal characteristic of superior emergency service response? It's the use of a Priority Dispatch System (PDS™), of course.

At least that's the foot in the door you need for an emergency service grant through the North Carolina Office of EMS (NCOEMS) Phase II EMS ToolKit project, funded through the Duke Endowment. This project provides funding in the amount of $2,000,775 during year one and an additional $395,145 during year two for a total requested amount of $2,395,920. A total of $395,145 of year one funding will be allocated to EMS systems based on the use of appropriate response tools— and that's where PDS comes into play. During the first project year, NCOEMS will distribute these funds through a competitive process that is expected to provide PDS Emergency Medical Dispatch (EMD) program protocol for 20 to 30 EMS systems.

Where did it all start?

Since 2005, North Carolina regulations have required that every EMS system submit data on all EMS events and response times across 30 different performance parameters. The results of the data collection showed, in part, that the lack of a properly performing EMD program was a common characteristic among emergency medical service systems that did not provide optimal response times. A second major flaw was the lack of EMS policies and procedures.

Common Characteristics of High Performing EMS Systems

According to the grant proposal, the following parameters mean you have a high performing EMS system:

- A 9-1-1 center with call location and phase II (cell phone locating) capability to quickly identify and better direct the EMS system to the event location
- The presence of an Emergency Medical Dispatch (EMD) program with the computerized quality management software; this formalized EMD program is designed to:
  - Through a series of standardized questions quickly identify emergent medical and traumatic conditions to direct the appropriate EMS system response
  - Dispatch an EMS unit (ambulance) to an emergent event within 1.5 minutes of the 9-1-1 phone ringing— 90 percent of the time
  - Provide pre-arrival medical care instructions such as CPR over the phone while EMS is en route to the scene of the event
- An EMS crew located 24/7/365 with the EMS unit (ambulance) so that wheels are rolling within three minutes—90 percent of the time
- An emergency EMS response to the scene of the event with the correct crew, equipment, supplies, and knowledge within 13 minutes—90 percent of the time

Walczak, who authored the proposal and is listed in the July 12, 2007, Federal Register as its contact person, said to expect slight changes to the original content based on comments his office has received since it was published as part of the proposed 2008 Medicare Physician Fee Schedule (M PFS).

The final M PFS rule, which is expected to include the signature requirement, was scheduled for publication in a November edition of the Federal Register.

According to the signature proposal in the July 12 Federal Register, ambulance providers and suppliers can submit claims without the signature of the beneficiary as long as the provider documents the following information:

- A signed contemporaneous statement, made by an ambulance employee present during the trip to
the receiving facility, that the beneficiary was physically or mentally incapable of signing a claim form and no representative was available or willing to sign the claim form on behalf of the beneficiary at the time the service was provided

- The date and time the beneficiary was transported and the name and location of the facility where the beneficiary was received
- A signed contemporaneous statement from a representative of the facility that received the beneficiary, which documents the name of the beneficiary and the time and date that the beneficiary was received by that facility

CMS says it wants to change the rules out of sympathy for ambulance providers and suppliers giving transport in emergency situations since getting signatures at the time of the emergency can be “impossible or impractical” due to the patient’s medical condition. Finding a representative can be equally frustrating, given the location and timing of the emergency. And tracking down the beneficiary “after the fact” can turn into a fruitless waste of time, not to mention the problem of going after the beneficiary for payment when the beneficiary refuses to sign for Medicare.

“We understand it can be difficult getting the beneficiary’s signature and going after payment,” said Walczak. “But the current regulation was ambiguous and it was our intent to clarify the issue. We were creating an exception and the proposal set forth the process for having the verification on record. It’s for everyone’s protection.”

Call Transfer does not preempt emergency assistance

Referring calls for telephone advice does not result in cancelled ambulance assistance, at least that’s according to the results of a study by ScHARR (School of Health and Related Research), University of Sheffield, Sheffield, UK.

In fact, the study results report that, “We have found this not to be the case and almost half of calls are returned to the ambulance service for an ambulance response indicating that, although non-urgent, many of these calls are for patients who need transport or some form of face-to-face assessment.”

For the future, the researchers recommend that it may be better to view telephone advice as a service that can solve some cases and provides an enhanced triage system to aid the increasingly complex decisions around the sending of emergency care resources.

The National Coordinating Centre commissioned this study for the National Health System Service Delivery and Organisation R&D programme, under the title “Managing Some 999 Calls by NHS Direct Nurse Advisers.” Janette Turner at the Medical Care Research Unit, University of Sheffield, led the research.

Other Key Findings in the Report

- Diverting non-urgent 999 calls to nurse advisers reduced the mean costs of emergency care in comparison with the current approach. The cost impact on subsequent services is less certain but it appears that further savings are possible.

- There is an expectation amongst some 999 callers that an ambulance should always be dispatched when requested.

- Many callers still require transport by ambulance or a face-to-face health assessment even if their medical condition is non-urgent. Consequently, the proportion of calls that can be effectively managed through nurse advice alone is sometimes smaller than anticipated.

- In general, callers referred to the nurse adviser were satisfied with the advice and reassurance provided by the nurse. The main reasons for dissatisfaction were the number of questions and the delay in sending the ambulance (if subsequently required).

- The ambulance service and nurse advisers participating in the study acknowledged the positive experience of joint working.

- Four key factors for an effective transfer system were identified: strong leadership with staff fully engaged in new processes; good knowledge of local health/social care services and the development of local care referral pathways; appropriate training; and fit-for-purpose IT systems that facilitate good communication between services.
Handbook for 2007 published these statistics about emergency dispatching:

- Dispatchers held 266,000 jobs in 2004. About 36 percent were police, fire, and ambulance dispatchers, almost all of whom worked for state and local governments—primarily local police and fire departments.
- Employment of dispatchers is expected to grow about as fast as the average for all occupations through 2014.
- The growing and aging population will increase demand for emergency services and stimulate employment growth of police, fire, and ambulance dispatchers.
- Median annual earnings of police, fire, and ambulance dispatchers in 2004 were $28,930. The middle 50 percent earned between $23,060 and $35,970. The lowest 10 percent earned less than $18,710, and the highest 10 percent earned more than $44,520.

### Southern California Wildfires Under Control—And Protocol Was There to Help

Blazing wildfires can bring out the best in people—and give a powerful demonstration of the dedication dispatchers give their job.

Take, for example, the San Diego Medical Service Enterprise (SDMSE), one of several communication centers in Southern California that relied heavily upon Priority Dispatch Protocols™ during the recent wildfires in Southern California.

Communication Center Manager Susan Infantino set up a cot in her office during the blazes that scorched several sections of Southern California in October rather than take the drive home to eat, sleep, and breathe between long shifts on the job.

“She was tremendous,” said Vickie Adkins, the center’s administrative coordinator. “They all were. The dispatchers sat at their consoles and worked constantly through the fires. I never saw such a dedicated group of people.”

The fires, which burned 809 square miles from the Mexican border to Los Angeles, chased a half-million people from their homes and into emergency shelters in seven Southern California counties. As of the last Sunday in October, fires had demolished 2,767 structures, a number that included 2,013 homes, according to the California Office of Emergency Services. Although news reports differ about the number of deaths directly attributed to the fires, at least 14 people were killed. In addition to deaths because of the fires, 9-1-1 centers received a dramatic increase in medical calls for respiratory illness, according to FirstWatch, a non-database specific data analysis and surveillance tool that identifies emergent public health trends.

A week after the fires prompted the largest evacuation in the state’s history, more than a dozen of the Southern California wildfires were fully surrounded and six remaining fires were more than 50 percent contained. Fire crews were reportedly benefiting from precipitation in various areas affected by the fires, and the National Weather Service was predicting Santa Ana wind speeds at “half or less” than those of the dry, withering blasts that fanned conflagrations at the height of the fires.

“We’re still fighting the hotspots,” said Adkins, who worked 11-hour days during the crisis. “But mostly for us, now comes the stacks of paperwork to fill out.”

Administrative tasks that lay ahead include continued work with the Federal Emergency Management Association (FEMA). According to one report, FEMA had received nearly 8,300 applications for aid and visited 641 homes to assess damage in the seven counties declared a major federal disaster area. As of Oct. 29, it had paid out $600,000 and was on pace to settle about 75 claims a day. Agencies from around the state and those sending emergency crews from across the country were also contacting FEMA to reimburse the extended services provided to combat the fires.

Editor’s Note: Check out the January/February issue of The Journal for more extensive coverage of the dispatch response to the Southern California wildfires.
Maybe you’ve heard someone say “Cowboy Up” when things start getting tough and there’s some dusting off that needs to take place. Sometimes, it’s meant as an attitude adjustor as in: “Let’s cowboy up and get this done.” You need to put all your effort into the task assigned.

At the Sunnyvale Department of Public Safety in Sunnyvale, Calif., the saying has taken on its own meaning, with a slight twist on the cowboy part. “Connie Up” is what we say, said Michael Spath, Sunnyvale DPS administrative senior PSD.

“When someone goes above and beyond his/her job, it’s a ‘Connie Up’ for us.”

The “Connie” refers to emergency dispatcher Connie Carson who has worked at the center going on 20 years. She is the fastidious, meticulous, and serious about her work kind of dispatcher that many want to emulate—at least to a point.

“Sometimes she goes well beyond what she needs to do,” Spath said. “She wants to be the best she can be and that can be a little hard for others to keep up with.”

Carson says she’s certainly not trying to outdo anyone. Often times, it’s just a matter of resolution.

“It takes a team spirit to do this job—no one can do it on her own,” she said. “Besides, the added information can mean closure for me and that’s something we don’t always get in this profession.”

The 9-1-1 transcripts Spath sent to the National Academies of Emergency Dispatch® (NAED) shed some light on how Connie goes the extra distance. One call is about a new life brought into the world. Another literally gave the breath back to a six-month-old boy. In both calls, Carson never skips a beat in following EMD protocol, from Case Entry to Post-Arrival Instructions for cardiopulmonary resuscitation (CPR) and childbirth and delivery. Her focus becomes the resolution.

“She’s a wonder,” Spath said.

Carson’s career got its start in Nevada when she applied for a secretarial position (the days before the term administrative assistant) at a county police department and was asked if she would rather go for the dispatch job. She gave it a try and two decades later she’s moved only twice—from Nevada to San Jose, Calif., and then to her current job at the Sunnyvale DPS nearly seven years ago.

The Sunnyvale dispatch center started using the NAED protocol about 10 years ago, which means Carson had previously been a “free form” calltaker for going on a decade. “For most it wasn’t easy to make the transition,” Spath said. “But you’ll have to ask her about that. I know it’s something she had to focus on.”

Carson simply says she’s “born again” when it comes to protocol.

“I can’t imagine answering a call in any other way,” she said. “They’re so well thought out that I can’t go wrong. They drive the outcome.”

As for what the future holds, Carson said she couldn’t imagine doing anything else. “You hear about people quitting the profession and finding out the other jobs don’t have the same impact,” she said. “There’s nothing that can be so frustrating yet, at the same time, give so much satisfaction.”
No Time Like The Present. Dispatcher retires after 30 years of service

Cindy Neilsen says she left while the going was good.

“But how could it be any different?” she asked. “The job was great and I worked with people I really liked.”

Neilsen retired July 16 after spending 30 years and one month as a dispatcher in Salt Lake City Utah. Her career started on June 16, 1977, in the police department, shifted several years later to a combined police and fire communication center, and when the two went their separate ways, she opted to go with the fire dispatchers.

Through it all, she said, it was one long and very good career that she chose to end before burn-out set in. “There are days I miss the job and that shows I left at a good time,” she said. “I left when everything was still very positive.”

Neilsen agrees that many people don’t feel that way 30 years into their profession and, she admits, that there were days that weren’t so rosy. “The downside was the calls that hit close to home, like when a child was hurt and there was a hysterical parent on the other end of the phone,” she said. “I’d go home and tell my kids that I wasn’t going to let them out of my sight. I’d be afraid to let them go out on their bikes.”

She said it was also hard not knowing the outcome of most calls, especially after feeling so close to the situation for the brief time she was in phone contact. Once or twice along the way she did consider changing professions but she could never think of anything else that would offer her the same challenge.

“It’s a funny kind of positive job,” she said. “You deal with a lot of tough situations yet it’s also very exciting and satisfying.”

Neilsen came into the profession by chance. She was a single mother who needed a job. She saw an ad for an opening in dispatch, applied, and took the position because it was offered. “When you’re alone raising a child you don’t think far ahead,” she said. “It’s more like day to day. But I found that I enjoyed the job and the 30 years just happened.”

Less than two months into retirement, Neilsen was already embarking on a second career, and this time taking reservations for Jet Blue Airlines. The job’s part time so that she can spend time with her husband, a retired firefighter, and her grandchildren. There are also the travel benefits. “It has all worked out really well,” she said.

Neilsen offers the following advice for those working as emergency service dispatchers:

• Stay with it. “Don’t quit and pass up a very good career because of something bad that happens one day. Things will get better.”
• Appreciate what you have. “There are things I don’t miss, like 12-hour shifts, but I do not regret for a second that I stayed. I had plenty of opportunities and the training was great.”
• Concentrate on the positive aspects. For Neilsen, the chance to start fresh was ideal. “Each day was a clean slate. You go home and, for the most part, leave the job behind. Some things would of course stay with you but it’s not like paperwork that carries over to the next day.”
• Think of the rewards and challenges. “There’s nothing else like this. Maybe you’re not the one giving the direct help but you’re doing all you can to help someone from where you’re sitting.”

“There are days I miss the job and that shows I left at a good time. I left when everything was still very positive.”

Cindy Neilsen retired after 30 years of dispatching
Call From Good Samaritan Nearly Ends in Tragedy. All dispatcher wanted to do was reach out and help, like her caller had tried to do.

This was the call Christine Dunmyer will never forget: he was a Good Samaritan who had parked his car at the side of a ramp icy from a nasty winter storm. At the time of the call he was walking in traffic to help a soon-to-be mom whom he had noticed was involved in a two-car crash.

"He stated he was trying to move through but more cars were piling up and he was stuck behind the accident," the Fort Worth, Texas, dispatcher wrote in a letter to The Journal describing the call. "He wanted to make sure she was OK and since I was worried about him getting hurt, I told him to get in his vehicle and put his seat belt on until we got there. I explained to him that it would certainly be better for him to be hit while in his vehicle as opposed to standing next to it."

Thinking he had heeded her advice, she disconnected to answer other calls coming in. Among the callers was someone she could barely understand. He was at one moment almost inaudible, and the next moment he was screaming. When he finally got through to her, she was amazed. The caller had fallen 70 feet from a traffic ramp after a vehicle struck him while he was standing next to a collision. "I realized that this was the same guy that I was talking to a few minutes prior! Somehow he had remained connected to PD, kept the phone in his hand, and remained conscious."

"My heart went out to him," said Dunmyer. "One minute he was fine, and the next he was sounding like he was in terrific pain. His cries were dreadful."

The police department, also on the call with Dunmyer, was able to get through to him that an ambulance was on its way. "We had our crew going back and forth trying to figure out which side he had landed on. Our crew finally found him; he had broken nearly every bone," she said. "It was dreadful."

Dunmyer later learned that the man had fallen from the icy ramp onto a snow-covered embankment. The snow, which is unusual for the Dallas-Fort Worth area, on top of a grassy slope, was probably the factor that saved his life, said Dunmyer.

Though Dunmyer has yet to meet the Good Samaritan, she heard that he has spent the better of two years in recovery. Through intensive physical rehabilitation, he should be walking again and able to at least partially resume the life the accident put on hold.

For her part, it's a call that stays with her. "It was spine tingling to hear his cries of pain, and I felt so helpless listening to him on the other side of the phone," she said. "All I wanted to do was to reach out and help him."

Dunmyer says it's the feeling that her job helps others that makes it worthwhile. A degree program in information technology following high school graduation did nothing for her, and neither did jobs in sales and product customer service. She decided to give dispatch a try based on the good experience she had when injured in high school while playing soccer. "I applied and was lucky enough to get the job," she said. "Five years later and I can't imagine doing anything else. I have found my niche."

Dunmyer is among nearly 25 dispatchers for the Dallas-Fort Worth MedStar Ambulance Communications Center. The center receives about 400 calls per day.
James O. Page Pens Defense of Dispatcher-Initiated CPR. His legacy lives on

By Audrey Fraizer

Fishing through a box of archival photos and stories kept in a storage box found in the basement of the National Academies of Emergency Dispatch® (NAED) offices produced a letter written in 1981 by James O. Page in support of giving CPR instructions over the telephone to a cardiac patient.

The letter came in response to a question posed by "Ms. Blackwood," who wanted Page's opinion regarding the necessity of a novel public safety program.

The letter said: "I don't understand how any public safety or health care worker can accept these recurring tragedies without actively seeking a solution to the 'response time' problem which proves fatal in so many cases."

The statistical proof as to the effectiveness of bystander-initiated CPR is beyond question, he writes later in the same letter, and this also goes for the "invaluable medical self-help instruction via telephone."

At the time the letter was written, Page, who had a long career in the fire service and later in publishing, was serving as executive director of the ACT (Advanced Coronary Treatment) Foundation. He was a recognized EMS leader and according to one of the many tributes published following his untimely death in September 2004, he was "known for his controversial editorial opinions and his longstanding commitment to integrating EMS into the fire service."

Page believed in proven bystander-initiated medical self-help programs, and even at this early date in the history of ED protocol he looked to the day when a municipality that maintains a dispatching service could be found negligent for failing to implement and operate such a system. He cited the success of the emergency medical dispatch priority card system created by Jeff Clawson, M.D., in association with the Salt Lake City Fire Department.

Page's opinion in support of bystander-initiated CPR is now considered anything but controversial—at least in most medical and some government circles—in the 26 years since the retired fire chief volunteered his ground-breaking personal and professional advice. Emergency medical professionals continue to reaffirm the position.

CPR training has been recommended for health care professionals for more than 30 years and for the lay public for more than 25 years. To reinforce the importance of time, the American Heart Association (AHA) adopted the concept of the "chain of survival":

1. The first link is the need for a bystander or witness to the event to quickly call 9-1-1 and activate the EMS system.
2. The second link is rapid provision of CPR, ideally through a bystander.
3. The third link is early defibrillation.
4. The fourth and final link is rapid advanced life support care.

From call processing efficiency to CPR Pre-Arrival Instructions, AED direction and support to ALS prioritization, the Medical Priority Dispatch System® (MPDS) now addresses all the links in the chain. Either the original cardset format or the modern ProQA® software versions are now used in approximately 2,800 centers nationally and internationally. To the ultimate satisfaction of Page, there are versions specially modified for police and fire communications centers. The MPDS Pre-Arrival Instructions include a step-by-step guide for bystander-initiated CPR and NAED has made it part of its mission to modify the instructions in line with the five AHA updates over the past 30 years.

A report describing the Cardiac Arrest Registry to Enhance Survival program, or CARES, credits dispatch Pre-Arrival Instructions as a major factor in communities with relatively high survival rates for out-of-hospital cardiac arrest patients. In addition, the report emphasizes the training of EMS dispatchers to provide telephone CPR instructions to laypersons: The resulting CPR is comparable in quality to that provided on a "no notice" basis by persons with prior CPR training. Combining prior CPR training and dispatcher CPR instructions produces better CPR than either technique alone.

CARES is a five-year (2004–2009), $1.5 million collaborative effort of the Centers for Disease Control and Prevention (CDC), the AHA, and the Emory University Department of Emergency Medicine, Section of Prehospital and Disaster Medicine, in Atlanta, Ga. The project aims to significantly reduce deaths from heart attack and stroke, and it includes the development of a national registry to measure progress in the treatment of out-of-hospital sudden cardiac death. The registry combines data collected from 9-1-1 dispatch centers, paramedic reports, and hospital discharge records.

The data collected from dispatch centers, as yet, does not capture the use of protocol and Pre-Arrival Instructions. But give it time.

Page believed in proven bystander-initiated medical self-help programs.

Allie Park, Master of Public Health (MPH), CARES program coordinator, said the program is in many ways a work in progress. Bystander intervention and accessibility to AEDs prior to paramedic arrival are among the data collection points. An agency in Austin, Texas, has asked about GIS mapping for AED locating by dispatchers.

"It's a great program," said Park. "We're all about finding ways to save lives."

James O. Page, who died from cardiac arrest, would be proud.
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