

Section 1 – Guiding Principles for Public Safety Answering Points (PSAPs)

*Objective: To establish the basic tenets for creating plans and protocols that involve **Primary and Secondary Public Safety Answering Points (PSAPs)**, where 9-1-1 calls from the public are routed. While our primary audience for these principles are State 9-1-1 and EMS administrators, PSAP managers and 9-1-1 stakeholders, it is also intended to be read by other local, State and Federal officials in public health, EMS, public safety, emergency management and homeland security.*

1. The Role of 9-1-1 Public safety telecommunicators (also referred to as call-takers or **emergency medical dispatchers**) are called the “first, first responder” because they are typically trained to give critical and often lifesaving instructions over the phone. They obtain important information for the EMS providers they dispatch to the scene, helping to appropriately allocate resources and provide scene safety. The public relies on their 9-1-1 service for help and have been trained to call 9-1-1 when they need assistance. The 9-1-1 system is frequently the caller’s first point of contact with the health care system, and often the only point of contact. The public safety telecommunicators who take these calls must have accurate, up-to-date information to be effective in call taking, dispatching and relaying information to the public.

2. Overall Planning Must be Coordinated with 9-1-1 9-1-1 stakeholders must be integrated into the incident command structure and in State planning, and be fully engaged as a collaborative partner in the response to pandemic influenza. To work effectively in mitigating the impact of pandemic influenza, 9-1-1 and EMS must work collaboratively, and their planning must be coordinated together, along with other entities representing public safety, public health, health care, emergency management, and Indian Health Services.

3. “Just-in-Time” Training and Education The PSAP’s response to pandemic influenza should be flexible, scalable, dynamic, and timely with the ability to change rapidly based on new information about the virus. The ability to be flexible and quickly respond allow for protocols and algorithms to be updated readily and rapidly as more current information is obtained about the virus. A method must be in place to quickly educate call-takers and other PSAP personnel on the updated information so it can improve dispatch and provide the public with current, accurate information. In this context, **“just-in-time” training** and education refers to the timely provision of information and instructions as they become available, and when users need them.

4. Using 9-1-1 Data for Surveillance **Surveillance** and early detection of pandemic influenza has been identified as one of three “pillars” of readiness in the National Strategy for Pandemic Influenza. Surveillance for pandemic influenza has also been identified as an issue of safety for first responders by 9-1-1 and EMS stakeholder groups. PSAPs are an important, but often overlooked, source of reliable, real-time data that may aid surveillance efforts and may assist in early detection. 9-1-1 data has additional advantages of being automated, able to be aggregated across multiple jurisdictions, and able to have precise patient location information. To take advantage of this, PSAPs should use standardized **9-1-1 protocols** that capture symptoms specific to the pandemic along with other possible indicators (such as recent travel to affected

areas) that can assist in this process. The use of these protocols will be triggered by either local, State or regional declarations, depending on the specific circumstances of each jurisdiction and the application of the Incident Command System as a part of the National Incident Management System NIMS. (See Appendix B for information about NIMS and Appendix C for more information about how 9-1-1 and EMS data can be standardized, collected regionally, and analyzed against historical trends for early detection and situational awareness.)

5. Consistent with National Incident Management System 9-1-1 personnel should be trained in incident command per the requirements of the National Incident Management System (NIMS). As noted before, all pandemic influenza response activities should be conducted within an incident command system and be consistent with NIMS. 9-1-1 should be fully integrated into the incident command structure

6. Continuity of Operations Planning Pandemic influenza planning should focus both on what may be the same, as well as what is *different* about this type of emergency that will require a response unlike that needed for other hazards the jurisdiction may have planned for in the past. Continuity of Operations (COOP) plans should already be in place, but the nature of a pandemic will test system resources because mutual aid may not be available, as neighboring communities will be coping with similar problems. Many of the suggested actions in this report can be incorporated into daily operations and become a *routine* part of 9-1-1 activities.

7. 9-1-1 is Part of the Critical Infrastructure When planning their response to pandemic influenza, agencies should incorporate recommendations of the Department of Homeland Security *Pandemic Influenza Preparedness, Response, and Recovery Guide for Critical Infrastructure and Key Resources*, published Sep 19, 2006. 9-1-1 personnel, and the technical staff who support them, should be considered in priority planning for vaccinations. In addition, the CDC publication: *Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States—Early, Targeted, Layered Use of Non-pharmaceutical Interventions*, should provide guidance to communities as they work to mitigate the effects of a pandemic rather than focusing solely on the response.

8. Infection Control Procedures Need to Be Implemented Infection control measures and industrial hygiene practices should be followed by all PSAP personnel and should be a standard part of daily practices, as well as reinforced with continuing education. Infection control procedures in the PSAP need to be in place well before a pandemic strikes. Appendix I will contain the Occupational Safety and Health Administration's *Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers* which is pending publication. Appendix D contains examples of infection control procedures and industrial hygiene practices.

9. Exercises and Drills are Critical In addition to drills specific to the functioning of PSAPs, community-wide exercises and drills are critical to demonstrating the readiness for pandemic influenza. 9-1-1 stakeholders, as a fundamental component of emergency response, should be included in community drills, along with elected officials. It is critical that PSAP line and staff personnel participate, and that questions of authority and responsibility be tested in these simulations. Readiness plans should be updated based on the after-action reports. Historically

pandemic influenza events occurred in waves, meaning we can learn from the initial response to better plan for future waves.

10. Plans Must Take Into Account and Be Consistent with Recognized Phases and Severity Index of Pandemic Influenza Plans and activities within PSAPs should generally be consistent with the phases of pandemic influenza as defined by both the World Health Organization (WHO) and the U.S. Federal Government’s Response Stages. (See Appendix E for information about the phases.) It is recognized that local jurisdictions will need to modify and adapt these recommendations based on their individual circumstances. (Figure 4 provides a matrix of suggested 9-1-1 and EMS activities/readiness steps based on the WHO phases of pandemic influenza.)

In addition to the WHO phases and the corresponding stages of the U.S. Federal Government response to pandemic influenza, the Centers for Disease Control and Prevention has created a Pandemic Severity Index (See Appendix F), which uses case fatality ratio as the critical driver for categorizing the severity of a pandemic. The index is designed to estimate the severity of a pandemic on a population level to allow better forecasting of the impact of a pandemic and to enable recommendations to be made on the use of mitigation interventions that are matched to the severity of future influenza pandemics. Future pandemics will be assigned to one of five discrete categories of increasing severity (Category 1 to Category 5). The Pandemic Severity Index provides communities a tool for scenario-based contingency planning to guide local pre-pandemic preparedness efforts. Accordingly, communities facing the imminent arrival of pandemic disease will be able to use the pandemic severity assessment to define which pandemic mitigation interventions are indicated for implementation.

11. Effective Use of Limited Resources In general, EMS and public safety resources available to the public will be limited during a pandemic. There will be fewer public safety telecommunicators to take calls, and they cannot effectively be replaced with clerical staff without training or experience in the PSAP. Quickly identifying non-urgent calls, and alternative ways of assisting them, will be critical in managing this situation. PSAPs should use call-taking protocols that provide for specific influenza-symptom monitoring, triage and priority dispatch of EMS and public safety resources. The proper legal and medical authority, in coordination with the *emergency medical services system*, should be predetermined in the planning process. Many agencies use algorithmic or formalized structured systems called EMD (Emergency Medical Dispatch) which their public safety telecommunicators use to gather valuable patient information, categorize patients, as well as to give instructions to callers. Implementation of EMD should be with the oversight of an EMS medical director. (For information about the elements of an Emergency Medical Dispatch system see Appendix G.)

12. Special Needs Communities Plans should take into account specific accommodations and considerations for those with special-needs, for example plans should address those with mental health needs and persons with limited English proficiency as well as being accommodating for children, the elderly, and individuals with disabilities. This also includes the group of patients who routinely receive home health care. This service may be interrupted and special needs patients may need to be directed to other resources by 9-1-1.