Embertide for treatment centers

B2B - Treatment centers | escalation telemetry for clinical staff.

Audience:	For treatment centers; Treatment-center program director. We have heard these from program directors, clinical supervisors, intake leads, and QA reviewers at enough residential + IOP networks to answer them straight.
Overnight coverage:	Continuous overnight monitoring - residential nights, IOP evenings, weekend off-sites. Continuous overnight monitoring - the dark-hour window stays a watch, not a gap.
Continuity:	Member continuity between sessions - bracketing every clinical touchpoint. The peer-chat tone and missed-touch pattern fuse into a single per-member arc, surfacing continuity through day-7 post-discharge, alumni-program gaps, and weekend-only windows into a single record your clinical lead reads.
Escalation order:	Peer sponsor -> Sponsor group -> Clinical counselor -> 988 safety-net on standby. Counselor-first, 988 safety-net
Outcome signals:	Escalation latency: < 6 min (median end-to-end to clinical counselor); Reached before 988: 74% (in-network counselor resolution on the cascade); Audit trail completeness: 100% (actor + recipient logged per routing action); Window-closed handoffs: 0.3% (988 safety-net fires only on window close)

Adjunct to your programming, never a replacement.

Representative aggregate figures drawn from the routing_actions ledger treatment-center reviewers read - never a member's private check-in.

Send your cohort size, the care tiers your network already staffs (residential, IOP, PHP, outpatient, MAT/OAT induction), the day-7 discharge-readiness workflow you currently run, and the compliance reviewer expectations you sign off against - we'll come back with a 90-day deployment scope and the routing_actions surface your reviewer will read.