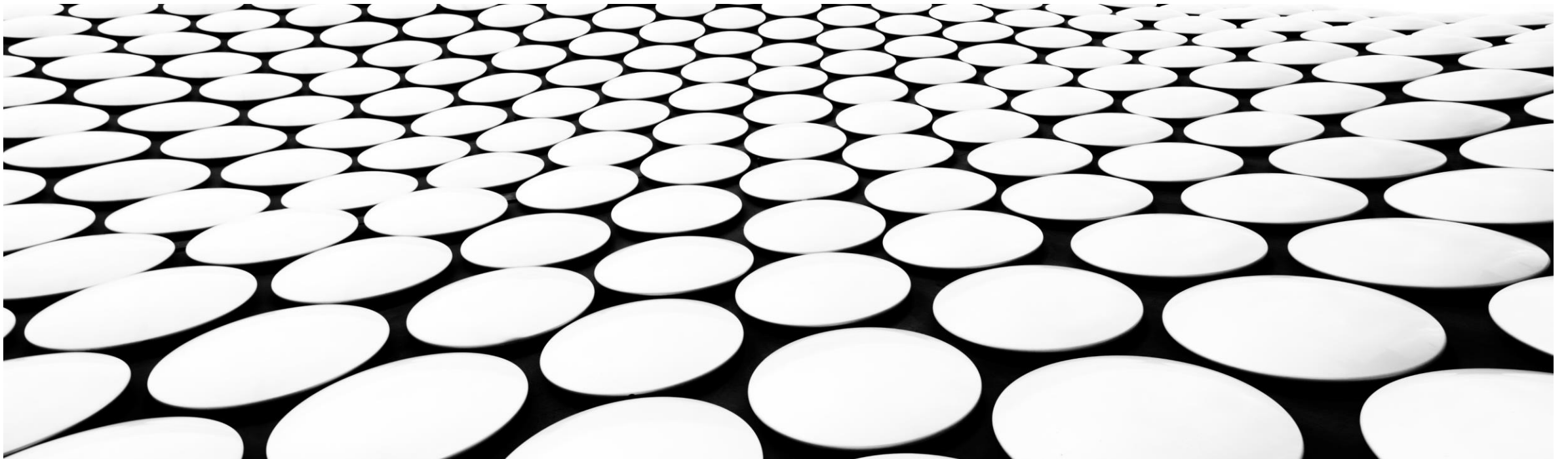

RHODE ISLAND E-911

EMERGENCY MEDICAL DISPATCH (EMD) PROGRAM

DISPATCHERS' EMD GUIDE



WHAT IS EMD?

- EMD is a structured approach to processing 911 medical calls for service
- EMD is both a new system and a philosophy of processing medical 911 calls based on “best practices” and clinically valid protocols
- EMD provides a rapid patient and scene assessment to prioritize medical calls for service using a decision support software program called “ProQA”
- EMD allows the Telecommunicator (TC) to quickly categorize emergency medical calls (life threat vs. non-life threat)
- EMD allows the 911 TC to provide “Pre-Arrival Instructions” for time/life critical situations, as well as general medical instructions for many situations
- **Fire and Police call processing is not impacted by EMD;** calltaking for these situations will remain with the downstream dispatcher.



WHAT ARE THE BENEFITS OF EMD?

- Consensus- and research-based questions and instructions for callers in nearly all medical situations
- Consistency from call-to-call, region to region, shift to shift
- Quality Assurance/Quality Improvement to recognize the TC and enhance protocol performance
- Risk reduction for patients, victims, bystanders, responders, TCs, dispatchers
- Medically appropriate pre-arrival care for patients

WHY IS RHODE ISLAND ADOPTING EMD?

- Improved patient outcomes
 - Better information for dispatchers
 - Standardized care across Rhode Island for all citizens and visitors
 - Increased cardiac arrest survival rate
 - State Law **RIGL 39-21.1-8**
- ❖ EMD is the right choice for Rhode Islanders to provide the best care and level of service from 911 that is expected by dispatchers, responders, and the people we all collectively serve in our communities

WHAT HAS RHODE ISLAND E-911 BEEN DOING TO PREPARE FOR THE EMD TRANSITION?

- Project led by RI E-911 Leadership and Priority Dispatch (vendor)
- All TCs have been certified by the International Academy of Emergency Dispatch (IAED) based in Salt Lake City, UT
- All TCs have performed roleplay and simulation practices
- Quality Assurance and Improvement (QA/QI) program and Continuing Education are in place
- Policy and procedure have been overhauled
- Technological infrastructure is in place (ProQA, AQUA, Xlerator, SecureLink)
- Oversight Committees to monitor health of EMD and make changes to improve use of the system are in place
- RI Department of Health endorses EMD
- Public education campaign with media component in progress

OVERSIGHT OF THE EMD PROGRAM

- **Quality Assurance Team**
 - 3 dedicated QA Supervisors
 - All supervisors QA trained by International Academy of Emergency Dispatch (IAED)
- **Executive Steering Committee (ESC)**
 - Oversight of the system by stakeholders including State Police, RI Department of Health, Dispatch Leaders
- **EMD Users' Group (EMDUG)**
 - RI E911 Telecommunicators
- **Statewide Dispatchers' Committee**
 - Communication and Feedback solicited to make the system work better

HOW WILL EMD IMPACT RI DISPATCH CENTERS?

- **Information for dispatchers about the patient's condition and scope of incident will be relayed**
- **EMD does NOT require a dispatch center or field resources to adopt hot (lights and siren) versus cold (no lights and siren) response models**
- **Information gleaned from EMD ProQA and passed along to the dispatcher is currently verbal only**
 - There is no unified technological mechanism to automatically send this data from ProQA directly to the 66 PSAPs, however, 3rd party interfaces to accomplish this are under consideration and will require substantial investment and planning
- **EMD does NOT require a dispatch center to alter any of its current priorities, response packages, or practices**
 - ❖ In the future, dispatch centers may elect to utilize the EMD information provided by 911 to improve dispatching of resources (e.g. tiered approach, hot/cot, etc.)
 - ❖ This will come in time as trust and confidence in the system is built

HOW WILL EMD IMPACT RI DISPATCH CENTERS?

- **Significant Overhaul of Call Transfer Workflow (began Winter 2021)**
- **The “old way” of transferring the caller blindly is ending**
- **New “Best Practice” workflow:**
 - TC introduces the caller to the dispatcher by “conferencing in” appropriate PSAP
 - TC provides **location** and **callback** number of the caller
 - TC provides **BRIEF** description of incident:
 1. **Chief Complaint** (the reason for the call)
 2. **Age/Sex** of the patient
 3. **Awake status** of the patient (Yes, No, Unknown)
 4. **Breathing status** of the patient (Yes, No, Uncertain, Ineffective, Unknown)

See additional “Workflow” for more information



EMD BASICS

PROTOCOL STARTS WITH THE TC



EMD HAS 5 BASIC COMPONENTS

- **Case Entry**

- Rapid survey by trained EMD (the least we need to know in order to choose a chief complaint and navigate through EMD ProQA)
- Immediate Life threats are identified and “fixed” early

- **Key Questions**

- Focused assessment (deeper dive)
- Each chief complaint has its own set of Key Questions

- **Diagnostic Tools**

- For certain situations/patient management

- **Final Coding**

- Clinical category and recommended priority (Planned for future use with downstream PSAPs)

- **Dispatch Life Support and Post-Dispatch Instructions**

- Instructions to callers for both routine and time/life critical events (step-by-step pre-arrival instructions)
- Prepare the caller/patient for rescue’s arrival

EXAMPLE OF CASE ENTRY

The TC will ask every caller **“Tell me exactly what happened”** to get objective, factual, relevant information from the caller as opposed to caller diagnosis, opinion, or perception.

The TC will ask the following (unless the answers are obvious or spontaneously provided by caller):

1. Are you with the patient now?

- Calling party establishes which questions and instructions will be directed by the software)

2. How many are sick/injured?

- Often this is obvious from the caller’s statements/incident type and is not verbalized

3. How old is the patient?

4. Is s/he awake?

5. Is s/he breathing?

6. TC then chooses a “chief complaint” to do a more in-depth assessment.

Paramount for Medical (5.1.1.44 - 5/9/2022 4:08:28 PM)

File View Spec Logs Options Go to Language Tabs Version About ProQA Release Notes

+ X [Icons]

:46

Entry KQ PDI/CEI DLS Summary

Case Entry Additional Information CC Selection Rules

Location is: []

Phone number is: []

Caller's problem description is: WORKER FELL OF SCAFFOLDING []

With patient now: Yes []

Number of hurt/sick is: 1 []

Patient's age is: 25 [] year(s)

Patient's gender is: Male []

Is he awake (conscious)? No []

Is he breathing? Yes []

Chief Complaint Code? 17 []

Falls

Conference In Dispatcher
Relay Case Entry Information before continuing EMD

Critical Caller Danger Instructions

When the patient is **not** conscious but **breathing**, the most likely code is **31** – followed by 9, 11, 12, 13, 14, 15, 23.

TIME/LIFE CRITICAL INCIDENTS

- ❖ For time/life critical events, the TC will conference in the dispatcher earlier in the call than non-time/life critical incidents so the call can be immediately dispatched.
- ❖ Once the dispatcher has the call for situations listed in the drop down shown here, the TC will segue into pre-arrival instructions for the caller.
 - ❖ This reduces unnecessary questions and time.
 - ❖ There will be times where the telecommunicator does not have good information to determine a time/life critical event is occurring. In such cases, once the time/life critical event is recognized the TC will shunt to the appropriate instructional sequence.

The screenshot shows the 'Paramount for Medical' software interface. At the top, there is a menu bar with options like 'File', 'View', 'Spec Logs', 'Options', 'Go to Language', 'Tabs', 'Version', 'About ProQA', and 'Release Notes'. Below the menu is a toolbar with various icons. The main area displays a list of emergency scenarios under the heading 'Okay, tell me exactly what happened.' The scenarios include: 'Obviously NOT BREATHING & Unconscious (non-traum)', 'Verified Choking - COMPLETE obstruction', 'Narcotic/Opioid arrest (obvious)', '1st Party OBVIOUS EXTREME RESPIRATORY DISTRESS', 'Hanging', 'Strangulation (no assailant present)', 'Suffocation', 'Underwater (non-SPECIALIZED rescue)', 'Underwater (SPECIALIZED rescue)', 'Sinking vehicle - Caller inside', 'Vehicle in floodwater - Caller inside', 'Person on fire', and 'ACTIVE ASSAILANT (SHOOTER)'. To the right of the list, there is a red bell icon and the text 'Conference In Dispatcher Relay Case Entry Information before continuing EMD'. Below the list, there is a pink bar with the text 'Critical Caller Danger Instructions'.

EXAMPLES OF EMD KEY QUESTIONS

Mix of Questions from various chief complaints:

- Is she responding normally?
- Is her breathing normal?
- Does she have any pain?
- Is she bleeding or vomiting blood?
- Has he had more than one seizure in a row?
- Tell me why you think she's having a stroke.
- What part of the body was injured?
- Does he have a prescribed inhaler for these attacks?
- What caused the fall?
- Does she have difficulty speaking between breaths?
- Is he violent?

The number and type of questions depends upon the Chief Complaint the TC chooses for the type of medical incident being reported. The TC will avoid asking questions where the answer has already been provided by the caller earlier in the conversation.

Paramount for Medical (5.1.1.44 - 5/9/2022 4:08:28 PM)

File View Spec Logs Options Go to Language Tabs Version About ProQA Release Notes

1:44 17: Falls

Entry KQ PDI/CEI DLS Summary

1. How far did he fall?

Ground level
Less than 10ft/3m (1 story)
Fall down (not on) stairs
LONG FALL – 10–29ft (3–9m)
EXTREME FALL – 30ft/10m (3 stories) or more
Unknown

Caller Statement: WORKER FELL OF SCAFFOLDING

KQ Answers Additional Info Problem Suffixes Determinants w/ Suffixes Det. Codes CC Selection Rules

LONG FALL
The patient has fallen from a distance of:
• Adult/Child – 10–29ft (3–9m)
• Infant – 6–29ft (2–9m)

EXTREME FALL
The patient has fallen from a distance of 30ft/10m (3 stories) or higher.

POSSIBLY DANGEROUS Body Area	NOT DANGEROUS Body Area
<ul style="list-style-type: none">• Abdomen• Amputation (excluding finger/toe)• Back• Chest (breathing normally)• Head (alert)• Leg, upper (obvious deformity)• Neck (breathing normally)	<ul style="list-style-type: none">• Ankle• Arm, upper*• Collar bone (clavicle)• Elbow*• Finger• Foot• Forearm• Genitalia• Groin• Hand• Hip/Pelvis• Knee*• Leg, lower

pdcc
MPDS 13.3.326 4/6/2022
175

O: NAE
C: NAE
P: STD

25-year-old, Male, Not Conscious, Breathing.

EXAMPLES OF DIAGNOSTIC TOOLS

Aspirin Diagnostic

ProQA Diagnostic Tools Version: 5.2.0.1

Abbreviations Additional Info Limitations Warning

Aspirin Diagnostic and Instruction Tool

Select one for a chest pain/discomfort (HEART ATTACK Symptoms) patient who is alert, ≥ 16, not pregnant, and has no reported STROKE symptoms:

1st Party 2nd Party

Does anyone there have any aspirin or medication containing aspirin available? (Ask them now.) YES NO UNSURE

Is s/he allergic to aspirin? YES NO UNSURE

Has s/he vomited blood or coffee ground material in the last 24 hours? YES NO

Has s/he passed black or bloody stools in the last 24 hours? YES NO

(Sent someone for ASA) Did they return with aspirin? YES NO

Recommendations
Get one adult aspirin or four low-dose (baby) aspirins and tell me when you have them.
(Which type do you have?) ADULT (325mg) LOW-DOSE or BABY (81mg) SPECIAL DOSES

Administration Instructions
Tell her/him to chew one adult aspirin right now.

Unable to chew Request to wash down ASA

Close

© 2004–2021 Priority Dispatch Corp. Protected by U.S. Patent 7,645,234. Other patents pending. All rights reserved.

Stroke Diagnostic

ProQA Diagnostic Tools Version: 5.2.0.1

Abbreviations Additional Info Limitations Warning

Stroke Diagnostic Tool

Start Now Tool Findings

Ask him to smile.
(Wait) Was the smile equal on both sides of his mouth?

Normal smile
 Slight difference in smile (possible difference)
 Only one side of mouth or face shows a smile (obvious difference)
 Patient unable to complete request (to smile)
 Patient/Caller refused to complete request (to smile)

Answer Selected C
Question Score 3

Ask him to raise both arms straight out in front of himself and hold for a moment.
(Wait) Was he able to raise and hold both arms equally?

Both arms raised and held equally
 One arm higher than the other, or unable to hold for any period of time
 Only one arm raised
 Patient unable to complete request (to raise arms)
 Patient/Caller refused to complete request (to raise arms)

Answer Selected C
Question Score 3

Ask him to say, "The early bird catches the worm."
(Wait) Was he able to repeat it correctly?
(Clarify) Was it slurred, garbled, or not understandable?

Said correctly
 Slurred speech
 Garbled or not understandable speech
 Patient unable to complete request (to speak)
 Patient/Caller refused to complete request (to speak)

Answer Selected d
Question Score 2

Stroke Diagnostic Evidence:

CLEAR evidence of stroke (c,c,d)

TOTAL SCORE 8

Return to KQs

© 2004–2021 Priority Dispatch Corp. Protected by U.S. Patent 7,645,234. Other patents pending. All rights reserved.

EXAMPLES OF FINAL CODING

- 10-D-1
 - Chest Pain - Not Alert
 - 26-A-1
 - Sick Person - No Priority Symptoms
 - 17-D-3-P
 - Falls – Unconscious in Public Place
- There are more than 2,000 possible codes in the Medical Priority Dispatch System; each code identifies a specific condition.
- **During initial rollout, these codes will be used only internally for statistical purposes.**
- **In the future, these codes may be provided to the dispatcher so that they can be cross-referenced to know the exact type of situation and thus trigger more precise responses that match the severity of the incident.**

Paramount for Medical (5.1.1.44 - 5/9/2022 4:08:28 PM)

File View Spec Logs Options Go to Language Tabs Version About ProQA Release Notes

5:50 5:23 17: Falls 17-D-3P

Entry KQ PDI/CEI DLS Summary

Last Key Question has been answered.

Caller Statement: WORKER FELL OF SCAFFOLDING

KQ Answers Additional Info Problem Suffixes Determinants w/ Suffixes Det. Codes CC Selection Rules

1. The fall was between 10 and 29ft (3 and 9m).
2. The fall was accidental.
3. There is SERIOUS bleeding.
4. The caller reports that the patient is in a public place (street, parking garage, market): OS SHOPPING CENTER

pdv
MPDS 13.3.326 4/6/2022
175

O: NAE
C: NAE
P: STD

25-year-old, Male, Not Conscious, Breathing. Code: 17-D-3-P: Unconscious (Public place (street, parking garage, market))

EXAMPLE OF ASPIRIN DIAGNOSTIC

DLS Links

X-Card

Unconscious

ASA Aspirin Diagnostic Tool

Use of the Aspirin Diagnostic & Instruction Tool may be considered when a patient reported to be not alert is known to be awake, talking, and responding (functionally alert). Sips of water should only be provided upon patient request.

ASA ProQA Diagnostic Tools Version: 5.2.0.2

Abbreviations Additional Info Limitations Warning

Aspirin Diagnostic and Instruction Tool

Select one for a chest pain/discomfort (HEART ATTACK Symptoms) patient who is alert, ≥ 16, not pregnant, and has no reported STROKE symptoms:

1st Party 2nd Party

Does **anyone there** have any aspirin or medication containing aspirin available? (Ask them now.) YES NO UNSURE

Is s/he **allergic** to aspirin? YES NO UNSURE

Has s/he vomited **blood** or **coffee ground material** in the last 24 hours? YES NO

Has s/he passed **black** or **bloody stools** in the last 24 hours? YES NO

Recommendations

Get one adult aspirin or four low-dose (baby) aspirins and tell me when you have them.
(Which type do you have?) **ADULT (325mg)** LOW-DOSE or BABY (81mg) SPECIAL DOSES

Administration Instructions

Tell her/him to chew one adult aspirin right now.

ASA Additional Information

Aspirin-Containing Medications

For AMI early treatment purposes, the following medications (listed by their commonly known brand names) **ARE the same as aspirin:**

- Alka-Seltzer (dissolve in water first)
- Anacin
- Ascriptin
- Asperbuf
- Aspergum
- Bayer
- BC Powder
- Bufferin
- Doan's pills
- Easprin
- Ecotrin
- Empirin
- Entrophen
- Excedrin (only if aspirin based; another variety contains acetaminophen)
- Goody's Powder
- Halfprin
- Measurin
- St. Joseph
- Vanquish

Do NOT Use These Medications

For AMI early treatment purposes, the following medications (listed by their commonly known brand and generic names) are **NOT the same as aspirin** and **should not be administered:**

- Advil (ibuprofen)
- Aleve (naproxen)
- Celebrex (celecoxib)
- Feldene (piroxicam)
- Indocin (indomethacin)
- Midol (acetaminophen)

EXAMPLES OF PRE-ARRIVAL INSTRUCTIONS

Compressions Counter to pace caller

Entry	KQ	PDI/CEI	DLS	Summary
C6 - CPR Landmarks		AED: Yes Sent At pt. Started Used		
<p>Listen carefully and I'll tell you how to do chest compressions.</p> <p>(Make sure he is flat on his back on the floor/ground.)</p> <p>Place the heel of your hand on the breastbone (in the center of the chest), right between the nipples.</p> <p>Put your other hand on top of that hand.</p>				

ProQA Diagnostic Tools Version: 5.2.0.2

Abbreviations Additional Info Limitations Warning

Advanced Compressions Monitor

Select the appropriate age range:

Adult 8 or over	Child (1-7 yrs)	Newborn (< 30 days)
	Infant (< 1 yr)	Neonate (< 24 hrs)

To start the counter, select the appropriate number of compressions:

600 Times	100 Times	30 Times	5 Times
-----------	-----------	----------	---------

Unlimited
Refused M-T-M

Okay. Start counting out loud now.

Now

Counter 0028

4

Pause Counter

Pause for breaths
Evaluate breathing
Clear/Restart

Seizure Instructions (partial)

If he is still **seizing** (or if he **starts to seize again**):

1. **Don't do CPR.**
2. **Don't hold him down** or **put anything into his mouth.**
3. **Move dangerous objects** away from him.

(**Not seizing & Not awake**) Let's **check his breathing** (again). (**Use the Breathing Verification Diagnostic.**)

Drowning Instructions (partial)

(**≥ 1 + Unconscious or Not alert**) If there is a **defibrillator (AED)** available, **send** someone to get it **now** in case we need it later.

(**Non-SPECIALIZED**) **Do not go in the water** unless it's **safe** to do so.


(**SPECIALIZED**) **Do not go in the water.**

EXAMPLES OF PRE-ARRIVAL INSTRUCTIONS

Q7 - Administer Medication

Place and hold the **tip** of the nozzle in **either** nostril until your **fingers touch** the **bottom** of their nose.


Press the plunger **firmly** to **release** the dose into their nose. Tell me **when** it's done.



Q8 - Monitor Patient/Assure Recovery

You need to **watch** their breathing **very closely**. Tell me if it **changes** or if they **start to wake up** or **move** around. I'll **stay on the line** with you until the **paramedics (EMTs) get there**. Tell me **when** they're right **next** to them.

*** Provide an additional dose, with a new device, if there is no improvement in their breathing (respiratory function) in 2–3 minutes or if their symptoms return after the first dose.**



←
→
Symptoms Recurring/Not Improving

Not Breathing/AGONAL/UNCERTAIN

Started Moving – Still Unconscious

Waking up Now

Arrival Interface

Entry	KQ	PDI/CEI	DLS	Summary
P2a - EpiPen® / EpiPen Jr.® Instructions				
<p>Hold the injector tightly in the middle of your hand (form a fist around the injector) with the orange tip facing down. Do not touch the orange tip.</p> <p>Now, with your other hand, pull off the blue safety release cap at the top of the injector (this will unlock the device).</p> <p>* If the caller doesn't understand the instructions, then clarify and reassure.</p>				
<p>Do you understand me so far?</p> <div style="display: flex; align-items: center;"> ← <input style="flex-grow: 1; border: 1px solid gray;" type="text" value="Yes"/> </div>				

Allergic Reaction (partial sequence for illustration)

Overdose Arrest with Naloxone (Narcan)
(partial sequence for illustration)

EXAMPLES OF PRE-ARRIVAL INSTRUCTIONS

Childbirth (partial sequence for illustration)

F6 - Deliver Baby

As the baby delivers, **support** the baby's **head** and **shoulders** and **hold** its **hips** and **legs** firmly. **Remember**, the baby will be **slippery**, so **don't drop it**.

Is the baby **completely out** now?

Yes Yes – STILLBIRTH
 No

Bleeding Control Instructions (partial sequence for illustration)

X5 - Control Bleeding (external)

(Tourniquet already applied) Do not remove the tourniquet. Let the **paramedics (EMTs)** handle it.

I'm going to tell you how to **stop** the **bleeding**. Listen **carefully** to make sure we **do it right**.

Get a clean, dry **cloth** or towel, and **tell me** when you **have** it. **[Pause until done]**

Now place it **right on** the **wound** and **press down** firmly. **Don't lift it up to look**. **[Pause]**

Without lifting the cloth/towel up, please **tell me** if the bleeding is **under control** now.

Bleeding Controlled Bleeding Not Controlled

Typical “disconnect” instructions

X2 - Routine Disconnect (≈ stable) – 2nd Party

I want you to **watch** him very closely.

If he becomes **less awake** and **vomits**, quickly lay him on his **side**.

(Appropriate)

Before the responders arrive, please:

- Put **away** any **pets**.
- **Gather** his **medications**.
- **Unlock** the **door**.
- **Turn on** the outside **lights/vehicle hazard lights**.
- Have someone **flag/wave** down the **paramedics**.

(Disconnect) If he gets **worse** in any way (**or has another seizure**), call us back **immediately** for further instructions.

Main Additional Info Special Information

Stay on Line Last instruction – Close case
 Go to PDIs Go to KQs



OPERATIONAL IMPACTS OF EMD

WORKFLOW CHANGES FOR DISPATCH CENTER PARTNERS



DISPATCHER EXPECTATIONS

- **The TC has a new and critical role in following EMD protocol as closely as possible**
 - Much of the interaction is protocolized, however, the TC may enhance protocol as needed within performance standards
 - Cooperation from downstream dispatchers is paramount!
- **Actively listening to the TC (who must manage the EMD caller) is critical**
 - All EMD calls must be managed by the TC. Police and Fire calls remain with the dispatcher*
- **Allow TC to “EMD” the caller**
 - Refrain from interrupting or interjecting unless there is a location issue or scene safety follow-ups are needed
- Dispatcher may disconnect after the TC has relayed the chief complaint, age/sex, awake, breathing status, or may choose to monitor the EMD call for additional details to update responders

BENEFITS TO DISPATCHERS

- **Streamlines call flow**
- **Eliminates the need for redundant questions**
- **Improves experience of the caller (reduces caller stress and frustrations)**
- **Improves experience between 911 and dispatchers**
- **Participation and Communication via statewide Users Group**
- **Reduces need for local dispatchers to become EMD trained**
- **Opportunities for data analysis and feedback**
 - Cardiac Arrest Outcome Tracking

WORKFLOW MODIFICATIONS

- **RI 911 Leadership implemented significant changes to operations to ensure EMD is rolled out successfully in 2 phases, pre-go live and go live**
- **The “transfer point” to the dispatcher occurs as early as practical instead of at the end of the call or the recommended “SEND” point in the EMD ProQA software.**
 - The TC will transfer the caller at the end of “Case Entry” (Case Entry is the least we need to know to understand what’s happening and to confirm the patient is (or is not) awake and breathing)
 - This balances the need for “early dispatch” with the need for the TC to manage the caller and provide care to the patient
 - Once the dispatcher acknowledges the basic information provided (location, age, gender, awake, breathing, incident type), the TC will continue to “EMD” the caller (the dispatcher may then disconnect or may remain on the line as long as desired)
 - TCs are the “First, First responders” along with dispatchers

The TC will suspend EMD when there is a scene safety issue such as assault, shooting, stabbing, or psychiatric/mental health emergency until the dispatcher has completed all localized law questioning AND the scene is secure to allow EMD to occur without jeopardizing the caller, bystanders, patients, or victims.

NEW EMD WORKFLOW

“911, what is the location of the emergency?”

“Tell me exactly what happened.”

EMD CALL INITIATED:

–“Are you with the patient now?”

–“How old is she?”

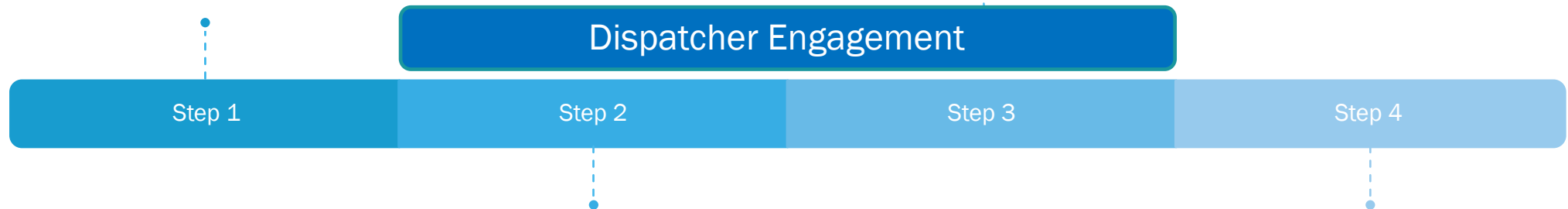
–“Is she awake?”

–“Is she breathing?”

TC then PAUSES and CONFERENCE IN THE DISPATCHER

TC Provides Dispatcher with:

- Location
- Callback
- Chief Complaint/Quick Incident Description
- Age of patient
- Awake Status
- Breathing Status



Step 1

Step 2

Step 3

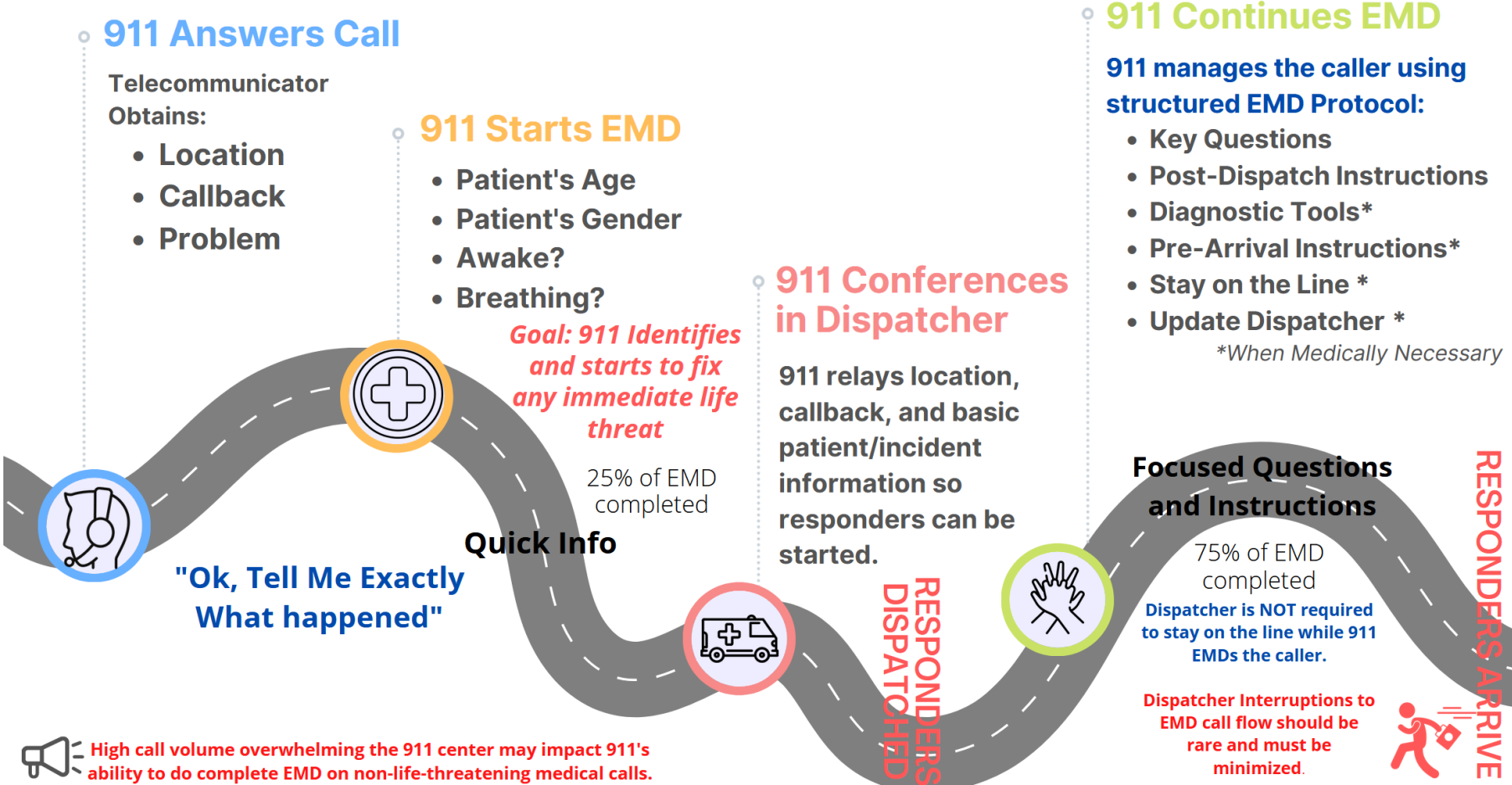
Step 4

TC conferences in dispatcher

TC continues to ask Key Questions
TC provides post-dispatch instructions to caller
TC provides pre-arrival instructions to caller (if needed)
TC stays on the line with caller until first responders make patient contact (only in critical situations)

Effective July 26, 2022

Emergency Medical Dispatch Roadmap Rhode Island E-911



High call volume overwhelming the 911 center may impact 911's ability to do complete EMD on non-life-threatening medical calls.

The TC will suspend EMD when there is a scene safety issue such as assault, shooting, stabbing, or psychiatric/mental health emergency until the dispatcher has completed all localized law questioning AND the scene is secure to allow EMD to occur without jeopardizing the caller, bystanders, patients, or victims.

WHY ARE DISPATCHERS DISCOURAGED FROM INTERRUPTING 911'S INTERVIEW WITH THE CALLER?

- **In order for standardized care to occur, the 911 telecommunicator must use protocol the way it was designed.**
 - It is recognized that some dispatchers in Rhode Island have been doing a form of medical screening for many years; however, while this is laudable, it is critical for the TC to follow the Medical Priority Dispatch System (MPDS) version on each and every call to ensure standardized care for all Rhode Islanders and visitors.
- **Interruptions/interjections by the dispatcher to the EMD call flow must be kept to a minimum.**
 - Interruptions or interjections into the call will throw the 911 telecommunicator off structured protocol and may delay other questions or instructions in the sequence. This can adversely impact patient care.
 - It is expected that on a routine medical call the dispatcher will interject only to verify/troubleshoot a location or address, and once that is done will tell the caller that **“911 is going to provide you some instructions”** so that the caller understands what’s happening. This will ensure a seamless transition back to the TC.
 - This will streamline the workflow and have the least impact on the caller. The mission is to work as a team. Adjusting to this new interplay will take time.
 - The TC will suspend EMD when there is a scene safety issue such as assault, shooting, stabbing, or psychiatric/mental health emergency until the dispatcher has completed all localized law questioning AND the scene is secure to allow EMD to occur without jeopardizing the caller, bystanders, patients, or victims.

GO LIVE

- **The Go Live begins July 26, 2022**
 - **Estimated time of go live is 10:00 a.m.**
- Priority Dispatch will provide ‘round the clock on-site support to TCs for 3 days, with additional remote support available as needed
- Long term support and quality assurance oversight will also be provided by PDC weekly so TCs can receive feedback
- The EMD project is a collaboration between RI E-911, RI State Police, the International Academies of Emergency Dispatch, and Priority Dispatch
 - *Law requires implementation of EMD no later than September 1, 2022*

EMD WORKFLOW PRINCIPLES

- **There is no expectation for the dispatcher to listen to the whole EMD interaction**
- **The TC will initially relay only the important parts of the call**
 - The dispatcher may choose to remain on the line to monitor the remainder of the EMD call
 - The TC will attempt to re-contact the dispatcher if there is a significant update in the patient's condition or incident.

Patient Info Relayed to Dispatcher

- **Incident type/problem**
- **Age** (or approximation)
- **Sex**
- **Awake status**
- **Breathing status**

The TC will suspend EMD when there is a scene safety issue such as assault, shooting, stabbing, or psychiatric/mental health emergency until the dispatcher has completed all localized law questioning AND the scene is secure to allow EMD to occur without jeopardizing the caller, bystanders, patients, or victims.

“TRANSFER BACKS”

- **While EMD is primarily focused on 911 callers, it is recognized that a small number of calls may be direct dialed into the local dispatch center, thus bypassing 911.**
- In such cases, the local dispatcher has the ability to transfer the caller directly to a 911 telecommunicator (TC). If you are a local dispatcher, please consult with your training supervisor for the proper method to contact a 911 (TC).
- To reduce misunderstandings, the dispatcher should state to the TC upon call pickup the name of the dispatch center and explain that they have a medical call that was received on a 7-digit line.
- If it not possible to transfer the caller, obtain a callback call using the above numbers so that the TC can make an outbound call to the caller and provide EMD if possible.
- **Medical staff from skilled medical facilities such as urgent cares and nursing homes requesting transport or transfer of a patient may continue to be handled by each dispatch center without the need of transferring the caller to a TC for EMD; this decision has been left to each municipality or PSAP.**



EMD GO LIVE & BEYOND

CHALLENGES, QUALITY & OPPORTUNITIES



CONTINUING CHALLENGES FOR 911

- **EMD is a whole new system and way of doing things, not a piece of software. Every part of the way calls are processed has been impacted by EMD planning and rollout.**
 - EMD will significantly increase the time TCs will be on the line even though the callers will be conferenced in with dispatchers at the earliest opportunity once the most basic (but critical) medical information is obtained
 - Changing the workflow that has been rooted for decades has added immense stress to TCs who now have new expectations and requirements of professional performance and accountability
 - The TCs' new role as the "first, first responder" (similar to dispatchers) for medical calls is also very stressful
 - TCs have a new responsibility to follow operational policy changes such as the workflow changes that work in concert with EMD
 - Weekly Quality Assurance and Quality Improvement will be a cultural change for 911 TCs
 - Approximately 80 EMD calls will be fully reviewed by internal and external QA reviewers each week
 - TCs will receive feedback and coaching to improve performance and recognize strong performance

STAYING ON THE LINE

911 will attempt to stay on the line with a caller when the situation falls into one of the following categories:

- Pre-Arrival instructions are needed (e.g. CPR, choking, childbirth, opiate arrest, sinking vehicle)
- Unconscious
- Priority Symptoms (e.g. priority chest pain, priority difficulty breathing, etc)
- Not alert
- Suicidal/Domestic Violence
- Elderly or child alone
- Serious injury or hemorrhage

High call volume overwhelming the 911 center may impact 911's ability to do complete EMD on non-life-threatening medical calls. Moreover, a telecommunicator may choose to stay on the line where the caller/incident is stable but there are other valid reasons to stay on the line.

QUALITY ASSURANCE/QUALITY IMPROVEMENT

- Quality Assurance will be provided both in-house and through an independent entity called “Quality Performance Review” (QPR)
 - EMD Performance Standards set forth by the International Academies of Emergency Dispatch have been adopted
 - Weekly reviews of 80 medical calls will be performed, including 14 cardiac arrests
 - In-person feedback using QA reports will be provided to TCs to coach and mentor TCs
 - 911 Leadership will recognize exemplary performance of TC
- **Quick Look at QA Evaluation Areas:**
 - TC asks and records correct answers to all questions in non-leading manner
 - TC selects best Chief Complaint for each situation (33 options)
 - TC follows protocol scripts, sequences and prompts correctly, enhancing where necessary or appropriate
 - TC verbalizes Post-Dispatch Instructions and Pre-Arrival Instructions when they are medically appropriate and possible
 - TC stays on the line when needed and delivers the standard of care for a given situation
 - TC uses diagnostic tools in EMD ProQA to assess certain types of patients
 - TC provides professional customer service to the caller

GROWING PAINS

- **Any new system such as EMD will experience challenges and unforeseen impacts**
- **Internal policy re-development means TCs will need to acclimate quickly to a new world**
- **Leadership and oversight committees are the conduit for improving the way EMD services are provided to Rhode Islanders, including PSAPs**
 - Dispatchers have a voice through the Statewide Dispatchers' Committee
- **The system will take several weeks to resolve kinks and unforeseen issues**
 - No plan can account for every conceivable variable
 - Leadership is prepared to “pivot quickly” in cases where rapid changes may be needed
- **As EMD is new to Rhode Island, it is expected for some callers to question or object to the “new system”**
 - TCs have been provided with samples of reassuring, explanative, and calming statements in these situations to provide good service
 - Local media will be engaged to help educate the public before and during go live

FUTURE STRATEGIC PLANNING

- **Rhode Island Department of Health Goals for Statewide EMS enhancements**
- **Opportunities for dispatchers to take additional EMD and public safety training**
 - Emergency Telecommunicator
 - Emergency Medical Dispatcher
- **RI E-911 to seek EMD “Accredited Center of Excellence” (ACE) achievement**
 - ACE validates compliance to protocol and best practices
 - ACE reduces risk to all stakeholders (callers, bystanders, patients, victims, responders, TCs, dispatchers)
 - ACE builds confidence in EMD through proven “high performance” and outcome links
 - ACE is achieved by only about 5% of emergency call centers worldwide as it is a very high bar of measured performance evaluated independently.



MYTHS ABOUT EMD IN RHODE ISLAND



MYTHS ABOUT EMD

- **TCs will ask questions that don't make sense.**

- Once the correct EMD chief complaint is chosen, the Key Questions asked relate directly to the situation. Questions are not asked when the answer is obvious or has already been provided spontaneously by the caller. The EMD may re-ask questions if the situation changes in order to confirm the information is still accurate.

- **TCs will slow down dispatch.**

- TCs will transfer the caller and provide the location, callback, and “4 commandments” as soon as they are known. At the time the caller is transferred, EMD is only approximately 25% completed. For time/life critical calls, the dispatcher will be conferenced in immediately upon recognition of the life threat.

- **EMD will take too long.**

- EMD will increase the amount of time the 911 TC is on the phone with a medical caller, but the transfer to the appropriate dispatcher will occur as soon as the TC knows location, callback, age, gender, awake status, breathing status, and chief complaint. This balances the need for accurate information with those situations where rapid dispatch are necessary.

- **EMD will replace a TC's ability to think.**

- EMD is a decision support tool based around proven, highly developed scripts. TCs have the flexibility to enhance (not substitute) protocol. The framework of EMD is structural and proven. The TC must continue to use enhanced situational awareness and caller management skills that are not scripted and are situationally dependent.

MYTHS ABOUT EMD

- **TCs will have to stay on the line with all callers, causing 911 calls to back up.**
 - Only a small percentage of calls require the TC to stay on the line until responders take over.
 - These include cases where life-saving “pre-arrival” instructions are given (CPR, childbirth, sinking vehicle, etc) or in cases where the patient is unstable such as unconscious, not alert, serious hemorrhage/injury, suicidal, priority symptoms, or priority chest pain.
 - When 911 calls go into “queue” at 911, EMD may be **abbreviated** or **suspended** until the surge is resolved.
 - There are controls in place to monitor incoming call volume and the impact of EMD call processing via Supervisor and Management review.
 - In some cases, the TC will have to “Urgent Disconnect” a medical call where they have stayed on the line with the patient in order to answer pending 911 calls such as when the TC is remaining on the line only to monitor an unstable (but not critical) patient. In life threatening situations, the TC will attempt to stay on the line to monitor the patient and provide care until responders arrive.
- **EMD will replace the dispatcher’s role.**
 - While there is a need for the dispatcher to allow each medical call to be “EMD’d”, the TC will pause EMD interrogation any time there is a location question or safety concern (e.g. hybrid police/medical call). In this way, the dispatcher will still ask pertinent information as needed such as suspect and vehicle information, etc.

MYTHS ABOUT EMD

- **Dispatchers will need to stay on the line extra long.**
 - Dispatchers may disconnect after the TC provides the call information
 - Dispatchers will be re-contacted (once they disconnect) if the TC has a significant update for the incident or patient's condition
 - In cases where the situation requires the TC to attempt to stay on the line until responder arrival, 911 will do that
 - 911 will provide all pre-arrival instructions to the caller for a medical event
- **EMD means 911 is taking over for dispatchers on police-related calls like shootings, stabbings, and assaults.**
 - While 911 takes the lead on medical calls once EMD goes live, incidents with a safety/law enforcement issue (hybrid police/medical calls) will be handed-off to the dispatcher like they always have been.
 - The TC will suspend EMD when there is a scene safety issue such as assault, shooting, stabbing, or psychiatric/mental health emergency until the dispatcher has completed all localized law questioning AND the scene is secure to allow EMD to occur without jeopardizing the caller, bystanders, patients, or victims.
 - The goal is to work as a team on these complex calls—when the dispatcher is finished covering local police/safety questioning, they should tell the TC it's ok to start EMD. Working cooperatively is paramount for the success of EMD and the relationship between 911 and PSAPs. The caller will then have a positive experience during a difficult situation.

MYTHS ABOUT EMD

- **EMD is only for time/life critical calls.**
 - EMD is for ALL medical calls, including minor injuries and illnesses
 - The TC will use EMD for all calls where someone is sick or injured
 - The TC will suspend EMD when there is a scene safety issue such as assault, shooting, stabbing, or psychiatric/mental health emergency until the dispatcher has completed all localized law questioning AND the scene is secure to allow EMD to occur without jeopardizing the caller, bystanders, patients, or victims.
- **EMD means my agency has to adjust all its responses to align with the EMD codes.**
 - EMD does not require a dispatch agency or any police, fire, or rescue agency to change anything (hot/cold, BLS/ALS, etc.)
 - In the future, dispatch centers may choose to use EMD information for “tiered responses” by utilizing the system’s priorities and codes in their CAD “run cards” to deploy resources more efficiently based on acuity and resource availability
 - “Determinant Codes” from ProQA will not be provided by 911 to dispatchers during the initial rollout of EMD.
 - Once confidence in the system are established, this future phase will kick off.



EMD “CHIEF COMPLAINT” EXAMPLES

CHEST PAIN, FALL, ASSAULT, STABBING/GUNSHOT, PSYCHIATRIC



Example Only. Protocol questions and instructions in ProQA are dynamic. The actual number, type, and sequence of questions can change based on many factors including caller party, awake/breathing status, etc.

CHEST PAIN/CHEST DISCOMFORT (NON-TRAUMATIC)

Examples of (core) Key Questions

- **Is s/he completely alert?**
- **Is s/he breathing normally?**
 - **No: Does she have any difficulty speaking between breaths?**
- **Is s/he changing color?**
 - **Yes: Describe the color change.**
- **Is s/he clammy or having cold sweats?**
- **Has s/he ever had a heart attack or angina (heart pains)?**
- **Did s/he take any drugs or medications in the past 12 hours?**

Examples of (core) Post-Dispatch Instructions

- **Help is on the way.**
- **Stay on the line and I'll tell you exactly what to do next.**
- **(HIGH ACUITY) If there is a defibrillator (AED) available, send someone to get it now in case we need it later.**
- **(Patient medication requested and alert) Remind her/him to do what her/his doctor has instructed for these situations.**
 - [Link to Aspirin Diagnostic tool if patient is eligible](#)
 - [Link to normal case exit/stay on the line](#)

Example Only. Protocol questions and instructions in ProQA are dynamic. The actual number, type, and sequence of questions can change based on many factors including caller party, awake/breathing status, etc.

FALLS

Examples of (core) Key Questions

- **How far did s/he fall?**
- **What caused the fall?**
 - Shunts to other chief complaints based on cause
- **Is there any **SERIOUS** bleeding?**
- **Is she completely alert?**
- **What part of the body was injured?**
- **When did this happen?**
- **Is s/he still on the floor/ground?**

Examples of (core) Post-Dispatch Instructions

- **Help is on the way.**
- **Stay on the line and I'll tell you exactly what to do next.**
- **(Unconscious or Not Alert) If there is a defibrillator (AED) available, send someone to get it now in case we need it later.**
- **Do not splint any injuries.**
 - [Links to other instructional panels as needed](#)

Example Only. Protocol questions and instructions in ProQA are dynamic. The actual number, type, and sequence of questions can change based on many factors including caller party, awake/breathing status, etc.

ASSAULT

Examples of (core) Key Questions

- **Is the assailant (attacker) still nearby?**
- **Were weapons involved or mentioned?**
- **Is there any SERIOUS bleeding (spurting or pouring)?**
- **Is s/he completely alert?**
- **What part of the body was injured?**
 - **Chest/Neck/Head: Is s/he having any difficulty breathing?**
- **When did this happen?**

Examples of (core) Post-Dispatch Instructions

- **Help is on the way.**
- **Stay on the line and I'll tell you exactly what to do next.**
- **TC Links to more specific instructions:**
 - **DANGER or CRIME SCENE**
 - **Arrest**
 - **Ineffective breathing and not alert**
 - **Unconscious and Effective Breathing**
 - **Control Bleeding**
 - **Amputation**

This is a scene safety protocol. The TC will suspend EMD when there is a scene safety issue such as assault, shooting, stabbing, or psychiatric/mental health emergency until the dispatcher has completed all localized law questioning AND the scene is secure to allow EMD to occur without jeopardizing the caller, bystanders, patients, or victims. *Duplicated questions are typically not re-asked by 911 unless the situation has changed.*

Example Only. Protocol questions and instructions in ProQA are dynamic. The actual number, type, and sequence of questions can change based on many factors including caller party, awake/breathing status, etc.

STABBING/GUNSHOT/PENETRATING TRAUMA

Examples of (core) Key Questions

- **Is the assailant (attacker) still nearby?**
- **Is there any SERIOUS bleeding?**
- **Is s/he completely alert?**
- **What part of the body was injured?**
- **Is there more than one wound?**
- **When did this happen?**

Examples of (core) Post-Dispatch Instructions

- **Help is on the way.**
- **Stay on the line and I'll tell you exactly what to do next.**
- **(Penetrating Trauma) Do no pull it out.**
TC Links to more specific instructions:
 - **DANGER or CRIME SCENE**
 - **Unconscious or Arrest**
 - **Ineffective breathing and not alert**
 - **Control Bleeding**
 - **Amputation**

*This is a scene safety protocol. The TC will suspend EMD when there is a scene safety issue such as assault, shooting, stabbing, or psychiatric/mental health emergency until the dispatcher has completed all localized law questioning AND the scene is secure to allow EMD to occur without jeopardizing the caller, bystanders, patients, or victims. *Duplicated questions are typically not re-asked by 911 unless the situation has changed.**

Example Only. Protocol questions and instructions in ProQA are dynamic. The actual number, type, and sequence of questions can change based on many factors including caller party, awake/breathing status, etc.

PSYCHIATRIC EMERGENCY

Examples of (core) Key Questions

- **Is s/he violent?**
- **Does s/he have a weapon?**
- **Where is s/he right now?**
- **Is this a suicide attempt?**
 - **YES: Multiple EMD pathways for additional questions and instructions depending on situation**
 - **NO: Is s/he thinking about committing suicide?**
- **Is s/he completely alert?**

Examples of (core) Post-Dispatch Instructions

- **Help is on the way.**
- **Stay on the line and I'll tell you exactly what to do next.**
- **If it's safe to do so, observe her/him continuously (beware of being attacked).**
- **If it's safe to do so, protect her/him from her/himself.**

Telecommunicator segues to “case exit”/other instructions

This is a scene safety protocol. The TC will suspend EMD when there is a scene safety issue such as assault, shooting, stabbing, or psychiatric/mental health emergency until the dispatcher has completed all localized law questioning AND the scene is secure to allow EMD to occur without jeopardizing the caller, bystanders, patients, or victims. *Duplicated questions are typically not re-asked by 911 unless the situation has changed.*

LIST OF PROTOCOLS

- 0** Case Entry Protocol
- 🔴** Accelerator Stuck & Can't Stop Vehicle
- 1** Abdominal Pain / Problems
- 2** Allergies (Reactions) / Envenomations (Stings, Bites)
- P** Epinephrine (Adrenaline) Auto-Injector Instructions
- 3** Animal Bites / Attacks
- 4** Assault / Sexual Assault / Stun Gun
- 5** Back Pain (Non-Traumatic or Non-Recent Trauma)
- 6** Breathing Problems
- 7** Burns (Scalds) / Explosion (Blast)
- 8** Carbon Monoxide / Inhalation / HAZMAT / CBRN
- 9** Cardiac or Respiratory Arrest / Death
- 10** Chest Pain / Chest Discomfort (Non-Traumatic)
- ASA** Aspirin Diagnostic and Instructions
- 11** Choking
- 12** Convulsions / Seizures
- 13** Diabetic Problems
- 14** Drowning / Near Drowning / Diving / Scuba Accident
- K** Person in Water
- 15** Electrocutation / Lightning
- 16** Eye Problems / Injuries
- 17** Falls
- 18** Headache
- 19** Heart Problems / A.I.C.D.
- 20** Heat / Cold Exposure
- 21** Hemorrhage / Lacerations
- 22** Inaccessible Incident / Other Entrapments (Non-Traffic)
- 23** Overdose / Poisoning (Ingestion)
- Q** Narcan / Naloxone Nasal Instructions
- R** Naloxone Auto-Injector (Evzio) Instructions
- 24** Pregnancy / Childbirth / Miscarriage
- G** Miscarriage
- 25** Psychiatric / Abnormal Behavior / Suicide Attempt
- 26** Sick Person (Specific Diagnosis)
- 27** Stab / Gunshot / Penetrating Trauma
- 28** Stroke (CVA) / Transient Ischemic Attack (TIA)
- 🧠** Stroke Diagnostic Tool
- 29** Traffic / Transportation Incidents
- L** Vehicle in Water
- 30** Traumatic Injuries (Specific)
- 31** Unconscious / Fainting (Near)
- 32** Unknown Problem (Person Down)
- 33** Transfer / Interfacility / Palliative Care
- N** Airway / Arrest / Choking (Unconscious) – Newborn / Neonate < 30 days
- A** Airway / Arrest / Choking (Unconscious) – Infant < 1 yr
- B** Airway / Arrest / Choking (Unconscious) – Child 1–7 yrs
- C** Airway / Arrest / Choking (Unconscious) – Adult ≥ 8 yrs
- D** Choking (Conscious) – Adult / Child / Infant / Neonate
- F** Childbirth – Delivery
- Ya** Tracheostomy (Stoma) Airway / Arrest / Choking (Unconscious) – Infant < 1 yr
- Yb** Tracheostomy (Stoma) Airway / Arrest / Choking (Unconscious) – Child 1–7 yrs
- Yc** Tracheostomy (Stoma) Airway / Arrest / Choking (Unconscious) – Adult ≥ 8 yrs
- Z** AED Support
- X** Case Exit

Who Benefits

from an **Academy-Accredited**
Emergency Medical Dispatch Program?

1. The Patient

- Effectively receives a Zero-Minute Response Time™ to medical care
- Receives professionally practiced Dispatch Life Support
- Receives the most appropriate EMS response
- Experiences the assurance of heightened personal safety

2. The Caller

- Effectively receives a Zero-Minute Response Time™ to access a medical professional
- Receives calm and reassuring assistance in a potentially chaotic environment
- Gains empowerment to act immediately upon transfer of treatment knowledge
- Receives consistent, medically correct, and time-proven Pre-Arrival Instructions
- Experiences less fear and overwhelming responsibility
- Acquires higher confidence in the EMS system response
- Experiences the assurance of heightened bystander safety

3. The Family

- Feels the reassurance that medically correct and time-proven advice is provided
- Receives the appropriate notification of family members
- Experiences the comfort of a comprehensive medical system from competent EMDs
- Gains the knowledge that everything possible is being done

4. The Community

- Receives safer, more appropriate field responses with decreased bystander risk
- Takes pride in a quality medical system, considered a wise investment of tax dollars
- Gains access to special community services for integrated, out-of-hospital care
- Enjoys recognition for responsive “customer service” and quality patient care
- Gives elected officials the assurance of highest performance distinction

5. The EMD

- Gains personal confidence and self-esteem
- Receives performance feedback (both positive and negative)
- Enjoys professional job security and satisfaction
- Experiences value-added education and continuing dispatch education opportunities
- Achieves Academy membership and association with peers

6. The Supervisor or Manager

- Enjoys highly trained employees who function as medical professionals
- Experiences an enhanced work environment
- Gains access to fair and objective evaluation tools to measure performance
- Gains access to up-to-date information on industry treatment standards
- Acquires effective mentoring and coaching tools
- Receives career and information networking opportunities

7. The Organization’s Administration

- Reduces liability due to use of standard practices
- Enjoys less wear and tear on equipment that now needs less replacing
- Experiences less turn-over and burnout, requiring less retraining and rehiring
- Experiences a stronger community presence and positive reputation
- More effectively allocates available resources
- Obtains pathway management opportunity to use the OMEGA protocol

8. Ancillary Organizations

(Such as: managed care, police, fire, security, regulatory agencies, hospitals, and standards organizations like DOT, DOH, HCFA, ISO, etc.)

- Decrease morbidity and mortality due to better “zero-minute” care
- Decrease their front-end gap in services, leading to more appropriate care
- Gain access to comprehensive patient information and sharing of system knowledge
- Attain more accurate determinant coding, useful for statistical analysis and outcome studies

9. Medical Control

- Receives external validation of compliance processes
- Acquires the ability to ensure the proper use of a medically correct and time-proven protocol
- Enjoys decreased liability exposure from the use of a widely recognized system
- Obtains scientific research opportunities
- Gains the ability to use the OMEGA protocol for more appropriate clinical care assignments
- Gains confidence in the Academy system—its Boards, Councils, and College of Fellows

10. The Field Responder

- Experiences a synergistic approach to establishing an improved relationship with the communication center
- Receives the opportunity to provide formal feedback into dispatch decision making
- Gains the ability to respond more safely and appropriately with proper resource allocation
- Receives the opportunity to partner with other agencies to share dispatch information
- Receives proper and consistent scene evaluation and patient care data

DISPATCH CENTER FEEDBACK

- **Feedback from dispatch centers is strongly encouraged to make the system work better**
 - Be part of the solution
- **This EMD rollout is very large and complex in scope and scale**
 - Despite robust planning, it's not possible to account for every operational nuance until we see how the system is working
- **RI E-911 leadership expects patience from our dispatch partners and other stakeholders during the transition to structured EMD.**
 - Oversight Committee (open forum - Statewide Dispatchers' Committee)
 - Quarterly meetings (including the week before, during, and after go live)
 - First 6 months after go live, group to meet monthly to resolve concerns
 - Q&A/educational sessions
- **Dedicated email for feedback and questions:** emdfeedback@rie911.gov

QUESTIONS ABOUT EMD?

- We want to enhance our relationship with all downstream dispatch centers with open communication
- We want to know of any issues you encounter, and to provide follow-ups as needed about the operational impact of EMD statewide

❖ Reach out to us at:

- ❖ emdfeedback@rie911.gov
- ❖ <https://ri911.ri.gov/>
- ❖ **401-459-0911**
- ❖ **311 Danielson Pike, North Scituate, Rhode Island 02857**