CONFIRE ECNS Analysis

October 2026

CONFIRE
Regional Emergency Communications

Index

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

October 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 October 2026

	All Calls	ECNS Operational Hours Only
Total Emergency EMS Calls	19,783	16,233
Total EMS Calls with Obtainable Determinant Code	14,741	12,204
Total EMS Calls with Determinant Code	12,799	10,479
% of EMD Obtainable EMS Calls with Determinant Code	86.8%	85.9%

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: October 2026 data comparison IAED Protocol and CONFIRE Adopted Policy.

	Based on IAED Protocol (All Hours)	Based on CONFIRE Policy (Staffed hours only)
Total Calls Eligible for ECNS:	1,911	1,529
% of EMS calls with Determinant Code Eligible for ECNS	14.9%	11.9%
Total calls eligible for ECNS transfer	1,911	1,414
Total ECNS Eligible Calls Transferred to ECN (Entered in Low Code)	790	790
% of Eligible EMS CallsTransferred to ECNS system	41.3%	55.9%

<u>Reasons why ECNS Eligible Calls were not Transferred to the ECNS Nurse Line</u>

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)	936	89.7%	572	88.4%
* Call Taker decided to not send incident to LowCode, with reason: MEDICAL FACILITY RP= RN/Dr requesting 911 AND is at PT bedside	23	2.2%	21	3.2%
*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	35	3.4%	35	5.4%
*Call Taker decided to not send incident to LowCode, with reason: REMOTE LOCATION= Coordinates given as location or not easily accessible	13	1.2%	13	2.0%
*Call Taker decided to not send incident to LowCode, with reason: TEST CALL	1	0.1%	1	0.2%
*Call Taker decided to not send incident to LowCode, with reason: REQUESTING TO CANCEL= no longer requesting medical aid	5	0.5%	5	0.8%
*Call Taker decided to not send incident to LowCode, with reason: CALL PROCESSED= sent to ECN, updated information	30	2.9%	30	4.6%

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 October 2026.

Incoming Calls to Emergency Communications Nurse (ECN) Nurse			**% of Total Transfers**
	Total ECNS Transfers	790	
	Calls Aborted, unable to complete assessment (Hangups, disconnects)	105	13%
	During assessment, nurse triaged call and returned to dispatch as an emergency	16	2%
	Total calls eligible for continuation of ECNS process	669	85%
Calls Returned for Emergency Transport			
	Nurse assessment completed and ECN recommended an emergency response	147	19%
	Number of returned calls for emergency resulting in actual transport	118	
	% of returned calls for emergency resulting in transport	80%	
	Total calls eligible for deferral/referral through ECNS	**522**	66%
Non-emergency with no Alternative Transport			
	Patient had no alternative means of transport (Transport Unit Sent)	398	50%
	Number of non-emergency ambulance responses that resulted in actual transport.	337	
	% of non-emergency ambulance responses that resulted in actual transport.	85%	
Total calls to reach ECN that resulted in an ambulance response		545	69%
	% of total calls to reach ECN that resulted in ambulance response	81.5%	
	Total ambulance responses that resulted in a transport	456	
	% of response with transport	84%	
	Number of callers who received ECN direction and did not transport by ambulance.	124	16%
	Number of calls where assessment was completed but ambulance was sent only because the patient had no other means of transportation.	398	50%
	Combined potential transport deferrals if additional transportation options were available	522	66%

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

Disposition of Care*		
Seek Emergency Care as Soon as Possible	294	43.9%
Seek Face to Face Care within 1-4 Hours	180	26.9%
Emergency Response	147	22.0%
Schedule an Appointment to be Seen by a Doctor/Health Care Professional within the Next 12 Hours (same day)	25	3.7%
Speak to Your Doctor/Health Care Professional to Review the Symptoms As Soon As Possible	9	1.3%
Self-Care	5	0.7%
Contact Poison Control or Local Pharmacist	4	0.6%
Schedule an Appointment to be Seen by a Doctor/Health Care Professional within the Next 1-3 Days	3	0.4%
Schedule a Routine Appointment with a Doctor/Health Care Professional	2	0.3%
Total	669	

**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 October 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.

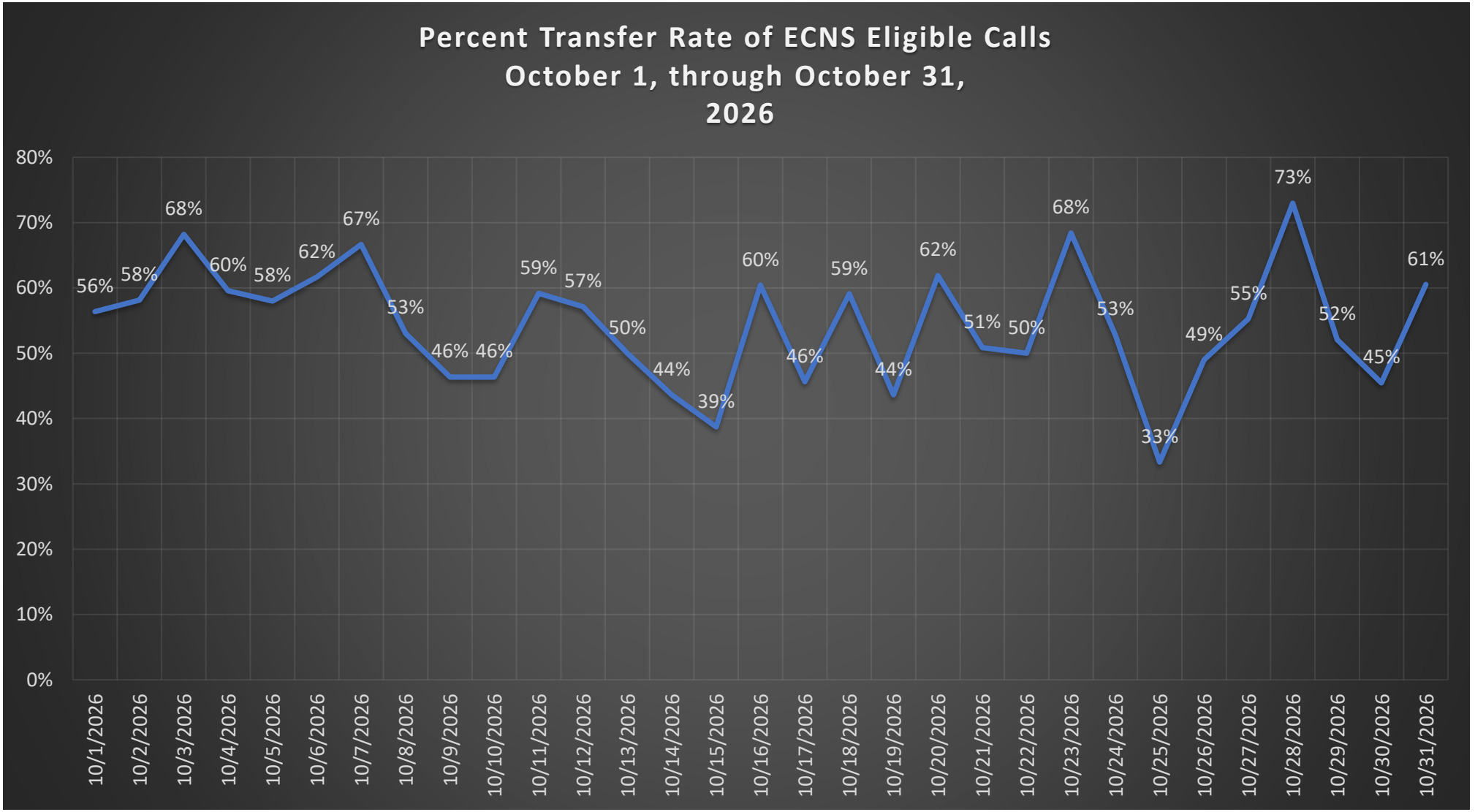


Figure 2:Total number of ECNS eligible calls and the number of them that were transferred to an ECN/entered into Low Code by date.

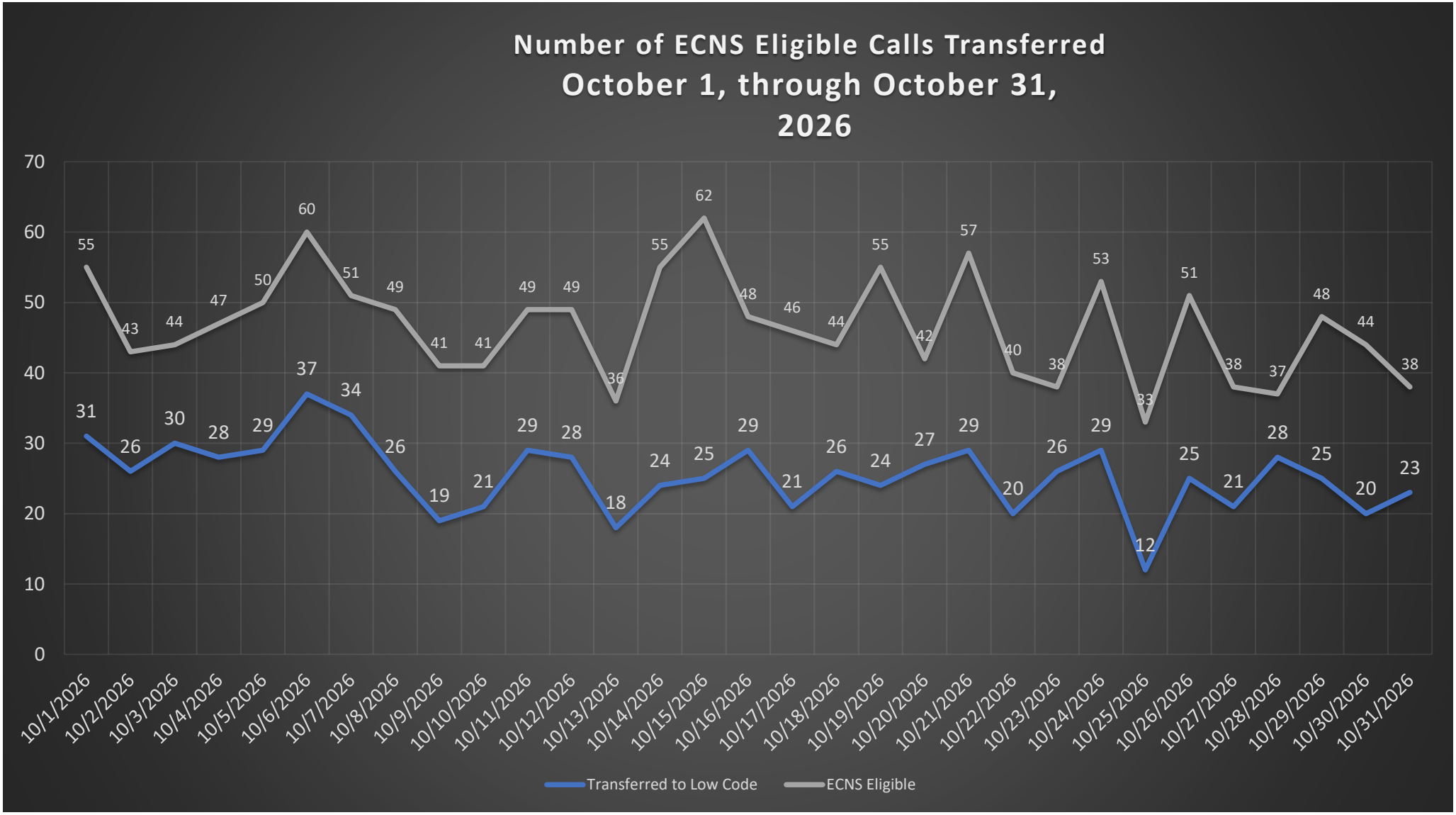
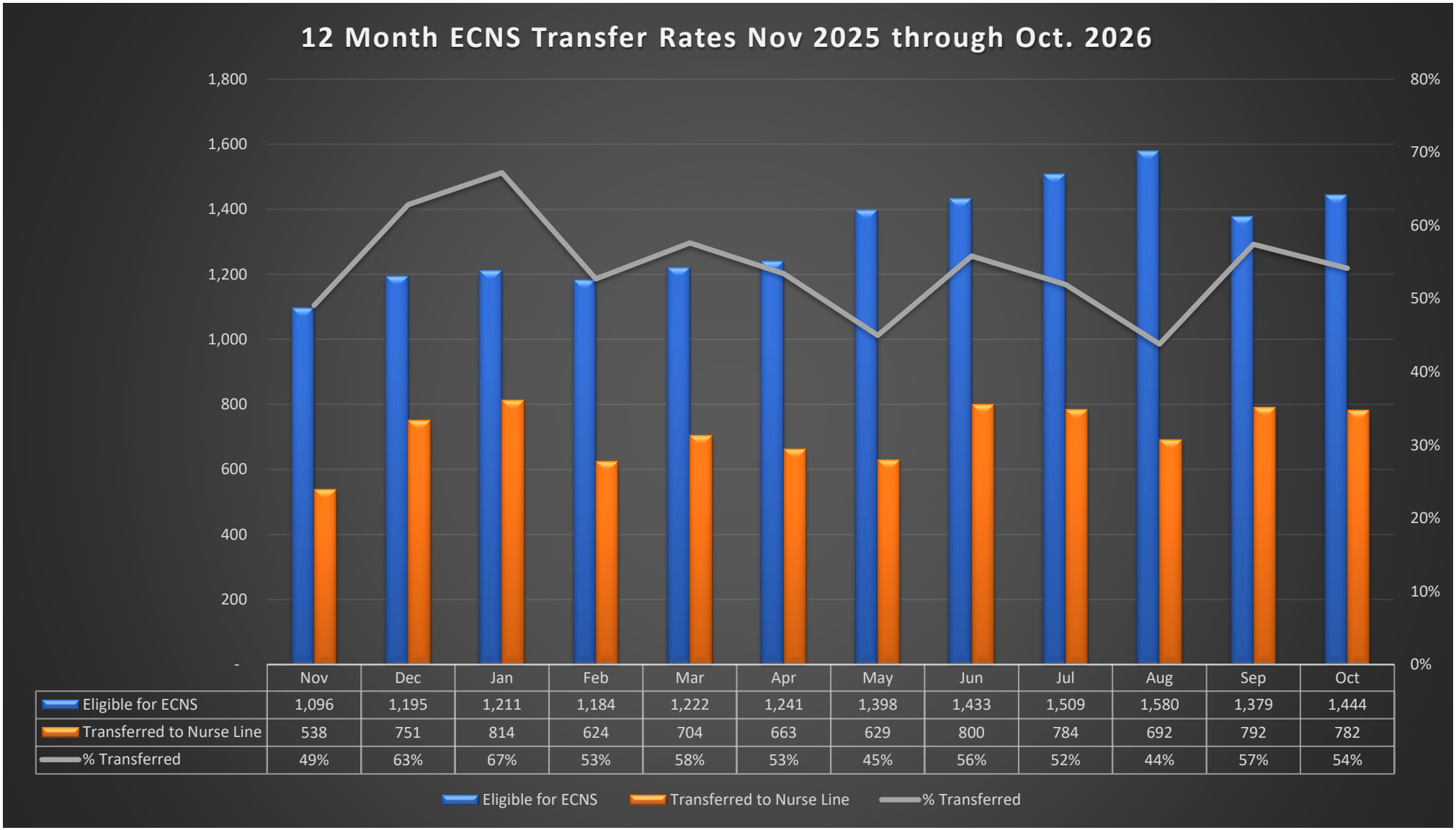


Figure 3: 12-month analysis of ECNS eligible calls and rates of transfer to ECN/Low Code system.



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Eligible for ECNS	1,096	1,195	1,211	1,184	1,222	1,241	1,398	1,433	1,509	1,580	1,379	1,444
Transferred to Nurse Line	538	751	814	624	704	663	629	800	784	692	792	782
% Transferred	49%	63%	67%	53%	58%	53%	45%	56%	52%	44%	57%	54%

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

