

# When Do Minutes Matter?

Prioritizing 911 calls when demand exceeds availability



**eso**  
Data Collaborative

# EMS AGENCIES ARE FEELING THE STRAIN.

In recent years, agencies across the U.S. have seen an increase in EMS call volume and a decrease in personnel and ambulance availability.<sup>1,2,3,4</sup> This rise in demand and lack of resources have put a strain on agencies, leaving systems with the difficult decision of determining which calls to prioritize first, which to defer, and which to refer to alternative care such as telemedicine or secondary nurse triage.<sup>5,6</sup>

Most standardized dispatch response prioritization systems are designed to determine a call's acuity and urgency assuming an immediate response. Nevertheless, in the absence of other guiding data, many EMS systems are turning to dispatch acuity Determinant levels to help guide response timing.<sup>7,8,9,10</sup>

A team of researchers from ESO and Johns Hopkins partnered with a group of eight EMS agencies to begin looking deeper into the relationship between the output associated with a widely used dispatch system and time-critical illness. The primary goal was to start creating a data-driven framework for informing 911 response prioritization. The eight participating systems all had dispatch centers that were accredited by the International Academies of Emergency Dispatch (IAED) and used Medical Priority Dispatch System (MPDS). MPDS includes **Dispatch Protocols** and **Determinant Levels**, which the research team used to evaluate time-critical intervention and hospital outcomes. The research team reviewed 1.7 million incidents that occurred between January 1, 2021 and June 30, 2023.

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**DISPATCH PROTOCOL:** a numeric code representing the clinical condition (chief complaint).

**DETERMINANT LEVELS:** letter codes ranging from OMEGA to ECHO represent acuity and help guide response, use of lights and sirens, and resources.

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# DISPATCH DETERMINANT LEVELS AND NEMESIS DISPATCH PRIORITY (PATIENT ACUITY)

A multi-round survey was sent to each EMS agency to create consensus on time-critical EMS interventions and emergency department (ED) outcomes.

## IN THE MULTI-ROUND SURVEY:

Cardiac arrest after EMS arrival and patient death in the ED were predefined as time-critical and were automatically included.

**≥75%**

Items identified by 75% or more of respondents in the first round were immediately classified as time-critical.

**25% - 74%**

Items with 25% to 74% of votes underwent a second round of voting, with those receiving at least 50% included.

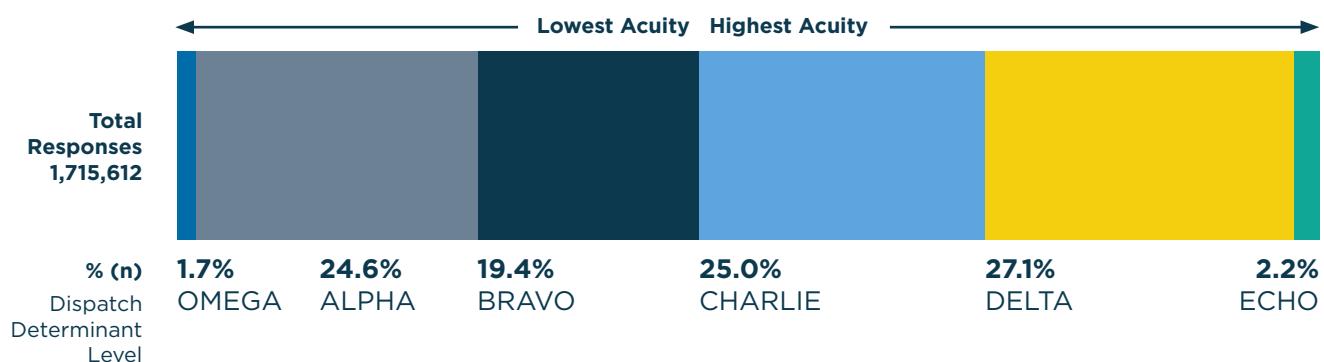
**<25%**

Items receiving 25% or fewer votes were excluded from the definition.

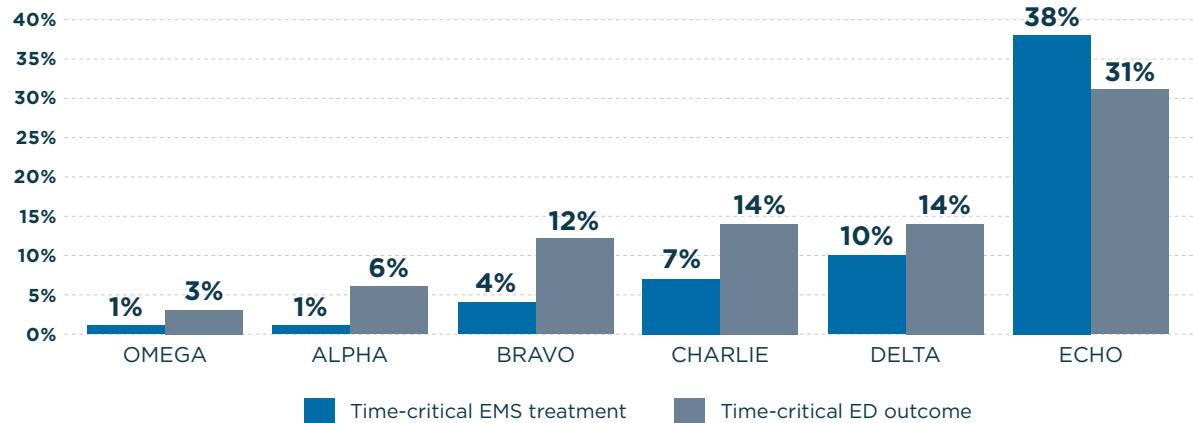
## THE RESULTS

The table below shows the overall Determinant levels of EMS responses in the study. The DELTA (critical) level was the most common, making up 27% of calls, followed by CHARLIE (emergent) and ALPHA (low acuity), each around 25%. The OMEGA (non-acute) level, indicating the least urgent calls, was the least common at 2%.

**PROPORTION OF INCIDENTS WITH TIME-CRITICAL EMS INTERVENTION OR TIME-CRITICAL ED OUTCOMES BY DISPATCH DETERMINANT LEVEL**

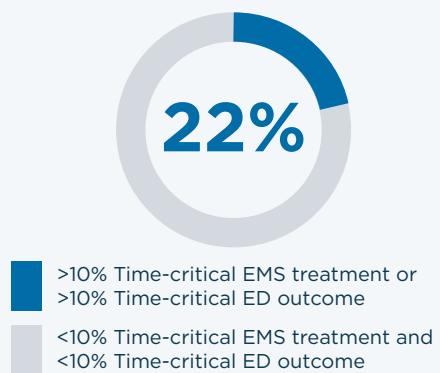


## TIME CRITICAL OUTCOMES BY DETERMINANT LEVELS



Overall, time-critical EMS intervention or ED diagnosis increased with dispatch Determinant levels—meaning as a call's Determinant level increased, the more time-critical treatments and outcomes were documented. However, there was a small portion of lower acuity Determinant level protocols with a high proportion of time-critical intervention or outcomes. As an example, 7/32 (22%) included ALPHA protocols had >10% of responses involving a time critical EMS intervention or outcome.

### NOT ALL LOW ACUITY DETERMINANT LEVELS (ALPHAS) ARE “SAFE TO HOLD”



## KEY TAKEAWAYS

**6%**

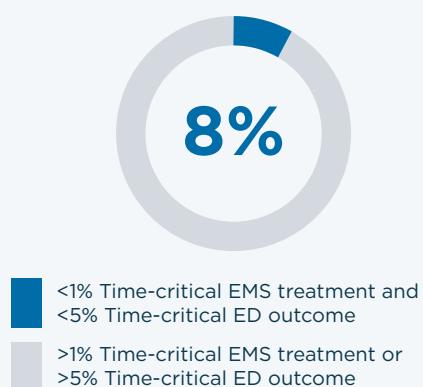
of all responses involved time-critical interventions by EMS.

**12%**

of patients transported had time-critical conditions diagnosed in the ED.

These findings may help inform prioritization frameworks. For example, if a system set a threshold of <1% time-critical EMS intervention and <5% time-critical ED diagnosis, 8% of EMS requests could be safely referred to alternative resources or deferred for non-emergent dispatch.

### CALLS ELIGIBLE FOR ALTERNATIVE DISPOSITION



## WHAT CAN WE LEARN FROM THIS?

The findings highlight the need to consider both the chief complaint and the acuity of dispatch to ensure the right calls are prioritized and met with the right resource. Here are a few other recommendations to help your system keep your community safe:

**1**

Update dispatch protocols to ensure serious conditions are quickly recognized and prioritized no matter the code.

**2**

Use basic life support more effectively to better manage resources without compromising response quality.

**3**

Avoid using the dispatch dispatch determinant level in isolation to determine if a call is safe to hold.

## THE WORK'S JUST GETTING STARTED

Due to the small number of lower acuity Determinant levels that meet criteria for being unsafe to hold, it's important for the industry to find ways to bring flexibility into their approach in determining dispatch prioritization while considering both Protocol and Determinant level factors. In order for us to fully optimize our prediction process in determining which responses to defer and which need immediate attention, more research is necessary.

TO REQUEST THE FULL STUDY, VISIT

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ESO's mission is to improve community health and safety through the power of data. That is why we produce our suite of Indices—the Fire Service Index, the EMS Index, and the Trauma Index—annually. Our mission drives which metrics we analyze, whether tied to quality and process improvement, community health, or provider safety. We make the Indices publicly available at no cost because we believe it is the right thing to do to not only fulfill our mission, but to help improve the industries that we serve.

## OUR PROMISE

ESO is dedicated to making a difference by improving community health and safety through the power of data. Since its founding in 2004, ESO continues to pioneer innovative, clinical software applications to meet the changing needs of today's hospitals, EMS agencies, fire departments, and federal and state governments. ESO currently serves thousands of customers throughout North America with a broad software portfolio, including the first-of-its-kind healthcare interoperability platform connecting clinical data across the patient's continuum of care with our ESO Patient Registry, ESO Health Data Exchange (HDE), [ESO Electronic Health Record \(EHR\)](#), the next-generation ePCR; [ESO Fire RMS](#), the modern fire Record Management System; and [ESO State Repository](#). ESO is headquartered in Austin, Texas. For more information, visit [www.eso.com](http://www.eso.com).

# OUR RESEARCH PARTNERS WHO MADE THIS WORK POSSIBLE

A thank you to the supporting agencies whose participation and dedication made this project possible.

- Johns-Hopkins University, Baltimore, MD
- Austin-Travis County EMS, Austin, TX
- Office of the Medical Director, Metropolitan Oklahoma City and Tulsa, OK
- Charleston County EMS, Charleston, SC
- Johnston County EMS, Smithfield, NC
- Guilford County EMS, Greensboro, NC
- Office of the Medical Director, Johnson County EMS System, Olathe, KS
- Lee County EMS, Fort Myers, FL
- Wake County EMS, Raleigh, NC

When multiple calls come in simultaneously, there's a likelihood that some are from individuals facing more severe health crises. By prioritizing the sickest patients, we ensure that ambulance resources are allocated first where they're needed most.

*- Jeff Williams  
Deputy Medical Director of  
Wake County Department  
of EMS*

This program has truly been a game-changer for us in Austin, especially during peak demand periods. Austin is a big hub for events, we often get an influx of out of towners, so it's crucial to maintain our resources appropriately.

*- Dr. Heidi Abraham  
Chief Deputy Medical  
Director for Austin-Travis  
County EMS*

By validating our data through ESO, we are confident that our expanded triage program aligns with the study findings.

*- Dr. Heidi Abraham  
Chief Deputy Medical  
Director for Austin-Travis  
County EMS*

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