REDIRECTING 911 CALLS FOR INFORMATION & LOW ACUITY MEDICAL COMPLAINTS

Product (91103) Purpose

As the COVID 19 pandemic continues to evolve, Public Safety Answering Points (PSAPs)/Emergency Communications Centers (ECC) may need to revise procedures and redirect resources for handling incoming calls for COVID-19 Information and Low Acuity Medical Complaints. These revisions may require administrative, technical and operational protocols, policies and procedures to be modified. This document provides guidance and considerations for these modifications and examples of how a sample of a few individual PSAPs/ECCs have handled/redirected these calls in response to the COVID-19 pandemic.

Developed By

The Federal Healthcare Resilience Task Force (HRTF) is leading the development of a comprehensive strategy for the U.S. healthcare system to facilitate resiliency and responsiveness to the threats posed by COVID-19. The Task Force's EMS/Pre-Hospital Team is comprised of public and private-sector Emergency Medical Service (EMS) and 911 experts from a wide variety of agencies and focuses on responding to the needs of the pre-hospital community. This Team is composed of subject matter experts from NHTSA OEMS, National 911 Program, CISA, CDC, FEMA, USFA, US Army, USCG, and non-federal partners representing stakeholder groups and areas of expertise. Through collaboration with experts in related fields, the team develops practical resources for field providers, supervisors, administrators, medical directors and associations to better respond to the COVID-19 pandemic.

Intended Audience

Federal, as well as State, Local, Tribal, and Territorial Government's (SLTTs) EMS and 911 agencies

Expected Distribution Mechanism

EMS.gov, Stakeholder Calls, EMS stakeholder organization's membership distribution, Email mechanisms, USFA webpage, USFA GOVdelivery and USFA social media.

USG Agency/ Program Consulted During Drafting

Members of the team were from USFA, National 911 program, DHS, NHTSA OEMS and CDC

Primary Point of Contact

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Purpose: As the COVID 19 pandemic continues to evolve, Public Safety Answering Points (PSAPs)/Emergency Communications Centers (ECC) may need to revise procedures and redirect resources for handling incoming calls for COVID-19 Information and Low Acuity Medical Complaints. These revisions may require administrative, technical and operational protocols, policies and procedures to be modified. This document provides guidance and considerations for these modifications and examples of how a sample of a few individual PSAPs/ECCs have handled/redirected these calls in response to the COVID-19 pandemic.

How to use this document: The general guidance and examples included in this document can be used to assist PSAP/ECC directors with the implementation and/or modification in Standard Operating Procedures (SOPs) and Emergency Medical Dispatch (EMD) protocols, for receiving and responding to two types of calls:

1. Calls for COVID-19 Information.
2. Calls for patients with Low Acuity Medical Complaints.

It is very important that PSAP/ECC directors refer to local medical direction, health department and other local COVID initiatives to ensure that the PSAP/ECC does not sustain any liability for the redirection of calls.

Contributors to this document This document was completed by representatives from: the Association for Public Safety Communications Officials (APCO), the APCO Institute, the International Academies of Emergency Dispatch (IAED), the National Association of State 911 Administrators (NASNA), the National Emergency Number Association (NENA), and Power Phone; as well as their members and some of their clients.

I. Calls for COVID Information

- **Purpose/Goal: To provide guidance for the redirection of callers requesting COVID-19 information to local and state health departments, COVID-19 hotlines, websites, links, and non-emergency lines such as 311, 211, 411 or other 10-digit lines.**

    - **General Considerations:**
        - Administrative

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- Coordinate messaging to be provided with the Medical Director, health care facilities, and health departments to ensure appropriate changes are consistent as the COVID-19 pandemic evolves.
- Identify appropriate local health departments and/or other local agencies' resources (e.g., those that administer non-emergent support lines, e.g. 211/311/411), to understand what links, websites, hotlines, three-digit lines and 10-digit lines are available/operational.
- Ensure relationships are established and supported, and conduct information sharing sessions by all mission partners to be effective and provide continuous communications.
- Frequently update local PSAPs/ECCs, emergency medical services (EMS) agencies, fire departments, public health (PH) agencies, emergency management agencies (EMA) and emergency operations centers (EOC), to ensure consistent messaging and evolving needs are met.
- Establish an ongoing mechanism for updating/changing information as the COVID-19 pandemic evolves.
- Identify any agreements/contracts/policies/ SOPs that need to be established. Agreements among emergency services organizations for 211, 311 and 411 should be consistent.
- Review employee contracts/ collective bargaining agreements, to understand possible impacts due to changes in protocols, policies and/or SOPs.

▪ Technical
- Implement a mechanism for collecting and aggregating data (such as number of calls by incident type, EMD codes, etc.) for program evaluation and decision. Establish a mechanism for collecting/reporting data on calls received exclusively seeking information. Utilize that data to develop public service announcements and post the response to FAQs on appropriate websites.
- Toll free numbers typically receive Automatic Number Information (ANI). If the PSAP/ECC transfers a 911 call to a toll free number via their selective router, the entity receiving the call may be able to call back the PSAP/ECC, using the ANI received upon call transfer. Work with service providers and receiving agencies, if possible, to ensure this function.

▪ Operational
- Promote the use of Public Safety Telecommunicator (PST) "Just-in-time" education, training and awareness of the technological tools available and changes in procedures.

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- Public education, training and awareness may be key for public acceptance of alternate call handling. Examples of available resources include:
  - CDC self-checker, or other decision tree approved by locally designated authority for the general public, on when to call 911 versus nurse/primary care provider/health dept./info line.
  - CDC Phone Advice Line Tool for possible COVID-19 patients
- PSAP/ECC, who dispatch EMS, should know the status of all hospitals i.e., COVID only hospitals, which hospitals have no hospital beds or ICU units.
- Utilize COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University* to understand COVID case locations
- Consider HIPAA constraints (if the PSAP/ECC/EOC and/or their personnel fall under the category of "health care providers who transmit any health information electronically in connection with certain transactions"), seek/coordinate with legal counsel. Please see the COVID-19 and HIPAA: Disclosures to law enforcement, paramedics, other first responders and public health authorities.

II. Low Acuity Medical Complaints Requests

- **Purpose/Goal: To provide guidance for the redirection of low acuity medical complaints to alternate medical resources (e.g., Nurse Triage/Call Line, Telemedicine, Paramedic Triage) due to increase in call volume and/or decline in hospital, EMS and other resources as a result of the COVID-19 pandemic.**

  - **General Considerations:**
    - Administrative
      - Work with local Medical Director to determine specific criteria for referral.
      - Work with current EMD personnel and local Medical Director to identify questions to be asked and the specific criteria the caller must meet to be transferred to alternate medical resources such as Nurse Call Line or Telemedicine Triage Line.

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- Confirm local Medical Director approval for changes to the medical call handling process, and/or response changes, including changes in EMD questions and referrals to alternate medical resources.
- Identify and execute any agreements/contracts that need to be established.
- Revise current policies and procedures and/or implement temporary procedures for PSTs.
- Consider additional security requirements if the alternate medical resource will be located in the PSAP/ECC (e.g. Criminal Justice Information Systems (CJIS), National Crime Information Center (NCIC), etc.)
- For Triage/Call Lines not already established: ensure notification of completion of training for nurse triage and PSAP staff —to understand how referral process will work; and how processes may change due to evolving circumstances. (Example: as COVID expands within a specific jurisdiction, is the behavioral hotline still active for referral?)
- Ensure agreements and arrangements with the alternate care resource to ensure they are ready to take calls.
- Facilitate consistent interaction among local PSAPs/ECCs, EMS, PHs, EMAs and EOCs is essential, to ensure evolving needs are met.
- If medical resource line is not a 24 hours/7 days a week call line, develop working schedule and communicate often between the call line side and the PSAP/ECC side.
- Consider Syndromic Surveillance[1] processes where available.

▪ Technical
- Work with 911 service providers to ensure call transfer can be made while keeping the caller's call-back number.
- Ensure call transfer works both ways in the event that the call needs to be transferred back to the PSAP/ECC.
- Implement one-button transfers of calls, if feasible.
- Work with information technology (IT) services to accommodate any necessary changes to computer aided dispatch (CAD) systems.

▪ Operational
- Develop and execute 911 Public Safety Telecommunicator (PST) training on all new processes and procedures.

[1] https://www.cdc.gov/nssp/news.html

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- Update pandemic guide cards/protocols with COVID-19 related questions and transfer instructions—modifiable at agency level and approved by the local Medical Director.
- Anticipate frequent changes as the pandemic progresses, which may include modified response criteria for EMS due to the depletion of personnel and other resources.

- **Examples of Low Acuity Call Redirection Protocols: The following are examples of PSAPs/ECCs that have implemented protocols to redirect low acuity calls alternate medical resources:**

  - **1. Location: Seattle/King County Washington**

    - **Description: Referral Program**
      For COVID-19, the Seattle Fire Department's Mobile Integrated Health program stood up a referral program to address the secondary impacts of the COVID-19 pandemic. This included generally concerned 9-1-1 callers as well as individuals who have been cut off from social services, healthcare, caregivers, substance abuse resources, critical supplies, or other services due to quarantine/isolation/shelter-in-place, or ill family members. The city has a team of two firefighters and four case managers who are fielding these referrals and reach out to callers by phone or in person. It is believed that non-emergent 9-1-1 calls will likely continue throughout the duration shelter-in-place lengthens.

      Seattle is in the early stages of exploring how to use nurse triage (either on-site in the 911 center or remotely) to further handle non-emergent calls, however, such a program has not been operationalized.

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- **2. Location: Washington, DC; Office of Unified Communications (OUC)**

  - **Description: DC Nurse Triage Line**
    Since 2018, DC's Office of Unified Communications currently transfers a portion of their basic life support (BLS) calls to a nurse triage line (NTL), with the goal of keeping people out of the emergency department and treating people at home. While the nurses are housed within the 911 call center, this is a program under DC's Fire and EMS Department. Other relevant points about this program:
    - Additional goal: Savings relate to not mobilizing EMS
    - Program has resulted in both a financial and human resources savings.
    - Office of Unified Communications (OUC) has incrementally increased the types of calls redirected to NTL. Now transferring 60-90 calls per day (approximately 6-10% of medical calls)
    - Public Service Ads – important to explain to the public the advantages of EMS tiered medical response that an RN answers NTL in advance of implementation to avoid caller resistance to call transfer.
    - Both OUC and EMS field units can call the NTL and initiate the process
    - Nurses answer calls from work stations within the OUC, and if needed, can access backup nurse triage personnel in TX and FL. Part of their protocol includes asking for insurance information, so patients can be coupled with appropriate clinics, MDs). Nurses also are able to schedule appointments for callers.
    - Targeting calls that were responded to, but not transported.
    - Now looking at how to anticipate changes in call volume relevant to COVID-19 and how to change current protocols
    - A strong relationship with Fire & EMS and Medical Director is essential
    - Not a failure if NTL screens and determines that the patient needs a response. This is the safety net.

  - **Point of Contact:**
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- **3. Location: Orleans Parish Communication District (New Orleans 9-1-1)**

  - **Description:**
    All Orleans Parish Communication District (OPCD) Operations Staff are certified Emergency Medical Dispatchers (EMD) using protocols from the International Academies of Emergency Dispatch (IAED)*. Within those protocols are both a pandemic surveillance tool and a response protocol referred to as Protocol 36*.

    Two directives and one guidance document enable the video medical triage process:
    - 1. Emergency Directive 20-01 - Advising staffing to start using the surveillance tool. (Issued 2/5/20)
    - 2. Emergency Directive 20-02- Formally activating Protocol 36 (Issued 3/9/20)
    - 3. Special Guidance advising elevating the pandemic level to Level 1

  The pandemic protocol identifies calls that are low acuity for which an emergency department is not the best option. At that time, a paramedic initiates a video call with the patient and reviews their symptoms. In the current situation, in most cases, they are being advised to self-quarantine and not go to an emergency department. The process then places that person on a "self-quarantine registry" and someone from the staff calls the person daily to check on them. If their conditions get worse, the person is triaged again as a new patient and they may then get transported if needed.

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- **4. Location: Orange County Virginia Fire and EMS Department**

  - **Description:**
    Area hospitals color code their status availability.
    Code Green: Open
    Code Yellow: Busy, not accepting trauma patients, running out of beds
    Code Red: Very busy, only accepting life critical illness/injury
    Code Black: Hospital lock down (i.e. pandemic), cannot accept more patients

    PSAP/ECC receive fax updates of hospital status. PSTs page out the status of the hospital to the responders. Life or death situations can still go to the closest hospital and override the color codes except in Code Black situations.

    Diversion Status Data

Status	Options	Definition
Diversion	Disaster Alert	Current event has exceeded hospital's capability to manage event, outside resources or aid is anticipated or needed.
	Full	Indicates that patient load is utilizing all current emergency department/hospital resources. EMS units are advised to transport to another health care facility if possible.
	Open	Unrestricted access to all EMS agencies
	Special Diversion	States that specific services are unavailable or are currently being utilized to maximum capacity. EMS units are advised to transport to another health care facility if possible for patients needing these specific services.
Comments	n/a	A comments area is provided to provide additional general text information about the status.
Last Update	n/a	Date Diversion Status form or Hospital Status form last updated.

  - **Contact:**
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- 5. **Location: New York City – Northwell Health**
  - **Description:** The Northwell Health Center for EMS, Clinical Call Center, Centralized Transfer Center, Telehealth Center and Health Solutions provide NYC 311 and FDNY EMS 911 with an emergent stand up of call center operations in order to provide telemedicine based services to callers seeking medical advice, clinical navigation or clinical care on the COVID-19 virus as well as work with the FDNY to take New York City based low and medium acuity groups of 911 callers, as possible, and cleared with Medical Director. This system of care includes a comprehensive integrated system of 911 Emergency Medical Dispatcher (AEMD) Triage, Nurse based telephonic triage, care navigation and advice, Qualified Healthcare Provider (QHP – MD, NP, PA, LCSW telephonic/telemedicine services, QHP based telemedicine services, Community Paramedicine services, traditional EMS services and home-based Primary Care services.

    At the Clinical Call Center, 12 RNs manage a steady flow of calls from patients and employees seeking clinical advice and navigation services including recently discharged patients whose multiple, chronic health issues make them a high risk for hospital readmission and patients seeking care during off hours from our physician practices. Using Emergency protocols, The International Academies of Emergency Dispatch's (**IAED**) certified Emergency **Communication** Nurse System (**ECNS**), the nurses telephonically screen patients for priority symptoms and determine the level of care that the caller needs, weighing additional factors such as medication use and allergies. Once the type of care is determined, the Nurse can provide care instructions or arrange the appropriate level of care based on the patient's clinical needs.

    Northwell 911 Telemedicine Resources*

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