Janet T. Mills
Governor

State of Maine
Department of Public Safety
Maine Emergency Medical Services
152 State House Station
Augusta, Maine 04333

Michael Sauschuck
Commissioner

Wil O'Neal
Director

# OPERATIONAL BULLETIN

| Bulletin # | Title | | Date Issued |
|---|---|---|---|
| #2024-10-22-01 | MPDS Medical Director Authorization (Version 14) | | October 22, 2024 |
| **Superseded** | **Released By:** | **Source:** | **Pages** |
| N/A | Maine EMS | EMD Program Coordinator, Committee & Medical Director | 1 |
| **Approved By:** | Dr. Matthew Sholl, State EMS Medical Director | | |

Dr. Matthew Sholl, the Maine State EMS Medical Director, has approved Version 14 of the Medical Priority Dispatch System (MPDS) protocols and, with it, the strategic transfer of defined emergency medical dispatch (EMD) cases, according to the Maine Behavioral Health Call Policy. An EMD Center is not required to adopt the Maine Behavioral Health Call Policy, but one must do so before staff engage in transferring callers out of the traditional emergency response pathway to Maine's 988 mental health services.

**All licensed EMD Centers shall upgrade to MPDS Version 14 or higher as soon as possible, but not later than November 30, 2024, regardless of the implementation of the Maine Behavioral Health Call Policy.**

As with previous versions of the MPDS protocols, there are several instances in Version 14 that require local medical director approval. Since Maine uses a single statewide set of EMD protocols, the State EMS Medical Director provides any and all required approvals (unless otherwise noted). The Medical Director Authorization document includes all specific definitions, approvals, and guidance by the State EMS Medical Director. The document includes:

- Appendix A: Authorized Protocols
- Appendix B: Local Medical Administration Definitions/ Authorization
- Appendix C: Jurisdictionally and /or Operationally Approved Questions
- Appendix D: Maine Behavioral Health Call Policy & Decision Tree

MPDS Version 14 includes the new Protocol 41: First Party Caller in Crisis. This protocol is in digital form only and approved for use in compliance with International Academy of Emergency Dispatch (IAED) standards, including required initial certification training for all certified EMDsin an agency. Until funds are secured for the cost of this required initial certification training for all licensed EMDs, Protocol 41 is optional.

STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY
MAINE EMERGENCY MEDICAL SERVICES
152 STATE HOUSE STATION
AUGUSTA, MAINE 04333

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISSIONER

WIL O'NEAL
DIRECTOR

To: Maine EMD Center Directors
From: Melissa F. Adams
Subject: State Medical Director Authorization for MPDS Version 14 and the transfer of eligible mental and behavioral health callers in accordance with the Maine Behavioral Health Call Policy.
Date: October 21, 2024

Matt Sholl, M.D., Maine State EMS Medical Director, has approved Version 14 of the Medical Priority Dispatch System (MPDS) protocols and, with it, the strategic transfer of defined emergency medical dispatch cases, according to the Maine Behavioral Health Call Policy. An EMD Center is not required to adopt the Maine Behavioral Health Call Policy but must do so to facilitate the safe and effective transfer of callers out of the traditional emergency response pathway to Maine's 988 mental health services when appropriate. Implementation of the Maine Behavioral Health Call Policy includes:

- Completion of the official Maine 911-988 Policy Training by the EMD Center's licensed Emergency Medical Dispatchers; and
- Update to MPDS Version 14.0 with ProQA v5.1.1.46, or higher; and
- Update to AQUA software to Version 7.1.1.4, or higher; and
- When administrative settings and use of the MPDS are consistent with the Emergency Medical Dispatch Priority Reference System (EMDPRS) and this document.

All licensed EMD Centers shall upgrade to MPDS Version 14 or higher as soon as possible, regardless of the implementation of the Maine Behavioral Health Call Policy. Except as otherwise noted in this document, the Medical Priority Dispatch Software (MPDS) Version 14 protocols listed in Appendix A of this document are authorized for use, as written.

Like previous versions of the Emergency Medical Dispatch (EMD) protocols, there are several instances in Version 14 that require local medical director approval. Since Maine uses a single statewide set of EMD protocols, the State EMS Medical Director provides any and all required approvals (unless otherwise noted). The appendices in this document identify the Protocols that require medical director definitions, approval, or guidance, along with specific definitions, approvals, and guidance by the State EMS Medical Director. The appendices include:

- Appendix A: Authorized Protocols
- Appendix B: Local Medical Administration Definitions/ Authorization
- Appendix C: Jurisdictionally and /or Operationally Approved Questions
- Appendix D: Maine Behavioral Health Call Policy & Decision Tree

MPDS Version 14 includes the new Protocol 41: First Party Caller in Crisis. This protocol is in digital form only and approved for use in compliance with IAED standards, including required initial certification training for all potential users in an agency. Until such time as funds are secured for the cost of this required initial certification training, Protocol 41 is optional. When funds are available to support uniform training and implementation, this directive will be revised with a timeline for implementation.

This document will be updated as needed and published on the Maine EMS website.

Please contact me with any questions or concerns at melissa.f.adams@maine.gov or 207-626-3862.

Respectfully,

*Melissa F. Adams*

Melissa F. Adams
Licensing Agent & EMD Program Coordinator

# Appendix A: Authorized Protocols

Appendix A: Authorized Protocols

**MPDS Version 14 Protocols Approved for Use**

01: Abdominal Pain /Problems
02: Allergies (Reactions) /Envenomation (Stings, Bites)
03: Animal Bites /Attacks
04: Assault / Sexual Assault / Stun Gun
05: Back Pain (Non-Traumatic or Non-Recent Trauma)
06: Breathing Problems
07: Burns (Scalds) /Explosion (Blast)
08: Carbon Monoxide /Inhalation /HAZMAT /CBRN
09: Cardiac or Respiratory Arrest /Death
10: Chest Pain /Chest Discomfort (Non-Traumatic)
11: Choking
12: Convulsions /Seizures
13: Diabetic Problems
14: Drowning /Near Drowning /Diving /SCUBA Accident
15: Electrocution /Lightning
16: Eye Problems /Injuries
17: Falls
18: Headache
19: Heart Problems /A.I.C.D
20: Heat /Cold Exposure
21: Hemorrhage (Bleeding) /Lacerations
22: Inaccessible Incident /Other Entrapments (Non-Traffic)
23: Overdose /Poisoning (Ingestion)
24: Pregnancy /Childbirth /Miscarriage
25: Psychiatric /Mental Health /Suicide Attempt /Abnormal
26: Sick Person (Specific Diagnosis)
27: Stab /Gunshot /Penetrating Trauma
28: Stroke (CVA) /Transient Ischemic Attack (TIA)
29: Traffic Collision/Transportation Incident
30: Traumatic Injuries (Specific)
31: Unconscious /Fainting (Near)
32: Unknown Problem (Person Down)
33: Transfer /Interfacility /Palliative Care
34: ACN (Automatic Crash Notification)
37: Interfacility Evaluation /Transfer
39: Active Assailant (Shooter)
40: Incident Standby /Staging
41: First Party Caller in Crisis *

*P41 is authorized for use when all of the agency's Emergency Medical Dispatchers have taken, and successfully completed, the initial certification training required for its use and provided by the IAED through the College of Emergency Dispatch. This protocol requires a special authorization license key to enable its use.

# Appendix B: Local Medical Administration Definitions /Authorization

# LOCAL MEDICAL ADMINISTRATION DEFINITIONS / AUTHORIZATION

## MEDICAL PRIORITY DISPATCH SYSTEM™ v14.0 IMPLEMENTATION

Local Medical Control must define and authorize the following definitions for each of the corresponding Medical Chief Complaints. Initials present in individual categories will indicate approval of usage of that definition. Absence of initials will indicate non-approval.

**Note:** This information must be entered and authorized on manual cardsets if only manual cardsets are used. If ProQA® is used, this information must be entered and authorized in the ProQA® Administrative Utility under the “Restricted Settings” and "Special Definitions" tabs. This document will note completed authorization by an electronic or executed signature and must be retained by the agency.

**INITIALS**

MS

MS

### RESTRICTED SETTINGS

Before these special Protocol options are turned on, all EMDs using ProQA must be properly trained in their use. If these options are changed from their default settings, CAD may fail to recognize the response codes properly. Improper use may lead to untoward results and inaccurate dispatch. Therefore, if these options are changed from their default settings, the user agrees to release PDC from any and all liability arising from their use (user assumes full responsibility).

- ■ Enable Protocol 33
- ■ Enable Protocol 34
- ☐ Enable Protocol 36
- ■ Enable Protocol 37
- ☐ Enable Protocol 38 – By enabling Advanced SEND, you verify that both the Emergency Dispatcher and the required officer training as provided by the IAED through the College of Emergency Dispatch has been completed.
- ■ Enable Protocol 39 – The IAED has approved the inclusion of the Active Assailant Protocol in the MPDS to assist EMDs in the unlikely event emergency medical dispatch, rather than police dispatch, is required to manage these high-risk events. EMDs should obtain specific training and be familiar with this protocol prior to its use. Ongoing and conjunctive training and practice is necessary to maintain proficiency in all high-risk, low-frequency scenarios.
- ■ Enable Protocol 40
- ☐ Enable Protocol 41 – Caller in Crisis (Suicidal) – By clicking here you verify that all your on-line Emergency Medical Dispatchers have taken, and successfully completed, the required training for its use as provided by the IAED through the College of Emergency Dispatch. This requires a special authorization license key to enable its use.
- ■ Aspirin Diagnostic Tool
  - ● Pass notification as urgent message
  - O Pass notification as standard comment
- ■ Launch Stroke Diagnostic Tool after dispatch
- ☐ SMS Traffic window displayed for each question

Choose only one (must enable in CAD/Responder Script to view and function):

- O Enable Police Suspect Info (Scotland Yard version)
- O Enable Person Description Essentials

© 1988–2024 IAED © 1987–2024 PDC

## INITIALS

Emerging Infectious Disease Surveillance Tools

COVID-19 Panel

- ● "Surveillance" mode
- O "Trigger" mode

Monkeypox Panel

- ● "Surveillance" mode
- O "Trigger" mode

Ebola Panel

- ● "Surveillance" mode
- O "Trigger" mode

Local Medical control must authorize one of the compressions pathways for the treatment of adult cardiac arrest of suspected cardiac origin (non-respiratory etiology).

- O Compressions 1st: 600 initial compressions followed by the 2 breaths/100 compressions sequence
- ● Compressions only: Continuous compressions until responder arrival

MS
MS

**OBVIOUS DEATH (B-1, D-2)**

Local Medical Control must define and authorize any of the patient conditions before these determinants can be used for reduced responses or referral. Situations should be unquestionable.

- ■ a = Cold and stiff in a warm environment
- ■ b = Decapitation
- ■ c = Decomposition
- ■ d = Incineration
- ■ e = NON-RECENT death
- ■ f = Severe injuries obviously incompatible with life
- ☐ g = Locally defined condition "g" (see policy): ____________________
- ☐ h = Locally defined condition "h" (see policy): ____________________

**Medical Chief Complaint(s): 9**

MS
MS

**EXPECTED DEATH (O-1, D-2)**

Local Medical Control must define and authorize any of the patient conditions before these determinants can be used for reduced responses or referral. Situations should be unquestionable.

- ☐ x = Terminal illness
- ■ y = DNR (Do Not Resuscitate) Order
- ☐ z = Locally defined condition "z" (see policy): ____________________

**Medical Chief Complaint(s): 9**

© 1988–2024 IAED © 1987–2024 PDC

**INITIALS**

MS
MS

**OBVIOUS DEATH (SUBMERSION ≥ 6HRS)**

Local Medical Control must authorize this condition.

- ■ Submersion (≥ 6hrs)

**Medical Chief Complaint(s): 14**

MS
MS

**BARIATRIC PATIENT WEIGHT THRESHOLD**

Local Medical Control must define and authorize this weight threshold setting.

- ■ X = 400 lbs (180kg)

**Medical Chief Complaint(s): 17**

MS
MS

**STROKE TREATMENT TIME WINDOW**

Local Medical Control must set and authorize the STROKE time treatment window before the Determinant Suffixes can be used.

- ■ T = 3 Hours

**Medical Chief Complaint(s): 18, 28, 37**

MS
MS

**HIGH RISK COMPLICATIONS**

Local Medical Control must define and authorize any of the patient conditions before this determinant can be used.

- ■ Premature birth (24–36 weeks)
- ■ Multiple birth (≥ 24 weeks)
- ■ Bleeding disorder
- ■ Blood thinners
- ■ Cervical cerclage (stitch)
- ■ Placenta abruption
- ■ Placenta previa
- ■ FEMALE GENITAL MUTILATION
- ☐ Other (approved by Medical Director): ______________________________

**Medical Chief Complaint(s): 24**

______

**OMEGA REFERRAL**

Local Medical Control must authorize the use of a non-mobile referral.

- ☐ Waters broken (no contractions or presenting parts)

**Medical Chief Complaint(s): 24**

© 1988–2024 IAED

© 1987–2024 PDC

**INITIALS**

______ **CRISIS TEAM / ALTERNATE RESPONSE CRITERIA**

Local Medical Control must define and authorize the criteria for CRISIS TEAM / ALTERNATE RESPONSE.

☐ CRISIS TEAM / ALTERNATE RESPONSE Criteria for **Protocol 25**:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

☐ CRISIS TEAM / ALTERNATE RESPONSE Criteria for **Protocol 41**:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Medical Chief Complaint(s): 25, 41**

MS
MS **ACUITY LEVELS I, II, III**

Before using the ACUITY Level (I, II, III) determinants, local Medical Control must define additional dispatch center policy and authorize approved patient conditions.

■ ACUITY Level I: Immediate response for transport to ot

■ ACUITY Level II: Time specific response for transport t

■ ACUITY Level III: Non-time sensitive response for trans

**Medical Chief Complaint(s): 33**

______ **HIGH RISK PATIENTS**

☐ *Other (approved by Medical Director): ________________________________________

* ≥ 65 years old (not COVID-19)

**Medical Chief Complaint(s): 36**

© 1988–2024 IAED

© 1987–2024 PDC

**INITIALS**

MS

**NURSE OR DOCTOR**

Local Medical Control must define and authorize the minimum qualifications of medical personnel defined as NURSE or DOCTOR.

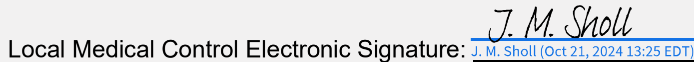
- ■ Medical doctor (MD)
- ■ Physician assistant (PA)
- ■ Nurse practitioner (NP)
- ■ Registered nurse (RN)
- ■ Licensed practical nurse (LPN)
- ■ Other (approved by Medical Director): Doctor of Osteopathy (DO), Midwife or Nurse Midwife (Not a Doula)

**Medical Chief Complaint(s): 37**

I have reviewed and initialed each of the approved items above and completed all applicable authorizations and protocol definitions required to implement the Medical Priority Dispatch System in:

Dispatch Agency Name: All Maine EMS Licensed EMD Centers

Local Medical Control Name: J. Matthew Sholl, MD, Maine EMS Medical Director

Local Medical Control Electronic Signature: 
J. M. Sholl (Oct 21, 2024 13:25 EDT)

Date Approved: Oct 21, 2024

© 1988–2024 IAED © 1987–2024 PDC

Appendix B: Local Medical Administration Definitions /Authorization

**MPDS Version 14 Paramount Admin, Restricted Settings (General Tab) and Special Definitions**

Items of note:

1. Agencies may select whichever option they prefer for Person /Suspect Description and are encouraged to make this decision with input from local law enforcement.
   - Enable Police Suspect Info (Scotland Yard version)
   - Enable Person Description Essentials

2. Compressions only: Continuous compressions until responder arrival. This authorization does not remove the decision for a Ventilations 1st pathway when specific conditions apply. While *compressions only* will always be highlighted based on the administrative setting, the EMD must select the most appropriate pathway for each situation. Airway management is the most important aspect of treating a patient with a suspected drug overdose. The EMD must ensure that airway management issues are addressed, especially in situations when Naloxone/Narcan Administration Instructions are indicated.

Entry | KQ | PDI/CEI | DLS | Summary

C4 - Pathway Director (select one) AED: Yes Sent At pt. Started Used

Ventilations 1st (if any of these conditions apply):
Allergic reaction
Asthma/COPD
Drowning
Hanging
Lightning strike
Overdose/Poisoning
Seizure
Severe trauma
Strangulation
Suffocation
Toxic inhalation

Unconscious Choking

Compressions 1st or Compressions only (if none of the above conditions apply):
Any other problems

Maintain airway | Continue M-T-M

Main | Additional Info | Reassure | Clear Airway | Remove Object | Control Bleeding | Extra Reassurance

* Select the most appropriate pathway:
Ventilations 1st | Compressions 1st
Unconscious Choking | Compressions only

3. Although a DNR (Do Not Resuscitate) Order is recognized as an expected death situation and may qualify for a reduced response or referral to law enforcement, an EMS unit shall be dispatched when there is any question about the advanced directive documentation or the patient or their family are requesting an emergency medical response.

4. The bariatric patient weight threshold of 400 pounds is consistent with the Maine EMS Pre-Hospital Treatment Protocols, which state, “A bariatric patient exceeds 180kg (400 lbs.) or possesses a body habitus that challenges the ability of a two-person crew to manage effectively.”

5. The stroke treatment window of 3 hours is consistent with Maine EMS Pre-Hospital Treatment Protocols.

6. No Omega referral is approved for Protocol 24. An EMD Center must be an Accredited Center of Excellence (ACE) to consider Omega- referrals other than those defined in the Maine Behavioral Health Call Policy and authorized by the State Medical Director.

7. Crisis Team/Alternate Response Criteria have not been established as we recognize the variables across our State with mental and behavioral health resources and the rapid changes occurring in the mental health field with 988 and other federal initiatives. This question is not approved for jurisdictional or operational use, as you will see in Appendix C. However, an EMD Center may be approached by their local EMS and/or Law Enforcement partners to establish local criteria, in which case a proposal can be made to the State Medical Director for local use. A proposal shall:
   - Define the proposed Crisis Team/Alternate Response Criteria,
   - List or describe the available Crisis Team/Alternate Response and a primary contact for the resource(s),
   - Include a quality assurance plan to ensure satisfactory outcomes or process improvement, and
   - Be endorsed by the jurisdiction(s)’s EMS service-level medical director(s).

8. Acuity Levels I, II, and III within Protocol 33 are defined explicitly for “transport to other than a hospital emergency department.” <u>All patient transfers to a hospital emergency department shall be processed using Protocol 37</u>. For EMD Centers that do not process calls for non-emergency transfers where the patient is delivered to a facility other than a hospital emergency department, it may be appropriate to turn off Protocol 33 in ProQA. Keep in mind that Protocol 37 is digital only; in the event that ProQA is not working, EMDs should use Protocol 33 in the card set to process all transfer requests.

9. High-Risk Patients are not defined because Protocol 36 is not authorized for use.

10. Nurse or Doctor includes Medical doctor (MD), Physician assistant (PA), Nurse practitioner (NP), Registered nurse (RN), Licensed practical nurse (LPN), and Other (approved by Medical Director): “Doctor of Osteopathy (DO), Midwife or Nurse Midwife (not a Doula).”
    The addition of “Midwife or Nurse Midwife (not a Doula)” recognizes the state credentialing of these clinical professionals and their skilled role in birthing care both in the hospital and in the pre-hospital or alternative clinical settings.

# Appendix C: Jurisdictionally and /or Operationally Approved Questions

# JURISDICTIONALLY AND/OR OPERATIONALLY APPROVED QUESTIONS

## MEDICAL PRIORITY DISPATCH SYSTEM™ V14.0 IMPLEMENTATION

This document is intended to identify those Jurisdictionally Approved Questions and optional answer choices that your agency is currently utilizing within the Medical Priority Dispatch System™ (MPDS®). Select the optional questions and answers that should be used in the protocol by checking the box next to each question or answer that has been approved.

### CHECK TO UTILIZE

### PROTOCOL #6 BREATHING PROBLEMS

**Optional Question**

☐ Ø Enter your level of coronavirus illness concern:

### PROTOCOL #9 CARDIAC OR RESPIRATORY ARREST/DEATH

**AED Locator**

▣ Ø Confirm answer based on the AED Locator findings.

### PROTOCOL #10 CHEST PAIN/CHEST DISCOMFORT (NON-TRAUMATIC)

**Optional Question**

☐ Ø Enter your level of coronavirus illness concern:

### PROTOCOL #13 DIABETIC PROBLEMS

**Optional Question**

☐ Ø Enter your level of coronavirus illness concern:

### PROTOCOL #25 PSYCHIATRIC/MENTAL HEALTH CONDITIONS/SUICIDE ATTEMPT/ ABNORMAL BEHAVIOR

**Optional Question**

☐ Ø Does this incident qualify for a CRISIS TEAM / ALTERNATE RESPONSE?

▣ Has s/he ever had a confrontation (run-in) with public safety responders?

▣ Does s/he (or the family) have a SAFETY PLAN in place?

### PROTOCOL #26 SICK PERSON (SPECIFIC DIAGNOSIS)

**Optional Question**

☐ Ø Enter your level of coronavirus illness concern:

© 1988–2024 IAED

© 1987–2024 PDC

## PROTOCOL #37 INTERFACILITY EVALUATION/TRANSFER

**Logistics Questions**

- ☐ What's the name of the patient?
- ▣ Does the patient have any advance directives?
- ☐ What's the name of the referring doctor?
- ☐ What's the name of the responsible Health Care Professional?
- ☐ What's your fax number?

## PROTOCOL #40 INCIDENT STANDBY/STAGING

**Optional Question**

- ☐ Is there a specific talk group or radio channel for this event?

## PROTOCOL #41 CALLER IN CRISIS (1ST PARTY ONLY)

**Optional Questions**
**INTENDING SUICIDE**

- ☐ Are you taking any medications for mental health?
- ☐ What are you taking?
- ☐ Are you taking any medications for anything else?
- ☐ What are you taking?
- ☐ What are the medications for?
- ▣ As awful as you've been feeling, what helped you decide to call us? (Ø Affirm caller's choice.)
- ▣ When you've struggled in the past, what has helped you most?
- ▣ In better times, what do you enjoy or find meaning in?

**NON-SUICIDAL/SUICIDAL IDEATION/Caller refuses to answer**

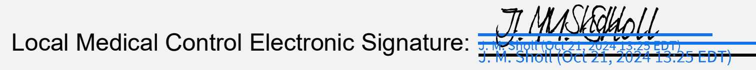
- ☐ Are you taking any medications for mental health?
- ☐ What are you taking?
- ☐ Are you taking any medications for anything else?
- ☐ What are you taking?
- ☐ What are the medications for?
- ▣ Are you struggling emotionally or mentally in some way?
- ☐ Are you seeing a Mental Health Professional to support you with this challenge?
- ☐ Could I bring them on with us now to help support you?
- ▣ Are there any skills or strategies you've learned that we could use right now while we're waiting for help to arrive?
- ▣ As awful as you've been feeling, what helped you decide to call us? (Ø Affirm caller's choice.)
- ▣ When you've struggled in the past, what has helped you most?
- ▣ In better times, what do you enjoy or find meaning in?

© 1988–2024 IAED © 1987–2024 PDC

I have reviewed each of the approved items above and have selected those Jurisdictionally Approved Questions that should be included within the Medical Priority Dispatch System.

Dispatch Agency Name: All Maine EMS Licensed EMD Centers

Local Medical Control Name: J. Matthew Sholl, MD, Maine EMS Medical Director

Local Medical Control Electronic Signature: 
J. M. Sholl (Oct 21, 2024 13:25 EDT)

Date Approved: Oct 21, 2024

© 1988–2024 IAED © 1987–2024 PDC

Appendix C: Jurisdictionally and /or Operationally Approved Questions

**MPDS Version 14 Paramount Admin, Restricted Settings (Tabs 9, 17, 25, 37, 39, 40, 41)**

Items of Note:

1. Protocol #9 - When an agency activates the Pulse Point AED Registry integration with ProQA, the AED locator key question is approved for utilization.

2. Protocol #25 – Crisis Team/Alternate Response has not been defined; this key question is not authorized for use. The other optional key questions shall be utilized.

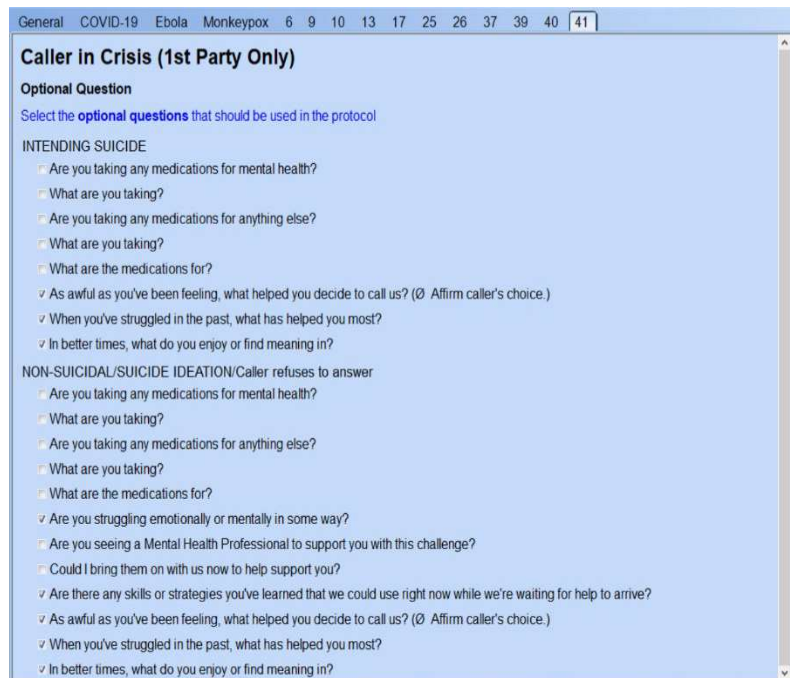
3. Protocol #37 – The optional key question "Does the patient have any advance directives?" shall be utilized; the other optional key questions are authorized but remain optional locally.

4. Protocol #39 – Enable Protocol 39

5. Protocol #40 – The optional key question is authorized but optional locally. Agencies are encouraged to make this decision with input from local response agencies.

6. Protocol #41 – All of the optional key questions are authorized for use, but some are optional locally for reasons we'll identify.

   The image to the right reflects the optional key questions that shall be turned on and available to EMDs during every caller interrogation. These are questions that appear after the SEND point to facilitate meaningful discussion and develop rapport between the caller and the EMD.



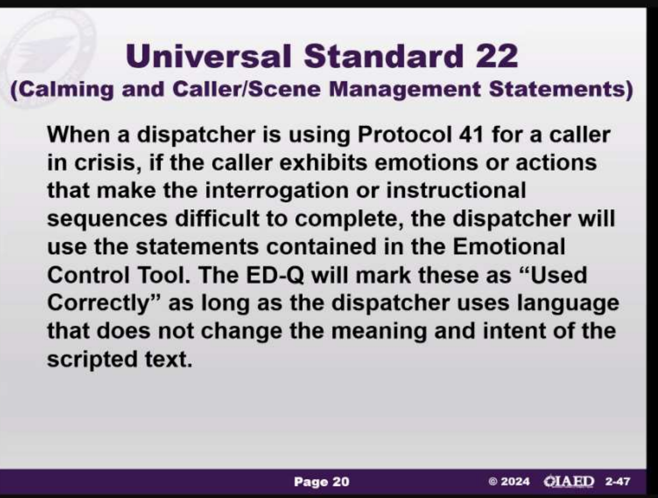

   Agencies are encouraged to make the decision to activate any of the other optional key questions in P41 with input from local response agencies, understanding that the questions are similar to those that EMS may ask when they arrive, and the caller/patient may feel agitated at having to provide the information again if the EMD center doesn't have the means to pass the information they gathered from the caller on to EMS.

### Rationale

After the caller is separated from the means, and you've gathered vital safety information, you should stay on the line with a caller in crisis until field responders arrive. Many Emergency Dispatchers have expressed discomfort and uncertainty about how to fill this time. **The later Key Questions on Protocol 41 go beyond filling time and fortify the caller's reasons for living, help you maintain your human alliance, provide buffers against suicidal ideation, and help the caller stay focused until field responders can take over.**

EMDs will learn more about the rationale for these optional questions in their initial Protocol 41: Caller in Crisis required certification course.

The agency may adopt a policy for using Protocol 41 that reinforces the importance of 1. staying on the line with callers in an unsafe or worsening situation and 2. customer service standards, while acknowledging that callers and situations are unique and the "optional questions" that shall be available on every caller interrogation after the SEND point, may not be necessary or appropriate for all first-party callers in crisis. This policy may reference or be similar in context to existing universal customer service standard 22 which supports the EMD in deciding the best flow for appropriate caller management while maintaining a human interaction using Protocol 41, and supports the QA team in their review of these calls.



# Appendix D: Maine Behavioral Health Call Policy & Decision Tree

STATE OF MAINE

CALL RECEIPT, ACKNOWLEDGEMENT, and TRANSFER OF BEHAVIORAL HEALTH CALLS[1]

| SUBJECT: | | NUMBER: |
|---|---|---|
| RESCINDS: | EFFECTIVE DATE: | |
| REFERENCE: | | |
| DISTRIBUTION: | REVIEW DATE: | |
| STANDARD: | | |

I. PURPOSE:

The purpose of this policy is to provide public safety answering points (PSAPs) with a minimum standard for a uniform response when receiving, assessing, conferencing, and/or transferring calls from persons in crisis (1st party caller) or other callers for mental and/or behavioral health-related assistance, including substance use disorder.

II. POLICY

It is the policy of Maine Emergency Services Communications Bureau (ESCB) and Maine Emergency Medical Services (Maine EMS) to provide the highest quality response to all requests for assistance for mental and/or behavioral health-related incidents. Incidents will be processed and assessed to determine if or when the caller can be safely transferred or conferenced with the State's Maine Crisis Line (MCL).

III. DEFINITIONS

A. **988 Suicide and Crisis Lifeline –**A three-digit number for individuals experiencing a mental and/or behavioral health crisis is routed to the National Suicide Prevention Lifeline. The 988 Suicide and Crisis Lifeline (988) is comprised of a network of 200+ independently owned and operated local centers. It is a national portal for connecting to localized crisis services. 988 serves as an alternative to 911 to appropriately manage mental and/or behavioral health-related calls, including substance use disorder, that do not present with an imminent safety concern.
B. **Active Engagement –** When a Crisis Counselor seeks to collaborate with and empower the caller towards securing their own safety, or the safety of the person they are calling about. Active Engagement is typically necessary for both a comprehensive, accurate assessment of a caller's suicide risk as well as for collaborating on a plan to maintain the caller's safety.
C. **Active Rescue –** Interventions by Crisis Counselor include, but are not limited to, making every effort to determine the name, location, and/or phone number of the caller; contacting emergency services with or without the caller's consent; tracing the call if there is no known identifying information; requesting 9-1-1 to dispatch police to a discovered location.

[1] December 14, 2022

D. **Call for Service –** Requests for service received by a PSAP, by various means (911, 10-digit phone systems, public safety radio system, counter walk-in), which require assistance either by telephone or response by a public safety or mental health resource.

E. **Call Receipt –** "Calls" are requests for service received by a PSAP, by various means (911, 10-digit phone systems, public safety radio system, counter walk-in). For the purposes of this policy, calls are received and answered by the PSAP and upon transfer, calls are received and answered by the MCL and 988 (future state).

F. **Caller Party**[2]

1. First Party Caller – The person in crisis experiencing the mental and/or behavioral health event or in need of resources. A First-Party Caller is the subject/patient/victim/suspect who is directly involved in the incident.
2. Second Party Caller – Someone who is with or is intimately familiar with a person in crisis or an individual in need of resources. A Second-Party Caller is someone who is with/near the subject/patient/victim/suspect and can potentially communicate with them.
3. Third Party Caller – Someone who is removed from or not in close proximity to the subject/patient/victim/suspect. A Third -Party Caller is a person who is reporting something witnessed or heard but is uninvolved or is not currently on the scene.
4. Fourth Party Caller – A caller from another public service agency and may or may not have specific information about the incident. A Fourth Party Caller is a referring agency, alarm company, or person that generally lacks personal direct knowledge but was asked or told by someone else to summon help.

G. **Chief Complaint –** The primary reason for a person seeking medical or mental health care.[3]

H. **Computer-Aided Dispatch (CAD) –** A computer-based system assisting emergency telecommunicators (ETCs) with activities such as call input, dispatching, call status maintenance, event notes, field unit status and tracking, and call resolution and disposition.

I. **Consent/Informed Consent –** The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention.[4]

J. **Crisis –** An event that may or may not exceed an individual's coping strategies, resulting in disturbances, reactions, or impairments in cognition, affect, and/or behavior.

K. **Crisis Counselor –** Staff member answering the phone call, text, or chat messages at a 24/7 crisis call center.

L. **De-escalation –** Attempting to lower or decrease the intensity level of emotions to redirect behavior so it can be controlled within safe boundaries.

---

[2] "Four Main Types of Callers" in IAED's ETC Manual version 4.1, Pages 3.14 – 3.15.

[3] The International Academy of Emergency Medical Dispatch. (2015). *Emergency Medical Dispatch Course Manual* (25th ed.). Priority Press.

[4] The American Medical Association. (2022). https://www.ama-assn.org/delivering-care/ethics/informed-consent

M. **Determinant Code –** Alphanumeric response codes formulated by combining the Chief Complaint protocol, the Determinant Level letter, the Determinant Descriptor number, and the Determinant Suffix letter (e.g., 6-C-1A).[5]
N. **Dispatch-Only Center –** An entity, either public or private, that is duly authorized to dispatch emergency services within a designated area but does not take 911 calls directly.
O. **Emergency Medical Dispatch (EMD) –** A medical protocol required by all PSAPs in Maine that is used to systematically obtain location, callback number, nature of the emergency, and answers to key questions for responders while consistently providing needed post-dispatch instructions.
P. **Emergency Medical Dispatch Center –** Any entity that provides EMD and is licensed as such by the Maine EMS Board.
Q. **Emergency Medical Services (EMS) –** A type of emergency service dedicated to providing out-of-hospital acute medical care, transport to definitive care, and other medical transport to patients with illnesses and injuries preventing the patient from transporting themselves.
R. **Emergency Services Communication Bureau (ESCB) –** The Bureau within the Maine Public Utilities Commission responsible for implementing and managing 911 in Maine.
S. **Emergency Telecommunicator (ETC) –** An employee who has successfully completed Emergency Telecommunicator Certification as required by the ESCB.
T. **Exigent Circumstances –** An exigent circumstance is an ongoing, potentially life-threatening situation that needs immediate attention. Exigent circumstances allow wireless carriers to disclose customer and/or location information to public safety agencies based on subscriber information.
U. **Imminent Risk –** May be determined if an individual expresses (or is reported to have stated by a person believed to be a reliable informant) both a desire and intent to die and has the capability of carrying through with their intent.
V. **Maine Crisis Line (MCL) –** Maine's primary 988 Lifeline center, and the state's centralized behavioral health crisis line. The MCL is staffed 24/7 by clinically trained crisis counselors who provide crisis intervention support by telephone, text, and chat. ETCs can also connect those in crisis with services in their area including community resources and referrals to outpatient services, mobile crisis response, local crisis units, and inpatient services.
W. **Maine Emergency Medical Services, or Maine EMS –** The Board, the EMS director, and staff within the Department of Public Safety.
X. **Non-Emergency Medical Call –** A situation in which emergency medical treatment is required, but an immediate response is not necessary to prevent a life, limb, or well-being threatening medical condition (e.g., Alpha, Bravo, or Omega level determinant codes).
Y. **Outbound Short Message Service (SMS) –** An outbound SMS initiated by the ETC with a wireless user. (This method does not utilize 911 lines; therefore, it is not considered Text-to-911.)
Z. **Permission –** The act of formally allowing an act to occur (e.g., a caller granting an ETC permission to transfer their call to another entity)
AA. **Person in Crisis –** An individual demonstrating signs and/or symptoms of poor behavioral health, a disturbed thought process, a behavior or a mood that may lead to a concern for

[5] The International Academy of Emergency Medical Dispatch. (2015). *Emergency Medical Dispatch Course Manual* (25th ed.). Priority Press.

safety of an individual or society, or a generalized higher acuity (severity) of signs and/or symptoms than of a normal time for the individual; the individual may benefit from admission or referral to treatment services.

BB. **Public Safety Answering Point (PSAP) –** A facility with 911 capability, operated 24/7, assigned the responsibility of receiving 911 calls and, as appropriate, directly dispatching emergency services or, through transfer routing or relay routing, passing 911 calls to public safety agencies.

CC. **Reference –** A single identifying number exchanged between agencies to share and communicate information on a mutual call.

DD. **Responder –** Public/Private response personnel identified as responding in person to crises, including, but not limited to, law enforcement, fire, EMS, onsite clinician, etc.

EE. **Text-to-9-1-1 –** The ability to send an SMS text message to reach 911.

FF. **Transfer –**

1. **COLD Transfer –** A cold transfer refers to the process of patching the caller through to another center without explanation or communication.
2. **WARM Transfer –** A warm transfer refers to the process of safely transferring a caller to another department, organization, or service and providing basic essential information to prioritize the continuity of care once scene safety concerns are ruled out.
3. **Conference Call –** Allows for two or more parties to converse on the same call at the same time.

IV. GENERAL

A. **Axioms –** "EMD Axioms are important statements that serve as the basis for many MPDS decision-making processes. They differ from Rules in that they explain why, rather than how to do things".[6]

1. MPDS[7] Protocol 25 Psychiatric/Abnormal Behavior/Suicide Attempt axioms:
   a. Behavior emergency patients (at any level of consciousness) are considered to be **a potential risk to themselves and others**.
   b. Certain serious medical problems can be confused as "just a psych problem." It would be a **serious EMD error not to respond at all**. These problems include insulin shock, severe blood loss, lack of oxygen, delirium tremens (the DTs), overdose, liver or kidney failure, etc.
   c. Certain stages of insulin shock can easily be **confused with alcohol intoxication or psychiatric problems**.
   d. **Delirium tremens** (the DTs) is a severe metabolic derangement that has a surprisingly high in-hospital mortality rate and **should not be underestimated**.
   e. **It is reasonable to utilize a police-only response** when a person is **THREATENING SUICIDE** (no injuries have occurred). This choice must be **approved by local policy** between law enforcement and EMS-provider agencies.

[6] IAED EMD Course Manual Edition 25 Page 2.33
[7] Medical Priority Dispatch System

B. **Ownership –** When a call arrives at [PSAP Name], it is considered to be owned by this PSAP, and we are therefore obligated to take charge of the call, take immediate action, and provide all necessary assistance to the caller until equal or appropriate care is provided for the subject.

C. **Quality Assurance –** Involves organized efforts to evaluate and ensure that performers maintain expected standards.[8] This includes monitoring and evaluating performance systematically to ensure the desired standards of quality are being met.

D. **Feedback –** All PSAP staff are encouraged to report any issues regarding this policy to their immediate supervisor. Feedback includes suggestions for improvement as well as any problematic issues that may surface with its use. As appropriate, please forward feedback to the Emergency Services Communications Bureau at info911@maine.gov.

E. **Crisis Accessibility** – The MCL currently has three dedicated lines for business:

1. **Dispatch direct line** – Unpublished direct line; calls to this line are prioritized to be answered first in the call queue. (207-553-5918)
2. **Crisis line** – Published phone number for public access (888-568-1112)
3. **988/Lifeline** – Calls are routed to this line based on the area code through the national Lifeline call hub.

When a PSAP or Dispatch-Only Center transfers calls to MCL, they are (generally) guaranteed to reach a Crisis Counselor. However, a call to MCL may be placed in a queue for the next available Crisis Counselor. MCL has established the dispatch direct line as the first line answered in the call queue to attempt to mitigate these instances. If this occurs, an MCL supervisor will be alerted that a call is in queue; MCL policy is for the supervisor to answer queued calls as much as practical to limit the hold time for ETCs.

V. PROCEDURE

**A. Call Receipt**

1. PSAPs may receive calls from a person in crisis through the 911 system, a 10-digit line, or through Text-to-911. 988 and MCL routinely receive calls from a person in crisis that may require a response from public safety emergency services; these requests for services will be received by the PSAP on a 10-digit line.

   The following shall serve as a mechanism for receiving requests for services by ETCs.

   a. Calls received, regardless of the method of receipt, should be answered using the standard agency greeting for that line of service (e.g., 911, 10-digit line, etc.)
   b. Call receipt should begin by obtaining location information including where services may be needed. All ETCs should follow address verification as dictated by existing policies.
   c. The ETC should obtain a callback number for the caller, following callback number verification policies.
      i. Where possible, a phone number for the caller should also be obtained if the caller is at a different location than the individual in need of services.

[8] The International Academy of Emergency Medical Dispatch. (2015). *Emergency Medical Dispatch Course Manual* (25th ed.). Priority Press.

d. The ETC shall determine the nature of the event as dictated by existing protocols.
e. Calls received in which the incident location is outside of the jurisdiction served by a PSAP or other licensed EMD dispatch center should be transferred to the appropriate PSAP.
    i. ETCs should utilize the National Emergency Number Association's (NENA) PSAP Registry[9] to assist in determining the PSAP to transfer to when the incident is occurring outside the state of Maine.
f. Calls from third-party callers are to be processed using existing call processing procedures.
    i. In limited circumstances, MCL may be able to provide information to the PSAP to aid in a response.

2. Initial minimum data needed when receiving calls for service:
    a. (Verified) location information (including exigency) and where services may be needed whether stationary, mobile, or if at a different location than the caller.
    b. (Verified) callback number
    c. Chief complaint
    d. Time of occurrence (in-progress, just occurred, past event)
    e. Known hazards (e.g., weapons, fire, hazardous materials [HAZMAT], etc.)
    f. Identity of those involved and their location
    g. Caller's name and, if possible, name of person in need of services, if not first party.
3. Public Safety Provider/Field Requests: Calls may also be received directly from public safety emergency responders (law enforcement, fire, and/or EMS) on the scene of a behavioral health crisis incident; these resource requests shall be directed to MCL.
    a. Scene response request – The following minimum information is required to request a mobile crisis team resource:
        i. Agency name
        ii. Name and date of birth of individual in crisis
        iii. Incident details
        iv. CAD reference/incident number
    b. Coaching request – Instances may arise where a public safety emergency responder can benefit from receiving information from MCL to assist with an incident. In these instances, the ETC can provide MCL's dispatch direct line to the responder.
        i. The MCL dispatch direct line shall be provided to officers only via telephone to avoid unintentional release of this number to the public.
        ii. For instances where a responder needs coaching from a Crisis Counselor on how to handle a specific incident, the Crisis Counselor does not need to speak to the individual in crisis.
        iii. For instances where a responder needs specific information about the person in crisis, they can contact MCL via speakerphone to allow MCL to obtain permission from the individual to release information.
    c. Case-history request – In some cases, the Crisis Counselor may need to speak to the public safety emergency responder directly to obtain specific information and/or ask detailed questions.

[9] https://eprc-apps.geo-comm.com/epr/12/index.html?mobileBreakPoint=400

i. The ETC shall follow the warm transfer procedures as listed in Section V.C.1. to enable direct communication between MCL and the field provider.
ii. In situations where a law enforcement officer indicates a call recording may be required for investigative purposes, the line must remain open throughout the entirety of the conversation.

**B. Call Screening and Classification**

Call Screening and Classification is defined as the action(s) taken by the ETC to assess the situation, including scene safety and possible exigent circumstances, in preparation to process the call. When screening and classifying calls, the variety of resources that may be needed can only be determined by the ETC's line of questioning, resulting in a course of action that may include a transfer to MCL.

There are four scenarios for consideration when screening and classifying mental/behavioral health calls:

- Request for an ambulance for unknown medical elements with a known mental/behavioral health component
- Request for an ambulance with no medical element but has a mental/behavioral health component
- Request for help – caller information is assessed by the ETC to determine if:
  - A safe transfer or conference to the MCL is appropriate,
  - A co-response of a local mobile crisis team is appropriate, if applicable and follows local policy,
  - Law enforcement is needed, or
  - The caller is requesting service or resources outside the public safety response system.
- Well-being checks

There are potential scenarios when the EMD protocol is not used, such as third-party reporting or inquiries; these include, but are not limited to:

- Reporting an incident involving a person in crisis but the caller is not involved in the incident.
- Seeking advice/support for a friend or family member.
- Inquiring about the mental/behavioral health of a person based on ongoing or previous actions or statements, which do not rise to the level or likelihood of serious harm or imminent risk.

ETCs should address these scenarios by following these steps:

1. **Requests for an ambulance for unknown medical elements with a known behavioral health component** shall be processed using the MPDS to reach an appropriate chief complaint and determinant selection.
   a. If unable to identify the chief complaint used,
      i. Protocol 32- Unknown Problem (Person Down)
   b. If a caller requests an ambulance, ETCs should use MPDS protocols to assess medical necessity and dispatch resources as per local policy.

c. While notes can be entered using CAD or ProQA[10], ETCs shall follow agency policy when indicating that the call includes a mental/behavioral component.
d. Depending on information received, a law enforcement response may also be needed for scene security.
e. If an extended field response is anticipated, once post-dispatch and/or pre-arrival instructions have been administered, the ETC may opt to obtain the caller's permission to conference the call to the MCL using the procedures listed in Section V.C.1.

2. **Requests for an ambulance with <u>no</u> medical elements but has a mental/behavioral health component** shall be processed using the MPDS to reach an appropriate chief complaint and determinant selection.
   a. If unable to identify the chief complaint, use Protocol 25 – Psychiatric/Abnormal Behavior/Suicide Attempt
3. Calls that receive a Protocol 25 Omega level determinant code shall be transferred to MCL using the procedures listed in Section V.C.1.
   **Request for help –** Caller requests assistance and it is determined, after initial questioning, that no medical component exists.
   a. The ETC determines that a safe transfer or conference to the MCL is appropriate
      i. Protocol 25 Omega level determinant code shall be transferred to MCL using the procedures listed in Section V.C.1., or
   b. A co-response of the local mobile crisis team is appropriate, if applicable and follows local policy,
   c. Law enforcement is needed, or
   d. The caller is requesting service or resources outside the public safety response system, (e.g., 211 services for basic needs such as food, clothing, housing, utility assistance, etc.)

The ETC should assess the caller's condition and scene safety by using the following matrix:

*Matrix 1 - Caller Condition and Scene Safety Information*

| High-to Unknown Priority Matrix: Caller Condition and Scene Safety Information | | | |
|---|---|---|---|
| | **Call Script (questions to ask based on disqualifying conditions)** | **Do not transfer to call if:** | **Recommended Action (based on affirmative response in column 2)** |
| **If the caller's response to the ETC's question is "maybe" or "silence," or the response is considered "yes," - a dispatch is appropriate.** | | | |
| A. | Are you sick or injured? | 1. A medical component exists (e.g., ingested drugs/poisons/ toxins, self-inflicted wounds) or | ETC uses EMD protocols and dispatches per agency policy.<br>A law enforcement response is per agency policy. |

[10] Software used by ETCs to process 911 calls through the EMD protocols.

| High-to Unknown Priority Matrix: Caller Condition and Scene Safety Information | | | |
|---|---|---|---|
| | **Call Script (questions to ask based on disqualifying conditions)** | **Do not transfer to call if:** | **Recommended Action (based on affirmative response in column 2)** |
| **If the caller's response to the ETC's question is "maybe" or "silence," or the response is considered "yes," - a dispatch is appropriate.** | | | |
| | | 2. A reaction resulting from not taking prescribed medication(s). | |
| B. | Do you have any weapons on or near you? What are they? Where are they? | Party states there are weapons in proximity, access exists, and/or the person in crisis has weapons history. | Scene safety information is entered in the CAD incident and resources are dispatched per agency policy. |
| C. | (1st) Are you or anyone near you in immediate danger? Are you violent?<br>(2nd) Is the person in crisis violent? | Anybody states they may be in immediate danger. | Scene safety information is entered in the CAD incident and resources are dispatched per agency policy. |
| D. | Are you or have you threatened anyone's personal safety? | The person in crisis is threatening others or their own personal safety. | Scene safety information is entered in the CAD incident and resources are dispatched per agency policy. |
| E. | Are you or have you threatened anyone's property? | The person in crisis is threatening others or their own property. | Scene safety information is entered in the CAD incident, and resources are dispatched per agency policy. |
| F. | Have you expressed plans to harm yourself today? | The person in crisis has stated plans, means, and/or an intent to harm themselves exist. | Scene safety information is entered in the CAD incident and resources are dispatched per agency policy. |
| G. | Have you committed a crime or intend to commit a crime in relation to your situation today? | A crime has been reported in association to this call or is known to have been committed and/or requires a level of investigation. | Scene safety information is entered in the CAD incident and resources are dispatched per agency policy. |

If medical signs and symptoms are presented during questioning, the ETC shall follow MPDS protocol and change the call type to the appropriate EMD determinant code.

Prior to a call transfer and when all disqualifying conditions have been ruled out (see Matrix 1 above), the person in crisis should meet the following criteria:

- Is cooperative

- Agrees to be transferred to an MCL (permission)

4. **Well-being checks** are to be processed when a caller makes a report or inquiries about the mental/behavioral health of a person based upon actions or statements that do not rise to the level of serious harm or imminent threat.
    a. ETCs should address such concerns by following these steps:
        i. The ETC should create a well-being check per agency protocol.
        ii. The ETC should record the reporting party's statements that the person in crisis may have or is known to have a mental/behavioral health condition and cannot be reached.
        iii. When the reporting party does not want the police for a well-being check and there is not a clear and present danger, the ETC may:
            1. Transfer the caller to the MCL for resource information
            2. Refer the information to the local social assistance agency(ies) with the caller's permission (e.g., Department of Social Services, 211, etc.)

The CAD incident should be closed when the caller has been provided a course of action (transfer or social services referral) or when the well-being call is complete per agency protocol.

The ETC will employ routine call-taking techniques as needed, such as the name of the calling party, and name and description of the person in crisis.

**C. Call Processing**

Call processing is defined as the action(s) taken by the ETC to identify the appropriate agency and/or agencies to safely transfer or conference a caller for higher levels of behavioral health care to include safeguards.

During call processing, the ETC's assessment may determine that there is more risk in transferring the caller than remaining on the line and continuing to establish rapport. Transferring a caller to MCL versus remaining on the line is at the agency's discretion, based on existing agency policy.

When a transfer or conference is appropriate, safety and medical conditions have been ruled out, and permission from the caller has been obtained, the ETC should then connect the caller to MCL allowing for the continuity of care. A successful handoff and overall better caller experience can be obtained by referring to the caller by name and explaining the steps of the upcoming processes.

1. When a warm transfer of first- or second-party caller(s) from the PSAP to the MCL is appropriate, the ETC shall:
    a. Advise the caller that the ETC would like to connect with a Crisis Counselor from the MCL and request permission to do so (e.g., "There is help available for you, I would like to connect you with a Crisis Counselor. Would that be alright with you?").
    b. After permission has been granted, advise the caller to stay on the line while the call is being transferred (e.g., "Please stay on the line while I connect our call. I will speak first and introduce you").

c. Stay on the line to announce the call to the MCL Crisis Counselor (e.g., "This is Regional 911 with a transfer…") and provide pertinent information, including, but not limited to:
    i. Agency name
    ii. Verified location where contact can be made
    iii. Verified callback number
    iv. Name of caller(s) and other parties involved
    v. Time element (e.g., in-progress, just occurred, past event)
    vi. Description of circumstances (known relevant information about the caller's condition)
    vii. Hazards validation (e.g., "There are no known hazards.")
    viii. Exchange and confirmation of reference numbers

d. The ETC will remain on the line with the person in crisis until a Crisis Counselor has taken ownership of the call. The ETC will announce they are disconnecting and advise if anything changes or immediate services are needed, to call 911.
    i. In the event the ETC needs to stay on the line with the caller and Crisis Counselor, all parties will remain conferenced until it is mutually agreed upon and safe for the ETC to disconnect.

e. Once a caller has been transferred to the MCL, in limited instances the call may be placed in a call-queue to await the next available Crisis Counselor. If this occurs, the ETC shall advise the caller "We are on hold for the next Crisis Counselor. I will remain on the line with you."
    i. If the ETC must answer another emergency call, the ETC may place the person in crisis or caller on hold, following agency policy, and after informing the caller they are placing the call on hold (e.g., "I need to answer another emergency call, please stay on the line. I am placing you on hold, but I will return as quickly as I can. If a Crisis Counselor picks up while you are on hold, please let them know you are being transferred from 911"). As soon as practical, the ETC shall return to the person in crisis.
    ii. If the caller is no longer on the line and the call has not been received by MCL, the ETC shall recontact the caller and reattempt a conference with MCL.

f. When a caller does not grant permission to be transferred to MCL, the ETC shall create a call for service and initiate a law enforcement, fire, and/or EMS response per agency policy.

2. Callers seeking next steps after accessing 911 may not be aware of the services provided by 988 or MCL. As part of an ETC's approach to transferring or conference to MCL, in the absence of a medical issue where protocols are not applicable, the ETC can obtain permission to transfer the call to MCL. The ETC shall reassure the caller that they are being helped throughout this process as a calming mechanism. Examples of this approach include:
    a. "You are not alone. There is help available for you, and I'm going to help connect you to a Crisis Counselor. A Crisis Counselor can provide resources and assist you; can I add them into our conversation?"
    b. "There is help available to get you through this. I'd like to connect you with a Crisis Counselor who can talk with you and provide resources to help you. Would that be okay?"

**D. Universal and Convenient Access**

Working with special groups is defined as a comprehensive suite of tailored services taken by the ETC to include accommodations such as interpreters and/or coordinated care to provide universal and convenient access to services. The procedures listed pertain to groups or individuals who need accommodation beyond standard ETC caller management practices.

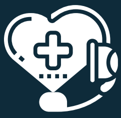
1. Foreign Language Barriers
    a. Calls involving persons in crisis or from callers who have limited, or no English-speaking skills may require language translation services.
        i. For 911 calls, ETCs shall conference in Maine's foreign language translation provider[11] as per existing policies to provide this service.
        ii. ETCs shall speak to the translator as if they are speaking directly to the caller. This allows the translation of the ETC's questions verbatim, and the return of the information the ETC is seeking.
        iii. When a public safety emergency responder requires translation services for person in crisis, the ETC shall request the responder to call the PSAP on an administrative line to then be conferenced with the appropriate service.
    b. Calls having a behavioral health component may be transferred to MCL with the translator on the line.[12]
        i. ETCs shall follow the warm transfer procedures as listed in Section V.C.1. to facilitate communication between the caller/translator and an MCL Crisis Counselor.
2. Relay Services
    a. When a telecommunications relay service (TRS) (711) and/or video relay services (VRS) call is received that qualifies for MCL assistance, the ETC may conference or conduct a warm transfer to MCL following the procedures as listed in Section V.C.1. When guidance only is needed from MCL to process a call, the ETC may contact MCL on a separate phone line.
3. Text-to-9-1-1 and SMS (Outbound)
    a. PSAPs will follow the State established and agency approved Text-to-9-1-1 Policy issued October 25, 2018, or as subsequently revised, when managing text-to-9-1-1.
4. Teletypewriter (TTY)
    a. PSAPs may receive calls from the deaf and hard of hearing community via a TTY device.
    b. ETCs shall follow agency policy for communicating via TTY, but the ETC shall maintain primary control of the call.
        i. When a TTY call is received that qualifies for MCL assistance, the ETC may contact MCL on a separate phone line.

[11] Language Link is the state's current language translation service provider (2022).

[12] It should be noted that the party who initiates the call to Maine's foreign language translation provider will be the party billed for these services through the end of the call. This includes any time spent on the call by an MCL Crisis Counselor after the ETC disconnects from the call. The Maine Public Utilities Commission handles invoicing for PSAPs, whereas Dispatch-only Centers will be billed directly.

   ii. Additional information can be found in NENA standard *TTY/TDD Communications Standard Operating Procedure Model (*NENA-STA-037.2-2018).

c. ETCs shall maintain primary control of all Voice Carry-Over (VCO) and Hearing Carry-Over (HCO) calls.



# Behavior Health Caller – Policy Decision Tree

Behavioral Health Event (911 call or Field provider initiated)

Field Responder

*Field provider requesting access to local resource*

Warm transfer to requested resource

*Field provider requesting MCL coaching or information*

Warm transfer to MCL

911

Answer call per policy and obtain location, call back and nature of call

Incident is in PSAP jurisdiction?

*No*

Transfer to appropriate PSAP

*Yes*

Does caller report a need for EMS?

*Yes*

MPDS PROTOCOL 25

Utilize MPDS Protocol 25

*Omega determinant codes*

Does caller give permission to transfer to MCL?

*All other determinant codes*

*No - use policy Matrix*

Does caller report weapon involved or available?

*Yes*

Enter info and dispatch per agency policy

*No*

*No*

Does caller report violence/danger?

*Yes*

*No*

Does caller report threat to anyone's safety?

*Yes*

*No*

Has person expressed self-harm?

*Yes*

*No*

Has person committed a crime?

*Yes*

*No*

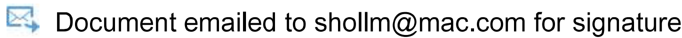
# State_EMS_Medical_Director_V14_Authorization

Final Audit Report 2024-10-21

| | |
|---|---|
| Created: | 2024-10-21 |
| By: | Melissa Adams (Melissa.F.Adams@maine.gov) |
| Status: | Signed |
| Transaction ID: | CBJCHBCAABAA06NSSm_YIuaeK3mP3KwSi-lYxZId5FI7 |

## "State_EMS_Medical_Director_V14_Authorization" History

2024-10-21 - 4:55:37 PM GMT




2024-10-21 - 5:05:55 PM GMT

2024-10-21 - 5:24:33 PM GMT

2024-10-21 - 5:25:27 PM GMT

Signature Date: 2024-10-21 - 5:25:29 PM GMT - Time Source: server

2024-10-21 - 5:25:29 PM GMT

Adobe Acrobat Sign