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Random can be exact

Audrey Fraizer

WHAT 3 WORDS

W

hat three words come to mind when relaying where you are?

Chances are if you gave the three words you selected to an emergency dispatcher, you’d remain in the same place.

What if they’re not your three words? What if the three words are seemingly random and never change from the place they originated?

The emergency dispatcher enters the three words, directing crews to locate you even if there’s nothing there for you to describe.

Introducing “what3words,” the brainchild of musician Chris Sheldrick who was tired of his band ending up at the wrong wedding because of bad directions. He devised a system that covers the whole world with three-meter squares and, based on an algorithm incorporating GPS coordinates, assigns a three-word sequence to each square. The system has gone worldwide.

Trevor Baldwin, Head of Service Department, Yorkshire Ambulance Service (YAS) NHS Trust, Emergency Operation Centre (U.K.), embedded what3words into the YAS CAD system. It works in a few ways:

• A caller can find the current three-word address on the what3words app, and the three-word address is used by the control center to identify the precise location for response.

• Emergency dispatchers on the phone with someone who can’t describe their location can send the caller a text with a link to the what3words map to discover their three-word address. This can then be used by control to find out exactly where they are.

• If emergency dispatchers need to provide a location of an incident to someone else within the service, they can click on the map to bring up the associated three-word location to use this as a more precise identifier that can be easily shared.

Responders can leave their vehicles and use the what3words app on their smartphones to navigate to the specific three-word location given to them by emergency dispatch through a text message, which is particularly helpful in rural areas, at crowded outdoor events, and for multi-trail parks.

The system went live in July 2019, and Baldwin is already thinking of the many ways it can be applied to emergency medical services, fire, and police and ways to increase public awareness.

“The more people get to know about it, the easier it is for us to find them,” Baldwin said. “It’s that simple.”

Go to what3words.com/emergencyservices for more information.
Brett:

I am currently seeking advice about the bleeding control panel. Yes, this boils down to a debate I am having with an ED-Q, and they have supplied me the article from 2012 where you are the author (Seeing Red, Journal, July/August 2012).

The ED-Q is adamant that the only time EMDs utilize the Control Bleeding Panel is when the bleeding is serious.

My counterpoint is that the bleeding control is when possible and appropriate and not only for SERIOUS Bleeding. The usage of the bleeding control panel can be effectively used to control (let’s call it) “moderate” bleeding and gives the caller actions to help stem the moderate bleeding, which can decrease the anxiety in the caller and/or patient.

As an EMD instructor I have never seen anything in the teaching material, which indicates the panel to be only used for SERIOUS Bleeding notwithstanding considerations of other injuries as Axiom 2 of Protocol 21 indicates.

I am not seeking, and never would seek, an answer from you or the Academy that indicates “ED-Q is right and you’re wrong,” but in the context of the attached article and in the context of doing the “right thing for our patients,” I’m just after some further guidance.

Thanks very much for your time. I look forward to your advice.

Cheers,
Guy A. Law
Communications Quality
Support Officer — QAS State
Communications Development/
Quality Assurance Unit
State LASN Operations
Office of the Deputy Commissioner
Queensland Ambulance Service
Department of Health
Brisbane, Queensland, Australia

Guy:

I am hesitant here because your question seems to be seeking a black-or-white answer, yet I think the answer is fluid.

There is no law or standard, that I am aware of, that mandates bleeding instructions for MINOR bleeding. As a clinician (and EMDs are clinicians), we need to consider the entire set of circumstances from the emotional needs of the caller, to the complexity of the scene, to the clinical needs of the patient.

I remember listening to an audio during my QA days long ago where an elderly lady found her husband of decades lying face down in an empty bathtub in cardiac arrest. He was a candidate for CPR but there was no way she could turn him over, much less get him out of the tub. The caller was very distraught, and simply hanging up the phone was out of the question. Anyway, with all other efforts exhausted, the EMD asked her if the patient was bleeding at all with the simple hope that some direct pressure instructions would keep her busy and feeling helpful rather than hopeless. I thought the move was genius. Anyway, I hope you get my point here.

While bleeding control instructions may not always be clinically necessary, they may be beneficial in some other way. Your example concerning moderate bleeding with an anxious caller or patient exemplifies this point. However, if bleeding is obviously minor, and there is other work to be done, triaging to some other direction may be entirely appropriate. As for the letter of the law in QA land, I would consider these factors before telling someone they did the wrong thing.

I did review the FAQ from 2012 and, although I was happy to see it resurrected and referenced, it was a bit brief and could do with a little more explanation. I wonder if our editor would consider updating it with this response. I think we could all do with a bit more color in our QA discussions that so often seem to be either black-or-white.

Brett A. Patterson
Academics & Standards Associate Chair, Medical Council of Standards International Academies of Emergency Dispatch

Brett:

My thoughts are in sync with your information and advice, and I totally agree with your key points.

Thanks for the reply. I totally understand the hesitancy as we deal with a lot of gray, and in our world, x is not always y. There is always “fluid.”

My seeking advice from you in this particular situation was that the article was being used by the ED-Q as a “black-and-white” solution, and my team and I are working hard to change this mindset. In my discussions with the ED-Q, I was advocating that it isn’t “black-and-white” and our actions need to be gauged upon the holistic assessment of the patient and situation based upon the information obtained by the EMD.

We know that there are subsets of our ED-Q/EMD staff who are “black-and-white” thinkers, and anything we can do to support these staff and give them strategies to help them to consider and deal with the gray and swim in the “fluid,” I’m always happy to support and assist where I can. The more color the better.

Onward through the fluid. 😊

Thank you very much for the reply.
Take care and stay safe.

Regards,
Guy
One of the dangers of our profession is that emergency calls become routine over time. Calls tend to lose their sense of urgency. And while it’s true that we can’t rush, we also can’t inadvertently delay. But it happens all too often.

On cardiac arrests, time is vital. The clock is ticking. In ProQA® medical it’s possible to get “hands-on-chest” in as little as 20 seconds from the time of ProQA launch. That depends, among other things, on recognizing a non-breathing patient early in the call and not being afraid to start CPR. One question I ask in refresher training scenarios is, “In Case Entry, if a caller reported that someone collapsed and is unconscious, and the caller wasn’t certain if the patient was breathing, what would you do?” The correct answer is to select “Uncertain (2nd Party)” in response to “Is s/he breathing?” Provided the emergency dispatcher then selects Protocol 9: Cardiac or Respiratory Arrest/Death that will cause ProQA to send a 9-E-1 and direct the emergency dispatcher into the pathway for cardiac arrest without checking breathing status further. And that’s exactly what’s supposed to happen. Unfortunately, many emergency dispatchers think that they should first confirm that the patient isn’t breathing through use of the Breathing Verification Diagnostic.

It’s understandable to be concerned about doing the wrong thing by starting CPR on a patient who’s actually breathing and has a pulse. Fact: You can’t kill someone who’s breathing by doing CPR. They’ll have some sternal pain for a week or so, and you may break a rib, but you won’t stop their heart. On the other hand, if you don’t start CPR, and quickly, their chance of survival decreases fast. And it’s not linear, it’s logarithmic.

That means that the longer you delay, the faster the rate of survival decreases within that short four- to five-minute window we have to re-oxygenate the brain.

The Breathing Verification Diagnostic is never used to confirm that the patient isn’t breathing. Its purpose is—and always has been—the opposite: to confirm that a patient is breathing when that’s what the caller has told us. If we want to save patients, we simply don’t have the time to check, and as research data clearly shows it’s not necessary anyway. The overwhelming majority of these patients are not breathing at all.

Recognizing ineffective breathing is also essential to saving lives. Certain descriptors, when volunteered by the caller, indicate insufficient breathing without requiring further checking. Example: A caller reports her father collapsed and is unconscious. You ask, “Is he breathing?” and the caller replies “barely.” You need not ask any further questions—the caller’s reply has met the protocol definition of INEFFECTIVE/AGONAL. Select that answer and move on.

Granted, many of the cardiac arrests we deal with are unwitnessed and the down time prior to discovery makes them non-viable from the beginning. But many do have a chance if we act decisively and act fast. That includes telling them to send someone to go look for a defibrillator when the caller isn’t sure if one is available, and the call is coming from a location that’s certain to have one. That’s not freelancing, it’s scene management.

You have the ability to return the gift of life. That’s rare. Not many people can say that about their jobs. You can. You might help save someone who will be around to watch their kids grow up or even save a young adult who will grow up to achieve greatness and make a difference in countless other people’s lives. Recognizing the need for an AED and hands-on-chest, and achieving both in the minimum time possible, gives everyone that chance.
When I started in emergency dispatch, no one told me I would have to learn a different language. Nor did they tell me that the language would continue to evolve and expand; nor did they tell me until later I would be teaching this language to new people. It’s not a recognized country language or a local dialect—it’s terms and phrases commonly used in the public safety profession.

“Cluster” was one of the first words I learned in its longer, R-rated form. I had no idea what that meant, but now I can identify one when it’s starting. I stopped saying “no” and switched to “negative” because that was the appropriate terminology. When someone asks me if something was “right” (as in the right answer), I say “correct” because “right” is a direction. Answering someone who is about to ask me if I heard something, I answer “direct” instead of “Yeah, I heard that.” Accepting information is “10-4” or “received.” Ping, plot, ALI, ANI, CAD … the list goes on.

The point is we rely on this language and without realizing, our usage may create confusion for others. The protocols have definitions for common terms so everyone is on the same page; do we do the same in our calls for service?

Here’s an example. A new trainee might have trouble with an EMS call that reads, “52yoa M SOB, poss OD on ETOH, AFIB, CHF HX.”

WTH? (I’m not putting the F-Frank there even though you are filling it in yourself). So think before you abbreviate to the point someone else will have difficulty understanding that the patient is a 52 years of age male, who is not the son of a biscuit, but having shortness of breath that possibly overdosed on alcohol and has both atrial fibrillation and a congestive heart failure history.

Let’s be honest; who didn’t pause when they saw SOB for the first few times in a medical call? That pause could throw a trainee off until they learn the language, and if a copy of the call is released, someone may think you’re calling the patient a son of a biscuit. (Remember, it’s a G-rated column. Hi editor!)

A funny moment was when a calltaker typed a suspect was wearing a brown shirt; in her haste, she forgot the “r” in shirt. WTH? The typo required clarifying questions, but it brings up accuracy. Wearing a brown shirt is different than wearing brown … yeah.

Don’t create your own abbreviations—BF has multiple meanings: boyfriend and best friend are two of many. Don’t use non-common terminology or dictionary words like the caller can’t stop lachrymation (the flow of tears); just say the caller can’t stop crying. Your co-workers will thank you by not ridiculing you. If you create a WTH moment, co-workers never forget … and neither will you.

Do be clear, concise, and use plain speech. It makes a difference. A ten-code in one jurisdiction may mean something else in a neighboring jurisdiction. On a status check, we had a lateral officer once give his previous jurisdiction’s code for everything’s OK; in ours, it meant man with gun. Boy was he embarrassed when he realized we sent plenty of backup for him.

Remember, whatever you put into your logs or calls needs to make sense to the person coming behind you, to the person trying to answer questions from a duty officer or chief, or for someone answering a court records request six months later. If the cluster call you took reminds you of a ball of yarn a cat’s shredded, take a few seconds, read what you’ve entered as if you were seeing it for the first time, and ask if it would make sense to you. This can save a lot of time and questions. Use your language wisely and your accuracy freely. That’s the best way to use this new language you’ve learned.
Emotional labor in emergency dispatch is the work you do to express or suppress your own emotions to produce the required emotions and responses in your caller. When I am feeling exhausted at 4 a.m. I put aside my personal feelings to meet the needs of my caller. A panicked caller requires me to adjust my conversational style and speak to them firmly. An urgent tone is required to get help organized quickly. The work of calltaking is emotional. Understanding this is crucial to learning how to care for ourselves as calltakers, and for leaders and organizations to support their staff.

Emergency dispatching energizes me. I feel a deep sense of satisfaction knowing that I contribute to the community. I am proud of my ability to manage a difficult and stressful job that not everyone can do. I feel connected to my crew who I work alongside and enjoy sharing stories of difficult and interesting calls with them.

Despite all this, the work can be emotionally exhausting. An incongruence between how I am feeling and how I need to sound on the phone can wear me out. When I have run out of caring, am tired, and don't want to face another death, I will not express this on the phone. If I don't express it, however, it builds up inside me and can leave me exhausted. This exhaustion can lead to numbness.

A certain amount of emotional distance is required to manage the ongoing emotional demands of the role, but numbness is more extreme. It reduces the benefits I feel from performing the role. I still have to endure shift work, time pressure, repetition, scrutiny, attention to detail, but when I am emotionally numb, I don't get to enjoy the excitement of babies that are born, appreciate callers who are helpful and thankful, or recognize the bravery of patients. The satisfaction of a job well done may be replaced by a cynicism regarding the impact of my work. I may withdraw from the camaraderie of shared storytelling with my colleagues and work alone. I am better able to enjoy my job when I am emotionally fit and healthy.

I can look after my emotional health by investing in my relationships, having a hobby, exercising, and eating well. Keeping emotionally fit and healthy, however, is not just the responsibility of individual emergency dispatchers. We can be protected from emotional exhaustion by a strong and supportive team culture, by organizations that recognize and celebrate our role, and by ongoing education. The emotional labor of taking emergency calls is better performed in a safe environment where we can express our anxieties, lack of confidence, and need for affirmation without fear of judgment.

Organizations can support and celebrate emergency dispatchers by hosting events where we are reunited with our callers, by working with the media to share stories of success, and by internally recognizing the genuine care and professionalism of individuals. When we believe our job is important and valued, we are better equipped to manage its challenges. Ongoing education is vital to cut through the emotional toll of calltaking. Education can introduce new coping skills and connect us to a worldwide network of others facing the same emotional demands that we are.

We are the emotional muscle on the front line of emergency services. Maintaining our emotional health equips us to function well in the role and to continue to enjoy the benefits long-term. When we are supported by our crews and organizations, continue to believe deeply in the intrinsic value of our role, and receive ongoing education, we can keep our emotional muscle strong, bounce back from exhaustion, and enjoy a job well done.
Can you begin all over again?

Brett Patterson

Brett:
We’ve recently had a couple calls where dispatchers had a call coded and were in the middle of PDIs when they went all the way back to call classification, changed the protocol, and then proceeded to ask the Key Questions for the new call type. In essence, they just started over. On one occasion, the calltaker realized she had initially chosen the wrong call type and started over, and on the second occasion the calltaker received new information and was simply confused as to what to do with it.

My question is this: Is it written somewhere, or is there any rule that says once you reach a certain point in a call you shouldn’t go back and start over? Universal Standard 17 seems to indicate that it’s okay to go back at any point if you realize a mistake has been made. Is this really the case? Or, if you are already in PDIs and realize a mistake, should the call just be manually updated to correct a previous mistake in protocol type? The difficulty is that it creates a lot of confusion for responders when we start changing the response and call type several times in the course of a call.

Hope that makes sense. Thanks for any clarity you can give.

Tim Lewis
Quality Assurance Supervisor
Weber Area Dispatch 911 and Emergency Services District
Ogden, Utah, USA

Tim:
We want to prevent what Dr. Jeff Clawson has described as “protocol surfing,” where the EMD hears a symptom that is clearly not a priority in the case but changes protocols simply because the EMD does not understand the current path is sufficient and appropriate. A common example of this occurs when the primary complaint is not a fainting or near fainting issue, but the caller mentions a level of consciousness issue so the EMD switches protocols even though the current pathway handles the not alert patient appropriately, while better dealing with the primary complaint.

I would applaud an EMD for “starting over” when it is clear they didn’t get it right the first time but would explore why this happened. Changing direction is certainly appropriate when a caller offers new or updated information that warrants a change, but this is where it gets a bit muddy and why education and training are important. If, after choosing another Chief Complaint Protocol, say Protocol 26: Sick Person (Specific Diagnosis) based on a vague or non-categorizable complaint description, the caller offers symptoms clearly handled better on another protocol, and described by Rule/Axiom/Law/Definition as such, i.e., Heart Attack or STROKE Symptoms, allergic reaction, TRAUMA, etc., switch protocols. However, if the “discovered” symptom is not clearly benefitted by the use of another protocol, the symptom
discovered is handled where you are, or a Rule tells us not to shunt, i.e., P26 Rule 2, stay where you are. Obviously, this can be somewhat subjective making education and training important. I would recommend the following article as a start:

iaedjournal.org/art-and-science

As always, reviewing specific protocols and their intent and proper use helps EMDs know when, and when not, to use them.

Brett A. Patterson
Academics & Standards Associate
Chair, Medical Council of Standards
International Academies of Emergency Dispatch

Brett:

After reading your insightful article, “Keep Them Awake?” from 11/28/2017, I found myself wondering a vital question about a scenario I’ve had many times.

In the case of a first party (alone) who exhibits a gradual decrease in consciousness or makes statements like “I think I’m going to pass out” or “I feel tired,” should we be interfering with this? My concern is that if the patient were to lose consciousness, we would have no one to maintain their airway. I have the urge to keep the patient talking so they can continue to update me with their symptoms and level of alertness. Letting them lose consciousness worries me that their airway may be compromised.

I would appreciate your opinion and directive on this scenario.

Thank you in advance!

Katelynn McAran
OnStar Emergency Advisor

Hi Katelynn:

I think it’s a great idea to keep a 1st party caller on the line and engaged, provided we are not asking a patient with severe difficulty breathing to talk. However, this is more about consoling, comforting, and monitoring than keeping alive, as Dr. Clawson points out in his article. Remember, speaking to someone is not likely going to stop the process that is causing the problem. Keeping someone awake by talking to them really only helps when sleepy, or sometimes encouraging them to fight exhausting difficulty breathing, and this really isn’t a good thing. There’s an old paramedic adage that asks, “When is it appropriate to intubate a conscious patient?” The answer, “When they allow it.”

But your 1st party concern is valid—airway is important. If the patient is alone, and you believe the patient is going to pass out, ask what position they’re in. Optimally, lying on their side would be best, although we don’t recommend this “recovery position” when someone is there to assist because it isn’t hands-on like the airway maneuver we utilize, and the caller may leave the patient. But, if alone, lying on their side at least helps protect the airway if they should pass out.

Brett

Brett:

Recently, some role-plays were being done on our site, and while practicing an overdose, we noticed an inconsistency with ProQA®. Fentanyl can be introduced to multiple different drug types, one being cocaine. When role-playing through a scenario for Protocol 23: Overdose/Poisoning (Ingestion), however, if you were to pick “cocaine” from “What did they take,” it does not prompt whether or not fentanyl was mentioned. If we were to pick an opioid however, it does.

Is there any reason for not prompting for cocaine, as fentanyl can be found there as well?

Thanks for your insight!

Kyle Moher
Brand & Cultural Ambassador
Emergency/Stolen Vehicle Assistance | Concentrix
Oshawa, Ontario, Canada

Kyle:

(Feb. 27, 2020) While we appreciate that fentanyl is sometimes added to cocaine, this can also be the case with other drugs. So, after discussion with our Council of Standards Rules Group, we have decided to address this by Rule. The Rule will effectively advise the use of the Narcotics answer choice when more than one option applies. This will ensure that the Fentanyl/Carfentanil/U4 option displays, and the Narcan DLS link is recommended, when unconscious.

Thank you for bringing this issue to our attention and inspiring change to the MPDS®!

(May 27, 2020) I just wanted to follow up and make sure you’ve noted the new v13.3 Rule you and your team have inspired regarding narcotics taken alongside other substances. As you can see from the accompanying graphic, the new Rule helps to ensure the Narcotics answer option is chosen in ProQA when substances in addition to narcotics are involved, thereby ensuring scene safety and an appropriate DLS response.

Brett
Niagara Regional 911 didn’t wait for the future to catch up. Rather, the center in Ontario, Canada, took giant steps ahead to navigate growth projections and increased demands upon emergency services.

And guess what? The changes—system transformations—are welcomed by 911 callers, said Karen Lutz-Graul, Commander, System Transformation, Niagara Regional 911. “It’s really been lovely,” said Lutz-Graul, a paramedic who in 2009 started as training supervisor at Niagara Regional 911. “We’ve learned that helping the patient is about the right provider or service, and not the transport.”

The changes in systems transformation rely on community collaboration, integrating medical and behavioral health professionals, enhancing existing tools in the communication center, and public awareness. Niagara EMS, which covers the highest population within the Ontario province, phased in each step backed by research and outreach.

Niagara EMS tackles the future of health care delivery

Audrey Fraizer

Fueling the transformation

Prologue to Niagara’s long-range planning and implementation was a consultant’s projection that call volume would climb substantially during the 10 years of 2017–2027. The current 65,000 calls to 911 would reach 110,000 calls each year, with a spike in calls favoring people aged 65 and older and, also, if current trends hold, calls from the age group 18 to 34.

A doubling of calls received without a matching doubling of resources, as anticipated, would create an imbalance and decrease in emergency services provided to the public. It was not so much a question of disparity based on lack or availability of health insurance. Canada’s health system is publicly funded at both the federal and provincial levels, explained Lutz-Graul. “When resource demand doesn’t mirror response demand, that’s a problem,” Lutz-Graul said. “The question became how can we do this work responsibly while sustaining the same high-quality care for our patients and protecting the welfare of our responders.”

In addition, the provincial government document “EMS Vision: Ontario 2050” set forth a plan that mirrors the U.S. EMS Agenda 2050 commitment to use evidence and best practices and focus on outcomes determined by the community and the patients, including outcome measures. Niagara EMS was simply positioning to beat the future. “It’s a new way of doing business,” Lutz-Graul said.

The road traveled

The road to transformation followed a “ready, shoot, aim” approach, Lutz-Graul said, a trial and error process supported with a plan to learn from what they had missed or overlooked and feedback. They queried existing patients, finding that alternative care was acceptable in non-urgent situations. They produced a video and distributed it to doctor’s offices and clinics. There were no random shots in the dark.

The Medical Priority Dispatch System™ (MPDS) does a “great job in giving us the
assurance and evidence of what we need for our callers,” Lutz-Graul said. It was now a matter of looking at outcomes.

What followed was an intensive scrutiny of patient data and categorizing both the types of calls received and how the calls were coded for response. They recruited the assistance of academics from Brock University, McMaster University, both in Ontario, Canada, and the University of Sheffield (U.K.). The collaborative research going back five years not only demonstrated the value of Niagara’s EMS patient data in identifying at-risk populations but, also, the ability to create novel, targeted approaches to public health intervention.

Data highlighted mental health emergencies going up across all demographics, an increase in falls, and the prevalence of repeated callers. A surprising phenomenon was the high rate of low-acuity calls from patients 65 and older who were experiencing higher-acuity medical conditions. This finding was opposite for callers between 18 and 34. Their calls often reported higher-acuity medical conditions than later determined.

**On the road and in the center**

The next phase was deciding who or what would best serve patients prior to the arrival of response and when transport alone did not provide longer-term interventions. They stepped out of the EMS silo and contacted social service, medical, and mental health specialists to support the initiatives.

**Mobile health units**

In July 2018, Niagara EMS rolled out Mobile Integrated Health (MIH) teams, a coordinated approach of health care that pairs paramedics with clinical and non-clinical resources donated by other community providers. Paramedics with advanced training can assess and treat the lower-acuity patients on scene, saving them a trip to the emergency department. Depending on the caller’s needs, mental, behavioral, and physical therapy specialists, for example, accompany the paramedics. Patients requiring mental health and behavioral interventions or patients with drug- and alcohol-related issues can be referred to programs that assist in prevention and recovery. A physical therapist can evaluate patients and tailor programs to improve balance and coordination. It’s up to the patient to accept or decline.

The MIH teams not only assist the patient who wants to avoid the emergency room, but the program also lets patients acknowledge medical issues earlier and reduces the risk of complications. The option lends to lower health care costs by treating the patient in the clinically correct setting.

As Lutz-Graul explained, MIH teams enhance the existing health care systems and fill the resource gaps within the local community.

“It takes a community to meet the health care needs of a community,” she said.

**Emergency Communication Nurse System**

Niagara EMS is the first paramedic service in Canada to use the Emergency Communication Nurse System™ (“ECNS”). The ECNS integrates into existing 911 practices to offer alternative care for patients calling 911 with non-emergent health-related complaints falling within the Academy-approved, low-acuity OMEGA Determinant Codes and many ALPHA Determinant Codes. A caller reporting a medical emergency (whether their own or someone else’s) phones 911 and is connected to an EMD, who triages the call using ProQA® to determine the most important, highest-priority symptoms, as well as severity and urgency of symptoms.

If the EMD determines—using medically-approved scripted protocols—that the caller is reporting a low-acuity call with no immediate life-threatening symptoms, the EMD transfers the call to the Emergency Communication Nurse (ECN). The ECN asks the caller additional questions, selects the most appropriate Chief Complaint Protocol, and through further questioning of the patient’s symptoms, determines the most appropriate care for each individual patient.

ECNS went live in September 2019 and has proven a “huge success,” Lutz-Graul said, resulting in reducing ambulance transport by 40% among the low-acuity patients during its first six months of operations. A return call is made 24 hours after initial contact when transport was not required or requested. Additionally, the ECNs work in collaboration with the MIH teams when they feel they would like “eyes” on the caller should they have some of those callers who are over 65 who may have some significant health issues.

**Showing results**

Changes already implemented are starting to show results. MIH teams have decreased call volumes related to frequent users and others benefiting from alternative care models. The numbers from the first year of the MIH program show that 80% of the 5,000 callers receiving services from an MIH team were helped without transport. Repeat calls increased by only 4%, compared to 15% during previous years.

A decrease in the number of ambulance transfers lightens an increasing demand on paramedics and frees the vehicle for patients with life-threatening emergencies.

Lutz-Graul said her assignment as the System Transformation project lead was an opportunity to make significant and sustainable changes “with the help of everyone” that got on board.

“This was never a one-person project,” she said. “It’s really nice to say we’re not siloed. It’s amazing to see how well this works through collaboration.”

Niagara Regional 911 is an Academy Accredited Center of Excellence (ACE). The center re-accredited for the fifth time in January 2020. Niagara Regional 911 is in southern Ontario on a peninsula created by the Niagara River on the east and between lakes Ontario (north) and Erie (south). The Canadian side of Niagara Falls and a burgeoning wine industry draw millions of tourists to the region each year.
THE LIFE-CHANGING CALL
Anger fueled crusade against sex trafficking

Audrey Fraizer

Probably the most common question asked of emergency dispatchers is the call they remember, the call that doesn’t leave them, the call that supersedes all the thousands of other calls in their memory.

The next question generally borders on coping with the call that keeps replaying in their heads. The tragic call involving a drowned child, a responder’s death while on duty, or the multiple calls during raging wildfires or an approaching tornado that left them feeling powerless to provide the assistance they are dedicated to give.

Sometimes, the call pushes the emergency dispatcher into action, moving in a direction never driven prior to that call. That is exactly what happened to EMD Tina DeCola, Communications Specialist Supervisor—Las Vegas Fire and Rescue (Nevada, USA).

DeCola remembers the time (11 a.m.) and the year (2017). She was in her fifteenth year dispatching for Las Vegas Fire and Rescue and, despite the thousands of calls she has answered and the thousands of callers she has listened to, she will never forget the voice of the caller.

“There was a fear that’s hard to describe,” DeCola said. “She sounded so young, and she sounded so scared.”

DeCola asked questions and gathered information. The woman was hiding from her pimp behind a dumpster, having escaped from a room at a Las Vegas hotel. While DeCola could not ping the location because of the heavy steel container, she could relay the hotel’s address to Las Vegas Metro Police. Although the woman was nearly paralyzed from fright—the consequences if discovered by the pimp before response arrived would be dire—she stayed on the line and was eventually coaxed out of hiding by police.

“This was a horrible call, and I was so mad once the call disconnected,” DeCola said.

DeCola has children, which further aggravated her in a situation clearly involving sex trafficking. How dare anyone coerce or kidnap somebody’s daughter or son and exploit them sexually for selfish gain? How could anyone demand sexual acts upon the exchange of money?

The call shifted DeCola along a path of action she had never traveled. To say it has become part of her life is an understatement. It sums up what she does when not working at the dispatch center or spending time with her family. She’s a walking, breathing database of statistics and contacts. She researches sex trafficking and creates spreadsheets of findings by city, state, and country. She contacted organizations committed to prosecuting the traffickers, sheltering the victims, and helping the male and female victims transition to a “normal” life.

The list of affiliations now fills a digital notebook. She was the first non-law enforcement emergency dispatcher assigned to the Las Vegas Metro Sex Trafficking task force. She works with the National Center for Missing and Exploited Children (NCMEC).
and is an instructor for the Denise Amber Lee Foundation. She helped develop a public campaign in Las Vegas to recognize sex trafficking and report suspicions to police.

She keeps going.

DeCola authored the first of its kind emergency dispatch training manual to identify calls that potentially involve sex trafficking. The manual is sprinkled with jargon as an assistive tool—“bottom” for a pimp’s trusted female facilitator to supervise and report rule violations and “branding,” which is a tattoo or carving on the victim denoting ownership. Manipulation of victims through gifts and affection during the “recruitment” or “romance” phase is also included.

During training workshops, she stresses the importance of a dispatcher’s situational awareness as demonstrated, for example, in the call from a “mother” reporting her “daughter’s” abdominal pain. Something was not right, as revealed in further information gathering. The “mother” knew nothing about her “daughter’s” medical history or whether the abdominal pain was a new or repeated complaint. That was the clue convincing DeCola to plug the call into Las Vegas Metro Police. The bottom, suspecting DeCola was on to her, left the apartment and the girl behind. The girl became one of at least a dozen victims rescued in Las Vegas since DeCola applied her laserlike focus.

The chance of further endangering a victim also led DeCola to establish a 911 coding system. Specific codes, unknown to the caller, alert responders to the possibility of confronting a pimp, john, bottom, or victim.

She emphasizes treating the victims with kid gloves.

“Treat them gently,” she said. “Let them know it’s OK and that you’re here to help. Above all, handle the situation with care. You cannot judge their reaction because you don’t know what they’ve been through.”

The Las Vegas task force and affiliated agencies offer help and if the victims are not ready to accept, they are given information to contact an organization or individual when they are.

Quite honestly, DeCola found it unsettling to fathom the depths of sex trafficking. A victim’s constant fear. The overshadowing reality of physical violence. Breaking down the victim and forcing compliance through intimidation, isolation, beatings, and threatening the victim’s family if the rules aren’t followed or the victim is caught attempting to escape.

It hasn’t been easy for DeCola to confront an ugly and sordid world of buying and selling young men and women against their will. It’s difficult sharing the atrocities of sex trafficking and depravities of profiteers to the emergency dispatchers she trains, especially those who are every bit as naïve as she was before that call four years ago that she’ll never forget.

“I feel bad because I have to do this, expose the cruelty of what’s happening in plain sight,” she said. “It’s hard on me, but I know I’m doing the right thing.”

Treat them gently. Let them know it’s OK and that you’re here to help. Above all, handle the situation with care. You cannot judge their reaction because you don’t know what they’ve been through.

GETTING STARTED

A frightened young woman hiding from sexual predators behind a hotel dumpster convinced Tina DeCola she had to do more than simply store the 911 call to memory. The call was a personal summons to help, educate, and train emergency dispatchers to leverage their abilities in ways they had not done before. DeCola, Communications Specialist Supervisor for Las Vegas Fire and Rescue (LVFR) (Nevada, USA), immediately set to work learning about human trafficking, its link to other heinous crimes, and compiling resources to aid emergency dispatchers in these calls. DeCola was a medical assistant in a first shorter-lived career, switching to emergency dispatch 18 years ago in a move to Las Vegas. She said she took to the profession like a fish out of water. DeCola rose through the ranks at LVFR and provides her insights on human trafficking through organizations that include the Denise Amber Lee Foundation and the National Center for Missing and Exploited Children. She said the intensity of the information can get her down, though knowing she’s doing the right thing keeps her going.
SUICIDAL CALLERS
There’s something you can do

Alex Graber

locating, phone number, call comments, and caller information ... next call. It is the process that we know all too well: moving onto the next call and disregarding the thoughts, emotions, and curiosities from the last incident you handled. We are told not to get attached to the situation. Other lines are ringing, and more calls are pending for dispatch. It is our norm. Have you learned this approach is one that prohibits building rapport with callers, learning more about their challenges, providing alternative resources, and closing a conversation with care?

Wanting to do more, learn more, and impact more is what started my volunteer work with The Trevor Project, which is “the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, queer & questioning youth.”

The first-party suicidal caller

Most of us have experienced the uncomfortable and prolonged first-party suicidal person 911 call. The person is upset, crying, and emotionally erratic. We run out of things to say and questions to ask. They may be hesitant to disclose their location, if they have a weapon, or if there are any injuries. They plead with you to help them, swear at you, and feel exhausted. The cellphone ping may be spot on or nonexistent. At the end of the call, you find yourself relieved it is over and begin thinking about this person’s life. Maybe you were the first person to care about them in a long time. Perhaps you said something that made them choose life instead of the weapon next to them. Sometimes the way the call ends is not the desired outcome, and we accept that reality.

Nonetheless, these are challenging calls because an hour-long conversation with someone in crisis is not our normal. As a volunteer LGBTQ Youth Digital Counselor, I challenged myself to embrace these tough calls. It slowly became my “normal.”

Putting aside habits

The Trevor Project’s support model is multifaceted: establishing rapport, assessing suicide risk, gathering information, exploring alternatives, reassessing suicide risk, and creating closure. It took a long time for me to get creative in my communications. There were many times I wished that ProQA would pop up on my laptop screen to prompt me as I got deeper into these intense conversations! Direct scripted questioning and providing life safety instructions to achieve a safe response for responders was no longer part of my workflow. I had to realign my thought process to take the youth’s side, provide a wealth of empathy, and work with them to identify resources of interest. While many of these conversations center around someone having a bad day, wanting advice on “coming out,” or venting about challenges in school, there are still plenty of situations that we strangely know as our norm in the
We all can take our gifts of making a difference to transform our world for the better.

dispatch world such as overdoses, cutting of wrists, and abuse.

The Trevor Project’s 2019 National Survey on LGBTQ Youth Mental Health disturbingly revealed that 39% of LGBTQ youth seriously considered attempting suicide in the past 12 months. Connecting my knowledge of imminent suicide risk incidents and active interventions with Trevor’s support model has resulted in a satisfying mold of counseling and 911 dispatch. As I became accustomed to talking with youth in crisis, I discovered a few go-to questions and successful phrases that apply to the majority of crises regardless if one works in dispatch or an online chat environment.

A. “What is your name?” Build personal rapport right off the bat, not to mention, obtain critical information for first responders. Use their name throughout the conversation to personalize it!

B. “I understand … [repeat what they said].” “Thank you for sharing … ” “It takes a lot of bravery to reach out. I am really glad you are talking with me.” Let them know you heard them correctly and acknowledge their statements. Encourage openness by saying thank you. Validate they did the right thing by reaching out for help.

C. “That makes sense and is a valid concern.” “I can see why [situation] would make you feel [emotion].” Validate their situation and how it has affected them.

D. Don’t say, “I’m sorry … ” Do not pity them. Replace this with, “That sounds like a really challenging situation,” or “That must have been very difficult to go through.”

E. “You deserve to feel [supported, safe, respected, healthy, etc.].” Everyone is worthy of basic human rights and needs.

The need for more

We have seen emergency dispatchers leave the console for a police squad or say goodbye to the erratic schedule with a plethora of overtime for a 9-to-5 corporate environment. Think about what you get out of putting on your headset every day. Are you satisfied with what you do, or do you need something more? For me, it was the need to impact more. I wanted to go beyond “location, phone number, call comments, caller information … next call.” The Trevor Project has afforded me opportunities to further engage with LGBTQ youth in crisis by learning about their support systems (or lack thereof), home and school lives, friendships, mental health struggles, and emotional coming out stories. As a 911 dispatcher, all I want to do is help. I get to do this with youth by exploring safety activities such as running, listening to music, art, meeting with a local therapist, or reallocating a potential weapon. Learning your impact during the risk reassessment or through a simple, “How are you feeling now?” message at the end of the conversation is ever so heartwarming and rewarding.

A study conducted by The Scottish Volunteering Forum revealed that “94% of volunteers noted an improvement to their mental health since volunteering, and 76% said they felt physically healthier.” Whether you find yourself wanting to take your career further to achieve a deeper sense of impact or scale back to take your mind elsewhere such as a community garden, church, or soup kitchen, we all can take our gifts of making a difference to transform our world for the better.

To learn more about The Trevor Project, donate, or find out how to become a digital crisis counselor, visit thetrevorproject.org.

Sources
Matt Grogan did not anticipate the direction 911 would take him when he got his first job at a consolidated dispatch center in a suburb southwest of Chicago (Illinois, USA), despite the immediate sense of landing in the perfect place.

His personality fit the demands. The job and the daily pace clicked. He enjoyed helping people during what very well may be the worst day in their lives, and the rapid-fire adrenaline rush with every call acting as a tiny electric shock. He moved to Nevada (USA) and did not skip a beat. Grogan was hired by Las Vegas Fire and Rescue.

Grogan said it is difficult to plot a point where 911 grew into more than taking responsibility for callers. When was it that he realized that 911 took a toll on emergency dispatchers and that being there for the callers meant being there for himself and co-workers? When did he accept that looking out for the good of the profession was all part of emergency communications?
“I was passionate about the job early on, and I still am,” said Grogan, who has been in 911 since 2005. “That hasn’t changed, but now, I’m in a stage of advocacy.”

Initially, there was Association of Public-Safety Communications Officials (APCO), and Grogan is vice president of the Nevada Chapter. He travels as an instructor for the Denise Amber Lee Foundation, advocating for training and continued education standards that maximize a best practices approach and elevate emergency dispatchers to a level of professionalism.

The concept of “professionalism” was Grogan’s segue into changing the classification system for emergency dispatchers. He started “hearing rumblings” about circumventing a protracted timeline for again attempting to upgrade their status from administrative assistants.

Grogan said the campaign is “going full steam” in picking up state and local momentum, with impetus fueled by the congressional stall in approving the 911 Supporting Accurate Views of Emergency Services (SAVES) Act.

The bipartisan bill, introduced by Rep. Norma Torres, California (USA), and Rep. Brian Fitzpatrick, Pennsylvania (USA), in March 2019, reclassified 911 dispatcher jobs as “Protective Service Occupations.” In July 2019, the 911 SAVES Act was among numerous amendments included in the National Defense Authorization Act (NDAA). Despite passing the House, the final version of NDAA had dropped the reclassification provisions. No other action on the bill has been taken.

Eric Dau, Communications Director, Clinton County Communication Center, Clinton, Iowa (USA), credits a joint effort by the Iowa Chapters of APCO and the National Emergency Number Association (NENA) going before the Iowa Legislature to campaign for the change. Dau is on the national executive board of APCO, an organization active in the reclassification campaign.

“The current category [administrative assistant] doesn’t characterize what we do,” Dau said. “No administrative assistant does anything close to what emergency dispatchers do. This is not meant as a slight to clerical workers. We are the critical link to help save lives and help save property, and it’s a profession that keeps evolving.”

There are bills in Iowa’s House and Senate that require consolidation into one bill before it passes to the governor for signature. If approved, the bill changes the language of Iowa’s Public Law (Chapter 80) without financial impact to the state or taxpayer. The minimal state impact gives Dau hope for the bill’s passage.


A decade was too long of a wait for many.

“Emergency dispatchers are highly trained individuals handling critical situations,” Grogan said. “We literally breathe life into people by what we do.”

At issue is the Standard Occupational Classification (SOC), which puts emergency dispatchers in the same category as “Office and Administrative Support Occupations.” The SOC update is preceded by a four-year review. Despite strong support from public safety, the 2018 release did not change the clerical designation to the Protective Service Occupations category of law enforcement, firefighting, and lifesaving (paramedics). The next update is 2028.

A decade was too long of a wait for many in the 911 community. The classification fails to give emergency dispatchers recognition for a job with responsibilities that has grown exponentially over the past decades and skimps on benefits comparable to the Protective Service Occupations. Federal denial generated state and local efforts to show support and increase chances in the next SOC update.

State and local action

Texas

Texas (USA) Gov. Greg Abbott signed legislation in June 2019 classifying 911 dispatchers and other public safety telecommunications professionals as first responders. The classification will qualify 911 dispatchers for mental health support and provide protections against civil damages liability when helping in an emergency. The law went into effect Sept. 1, 2019.

California

A bill changing the occupational status of public safety dispatchers is on the road in California (USA) to get signed into law. Assembly Bill 1945, authored by Assemblyman Rudy Salas (Bakersfield), was placed in the Governmental Organization and the Public Employment and Retirement Committee in February 2020.

Colorado

The Texas legislation convinced Brett Loeb, Communications Director, Pitkin County Regional Emergency Dispatch Center, Aspen, Colorado (USA), that the same should be done for their county, particularly with the 911 SAVES Act stalled in Congress. “I reached out to our county administration and the sheriff and asked, ‘Why not us?’” Loeb said. “It really doesn’t change much for our staff—maybe gives us access to some PTSD and mental health resources and trainings that are specific to first responders.’ From a director and user agency perspective, I’m hoping it’ll be a short-term boost to morale and a long-term benefit in being recognized for their contributions to the citizens and fellow first responders.”

(Reader’s Note: Click here to see the Pitkin County Proclamation.)

West Virginia

On Nov. 5, 2019, the Mineral County Commission, West Virginia (USA), passed a resolution to reclassify 911 dispatchers as first responders. The proclamation is honorary and part of a larger picture that could grant emergency dispatchers the same status as firefighters, police officers, and emergency medical services field response.
“People in the field think they [emergency dispatchers] push buttons,” said Luke McKenzie, Director, Office of Emergency Management, Mineral County 911. “It’s so much more complicated than that. They go through trauma every day, things that most never dream about. They save lives. They work weekends and holidays. Their job is very different from clerical work.”

(Editor’s Note: Click here to see the Mineral County Proclamation.)

West Virginia House Bill 4123, clarifying that 911 telecommunication workers are included in the definition of those individuals who perform “emergency services” during a disaster, has passed through the House and Senate and is awaiting a signature from Gov. Jim Justice (passed March 7, 2020; in effect 90 days from passage).

Opposition

While AB 1945 is already gaining bipartisan support with no known opposition, problems may arise with the bill during the committee meetings and votes in the coming months.

States going against the federal definition is why Billy Campbell, a former Texas police officer, tried to stop similar legislation from passing in Texas.

“I’ve never claimed dispatchers don’t deserve this,” Campbell said. “But states need to be smart about how they do this. If California passes it, it may catch the eye of the federal government, and it [the federal government’s intervention] may knock it down for everyone.”

Another issue is the notion that reclassification is in pursuit of collective bargaining rights in the negotiation of wages and other conditions of employment. As the APCO statement of support indicates, the word collective—if used at all—applies in a broader sense to a reclassification “uniformly endorsed by the 911 community” and the “bicameral [two chambers] and bipartisan support from Congress.” Reclassification is a collective effort.

Grogan said funding is an issue.

“There’s also a state’s desire for autonomy and not wanting to be told on the federal level what to do about pay, hours, training, and operations.

Grogan said changing the classification will take time. He’s “happy” with progress so far and the support they’re receiving from the National 911 Program, NENA, APCO, and people in public safety who are gaining a better understanding of emergency dispatching because of what they’re doing.

He said the bigger drive, overriding benefits and higher pay, is the respect they’d gain in a category equivalent to their partners in response.

“We truly want to show the amazing job done by the amazing people saving lives every day,” Grogan said. “It’s time we got our due.”

National 911 Office

The National Highway Traffic Safety Administration (NHTSA) National 911 Program is every bit behind the reclassification; however, as a federal agency the

Las Vegas Fire Communication Specialists
national office cannot lobby Congress or request funding.

During a public safety status webinar sponsored by the National 911 Program on March 10, 2020, speakers provided background information (such as how the Standard Occupational Classification works) and tools for a call to action.

Kate Elkins, National 911 Program EMS Specialist, briefly explained why their office is behind the push for reclassification, stating the profession’s evolution over the past several decades. She believes Next Generation 911 (NG911) will make an emergency dispatcher’s role in EMS even more critical and demanding. The task ahead, she said, was the job’s description. Her office’s study into descriptions used by local, regional, and state agencies and governmental bodies overseeing emergency dispatch showed that many descriptions were “older than the employees filling them [the jobs].”

For example, the job description should include alignment with current Emergency Operations Center (EOC) procedures, licensing, certifications, and training requirements. It also helps to outline the soft skills required, such as critical thinking and decision-making.

“When was the last time you updated your job description?” Elkins asked. “An out-of-date description doesn’t help.”

Dan Henry, Director of Governmental Affairs for NENA, described legislative and regulatory strategies and advocated a combination of following the leads of states and localities already making headway, sharing information, and tenacity.

“You don’t have to reinvent the wheel,” he said. “Taking those first few baby steps from the lead of others can be used as stepping-stones to broaden the classification.”

Michael Nix, Executive Director of the Georgia Emergency Communications Authority (GECA), described the steps taken to expand benefits for emergency dispatchers and achieve accountability in funding. Nix is also Statewide Interoperability Coordinator for Georgia Emergency Management Agency and Homeland Security (GEMA/HS).

As Nix explained, funding comes from 911 fees, the $1.50 surcharge customers pay on their monthly phone bills. A state law, effective Jan. 1, 2020, directed phone companies to send the surcharge collected to the Georgia Department of Revenue, rather than the companies sending fees directly to 911 centers. The law also requires a report outlining how much money each 911 center is supposed to get. In September 2019, GEMA/HS and GECA were awarded a federal grant of $3,994,283 to aid in the transition to NG911 services throughout the state. The money funds implementation and training.

He also established regional response teams to coordinate communications during potentially catastrophic emergencies.

Few would disagree with Nix’s belief that emergency communications provides the backbone to response. It was a matter, he said, of achieving buy-in, and he personally visited 60 directors at Georgia’s 911 centers to garner support for his goals.

The same principles apply to reclassification, Nix said. “No effort is ever mutually exclusive,” he said.

The National 911 Program collaborated with 911 stakeholders to create resources to support this effort. They are available at 911.gov/project_telecommunicatorjob reclassification.html and include:

- a guide that describes the need for reclassification and how the improvement of telecommunicator job descriptions can help.
- a list of many of the public safety telecommunicator responsibilities and key job skills.
- a sample job description to use to more accurately reflect the roles telecommunicators take on today and in the future.²

**Keys to success**

Dau said the “key” to reclassification is finding support in your state legislature to champion the bill and push it forward. For example, Iowa’s 49th District State Sen. Chris Cournoyer released a statement in support of the House bill, which, in part, states: “Emergency telecommunicators often talk to callers on the worst day of their life and must use a caller’s eyes to gather information to ensure the proper response and vital instructions are provided. The job of emergency telecommunicators is constantly evolving with technology. Many communications centers also monitor traffic cameras and cameras in public buildings, including schools. Iowa Emergency telecommunicators are the first, first responder.”

Loeb measures their success in the county’s response, and it has been great, he said.

“The reaction has been tremendous,” he said. “Our proclamation shows what we do, and it’s finally coming to the forefront. I’ve not heard one negative comment from anyone. Everyone’s supportive.”

The same reaction was heard in Mineral County.

“Everybody was really excited,” McKenzie said. “I told them it was all part of a larger picture. The commission appreciated them enough to give them the recognition, reassuring them that they are indeed saving lives.”

**Federal classification**

The Office of Management and Budget (OMB) coordinates the SOC, a statistical standard used by federal agencies to classify
workers into occupational categories for collecting, calculating, or disseminating data. The SOC identifies 911 professionals as “Police, Fire, and Ambulance Dispatchers” under the classification of “Office and Administrative Support Occupations.”

For the 2018 update, the OMB approved a title change to “Public Safety Telecommunicators,” as shown in the following:

**43-0000 Office and Administrative Support Occupations 43-5030 Dispatchers**

- **43-5031 Public Safety Telecommunicators**
- Operate telephone, radio, or other communication systems to receive and communicate requests for emergency assistance at 911 public safety answering points and emergency operations centers. Take information from the public and other sources regarding crimes, threats, disturbances, acts of terrorism, fires, medical emergencies, and other public safety matters. May coordinate and provide information to law enforcement and emergency response personnel. May access sensitive databases and other information sources as needed. May provide additional instructions to callers based on knowledge of and certification in law enforcement, fire, or emergency medical procedures.
- **Illustrative examples:** 911 Operator, Emergency Operator, Public Safety Dispatcher, Public Safety Telecommunicator

The OMB denied the request to move the profession to the same classification as police and firefighters (Protective Service Occupations). According to their denial:

> The work performed is that of a dispatcher, not a first responder. Most dispatchers are precluded from administering actual care, talking someone through procedures, or providing advice. Moving the occupation to the Protective Services major group is not appropriate and separating them from the other dispatchers would be confusing.

Also, dispatchers are often located in a separate area from first responders and have a different supervisory chain.5

**Sources**

SAVE RESOURCES, PROVIDE GREAT CARE
ECNS offers alternative to ambulance response

Audrey Fraizer

Since a designated emergency number is increasingly the first point of contact for many patients entering the health care system—even those with non-emergent conditions—one potential approach to decreasing emergency costs and emergency department overcrowding is to reinvent the 911 dispatch center and to direct patients to optimal health care alternatives.

The International Academies of Emergency Dispatch® (IAED™) has done just that with its Emergency Communication Nurse System™ (ECNS™), a second-tier telephonic nurse triage system for low-acuity calls.

Emergency department use has been increasing steadily for decades. Emergency departments were the only type of outpatient visits to show increases every year between 2013 and 2017 in patient number (cumulative 10% increase in utilization and a 24% growth in average prices).\(^1\) Spending on ambulance services increased 21% (2013–2017), while utilization remained relatively unchanged.\(^2\)

The ECNS solution
Calling for an ambulance via 911 has become a common method of accessing the health care system not only for life-threatening emergencies, but also for non-life-threatening conditions and non-urgent medical problems. Many patients who access 911 have non-emergent conditions that do not require a “HOT” ambulance response (using lights-and-siren) and can possibly be handled without transport to an emergency department.

Nurse triage at the 911 dispatch point is one solution to reduce emergency department overuse and costs while helping ensure that patients can access appropriate alternative care.

The ECNS integrates into existing 911 practices to offer alternative care for patients calling 911 with non-emergent health-related complaints falling within the Academy-approved, low-acuity OMEGA Determinant Codes and many ALPHA Determinant Codes. A caller reporting a medical emergency (whether their own or someone else’s) calls 911 and is connected to an EMD, who triages the call using ProQA® to determine the most important, highest-priority symptoms, as well as severity and urgency of symptoms.

If the EMD determines—using medically-approved scripted protocols—that the caller is reporting a low-acuity call with no immediate life-threatening symptoms, the EMD transfers the call to the Emergency Communication Nurse (ECN). The ECN asks the caller additional questions, with the answers driving a search through more than 200 medical protocols that are powered through the software application LowCode®.

Each question within the ECNS medical protocols contains a clinical rationale for easy access to additional information for the ECN’s use. Protocols are symptom-based and take into account gender and age. The ECN also considers additional information, such as the patient’s past medical history and medications, as well as the patient’s physical, psychosocial, and economic background. The ECNS selects the most appropriate Chief Complaint...
Protocol, as different protocols prompt the ECN to ask different questions about the patient’s symptoms to determine the most appropriate care for each individual patient. Protocols are classified as either medical or trauma related. Medical-related protocols cover illness-related symptoms and conditions—for example, chest pain, abdominal pain, wheezing, back pain, fever, and many more. Trauma-related protocols deal with physical injury—for example, chest injury, abdominal injury, ankle injury, falls, and many more.

Medical directors at the 911 centers select from a list of IAED-approved Determinant Codes that an EMD can transfer to an ECN. These include common low-acuity conditions such as minor injuries, chronic pain and chronic illness, weakness and flu-like symptoms, rashes, and allergies, among others.

Once the call is transferred, the ECN performs a more detailed triage of the caller’s complaint and, with the aid of software-based protocols, determines the most appropriate level, location, and type of care. Asking and entering the answers to a series of complaint-specific questions is designed to direct the ECN through a logic-based decision support process, resulting in the ECN determining the Recommended Care Level (RCL): the optimal level of care, including a clinically sound time frame for receiving care.

Possible dispositions include a wide range varying from home care to sending an ambulance for immediate transportation to the emergency department. If the patient requires treatment (for example, at the emergency department, at an urgent care clinic, or at a primary care provider’s office), the ECN can also arrange for alternative transportation (e.g., a wheelchair van or a cab). The ECN not only recommends but may also arrange appointments and calls with pharmacists or other providers.

An ECN also has the option to refer patients for telemedicine appointments to discuss their symptoms with a physician via a video conference.

The ECN can transfer the call back to the 911 calltaker at any time if, for example, the patient’s condition deteriorates and the ECN determines an elevated level of response is required or the patient has downplayed symptoms that are indicative of a more serious condition. The ECN is also trained as an EMD and may access ProQA after requesting an ambulance to offer Pre-Arrival or Dispatch Life Support Instructions.

ServiceLead™, an integrated Directory of [local] Service application, interfaces with LowCode to provide accessible local community resources that allows the ECN to assist the patient in scheduling the RCL appointments and offer other assistance, as necessary. ServiceLead also operates like a confidential electronic medical record: It confidentially passes patient data to all resources involved in the specific case and stores call handling data for analysis and quality assurance.

**ECNS calls last 8-15 minutes.**

It has been found that most ECNS calls last about 8-15 minutes. On average, approximately 15%–20% of total medical call volume qualifies for ECNS.

**Significant savings**

A retrospective cohort study involving two agencies employing the ECNS program showed significant savings.

MedStar EMS-Mobile Health (MedStar), located in Fort Worth, Texas (USA), serves a population of nearly 810,000 residents (with a daytime population of approximately 1 million) and handles roughly 107,000 911 calls per year. Louisville Metro EMS (LMEMS), located in Louisville, Kentucky (USA), serves a population of approximately 741,000 and handles about 91,000 911 calls per year. A total of 7,231 calls were studied. The most frequently used RCLs were Emergency Care as soon as possible (62.4%), Seek medical care within 1–4 hours (12.0%), and See a doctor in the next 12 hours (7.0%). High-acuity calls that needed a 911 ambulance response only made up 3.8% of the RCLs used. During the early morning (i.e., 6–8 a.m.) and early evening (i.e., 5–8 p.m.) the percentages of calls referred to the emergency department increased.

A related study analyzing the MPDS Protocols most frequently triaged through the ECNS found that the Sick Person and Falls Protocols had notably high frequencies. Falls, Abdominal Pain, Back Pain, and Vomiting were overall the most frequently used protocols in the ECNS itself. Female patients were users of the ECNS in significantly greater numbers than males, particularly within the Abdominal Pain and Vomiting Chief Complaints. Overall, 91.2% of the patients were satisfied with the ECNS service, and these rates were highly comparable between agencies.

According to study results, collectively nearly $1.2 million (USD) in payments were avoided as a result of directing patients away from the emergency department and to alternative providers or points of care. Studies analyzing the safety of the telephone consultation process have concluded that nurse telephone triage is a safe alternative response to non-serious EMS callers. ECNS is IAED’s “Fourth Pillar of Care” along with Emergency Medical Dispatch, Emergency Fire Dispatch, and Emergency Police Dispatch.

**Sources**


2. See note 1.


6. See note 3.
SOUND THE ALARM
Most used FPDS Protocol rings a bell

Becca Barrus

The role of firefighters in modern society has shifted somewhat since its inception. Yes, firefighters still put out fires, but they do much less of that than in generations previous thanks to updated building codes and flame-resistant construction materials. This doesn't mean that fire departments have less to do, however. The National Fire Protection Association (NFPA) reported that fire department responses have nearly tripled from almost 12 million total incidents in 1985 to more than 33 million in 2015. Firefighters are going out on more calls than ever before.

If firefighters aren't spending lots of time on fires, what are they spending it on? What kinds of reported incidents make up the majority of calls triaged using the Fire Priority Dispatch System™ (FPDS)? The International Academies of Emergency Dispatch® (IAED®) has data from 24 agencies across the world spanning from September 2012 to April 2020 (roughly 343,030 calls total). The data shows, overwhelmingly, that a little over 40% of FPDS calls were triaged using Protocol 52: Alarms—41.22% to be precise. That’s 141,383 calls from alarm monitoring companies and private callers to report some kind of alarm issue.

Agencies using FPDS aren’t alone, either. There are nearly 30,000 public fire departments across the U.S. and between them, they responded to nearly 3 million false alarm calls in 2018, according to the NFPA. That’s 8% of the total number of calls reported.

What does that mean for you—the EFD, specifically—in your center? It means that a huge portion of your time is spent on triaging alarm calls, so the more familiar you are with the “why” and “what” of the protocol, the better.

Right response
Not only has the number of alarm calls changed over the years, the way fire departments respond to them has changed too.

“You used to send multiple units on alarm calls,” said Gary Galasso, Chair of the IAED Fire Council of Standards. He was with the San Jose Fire Department (California, USA) for 26 years, which handled both fire and EMS calls. The SJFD covers the southern area of the Silicon Valley and would typically go out on “two or three alarm calls a night,” usually with multiple fire trucks.

When the Great Recession of 2008 hit, that changed. Most of the larger fire departments had their budgets cut, and some simply didn’t have the resources to send multiple units or lights-and-siren responses to calls involving alarms. Running fire response vehicles HOT was already a liability. In order to ensure that responses to the most commonly used FPDS Chief Complaint were always appropriately sized meant that things had to be reconsidered.

Because the highest Determinant Level on Protocol 52: Alarms is CHARLIE, not DELTA or ECHO, one might imagine that alarm calls are less emergent or less important than other kinds of calls. And while most alarm calls may well turn out to be false alarms, the First Law of Alarms...
Setting off alarm bells

The first Key Question on Protocol 52: Alarms is “What type of fire alarm is this?” In approximately 40% of the calls collected by the IAED, the G suffix was used, which stands for General/Fire. A General/Fire call means that the alarm was triggered by either a smoke detector, heat detector, or manual activation. What’s the difference? A smoke detector detects smoke particles, which means it’s as likely to be set off by a burned pancake as an actual fire. A heat detector only goes off when it senses that the temperature in the building or room has surpassed 135 degrees Fahrenheit (57 degrees Celsius). Manual activation of a fire alarm could mean someone pressed an “Alarm” key or a certain combination on a keypad fire alarm or pulled the lever on a pull station. There are individual suffixes for each of these kinds of alarms—S for Smoke detector, H for Heat (temperature) detector, K for Keypad (manual), and P for Pull station—but they are used less frequently than the G suffix.

Don’t forget that calls involving carbon monoxide alarms should be handled using this protocol. Not only does carbon monoxide have adverse effects on humans if they are exposed to high levels of it, Axiom 3 states that “Carbon monoxide (CO) can be explosive when confined to an enclosed area.”

What if someone calls asking for help installing a smoke detector or changing the batteries of a carbon monoxide detector? Rule 2 states that “For fire protection equipment maintenance or repair requests (install detectors, change batteries), use Protocol 53,” which is Service Call. How fire departments will respond to these kinds of calls will, according to Galasso, “depend on the individual agency’s scope and mission.” SJFD regularly responded to similar service calls when he was working with them.

Different paths

After KQ 1 and KQ 2 (“What area or zone/room was activated?”) are answered, Protocol 52: Alarms has two different Key Question and Post-Dispatch Instruction pathways depending on who made the call. In most FPDS Protocols, the questions stay the same no matter who’s calling. On this one, however, questions will vary depending on whether the call is from an alarm monitoring company or whether it’s from a private caller. This has always been the case, all the way back to the very first version of the Fire Protocol.

“What the difference] has been there from the beginning,” Galasso said. The FPDS was released in 2000 and already there was an established relationship between fire departments and alarm companies.

The Key Questions for a private caller are more fitting for someone who is on scene. There’s not much point in asking someone from an alarm monitoring company if they see flames or smoke when they are calling from somewhere besides where the alarm is going off. Additionally, KQ 6 for callers from an alarm monitoring company is “What is the reference number for this alarm?”—information private callers won’t have access to. KQ 6 may or may not be used by your agency as it is a jurisdictionally approved question.

In that vein, the fact that there are separate Post-Dispatch Instructions (PDIs) for callers from alarm monitoring companies and private callers makes sense too. Callers from an alarm monitoring company are told to try to contact a responsible party to send to the site of the alarm (PDI-a) and asked to call back if they “get a reset of the alarm, additional alarms, or other information” (PDI-b). Note that there is no DLS pathway to Case Exit for alarm monitoring companies; these types of calls end with PDI-b.

Private callers, however, are instructed to stay on the line (PDI-c) and, among other things, evacuate the building if safe to do so (PDI-g).

“Protocol 52: Alarms is like the ‘sick call’ for fire,” said Galasso referring to how commonly both protocols (52 and 26: Sick Person (Specific Diagnosis)) are used in their respective fields. Just as it makes sense to become familiar with the priority symptoms that separate a high-acuity sick person from a low-acuity one, it’s imperative for you to be able to recognize when one alarm call is more of a priority than another. As always, it’s important to send the right thing to the right person in the right way at the right time. ●

Sources

ALARMS ARE ALARMING

Roughly 3 out of 5 fire deaths happen in homes with no smoke alarms or no working smoke alarms.¹

People who are hard of hearing or Deaf can use special alarms with strobe lights and bed shakers.²

Most home fire alarms detect smoke particles rather than heat levels.⁴

Long-term exposure to dust or cigarette smoke creates contamination in smoke alarms that can increase the number of nuisance (false) alarms.⁵

In 2018, U.S. fire departments responded to an estimated 888,000 calls involving a system malfunction.³

Dust buildup can cause smoke alarm nuisance/malfunction in hotels where vacuuming and linen changing occur daily.⁶

ESSENTIAL TRUTHS
Quotes impart a deeper understanding of ideas

Jeff Clawson, M.D.

_If you can fill the unforgiving minute, with sixty seconds’ worth of distance run—Yours is the Earth and everything that’s in it ..._

- Rudyard Kipling

The above elegant quote from Kipling, as an opening statement for The Principles of EMD, truly defines our profession’s sometimes “politically correct” and often manipulated objective—time—a dilemma which is faced daily by every single Emergency Dispatcher on the planet—and that, my brothers and sisters, is quite a professional responsibility to bear—because we all know just how important time can be in doing our jobs correctly.

Often, the essential, focal messages that define the most important things in our dispatch lives can be lost in a forest of words and the lengthy discussions that attempt to impart a deeper understanding of the meaning of a given article, chapter, manual, or, in this case, a book. While The Principles were being revised, we (the authors) at times engaged in some creative thinking, and even a bit of semi-wild speculation, regarding the idea of simply adding some engaging and appropriate quotes to each chapter. This began with a sporadic placement of a number of interesting, but specifically telling quotes that we thought might enhance, or at least help frame, the important issues we intended to be understood within these pages—at the beginning of, and in later editions at the end of, each chapter.

These quotes are meant to impart not only a literary, but a historically-based distillation of the important ideas represented within. Look carefully at the title of each chapter, then take your time in reading, and rereading, each quote. Each of which is intended to call out in just a few words a deeper understanding of the essential truths each chapter was meant to impart into our workaday lives.

If, in any way, this reintroduction of quotes accomplishes that objective, then, in the aggregate, we have succeeded in cultivating a deeper understanding of what this unified, structured, and evidence-based protocol, and the complete system it is surrounded by that you use daily, is truly all about. Slow the pace, read carefully, and enjoy them as I do each and every time I read them.

_For me, they always get better this way ... Doc_

_P.S._ Great minds wrote these statements, and great dispatch minds like yours and your colleagues’ will read and hopefully be inspired and improved by them ...  ●
CHAPTER 1: The First, First Responder

*Emergency Medical Dispatch is the jewel upon which the watch movement of public safety turns.*

—Fred Hurtado

*Change is the way the future reveals itself.*

—Unknown futurist

CHAPTER 2: Basic Telecommunication Techniques

Remember not only to say the right thing in the right place, but far more difficult still, to leave unsaid the wrong thing at the tempting moment.

—Benjamin Franklin

**Courage is the first of human qualities because it is the quality which guarantees all others.**

—Winston Churchill

CHAPTER 3: Structure and Function of Priority Dispatch

*Everything should be as simple as possible, but not simpler.*

—Albert Einstein

*Don’t rely on words or equations, until you can picture the idea they represent.*

—Lewis Epstein and Paul Hewitt

CHAPTER 4: Dispatch Life Support

*I get by with a little help from my friends.*

—Lennon and McCartney

*It’s okay. We can do this together.*

—Jennie Greenwood, EMD (Greater Manchester, U.K.)

CHAPTER 5: Caller Management Techniques

*You can only see a thing well when you know in advance what is going to happen.*

—John Tyndall

*The more details I can foresee, the more probabilities I have of saving myself.*

—Italo Calvino

CHAPTER 6: Medical Conditions

*When you have eliminated the impossible, whatever remains, however improbable, must be the truth.*

—Sir Arthur Conan Doyle

*Of all the treatments possible, the first to consider is to do nothing.*

—Gerasim Tikoff, M.D.

CHAPTER 7: Trauma Incidents

*When you’re confused, beat up and hurting, nothing feels as good as some calm, capable, credible, concerned person paying attention.*

—Alan Brunacini

*What you see, yet can not see over, is as good as infinite.*

—Thomas Carlyle

CHAPTER 8: Time-Life Priority Situations

*Listen to the newborn infant’s cry at birth—see the death struggle in the final hour—and then declare whether what begins and ends in this way can be intended to be enjoyment.*

—Søren Kierkegaard

*If you can look into the seeds of time, And say which grain will grow and which will not, Speak then to me ...*

—William Shakespeare (Macbeth)

CHAPTER 9: Scenarios & CDE

*Practice what you know, and it will help to make clear what now you do not know.*

—Rembrandt

*Laziness is nothing more than the habit of resting before you get tired.*

—Jules Renard

CHAPTER 10: Stress Management in Dispatch

*Dispatchers’ First Rule of Randomness: Emergency calls will randomly come in all at once.*

—Unknown

*Every life has a measure of sorrow. Sometimes it is this that awakens us.*

—Buddhist proverb

CHAPTER 11: Legal Aspects of EMD

*The point is, while your dispatching personnel express anxiety over the possibility of liability for providing such a service, we may well see the day when a municipality faces allegations of negligence for not providing such a service.*

—James O. Page (September 28, 1981)

*Perform your duties well while always caring about those whose terrified moments and painful days are entrusted to you, and you will seldom go wrong.*

—Anonymous physician

CHAPTER 12: Quality Management

*We must touch his weakness with a delicate hand. There are some faults so nearly allied to excellence that we can scarcely weed out the fault without eradicating the virtue.*

—Oliver Goldsmith

*No, you don’t have to do this. Survival is not compulsory.*

—W. Edward Deming

CHAPTER 13: Evolution of EMD

*The art of progress is to preserve order amid change and to preserve change amid order.*

—Alfred North Whitehead

*New and stirring things are belittled because if they are not belittled, the humiliating question arises, why, then are you not taking part in them?*

—H. G. Wells
BEYOND THE COMFORT ZONE

Challenging self-doubt opened his world

Audrey Fraizer

ENP Brian MacMurdo was tipping the scales at 430 pounds. He was guzzling caffeinated soft drinks and energy drinks, particularly between the hours of 3 a.m. and 5 a.m. during his night shift at the Hamilton County Communications Center, Cincinnati, Ohio (USA).

The caffeine needed to stay awake dropped when he was promoted to supervisor but not the level of daily stress. He rose through the ranks, becoming a training officer, supervisor, shift manager, and operations manager. Two calls he reviewed stick in his memory. A mother calling 911 and watching her child bleed from a fall into a glass cabinet as the emergency dispatcher listened and summoned response. A father accidentally running over his child who was playing hide-and-go-seek and using the space under the family car to hide.

These are the calls that never leave you, MacMurdo said. These are the types of calls emergency dispatchers compartmentalize, never letting them go and pretending they can take it.

MacMurdo was stressed to the max. He was heading down a path that was not healthy for him or his family. The profession he loved and found extremely rewarding was killing him. His frustration culminated on a muggy Cincinnati summer night. Making sure his wife and children were asleep, he stepped outside. He went to his truck parked in the driveway and sat there until morning.

“I had to get some of this stuff out,” he said. He turned to employee assistance and did some mental and emotional unloading. He decided to go ahead with elective surgery to reduce and control his weight. He crossed paths during his morning walk with a “Spartan.” A Spartan is a sport and community born out of the philosophy of world-class adventure racer Joe DeSena. A Spartan doesn’t follow someone else’s objective, but enters the sport for personal reasons, such as “I’m doing this in honor of my best friend who died while serving her country,” or “I’m doing this because I want to prove to myself that I can.”

MacMurdo didn’t think he had the “right stuff” to become a Spartan and resisted a suggestion to shift his comfort zone and train like a Spartan. The Spartan in the park kept after him. He relented. He had even fooled himself. “I realized I had more potential than I thought I had,” he said.

A Spartan Race is an obstacle course on a global scale offered in categories escalating in distance, obstacle count, and challenge level. MacMurdo chose three consecutive races. He covered a three-mile Spartan Sprint through concrete and natural obstacles like mud, barbed wire, and walls. The Spartan Super doubled the distance and added spear throwing and other ancient Spartan challenges to the obstacle course. The 13.1-mile Spartan Beast threw in steep climbs, fast descents, and heavy carries. Completing the three courses made MacMurdo eligible for a Trifecta weekend (a marathon distance in the mountains of West Virginia, USA).

He conquered and is now among the elite Trifecta Tribe.

What did MacMurdo say he learned from the experience? Yes, he pushed beyond the fear and into the exhilaration of reaching the finish line mud-splattered, scratched, bruised, and holding up his arms in triumph as part of the Spartan community. Challenging his perceived limits accomplished things he never thought he could do. “This lesson is important to all of us,” he said. “Taking good care of yourself and going beyond your comfort zone will revive the best of you, rather than take what is left of you.”


Source
TAKE THE CAT OFF THE WIRE
New thought patterns embrace value and self-worth

Audrey Fraizer

The poster of a cat holding tight to a pull-up bar was hardly the inspirational message that Stephen James Johnson wanted for the Stratford (Connecticut, USA) Public Safety Communications Center (SPSCC). The retro 1970s motivational poster that has since morphed into images of cats clinging to tree limbs, ropes, and clotheslines to stay alive may work for some places, but inside a generally stressful environment? “It wouldn’t work,” said Johnson, Supervisor, SPSCC. A cat in jeopardy did not reflect the long-term positive change in culture he was after. Rather, the distressed cats highlight a contradiction in professional thinking: People stay in emergency dispatch because of personal satisfaction (“I gave CPR instructions that helped save a life”) while, ironically, accepting a persona that undercuts their importance to field responders (“I’m just a dispatcher”). As a trainer and supervisor, he heard “I’m just a dispatcher” frequently among his staff. It was becoming a mindset and not something situational. Johnson found the phrase contradictory. It diminishes the vital importance of their work and the training it takes to stay in the profession. “We’re not just anything. We’re essential,” he said. His cat had to let go of the rope, land on all fours, and walk away. As Johnson explained, a conflict between what we say and do and what we believe about ourselves and our value creates personal priority dissonance within an individual. The misalignment causes internal conflict, stress, and self-diminishing behavior. The words we say and the actions we take conflict with the truth we believe about ourselves and the values we embrace. Johnson uses the example of an emergency dispatcher at the end of her rope. The caller is demanding. Uncooperative. The caller says, “Get me an ambulance. Stop with the questions.” The emergency dispatcher loses her cool and snaps at the caller, disrupting her colleagues. Internalizing the message we’re “just dispatchers” makes it easy to excuse or rationalize the missteps and poor performance, Johnson said. “We cannot accept that as an industry,” he said. “We have to find our own true north.” True north is the point on our metaphorical compass, Johnson explained. True north guides us to alignment with our organizational and personal values and standards. The way we interact becomes a reflection of professional values and living within our personal true north. As part of his anti-dissonance measure, Johnson teaches emergency dispatchers to compile a personal vision statement that complements their organizational mission statement. He encourages them to list their values and integrate those values in their daily performance. “There’s likely no room for ‘just a dispatcher’ on the list,” he said. Johnson’s vision statement, Be a Blessing, reflects his own faith background. He is an ordained pastor and serves several departments as a chaplain. He has identified his values as faithfulness, integrity, compassion, and service. He admits there are times he has fallen short. He is not perfect and recognizes a digression as a chance to learn from the experience and grow. The value-based checklist, Johnson said, is the looking glass in perceiving ourselves. It is a personal inventory that allows for a philosophical change away from the “hang in there” thinking that “I’m just a dispatcher.” “Emergency dispatchers do incredibly meaningful work;” he said. “Discovering their true north by embracing new thought patterns is a treasure that lasts for a lifetime.” Stratford Public Safety Communications Center is a police, EMS, and fire dispatch center staffed by three dispatchers, 24 hours a day. Johnson supervises a team of 15 full- and part-time public safety emergency medical dispatchers who process over 128,000 inbound and outbound phone calls per year (350 per day). Johnson has been in the profession since 2012. He was supervising a criminal court diversionary program and wanted work closer to emergency services. He landed his first public dispatch position at the East Haven (Connecticut) Fire Department. He soon discovered that emergency communications was not just a job—it suited his character and skills.
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