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COMMITTEES

Claims and Pending Suits
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October 31, 2016

City of Providence, Rhode Island

Honorable John Igliozzi
Chair, Finance Committee
Providence City Council
25 Dorrance Street, 3rd Floor
Providence, RI 02903

Re: Local 799 Tentative Agreement

Dear Chairman Igliozzi:

In connection with the Finance Committee's review of the tentative agreement with Local 799 (fire fighters), I request the Committee consider two issues related to minimum manning.

1. At page 23 of the draft MMA report, the consultant states the following:

> The City operates eight ladder companies. Reliability data show that ladders are available to respond to more than 95% of the time, suggesting that the City could operate with fewer ladders. In addition, normative data (comparative information) indicate that the Fire Department has more ladders than other comparable jurisdictions.
>
> *RECOMMENDATION 3: The Providence Fire Department should deactivate two ladders*

The Tentative Agreement reduces staffing by one ladder company, not two. By removing the second ladder company recommended by MMA, minimum manning could be reduced by 3 more, resulting in savings of approximately $2 million per year.

2. At page 27 of the draft MMA report, the consultant states the following:

> The City should implement an emergency medical dispatch (EMD) system which triages calls for service and provides for pre-arrival instructions in certain circumstances. An EMD system provides a systemic approach to responding to incidents based on the severity of an incident.
>
> *RECOMMENDATION 15: The PFD shold implement a status system management strategy for EMS resources.*
>
> *RECOMMENDATION 16: The City should implement an emergency medical dispatch system.*

The attached report from Charles Tetelman of the City Council's policy research office describes how the cities of Fort Worth and Louisville have implemented a nurse triage system that identifies non-emergency transportation service calls which can be assigned to alternative transportation, resulting in substantial financial savings. I also attach an September 24 Providence Journal op-ed piece by a retired Providence fire fighter describing how people routinely request ambulance service for non-emergencies, and an October 17 report from WRNI about the opening of a "sobering center" for alcoholics.

Clearly it would take some time for Providence to develop and implement a quality nurse triage/non-emergency dispatch system. With that said, such a system could deploy resources more efficiently and potentially increase the job satisfaction of the Fire Department's ambulance corps. As we are asked to consider a 5-year contract, the research supports building flexibility into the contract so that such a system can be implemented (and the City can realize financial savings) if it is successfully developed.

Thank you for your consideration.

Sincerely,

Samuel D. Zurier

Enclosures: City Council research report
Providence Journal op-ed (Michael Morse)
WRNI report (drying stations)

cc (w/enc.): Providence City Clerk

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Providence City Council

City of Providence

To: Councilman Samuel D. Zurier

From: Charles Tetelman, Policy Analyst

CC: Nick Freeman, Manager of Policy & Research

Date: October 14, 2016

Re: Emergency Triage and Transport Approaches

Per Your Request, I have attached a report covering Nurse Triage Lines and Emergency Service structures in Fort Worth and Louisville. Included in the report are the two studies done on the programs regarding the cost benefits and effectiveness of the programs. There is a small section pertaining to Washington DC and their efforts in establishing a Nurse Triage Line.

In addition, I have included statistics and information related to Providence. This includes a Rhode Island State Senate Special Commission report as well as some statistics from medical services throughout the city. Please let me know if you require any further information

INTRODUCTION:

Throughout the country, emergency services and dispatch centers experience a significant number of 911 calls. In the last few years, the increasing call volumes have proven to be too much for current emergency dispatch infrastructures. As the amount of calls increases, including the prevalence of low acuity calls[1], the emergency department becomes strained. The standard response to these types of calls includes emergency ambulances and, in most cases, fire trucks; this protocol is standard for most 911 calls. Vital ambulance resources are often wasted on low acuity calls and are delayed or unavailable to those in more intense medical situations. Dispatching ambulances for low acuity calls not only deplete scarce resources, but there is also a substantial cost for municipalities and receiving hospital departments.

Providence is not immune to this problem. Over the last few years, emergency call volume has increased. As of September 2016, Providence has received 25,612 calls[2]. At the end of September 2015, Providence had only received 23,861. Each call requires a response from either an ambulance, fire engine, or, in most cases, both. Providence is equipped with 15 engines and 6 ambulance transport vehicles. The ambulances are almost always active; at any given point, all 6 ambulances can be in operation. Although fire engines can provide either advanced life support (ALS) or basic life support (BLS), they do not have the capability to transport a patient to the hospital. As calls increase, all of the Providence ambulances are more likely to be active resulting in the need for fire engines to step in.

NURSE TRIAGE LINES:

Fort Worth, Texas and Louisville, Kentucky experience a similar call overload in their emergency services. Although the state infrastructures of Texas and Kentucky are different from Rhode Island's, Fort Worth and Louisville implemented new protocols and systems in order to provide the best urgent care that could be models for Providence. This system addressed low acuity calls by creating a nurse triage line. Formally called the Emergency Communications Nurse System (ECNS), Emergency Communication Nurses (ECN) staff the ECNS. The system is a potential solution to the mismatching of emergency medical services (EMS) to low acuity calls. In short, when a 911 dispatcher identifies a low priority call, either Alpha or Omega[3], the

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[1] Acuity is the measurement of the intensity of nursing care required by a patient. Low acuity calls typically do not require ambulance transport.

[2] Total number of calls that required ambulances

[3] The National Academy of Emergency Medical Dispatch have six dispatch codes with Alpha and Omega as the lowest priority.

call gets transferred to the on-call nurse. The ECNS has more medical protocols than the standard emergency medical dispatch service. This triage line can offer patients alternative transportation and/or treatment facility options, potentially negating an ambulance transport, a trip to the emergency department, or both.

The International Academies of Emergency Dispatch (IAED) published two studies on the effectiveness of ECNS in Fort Worth and Louisville. The first study[4] examined data from both cities including the protocols utilized and patient distributions. Roughly 7,000 calls were observed and tracked – the study did not include the total number of calls the service providers received. Over the course of the study, the most common low acuity 911 calls were classified as "Sick Person," "Fall," and "Abdominal Pain." Female patient-callers were the most frequent users of the ECNS with protocols related to abdominal pain and vomiting. The study concluded that the non-life-threatening common symptoms associated with the female reproductive system are likely a major contributor to the data.

The second IAED study[5] reviewed the financial impact of using ECNS in Fort Worth and Louisville. Specifically, this study examined the savings of the cities and patients. These savings stem from alternative method of medical care including the directing of patients away from the emergency departments and the avoidance of ambulances and other EMS support. For patients, nearly 4,000 patient records were analyzed and showed that $1.2 million in payments were avoided "as a result of directing patients away from the [emergency department] to alternative provider points of care." In both Fort Worth and Louisville, nearly 500 emergency ambulance transports were avoided – a savings of nearly $450,000.

In Fort Worth and Louisville, the ECNS triage lines have proven to be feasible solutions for reducing costs and effectively allocating resources. Other cities and municipalities are beginning to develop a nurse triage line in some regard. For example, Washington, DC began its process in 2016. The DC Fire and Emergency Medical Services' (DC FEMS) Integrated Healthcare Collaborative (IHC) is investigating alternatives to immediate ambulance transports for low acuity patients as well as identified high volume users (HVUs). In DC, 48% of all calls were determined to be low acuity at the time of the call (during dispatch). Individuals called 911 and requested ambulances without consideration of consequences or overuse. Furthermore, these high volume users seem to abuse the system, with fewer than 600 individuals calling for nearly 13,000 transports in 2015 alone, for an average of more than 21 transports per HVU that year.

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[4] Nurse triage evaluation
[5] Nurse triage reduces ems patient cost

DC FEMS working groups began meeting in the summer of 2016 and the subcommittees first reported back in August. Two of the subcommittees were on Alternate Transport of Low Acuity Callers and a Nurse Triage Line, respectively. The Alternate Transport and Low Acuity Calls subcommittee recommended looking into public transport for medical transportation purposes, increasing education of patient population with incentives for participation, and expanding service hours to allow transport of non-emergency 911 callers to emergency room but not immediate. The Nurse Triage Line subcommittee recommended to create and manage the operational infrastructure for a nurse triage line in cooperation with the Office of Unified Communications, hire nurse triage professionals, partner with an external vendor to provide nurse triage technology, and model itself based off of successful nurse triage systems like Fort Worth and Louisville.

PROVIDENCE AND RHODE ISLAND:

ECNS in Fort Worth and Louisville was created alongside their respective State Statutes. These states both delegate emergency services and dispatch centers to municipalities. Together, municipalities form emergency dispatch centers that service a given area. In Rhode Island, however, the State has a unified E-911 emergency telephone system that is the primary center for calls. Yet, RI's state call center does not have dispatching capabilities – it merely transfers to municipal dispatcher (i.e. the Providence Office of Telecommunications). The Unified E-911 system receives caller information and, in most cases, location from wired and cellular devices.

In 2012, a Special State Commission formed to Study Emergency Department Diversion. The study published its report with findings and recommendations. However, Nurse Triage Lines had not become mainstream. The primary finding was that "[RI's] emergency departments currently face an over utilization of high cost, high levels of non-urgent behavioral health usage that could be appropriately treated in alternative settings." The report cited the overwhelming misuse of emergency medical services specifically related to intoxicated individuals, substance abusers, and patients with behavioral disorders. In addition, it concluded that the cost per patient was, on average, nearly 10 times higher than the best suited medical care.

The report recommended:

- Amend the existing RI alcohol statute to create a pilot program to make it more flexible by allowing, but not requiring, such persons to be evaluated in alternative

community-based settings by defined licensed healthcare providers, if deemed appropriate.

- Create state-wide care partnerships to enhance patient-centered systems of care to include on-demand services, 24-hour triage center programs, mobile outreach transportation teams, and telephone triage systems for substance use disorders/behavioral health issues.
- Support opportunities through Health Homes Medicaid enhanced funding, to include person centered on-demand, substance use and/or behavior health care and transitions to community supports.
- Support a pilot program for the coordination and implementation of an evidence based suicide/mental health assessment tool and training for Rhode Island healthcare providers and first responders for determination of placement in emergency department or alternative settings.
- Support the development of a pilot program proposal and protocols for Emergency Medical Services (EMS) transports to alternative facilities.
- Support opportunities to enhance or reinvest savings for best practice housing models that include supportive services and employment/training linkages.
- Support the department of behavioral healthcare developmental disabilities and hospitals in exploring opportunities for funding the alternative pilot program.

These recommendations reflect similar work being done in DC and work accomplished in Fort Worth and Louisville. Due to RI statutes, some of the changes would need to be implemented at the State level. However, the City of Providence can propose changes to the dispatch service through the Department of Public Safety and the Office of Telecommunications.

NEXT STEPS:

- Follow up with State Senate Special Commission
- Meet with Providence Department of Public Safety
- Analyze City of Providence data to isolate 'low acuity calls'
- Gather additional research and identify potential problems in Providence structures

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Providence City Council

City of Providence

To: Councilman Samuel D. Zurier

From: Charles Tetelman, Policy Analyst

CC: Nick Freeman, Manager of Policy & Research

Date: 10/25/16

Re: 911 Alternative Systems and Financial Benefits

Per Your Request, I have attached a summary of the financial data from the Sobering Center in Cambridge as well as the Nurse Triage Line / Alternative Transport Model in Fort Worth, Texas and Louisville, Kentucky.

I still haven't been able to find recent data from Texas or Kentucky and I am waiting to hear back from Cambridge. I will update you if I find any more information.

Please let me know if you require any further information

For many years, Emergency Medical Services (EMS) has been impacted by an increased volume of 911 calls. Chronic, high volume users (HVUs) will often call for ambulances multiple times a week for the same reasons for non-emergency situations. Research has proven that 30% to 50% of all ambulance transports to the emergency department (ED) are inappropriate.[1] In the context of Providence, 6 ambulances responded to nearly 25,000 calls from January through September in 2016. EMS ambulances are constantly in motion and delayed as a result of increased call volumes. Not only are emergency services not reaching those in real emergencies, each transport to an emergency department costs the City about $500.

Cities throughout the country have begun adapting EMS structures in order to provide the most effective patient care and reduce financial costs. Most patients who utilize 911 EMS, especially the HVUs, have low-acuity medical needs that do not require emergency medical attention. The Cambridge and Somerville Program for Alcoholism and Drug Rehabilitation (CASPAR) provides alternative EMS for chronic abusers of alcohol and other substances. CASPAR's Emergency Service Center integrates an outreach component by working in partnership with the Cambridge Police to train outreach workers that have the ability to directly transport individuals identified through 911 dispatch calls and transport to their emergency services center. CASPAR's emergency service center has a budget of roughly $1.3 million which includes $500,00 for outreach and transportation services.

The Emergency Services Center (ESC) reduces both immediate and future costs. Across the board, CASPAR emergency services are cheaper alternatives compared to EMS ambulance transports and emergency department treatment. More importantly, the ESC addresses patients who are typically HVUs and serves as the gateway to other CASPAR programs related to alcoholism and substance abuse care. By doing so, the ESC and CASPAR reduce the frequency of calls to 911 and EMS. Furthermore, these services alleviate EMS ambulances and allow them to respond to true emergency situations.

[1] Bighm, B et al. Prehospital Emergency Care 17:3, July/September 2013. "Expanding Paramedic Scope of Practice in the Community."

In an attempt to address the increased call volumes and filter non-emergent 911 calls, Fort Worth, Texas and Louisville, Kentucky have implemented a nurse triage line within their Emergency Medical Dispatch Services (EMDS). Staffed by professionally trained dispatch nurses, the nurse triage line can offer patients alternative transportation and/or treatment facility options, potentially negating an ambulance transport, a trip to the emergency department, or both.

While differences between the 911 processes of Kentucky, Texas, and Rhode Island make it difficult to estimate potential savings or efficiencies locally, there is evidence that nurse triage lines do reduce costs. The International Academies of Emergency Dispatch published a study[2] reviewing the financial impact of the nurse triage lines in Fort Worth and Louisville. Nearly 4,000 patient records were analyzed and the study showed that $1.2 million in payments were avoided "as a result of directing patients away from [emergency departments] to alternative provider points of care." In both Fort Worth and Louisville, EMS1 reported that nearly 500 EMS ambulance transports were avoided – a savings of nearly $450,000 or 28% - over the course of two years.

[2] Gardett, I PhD et al. Ann Emerg Disp Resp 2015; 3(1):8-13. "911 Emergency Communication Nurse Triage Reduces EMS Patient Costs and Directs Patients to High-Satisfaction Alternative Point of Care."

EMS1 News

PARAMEDIC CHIEF
with EMS1 & NEMSMA

Using nurses to answer non-urgent 911 Calls

Protocols and partnerships are critical to success of implementing a nurse triage program

Sep 30, 2013

In 2009, Rick Roller, assistant director for Louisville (Ky.) Metro EMS, was recuperating from a serious motorcycle accident that had left him with a broken back and other injuries. When he eventually returned to work, his colleagues figured Roller should take it easy. So they asked him to head up the launch of one of the nation's first 911 nurse triage programs. A nurse himself, Roller could work regular hours and stay put in the communications center.

"I was probably the most skeptical person in Louisville," Roller says of the program, which took its first caller in April 2010. "But then I started seeing that this has the potential to make a huge impact."

Over the next three years, the program grew from a single nurse answering a handful of non-urgent 911 calls a few days a week to three nurses who talk to patients 12 hours a day, seven days a week. His team is continually working to maintain and expand their network of transportation and alternative care options for patients who don't need the emergency department.

And Louisville is beginning to collect data showing that nurse triage is saving money. From February 2011 to February 2013, nurses spoke to 3,380 callers. If all of those patients had gone to an ED via a Louisville Metro EMS ambulance, total BLS charges at $434 per transport would have been $1.46 million.

By using a variety of other modes of transportation—including cabs, wheelchair vans and even a

private ambulance provider that charges a bit less—along with diverting some patients to doctors' offices or urgent care clinics instead of the hospital, transportation costs fell to $1.05 million—a 28% drop.

"For 30 years, no matter what your problem was, we only offered one solution: a trip to the emergency department," says Kristen Miller, chief of staff of Louisville Metro EMS. "What business stays in business when they ignore customer need and only offer one product? We need to be adjusting our solution to the customer need."

"We determined a year or so ago to change our model of how we do business," she adds.

While nurse triage has been used for more than a decade in the U.K. and Australia, the concept has been slower to take hold here. Faced with difficulties in finding alternative destinations for patients, early attempts at nurse triage programs in the U.S. petered out.

Yet there are signs that's beginning to change as EMS agencies seek out ways to use their own, and the healthcare system's, resources more efficiently—and potential partners are interested in hearing what EMS has to offer. For instance, as part of its $9.8 million federal Innovation Grant, the Regional Emergency Medical Services Authority in Reno is developing a seven-digit nurse triage line as an alternative to 911.

In Fort Worth, Texas, MedStar Mobile Health added nurse triage last spring. The nurse's salary is paid for by four local hospitals that see the program as a way of preventing unnecessary ED visits, says Matt Zavadsky, MedStar's public affairs director. The program is going so well that MedStar is adding a second nurse. "We know we have to change to survive in the new health arena. We have to demonstrate value to the check signer," Zavadsky says. "What we're doing, and what Louisville is doing, is finding ways to show that."

Protocols make it possible

One of the keys to nurse triage is having a means for dispatchers to reliably distinguish between urgent and non-urgent calls, and subsequently giving nurses a scientifically validated method to further evaluate patients and determine what help they need.

Both MedStar and Louisville rely on LowCode protocols and software, created by Priority Dispatch Corp. Priority Dispatch was already well known for its emergency medical dispatch protocols and ProQA software, which guides dispatchers through a series of evidence-based questions that categorize 911 callers into a range of call types, from low (Omega) to high-priority (Echo).

LowCode extends that by enabling nurses to drill down further into a subset of Omega calls, asking questions to further assess patients, says Mark Rector, director of consulting. Depending on the situation, nurses may counsel patients on self-care at home or make an appointment with a physician or urgent care clinic. Communities can also customize it, determining exactly which codes should be sent to the nurse.

In Fort Worth, the nurse also has the option of sending a mobile healthcare paramedic to the home.

MedStar's mobile healthcare paramedics travel in non-transport vehicles and have received additional training on patient assessment and navigating patients through a complex healthcare system.

Another element of nurse triage is follow-up. In Louisville and Fort Worth, nurses contact patients 24 hours after the initial call to make sure they've gotten what they needed.

In the United States, Richmond (Va.) Ambulance Authority launched the nation's first nurse triage pilot program in 2004. But the program struggled, says Wayne Harbour, the Ambulance Authority's chief clinical officer, in part because patients didn't want to speak to a nurse. "We'd put them through to the nurse, but as soon as they were talking to her, they'd say, 'Just send an ambulance,'" Harbour says. "And the Virginia code we have to follow is if somebody really wants to go to the hospital, we have to take them."

But the even bigger obstacle was a lack of physicians, clinics and urgent care centers willing and able to make room for patients referred by the nurse, and they reluctantly dissolved the program a few years ago. "There were very few doctors' offices that would take patients, and the patients themselves didn't want to wait greater than two hours," he says. "It was an idea that was probably five or six years ahead of its time."

Building and maintaing partnerships

The team at Louisville Metro EMS is well aware of the challenges faced by Richmond. Led by chief executive officer and medical director Neal Richmond, M.D., they spent the better part of a year recruiting a network of family health clinics, urgent care clinics and physicians willing to take referrals, as well as overcoming skepticism from some physicians that nurse triage is safe.

They launched their program with a $50,000 grant from Passport Health Plan, a Medicaid managed care plan, plus $50,000 of in-kind donations and their own funds. Initially, nurse practitioners at Spalding University staffed the triage line in return for clinical training credits.

The program got a boost in 2011, when Louisville was one of five U.S. cities chosen to receive $4.8 million in grants over three years from Bloomberg Philanthropies. The grants were awarded to cities that had developed innovative programs to improve city services.
"Each run a crew makes averages one hour to one hour, 15 minutes. For each call we're taking out of the 911 system, we're providing another hour of coverage to our streets," Miller says. "If I don't have a crew waiting at the hospital for an hour with someone with a sore throat, I have a crew ready to respond to someone having a cardiac arrest."

With several more years of viability shored up by the grants, Louisville Metro was able to focus on expanding and fine-tuning the program. For instance, when nurse triage launched, Roller and his team initially asked callers if they were willing to speak to a nurse. Many refused. Today, dispatchers don't give callers with clearly non-urgent problems that choice. They tell them that they will be transferred to the nurse.

As they gained experience, Roller and the other nurses gained confidence in their new role. "If I have a patient resistant to triage, I might say, 'Ma'am, if you still want to go to the hospital after talking with

me, I'll make sure you get there. But if you go to the hospital, you're probably going right to the waiting room. A hospital wait for this is probably four to six hours. Or, I can get you in to see a doctor right away or I'll make an appointment for you,'" he says.

They've also learned more about who is calling 911 with non-urgent medical needs. Initially, Richmond says, they suspected most callers would be uninsured. Instead, the more typical barrier is not being able to get an appointment with a doctor in a timely manner, and not having a way to get there, he says.

To address that, Louisville Metro EMS has worked hard to identify healthcare and transportation partners. One physician has given them a standing appointment at 1:20 p.m. daily. Other partners include a dentist/oral surgeon's office, federally funded clinics and First Stop Urgent Care, which promises to see patients within 40 minutes and is equipped with X-rays and a lab and is intended to serve as an alternative to EDs.

MedStar has faced some of the same challenges as Louisville. Before launching nurse triage, an analysis found that just over one-half of the non-urgent calls appropriate for nurse triage were coming in Monday to Friday from 9:00 to 5:00; those are the hours the nurse has covered. With their second nurse, they'll have two nurses answering calls during the heaviest hours in the afternoon and be able to cover until about 11 p.m. weekdays and some weekend days. They'd like to have a nurse taking calls all night, but there are no urgent care centers open then, Zavadsky says.

At MedStar, each of four hospitals covers 25% of the nurses' salaries. Because the hospitals have skin in the game, they're also more committed to making sure patients triaged by nurses have a place to be seen. Several of the hospitals run clinics, including a pediatric clinic, where staff have been told to give priority to patients referred by MedStar nurses, Zavadsky says.

As in Louisville, transportation is also a challenge for many patients. So if patients don't have a car or can't get a ride to their appointment, MedStar will foot the bill for a cab ride—one way. "We only pay for the trip to the appointment. We tell patients that we don't pay for their trip back," Zavadsky says. "Some of them say, 'How am I going to get home?' And we say, 'How would you have gotten home if we had brought you to the ER?'" To help patients get home, MedStar nurses can offer a bus pass, he says.

Paying for the patients' bus or cab fare is well worth it, he adds. MedStar estimates its cost to transport a patient at about $300. "For us, the choice is eating $300 or eating $20 for a taxi," Zavadsky says. "I'd rather eat the $20."

To maintain the hospitals' support, MedStar is also collecting data on how much nurse triage stands to save the healthcare system as a whole. National estimates show the average cost of an ED visit is $774; physician charges add to that. Although MedStar hasn't been able to collect data on how much patients end up spending at clinics or urgent care, it's safe to say it's a lot less than the ED, Zavadsky says.

A work in progress

Despite some positive signs, all agree: Nurse triage is still very much a work in progress. At MedStar, about 54% of patients who speak with the nurse go to an alternate destination; 46% still get sent to the ER. In some cases, after hearing more from the patient, the nurse decides the patient would be best treated at a hospital. For other patients, especially those with mobility problems, sending a cab isn't appropriate. Still other patients refuse anything other than an ambulance. "If a patient insists on an ambulance three times, we will send them one," Zavadsky says.

In Louisville, the operators of wheelchair vans and other alternative means of transportation won't go into the home to help patients into the vehicle. So as in Fort Worth, if a patient has mobility issues, they're getting an ambulance. Of the 3,380 triaged by the nurse, 2,335 of the patients still had an ambulance dispatched to pick them up. Many of those responses were handled by a private company that charges $396 a trip—$38 less than Louisville Metro EMS. But there have been issues with that solution, too, Richmond says. While they thought giving some non-urgent transports to the other company would be a revenue gift, the company recently told them they were at capacity and didn't necessarily want them, he says.

Yet the team at Louisville Metro is determined to press forward, seeing nurse triage as one step in a process of innovation that will move their EMS agency into a new era of healthcare. "This is the beginning," Miller says. "We're using it as a springboard for a bunch of new initiatives we want to do."

That includes plans to add community paramedics who can make house calls for nurse triage patients as needed, as well as finalizing plans to host medical outreach clinics in high-volume addresses. Again partnering with Spalding University, the plan is to send a paramedic and nurse practitioner student to head off issues that might result in a 911 call. "We are helping patients on the front end rather than the back end, which saves us some resource capacity," Miller says. "We feel like EMS has done the same thing for 30 years, and it can't continue."

That's good news to Roller, who has little interest in returning to his EMS administration job. In pain for months after his motorcycle accident, the experience gave him a renewed compassion for those who are suffering and at the mercy of the healthcare system, he says.

"When Kristen put me in charge of this program, I was in a ton of pain. I've been in the medical field long enough as a paramedic and a nurse to know that there isn't enough time to really talk to patients. Patients get asked, What is your issue? Are you in pain or not? That's how you get talked to," he says. "Once people find out you are really on their side, you've got a friend."

Today, during an eight-hour shift, nurses answer between 16 and 24 calls. A few patients are unpleasant and uncooperative, but many are thankful someone listened to them and tried to help, Roller says. "I had a call from an elderly lady who started crying, saying, 'Thank you so much for helping me. I didn't know where to go and what to do,'" he says. "I feel like I'm doing more to help my patients, my community, the agency I work for and the surrounding medical facilities.

"I used to go from board meeting to board meeting," he adds. "Now I get, 'God bless you.' I'll take that any day."

About the author

Produced in partnership with NEMSMA, Paramedic Chief: Best Practices for the Progressive EMS Leader provides the latest research and most relevant leadership advice to EMS managers and executives. From emerging trends to analysis and insight, practical case studies to leadership development advice, Paramedic Chief is packed with useful, valuable ideas you simply can't get anywhere else.

911 Emergency Communication Nurse Triage Reduces EMS Patient Costs and Directs Patients to High-Satisfaction Alternative Point of Care

Isabel Gardett, PhD[1]; Greg Scott, MBA[1]; Jeff Clawson, MD[1]; Kristen Miller[2]; Neal Richmond, MD[2]; Comilla Sasson, MD[3]; Mat Zavadsky, MS[4]; Mark Rector[1]; Andrew Wilcox[5]; Chris Olola, PhD[1]

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Keywords:
Emergency Communications Nurse System, Emergency nurse triage, Low acuity calls, Patient satisfaction, Patient care, Cost Avoidance, Emergency Dispatch

Citation:
Gardett I, PhD et al. Ann Emerg Disp Resp 2015; 3(1):8-13

ABSTRACT

Introduction: Recent estimates indicate that more than half of all Emergency Department (ED) visits could be avoided, reducing patient costs and increasing satisfaction with care. Since 911 is increasingly the first point of contact for many patients entering the health care system—even those with non-emergency conditions—one potential approach to decreasing emergency costs and ED overcrowding is to reinvent the 911 dispatch center as a clearinghouse for directing patients to alternative care providers. This study presents a cost avoidance analysis of two 911 dispatch centers that implemented such a service, the Emergency Communication Nurse System (ECNS).
Objectives: The primary objectives were to determine the amount of cost avoidance realized by payers using the ECNS to send patients to alternative final points of care, and to identify the amount saved by transporting patients by alternative means an ambulance. The secondary objective was to quantify patients' satisfaction with the service through analysis of patient follow-up survey data.
Methods: This was a retrospective cohort study involving two agencies employing the ECNS program in the USA. Fort Worth, Texas (MedStar) provided 9 months of 911 call data, and Louisville, Kentucky (LMEMS) contributed 34 months of 911 data. Both agencies are designated by the International Academies of Emergency Dispatch (IAED) as Emergency Medical Dispatch (EMD) accredited "Centers of Excellence". Certain areas affecting the study were also evaluated, including patient dispatch information, cost of care, and patient satisfaction.
Results: Patient records from 3,976 cases were analyzed (n=304 for MedStar, and n=3,672 for LMEMS). Collectively, nearly $1.2 million (USD) in payments were avoided as a result of directing patients away from the ED to alternative provider points of care. Additionally, MedStar avoided 284 emergency ambulance transports, and LMEMS avoided 209 emergency ambulance transports resulting in a combined savings of nearly $450,000 (USD) in costs (Table 2). Overall, 91.2% of the patients were satisfied with the ECNS service.
Conclusion: The study findings suggest that a 911-based service such as the ECNS is a feasible solution for reducing patient costs, using resources more efficiently, and maintaining high levels of patient satisfaction.

INTRODUCTION

Emergency medical care accounts for as much as 10% of the total $2.6-trillion U.S. healthcare bill, and this percentage is increasing fast.[1] Between 1992 and 2008, Emergency Department (ED) visits rose by more than 30%, despite ED visits costing up to five times as much as comparable office visits.[2] Compounding the problem is the fact that emergency care is commonly used by those least able to pay. Although they make up less than 5 percent of the total number of physicians, emergency physicians have been estimated to provide more acute care to the uninsured and to Medicare recipients than all other providers combined,[3] and overall, less than half of outpatient ED visits are ever reimbursed.[4] Overuse of emergency services is one of the major causes of the rising overall cost of emergency care. It has been estimated that as many as 56% of ED visits could be avoided, with a potential savings of $38 billion.[5] These avoidable visits are almost all low-acuity (non-urgent) cases,

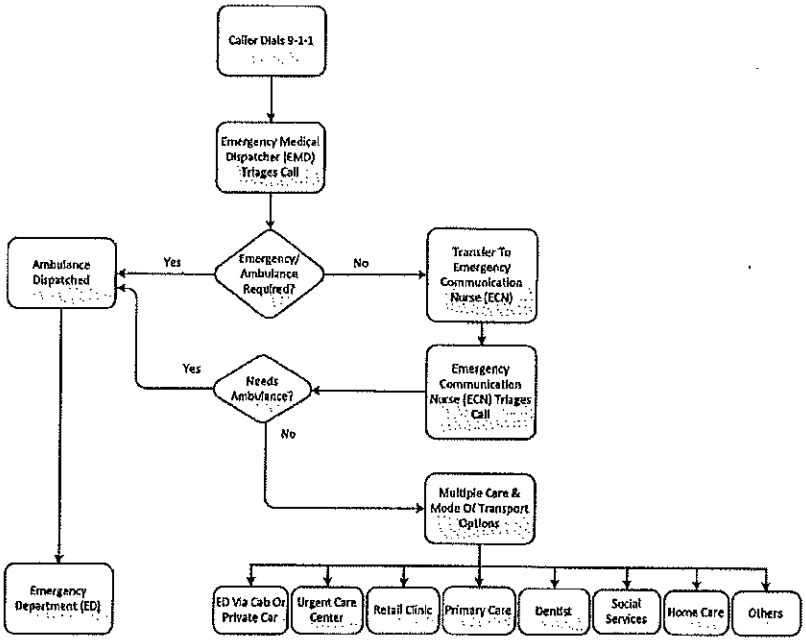

Figure 1. ECNS call triaging process

which suggests that patients are not being matched with the healthcare resources most appropriate for their symptoms. In essence, emergency care providers have become the primary access points for all kinds of unscheduled care—a broad and increasingly costly mandate.

One of the growing challenges for emergency dispatching is the increasing number of non-emergency calls coming into the 911 call center. Like EDs, the 911 service is now very commonly used as an entry point into the health care system by those without insurance or a primary care provider, even when their conditions are minor. Lacking both primary care resources and basic health education, many people call 911 because they are not sure whether a condition is serious. Such callers have been known to call 911 for chronic pain, stomachaches, flu and cold symptoms, and even for hiccups.

One solution for the problem of emergency services overuse that has been shown to reduce costs to payers while helping ensure that patients are able to access alternative care is nurse triage at the 911 dispatch point. Calling for an ambulance via 911 has become a common method of accessing the health care system not only for life-threatening emergencies, but also for non-life threatening urgent conditions and even non-urgent medical problems. Many patients who access 911 have non-emergency conditions that do not require a "hot" ambulance response (using lights and siren), and that in many cases can be handled without transport to an ED—and in fact more adults access emergency medical care because of lack of access to other providers than because of the seriousness of their problem.[6] Traditionally, however, 911 systems dispatch an ambulance, often with an accompanying first response vehicle such as a fire engine, for all medical problems. In most cases the only destination available for these responding ambulances is the hospital emergency room. Thus, intervening upstream from the ED may hold some of the greatest potential for decreasing emergency care costs and appropriately allocating scarce and costly healthcare resources.

Thirty years ago, medical dispatching was considered the "weak link" in the chain of prehospital care.[7] Emergency Medical dispatchers (EMDs) were largely untrained laypeople who simply collected an address, phone number, and complaint information and sent an ambulance to every call. This is no longer the case. The use of scripted, medically-approved protocols is now the standard of practice for certified EMDs, who use such protocols to accurately and efficiently prioritize and triage calls by categorizing patients into high, moderate, low, and non-emergency acuity levels.[8]

Nearly two decades ago, the "Agenda for the Future" of Emergency Medical Services (EMS) distributed by the U.S. Department of Transportation called for EMS systems to offer "community-based health management that is fully integrated with the overall health care system" and to "improve community health and result in more appropriate use of acute health resources."[9] The current study proposes, and investigates, the cost-effectiveness of one 911 method for finally achieving this goal.

The 911 nurse triage system studied in this paper was the International Academies of Emergency Dispatch (IAED) Emergency Communications Nurse System (ECNS). Agencies using this system in the United States hire nurses to work in the 911 emergency communications center itself, not off-site or at EDs. This provides a pathway to alternative care at the earliest point of patient interaction with the

emergency system. The ECNS integrates into existing practices in the 911 dispatch center. A caller reporting a medical emergency (whether their own or someone else's) calls 911 and is connected to an EMD, who triages the call to determine its severity and urgency as well as the most important, highest-priority symptoms. If the EMD determines—using medically-approved scripted protocols—that the caller is reporting a low-urgency, low-acuity call with no immediate life-threatening symptoms, the EMD transfers the call to the Emergency Communications Nurse (ECN). The IAED and the medical directors at the 911 centers can determine which types of calls may be transferred. These include common low-acuity conditions such as minor injuries, chronic pain and chronic illness, weakness and flu-like symptoms, rashes, and allergies, among others.

Once the call is transferred, the ECN performs a more detailed triage of the caller's complaint and, with the aid of software-based protocols, determines the most appropriate level, location, and type of care. Possible dispositions include a wide range varying from home care to sending an ambulance immediately. If the patient requires treatment (for example at the ED, at an urgent care clinic, or at a primary care provider's office), the ECN can also arrange for alternative transportation (e.g., a wheelchair van or a cab) (figure 1). Often, the ECN not only recommends but actually arranges appointments, calls with pharmacists or other providers, and transportation.

This paper presents a cost avoidance analysis of two 911 dispatch centers in the USA that implemented the ECNS. It describes the relative patient costs of traditional (ambulance-to-ED) emergency response versus ECNS-driven alternative care pathways, examines levels of patient satisfaction with the service, and proposes best practices for such 911 nurse triage programs.

OBJECTIVE

The primary objectives were to determine the amount of cost avoidance realized by payers using the ECNS, via sending patients to alternative final points of care (primary care physicians, urgent care clinics, etc.) or providing home care, rather than routing them directly to the emergency department, and to identify the amount saved by transporting patients by alternative means (a cab, the patient's own car, etc.), than by an ambulance. The secondary objective was to quantify the percentage of patients who were satisfied with the ECNS service.

METHODS

Study Design and Setting

This was a retrospective cohort study involving two agencies (MedStar, Fort Worth, Texas and LMEMS, Louisville, Kentucky) employing the ECNS program. Each agency is similar in general population as well as the number of 911 emergency calls fielded by their emergency dispatchers. MedStar EMS-Mobile Health (MedStar), located in Fort Worth, Texas, serves a population of nearly 810,000 residents (with a daytime population of approximately 1 million) and handles roughly 107,000 911 calls per year. Louisville Metro EMS (LMEMS), located in Louisville, Kentucky, serves a population of approximately 741,000 and handles about 91,000 911 calls per year. Both are designated by the IAED as EMD "Accredited Center of Excellence"—meaning that they meet stringent criteria set by the IAED. (This is an IAED requirement for implementation of the ECNS program.)

Both centers implemented the ECNS as a pilot program during the study period. For this reason, staffing and coverage hours varied considerably during that period. Staffing varied from a single ECN working regular business hours to four part-time ECNs taking shifts that varied based on the schedules of their other jobs. While 24-hour, fully-staffed ECNS programs would be ideal in terms of providing the greatest cost savings and patient benefits, this was not possible in either center during the pilot stage. Although the two agencies are approximately equal in size and handle a similar number of 911 calls per year, MedStar chose to use the ECNS program more conservatively during its pilot program than did LMEMS (e.g., assigning a smaller number of call types as eligible for ECNS triage). Therefore MedStar handled significantly fewer calls through the ECNS system than did LMEMS. The system is designed to be used in this flexible manner, according to the needs of each user agency and the decisions of its medical directors.

Outcome Measures

The primary endpoint was the amount of cost savings achieved using an alternative point of care as compared to going to the ED, and an alternative mode of transport as compared to a typical ambulance response. The secondary endpoint was the percentage of patients who were either satisfied or not satisfied with the ECNS service.

Data Analysis

Cost savings were determined by comparing actual costs incurred with the costs that would have been incurred by going to the ED and sending an ambulance. Cost data were obtained from the US averages per patient and/or figures provided by each agency. STATA for Windows® software (STATA Statistical Software: Release 13.1 ©2013, StataCorp, College Station, TX, USA) was used to analyze patient dispatch data. As for patient satisfaction, each agency provided data they collected using a 5-point Likert Scale. These scores were then simply converted into percentage points and graphed on a bar chart.

RESULTS

Patient records from 3,976 cases were analyzed (n=304 for MedStar, and n=3,672 for LMEMS) (Table 1). Collectively, nearly $1.2 million (USD) in payments were avoided as a result of directing patients away from the ED and to alternative providers or points of care (Table 1). Redirect-

Final point of care	MedStar				LMEMS			
	Cost per patient[a] (US$)	Patients (n) (N=304)	Savings per patient[b] (US$)	Total saving[c] (US$)	Cost per patient[a] (US$)	Patients (n) (N=3,272)	Savings per patient[b] (US$)	Total saving[c] (US$)
ED *(Base)*	1,349	111	0	0	1,349	2,896	0	0
ICC/UCC	156	63	1,193	75,159	156	330	1,193	393,690
PCP	145	115	1,204	138,460	145	196	1,204	235,984
HC/LA	0	11	1,349	14,839	0	250	1,349	337,250
Other[d]	218	4	1,131	4,524	218	0	1,131	0
Sub-total				232,982				966,924
Total (combined)								1,199,906

LMEMS: Louisville Metro Emergency Medical Service ED: Emergency Department ICC/UCC: Instant Care Clinic/Urgent Care Clinic PCP: Primary Care Physician HC/LA: Home Care/Lift Assist [a]USA average [b]Saving per patient i.e., if a patient avoided using emergency department as his/her primary point of care [c]A product of the number of patients and savings per patient. [d]Includes dentist, specialty, social services, or health information agency.

Table 1. Healthcare cost savings by avoiding a visit to the ED as the primary point of care

Mode of transport	MedStar				LMEMS			
	Cost per patient[a] (US$)	Patients (n) (N=304)	Savings per patient[b] (US$)	Total saving[c] (US$)	Cost per patient[a] (US$)	Patients (n) (N=3,672)	Savings per patient[b] (US$)	Total saving[c] (US$)
Ambulance 1 (Base)	418	20	0	0	434	0	0	0
Ambulance 2	-	-	-	-	396	3,026	38	114,988
Wheelchair/Van	-	-	-	-	26	326	4,708	133,008
Other[d]	21	284	397	112,748	18	209		86,944
Sub-total				112,748				334,940
Total (combined)								447,688

LMEMS: Louisville Metro Emergency Medical Service [a]Average given by agency [b]Saving per patient i.e., if a patient avoided using ambulance 1 (base) to his\her final point of care [c]A product of the number of patients and savings per response. [d]Includes cab/taxi, private owned vehicle, or bus.

Table 2. Transport cost savings by avoiding the use of an ambulance 1 (base mode of transport) as primary mode of transport to the final point of care.

ing patients to primary care physicians (PCP) and Immediate Care Centers/Urgent Care Centers (ICC/UCC) provided the most significant savings. LMEMS redirected a significantly higher proportion of ECN-triaged callers to home care options (n=250) and ICC/UCC (n=330) than did MedStar, while MedStar redirected the majority of its ECN-triaged patients to a PCP (n=115).

Overall, ECNS-based redirection of 911 callers away from the traditional ambulance-to-ED care pathway provided more than $1.6 million USD in costs avoided (i.e., $345,730 for MedStar, and $1,301,864 for LMEMS).

Patient satisfaction

Overall, 91.2% of the patients were satisfied with the ECNS service, and these rates were highly comparable between agencies (Figure 2). MedStar and LMEMS saw a 93.7% response rate and an 88.8% response rate, respectively. The specific overall patient satisfaction rates were: 92.4%

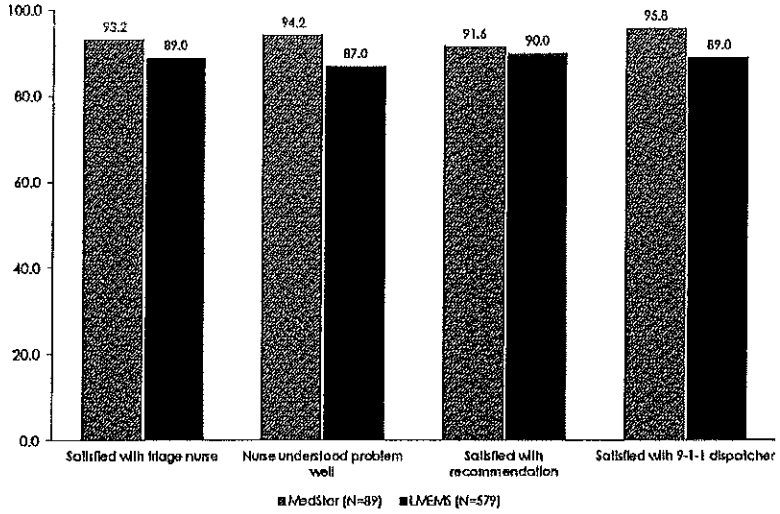

Figure 2. ECN and EMD Patient Satisfaction Outcomes

satisfaction with the EMD; 91.1% with the ECN, and 90.8% with the recommendation advised by the ECN; and 90.6% with the ECN's understanding of the patient's problem.

DISCUSSION

Our findings show that the ECNS service substantially reduced both the overall number of 911 callers routed to the ED and the per-patient charges, while offering patients access to a broader range of alternative care. The two agencies that implemented the ECNS program, MedStar and LMEMS, were able to save $345,730 and $1,301,864 respectively during the pilot implementation period, with high patient satisfaction rates. Thus, this study suggests that the ECNS service, which introduces nurse triage at the 911 dispatch point, is a feasible and potentially cost-saving approach to effectively match healthcare resources with patient needs and to reduce ED use by patients with low-acuity conditions. The results of this study also indicate that patient savings could potentially be significantly greater for agencies that implement the system with 24-hour ECN coverage. In most communities, moreover, the patient cost savings will only be one of several benefits of this type of service. For example, emergency response agencies, including both ambulance and fire departments, will be better able to direct scarce resources to true emergencies and may see staffing and vehicle costs reduced.

ED overcrowding

The potential of a 911 nurse triage service such as the ECNS to reduce ED overcrowding is one of its most significant potential benefits. Even as ED visits have increased substantially and more patients are using EDs as their point of access for all unscheduled care, the number of EDs in the US has dropped.[10] As a result, EDs are increasingly overcrowded with patients whose conditions are not emergencies and who would be better served elsewhere.[11] (O'Malley, 2013). Many of these patients are uninsured, are on Medicare or Medicaid, or have no primary care provider.[12] The 911 dispatch point, as the earliest point of contact many of these patients have with the healthcare system, provides a strategically effective location for navigating them away from the ED to more appropriate—and significantly less expensive—care options. This issue may very well become more important for both providers and payers as Medicare begins to base is own reimbursement rates in part on patient satisfaction surveys.[13] In fact, one of the agencies involved in this study was able to convince local hospitals to fully fund the ECNS service (despite the fact that it diverted patients from those hospitals) because it reduced the number of low-acuity patients in their ED waiting rooms, thus reducing wait times and increasing overall patient satisfaction with the hospitals.

The spectrum of care

It is of paramount importance that administrators understand the broad spectrum of care and transport alternatives a community must offer, and the practices that must be in place in the emergency communication center, in order for a service such as the ECNS to reduce costs and increase efficient resource use without increasing patient risk. The ECNS service was successful in the emergency systems in which it was implemented in part because of the networks of services to which the ECNs—and thus patients—had access. For example, if the ECN advises the patient visit a doctor in the next 1-3 days, the ECN must also be able to provide names and locations of clinics or doctors, transfer patient information, and often contact the providers to set up appointments for patients. This is particularly necessary for the many callers who access the emergency care system specifically because they have no regular primary care provider.

In short, for a system to successfully implement the ECNS service, the community must offer clinic services and/or "retail" medical establishments that will see

patients on a one-time basis and are willing to offer same-day appointments. In the agencies studied here, many local clinics were willing to set aside, in advance, appointment slots that could be filled by the ECN. Community crisis lines, pharmacies, dentists, and other care access points must also exist in order for an emergency nurse triage program to most efficiently and accurately match patients with the appropriate resources for their conditions. In this way, emergency dispatch services may help provide an organizing model for effective well-coordinated care community-wide.

Best practices

A 911 nurse triage service such as the ECNS also cannot be effective without certain practices in place in the 911 dispatch center itself. Medically-approved protocols (considered the standard of practice in emergency dispatch) must be used in order for EMDs to be able to accurately and consistently identify low- acuity cases over the phone. Without such protocols in place, too much variation exists from one dispatcher to the next, and high-severity calls are too apt to be misclassified or high-acuity symptoms missed. Although nurses have more medical training than dispatchers and often have many years of emergency department experience before moving into telephone triage, they should be provided with decision-support systems in order to make accurate and consistent determinations of acuity. In addition, both EMDs and ECNs should be trained specifically in the identification of high- and low-acuity calls and receive ongoing training and skills maintenance, and must be subject to quality assurance processes through consistent, random review of their calls.

CONCLUSION

The findings in this study demonstrate that an emergency nurse triage service such as the ECNS may allow us to rethink the role of 911 dispatch centers more inclusively, allowing those centers to work effectively with the common attitude that when in doubt, patients should call 911. If every patient who calls 911 need not be transported via emergency ambulance to the ED—the most expensive possible route of care—then 911 can be a clearinghouse for directing patients to alternative care providers. A 911 nurse triage service such as the ECNS can change the way EMS responds to patients' calls for help, simultaneously reducing costs, using resources more efficiently, and maintaining high levels of patient care and satisfaction.

ACKNOWLEDGMENTS

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PROVIDENCE Journal

Michael Morse: Firefighters padding numbers or saving lives?

Saturday Posted Sep 24, 2016 at 3:00 PM

By Michael Morse

The tones go off, the fire station fills with light and the message comes over the PA system: "Attention Rescue 1 and Engine 13, respond to 1 Broad Street for an elderly female with difficulty breathing."

Engine 13 is in quarters and is out the door in 25 seconds. Rescue 1 responds from the hospital, five miles away. The man who called 911 waited three minutes for the first company to arrive, then four more minutes for us. He glared at us as we approached, then folded his arms across his chest.

"More people? This is ridiculous!" he scowled.

"Excuse me?" I replied, not quite sure what he was getting at.

"Why don't you bring the army next time? She just needs a ride to the hospital!"

"Where is she?"

"She's upstairs with the rest of you," he managed without concealing his contempt.

I've been around for a while, and responded to calls for difficulty breathing in a number of forms: the sniffles, chronic emphysema, a cold, congestive heart failure, anaphalixic shock, airway obstructions and death, to name a few. Dispatchers assume the worst when somebody calls 911. Often, the worst is what we find.

It is always better to have too much help than not enough, especially when somebody has only minutes to live without intervention. We can, and often do, save people from an early demise. It isn't easy, and it takes a skilled team working together to move a patient, perform CPR, start IVs, administer drugs, drive the apparatus, and control an airway.

"This is ridiculous. No wonder my taxes are so high!"

"Did you call 911?"

"Yeah, she needs a ride to the hospital."

"Did you tell them why she needs a ride to the hospital?"

"I told them she was having trouble breathing."

"And if she stopped breathing, what good would two of us do, when one is doing compressions and the other bagging her [supplying oxygen]? We could stay there all day."

"She didn't stop breathing. She's perfectly fine — just needs some medication!"

I had to let it go; 911 is no longer reserved for emergencies. The public uses it because it is there. The responders are required to respond as if lives are hanging in the balance.

The patient was walking down the stairs now, escorted by three firefighters who arrived with equipment ready — defibrillators, medications, airway — everything needed to run a full code except for transport capabilities.

"All these handsome men!" she said, delighted by the attention.

Her son scowled as she walked past him, out the door and into the ambulance. She's 60, has had bronchitis for a few days and wants antibiotics. Her doctor told her to call 911 for a ride to the emergency room; he didn't have any appointments until later in the week.

I spent a quarter century responding to emergencies. Twenty-five years ago, an emergency was just that. In today's world, everything is an emergency. People mistakenly believe that fire departments pad their numbers with EMS responses

to justify their existence. The truth is, the public is completely responsible for the high number of calls that the fire department responds to.

When somebody calls for help there are policies in place that managers, not the people responding, have designed. Difficulty breathing, chest pain, a person unconscious, dizziness in an elderly person, altered state of consciousness, severe bleeding and anything potentially life-threatening are met with appropriate resources. Sending a strategically located fire company that can arrive on scene in seven minutes or less is the ideal. 911 response ambulances are not as plentiful as fire companies, and take longer to get to the person in trouble. The system works — as long as the people who call are actually having an emergency.

When 911 is called for rides to the emergency room, resources are squandered, urgent care for those who truly need it is delayed, and myths about firefighters padding their numbers responding to little old ladies who just need a ride to the ER are born.

Michael Morse (mmorsepfd@aol.com), a monthly contributor, is a former captain with the Providence Fire Department and the author of the books "Rescuing Providence" and "City Life."

New Sobering Center Under Construction.At Last

By Kristin Gourlay • Oct 17, 2016

Plans for the sobering center are no longer on the drawing board.
Credit Kristin Gourlay / RIPR

A new sobering center opens next month at a homeless shelter in Providence. It's a place where inebriated people who would typically be brought to the emergency room can safely sober up. It's meant to save money and guide those patients toward recovery.

Lawmakers authorized the creation of a sobering center more than three years ago. The idea was to provide an alternative to the emergency room where drunk people can sober up. But it's been on the drawing board ever since, with state, Providence, and nonprofit partners trying to figure out a way to fund and operate it. Now, the newly dubbed "Recovery Navigation Program" is close to becoming a reality. It's under construction on the second floor of Emanuel House, a homeless shelter in Providence. It's a pilot, slated to cost about $850,000 dollars a year.

The new sobering center is slated to open in early November. It's been a long time in the making, since lawmakers authorized its creation more than three years ago.

"This is where the recovery navigation program will be next month," says Owen Heleen. Nonprofit mental health care provider The Providence Center is taking the lead running the program. Spokesman Heleen tours the bare bones space.

"So we finished demolition. And as you can see we've started framing out the space where we'll serve the clients."

Heleen says the program is designed for patients some emergency medical technicians and 911 operators have called "Frequent Flyers."

"The recovery navigation center is designed to serve people who are chronic inebriates, who abuse alcohol, get intoxicated, are most often transported to hospital emergency departments, stay awhile, are discharged, and then that process repeats several times a week."

Heleen says they hope to break that cycle at the new center. And save the health system some money. Providence spends about $500 dollars for each ambulance run. And the city's public safety officials say about two-thirds of those runs are for non-emergencies – like transporting a drunk patient to the ER. The emergency department visit itself can cost hundreds of dollars – and that's just for a bed, a sandwich, and a place to sleep it off. But there's a better, cheaper way of doing things, Heleen says, that can lessen the burden on emergency rooms and ambulances *and* connect patients to the help they need to treat their addiction. Lauren D'Andrea will manage the center when it's up and running.

"And if I'm your client this is the admission desk," says D'Andrea.

She says ambulances have agreed to bring drunk patients here, if they're medically stable. Nurses will monitor them.

"So once they're done with the nurse and the nurse believes they're safe to move on, over on this side what we have is really a lounge area. They'll be able to meet with a case manager and a peer recovery specialist."

That recovery specialist knows addiction first-hand, and can talk to patients about their options. While the center remains an empty space for now, you can imagine it full of patients. One room will hold several patient beds. The other, places to sit and meet with counselors. Clients can shower and change. And if they need other help like a place to stay, there's a shelter downstairs.

Cambridge, Massachusetts has been operating a similar sobering center for several years now. They've seen emergency services costs decline. And some clients are ready for the helping hand to get into recovery from addiction.