**About the Advanced MPDS Protocols...**

**Avoiding Response Code Confusion**

*Jeff J. Clawson, MD*

Occasionally the Academy will receive a request asking for clarification of how to utilize the Advanced MPDS response code system; or more specifically, how to properly assign system resources to the MPDS subdeterminant codes. Typically, an agency may request to change or delete codes and/or text in the Determinant section of the protocol cards in an effort to match them to local field responses. This article will utilize a series of actual protocol card graphics to more visually address this process and its correct implementation.

Some frustration often results with EMDs confusing the MPDS Determinant codes with local unit response assignments. Understanding the difference is vital in the everyday work of an Academy-certified EMD. Each dispatch Determinant code is just that—a code. It has no response value as such. In essence, these codes are the dispatch equivalent to a type of medical coding system called DRGs (diagnosis-related groups) used by most hospitals and clinics to bill patients. While DRGs are universal (like the MPDS codes worldwide) the specific amount billed for each code by one hospital may differ from that billed by another (just like different agencies may respond differently to the same dispatch code). It is not necessary to change or move the determinant codes in either case, as they only represent the medical classification determined by the system, and not a response per se.

In the case of the MPDS protocols, each locality’s responses are always selected by the user agency, approved by the agency’s medical director, and then written into the “Responses-Modes” area located to the right of the subdeterminant numerals printed near the center of the protocol card. Please note that it is not necessary to assign the same response (continued on page 5).

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From the field...

**MPDS Q&A**

**Don’t ‘Surf’ the MPDS...**

*Bill Kinch, EMT-P, EMD Instructor*

During my travels as an EMD instructor and consultant, it’s always a pleasure when I witness an EMD call “done right.” There’s a certain thrill in seeing a newly trained EMD follow the MPDS protocol confidently and precisely all the way through key questions, coding, and then post-dispatch instructions. Unfortunately, this experience doesn’t happen often enough.

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I’ve recently noticed how some EMDs incorrectly “surf” their way around the MPDS, catching whatever “wave of questioning” suits their fancy at the time. By so doing they unnecessarily confuse themselves on a regular basis, often assigning the wrong chief complaint code at the outset. I’ve seen EMDs flip back and forth between chief complaints. Upon getting a positive response to a key question, they flip to that card and begin to ask those key questions. For example, if a call comes in for a traffic accident and the EMD asks the question “What kind of injuries does she/he have?” The caller might say, “I don’t think I’m injured badly but I have a headache,” it is not appropriate for the EMD to then go to Card 18 (the headache card); rather, they should stay on Card 29 and set the appropriate dispatch determinant from there. (continued on page 2)
From the President’s Desk...

The Academy and The Alliance...

• Alexander Kuehl, MD, MPH, FACS

I had the recent opportunity to represent the Academy at the National EMS Alliance meeting in Naples, Florida. At this meeting several national sponsors (including your Academy), as well as individual members, forged the last link in building an organization designed to bring EMS consensus positions to closure.

Positions on the need for standard definitions of emergency patients and in the need for the Chain of Survival are close to being adopted. A final version of the Academy’s Position Paper on dispatch and managed care that was developed at the Navigator ‘96 Leader Summit will be presented to the Alliance for approval prior to the next meeting at Lake Tahoe this July.

Throughout our association with other EMS industry organizations such as the Alliance, we will continue to promote the Academy, and your individual Academy EMD Certification, as the standard marker for EMD. These associations should go a long way in further professionalizing EMD as an integral component of EMS prehospital care.

Those Academy members who are also associated with other EMS Alliance member organizations such as NENA, NAEMT, NAEMS, IAFC, and the Red Cross, should join with us to try and elicit uniform support of EMS Alliance consensus positions, including the Academy’s paper on dispatch and managed care. Interested parties can call the Academy for more information about the Alliance and to obtain copies of relevant papers, including the final version of the dispatch and managed care paper. ■

(For more information about the National EMS Alliance, please call either Barbara Sanders or Lisa Lindsay at (601) 924-3235. Individual memberships are $50.)

Don’t ‘Surf’ the MPDS

(continued from page 1)

There are only two times when an EMD should “shunt” or “go to” a different chief complaint card. First, when directed to do so by a printed shunt arrow in the “go to” column; and second, whenever it becomes clear that, without much question, you realize that the wrong chief complaint was selected in the first place due to caller confusion and/or clarification of the situation during subsequent questioning. Most protocol cards “handle” the identification of priority symptoms within the coding structure of that card (see “not alert” on Card #26).

The only exception to this rule is on Card 32 (Unknown Problem) and during interrogation before a chief complaint is identified. There are no-specific chief complaints that require a ‘shunt’ or the EMD might be advised in the MPDS to ‘go to’ a different card for a more specific chief complaint. For example, the suicide card (25) shunts to the specific method of suicide (i.e., carbon monoxide poisoning, #8) in some situations.

Remember, the MPDS is designed to identify life threats and prioritize calls through appropriate and full key questioning. This process never changes no matter the chief complaint. The Case Entry protocol (See past article “Where do I go from here?”), has its own necessary questions, dispatch prompts, with subsequent “bridge” statements and PDIs/PAs as appropriate. If there is no identified life threat found during case entry, the EMD process attempts to identify “priority symptoms” depending on the chief complaint, or incidents (such as suicide attempt) when a more specific method of injury may be identified.

Generally speaking, the EMD should stay with the initial chief complaint identified through consistent use of the valuable identifier, “What’s the problem? Tell me exactly what happened.” A consistent protocol selection process allows for appropriate safety and patient treatment issues. To needlessly surf the MPDS is not only frustrating it may be dangerous. Feel free to surf the internet, but please, not the MPDS! ■

Mr. Bill Kinch is a certified EMD Instructor and a Senior National Faculty member for the Academy. Bill now resides in Salt Lake City, Utah, on those rare occasions when he’s not traveling on the EMS or EMD teaching, speaking, or consulting circuits. He can be reached through the Academy or if you find yourself surfing, try: pmedic1041@aol.com.

Stay with the initial chief complaint identified...

A consistent protocol selection process allows for appropriate safety and patient treatment issues
New to the College of Fellows...

Introducing...

We are pleased to welcome the following EMS and EMD experts from around the world into the Academy's College of Fellows.

• Norm M. Dinerman, MD, FACEP
  Dr. Dinerman is currently the Chief of the Emergency Medicine Service at Eastern Maine Medical Center, Bangor, Maine. He has just completed a four-year term as Medical Director for the State of Maine, EMS. An honors graduate of Columbia University and the Yale School of Medicine, he is an accomplished educator, public speaker, and the author or numerous EMS papers and studies. He serves on the editorial review boards of JEMS and Annals of Emergency Medicine.

• Clemens Kill, MD (GERMANY)
  Dr. Kill first got in contact with EMS as an EMT, then as a Paramedic, trained EMD, and going on to work as a Paramedic instructor. He attended Medical School at the University of Marburg and today is a physician at Marburg Emergency Medical Physician Service and Marburg Intensive Care Medicine Transport System. The President of R.U.N. (Rettungswesen und Notfallmedizin), he's been involved in translating and adopting the MPDS in Germany since 1993.

• Gianluca Ghiselli, MD (ITALY)
  Dr. Ghiselli is Chair of the Italian Cultural Sub-Committee of the Academy, having been involved in the Italian translation of the MPDS since early 1993. After graduating from medical school at the University of Pisa in 1989, he completed his residency Magna cum Laude. For the past two years he's been involved with the Alabama University School of Medicine in the American Heart Association's BLS, ACLS, and PALS course development for Italy. A certified Academy EMD Instructor, Dr. Ghiselli personally trained and tested the first 131 Italian EMDs and is the foremost authority on EMD and MPDS implementation in Italy.

• Marie Leroux, R.N. (QUÉBEC, CANADA)
  A supervisor-instructor in the Communications Centre of Montreal's EMS system, Marie Leroux has been involved in Emergency Medical Dispatch since 1985, consecutively as a nurse call-taker, team leader, dispatch supervisor and as one of Montreal's project managers for the MPDS implementation in 1991. Marie keeps in touch with nursing through the local community services centre, via a health information line system.

• Thera Bradshaw
  The Director of Emergency Services for Clark County in Vancouver, Washington—the Academy’s Fourth Accredited Center of Excellence—Thera’s worked in EMS for 24 years and is the 94-95 past-president of NENA. She is a member of APCO’s 9-1-1 Committee, Project 31, and Chair of Project 33—establishing minimum training standards for 9-1-1 dispatchers.

• Steven A. Forry, NREMT-P
  Steve is an EMS Specialist for the Emergency Services Consulting Grp., a division of Glatenbetter Insurance Grp. (GIG), located in York, Pennsylvania. He has over 25 years’ experience in prehospital patient care and transportation. He is a nationally registered Paramedic, ACLS and BTLS instr., and an award-winning speaker/trainer for insurance industry, EMS organizations, and hospitals. Steve is co-author and master trainer for the Emergency Vehicle Driver Training Program published by GIG. He is a strong proponent of EMD and the use of priority dispatch for assigning the right personnel, the right equipment, and the correct response mode for patients’ needs.

• Fred Thorpe, MPA
  A public safety consultant and past Director of EMS for the Kansas City, Kansas Fire Dept., Fred is nationally known for his invigorating articles on all aspects of EMS and now writes a monthly article for Responder magazine. He was first certified as a paramedic in 1974 and graduated with honors for both a Bachelor's degree in Public Administration and a Master's degree in Public Affairs. Fred was a charter member of the Executive Dev. EDIII and Fire Service Mgt. of EMS at the National Fire Academy, where he also completed Executive Information Planning training in 1994. Fred is an adjunct faculty member at Park College, Parkville, Missouri.

• R. Gene Moffitt
  Mr. Gene Moffitt is Founder, President, and CEO of Gold Cross Ambulance in Salt Lake City, Utah. The immediate Past-President of the American Ambulance Association, Mr. Moffitt has been involved in EMS and in the ambulance industry for nearly 30 years, having served as past Vice-President, Region Director, and Secretary for the AAA. He first certified as an EMT in 1969.
Two more dispatch centers were recently awarded Accreditation as a "Center of Excellence" by the Academy. This is the highest honor the Academy can bestow to an agency and requires implementation of a full quality improvement program and consistent compliance to the MPDS protocol. The center must also undergo a site evaluation and fully document its dispatch training and operations in accordance with the Academy's "20 Points of Accreditation."

The San Ramon Valley Fire Protection District in Danville, Contra Costa County, California became the 7th Accredited Center of Excellence (ACE) on September 25, 1996. Nancy Justin is the District's EMS Quality Improvement Coordinator and was largely responsible for providing the necessary documentation for the award. "A lot of work and a lot of training of our dispatchers went into it," said Valley Fire Chief Bill Dutcher, "The certification wasn't our goal. It was the result of our initiating this program and maintaining a very high level of service to the community." The center processes between 10,000 and 20 EMS calls a day, which it processes through a high-tech Computer-Aided Dispatch system (CAD).

The City of Memphis Fire Department became the 6th ACE on October 3, 1996. Dr. Clawson and Bill Kinch presented the award at a press conference held at Fire Headquarters. Under the direction of Raymond Chiozza, Manager of Fire Communications, the Memphis Fire Communications Bureau worked hard and diligently to achieve this accomplishment. Memphis processes 70,000 EMS calls annually. The EMDs use manual MPDS "flip-cards" and calls are reviewed manually by the Quality Improvement staff: Paul Harkins, Steve Fort, Vicki Logan, and Wardell Seals, Jr. — who are each to be commended for their efforts.

Memphis also introduced a "Lives Saved" board and issues awards to those EMDs credited with aiding in saving a life. One EMD, Renee Mathis, helped save two lives with obstructed airway PALS. The calls came in just minutes apart. The Fire Communications Bureau's dedication stems from their mission statement: "Teamwork with commitment to excellence, compassion and immediate community protection."
Avoiding Response Code Confusion

(continued from page 1)

to all subdeterminant codes within a single level or tier (ALPHA, BRAVO, etc.). Even though the dispatch codes are grouped into one of the four levels (tiers) because of their medical relationship to one another, it is not necessary to adhere to this grouping concept locally by assigning the same response to all subcodes within a given level.

For example, if an agency wants to assign a response group to the "Any snake" subdeterminant (3-D-5) that is different from the one assigned to the other five remaining DELTA subdeterminant codes they should not put a sticker over it and then retype it into another level. Figure One (below) illustrates the correct process for achieving what is desired.

The Academy recommends initially assigning what we call "default responses" to the four generic levels – ALPHA, BRAVO, CHARLIE, and DELTA – as starting points. These represent a conservative response to a given Determinant level regardless of the chief complaint or subdeterminant problem ultimately identified. With the default response in mind, each protocol should then be carefully reviewed by local medical control, with special attention given to any subdeterminant group whose optimal response type, from the agency’s perspective, doesn’t exactly fit the default for that level. Such special resource assignments are the exceptions to the defaults. It is wise to document the rationale for why any exception to the default response was preferred for potential medical/legal support should that be necessary in the future. This would then become the agency’s own defined standard of practice.

Each agency, therefore, may user-define specific responses for any one of the 250 separate subdeterminant codes that are listed throughout the Advanced MPDS. Theoretically, it is conceivable for an agency to have up to 250 different response types in a single protocol, although the average actual user appears to only use around three. For example, the CHARLIE-level on Protocol #10 – Chest Pain could appear as shown in Figure Two (below).

Some confusion may also arise if an EMS agency uses the same names for their response group that are used within the protocol for its codes – e.g., ALPHA, BRAVO, CHARLIE, and DELTA. Such practice renders exceptional assignment of codes to responses extremely confusing (i.e., "send a BRAVO response for an ALPHA code problem"). By referring to your three or four unit response groups with terms that differ from the words used for the codes, such as numerals, proper names, or even the last few letters of the alphabet (X,Y,Z), such confusion can be minimized. See Figure Three (below) for an example of how this might work.

With the default response in mind, each protocol should then be carefully reviewed by local medical control.

In accordance with the Academy’s scientific process, individual users are not to make changes to, or deletions from, the printed text on the cards. Such revisions are only implemented through the Academy’s College of Fellows and may be requested, following appropriate research, by an experienced user submitting a formal "Proposal for Change" form (below) to the Academy as outlined in the Appendix of every EMD Course Manual.

<table>
<thead>
<tr>
<th>Proposal for Change From</th>
<th>Proposal for Change To</th>
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<tbody>
<tr>
<td>XRAY COLD ALPHALX</td>
<td>RAY COLD ALPHALX</td>
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<th>EXAMPLE</th>
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| The Revised EMDCQ of Fellows will review the attached proposal for change and a 75% or greater approval from a quorum must be achieved to amend a protocol. If adopted, the proposed change may be modified slightly to maintain internal consistency with the protocol language and documentation of the AEMPD protocols. You will be notified of this change along with the Fellows’ final decision. |

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Upcoming Courses

For more information on these and other approved EMD Certification Courses call Medical Priority: (800) 363-9127:

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Marlboro County 911

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East Region EMS & Trauma Council

Apr. 2-4 Silsbee, TX
Trans Star EMS/EMS Educators

Apr. 3-5 No. Camton, OH
City of Green Fire Dept

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Lowcountry Regional EMS Council

Apr. 9-11 Dorchester, MD
Memorial Hospital EMS

Apr. 9-11 Oklahoma City, OK
Mercy Emergency Medical Services

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Lifeskill Risk & Risk Intl Ltd.

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Allegan County Central Dispatch

Apr. 14-16 Millersville, MD
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Apr. 14-16 Swift Current, SK, CANADA
Cypress Hills Regional College

Apr. 14-16 Spartanburg, SC
Spartanburg 9-1-1

Apr. 16-18 Yellowstone Nat’l Pk, WY
National Park Service

Apr. 21-23 Huntsville, AL
Univ. of AL, EMS Education

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Barberton Police Dept

Apr. 23-25 Cambridge, MA
Cambridge Emergency Comm.

Apr. 24-26 Jackson, MS
AMR South (Jackson)

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Brunswick County EMS/911

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AVC Prehospital Care Program

Apr. 25-27 Springfield, MO
St. John’s EMS

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Mercy Ambulance Service

Apr. 28-30 Lake Worth, FL
Palm Beach Community College

Footnotes:
The following organizations offer training & services of interest to Academy EMDs.

University of Iowa—EMS Learning Resource Center
Mike Hartley (319) 356-2597.

U. of Alabama-Huntsville
Sheila George or Rick Beck (205) 551-4413.

U. of South Alabama
Phyllis Vinson (334) 639-1070

Rogers Univ., Tulsa, OK
Judy Dyke (918) 343-7641.

Columbus State Comm. College (Ohio & region)
Art Ghiloni (614) 226-2400.

Palm Beach Community College (Florida & region)
Barry Duff (407) 439-8213.

Nashville College (Tenn., NC)
Bryan Berti (615) 641-7999 x312.

Phoenix College (Arizona)
Dr. R. M. Lewis 602-285-7207.

N.H. Bureau of Emer. Com.
Bruce Cheney (603) 271-6911.

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