Be Multi-Agency Prepared

You never know what's waiting at the other end of a 9-1-1 call. Choosing Priority Dispatch™ products, training, and services means you'll be prepared to make critical decisions quickly and correctly, even when multiple agencies are involved. ProQA® dispatch software moves seamlessly between police, fire, and medical, and our training and certification courses are the most rigorous in the field. When this training is combined with use of our protocol cards or software, even your newest dispatcher will be ready to handle calls with confidence and expertise—no matter what's waiting at the other end of the call.

dispatch faster. dispatch smarter. dispatch multi.

Multi-Agency Integrated Products for Police, Fire & Medical:
- Dispatch Software
- Quality Improvement Software
- Dispatch and CI Training
- Cards
- Support Products

800-811-0047
www.dispatchsmarter.com

Priority Dispatch™

131 East South Temple, Suite 500, Salt Lake City, Utah 84111
24 | feature

An Evening of Terror at a Shopping Mall. Callers jam 9-1-1 phone lines.

Cover image courtesy Deseret Morning News. Mike Terry, photographer.
Scott Freitag, NAED President

I work so closely with emergency communications in Salt Lake City that it’s easy to lose perspective on the importance of what happens here in relation to what the rest of the country remembers or “takes home” from our incidents. In other words, what goes on in my own backyard may seem like the rest of the world should be watching when, in fact, most people are often too busy tending to their own emergencies. They don’t have time to worry about mine. There are exceptions and, sometimes, incidents so big that it forces us to look over the fence. The attack on the World Trade Center on Sept. 11, 2001, for example, riveted us. We couldn’t look the other way. That single day six years ago in New York City drew us together as a nation in mourning the dead and wounded. The shock forced us to see the vulnerabilities we face in life. The death of 32 students and faculty members at Virginia Tech in April at the hands of one gunman serves as another reminder. We shudder at the possibility of something like that happening to someone we love. Tragedy turns inward and we do what we can to protect our own backyards. At least, that’s how it may seem. Read on.

In Salt Lake City, the multiple shooting deaths at a shopping center we call Trolley Square is the tragedy and heartbeat in our backyard. As described in a story in this issue of The Journal, dispatchers at our fire and police communication centers responded to more than 600 calls in the time it took for one man to murder five people, and critically wound four others. The incident that occurred two days before Valentine’s Day made national news, and it has since most likely faded from the rest of the country’s collective memory. Only in Salt Lake City will the physical presence of the shopping mall remind us of something that happened; something that was well beyond the expectations of daily routine.

Maybe that’s how it is. An incident so personal to a community, and the families affected, eventually loses national attention. Does that mean we are alone to fend for our own personal and community security? That single day six years ago in New York City drew us together as a nation in mourning the dead and wounded. Are we always left to minding our own backyards? I don’t think so.

In the wake of tragedies at Virginia Tech and Trolley Square, and other such terrible events across the country, President Bush asked cabinet-level officials to travel across America to review security measures to determine the federal government’s role in avoiding crisis situations. In a report released in June, Department of Health and Human Services Secretary Michael Leavitt states that officials had found “great commonality in the themes that emerged” from their meetings around the country and he encouraged an “ongoing national dialogue” that protects freedoms while minimizing risks to public safety. States that have since developed task forces and other initiatives include Oklahoma, Utah, and Florida. Other organizations, such as the National Association of Attorney Generals, have created similar programs independent of the federal project. A few of these are described alongside the story of our incident at Trolley Square, and many more are no doubt in the making.

As a nation we do pause, we do notice, and try to do something about the tragedies that affect others across our fences. In time, we lose only the details of what we hear and see. The essence of the stories stays with us. It may be my backyard, or yours, but we’re in this together. Dispatchers know this truth only too well.
Jeff Clawson, M.D.

Question:
Doc, if you could start your own brand new communication center would you use cards or ProQA? We use ProQA and love it. Since ProQA has been out for about 16 years why are there MPDS centers still not using it?

Answer:
I feel like Barry Bonds (but not because of the steroids), but by getting a pitch right down the middle. I’ll swing for the wall.

The answer is ProQA. From the beginning, the main problem with Priority Dispatch System Protocols was not the content, but the lack of compliance to the protocols’ defined processes (which means the inherent inability to accomplish all protocol objectives: safety, response allocation, patient care, and information for responders). While quality assurance case review gives us a significant, proven ability to improve that goal, it is, at best, retrospective and not necessarily certain on an EM D-by-EM D, call-to-call basis.

In my humble opinion, ProQA is a light-year better at accomplishing these objectives than manual cards, and it does some other amazing things in the process. First, you can’t fake it and surf around, out of sequence, within the protocol. This means it is actually easier to follow the protocol’s process, in the correct order, than it is to get around it; ProQA does the navigation for you! Many centers initially don’t like this fact because they are not following the protocol as indicated in the manual format. Case review experience proves this out.

With ProQA, call processing times are actually improved, since superfluous typing, extra questions, and silent gaps are eliminated. If you are adding extra questions, or dispatching early because you can, you are not practicing dispatch-based medicine correctly. “Surfers” have more episodes of caller interjection into their calls because they are “gapping” (pausing) as they ponder the next, non-protocol listed question. During these gaps, the caller will unconsciously attempt to take command of the call, often inserting demands like, “Why are you asking all these questions?” or “Why don’t you just send someone?” ProQA supplies each question, advice, recommendation, or special caller reassurance precisely at the right moment needed.

Those new to ProQA sometimes find that they don’t like the automated system. We even have a name for this early but predictable “ProQA doesn’t work” statement—it’s called the Bonneville Effect. Several years ago a center in a western U.S. county called us and said that ProQA didn’t work. We sent two different CAD interface experts to the site. Each came back and stated that the integration of ProQA with the center’s CAD was correct — but observed that the dispatchers had raised a ruckus because they didn’t like the requirement to follow protocol. We have seen this many times. We said keep at it.

Following three continuous months of ProQA automated use, you can’t drag the EMDs away from the system. They are convinced it works. It’s basically a process of change management that requires top management support, especially in the early going. This center is becoming a progressive police, fire, and medical ProQA user and moving toward Academy accreditation.

There are various reasons that an agency goes with cards instead of ProQA — cost is an obvious reason. We found that the actual functional interface with the CAD is an overwhelming reason for not using, or delaying the implementation of ProQA. Unfortunately, a lot of CAD interfaces are too narrow in their scope or reflect the requirements of only one client, the first one, and thus limit what their other clients need. As competition increases and clients become more knowledgeable, the tide is turning. ProQA is now interfaced with more than 130 CADs. Many are mapping ProQA in detail and at the beginning of the CAD process, often at the RFP phase.

ProQA clearly exceeds the ability of manual cards to do the things required for correct patient care in today’s communication centers. These many new evaluations, features, and processes that help the EMD do a better job include: the Agonal Breathing Detector, Pulse Check, Compressions Monitor, Contractions Timer, Aspirin Diagnostic & Evaluation Tool, and the soon to be added Stroke Identification Diagnostic, and Police Suspect Info Tool in medical ProQA — as recently requested by Scotland Yard in London. Today, more MPDS-current agencies use ProQA than those using manual cards. That says a lot about the understanding of today’s communication centers to perform EMD the right way.

The manual card system has become an increasingly distant and minimalistic system that can only approximate, for backup purposes, the automated system. I believe this crossover occurred at the turn of the century, in the year 2000, with the release of version 11 of the MPDS. From this time on, the “mother” protocol is no longer possible to recreate in cardsets. Cardsets will continue for back-up purpose, but cannot any longer be made to directly replicate the “mother” protocol in ProQA. Simply put, the cardsets can no longer accommodate the complex interrogation and instruction sequences that ProQA easily handles without making protocol navigation a chore.

ProQA also provides a documented process. Virtually every keystroke is recorded and accessible by case reviewers, without having to actually listen to the specific case under evaluation. The ProQA reports system gives managers, QA personnel, and even EMDs themselves, the ability to easily review their performance on a case, or group of cases, basis.

I could go on. Let me put it this way. In today’s world, you wouldn’t use a paper CAD system would you? Why then would you use a paper protocol? It’s the 21st century. Computer-based systems in public safety are required. It’s time to accept this simple but essential fact. And, in my opinion, which you asked for at the beginning, there is not one thing that is not made better by the automated system. As we say in medicine, “Trust me, I’m a doctor.”
Editor’s Message.
Story of shooting deserves telling from our angle

Audrey Fraizer, Managing Editor

A story in this edition of The Journal chronicles the events at a local mall when a man with a shotgun killed shoppers on a cold winter evening in February. News coverage focused on that night reached a point that many from Salt Lake City started to consider obsessive, and so it was with pause that we decided to approach the story again for our publication. There’s nothing worse than a story that overstays its welcome; even a tragic story loses meaning if played too long before the public.

So, why did we choose to go over something that happened nearly eight years ago and an event that few outside this part of the country remember only in a vague sort of way?

We think it’s important, at least from the perspective of those helping behind the scenes. As most of our audience knows too well, news reporters struggle to cover stories from the viewpoint of the emergency dispatcher. Usually stories reaching the media are isolated events—childbirth, in particular—or the times when dispatchers, many of whom were probably making the first 9-1-1 calls of their lifetimes.

The calls for help from the shopping mall prompted a friend into thinking about the novelty of emergency dispatch when we were later discussing the story. Punching those three digits, 9-1-1, is the first impulse once tragedy occurs, when our lives become desperately suspended in the moment. There is someone there to listen to us. There is no referral to a voice messaging system or repeated reminders that our call will be answered in the order received. Our distress matters to someone in a society that seldom seems willing or able to notice. Yet, how often do we take the opportunity to meet the stranger answering our call?

Dispatchers I’ve talked to say they stay in the profession because of the chance to help; they are willing to remain faceless and nameless. That’s part of the job. Odd as it seems, these are the most critical connections we make in our lives may be with people we never meet.

That’s our approach: there’s nothing worse than a story untold when it comes to people making a difference in the lives of others.
Arthur H. Yancey, II, M.D., M.P.H., deputy director of emergency medicine for the Fulton County Department of Health and Wellness (Georgia) and attending emergency physician at Grady Memorial Hospital (Atlanta, Ga.) received the Jeff Clawson Leadership Award at the Navigator Conference of the National Academies of Emergency Dispatch (NAED®) held in Las Vegas. The award is given annually to an individual who has made a significant contribution to the emergency dispatch profession and represents the highest standards and pursuit of excellence in research, education, management, or operations.

Dr. Yancey graduated from the University of Michigan Medical School, trained in General Surgery at Howard University, and Burn Surgery at the U.S. Army Institute of Surgical Research. He received the M.P.H degree from the Johns Hopkins School of Hygiene and Public Health. As medical director of the Fulton County Department of Health and Wellness, Dr. Yancey provides oversight of the EMD program at the County’s 9-1-1 center, which includes protocol and surveillance issues.

He serves on the NAED Council of Standards, which evaluates Priority Dispatch System protocols and recommends improvements for future versions of the system. He is also a member of the National Association of Emergency Medical Services Physicians (NAEMSP) Public Health Committee and a member of the EMS Medical Director and Public Health Integration Task Force sponsored by the National Highway Traffic Safety Administration (NHTSA). In Georgia, he led efforts to require that hospitals notify Fire First Response and EMS responders about contagious diseases in patients they treat and transfer.

He spoke to us briefly following the presentation, and answered these questions.

How and when did you first become involved with the NAED?
I first became involved with Emergency Medical Dispatch (EMD) in 1997 in our long and ultimately successful struggle to implement EMD in Fulton County, Georgia.

Why do you find the use of standard protocol important to emergency dispatch?
Utilization of protocol standards is crucial to appropriate EMD as a risk management tool, imparting confidence to 9-1-1 center managers that performance can be measured against standards. This will allow continuous quality improvement when continuing EMD education is based on areas where performance can improve. Managers can project an accurate image for their EMD program of expertise and diligent responsibility to the public through the media, even in the face of an adverse event. Protocol standards also engender dispatchers’ confidence in their work because it is guided by the highest standards of medical care available to the telecommunications environment. The origins of these standards are a broad, experienced base of the emergency medical services community embodied in the Council of Standards.

What have you seen as far as the use of protocol? For example, is the acceptance of standard protocol growing, and, if so, why?
As more members of the public hear about and experience care from standard protocols, they increasingly assume an expectation that this level of care will be provided to each of them if they need it. On the provider side of the issue, the EMS community has increasingly adopted the position that standard-based protocols are a crucial component of the EMS response.

Do you think protocol has added to a positive image of emergency dispatch—one of professional caliber?
Protocol development has contributed to a positive image of EMD by manifesting a unique body of knowledge supporting skilled and practiced professionals.

What does the Jeff Clawson Leadership Award signify to you?
The Jeff Clawson Leadership Award signifies recognition of those who work to contribute to medically sound protocols and who champion the importance and ideals of sound EMD to colleagues and the public. It is an honor to be recognized for these reasons.
Kathryn Buck likes her job but admits it’s not always the happy ending of saving people in crisis. “There are good days and calls that turn out really well,” she said. “But that doesn’t happen all the time. There are a lot of calls that make me cry in between the feel good moments.”

During her 30 years in dispatch at three centers in Ohio, Buck has answered innumerable calls but those that come back to either lift or haunt her most often involve children. “I can’t hang up the phone and easily go on to the next when something’s happened to a child,” said Buck, a dispatcher with the Twinsburg Police Department. “Those are the calls that stay with me.”

Buck started in dispatch quite by accident. She was fresh out of school and literally racing daily to get to work on time. A police officer familiar with the speeding Buck half-jokingly suggested that she “join them rather than trying to beat them.” Buck liked the idea and applied for a dispatch position with the Beachwood Police Department. She worked there for two years and moved to the Shaker Heights Police Department for another six years before transferring to Twinsburg.

It’s the current job that gives her the press. The first story, published in two newspapers, details Buck’s effort on Aug. 8, 1995, at talking a frantic mother through the steps of CPR for her two-year-old toddler. The boy, who had stopped breathing, lived. Buck was recognized for her “heroic actions” in a proclamation signed by the Ohio House of Representatives. Twinsburg Chief of Police Richard H. Deal commended Buck for her “quick and skillful actions” and for her “efforts in stopping a potentially tragic situation.”

Success times two and Buck knew she had selected a perfect career. As the accompanying letter shows, she felt blessed to have such good outcomes. “I was on top of the world,” she said. “I mean things didn’t go as smoothly as the newspapers reported but, still, the outcomes were positive and I felt good about that.”

Then tragedy struck. A baby drowned after falling into a pool. No amount of CPR instruction Buck gave over the phone could save him. Buck was devastated. “I wanted to quit, badly,” she said. “I couldn’t take another tragedy. This wasn’t the first but I didn’t think I could last any longer.”

Buck searched for a job without the

---

**LETTER TO THE EDITOR**

**Time To Reconsider. Career was at a high until that call came in...**

By Audrey Fraizer

Nine years later, in April 2004, Buck gave CPR protocol instructions to a mother whose five-day-old infant had stopped breathing. Again, the baby survived. Twinsburg Chief of Police Richard H. Deal commended Buck for her “quick and skillful actions” and for her “efforts in stopping a potentially tragic situation.”

Success times two and Buck knew she had selected a perfect career. As the accompanying letter shows, she felt blessed to have such good outcomes. “I was on top of the world,” she said. “I mean things didn’t go as smoothly as the newspapers reported but, still, the outcomes were positive and I felt good about that.”

Then tragedy struck. A baby drowned after falling into a pool. No amount of CPR instruction Buck gave over the phone could save him. Buck was devastated. “I wanted to quit, badly,” she said. “I couldn’t take another tragedy. This wasn’t the first but I didn’t think I could last any longer.”

Buck searched for a job without the
emotional turmoil. Then by coincidence, or fate, she received a letter the same week the baby drowned from the mother of the five-day-old infant she had helped to save. “Just wanted to let you know that we still think of you often & fondly,” the mother, Heather Gansler, writes. “Hope you are doing well. Drake is 24 mos. old. He’s extremely tall—thinned out a lot over the last year. You are very appreciated.”

The letter buoyed her spirits and Buck hung on even after a second horrific call. This time her co-dispatcher Michelle McKay answered a call involving a baby who may never recover from injuries received at the hands of caregivers. “Michelle felt terrible about what happened to the baby. We felt good leaving that day because the baby had survived. It was the next day we learned what had happened.”

That’s when Buck wrote the letter to The Journal, “I wanted to encourage people. I felt horribly for Michelle and I wanted other dispatchers to know that it does matter what you do even when things don’t turn out,” she said. “You can’t save everyone, but never give up trying.”

Buck credits the protocol Newspaper articles at the time of her second save report Buck’s reliance on the Medical Priority Dispatch System’s® (MPDS®) protocol. A story in the Twinsburg Sun refers to her questions based on the “EMD cards” and her ability to follow the cards and focus on communications with emergency personnel through the aid of dispatcher Ron Good. In our recent interview, Buck said the protocol makes her job easier. “I read it as written. I never stumble over what to say next.”

Time to Move On Many times the tragedy of a situation pushed Buck into thinking about a career change. “I always came back because this job is something I was meant to do.” However, now, the time seems right. After 30 years in dispatch, Buck is looking to what comes next in her life. She plans to retire to the family’s horse ranch and spend more time with her two daughters and a grandchild. She said the change might be more difficult than she anticipates, although it may not be as clean of a break since her husband is police chief in the next town over. “It’s been a wild ride and, for the most part, a job I’ve loved,” she said.

“There are good days and calls that turn out really well. But that doesn’t happen all the time.”

Kathryn Buck is looking toward the future after nearly three decades as a dispatcher.
Dispatch Under Scrutiny. Research takes a close look at ALS prehospital interventions

By Brett Patterson

EMD process tough to research

The best scientific research is conducted in a controlled, randomized environment; optimally, it is done in a laboratory. Researching emergency medical dispatch is a difficult process because there are so many variables involved and the objectives, appropriate response assignment, and pre-arrival care are difficult to impartially establish and measure. However, in the interest of EMS system efficiency and patient care, determined researchers are pressing forward and conducting dispatch research of reasonable quality, and lessons are being learned.

In a recent study published in Prehospital Emergency Care, researchers at the Department of Medicine at the University of California have attempted to compare selected MPDS response codes with the pre-hospital need for ALS medication or procedures. Specifically, the study retrospectively compared certain ALS procedures or medications given and documented on the field patient care record with response codes derived from the MPDS Chief Complaint Protocols of abdominal pain, chest pain, seizure, sick person, and unconscious/fainting in an attempt to discern whether the selected response level (ALPHA, BRAVO, CHARLIE, DELTA, or ECHO) matched an ALS-level patient care need.

Basic problems with this sort of study design (some of which were mentioned in the study’s limitations section) include the misconception that all of the DeterminantDescriptors within a particular Determinant Level will require a like response and that the provision of an ALS procedure or medication on the scene actually implies an ALS or pre-hospital need (such scene therapies are often somewhat subjective and may be diagnostic or precautionary, rather than therapeutic). However, this project did take some steps to address these concerns and, when looked at objectively, the study has a lot to offer.

Study: MPDS highly sensitive but less specific

In very basic terms, the study concluded that for the codes included, the MPDS was highly sensitive (84 percent overall sensitivity—captured most patients needing ALS procedures—small under-triage rate), but...
far less specific (36 percent overall specificity—called for an ALS response when one was not needed—high over-triage rate). The high over-triage rate has long been known and is somewhat purposeful in an effort to err on the side of the patient in the nonvisual realm of dispatch triage.

What is likely of greater significance is that this study, unlike some previous attempts, included some individual Determinant Descriptors in its data set. Unfortunately, however, this factor was not consistent, i.e., individual Determinant Descriptors were separated completely in Table 1, “EMD Codes Analyzed,” but only partially or incompletely in the other data tables and charts that illustrate the study’s results. This may be due to statistically insignificant call volumes for particular Descriptors that necessitated the bundling within a particular level.

Although these Descriptor-specific findings were not mentioned in the study’s conclusions (the conclusions were Level-specific), the relatively detailed data set provides some very useful information to be considered for further study and for response planning. For instance, among the BLS-coded abdominal pain set of 332 patients (1-A), 4 patients received nitroglycerin, 6 received aspirin, and 20 received morphine. Because of the obvious discrepancy between the reported condition of the patient at dispatch and the apparent needs of the patient at the scene (patients with chest pain or difficulty breathing should be “shunted” from the sick person protocol and patients with active seizures should not be coded as 12-A), additional examination of this data set seems prudent, as well as random audio review of a reasonable number of these cases to determine if the correct Chief Complaint was selected. We know this to be a widespread problem concerning the initial choice of “sick person” as the correct protocol.

Although the study’s methods section stated that the communication center was “…recently recognized by the NAEMD as a Center of Excellence,” and such accreditation implies very high compliance to dispatch protocol, the study was retrospective and analyzed data between November 1, 2003 and October 31, 2005 and the center was not accredited until April of 2005. Even with current accreditation by the NAEMD, cases associated with under-triage risk should be carefully analyzed for strict protocol compliance to provide positive assurance that the protocol actually produced the resulting dispatch code, rather than the subjective decision-making of an individual EMD. Although it may not be feasible to review 100 percent of the study’s calls to ensure EMD protocol compliance, it seems possible and prudent to closely examine the limited under-triage rate discovered here.

With the exception of the one seizure patient mentioned, the reported under-triage rate (calls coded as BLS but requiring ALS intervention) was medication or IV infusion-generated rather than ALS procedure related. This fact requires further study to determine whether or not such pharmacological intervention was medically necessary, or time dependent, as the study’s limitations section suggests.

With regard to the reported over-triage rates, bundling of Determinant Descriptor codes into one Determinant Level occurred in the 31-C and D Levels, and in the 12-C and D Levels. This is unfortunate because it would be very useful to know which actual Descriptor may be responsible for the over-triage. It would also be helpful to know the call volumes for each category. Although these volume numbers were

<table>
<thead>
<tr>
<th>ABDOMINAL PAIN/PROBLEMS</th>
<th>CHEST PAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A Abdominal pain</td>
<td>10A1 Breathing normally, age &lt;35</td>
</tr>
<tr>
<td>1C With fainting, or female &lt;35, males &gt;35, females &gt;45</td>
<td>10C1 Abnormal breathing</td>
</tr>
<tr>
<td>1D Not alert</td>
<td>10C2 Cardiac history</td>
</tr>
<tr>
<td>12A1 Not seizing and breathing verified</td>
<td>10C3 Cocaine use</td>
</tr>
<tr>
<td>12B1 Breathing regularly not verified, age &lt;35</td>
<td>10C4 Breathing normally, age &gt;35</td>
</tr>
<tr>
<td>12C1 Pregnancy</td>
<td>10D1 Severe respiratory distress</td>
</tr>
<tr>
<td>12C2 Diabetic</td>
<td>10D2 Not alert</td>
</tr>
<tr>
<td>12C3 Cardiac history</td>
<td>10D3 Not alert</td>
</tr>
<tr>
<td>12D1 Not breathing</td>
<td>10D4 Breathing regularly not verified, age &gt;35</td>
</tr>
<tr>
<td>12D2 Continuous or multiple seizures</td>
<td>12A2 Not seizing and breathing verified</td>
</tr>
<tr>
<td>12D3 Irregular breathing</td>
<td>12B2 Breathing regularly not verified, age &lt;35</td>
</tr>
<tr>
<td>12D4 Breathing regularly not verified, age &gt;35</td>
<td>10C1 Abnormal breathing</td>
</tr>
</tbody>
</table>

SICK PATIENT

| 26A Non-priority symptom | 26B Unknown status (3rd party caller) |
| 26C Cardiac history      | 26D Not alert |

UNCONSCIOUS/FAINING (NEAR)

| 31A Single episode, alert, and age <35 | 31C Abnormal breathing, cardiac history, multiple episodes, etc. |
| 31B Abnormal breathing, cardiac history, multiple episodes, etc. | 31D Unconscious, severe respiratory distress, not alert |
| 31E Ineffective breathing | 31F Ineffective breathing |

Table 1. EMD Codes Analyzed

For an abstract and other information about this article.
reported for the complaints with an over-
triage rate of greater than 80 percent in the
interventions table (1-C, 1-D, 12-C, 12-D,
26-C, 26-D, and 31-C), the boldfaced
codes were bundled and the absent codes
did not report volumes.

Additionally, the 6-D-1-A code was the
only reported difficulty breathing code
with the asthma suffix. Although possible,
it does not seem likely that out of 4,191
included Protocol 6 calls, that only the D-
1 Determinant Descriptor would contain
a statistically significant number of calls
with the asthma suffix.

The “elephant in the room” in this type
of study is the failure to mention that
ALS is correctly sent on many calls because
that level of evaluation is required.

The “elephant in the room” in this type
of study is the failure to mention that
ALS is correctly sent on many calls because
that level of evaluation is required.

In cases where more than one
descriptor’s qualification is met, only one
code can ultimately be selected. The auto-
ated protocol used in this study (ProQA®)
defaults the selection cursor to the
first-listed code, within a particular
level, when more than one code is identi-
fied (present). EMDs routinely pick the
default code unless a locally assigned
response is higher. The propensity to select
the first code within a given level when
more than one code applies is called code
hierarchy bias and should be considered
when evaluating data associated with indi-
vidual Determinant Descriptors.

This study provides useful information
to be considered when allocating respons-
es and modes to M P D S Determinant
Descriptors, provided that its limitations
are understood and considered. Future
studies should consider and report compli-
ance to both E M D and field protocols.

When 100 percent sampling of calls for
compliance reporting is not possible, statis-
tically significant random sampling should
be conducted.

Because of the lack of consensus regard-
ing what constitutes a prehospital need for
ALS intervention as well as evaluation, and
what interventions and evaluations should
actually be considered ALS, the N A E D
supports any dialogue among industry
leaders that may foster a consensus. What
may have more applicable value in the eval-
uation of prehospital need is comparing the
EMD code with both the field patient care
record and the actual hospital outcome
data. Such a comparison should help to
determine which ALS procedures, for a
given patient, were actually therapeutic.

The N A E D commends the researchers
of this study who have made a valuable
contribution to the science of E M D .

<table>
<thead>
<tr>
<th>Nitroglycerin</th>
<th>Aspirin</th>
<th>Midazolam</th>
<th>IV infusion</th>
<th>Dextrose</th>
<th>Morphine</th>
<th>Albuterol</th>
<th>Airway</th>
<th>Defib</th>
<th>Total Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLS CALLS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abd pain (1A)</td>
<td>4</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chest pain (10A1)</td>
<td>7</td>
<td>7</td>
<td>0</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Seizure (12A)</td>
<td>3</td>
<td>3</td>
<td>15</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Seizure (12B)</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sick (26A)</td>
<td>10</td>
<td>13</td>
<td>0</td>
<td>53</td>
<td>6</td>
<td>19</td>
<td>18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sick 3rd party (26B)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

| ALS CALLS   |         |           |             |          |          |           |        |      |               |
| Abd pain/fainting (1C) | 4     | 7         | 1           | 21       | 0        | 12        | 3      | 1    | 0             | 315     |
| Abd pain/not alert (1D) | 0    | 0         | 0           | 9        | 1        | 2         | 1      | 0    | 0             | 58      |
| Seizure (12C) | 2       | 1         | 1           | 4        | 4        | 0         | 3      | 0    | 0             | 77      |
| Seizure (12D) | 4       | 4         | 100         | 19       | 22       | 0         | 1      | 4    | 3             | 760     |
| Seizure (26C) | 11      | 12        | 0           | 34       | 3        | 4         | 9      | 0    | 0             | 413     |
| Sick/not alert (26D) | 7     | 6         | 2           | 52       | 22       | 3         | 15     | 2    | 0             | 553     |
| Unconscious (31C) | 31    | 37        | 1           | 115      | 3        | 9         | 14     | 0    | 0             | 956     |

Table 2: Number of Interventions (Medications Administered, IV Infusions, and ALS Procedures) Performed on BLS and Selected ALS Coded Calls
Without Minutes To Spare: Call processing time should reflect nature of the crisis

By Greg Scott

Not too long ago we received a letter from a MPDS® user who was asking about national standards for total dispatch transaction time (i.e., from receipt/pick-up of initial 9-1-1 call, caller interrogation, determinant prioritization/selection and tone out of resources); and for a position from the perspective of the National Academies of Emergency Dispatch® (NAED®). This was not an unusual request. People frequently ask us about adequate time frames and/or standards to fully assess and select the final determinant for ensuring proper response. Some centers have adopted the National Fire Protection Association’s (NFPA) standard, which requires emergency calls to be dispatched in 60 seconds, 95 percent of the time. The reality is that there is no validated research to support a 60 second dispatch standard, particularly one that requires 95 percent compliance to all calls, regardless of their nature. Is it really reasonable to expect the dispatch time standard on a sprained ankle be the same as for a sudden arrest?

The NAED does not endorse a single, one-size-fits-all national standard for call processing times. Why? For one thing, existing computer-aided dispatch (CAD) technology is not standardized enough across emergency call center boundaries to accurately compare times from agency to agency. Beyond that, there may be design and control weaknesses that significantly affect conclusions based on the data. Until we reach a consensus, the following information may be helpful in setting your standards locally.

We know that address verification time—the first stage of call processing—is lengthening on average because of the widespread use of wireless technology and the greater proportion of 9-1-1 calls originating from a wireless phone. Also, we know that when using our EMD program properly, the highest priority calls are coded faster than the intermediate and lower priority cases. Generally, ECHOs take about 35 to 45 seconds to code AFTER address verification has been completed and DELTA’s take, on average, about 50 to 55 seconds.

I recommend that your call processing standard reflect the nature of the call. That is, DELTA’s and ECHOs could have one target time window, while the remainder could have another longer time window. In general, a 90 (to 100)-second time frame is a reasonable target for completing DELTA and ECHO cases, although 90 or 95 percent fractal compliance to such a target is difficult to meet given the issues with address verification from wireless phones.

There are other questions you might address, also, before setting your standards.

### Priority Level | Time to Final Coding | # Cases | %
--- | --- | --- | ---
ECHO | :38 | 433 | 0.3%
DELTA | :49 | 42,753 | 29.3%
CHARLIE | :58 | 30,356 | 20.8%
BRAVO | :47 | 50,328 | 34.5%
ALPHA | :66 | 20,832 | 14.3%
OMEGA | :59 | 1154 | 0.8%
ALL | :52.9 | 145,866 | 100%

Note: "Time to Final Coding" starts at the completion of address and phone number verification, and ends when final coding is sent to CAD for dispatch. Average Time on Key Questions = 27.7, Agency: Emergency Medical Services Authority, Tulsa/Oklahoma City, U.S.A., Case Date Range: 4/1/2002 to 6/22/2004

These include:
- Do you know the percentage of 9-1-1 calls come from wireless sources in your region? According to the Federal Communications Commission (FCC), the number of 9-1-1 calls placed by people using wireless phones has more than doubled since 1995, to over 50 million a year. While the location of the cell tower used to carry a 9-1-1 call may provide a very general indication of the location of the caller, that information is not usually specific enough for rescue personnel to deliver assistance to the caller quickly.
- Are dispatchers following their call-taking protocol? Calltakers who follow a protocol consistently can gather more information in the same time frame or faster than those who try to make up questions and instructions on the fly.
- Is the center using the ProQA EM D software? The software assists dispatchers in quickly determining the appropriate response determinant code for each case and then guides dispatchers in providing all relevant Post-Dispatch and Pre-Arrival Instructions, as well as important case completion information.
- Are dispatchers being given enough time to complete their call-taking protocol so as to be accurate and safe in their information gathering? Or are they being pressured to meet a time standard simply to make the stats look good to outside observers?

We know that errors increase rapidly the less time is allowed a person performing multiple complex tasks in a compressed-time environment. Couple that with the mission-critical nature of the information gathered by the emergency calltaker, and a 60 second time standard can be a recipe for disaster. It is more important to do it right the first time than do it a few seconds faster and get it wrong (or incomplete).

Are there too many distractions in the center to allow for timely and accurate call processing? Distractions are a big cause of error, and emergency call centers are generally full of distracting sounds, visual clutter, and dispatch activity. While distractions in the dispatch environment cannot be eliminated, they can be mitigated with good center design, regulated work flows, and proper staffing.
The New ProQA 5 Goes to Beta

Priority Dispatch Corp.® (PDC) has announced that an exciting new version of ProQA® is in development. According to Ron McDaniel, CPO and head of PDC’s software and support department, the software is currently in alpha testing and may see a beta release by the end of the year.

PDC has developed a number of new features for the new software. McDaniel and PDC consultant Eric Parry demonstrated some of the new functionality during a special Navigator conference session in Las Vegas on April 25, 2007.

One of the most obvious changes PDC demonstrated is a slick new window nicknamed Ming that slides out of the edge of the main ProQA screen to display dialogs for diagnostic tools, descriptions, and more. Ming provides new “smart” behavior for descriptions, Post-Dispatch Instructions (PDIs), and Additional Information (AI). For example, it can automatically display relevant, context-sensitive PDIs and AI as necessary. It can also display the results of person and vehicle description queries.

Perhaps the biggest change PDC has reported involves breaking away from third party database providers in favor of a new, proprietary, SQL-compliant database server called X Lerator™. X Lerator is faster, more stable, and flexible enough to make any change needed at any time.

Features of X Lerator include the ability to farm ProQA across multiple servers, specify individual user settings via the server, transfer live calls between stations and operators, send user alerts, and perform automatic software updates.

According to McDaniel, there are even more new features planned for ProQA 5 that have not yet been revealed.

“New improvements and fixes are occurring almost daily, and we have some more new features planned for ProQA 5 that have not yet been revealed.”

New IAED Office Opens.
One-stop shop offers everything to discriminating tourist

Bristol is a city in England bustling with things to do.

A quick check of the website targeted at the Bristol tourist industry reveals such impressive stops as the maritime Brunel’s ss Great Britain and the Georgian House, which are both touted as some of the finest museums in their respective classes.

Those less entrenched in history or cultural fare may prefer the shopping, parks, and nightspots found in the city so renowned for what it offers that it’s ranked among the United Kingdom’s top 10 destinations.

And, for those interested in mixing pleasure with protocol, there’s something that will satisfy even the most discriminating tourist: the Bristol office of the International Academies of Emergency Dispatch® (IAED®) that opened on July 2, 2007.

The office’s location sounds like something the travel guru Arthur Frommer would describe in his guide to England, although put in the words of Beverley Logan, IAED Associate Director:

Bristol was selected as the ideal location for the IAED/PDC Office due to it being virtually central to all our UK Agency sites. It has an international airport with excellent connections to other European destinations, a superb network via motorways and railways to both the North and South of the UK and is easily accessible for all. Bristol is currently undergoing a £500 million development programme, which includes over 1 million square foot of high quality shops, restaurants and leisure space. Its harbour-side is buzzing with artistic and cultural activity and its City Centre packed with hotels, bars, restaurants and cafes—all within 5 to 15 minutes walk from the office location! It is an ideal location for both business and visitors alike.

But that’s not all, folks

“This office has everything.” said Ron McDaniel, CPO for Priority Dispatch Corp.® in Salt Lake City, Utah, and IAED Systems Implementation Director. “Whatever you need from us, it’s available here.”

Well, you might not be able to reserve tickets to the Brunel’s vs Great Britain, but it is a sure bet that fact sheets about protocol...
distance to go before nearing completion,” said McDaniel. “Everything is still subject to change at this point.”

If your center is interested in beta testing ProQA 5, please contact Priority Dispatch Corp. for more information. – BY BEN ROSE

Parry Accepts Second Term as Chair of NENA Education Advisory Board

Eric Parry is at it again. The police protocol expert for the Priority Dispatch System (PDS) has accepted a second one-year term as chair of the Education Advisory Board (EAB) for the National Emergency Number Association (NENA). The current term extends through June 2008 and comes in the midst of dramatic changes to the way 9-1-1 operates into the future.

Now, that was a loaded paragraph. First we have Parry, a long-time veteran of police, communications and protocol work, and then we have NENA, the national organization leading the pack in keeping emergency communications and protocol work, in addition to McDaniel, the Bristol Office.

The Bristol Office

The Bristol office features conference rooms, areas for testing and demonstrating software, and space for shipping and receiving. Here, you will also find the professional and technical materials—such as the ProQA software (the core of the UK emergency dispatch system), instructor teaching materials, and the certificates awarded to students achieving the IAED credential.

The center will be staffed by four full-time employees, in addition to McDaniel, to handle the technical, clinical, and administrative tasks necessary to facilitate assistance communications accessible to the public no matter the technology in the user’s hands. So, let’s just get to the point: Parry’s background and relating that to what NENA is up to.

Parry and technical communications go a long way to the days before he was with the NAED® and during his 23-year career as a member of the Royal Canadian Mounted Police (RCMP). Because of his education (college certified electronics engineer), Parry got hooked into public-safety communications and moved between British Columbia, Ontario, and Alberta in positions that included overseeing the operations and staffing of police communication centers, 9-1-1 system design and implementation, CAD and mobile data terminal user training, and tactical communications.

Along the way, he developed a set of policies and programs addressing staffing issues (how to find the best personnel for the job and how to keep the best once you’ve got them) that caught the attention of NENA at a conference the organization held in Montreal, Quebec. “Everything began falling into place,” said Parry. “I popped into the NENA radar and it went from there.” He retired from the RCMP in 1995 to devote full-time to consulting work in communications.

This is not Parry’s first brush with the EAB. Not long after his retirement, NENA convinced Parry to chair the EAB. He served the board as president for seven years and then took a three-year break. During his first terms holding office, he wrote

“AMPDS has done a good deal to assist ambulance services in delivering high-quality patient care.”


Central office caters to agreement

The provision of a central office meets the standards of the National Enterprise Maintenance Agreement (NEMA) between the National Health Services (NHS) and the IAED. The agreement, signed on July 25, 2006, establishes the use of the AMPDS as the standard for emergency dispatch in the control rooms and ambulance trusts operating across England.

The benefits of participation include EMQD and ED-Q certification and recertification, version upgrades, product maintenance and support, onsite visits, and product support, and UK account management for those using the system (the Bristol office).

Meeting England’s health care needs

The publicly funded NHS provides the majority of health care in England, including the funding of emergency medical services divided among the country’s 13 ambulance trusts. The NHS monitors 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. The NHS introduced several initiatives to meet the goal, including the use of the MPDS protocol, which Jeff Clawson, MD, created in 1978 to improve emergency response modes based on the appropriate medical decision-making. The number of protocol users worldwide is around 2,900 agencies, with the vast majority in the United States, Canada, England, Germany, and Italy.
NG9-1-1 Project

For more on the project, click on the NENA NG9-1-1 Project.

The book Managing the 9-1-1 Center, which is still considered the core course of the NENA certification program (Parry holds the Emergency Number Professional, ENP, credential) and, lately, he’s been adding lots of material about technology in relation to 9-1-1.

In 2001, the National Academies of Emergency Dispatch (NAED) cornered Parry because of his police communications expertise and interest in protocol.

“They needed someone to take over the police protocol,” he said, and in 2004 he suspended his consulting work and came on full-time. His biggest accomplishment at the NAED, so far, he says, was guiding the Medicine Hat Regional 9-1-1 Communication Centre (located near Calgary in southern Alberta, Canada) to becoming the first ever Accredited Center of Excellence (ACE) in use of the NAED’s Police Priority Dispatch System® (PPDS).

“That means a lot to me, to get them on the map,” he said. “They proved beyond a shadow of a doubt that we have something amazing. They did it and it was quite a project for everyone involved.”

It’s safe to say that Parry has enjoyed the long journey, from the Royal Canadian Mounted Police to NENA, and to the central offices of the NAED in Salt Lake City, Utah, where he has made significant contributions to the academy’s police protocol. So, what does it all add up to? “I’d like to think I’ve had a positive effect on public safety and a massive effect on police protocol,” he said.

And, aside from that, he says, “I’ve had a very good time throughout it all.”

NENA 2007 9-1-1 Conference Celebrates 25th Anniversary. Four-day event highlights quarter century of progress

Over 2,000 industry professionals and exhibitors met June 9-14 at the Charlotte Conference Center for the industry’s premier 9-1-1 event, culminating NENA’s 25th Anniversary Year. The event featured top-notch presenters, expanded session tracks and selections, and several social opportunities to network and relax with peers.

Sunday’s Welcome Reception featured awards from 9-1-1 for Kids and 9-1-1 Cares. There was also a special appearance by Randolph Mantooth — “Johnny Gage” from the popular television series Emergency! — who addressed attendees about heroism and service, assisted with presenting the 9-1-1 Cares “Everyday Hero” Recognition Award, and spent additional time in the Exhibit Hall during the conference to host fundraising autograph sessions to benefit the County of Los Angeles Fire Museum’s James O. Page Memorial Building Fund. Two remote-controlled race tracks and a “keg race” course, food, drinks, and entertainment by Lia and the Wave made the welcome event one to remember.

Monday’s Opening General Session featured an inspiring discussion of eight key leadership values — loyalty, duty, respect, selfless-service, honor, integrity, and personal courage.

At the Wednesday evening Installation Banquet and Celebration, Craig Whittington, ENP, was elected by the NENA membership to the position of 2nd Vice-President, the first step along the way to assuming the NENA presidency in 2009. Eight other Executive Board members were also sworn in — Jason Barbour, ENP, President; Ronald Bonneau, ENP, 1st Vice-President; John Crabill, ENP, N. east Region Director; Bob Currier, ENP, North Central Region Director; Toni Dunne, ENP, Southeast Region Director; Rick Galway, ENP, Canadian Region Director; Barbara Jaeger, ENP, Western Region Director; and Ron Bloom, ENP, the Association’s first-ever Private Sector Director.

Three Executive Board members — John Crabill, ENP, Rick Galway, ENP, and Ronald Bonneau, ENP — were also inducted into NENA’s Hall of Fame.
Door kicked open. NENA First Vice President glad he walked through

Ron Bonneau, ENP, put off getting a Blackberry until it became obvious that his schedule demanded more than periodic checks from his desktop for e-mail messages and calendar updates. "I was not anxious to get one of these," he said over breakfast at a Las Vegas coffee shop during his trip in April to Navigator.

But like everything else, it was something he had to do—given the opportunity.

Bonneau is executive director of the SouthCom™ Combined Dispatch Center in Matteson, Ill., and the first vice president of the National Emergency Number Association (NENA). The management job at the busy dispatch center (an annual 235,000 calls that results in 70,000 dispatches) evolved much the same as his position with the nation's preeminent 9-1-1 advocacy organization: an opportunity that developed from being at a particular place when someone needed something done.

Push came to shove

Bonneau was a police officer in 1989, albeit junior police officer, when tapped to establish an emergency communication center for the Chicago suburb of Riverdale. He wasn't crazy about the idea, but "What choice did I have?" he asks. "They wanted a 9-1-1 center installed in the village and they anointed me the project manager." His take-charge approach produced a dispatch center rivaling his contemporaries. But, there was no contest involved, he said. "I was assigned to do it, so I decided to do it right."

Bonneau can sound like he does things out of obligation—the person in the crowd who steps forward because no one else will. He is manner when talking about dispatch and NENA, however, betray the appearance. Bonneau likes to take charge and he is dedicated to 9-1-1 communications. "After I built the center, I started to run it and, after a while, I even started to like it. A lot." Building the center became his only job for the next 18 months and, since it seemed the practical thing to do, Bonneau joined NENA. "It was the quickest way to learn about THE 9-1-1 system," he said.

Turns into ardent NENA advocate

One thing led to the next, and in no time Bonneau ran for a board position with the Illinois NENA Chapter. He made it to first vice president in Illinois and in 1995 he ran for national office. Come June 2007, Bonneau will make NENA history as the longest serving national board member. If all goes by practice, he will assume the presidency of the 7800-member national organization in 2008. The reason he stays is simple: it's a matter of doing the right thing. "NENA is an advocate of the industry," he said. "It is one of the few independent voices left."

Holds front seat to NENA workings

The years gave Bonneau a front row seat to NENA's workings, the ups and downs that mold the organization. "I know the thing we do well," he said. "NENA is on an upswing and we're getting a lot done. The new IP based technologies offer exciting opportunities in the field of emergency communications as well as 9-1-1." Yet with opportunity come the significant challenges NENA is addressing. First there's the ability to locate people through wireless and IP-based communications devices used to call 9-1-1 in an emergency, which is an issue that will be addressed in the NENA Next Generation 9-1-1 (NG9-1-1) project. Then, there's the funding issue—the surcharge 9-1-1 receives from land phone lines versus a market moving toward an IP based technology that may or may not collect surcharge—and the continued lack of funding for Phase II wireless system deployment throughout the United States. And what about the needed changes to regulations and legislation in an IP based world fraught with network security violations?

The list goes on but even at that, Bonneau admits the challenges are tremendous. Does that deter him or cause second thoughts about the opportunity presented earlier in his career? No, he said. "This is the door that was kicked open and, in retrospect, I'm glad that it happened this way."

Determined Path. NENA President leads way to national TERT initiative

Jason Barbour always knew he wanted a career in public service, but little did he expect that it would include presidency of the largest emergency number advocacy organization all because of his single-minded devotion to multi-agency response.

The president of the National Emergency Number Association (NENA) was a career deputy sheriff (nine years) and firefighter (13 years) in Johnston County, N.C., when in 1997 his duties as a deputy sheriff for the Johnston County Sheriff’s department were expanded to include management of the Sheriff’s communications center. He joined NENA since, he said, it was the premier organization for issues and best practices of 9-1-1 communications. A few years later, Barbour became director of Johnston County (N.C.) E9-1-1 Communications and ran for state office as a regional representative. The post led to his becoming president of the NENA North Carolina chapter in 2003-2004 and his election to second vice president of NENA in 2005.
Congressman Turn’s Telecommunicator.

Craig Whittington shows Congressman Mel Watt how protocol applies to dispatch.

Before assuming political motivation on Barbour’s part, there’s something else you should know about him. “I am very passionate about TERT,” he said. “It’s a major reason why I moved to the national level. TERT needed more exposure than it was getting from the few states than involved.”

TERT — the Telecommunicator Emergency Response Taskforce — is a national initiative to expedite 9-1-1 responses to an emergency. TERT is more-or-less an insurance policy for dispatch power. The program provides dispatch assistance across states at centers responding to the hurricane, tornadoes, flooding or other disaster. Teams are ready to deploy tomorrow even if the state or states needing assistance are not TERT affiliates. The Federal Emergency Management Agency (FEMA) is mandated by Congress to provide reimbursement to the responding centers.

With this kind of drive for a project, it comes as no surprise that Barbour was among the six original members of the TERT Steering committee and participated in the first TERT deployment in North Carolina. He was instrumental in the North Carolina TERT response to St. Tammany Parish during the aftermath of Hurricane Katrina and he signed the first Memorandum of Understanding with the North Carolina Emergency Management for use of TERT.

In the three years since, four other states have developed task forces, and 22 more states are interested in doing the same. “It shows you the huge impact anybody can make,” said Barbour. “If you have the desire and drive to achieve something, it can be done.”

At this point it may seem that Barbour is a single-issue sort of president. He isn’t. TERT got him rolling, but it was the organization and what else it’s trying to achieve that keeps him going nearly around the clock, especially considering that he still is the director of Johnston County E9-1-1 and Captain of the Clayton Fire Department in addition to the year and nine months he will serve as president. The term of office is normally one year, commencing in June; Barbour stepped up from the first vice presidency in October 2006 when the former president resigned.

There’s the NG91-1-1 initiative, in addition to NENA’s affiliation with the National Center for Missing and Exploited Children, and the stacks of legislative issues particularly in connection to 9-1-1 funding and wireless communications. There are also the reasons he believes should drive others in 9-1-1 to NENA. “This is a great organization,” he said. “And with an industry changing so rapidly, it’s the place to be to keep up with tomorrow.”

Close Call: Making the Stories of Our Callers and Our Lives Accessible

Dispatchers are more than the sum of their callers and help during an emergency. Between a demanding work load and a plurality of other obligations, many dispatchers find an outlet in creative writing. Our new Close Call column in The Journal of Emergency Dispatch will showcase 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 penned a book or movie review, or simply have an inspiration, Close Call welcomes the opportunity to share your work. For consideration, please e-mail Audrey Fraizer at audrey.fraizer@emergencydispatch.org.
The Premiere Educational Conference for Police, Fire, and Medical Dispatch

NAVIGATOR

Baltimore’s Inner Harbor

APRIL 23 - 25, 2008

PRE-CONFERENCE TRAINING
April 20 - 22, 2008
Hands-on certification courses
Special Workshops

EDUCATION AND INSPIRATION
Choose from 75 incredible opportunities
To learn and rekindle the spark

EXPANDED EXHIBITS
Meet, Greet, and Eat at our Gala Grand Opening
The latest in technology and services

www.emergencydispatch.org  800.960.6236
**Opening Session with Keynote Speaker**  
**Dr. Marc Eckstein**

### Exhibit Hall Open

<table>
<thead>
<tr>
<th>LEADERSHIP</th>
<th>MANAGEMENT &amp; OPERATIONS</th>
<th>MEDICAL</th>
<th>POLICE</th>
<th>FIRE</th>
<th>SPECIAL INTEREST</th>
</tr>
</thead>
</table>
| Leadership for the Future: Managing a Diverse Workforce  
Ron Two Bulls, John Ferraro | Learning from Abroad  
Guillermo Fuentes | Regional EMD Project  
Omar Qassim, Frank Marshall | The New NENA Protocol Standard  
Eric Perry, Michael Spath | FPDS Dispatch Accuracy  
Jay Dornseif | Published Articles  
Dr. Jeff Clawson, Brett Patterson |

### Exclusive Exhibit Hall Hours and Box Lunch

| Appreciative Inquiry  
David Nelson | Control Chatting  
Jason Shearer | Pandemic Flu  
Greg Scott, Dr. Jeff Clawson | Domestic Violence and the EPD  
Michael Spath | The Sentinels Now Fire: Lessons Learned for the Emergency Rule  
Gary Galasso, Deanna Matteo | Going Beyond the Protocol and Being Right  
Chris Bradford |
|---|---|---|---|---|---|
| Call Processing  
Greg Scott, Brian Dale, Scott Freitag | The Comm. Center is gone. Now what?  
Tom Somers | Who Wants To Be an EMD Millionaire  
Ron Two Bulls, John Ferraro | Mobile Crisis Team: Baltimore County Police and Mental Health Officers  
Sgt. Todd Rassa | FPDS and Preventing Fire Apparatus Accidents  
Jay Dornseif | Caller Locator Diagnostics  
Dr. Jeff Clawson, Brett Patterson |
| Coaching Skills  
David Nelson | How to Get The Best Out of Your Supervisor  
Lyne De Grasse | Being Effective: Are You, Can You, Will You?  
Chris Bradford | Why We Need Police Protocols  
Michael Spath | How to Implement an EFD Program  
Gary Galasso, Deanna Matteo | PSIam Data Studies from Richmond Ambulance  
Jerry Overton |

### Friday, April 25

#### Registration & Continental Breakfast

<table>
<thead>
<tr>
<th>LEADERSHIP</th>
<th>MANAGEMENT &amp; OPERATIONS</th>
<th>TECHNOLOGY</th>
<th>CDE</th>
<th>QUALITY IMPROVEMENT</th>
<th>SPECIAL INTEREST</th>
</tr>
</thead>
</table>
| Appreciative Supervision  
David Nelson | Beyond the Incident Action Plan  
Chip Hlavacek | ProQA for Dummies  
Chip Hlavacek | Modulate and Specialize Your CDE  
Jerry Chaney | Dealing With Your Most Difficult Calls  
Brian Dale, Scott Freitag | Dispatcher Stress Management  
Alice Valle |
| Maryland - A Statewide Approach to Protocol Implementation  
Gordon Deans | Package Yourself For Promotion  
Steve Reinko | AQUA for Dummies  
Chip Hlavacek | CDE Advancement Series  
Brian Dale | Quality Improvement in the Non-Protocol Environment  
Michael Spath | Hysteria - Your Fault or the Callers  
Chris Bradford |
| Leadership: What Exactly Does That Mean?  
Bill Kinch | Is Behavior Predictable? EMDs and Difficult Callers  
Louise Ganley | NG Communications  
Ronald Bonneau | Thinking Outside the Box for CDE  
Chris Bradford | EDQ Fundamentals  
Brian Dale | High Stress Low Frequency Calls: Doing it Right the First Time... Every Time  
Michael Spath, Kim Ridgden - Biscali |

### Closing and Keynote Luncheon

**Dr. Jeff Clawson Award**
Accredited Centers of Excellence

Here is what some of our members say about the importance of achieving excellence. We agree, and invite you to join us in congratulating the 2007 Accredited and Re-Accredited Centers of Excellence. They stand as beacons in the public safety community.

“Excellence matters because with it as the core focus of our goals it defines everything we do. We strive for excellence in the care and service we give our callers, excellence in how we treat our citizens and each other, and excellence in the use of the protocol. We touch the lives of so many people in our communities through dispatch. If we have excellence as our main focus, we’re really going to make a difference.”

Wade Mitzel—Fargo, North Dakota

“Excellence gives pride and confidence to emergency dispatchers working hard to provide the best care and service possible, often in very difficult circumstances.”

Michel Courtois—Montreal, Canada

“Excellence means striving to give 100 percent all the time. Looking for ways to constantly improve the help you give citizens calling 9-1-1, often in the most critical and stressful moments of their lives. That’s why we all chose to pursue dispatching, we want to help. For me that means pursuing and achieving excellence.”

Alexander Perricone—Baltimore, Maryland

“Excellence is like the motor of the car: without it what do you have?”

Christine Waegli—Switzerland

You can learn more about becoming a NAED Accredited Center of Excellence and view the 20 Points of Excellence at www.emergencydispatch.org or call 800-960-6236 for more information

2007 Re-Accredited Centers of Excellence

Albuquerque Fire Department
Clark Regional Emergency Services Agency
AMR of Denver
South and East Mamhilad
AMR Statewide Communications Center
Sunstar Communications Center
Emergency Medical Services Agency – Eastern Division
Emergency Medical Services Agency – Western Division
Austin Travis County EMS
Muskogee County EMS
Metro Communications Minneehaha County
Kent County Department of Public Safety
Welsh Ambulance Service NHS Trust Central and West Region
Collier County Sheriff’s Office
East Anglian Ambulance NHS Trust
MedStar EMS
The London Ambulance Service NHS Trust
AMR of Fort Wayne
Jefferson County Emergency Communications
Seaford 911 Communications Center
Broward County Sheriff Fire Rescue
Sedgwick County Emergency Communications
Sarasota County Public Safety Communications Center
Mecklenburg EMS Agency

2007 Accredited Centers of Excellence

Medical ACE
EMAS Nottingham Control Centre
Dublin Fire Brigade
AMR Western Washington Communication Center
Warren County Joint Communications
Central EMS
Centre de communication santé de la Mauricie et du Centre-du-Québec
Montgomery County Hospital District

Fire ACE
Mecklenburg EMS Agency
Salt Lake City Fire Department

Police ACE
Medicine Hat Regional 9-1-1 Communications

139 East South Temple Ste. 200 Salt Lake City, UT 84111
800.960.6236 | www.emergencydispatch.org
Calls for Help

Salt Lake City Dispatch Answers Calls from Panicked Mall Shoppers

By Audrey Fraizer

On the night of February 12, 2007, all heads were turned to news broadcasts about Trolley Square in Salt Lake City, Utah, where a lone gunman opened fire and was shooting to kill.

Illustration by Jess Cook.
Photographs courtesy Deseret Morning News.
Photographers: Michael Brandy, Mike Terry, Scott G. Winterton, Jeffery D. Allred.
"Here's a guy shooting with a rifle. He's shot a couple of people," one desperate caller tells a dispatcher at the Salt Lake City Police Dispatch Office. "Can you see him?" the dispatcher asks.

"He has a long, black gun," she answers. "I know there are at least two people shot."

The caller, Sarita Hammond, a dispatcher for Weaver Consolidated Dispatch (Utah), was inside a Brazilian steak house named the Rodizio Grill at the end wing of the popular mall where, only moments earlier, she and her husband Kenneth had finished an early Valentine’s Day celebration dinner. "My husband's an Ogden City cop," she tells the dispatcher using a cell phone she had borrowed from a waiter. "He's off duty and he has a gun. He's out there somewhere."

Sarita's call at about 6:50 on that Monday evening was one of nearly 600 calls made the night Sulejmen Talovic, armed with a shotgun and a handgun, shot and killed five people and injured four others.

Ten Salt Lake City police and fire dispatchers were working that shift and they tried to take every call. According to later reports, their work on the phones helped to piece together the terror caused by the unknown assailant stopped approximately seven minutes after the first call had been answered.

Shawna Smith, a dispatcher for the Salt Lake City Fire Department, remembers coming into a full screen of active calls when she arrived at the dispatch office in the Salt Lake City Public Safety Building slightly before shift change. "It was lit up like a Christmas tree," she said. "I had never seen so many calls before at one time."

Their work on the phones helped to piece together the terror caused by the unknown assailant.
18-year-old Sulejman Talovic, parks his car on the upper parking terrace on Trolley Square's west side. He approaches two people outside the mall's west entrance and shoots them with a pump-action shotgun.

Walking east on the mall’s lower-level corridor, Talovic shoots and kills a woman.

Talovic heads toward the gift shop Cabin Fever and shoots at least four people inside, killing three.

After reloading, Talovic continues walking east.

Hammond goes to the lower-level and yells to get the gunman’s attention, then exchanges gunfire with Talovic.

Talovic shoots a mother and kills her 15-year-old daughter.

Salt Lake City SWAT officers take down Talovic near Pottery Barn Kids.

Salt Lake City police officer arrives on the scene.

Inside Trolley Square, people hear shots. Many use their cell phones to call 9-1-1 while others find a place to hide.

18-year-old Sulejman Talovic, parks his car on the upper parking terrace on Trolley Square’s west side.

He approaches two people outside the mall’s west entrance and shoots them with a pump-action shotgun.

Talovic shoots a mother and kills her 15-year-old daughter.

Salt Lake City police officer arrives on the scene.

The Story Behind the 600 Calls to Salt Lake City Dispatch
Smith, a dispatcher for 18 years, and four other dispatchers from the Salt Lake City Fire Department spent the next several hours answering calls—one after the other—flowed over from the five dispatchers answering calls from the Salt Lake City Police Department dispatch office across the hall.

It was rapid-fire work, said Shahara Clark, a dispatcher for 10 years who stayed on that evening to assist past the hours of her daytime shift. “We went from one call to another for most of the night.”

Laurie Wilson-Bell, shift supervisor for the Salt Lake Fire dispatch office, said that despite the volume of calls coming in they did their best to answer every one. “We moved from call to call as quickly as possible,” she said.

There were exceptions, she said, depending on the caller’s frame of mind and the relaying of new and significant information. For example, the dispatcher answering Sarita Hammond’s call spent a comparatively lengthy 2 minutes and 10 seconds talking to her about the incident and her husband’s part in tracking the shooter.

The hard part, at least at first, was answering without knowing what was happening at the mall just two miles southeast from their dispatch center.

Connie Kelson, a dispatcher for the Salt Lake City Fire Department for 23 years, said it was simply a matter of talking into the headphones from the moment she started her shift. “It was something at Trolley Square, we knew that much,” she said.

The 9-1-1 call transcripts available to the public reveal the efforts of dispatchers to calm callers, virtually all of them using cell phones, and to convince them to take cover.

“There were so many calls coming in that all we could do was assure the caller that help was on the way and to make sure they were in a safe place.”

—Shawna Smith
until help arrived. Smith said that was all they were able to do. “There were so many calls coming in that all we could do was assure the caller that help was on the way and to make sure they were in a safe place,” she said. “We felt bad about that but there was really nothing more we could do.”

The emergency rule of public safety dispatch allows some variance in crucial situations, such as what happened that night at Trolley Square. With so many calls coming in from the mall, there was no opportunity to give Pre-Arrival or Post-Dispatch Instructions. That doesn’t mean that the fire department dispatchers threw caution to the wind that night. “The protocol we used gave us the voice of authority,” said Wilson-Bell. “We knew exactly what to say to calm them down.”

Alan “AJ” Walker was one of the first victims of Talovic’s rampage. AJ and his father were shot in the parking garage and AJ ran to cars desperately seeking help. Mackenzie Flanders was the parking garage when AJ came running down the stairs and toward her car. “A kid came running up to our car asking for help, and he was covered in blood,” she tells the dispatcher. AJ survived. His father, 52-year-old Jeffrey Phillip Walker, did not.

Clark took two calls about AJ, not the one from Flanders, but a later call from a woman who had AJ in her car and was driving him to safety away from the parking garage. Her son was one of the few contacts that was anywhere near a victim of the shooting, said Wilson-Bell. “I just wanted to know what was going on or they were calling to report what they were seeing,” she said. “Like Shawna said, we told them to take shelter, to find a place to hide and to stay there until help arrived.”

A caller describes the 18-year-old gunman.

“The shooter looks like he was wearing a tan trench coat, and he was in the area of Williams-Sonoma.”

Others stayed in their hiding places, too frightened to move and relying on the voices of 9-1-1 to help them through the danger.

“Please tell me what’s going on,” a voice begs.

A woman, in a frightened voice, with the cries of her children in the background, pleads for help. She is scared. The dispatcher tells her to stay behind the couch where she has taken shelter. “If you need to, call The Journal sept/oct:Layout 1  5/20/08  8:18 AM  Page 29

Lawmakers Respond to Violence. Task forces review what else needs to be done

Oklahoma

Former Attorney General Alberto Gonzales met with Oklahoma educators on May 2 and by that time Governor Brad Henry had already called for the creation of the Campus Life and Safety and Security Task Force to look at security measures for the state’s institutions of higher learning.

The task force will pay particular attention to improving communication on campus when emergency situations do arise, according to CNN News Service.

Utah

The University of Utah Task Force on Campus Security, headed by law professor Wayne McCormack, was announced in June independent of the federal initiative. Similar to the federal plan, the University’s task force will provide guidance to students, staff, and faculty should they become aware of the presence of weapons in their midst, according to a University press release (dated June 5, 2007). In Utah, students with concealed weapon permits are allowed to bring guns on campus, and on any state controlled property. The task force will also consider early warning signals regarding possible hostile behavior and seek ways to provide appropriate help to such individuals while protecting the campus environment. In the case of an incident, the task force wants to clarify policies regarding rapid, appropriate response by law enforcement and other security operations.

Since the University does have a security plan in place, McCormack said the task force will look at what else needs to be done. For example, the current security plan addresses two key areas: the gun-free roommate option for those moving on campus and unwilling to share a dorm space with someone who carries a concealed weapon and the secure hearing room exception. Other issues they want to study are changes in technology and communication systems, such as campus wide notification when an incident occurs and questions that can faculty can use to help identify potentially dangerous behaviors among individuals without compromising privacy. “The response plan does not need amendment because it is a basic procedural outline,” he said. “We will be working on details that are not part of that plan.” They intend to have recommendations to University President Michael K. Young following fall semester.

Florida

In April, following his meeting with Dept. of Health and Human Services Secretary Michael Leavitt, Florida Governor Charlie Crist signed Executive Order 07-77, establishing the Gubernatorial Task Force for University Campus Safety to review all security measures on Florida’s college and university campuses. The task force will look at emergency notification capabilities, support, and training for first responders, and student mental health issues.

National Association of Attorneys General

The Task Force, chaired by Colorado Attorney General John Suthers and Rhode Island Attorney General Patrick Lynch, will work to identify programs, policies, and legislative initiatives that might fill in the gaps of existing campus safety protocols. Task Force members also will examine key types of relationships attorneys general must build to address school violence and safety issues, including those with law enforcement.

Crisis Planning

From the federal booklet: Practical Information Crisis Planning—A Guide for Schools and Communities.

During the process, create working relationships with emergency responders. It is important to learn how these organizations function and how you will work with each other during a crisis. Take time to learn the vocabulary, command structure, and culture of these groups. Some districts have found it useful to sign MOUs with these agencies that specify expectations, including roles and responsibilities.
out of the wrong hands
Firearms is essential to keep guns individuals prohibited from possessing accurate and complete information on

A report subsequently issued includes several key findings:

Critical Information Sharing
Faces substantial obstacles

Education officials, healthcare providers, law enforcement personnel, and others are not fully informed about when they can share critical information on persons who are likely to be a danger to self or others, and the resulting confusion may chill legitimate information sharing.

Accurate and complete information on individuals prohibited from possessing firearms is essential to keep guns out of the wrong hands.

State laws and practices do not uniformly ensure that information on persons restricted from possessing firearms is appropriately captured and available to the National Instant Criminal Background Check System (NICS).

Improved awareness and communication are key to prevention.

It is important that parents, students, and teachers learn to recognize warning signs and encourage those who need help to seek it, so that people receive the care they need and our communities are safe.

It is critical to get people with mental illness the services they need.

Meeting the challenge of adequate and appropriate community integration of people with mental illness requires effective coordination of community service providers who are sensitive to the interests of safety, privacy, and provision of care.

Where we know what to do, we have to be better at doing it.

For the many states and communities that have already adopted programs, including emergency preparedness and violence prevention plans, to address school and community violence, the challenge is fully implementing these programs through practice and effective communication.

National conversations

The following are comments taken from conversations between Leavitt and the governors he met around the country.

Texas, April 30, 2007 — "When tragedies like this happen, it causes us to reevaluate whether we are doing all we can to protect our students and citizens. That's why we are here today; to have discussions with key leaders in the law enforcement, education, and healthcare communities to ensure we are fully prepared to not only respond to a tragedy when the unthinkable happens, but to prevent it altogether because of rapid intervention in a troubled person's life." -Gov. Rick Perry.

Florida, April 30, 2007 — "The hearts of Floridians have gone out to the families of the victims of the tragedy at Virginia Tech, and the compassion we feel for them urges us to be prudent and review our own state's emergency plans for schools and college campuses. Florida's already advanced level of disaster preparedness will serve as a strong foundation for Florida's law enforcement, education and mental health agencies and partners to develop the best safety plans possible." -Gov. Charlie Crist.

Tennessee, April 28, 2007 — "Not one of us has gone untouched by the events that unfolded at Virginia Tech. Our thoughts and prayers continue to be with our neighbors in Virginia and the loved ones of the
two more would have died without the quick response of EMS," he said.

Paul Patrick, director of the Utah Bureau of Emergency Services, said he was proud to honor those who took part in an extraordinary and a tragic event. “Those who lived through the experience will forever be changed,” he said.

Paul Hewitt, of the Salt Lake City Fire Department, said the awards are a way to find hope. “After an incident like this, we look for the positive,” he said. “What we saw that night was truly coordinated. All these folks were more than willing to lay their lives on the line to save the life of a stranger.”

The same applies to the dispatchers at the police and fire departments.

“Teamwork kicks in,” said Kelson. “We all flowed through this smoothly working together as a team.”

victims in this tragedy. We need to take the lessons from this tragedy, and work to better protect all citizens from violence of any kind. I welcome the opportunity to be part of the conversation that may help our state and others work through these serious issues.” -Gov. Phil Bredesen

Colorado, April 27, 2007 — “Colorado has unfortunately learned painful lessons from the tragedy at Columbine High School. We will do everything we can to share those lessons and experiences, especially at a time like this when the nation’s attention is focused so intently on what happened at Virginia Tech.” -Gov. Bill Ritter

Utah, April 27, 2007 — “For all of us, it was a wake-up call.” - Gov. Jon Huntsman (quote taken from story by Associated Press Reporter Paul Foy and published in the April 28, 2007, Daily Herald)

West Virginia, April 26, 2007 — “Our thoughts and prayers continue to be with those directly affected by last week’s violence. What happened is devastating and we must quickly begin to explore ways to prevent it from happening again.” -Gov. Joe Manchin

Minnesota, April 26, 2007 — “Our state and nation come together to mourn the senseless loss of life and support the victims, families, and friends who are still reeling from this tragedy.” -Gov. Tim Pawlenty
All too often the Emergency Medical Dispatcher (EMD) receives a reported drug overdose from a caller who lacks information sufficient to accurately describe the situation. The caller can usually provide the names of the medications or tablets taken and sometimes the reason the medication was prescribed. In many cases, however, the EMD is at a loss as to what exactly is being reported, especially when the situation involves someone the caller has found unconscious or in another state of medical emergency believed to be related to an intentional or accidental drug overdose. In the conscious patient, the information given may be misleading in terms of the time, amount, and type of medication because there is motive for the action (Medical Priority Dispatch System® (MPDS) Protocol 23, O overdose/Poisoning, Axiom 1).

The following information is meant to clarify some of the issues.

Is there a difference between an overdose and a poisoning?

The dispatch definitions of OVERDOSE and POISONING are somewhat contrary to generally accepted definitions. This is necessary for the type of decision-making unique to DLS. In DLS language, an OVERDOSE is an intentional act while POISONING is an accidental intake. Either can occur when an excessive amount of a drug or poison is taken, leading to a toxic (poisonous) effect on the body. There are many drugs that can cause harm when too much is taken including alcohol, prescription drugs, over-the-counter drugs, illegal drugs and some herbal remedies. The first Key Question in Protocol 23 asks whether the overdose was accidental or intentional.

By Beverley A. Logan

Drug overdoses may be tough to identify, unless asking the right questions.
What are the symptoms?

Drug overdose symptoms vary widely depending on the specific drugs used, but may include:

- Unconsciousness (coma)
  (Determinant Descriptor 23-D-1)
- Severe respiratory distress
  (Determinant Descriptor 23-D-2)
- Violent or aggressive behavior
  (Determinant Descriptor 23-C-1)
- Not alert
  (Determinant Descriptor 23-C-2)
- Abnormal breathing
  (Determinant Descriptor 23-C-3)
- Abnormal pupil size
  o Dilated pupils (enlarged)
  o Pinpoint pupils (very small)
  o Nonreactive pupils (pupils do not change size when exposed to light)
- Sweating
- Agitation
- Tremors
- Convulsions
- Staggering or unsteady gait (ataxia)
- Rapid breathing (tachypnea)
- Drowsiness
- Hallucinations
- Death

Sources: MedLine Plus Encyclopedia and Protocol 23

How to respond

According to Protocol 23 Rules:

1. Ineffective breathing discovered during Key Questioning should be coded as severe respiratory distress and requires a DELTA response.

2. If an OMEGA (Ω) referral to a Poison Control Center is not locally approved, the appropriate response is locally determined. "Home care," which has been used by regional Poison Centers with great success, is an OMEGA (not an Alpha) code because an EMS response may not be necessary.

3. Consider call tracing if there are problems with location, identification, or information cooperation.

Antidepressant drugs

Three main types of drugs are used to treat depression: tricyclic antidepressants (TCAs), selective serotonin re-uptake inhibitors (SSRIs), and monoamine oxidase inhibitors (MAOIs). TCAs are not prescribed as often as they had been in the past because of other types of anti-depressant drugs that have been introduced over the past several years. Determinant Descriptor 23-C-4 addresses the antidepressants. They work in different ways:

- TCAs act by blocking the re-uptake of the neurotransmitters serotonin and noradrenaline, thereby increasing the neurotransmitter levels at receptors; TCAs include amitriptyline, clomipramine, dothiepin, imipramine, and lofepramine.
- SSRIs act by blocking the re-uptake of only one neurotransmitter, serotonin; SSRIs include citalopram, fluoxetine, fluvoxamine, paroxetine and sertraline.
- MAOIs act by blocking the breakdown of excitatory neurotransmitters, mainly serotonin and noradrenaline; MAOIs include moclobemide, phenelzine and tranylcypromine.

The antidepressant effect of these drugs is not usually apparent until 10 to 14 days after starting treatment, and it may be up to six to eight weeks before full effect is seen. Side effects, however, may happen at once. For example, a TCA may cause drowsiness and blurred vision, and SSRIs are known to cause nausea and vomiting.

Overdose of tricyclics and MAOIs can be dangerous. Both are prescribed with caution if the patient suffers heart problems or epilepsy. Tricyclics can produce coma, seizures, and disturbed heart rhythm. MAOIs taken with certain drugs or foods that are rich in tyramine (e.g., cheese, meat, yeast extracts, and red wine) can produce a dramatic rise in blood pressure, with headache or vomiting. People taking these drugs are given a treatment card that lists prohibited drugs and foods.

The Journal sept/oct:Layout 1  5/20/08  8:19 AM  Page 33
Types of antidepressant drugs

Amitriptyline. This tricyclic antidepressant drug carries a high overdose danger rate. Dependence rating is low and a prescription is needed. Brand names include Domical® and Elavil®.

Clomipramine. This tricyclic antidepressant drug carries a high overdose danger rate. Dependence rating is low and a prescription is needed. Brand names include Anafranil®.

Dothiepin. This tricyclic antidepressant drug carries a high overdose danger rate. Dependence rating is low and a prescription is needed. Brand names include Dothapax® and Prepadiine®.

Fluoxetine. This antidepressant drug carries a medium overdose danger rate. Dependence rating is low and a prescription is needed. Brand names include Prozac®.

Imipramine. This tricyclic antidepressant drug carries a high overdose danger rate. Dependence rating is low and a prescription is needed. Brand names include Gamanil® (UK, not used in the United States).

Moclobemide. This antidepressant drug carries a medium overdose danger rate. Dependence rating is medium and a prescription is needed. Brand names include Manerix® (UK and Canada).

Lofepramine. This tricyclic antidepressant drug carries a medium overdose danger rate. Dependence rating is low and a prescription is needed. Brand names include Lustral® (UK) and Zolof® (US).

Cocaine. Determinant Descriptor 23-C-5 addresses cocaine, and Axiom 4 states that cocaine's ability to induce strokes and heart attacks is of serious concern. Cocaine has several derivatives and street names such as coke, nose candy, snow, and crack.

This drug is a central nervous system stimulant and local anaesthetic and taken regularly, cocaine is habit-forming. It can be smoked, sniffed, or injected. Users may become psychologically dependent on its physical and psychological effects and may step up their intake to maintain or increase these effects or to prevent the feelings of severe fatigue and depression that may occur after the drug is stopped. The risk of dependence is especially pronounced with the form of cocaine known as crack, which appears to have more intense effects than other forms of cocaine.

Continued use may cause increasing paranoia and psychosis and, when taken in large doses, death due to heart attack or heart failure. Repeated sniffing damages the membranes lining the nose and may lead to the destruction of the septum (between the nostrils). People with heart disease, high blood pressure, or an overactive thyroid gland run the risk of heart problems.

The Statistics.

Death from drug overdoses is on the increase around the world, as these statistics show.

United States –
The Centers for Disease Control

- Poisoning mortality rates in the United States increased by 62.5 percent during 1999–2004.
  - In 1999, 11,000 deaths were attributed to drug overdoses; the number in 2004 was 20,000.
  - In 2004, poisoning was second only to motor-vehicle crashes as a cause of death from unintentional injury in the United States.
  - 50 people die daily from unintentional drug overdoses.
  - Men are twice as likely to die from an overdose compared to women.
  - The number of deaths between the ages of 15 to 24 is growing, although a large percentage occurs in the ages of 35 to 54 due to medications used for depression, anxiety, and insomnia (antidepressants).
  - Nearly all poisoning deaths are attributed to abuse of prescription and illegal drugs.

Utah – No Different Than Other States

In 2003, the typical drug overdose death in Utah was an overweight adult, aged 25–54 years who died from the effects of non-illicit drugs. In contrast to deaths due to illicit drugs, this newer problem has affected urban and non-urban areas and both men and women similarly. Prescription narcotic drugs contributed to the most deaths (Utah Dept. of Health).

Canada – Canadian Institute for Health Information

Poisoning ranks next to falls and motor vehicle collisions as the third most frequent type of injury leading to hospitalization in Canada. There were 28,581 poisoning cases admitted to Canadian hospitals in 1999–2000, out of a total 197,002 admissions for all injuries. Medications are the most common substances in all poisonings.
CDE-Quiz  +  Medical

Answers to the CDE quiz are found in the article “Truth Be Known,” which starts on page 32.

1. Which MPDS Protocol addresses Overdose/Poisoning?
   a. Protocol 2
   b. Protocol 8
   c. Protocol 23
   d. Protocol 26

2. What is a major reason information given about drug overdose may be misleading in terms of the time, amount, and type of medication?
   a. The patient has motive for the action.
   b. The caller could care less about the overdose patient.
   c. The prescription bottle is unavailable.
   d. The caller and patient are worried about legal consequences.

3. Only illegal drugs can cause harm when taken in excess.
   a. true
   b. false

4. The first Key Question in Protocol 23 Overdose/Poisoning asks which of the following:
   a. Is the patient violent?
   b. What did the patient take?
   c. Was this accidental or intentional?
   d. Is the drug ingested considered the patient’s drug of choice?

5. What is the Determinant Code for cocaine?
   a. 23-D-2
   b. 23-C-4
   c. 23-C-5
   d. 23-C-9

6. Another term for rapid breathing is:
   a. ataxia
   b. tachypnea
   c. coma
   d. hypersonmia

7. Ineffective breathing discovered during Key Questioning should be coded as:
   a. Overdose without priority symptoms (23-B-1)
   b. Unknown status (23-C-8)
   c. Abnormal breathing (23-C-3)
   d. Severe respiratory distress (23-D-2)

8. “Home care” is an OMEGA code because an EMS response may not be necessary.
   a. true
   b. false

9. MAOIs act by (choose one of the following):
   a. blocking the re-uptake of the neurotransmitters serotonin and noradrenaline, thereby increasing the neurotransmitter levels at receptors.
   b. blocking the re-uptake of only one neurotransmitter, serotonin.
   c. blocking the breakdown of excitatory neurotransmitters, mainly serotonin and noradrenaline.
   d. blocking the re-uptake and breakdown of all neurotransmitters.

10. Death from drug overdose continues to be on the decrease.
    a. true
    b. false

CDE Quiz Mail-In Answer Sheet

Answer the test questions on this form. (A photocopy of the answer sheet is acceptable, but your answers must be original. Please do not enlarge.) Within six weeks, you will receive notification of your score and an explanation of any wrong answers. Once processed, a CDE acknowledgment will be sent to you. (You must answer 8 of the 10 questions correctly to receive credit.) Clip and mail your completed answer sheet along with the $5 processing fee to:
The National Academies of Emergency Dispatch
139 East South Temple, Suite 200
Salt Lake City, UT 84111 USA
(800) 960-6236 US; (801) 359-6996 Intl.
Attn: CDE Processing
Please retain your CDE acknowledgement to be submitted to the Academy with your application when you recertify.

Name__________________________
Organization__________________________
Address__________________________
City__________________St./Prov._ZIP__________________
Country__________________
Academy Cert. # _______________________
Daytime Phone ( ________ )______________
E-mail:__________________________

PRIMARY FUNCTION
☐ Public Safety Dispatcher (check all that apply)
   Medical_____Fire_____Police
☐ Paramedic/EMT/Firefighter
☐ Comm. Center Supervisor/Manager
☐ Training/QI Coordinator
☐ Instructor
☐ Comm. Center Director/Chief
☐ Medical Director
☐ Commercial Vendor/Consultant
☐ Other__________________________

ANSWER SHEET - MEDICAL

September/October 2007 Vol. 9 No. 4 (Truth Be Known)
Please mark your answers in the appropriate box below.

1. ☐ A ☐ B ☐ C ☐ D
2. ☐ A ☐ B ☐ C ☐ D
3. ☐ A ☐ B
4. ☐ A ☐ B ☐ C ☐ D
5. ☐ A ☐ B ☐ C ☐ D
6. ☐ A ☐ B ☐ C ☐ D
7. ☐ A ☐ B ☐ C ☐ D
8. ☐ A ☐ B
9. ☐ A ☐ B ☐ C ☐ D
10. ☐ A ☐ B

To be considered for CDE credit, this answer sheet must be received no later than 10/30/08. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements (up to 4 hours per year). Please mark your responses on the answer sheet located at right and mail it in along with the $5 processing fee to receive credit. Please retain your CDE certificate to be submitted to the Academy with your application when you recertify.

Expires 10/30/08
Age Discrimination. Deceptive and fraudulent practices target seniors

By Greg Spencer

News outlets around the world report fraud and deception daily, especially acts that target the elderly. On one day alone, the search term "elderly fraud" brought up 305 stories launched over the Internet during the second week of August 2007 from media sources in North America, including the following three examples:

WVEC News, Rhode Island:
A former Chesapeake man facing a number of charges, including fraud, was sentenced to 10 years in prison.
According to Virginia State Police, Anthony John Carrea, 44, fraudulently sold insurance products to the elderly. In the past he was a licensed insurance agent and financial consultant, but the State Corporation Commission revoked those privileges in 2003. Police say Carrea continued selling insurance-related products to senior citizens despite the revocation by using his former employees' identities.

Mercury News, San Jose, Calif.:
Three members of an Eastern European organized crime group have been sentenced to federal prison for operating a $20 million Medicare fraud operation that exploited elderly immigrants in San Jose and Southern California.
Ringleader Konstantin Grigoryan, a Ukrainian immigrant who was once a Soviet army colonel, was sentenced to four years and eight months in prison after pleading guilty to conspiracy and filing a false tax return.
Grigoryan operated a string of health clinics and medical testing services in Southern California, which recruited elderly patients with the promise of free check-ups. The group then used the unknowing patients' Medicare accounts to submit bills for a variety of medical procedures that were unnecessary or never performed.

News Journal, Pensacola, Fla.:
A Pensacola woman accused of trying to swindle an elderly man out of his $100,000 trust is scheduled to appear in court today.
Amy Nally, 37, will be arraigned on an exploitation of the elderly charge at 9 a.m. Judge Frank Bell also will consider her bond at the court appearance.
Nally is suspected of having Michael Bogan's power of attorney switched from his brother's name to her name, according to a police report.
Bogan, 66, is mentally disabled. "She dissolved one power of attorney and gained the power of attorney by having the gentleman sign for it," Pensacola Police Officer Jimmy Donohoe said.

Elderly are frequent targets
Axiom 2 of Protocol 11 of the Police Priority Dispatch System (PPDS) points out that "elderly people are frequently the targets for con artists." The following statistics clearly support this claim:
- The nonprofit National Center on Elder Abuse estimates that there are five million cases of elder financial exploitation annually.

POLICE
The Federal Trade Commission estimates that consumers lose more than $40 billion a year to telemarketing fraud; people age 50 and older account for 56 percent of all victims. Medicare lost $11.9 billion to waste, fraud, and mistakes in 2000, half of what was lost five years ago from improper payments to doctors and hospitals due to the intentional inaccuracy of information about the medical services provided.

Why the elderly

Characteristics that the Denver (Colo.) District Attorney's Office has observed in its cases that increase older adults' risk of victimization include the following, according to the April 2006 article in the Office for Victims of Crime (OVC) Bulletin:

- Living alone and being isolated or lonely, no family members or friends in the immediate area from whom to seek advice
- Lack of knowledge about financial, legal, and insurance matters; little attention paid to financial accounts
- Overdependence on one caregiver or advisor, particularly if that person is financially dependent, controlling, or seeks to further isolate the older adult
- Adding insult to injury is the reluctance to report the incident because the individual may fear retaliation or the humiliation of seeming incompetent. In addition, a fixed income limits the ability to seek professional help even when a person recognizes a crime has occurred.

Protocol can help

PPDS Protocol 118 helps EPDs handle calls for suspected fraudulent or deceptive practices. Often these are Cold Call situations. A Cold Call is "a call for service involving a past event that does not require a full interrogation because by the caller's assessment, the suspect is not on scene or in the area." Notice that the case should be dispatched immediately after Key Question 1. This ensures that dispatch has been sent in the event you need to leave interrogation and go to the Caller in Danger Protocol because the caller reports that s/he is in immediate danger in response to Key Question 2. Fraud/ deception suspects may become violent, especially if they learn that someone is trying to report their crimes.

When the caller is not in immediate danger, you should continue Key Questions interrogation to gather additional scene safety and suspect information. Similar to many other PPDS protocols, you are directed to determine if anyone else is in immediate danger and, if so, where exactly they are now. You are also directed to ask where the suspect is now. If the suspect is leaving, you must determine how s/he is leaving and get a vehicle description when appropriate. Next, you ask for a description of the suspect. If the suspect is still on scene and arrived in a vehicle, you should obtain a description of that vehicle. This information can be useful for responders if the suspect later flees the scene.

The Post-Dispatch Instructions direct the caller to have all required paperwork ready for the responding officers. In cases of forgery (as in a forged check) an Affidavit of Forgery may be required. This document, signed by the victim, disclaims authorization by officially declaring that the signature on the document is a forgery and not valid. Sometimes, a notary is required, depending on the amount of money involved. These forms are available from the bank that issued the check(s).

What others are doing

Programs and projects to fight elder abuse, including fraud and deception, number into the hundreds, particularly since most people find this type of behavior deplorable. Examples that could help victims like the ones described earlier in this article include the following:

- Medicare's senior patrols are trained volunteers who work with the Postal Inspection Service (PIS) to catch fraudsters, especially those involved in Medicare fraud.
- The Office for the Elderly of the Inspector General (OIG) reports that since the inception of the Medicare Patrol programs in 1997, investigations have resulted in recovering $4,679,644 in Medicare funds nationally.
- A group from the Ohio Association of Probate Judges is developing ways to improve guardianship law and practice in the state through a grant from the Partnerships in Aging of the American Bar Association.
- The Coalition Against Insurance Fraud, founded in 1993, is a leading national source for tough, anti-fraud legislation and regulation and 19 states have passed anti-fraud laws based on the coalition's model insurance fraud bill.

Source: Office for Victims of Crime (OVC) Bulletin, April 2006
To be considered for CDE credit, this answer sheet must be received no later than 10/30/08. 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 acknowledgement to be submitted to the Academy with your application when you recertify.

CDE Quiz Mail-In Answer Sheet

Answer the test questions on this form. (A photocopied answer sheet is acceptable, but your answers must be original. Please do not enlarge.) Within six weeks, you will receive notification of your score and an explanation of any wrong answers. Once processed, a CDE acknowledgment will be sent to you. (You must answer 8 of the 10 questions correctly to receive credit.)

Clip and mail your completed answer sheet along with the $5 processing fee to:

The National Academies of Emergency Dispatch
139 East South Temple, Suite 200
Salt Lake City, UT 84111 USA
(800) 960-6236 US; (801) 359-6996 Intl.
Attn: CDE Processing

Please retain your CDE acknowledgment to be submitted to the Academy with your application when you recertify.

Name_________________________________
Organization_____________________________
Address______________________________
City____St./Prov.____________
Country_____________________ZIP________
Academy Cert. # _______________________
Daytime Phone (________)_________________
E-mail:_________________________________

PRIMARY FUNCTION
☐ Public Safety Dispatcher (check all that apply)
☐ Medical
☐ Fire
☐ Police
☐ Paramedic/EMT/Firefighter
☐ Training/Ed Coordinator
☐ Instructor
☐ Comm. Center Director/Chief
☐ Medical Director
☐ Commercial Vendor/Consultant
☐ Other__________________________

ANSWER SHEET ✐ POLICE

September/October 2007 VOL. 9 NO. 4 (Age Discrimination)
Please mark your answers in the appropriate box below.

1. A ☐ B ☐ C ☐
2. A ☐ B ☐
3. A ☐ B ☐
4. A ☐ B ☐ C ☐ D ☐
5. A ☐ B ☐ C ☐ D ☐
6. A ☐ B ☐ C ☐ D ☐
7. A ☐ B ☐
8. A ☐ B ☐
9. A ☐ B ☐
10. A ☐ B ☐ C ☐ D ☐

To be considered for CDE credit, this answer sheet must be received no later than 10/30/08. 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.
Located in the Ozarks Region in the northwest section of Arkansas near the Missouri and Oklahoma borders, Central EMS recently became an Accredited Center of Excellence (ACE) and hopes to become a central tool in the shaping of the industry into the future.

Central EMS dispatches a formidable lineup of eight ambulances, with the potential of five more if needed; 17 fire departments; tactical rescue; search and rescue; the Department of Emergency Management; and the Washington County Coroner. The center services an area population of 120,000, including the University of Arkansas students, faculty and staff in Fayetteville. They dispatched 21,000 calls out of the 170,000 calls received in 2006.

Central had a variety of motivating factors leading them to become accredited. Assistant Chief Steve Harrison and Captain Samantha Paul had long been involved with Navigator, so being recognized as an ACE was an important goal for them.

“We strive to do an excellent job here providing the public with emergency medical dispatch, and we felt like if we could achieve the goals for accreditation than that was just one more validation that we were doing what we wanted to do,” Harrison said. “We were achieving our goals.”

Paul said validation gained through the ACE process was important to them.

“We wanted external validation of our processes with strong backing from our
EMD protocol provider," she said. "We found that in the NAED. We continue to strive to get better every day. It isn't just that one set of numbers to reach, it's providing consistency to our patients."

Harrison said their desire to become an ACE was kicked up a notch when they started using the protocol. While it took some time and effort to reach their goal, it paid off when they were recognized in front of a crowd of their peers at Navigator 2007 in Las Vegas.

"Seeing those people on that screen every year, the new accreditation recipients as well as the reaccreditation services," Harrison said. "Yeah, that was a motivator. We wanted to see our name on that screen."

"It did mean a lot to us," he added. "It's a matter of fact that is what we were striving for, to have all of our stuff complete. To have the evaluation done and our accreditation be awarded at Navigator, that was important to us. We've been involved with Navigator for a long time."

Central dispatcher Brandi Beale said being recognized as dispatchers means a lot.

"You get the pat on the back just from the agency, but it means so much more to be nationally recognized and internationally recognized for actually doing something to help save someone's life or just make a difference really," she said.

Overcoming challenges

The obstacles Central EMS faced on the road to accreditation ranged from a rapidly growing service area and population to dispatchers riders the waves of change.

"We want to provide value-added service to the public," Paul said. "The major challenge is making sure that the dispatchers understand why we are doing this, and why it's important for them. After that you have to have managers that you can talk to, really communicate with, and that are willing to make the hard decisions to change processes and overcome the bumps in the road. Pre-Arrival Instruction training was the most difficult to obtain and obviously the most important for our patients. Everyone involved has to be willing to get out of the 'this is what we've always done' mindset."

It wasn't an easy task.

"You really have to take those instructions and give them verbatim and not veer off of them," Paul said. "With the information that you're getting from usually difficult callers sometimes it's hard to do that. So, it took us a long time to get to that level. It's really just perseverance."

Harrison said the center also needed to adopt a service-wide culture, but because change can take time since it requires every-
up with the paperwork that's out there. That's a big challenge."

A call away

Paul said Carlynn Page, NAED associate director, was a great resource for Central during the ACE process. She met Page several years ago at the first CCM course and she turned to her when she needed motivation, answers to questions, examples of paperwork, and validation that Central was moving in the right direction toward ACE completion.

“We couldn’t have done it without Carlynn,” Paul said. “She keeps your direction true. She makes sure that you’re on the right track. Any question you’ve got about ACE whatsoever she’s there to answer it and give you to other people that can help you get through those final questions. The final question at the end for the paperwork is overwhelming. She’ll get you in touch. Probably truly one of the biggest things is just telling you not to quit, don’t give up.”

Post-ACE achievement

Even after becoming an ACE, Central wasn’t satisfied with resting at that point. The center’s dispatchers received two months of 100 percent PAI compliance. Paul said it made a difference to arm dispatchers with the knowledge they need about the impact they make, tendered with feedback from a QA officer.

“It has never been O.K. to just be better than any competition; it’s about being the best that we can be for the people that we serve,” Paul said. “Our dispatchers have finally been recognized for the incredible work that they do day in and day out. They worked hard for it and they attained it.”

Sage advice

Now that Central has been through the ACE process other agencies are asking them what they can share from their experience.

“We have a number of agencies that we work very close with around that are asking how we did it,” Harrison said. “They know how hard it is. They’ve been looking at it, looking for guidance, and maybe even a little more coaching from us since we’re there. They do know how difficult it is and yes, we’ve had a couple of them asking how they attain this.”

Chief Becky Stewart said in order for the process to come together and succeed

**So You Want to be an ACE?**

The Academy’s Twenty Points of Accreditation

While it’s not easy admits Carlynn Page, associate director, National Academies of Emergency Dispatch® (NAED®), ACE status could be one of the most rewarding projects your communication center team can approach and achieve together.

“ACE says you’re a leader in patient care,” said Page. “It means your center is providing the best care at a consistently high level and it fosters a sense of pride and accomplishment among your dispatchers.”

The process requires the submission of an application (available from the NAED web site) along with a detailed, self-study document based on the Academy’s Twenty Points of Accreditation. The Academy’s Accreditation Board will review the application and documentation and, from there, arrange an onsite evaluation. The accreditation is renewable every three years.

The Twenty Points are listed below:

1. Communication center overview and description
2. Medical Priority Dispatch System® (MPDS) version and licensing confirmation
3. Current Academy EMD certification of all personnel authorized to process emergency calls
4. All EMD certification courses conducted by Academy-certified instructors, and all case review conducted by Academy-certified ED-Qs
5. Full activity of quality improvement (QI) committee processes
6. NAED quality assurance and improvement methodology
7. Consistent case evaluation that meets or exceeds the Academy’s minimum performance expectations
8. Historical Baseline QA data from initial implementation of structured Academy QA processes (first QI summary report, if available)
9. Monthly average case evaluation compliance scores for the dispatch center for six months immediately preceding the accreditation application at or above accreditation levels
10. Verification of correct case evaluation and QI techniques, validated through independent Academy review
11. Implementation and/or maintenance of MPDS orientation and dispatch case feedback methodology for all field personnel
12. Verification of local policies and procedures for implementation and maintenance of EMD
13. Copies of all documents pertaining to your Continuing Dispatch Education (CDE) Program
14. Secondary Emergency Notification of Dispatch (SEND) orientation
15. Established local response assignments for each MPDS Determinant Code
16. Maintenance and modification processes for local response assignments to MPDS Determinant Codes
17. Documentation for the call center’s incidence (numbers) of all MPDS codes and levels
18. Appointment and appropriate involvement of the Medical Director to provide oversight of the center’s EMD activities
19. Agreement to share nonconfidential EMD data with the Academy and others for the improvement of the MPDS and the enhancement of EMD in general
20. Agreement to abide by the Academy’s Code of Ethics and the standards set forth for an Accredited Center of Excellence
The major challenge is making sure that the dispatchers understand why we are doing this, and why it’s important for them.”

—Captain Samantha Paul

for it to be successful. It has to be an integral part and woven throughout your standard operating procedures and the culture of your organization. It can’t be one person’s idea. It has to be part of the culture.

“You can’t focus on the numbers alone; if you focus on the numbers it will drive you crazy,” Stewart added. “You have to focus on the end result and the process and the people that are doing the work. It will come eventually, and I think the numbers aren’t going to be there until the support and the culture are there. That’s what took so long here at Central, I think, a big part of it anyway. You certainly have to have a champion for it. So keep pushing, and pushing, and pushing.”

“Throughout the ACE process it can be easy to get discouraged, but you can make it through like Central did with guidance and perseverance.

“Don’t forget about your dispatchers,” Paul said. “They will be the ones that actually get this done for you. Managers, supervisors, trainers, Qs, and the EMDs have to work together for the people that you serve. Use the NAED consultants to keep your direction true, and to give you moral support.”

Paul adds some direction for the people filling out their agency’s ACE paperwork.

“For the person that is hammering out the paperwork and guiding the process for your agency, don’t quit,” she said. “It’s easy to get lost in details and there are all kinds of bumps in the road. Don’t give up. It took years of perseverance through personnel changes, protocol changes, and rapid growth.”

Making their mark on the future

Central’s primary goal is to maintain the level it has achieved and stay accredited.

“The dispatchers and all of us throughout the whole organization have made a commitment to being accredited, doing the best that we can do, meeting those expectations and our goal now is to continue that—continue to be accredited and in three years be reaccredited,” Harrison said. “Not to lose what we’ve got. We worked really hard, everybody, to get to this point and our goal is to make sure we do everything we have to do to maintain that and stay at this level.”

Paul said Central is the first ACE in Arkansas and would like to help lead as an example of “Best Practices” in EMD for their state, as well as nationally and internationally.

“We want to be part of the EMS and public safety community that guides the direction of emergency dispatch centers for the future,” Paul said. “We want to be involved in helping to test, document, and recommend changes for our industry. We want our stakeholders to understand that we are in this to be great at what we do. We eventually want to look at expanded scopes of service.”

Accolades at Navigator.

Chief Becky Stewart; Johnna Jackson, EMD-Q; Asst. Chief Steve Harrison; Capt. Samantha Paul; Erin Holland, EMD.
The Aspirin Diagnostic.
Dispensers can direct some patients to take an aspirin

By Ben Rose

A new recommendation in the AHA 2005 Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care advises that dispatchers should direct certain patients with symptoms of acute coronary syndrome (which includes a range of heart problems) to take aspirin. In response to the recommendation, and considering some of the potential complications involved, the National Academies of Emergency Dispatch® (NAED®) called together its Medical Council of Standards to devise more specific dispatch recommendations to include in the Medical Priority Dispatch System® (MPDS®).

The NAED has now released the Aspirin Diagnostic and Instruction Tool to help dispatchers determine when to advise the administration of aspirin and when not to.

"This diagnostic tool leads into a new frontier in which we are actually practicing medicine at dispatch in terms of prescribing and administering medication," said Arthur Yancey, Deputy Director for EMS in Fulton County, Ga., and a associate Professor at the Emory University School of Medicine—and also a member of the NAED's Medical Council of Standards.

Priority Dispatch Corp. has incorporated the new diagnostic tool into both the MPDS cardset and ProQA®. In the cardset, the Aspirin Diagnostic pulls out from inside the sleeve for Protocol 10, Chest Pain. In ProQA, you can access the Aspirin Diagnostic by clicking on a button in the toolbar.

The NAED recommends using this life-saving tool whenever a patient reports chest pain or heart attack symptoms. Refer to the Additional Information on Protocol 10 for a list of heart attack symptoms. The Aspirin Diagnostic should also be used for chest pain patients identified on Protocol 19.

Typically, the calltaker will refer to the Aspirin Diagnostic immediately after dispatch on Protocol 10 or 19. The Aspirin Diagnostic begins with a series of diagnostic questions designed to find out whether the patient qualifies for aspirin, whether they have any aspirin, and if so, what type.

Patients do not qualify for aspirin if they are not alert, if they are under 16 years of age, if they are allergic or ever had a bad reaction to aspirin before, or if they currently suffer from any kind of internal bleeding.

Aspirin, or acetylsalicylic acid (ASA), helps improve blood flow to the heart in patients experiencing any acute coronary syndrome, including unstable angina and acute myocardial infarction (AMI)—or, in the caller's terms, chest pain and heart attack. Although aspirin does not act as a blood thinner like warfarin, it essentially "greases" the platelets, allowing blood to flow more freely. This can pose a danger to patients with internal bleeding problems such as bleeding ulcers. Taking aspirin is not recommended for such patients.

Experts in the NAED's Council of Standards and College of Fellows recognize that a few patients who qualify for aspirin based on the diagnostic tool may still experience adverse effects from aspirin administration. However, because of the high risk of patient death in AMI situations, the early administration of aspirin clearly benefits more patients than it may compromise. This is especially true where long response times can occur, such as in rural areas or areas with bad traffic.

Prior to using the Aspirin Diagnostic, each agency's medical control must weigh the risks and benefits of its use. Supervisory personnel must approve (in ProQA) and activate (in ProQA) the Aspirin Diagnostic before implementing it in the call center.
They’re something we’ve all been waiting for—at least, for the past several months since their imminent arrival was announced at the Navigator Conference.

We’re talking about the recommended procedures for handling calls concerning missing children put together by the Joint Steering Committee on Call Center Best Practices in Cases of Missing and Exploited Children. The committee was created through a Memorandum of Understanding (MOU) signed by the National Emergency Number Association (NENA), National Academies of Emergency Dispatch® (NAED®), the Association of Public-Safety Communications Officers (APCO), National Amber Alert, and the National Center for Missing and Exploited Children (NCMEC).

Guidelines create best practice for recovering missing child

The guidelines create the best practices for identifying and recovering a missing child, said Michelle Moore, administrative supervisor for the NCMEC 24-hour emergency call center and the point person for

By Audrey Fraizer
the new emergency center telephone procedures. That information is not unlike what is needed for any major case and should not place an unusual burden on call-taking staff, according to the call center protocol document. The guidelines assume the process of recovering the missing child begins when the calltaker takes the call; it is this first interaction with the public safety community that can define how subsequent responses will be organized and perceived.

The guidelines assume the process of recovering the missing child begins when the calltaker takes the call; it is this first interaction with the public safety community that can define how subsequent responses will be organized and perceived.

1. Obtain and verify incident location, callback, and contact information
2. Maintain control of the call
3. Communicate the ability to HELP the caller
4. Methodically and strategically obtain information through systematic inquiry to be captured in the agency’s intake format
5. Recognize the potential urgency of the missing child incident and immediately begin the proper notifications consistent with agency policy
6. Perform all information entries and disseminations, both initial and update

The intake checklist of suggested questions—the precise protocol like that found in the Medical, Police, and Fire Priority Dispatch System protocol—includes those for location, the type of emergency, time frames, and information to identify the suspect and the alleged victim. For example, the guidelines for determining the type of emergency are as follows:

- **WHAT IS THE EMERGENCY**
  - A certain exactly what happened
  - Any injuries?
  - Weapons involved?
- If reported as an Abduction continue on...
- If reported as Lost, Injured or otherwise missing go to page_____
  - If reported as a Runaway go to page_____

All cases of missing children must be entered into the National Crime Information Center (NCIC) and their names must remain in NCIC until they are recovered.

How to get your hands on the protocol

Each organization signing the MOU reviewed the guidelines and had the opportunity to revise them according to the needs of their organization. The generic guidelines—the initial set—will be posted to the NCMEC site later this year and the organization is working on training materials, with the help of the Steering Committee, to teach staff how to use the guidelines in their respective emergency communication centers.

In addition, NCMEC plans to prepare a one-page dispatch checklist based on the guidelines, similar to the first responder checklist now available from the organization. The checklist will be designed to post in any dispatch and emergency call center to provide immediate help to someone calling 9-1-1 in the case of a missing child.

Moore said the checklist will be available online and at public safety conferences attended by members represented by the joint steering committee.

Guidelines are part of a bigger picture

The telephone procedures are a big part of the plan the public safety consortium will use to bring more missing children home and keep more children safe. Ernie Allen, NCMEC president and chief executive officer, highlighted these four steps in particular at the Navigator Conference:

- Together we will put in place best practices to include minimum performance levels and performance measures for evaluating effectiveness
- We will improve awareness regarding missing and exploited children on the part of calltakers and dispatchers so they can make decisions and provide information to the public that can protect children
- We will develop and disseminate tools to improve the knowledge and skills of public safety communications staff to effectively respond to reports of missing and exploited children
- We will develop and deliver training for all levels of public safety communications staff to improve knowledge and ability to effectively respond to reports of missing and exploited children
NCMEC is designated national clearinghouse

NCMEC is designated by Congress to serve as the national clearinghouse for training and technical assistance. The organization’s emergency call center generally applies to law enforcement efforts. The center does not dispatch personnel to the scene but, rather, aids law enforcement in their search and recovery efforts. The guidelines, however, are something NCMEC wants implemented in 9-1-1 call centers throughout the United States. According to the statistics, almost 800,000 children are reported missing to law enforcement agencies each year and research has shown that children abducted and murdered live a very short period of time in most cases. The swift and accurate collection of information contributes to their recovery.

NCMEC and the other steering committee members are obviously not alone in their enthusiasm.

“Wherever we go and talk about this people have been excited,” said Moore. “It’s becoming a huge success. People want these guidelines.”
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
Who knows where a background in protocol and standardization can lead?

In the case of Carlynn Page, associate director of the National and International Academies of Emergency Dispatch® (NAED<sup>®</sup>, IAED<sup>®</sup>), the expertise took her to a rural Peruvian village to assist in the study of the village’s birthing methods in the hopes of developing safer prenatal and antenatal practices. “It was awesome,” said Page. “Not only was the area beautiful, but the people there stole our hearts.”

Page serves on the Board of Primary Cares, a nonprofit association founded in 2004 by Laura Caton, M D., a primary care physician based in Denver, Colo., to provide health care and health education programs to under-served populations.

Currently, her group of mostly volunteer health and business professionals is focusing on indigenous cultures in Southern Mexico and South America. Their projects, identified through the help of government and health ministries, include maternal and fetal health in Peru.

Tradition and isolation put women at risk. There are multiple issues Primary Cares addresses in the Peru initiative.

First, Peru has the second highest maternal death rate in South America, so Primary Cares decided to use their travel clinic program to help identify any possible problems before births and to prevent the deaths of the mother or infant.

They also want to set-up a preventive health program built on protocol. “That’s why we got Carlynn involved,” said Caton. “We want to develop protocol that gives easy and dependable access to preventive health care and treatment.”

The presumed need for intervention, however, brings up deeper issues, such as native resistance due to tradition and circumstance.

Home birthing with midwives transcends generations and, for women living in the remote and inaccessible regions of the Andes Mountains, it’s the choice that’s economically feasible and accessible. Health...
care is limited—a clinic can be one or more day's travel from home—and the majority of families cannot afford the cost of care—either the expense of going somewhere outside the village or paying for the help once they get there.

Just look at the statistics, said Caton. In the remote areas of Ayacucho, Primary Cares' intervention area, the poverty rate is 72.5 percent, and 45.4 percent of the population lives in extreme poverty. Families subsist on food grown on their land, and there isn't much money leftover for luxuries like health care provided in cities miles away from home.

Peruvian intervention helps

Peruvian programs over the past decade have resolved part of the problem. For example, waiting houses for pregnant women, the integration of modern and traditional birth methods in Western style clinics, and even the less popular sterilization campaigns have combined to reduce the maternal death rate from 265 per 100,000 live births in 1996 to 185 per 100,000 live births in 2000.

The interventions, however, far from crack the cultural resistance. Peruvians are aware of services available and, through globalization, the benefit of adopting at least some of the Western medical practices. That isn't enough, said Caton. Many women don't want to leave their villages to deliver a baby among strangers in unfamiliar settings. “Giving birth is a family affair. They're not with their mothers. They're not with their husbands. There's not a family feeling and they feel abandoned.”

Welcome primary cares

That’s where Primary Cares steps in. In May, Caton and Page were part of a team that spent 12 days traveling in Peru to begin plans for establishing prenatal and antenatal programs at the village level. In the long run they hope to raise enough funds from private donations and grants to purchase portable ultrasound devices for screening tests. They are also in the process of developing protocol-based instruction for midwives and other local health care professionals. The process takes time, said Page.

They raise funds, write grants, recruit teams, and put lots of energy into building relationships among the people they visit. They don’t tell them what to do or accuse them of bad medical practice. “We exchange ideas,” said Caton. “Through our research and talking to people we create programs that are accepted into the local practices. We suggest Western remedies that would enhance what they're already doing.”

Will Page repeat the thousands of miles traveled from home and through the winding Andes Mountains now that she's back in Salt Lake City, Utah, among Western conveniences like hot tap water, fast foods, and easy and instant access to technology? “Most certainly,” she said. “The volunteer work adds a terrific dimension to my life.”

“We exchange ideas. Through our research and talking to people we create programs that are accepted into the local practices.”

—Laura Caton
Rebecca Kiel may be one in a million, yet it’s a distinction that she’d rather not talk about or, at least, not have broadcasted outside of her own PSAP console.

“She is very shy, which is probably the reason she thrives in the dispatch environment,” said her supervisor Michael Eckler, EMD instructor and EMD-Q® for the Elgin (Ill.) Police Department. “She doesn’t feel judged from where she sits.”

Kiel is the EMD compliance star. In the seven years since Elgin started using the Medical Priority Dispatch System® (MPDS®), she has received perfect scores on all her quality assurance reviews. “She’s an inspiration to others,” said Eckler.

The over-the-top rating, however, was not something Kiel anticipated when the Elgin Police Department decided to put the MPDS into practice. Every dispatcher was required to take the three-day EMD course. Certification was the prerequisite for using the new protocol. “Becki was worried,” said Eckler. “She had been in dispatch for two years, and loved it.”

Didn’t know what to expect
Before sitting for the course and exam, Kiel was anxious about elements that might work against her ultimate success. “I was one of the first to take the course [from the center in Elgin] and I really didn’t know what to expect,” she said. “I just thought I wouldn’t be able to do it right.”

Contrary to her personal doubts, Eckler said he knew she would make it. “She underestimates herself,” said Eckler. But just to make sure of her success, Eckler tutored Kiel for two nights after the EMD class (the test is given on the third day). Apparently, his help bolstered her confidence. “I can’t remember her exact score, but I think it was well above 90 percent. She was proud of that,” he said.

Keeps focused on the task
Kiel takes the same sort of determination daily to her job. She follows MPDS protocol to the letter, regardless of the emergent situation or the person on the other end of the phone. A recording of her recent calls provided to the Academy presents calm-voiced Kiel gathering patient information using the protocol exactly as it is written. “She does the protocol the way it’s supposed to be done, every time and without fail,” said Eckler.

There’s no reason to change, or improvise, a response, Kiel explained. “By following the protocol, I have nothing to worry about. It’s proven to work the way it is.”

The attention to detail also helps her in handling even the toughest customer, like the callers who don’t want to go through the Key Questions or who expect the EMTs to show up the second they make the 9-1-1 connection. Kiel said it’s only human nature for the caller to react in anger, impatience, or fear given the emergency situation. “They’re not upset with me, and I have to remember that. It’s nothing personal,” she said.

Takes work to heart
Kiel, however, does take her job very personally since her response can make a huge difference in somebody’s life. “I can talk them through the emergency and calm them down until the paramedics arrive,” she said. “Giving that help is important to me.”

The Facts.
Elgin’s Emergency Communication Center

The center dispatches police, fire, and emergency medical services in response to the needs of the public for emergency and nonemergency situations and handles after-hours call activity for various city departments, such as emergency call-outs for public works.

- Number of employees: 16 full time, 4 part time, and 4 supervisors
- Average length of service: 8 1/2 years
- Telephone calls handled per day:
  - 900 incoming calls
    - 9-1-1 and other lines combined
  - 230 outgoing calls
- Fire events handled per day: 30
- Police events handled per day: 250
- Radio transmissions per day: 6,000

Source: http://www.cityofelgin.org/index.asp?NID=634

For more information
The Call That Lingers.
Veteran dispatcher takes call that stays with her

Call: 5:56 a.m. on April 27, 2007—“My baby’s not breathing.”

And it went down hill from there. My CAD and ProQA® were down, and the mother was very hard to understand because her 16 month old was not breathing. I went into whatever mode it is that dispatchers go into when they know things are not going well. I grabbed my cards and we started CPR. Mom did a really good job but there was no helping her little girl. Firefighters arrived and continued CPR while taking the child outside to meet the ambulance. The ambulance crew and two firefighters transported her to a local hospital where they pronounced her dead.

I can only imagine what a nightmare this ordeal was for the family, and my heart aches for all of them. After 18 years of dispatching, I have to say this is one of the most devastating calls I have ever handled. However, being able to give the mother instructions, prior to arrival of the firefighters, was rewarding. Someday, I hope the mom can look back and know she did everything she could to help her little girl.

Dispatchers say there’s a call that gets to them. The call doesn’t have to involve an extraordinary event like the September 11, 2001, attack on the World Trade Center, or an exceptionally personal event such as an accident that coincidentally happens to someone the dispatcher knows. The call that does it can almost seem routine, despite the crisis generally associated with 9-1-1 contacts. After all, that’s the nature of the business.

Jill O’Brien, a veteran dispatcher for the Arvada Fire Protection District, a metropolitan area of Denver, Colo. Her letter to The Journal of Emergency Dispatch tells about her experience; the call that turned into the most “devastating” one she had ever had in her years of dispatching emergency services.

“This call doesn’t effect me the way this one did, and I honestly don’t know why it stayed with me,” said O’Brien. “It just has. What we tried to do didn’t work for her, and maybe that’s what bothers me.”

As O’Brien describes in the letter, the 16-month-old child had stopped breathing and the mother’s repeated CPR attempts, guided by O’Brien’s over-the-phone instructions, did not revive her. “The mother tried desperately but we couldn’t get her to breathe,” said O’Brien. The little girl paramedics transported to the local hospital was pronounced dead later that same morning.

A part of the story not reported in the letter was the little girl’s previous visit to the emergency room the night before. She had experienced a seizure [later attributed to high temperatures caused by an infection] and, since doctors could find nothing obviously wrong, the family was sent home. A later autopsy revealed the congenital absence of a spleen, an organ that fights infection. Although other organs, such as the liver, can take over some of the spleen’s work, and people do survive without a spleen, the child’s compromised immune system could not combat the illness that foreshadowed her death. The call for emergency assistance came the next morning when the mother discovered her child unconscious.

When situations like this occur, O’Brien turns to her most valuable resource—co-dispatcher Judy Schneider.

“We talk things out. She’s been in the business for 19 years so we share a long history,” said O’Brien. “We know that we can’t always fix lives over the phone. We accept there are some things we can’t change.”

Since dedication to their jobs makes leaving out of the question, they find that it helps to discuss the positive elements of their job, such as the good outcomes and the opportunity to provide a public service.

The Journal of Emergency Dispatch

September/October 2007

51
An Idea Borne Of Experience. Medical Protocol entering third decade

By Audrey Fraizer

The cover illustration of the February 1981 issue of JEMS shows a novel concept, at least for state-of-the-art emergency dispatch systems 26 years ago. The dispatcher in the picture is talking on the phone—presumably on an emergency call—as she refers to a set of cards in front of her on the console. The cards are arranged in a flip-up index much like the original Rolodex invented in 1958 but without the rotation.

“I played with several types of designs before deciding on the flip index,” said Jeff J. Clawson, M.D., creator of the emergency protocol system featured on the cover and in an article credited with being the first published about the Priority Dispatch System.

And, similar to the fate of the Rolodex, it’s a style that over the years is going the way of computer applications that perform the same function more efficiently and—in the long run—at less expense.

This article, however, isn’t about current applications or even what to anticipate with protocol in the communications centers of the future. Sure, dispatchers can expect changes in the delivery of protocol, especially when applied in combination with cellular and voice activated technologies, but, again, this article isn’t about that.

This article is about the history of protocol and one of many “blasts from the past” we plan to run in subsequent issues. Future articles will highlight the creation of the National Academies of Emergency Dispatch® (NAED®) and International Academies of Emergency Dispatch® (IAED®) and the evolution of the medical, police, and fire Priority Dispatch Systems, as well as the people involved in creating and using the protocol. We would also like to publish your stories about creating and what it has meant to you. For more information, contact Audrey Fraizer, at Audrey.fraizer@emergencydispatch.org. Her phone number is 1-800-960-6236, ext. 147.

The first story in the August/September 2007 issue of The Journal steps back to when protocol was as revolutionary as the TTY program that was “picking up fast” around the country, according to another, briefer article in the same 1981 issue of JEMS.

Amazing, what a couple of decades can bring.

The straw that built the haystack

Clawson wrote the article in JEMS several years after he had created his system of protocol. Up until that time, he and others in the emergency medical services (EMS) profession considered dispatchers the weakest link in the EM S-response chain.

“They had no medical instruction and they were treated like a clerk,” explained Clawson. “They'd step into the job without any training or expectations. A lot of times, the job was given to someone working in the police or fire departments and looked at as some sort of punishment.”

Clawson knew what he was up against, but it went deeper than providing medical training for emergency dispatchers. He wanted to change their image, to let the public know their work involved more than simply answering the phone. “Every time the phone rings it’s the equivalent of somebody in a crisis. It’s stressful work and it takes a certain type of personality,” he explained. In addition, Clawson believed that something was needed to modify the way dispatchers responded to 9-1-1 calls.

“We lacked efficiency and standards,” he said.

Protocol was the answer

Clawson designed a set of protocols that would standardize the way dispatchers communicated with callers and, in turn, improve the emergency response system.

The system’s growth over the years only emphasizes the reason Clawson created the protocol-based training system.

Experience sparks an idea

For five years prior to graduation from medical school, Dr. Clawson had worked as a certified emergency medical technician (EMT) and erstwhile dispatcher for Gold Cross Ambulance Service, an emergency medical transport company operating in Utah since 1968. The years at the ambulance company confirmed his notion that the use of lights-and-siren runs was not always the most appropriate response. Not only did the lights-and-siren runs increase wear and tear on vehicles, but the runs also were dangerous to the public. Gold Cross policy restricted lights-and-siren runs to cases when the response time made a difference and, according to Clawson, the policy made a significant difference: 50 percent of the runs could be handled appropriately without lights-and-siren.

“Think about the last time you responded red-light-and-siren on that possible appendicitis (saving one minute and 25 seconds)—only to have the patient, subject to regular Emergency Room routine, undergo surgery more than three hours later,” he writes in the article. “Was that 1 1/2 minute you saved significant? I don’t think so. But this and thousands of similarly needless red-light-and-siren responses occur daily in this country. What can be done about it?”

What could be done to standardize response like Gold Cross was doing by policy but at the onset—from the moment the call comes into the communication center?

The original set of protocols published in 1978 contained 29 sets of two 8-inch-by-5-inch cards. Each caller complaint was listed in alphabetical order, as they are today, and reflected either a symptom (e.g., abdominal pain, burns, cardiac/respiratory arrest) or an incident (e.g., electrocutions, drowning, or traffic injury accident). The core card contained three color-coded areas: Key Questions, Pre-Arrival Instructions, and...
dispatch priorities, and they were distributed on for the good of dispatch. "We gave away the cards just so they [the public safety agencies] would do something about their dispatch," Clawson said. The doctor believed in the protocol system, and he wanted others to share in the success of a well-coordinated response team that included dispatchers as the "first, first responders"—a phrase he coined in 1981 for the first national meeting that included emergency medical dispatch.

The system wasn't an easy sell.

Communications centers were set in their ways and some considered the protocol controversial because of the authority protocol handed to the dispatcher. "We couldn't give it away with a $100 bill glued to it," Clawson said. "Dispatchers aren't seen as medical personnel, and we had to convince the emergency community that what they do is medical in every sense of the word. They just do it in 60 seconds."

Prove it, he did.

Training worked hand-in-hand

The manual protocol system—dispatch cards—became the core of a 25-hour training course used to educate and certify dispatchers as Emergency Medical Dispatchers (EMDs); the 25th hour was for taking the final examination. The first courses, taught in Utah, basically followed what happens now in the classroom. NAED-certified instructors teach the trainee how to coordinate and prioritize the dispatch process and actions. Students practiced calls using the card system and listened to tape recordings of actual emergency calls. The final exam—then 25 questions—was given on the last day. Those passing became certified EMDs.

The system takes off

In 1981, about 100 public safety and private agency dispatchers (all in Utah) had been trained and certified as EMDs using what was to become known as the Medical Priority Dispatch System® (MPDS®). Clawson called use of the system "far reaching," a claim that holds today as the number of public safety agencies has grown to more than 3,000 centers and in 23 countries worldwide; the electronic and hard copy cardset reaches communication centers in each state and province and many centers outside of the United States and Canada. The medical protocol has gone through 18 revisions to reflect advances in medicine, such as the addition of compressions first cardiopulmonary resuscitation (CPR), and it shares the stage with protocol designed for police and fire dispatch centers. The NAED, established in 1988, has more than 35,000 members and the IAED oversees the use of protocol in nearly two dozen countries, including Great Britain, Ireland, Germany, Italy, Azerbaijan, New Zealand, and Australia. In July 2007, the IAED opened a major office in Bristol, England, to serve the communication centers and trusts using the MPDS, according to the National Enterprise Maintenance Agreement (NEMA) between the National Health Service and the NAED.

The system's growth over the years only emphasizes the reason Clawson created the protocol-based training system: it saves paramedic teams for true advanced life support emergencies. The system also provides a plus around the communication center that Clawson finds particularly gratifying. "Emergency dispatchers are a respected part of the emergency response team," he said. "They are the first of the first responders, an important first link in the chain of emergency medical care. They are the helping hands when you need it the most—now!"

Source: Jim Page’s "EMD in the Fire Service: Born of Necessity"
Alan Brunacini is somewhat of a pioneer in the dispatch field and, as he himself admits, almost purely by accident.

A little more than 30 years ago, in 1974 to be exact, the former fire chief of the Phoenix Fire Department (PFD), and at that time assistant fire chief, happened to walk into the department’s dispatch center as paramedic Bill Toon was giving unplanned and uns scripted pre-arrival instructions to the mother of a child found nearly drowned. The baby survived and, apparently, Brunacini liked the instructions so much that he told the dispatch center to routinely offer prearrival instructions as part of training their recruits, according to a historical perspective about the incident published 20 years later. “Watching Toon I said this is something that we should be doing,” said Brunacini, who retired from the PFD last year after 48 years of service. “You just said, ‘hey, this works so let’s do it.’”

This program became known as “medical self help 00” and it used no formal dispatch protocols or scripts, at least as we know them today. Brunacini had the paramedics, who did double duty as dispatchers at the time, develop routines for answering emergency service calls. “They wrote objectives and the dynamics of how to help people remotely,” said Brunacini. “I wanted them written in a language that people would understand. Nothing academic. It was very simple.”

What about Brunacini and Toon?

Over the years, Brunacini, incorporated all sorts of the emergency service codes into the communications center, and he included a dispatch training station at the department’s former Command Training Center (CTC). Toon retired in 2006, after spending 35 years in paramedics and dispatch and helping to save what Brunacini estimates at thousands of lives. “He was a terrific character,” said Brunacini, who we caught up with at the Fire Departments Instructors Conference (FDIC) held recently in Indiana. “Toon loved his work.”
Two weeks that will change your life...

...without spending a fortune on books.

The Communications Center Manager Course

"The CCM course gave me the opportunity to be with like-minded, motivated individuals and have a curriculum that would challenge me to think 'out of the box.' I've made lifelong friends and now have a network of colleagues—from big centers to small, private to public, national to international. Bottom line: If you want to make a big difference in your communications center and stretch yourself personally and intellectually, this course is for you."

— Tom Somers, Los Angeles City Fire Department

Now accepting applications for the 2007-2008 course to be held in Kansas City, MO. Online applications begin October 14, 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.
Join us April 23-25, 2008 for the Navigator conference in Baltimore, Maryland.