

CONFIRE ECNS Analysis

May 2026



Index

List of Tables

<i>Table 1: EMS 911 calls for service and EMD completion for May 2026.....</i>	<i>4</i>
Table 2: May 2026 data comparison IEAD Protocol and CONFIRE Adopted Policy.....	5
Table 3: Dispatcher response as to why eligible calls were not transferred to ECNS.	6
Table 4: Transport/treatment status of ECNS calls May 2026.	7
Table 5: Recommended Point of Care Disposition for patients completing ECNS process for May 2026*.	8

List of Figures

Figure 1: Percentage of ECNS eligible Calls that are transferred to ECN and entered into Low Code system by date.	9
Figure 2: Total number of ECNS eligible calls and the number of them that were transferred to an ECN/entered into Low Code by date.....	10
Figure 3: 12-month analysis of ECNS eligible calls and rates of transfer to ECN/Low Code system.	11
Figure 4: Number of eligible ECNS calls and rates of transfer from May 2025 through May 2026.	12

CONFIRE Dispatch Processing of EMS Calls and Disposition of ECNS Eligible Calls

May 2026

The following is an analysis of various Emergency Communications Nursing System (ECNS) call processing components and disposition of callers participating in the ECNS process. The analysis looks at various components in the call processing continuum including determination of ECNS eligibility, proper transfer and capture in the LowCode ECNS processing software, and final disposition of pre-hospital care. Data for this analysis was extracted from CONFIREs CAD database, the LowCode database, and ImageTrend medical records.

Establishing Low-Acuity Symptoms and Eligibility for ECNS

The first step in the ECNS continuum is for the 911 dispatcher to determine the medical severity of the patient's condition. This is done through CONFIRE's Emergency Medical Dispatch (EMD) process, which uses a scripted question/answer format with the caller to identify key symptoms that help categorize medical complaints by type and severity. The final determination is captured as a "Determinant Code". Determinant codes are then used to establish the most appropriate level of response, which can include ALS or BLS units code-3 or no-code, or a transfer of the call to an ECNS nurse for alternative care and transport as appropriate.

In order to obtain a determinant code, the dispatcher must be able to speak directly to a cooperative patient or someone who is in direct communication with the patient. Factors that impede the ability to obtain a determinant code include calls coming from a third party, such as law enforcement or alarm companies, when there is a language barrier, or when the caller simply does not cooperate with the process. These situations occur on approximately 25% of the incoming 911 medical calls for service. For the purposes of this analysis, only calls where a determinant code can be obtained are used performance measurements.

Table 1 provides an overview of CONFIREs EMS call volume and EMD effectiveness based on all emergency calls coming into the system. To align with the ECNS data, the numbers are also shown during hours when the ECNS is currently operational (0700 to 2330 hrs).

Table 1: EMS 911 calls for service and EMD completion for May 2026

	All Calls	ECNS Operational Hours Only
Total Emergency EMS Calls	18,959	15,542
Total EMS Calls with Obtainable Determinant Code	14,257	11,723
Total EMS Calls with Determinant Code	12,655	10,321
% of EMD Obtainable EMS Calls with Determinant Code	88.8%	88.0%

Table 2 analyzes these elements using two different approaches. The first approach (column 2) is an ideal, capacity-based analysis using all EMS calls with a determinant code that qualifies for ECNS transfer using International Academies of Emergency Dispatch (IAED) protocols. This also includes eligible calls that occur during times when CONFIRE’s ECNS is not staffed (2301 hrs. to 0659 hrs.).

The second approach (column 3) takes a more refined and real-world operational approach by excluding calls that, while technically eligible by determinant code, are not suitable for ECNS transfer due to situational limitations. Examples of excluded scenarios include

- The patients’ condition becomes more serious during the interrogation.
- The caller is a medical facility.
- The caller is a minor with no adult on scene.
- The Patient is in a public place which inhibits detailed communication with the ECN.
- The patient is completely immobile.
- Other inability to interrogate patient (Language barrier, uncooperative).

Additionally, the second approach considers that CONFIRE’s ECNS center is only staffed from 0700 hrs. to 2330 hrs. and excludes calls that are received outside ECNS operational hours. With these differences, the first approach serves as an indicator of the system’s capacity with ideal circumstances, where the second approach provides a view of the practical application of the program with CONFIRE’s current operations and limitations. These differences are summarized below:

Summary of Methodological Differences

Feature	First Approach – Ideal Capacity	Second Approach - Practical Application (CONFIRE Policy)
Time of Call	All hours included	Only calls within ECNS operational hours
IAED Code Eligibility	Included	Included
Situational Limitations (e.g., public setting, minor without adult)	Included	Excluded
Purpose	Measures theoretical capacity	Measures practical effectiveness

Table 2: May 2026 data comparison IEAD Protocol and CONFIRE Adopted Policy.

	Based on IEAD Protocol (All Hours)	Based on CONFIRE Policy (Staffed hours only)
Total Calls Eligible for ECNS:	1,832	1,478
% of EMS calls with Determinant Code Eligible for ECNS	14.5%	11.7%
Total calls eligible for ECNS transfer	1,832	1,376
Total ECNS Eligible Calls Transferred to ECN (Entered in Low Code)	643	643
% of Eligible EMS Calls Transferred to ECNS system	35.1%	46.7%

Reasons why ECNS Eligible Calls were not Transferred to the ECNS Nurse Line

CONFIRE's CAD system is configured to prompt dispatchers whenever a call meets the criteria for potential transfer to the Emergency Communications Nurse System (ECNS). Eligibility is determined by the established determinant code assigned to the incident.

When prompted, the dispatcher may choose to bypass ECNS and dispatch a standard response instead; however, they must select a reason for doing so from a predefined list. The summary below outlines the reasons calls were not transferred.

These determinations rely on the dispatcher's interpretation of the information available at the time of the call, introducing an element of subjectivity. Additionally, because the list of bypass reasons is predefined, it may not encompass every possible situation. As a result, dispatchers must exercise judgment in selecting the category that best fits the circumstances, even if it does not perfectly describe the situation.

Table 3: Dispatcher response as to why eligible calls were not transferred to ECNS.

Disposition Text from CAD	Total Number of Calls	% of Total Eligible Calls Not sent to Low Code	During Staffed Hours Only	% of Total Eligible Calls Not sent to Low Code During Staffed Hours
* Call Taker decided to not send incident to LowCode, with reason: ECN NOT AVAIL= No ECN staff available in house or remote (Sup Approval Required)	1032	91.6%	687	88.0%
* Call Taker decided to not send incident to LowCode, with reason: MEDICAL FACILITY RP= RN/Dr requesting 911 AND is at PT bedside	17	1.5%	16	2.0%
*Call Taker decided to not send incident to LowCode, with reason: CALL PROCESSED= sent to ECN, updated information	37	3.3%	37	4.7%
*Call Taker decided to not send incident to LowCode, with reason: STUDENT AT SCHOOL OR MINOR ONLY SCENE= PT is a minor student at school or there is NO adult on scene	28	2.5%	28	3.6%
*Call Taker decided to not send incident to LowCode, with reason: REMOTE LOCATION= Coordinates given as location or not easily accessible	7	0.6%	7	0.9%
*Call Taker decided to not send incident to LowCode, with reason: TEST CALL	1	0.1%	1	0.1%
*Call Taker decided to not send incident to LowCode, with reason: REQUESTING TO CANCEL= no longer requesting medical aid	5	0.4%	5	0.6%

For the purposes of this report, the remaining charts and graphs will represent the practical application (CONFIRE Policy) methodology.

Table 4: Transport/treatment status of ECNS calls May 2026.

Incoming Calls to Emergency Communications Nurse (ECN) Nurse			% of Total Transfers
	Total ECNS Transfers	643	
	Calls Aborted, unable to complete assessment (Hangups, disconnects)	94	15%
	During assessment, nurse triaged call and returned to dispatch as an emergency	30	5%
	Total calls eligible for continuation of ECNS process	519	81%
Calls Returned for Emergency Transport			
	Nurse assessment completed and ECN recommended an emergency response	98	15%
	Number of returned calls for emergency resulting in actual transport	74	
	% of returned calls for emergency resulting in transport	76%	
	Total calls eligible for deferral/referral through ECNS	421	65%
Non-emergency with no Alternative Transport			
	Patient had no alternative means of transport (Transport Unit Sent)	293	46%
	Number of non-emergency ambulance responses that resulted in actual transport.	240	
	% of non-emergency ambulance responses that resulted in actual transport.	82%	
Total calls to reach ECN that resulted in an ambulance response		391	61%
	% of total calls to reach ECN that resulted in ambulance response	75.3%	
	Total ambulance responses that resulted in a transport	314	
	% of response with transport	80%	
	Number of callers who received ECN direction and did not transport by ambulance.	128	20%
	Number of calls where assessment was completed but ambulance was sent only because the patient had no other means of transportation.	293	46%
	Combined potential transport deferrals if additional transportation options were available	421	65%

Table 5: Recommended Point of Care Disposition for patients completing ECNS process for May 2026*.

Disposition of Care*		
Seek Emergency Care as Soon as Possible	239	46.0%
Seek Face to Face Care within 1-4 Hours	124	23.8%
Emergency Response	98	18.8%
Schedule an Appointment to be Seen by a Doctor/Health Care Professional within the Next 12 Hours (same day)	31	6.0%
Speak to Your Doctor/Health Care Professional to Review the Symptoms As Soon As Possible	16	3.1%
Schedule a Routine Appointment with a Doctor/Health Care Professional	4	0.8%
Contact Poison Control or Local Pharmacist	4	0.8%
Schedule an Appointment to be Seen by a Doctor/Health Care Professional within the Next 1-3 Days	2	0.4%
Self-Care	1	0.2%
Total Calls Eligible for Deferral (total minus "Emergency Response")	422	

**This represents recommended care given by the ECN. The ECNS program does not have a mechanism to follow up on whether callers follow through with the recommendations. Also, the numbers in this table include callers calls that were returned to 911 as emergency and callers who were provided a recommendation that did not require ambulance transport, but may have received an ambulance transport due to lack of alternative transportation (see table 4 for detail)*

Figure 1: Percentage of ECNS eligible Calls that are transferred to ECN and entered into Low Code system by date.

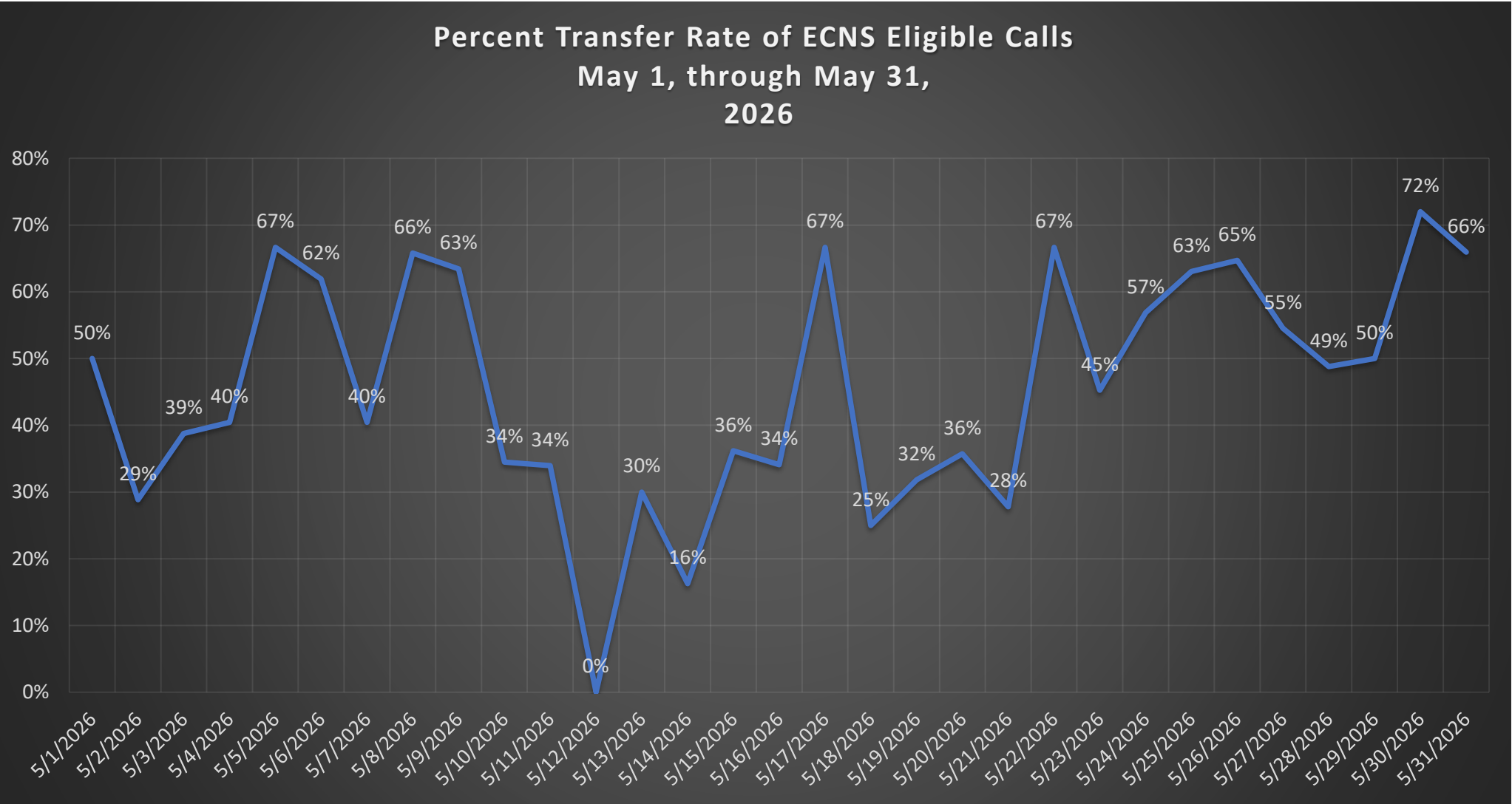


Figure 2: Total number of ECNS eligible calls and the number of them that were transferred to an ECN/entered into Low Code by date.

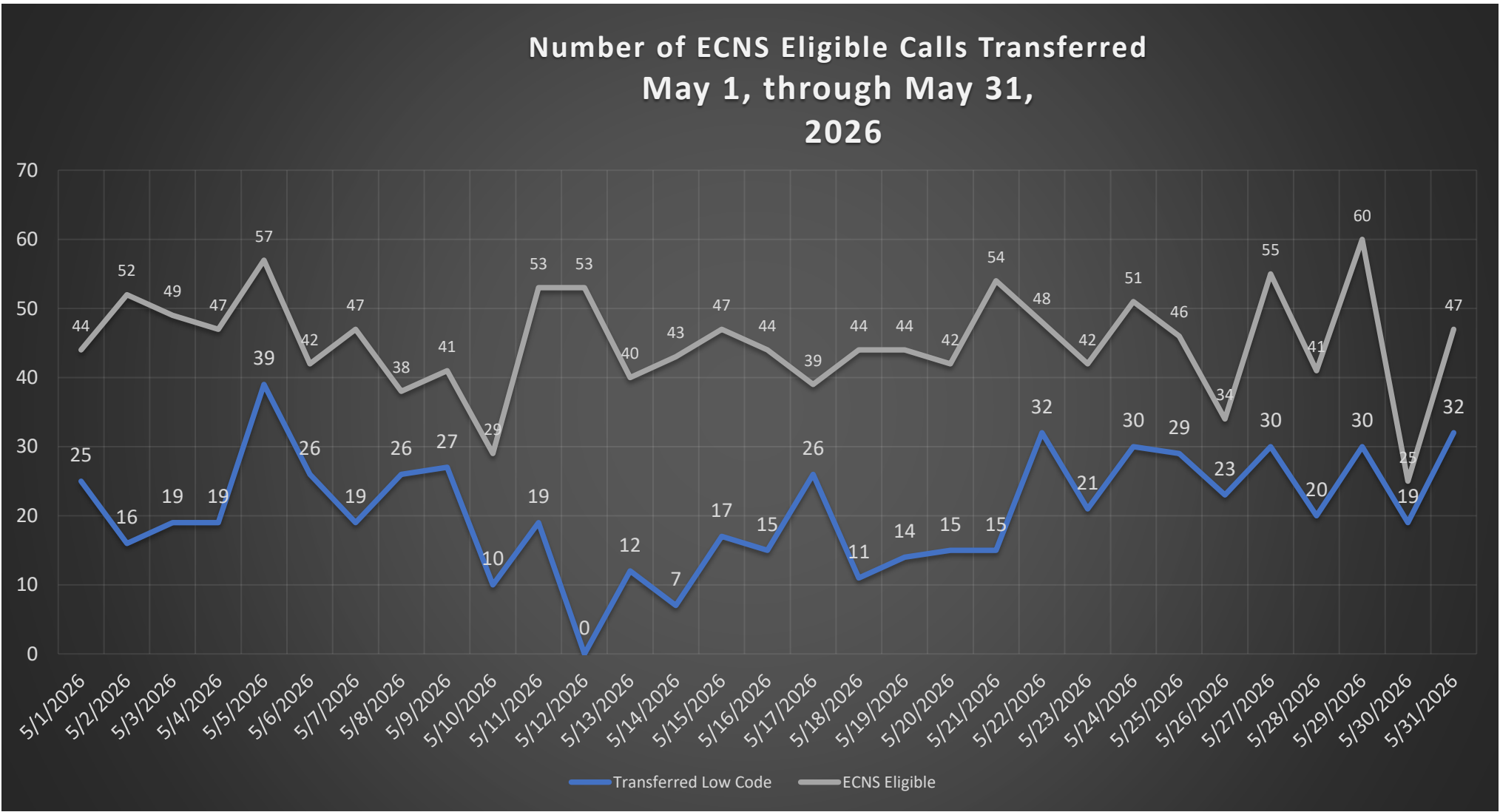


Figure 3: 12-month analysis of ECNS eligible calls and rates of transfer to ECN/Low Code system.

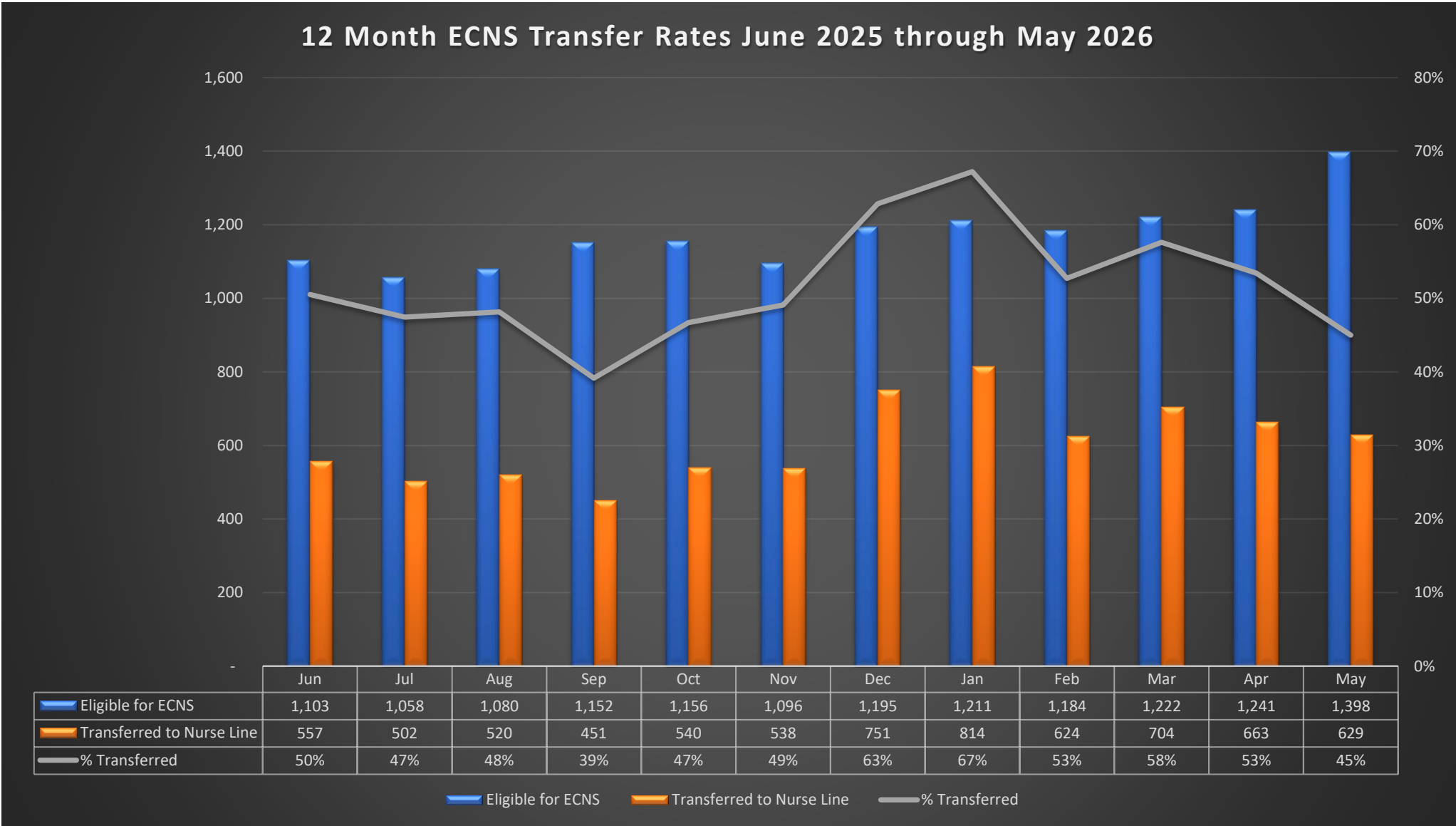


Figure 4: Number of eligible ECNS calls and rates of transfer from May 2025 through May 2026.

