ON THE SCENE
Covering EMS in Colorado

Are You Prepared
When An Emergency Strikes?

by Chris Lindley

Hundreds of Coloradans learned harsh lessons in emergency preparedness this past February and during the snowstorm of December 2007: snowstorms can leave you stuck in your home for days, retail establishments may sell out of key merchandise, and key roads and highways often are impassable. Now imagine an emergency or disaster on a scale much larger than the blizzards we experienced, such as pandemic influenza or an extended power outage – both of which could potentially affect thousands of Coloradans and could temporarily paralyze the state. How prepared would Colorado residents be in the case of such emergencies?

Surveys both in Colorado and nationally demonstrate that more than half of Americans are not prepared for emergencies. In fact, most say they do not think a public health crisis is likely, even though our country has experienced three pandemic flu outbreaks in the last century. However, pandemics are unpredictable. And as history has shown us, another pandemic is not a matter of if, but a matter of when.

Just like a working smoke detector in your home provides peace of mind against disaster, maintaining an emergency preparedness kit in your home is the best way to provide for yourself and your family should a sudden emergency strike. Depending on the extent of the crisis, residents could be forced to improvise and use what they have on hand to get by for anywhere from three days to two weeks. Stocking a kit with certain essential items can truly make a difference when it's needed most.

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Section Chief's Corner

Recruitment & Retention: A Crisis in Emergency Medical and Trauma Services

by D. Randy Kuykendall

Recruitment and retention continues to be one of the most significant issues facing the Emergency Medical and Trauma Services (EMTS) community. Over the years, many EMTS professionals have thought of this issue as affecting only our rural and frontier health care systems. Without question, our ability to provide care and transportation in rural and frontier Colorado has been most challenging and is a long-standing problem. Not only have these communities faced barriers in recruiting emergency medical technicians to serve on ambulance and rescue units, but retaining nurses, respiratory therapists, radiology technicians and physicians is a concern as well. However, as our emergency medical and trauma services system continues to mature and expand, it is clear that issues of recruitment and retention are of significant concern in many of the state's urban areas as well. Metropolitan and urban EMS providers are working continually to identify and recruit qualified emergency medical technicians.

So what does this "recruitment and retention crisis" mean in terms of providing care throughout our state? First, it is important to identify the prehospital care work force and make some observations about its current status. Figure 1 shows the number of EMS agencies, by Regional Emergency Medical and Trauma Advisory Council (RETAC) area and whether they are paid, volunteer or a combination of paid/volunteer staffing. Figure 2 shows the numbers of emergency medical technicians that staff the 180+ ambulance services and numerous rescue services that care for patients throughout Colorado. Figure 3 shows the percentage of EMTs, by category, that have recertified during the past three years.

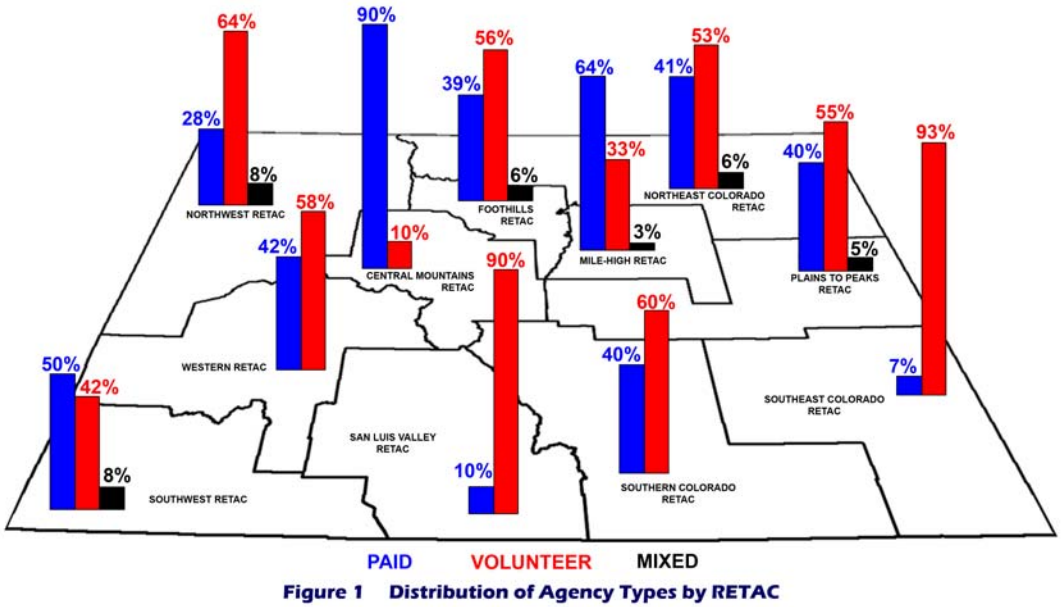

Figure 1 Distribution of Agency Types by RETAC

Volunteer personnel staff the majority of ambulance agencies in rural Colorado, while the state's more urban and metropolitan areas are served by paid services. Although this is not a surprise, it illustrates the diverse issues that exist in developing and maintaining a proficient work force in both settings.

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Section Chief's Corner
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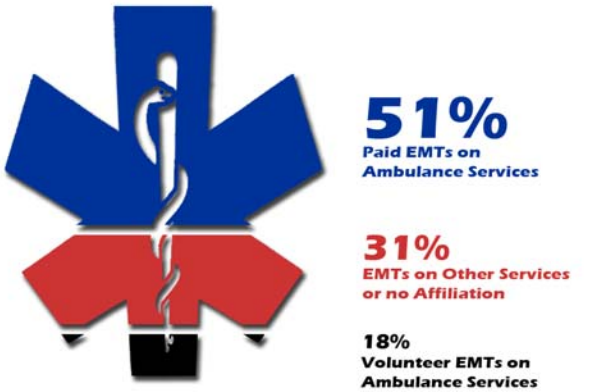

Figure 2 Colorado EMTs by Affiliation 2007

Approximately 18 percent of the certified EMT personnel in Colorado staff more than 50 percent of the ambulance services throughout the state. Almost one-third of the work force is affiliated with non-transporting rescue services or was not affiliated with an EMS agency at the time of the last certification cycle. This distribution would indicate that many volunteer agencies operate on a very thin personnel margin and may be continually at risk of having insufficient personnel to meet community needs. Approximately 40 percent of the EMT-Basic personnel certified three years ago did not choose to recertify while 8 percent of EMT-Intermediates and approximately 25 percent of EMT-Paramedics chose not to renew their Colorado certifications. These statistics provide a very broad glance at the Colorado EMTS work force, and further research is necessary to determine why a relatively high number of trained prehospital health care providers leave the industry each year. Beyond the drain in personnel, when experienced providers leave, they take with them the collective experience gained in ways that may take years to replace in new EMT graduates.

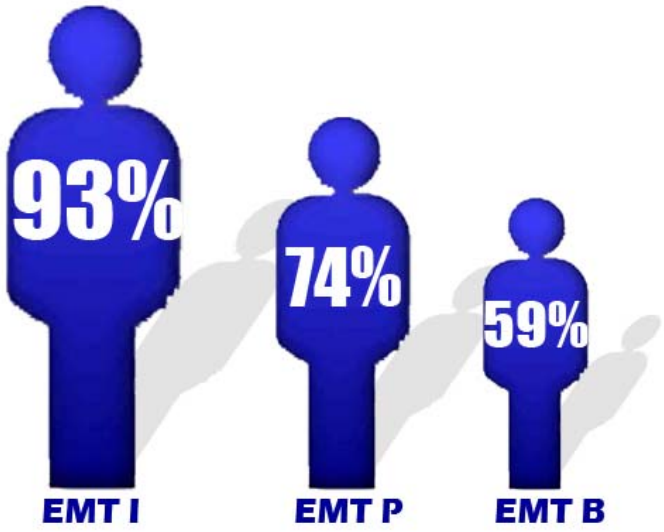

Figure 3 Percent of EMTs who Recertify, by EMT Type

Although little research exists to identify either barriers or solutions regarding recruitment and retention throughout the EMS industry, this issue is becoming more critical each year as the demands on the system continue to increase and communities find it more difficult to meet their staffing needs. Anecdotal data from the past several years seems to indicate that demands on personal time, life changes and making a living are among the most frequent reasons volunteer professionals leave EMS organizations. Although many of these same issues arise for paid EMS personnel, concerns with salaries, working conditions and career advancement also play an important role in career choices that lead them out of the EMS professions.

I believe that everyone in our EMTS system agrees that we need to address the problem. Many agency leaders and policymakers understand that the EMTS community has a recruitment and retention problem. We simply have trouble identifying successful solutions.

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Criminal Activity Review
EMT Certification

by Michelle Reese

The Emergency Medical and Trauma Services Section receives calls occasionally from potential EMT applicants concerned that a criminal conviction will prohibit them from obtaining Colorado EMT certification. This article will outline the process used and the information reviewed by the section when making certification determinations where criminal activity is involved.

The most important point to remember is that the section considers each applicant's situation on a case-by-case basis. Our charge, with respect to certification determinations, is to review the facts and circumstances surrounding an applicant's criminal activity and determine whether that activity should disqualify the applicant from certification. We understand that an EMT's certification is a vocational credential that provides a livelihood for many. We make the most informed decisions possible, keeping in mind that the department's mandate and first priority is to protect the public health, safety and welfare by ensuring that certified EMTs are competent and can be trusted with the lives of others.

That being the case, we are unable to make a definitive determination for someone who calls us to disclose a criminal background, but who has not yet submitted an EMT certification application or submitted to a Colorado Bureau of Investigation (CBI) fingerprint-based criminal history record check. We have received calls from people convicted of crimes who are considering taking an EMT-Basic training course and they ask whether they should even take the course if they will be denied certification by the state after completing the training. Although potential applicants are free to call us with this question, unless the crime is clearly one that requires certification denial by our rules/policy (see below), then we cannot definitively answer these questions until we have looked at all of the facts and circumstances surrounding a criminal history background, including the official CBI report.

As far as the process that the section follows when an applicant has a background report with criminal activity, prior to making a determination, we invite the applicant to submit any information or data that relates to the area of concern and, if desired, to meet with the section chief and deputy section chief to present his or her side of the story. This helps to better ensure that all facts are understood before a departmental decision concerning certification is made. We also review the fingerprint-based criminal history report from the CBI, any documents provided by the applicant, information obtained from court dockets and databases, and police arrest warrants and reports.

In most cases, there are two sides to a story and, without this level of interpersonal contact, extenuating circumstances or actions subsequent to the criminal activity that may weigh in favor of the applicant are not available for consideration. Taking advantage of this opportunity to meet with section staff will help ensure that the best possible decisions are made in terms of protecting both the applicant and the public we serve.

The same holds true for currently certified EMTs who are arrested or convicted of a crime, after which the section is notified by the CBI. Once the report is received, section investigation staff will attempt to contact the EMT and invite him or her to provide additional information or to meet with section staff.

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Criminal Activity Review
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For EMTs who have taken advantage of such an opportunity, several have received considerations such as probation instead of revocation, because staff was able to understand information and/or circumstances not easily accessible otherwise.

This process underscores the critical importance for certified EMTs to notify the section of any change in address and to maintain current information in their certification record. It is strongly recommended, as well as required by current EMT certification rules, that you keep your contact information with us current at all times. Otherwise, you may not receive important correspondence about the opportunity to tell your side of the story.

As far as what factors and circumstances are reviewed in making certification determinations, the regulations permit the department to deny certification to those who have been convicted of, or plead guilty or no contest to, felonies or misdemeanors that relate to the duties and responsibilities of an EMT. The EMT certification regulations set forth the types of offenses that are considered to relate to the duties and responsibilities of an EMT. These offenses range from crimes against a person to offenses involving fraud, as well as offenses under the Uniform Controlled Substances Act. The regulations also state that a "conviction" includes the imposition of a deferred judgment and sentence.

To assist us in applying the EMT certification regulations in a fair and consistent manner, the section has adopted a Criminal Conviction Policy. This policy requires that certain crimes, such as those involving sexual misconduct or abuse of children, the elderly, or an ambulance or health-care facility patient, are considered to present such an unreasonable risk to the public that an EMT applicant will presumably be denied certification if convicted of such a crime. The policy goes on to list crimes (or circumstances, such as probation) that may lead to some disciplinary sanction, but not necessarily denial of certification. This category includes crimes involving controlled substances, serious crimes of violence against persons, arson, embezzlement and burglary. Finally, the policy lists factors that are considered when reviewing an application, such as the nature and seriousness of the crime, the length of time elapsed since the crime was committed, the applicant's action and conduct since the crime occurred and compliance with all court orders associated with the conviction.

You can review the Criminal Conviction Policy at www.coems.info/EMT Education and Certification/EMT Certification Information/Criminal conviction policy.pdf. If you have questions or would like to discuss these issues in more detail, contact the Certification Unit at (303) 692-2980.

Michelle Reese is the deputy section chief of the Emergency Medical and Trauma Services Section and can be reached at michelle.reese@state.co.us.

Prehospital Transfers
A Complex Issue in Colorado

by Dr. Fred Severyn

The universal challenge of interfacility transfer of patients is nothing new, but unique geographic isolation and weather limitations coupled with a potential lack of availability of appropriately trained personnel add a unique Colorado flavor. Since many of these patient transfers originate in emergency departments, medical staff must be educated in the resources and limitations of EMS providers' services, as under the broad umbrella of EMTALA, the transferring physician is still responsible for the patient's care until formal turnover to another physician's care occurs.

There sometimes is a disconnect in Colorado between ambulance licensing and EMS provider certification/ scope of practice in terms of matching appropriate skill sets to the needs of patients requiring transfer from one medical facility to another. Colorado does not certify EMS personnel at a "critical care paramedic" level, and has chosen to allow individual EMS medical directors to apply for additional skills/procedures through the waiver process that is administered through the Board of Medical Examiners. Colorado has chosen to follow the majority of the United States in this decision since no national consensus has been reached in terms of what a "critical care/advanced" paramedic should be capable of doing.

As an attempt to help facilitate patient care, the Emergency Medical and Trauma Services Section has worked with the creation of EMS formularies that can help facilitate patient transport using available regional resources, while continuing to emphasize patient safety during this process. Initially, through the Medical Advisory Group, then through the formulary task force, and now with the aim of annual review and revision by the Medical Direction Committee, the interfacility transport formulary has been created and put into Rule 500 of the Board of Medical Examiners—a substantial contribution to patient care and transport.

Patients, however, often are stabilized only after the initiation of medications, procedures or even blood product administration that involve care outside the current scope of practice as defined in the "Acts Allowed" of the Board of Medical Examiners.

Current options available to the transferring physician allow some latitude, but local resources as well as the limitations provided by Mother Nature herself (geography and weather) may impose additional twists to this process. There has been, and always will be, the option of sending specially trained nursing/allied health care providers with the patient during ground transfers. These individuals can continue to provide hospital-based care that may be outside of the scope of practice of EMS personnel in situations where transfer is required and traditional critical care transfer services are not available. In these situations, nurses or other appropriately credentialed allied health care providers have the expertise to initiate and monitor the life-saving treatments at the referring institution, and can continue it during transfer, knowing the nuances of the infusion apparatus, the pharmacology concerns, and what to look for in terms of complications of the therapy itself. Nursing shortages and liability issues on the part of the hospitals are of concern and can be a limitation from an operational management perspective.

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Prehospital Transfers
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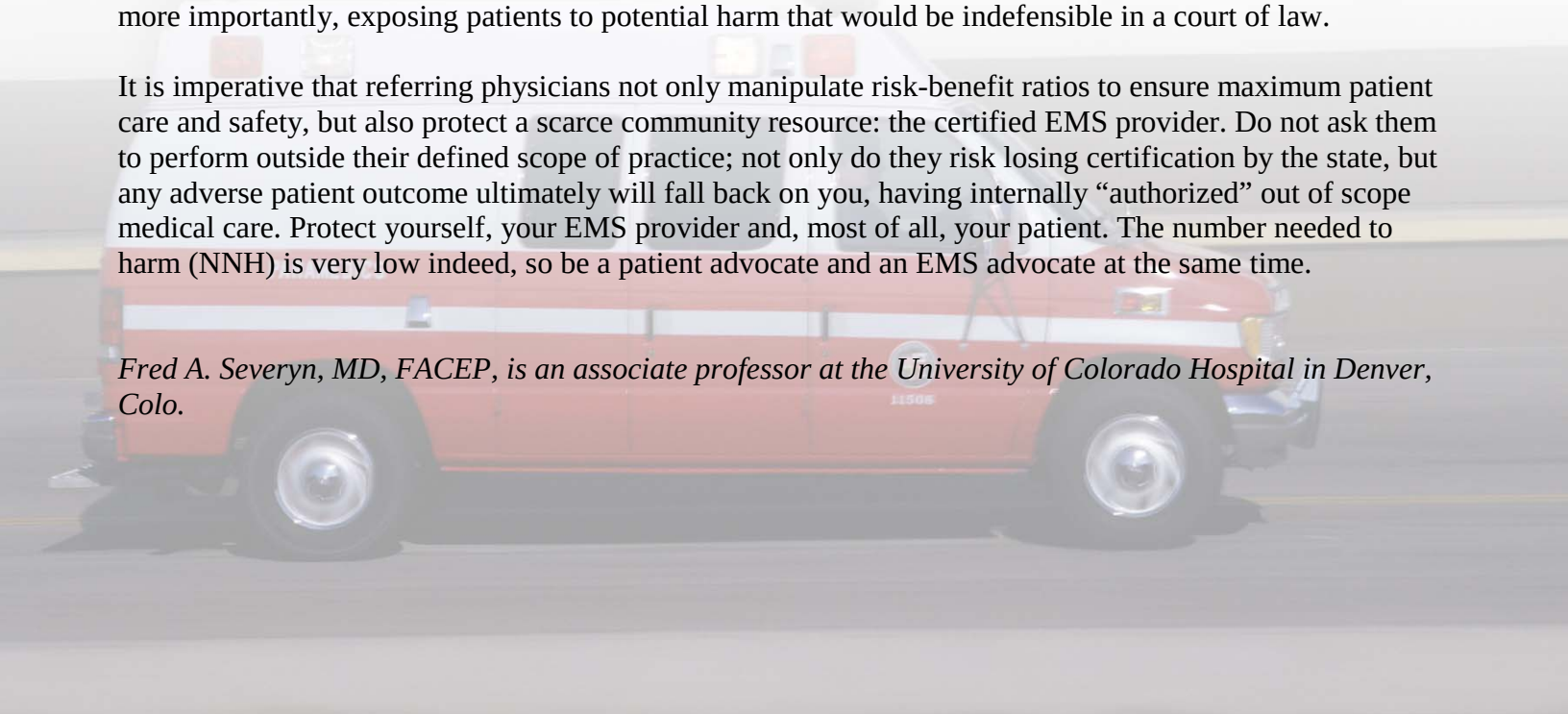
However, it is important for ambulance services, hospitals and service medical directors to discuss these issues in advance and work to develop solutions that keep providers functioning within state law and taking every step to ensure patient safety.

Specialty care transport systems exist in a variety of areas throughout the state. Air transport systems, either fixed wing or rotorcraft, offer a team approach in patient care during transport. Typically a nurse with extensive critical care training and experience partners with a paramedic who has additional training and experience, and they provide the basis for a traditional critical care transfer team. This partnership allows maximum flexibility in often cramped quarters to provide a modified critical care environment for the patient during transfer. Ground-based critical care ambulances also use this specialty RN-experienced paramedic team composition to provide safe and advanced care when weather prohibits air transport. However, the numbers of ambulances with this configuration are not substantial in Colorado and timely access can be problematic.

There are just a few agency medical directors who have had waivers extended to them by the Board of Medical Examiners for their EMS personnel to provide monitoring of certain medications and procedures above and beyond the standard interfacility formulary. These medical directors have extended their licenses and liability in attesting to the board that their system has a medical need and that they have set internal processes in place via protocol, training and retraining to attest to continued crew competency, with adequate run review and quality assurance programs in place. The “grandfather period” of allowing EMS providers to provide care outside scope will be formally ending in June 2008, with no probability of extension by the Board of Medical Examiners. If medical directors don’t apply for waivers in the next cycle of the Medical Direction Committee process, certified EMTs that provide care outside the Rule 500 scope of practice will be exposed to increased liability and risk their certification status. EMS medical directors and providers alike need to follow the existing rules in the state or potentially face not only sanctions, but more importantly, exposing patients to potential harm that would be indefensible in a court of law.

It is imperative that referring physicians not only manipulate risk-benefit ratios to ensure maximum patient care and safety, but also protect a scarce community resource: the certified EMS provider. Do not ask them to perform outside their defined scope of practice; not only do they risk losing certification by the state, but any adverse patient outcome ultimately will fall back on you, having internally “authorized” out of scope medical care. Protect yourself, your EMS provider and, most of all, your patient. The number needed to harm (NNH) is very low indeed, so be a patient advocate and an EMS advocate at the same time.

Fred A. Severyn, MD, FACEP, is an associate professor at the University of Colorado Hospital in Denver, Colo.



CE Changes
Continuing Education Requirements

by Marilyn Bourn

In December 2006, revisions to the continuing education requirements were adopted for Colorado EMT recertification. These revised requirements will become effective July 1, 2008. The required hours for the EMT-Basic level will remain the same, but the required hours for EMT-Intermediate will increase from 36 hours to 50 hours. The required hours for EMT-Paramedic will increase from 45 hours to 50 hours. Additionally, the content requirements will change and will be more inline with those of the National Registry of Emergency Medical Technicians.

EMT-Basics are required to have no less than 36 hours of education/training. These hours may be obtained in one of two ways:

1. A refresher course at the EMT-Basic level conducted or approved by a department-recognized EMS education center or group. Additional continuing education topics then may be taken to equal the total requirement of no less than 36 hours.
2. Continuing education topics consisting of no less than 36 hours of education that is conducted or approved by department-recognized EMS education centers or groups consisting of the following minimum content at the EMT-Basic level:
    - one hour of preparatory content that may include scene safety, quality improvement, health and safety of the EMT, or medical legal concepts
    - three hours of OB and pediatric patient assessment and treatment
    - six hours of trauma patient assessment and treatment
    - five hours of patient assessment
    - three hours of airway assessment and management
    - six hours of medical/behavioral emergency patient assessment and management
    - 12 hours of elective content that is relevant to the practice of emergency medicine

EMT-Intermediates and EMT-Paramedics are required to have no less than 50 hours of education/training. These hours may be obtained in one of two ways:

1. A refresher course at the EMT's level conducted or approved by a department-recognized EMS education center or group. Additional continuing education topics then may be taken to equal the total required hours of no less than 50 hours.
2. Continuing education topics consisting of no less than 50 hours of education that is conducted or approved by department-recognized EMS education centers or groups consisting of the following minimum content requirements at the EMT's level:

    No less than 25 hours as described below
    - eight hours of airway, breathing, and cardiology assessment and treatment
    - four hours of medical patient assessment and treatment
    - three hours of trauma patient assessment and treatment

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CE Changes
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- eight hours of OB and pediatric patient assessment and treatment
- two hours of operational tasks
- plus no less than 25 hours of elective content that is relevant to the practice of emergency medicine

As before, continuing education hours may be obtained through both direct instructor contact and non-instructor contact. Direct instructor contact is defined as lectures, conferences, hands-on sessions, etc. Non-instructor contact is defined as self-study programs, online courses, video programs, etc. A department-recognized EMS education center or group can help determine if non-instructor contact education is acceptable for recertification. In general, non-instructor contact hours should not exceed 50 percent of the total hours required for recertification. Again, it is important to discuss this with an EMS education center or group. In most cases, the EMS center or group is affiliated with a provider agency (whether volunteer or paid), a medical director, a community college or local hospital. If you are not affiliated with an agency or do not know where to find a department-recognized EMS education center or group, go to www.cdphe.state.co.us/em/CertificationEducation/Education/programs.

Plan ahead, don't get caught short and remember: These revised requirements will become effective beginning July 1, 2008.

Marilyn Bourn RN, MSN, NREMTP, is the state EMS training coordinator and can be reached at marilyn.bourn@state.co.us.

Colorado's Safe Haven Law

by Scott Bates

Preventability is what separates an unfortunate event from a true tragedy.

Such is the case with newborn infants who have been left to die in trash cans or dumpsters. These children could have been taken to the staff at one of Colorado's designated safe havens: hospital emergency rooms or fire departments.

The generally accepted stereotype of a person who abandons a newborn child is that of a teenaged, underprivileged mother. However, research indicates that this is a tragedy that crosses all categories of age, ethnicity and socioeconomic status.

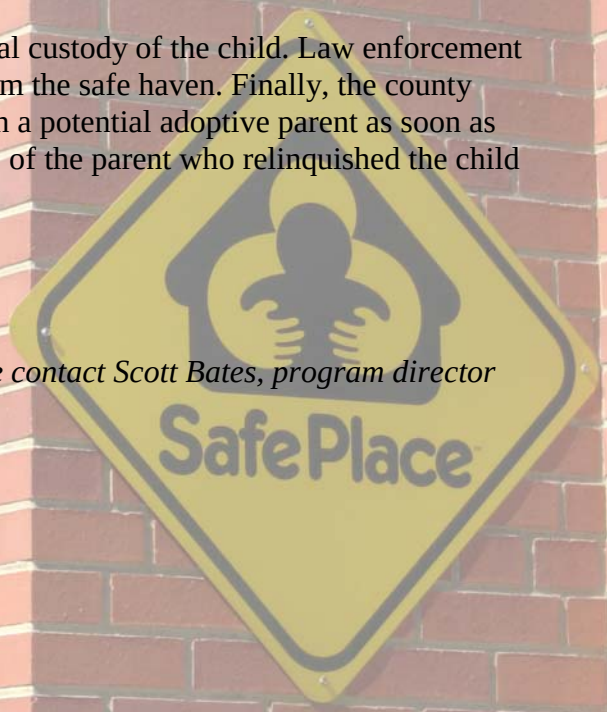
Colorado's Safe Haven Law permits parents to take their infants to staff at one of these havens to relinquish custody if they decide that they are unwilling or unable to adequately care for their child. Staff includes a firefighter at a fire station and hospital staff members who engage in the admission, care or treatment of patients.

The law protects parents who bring infants to these havens who are less than 72 hours old and unharmed.

Once a child is relinquished to a safe haven, staff must perform any act necessary to protect the health of the child. Also, law enforcement and the county department of social services must be notified of relinquishment within 24 hours .

Colorado's Safe Haven Law provides some protections from liability for both the provider of the safe haven and the parent. The safe haven provider "shall incur no civil or criminal liability for any good faith acts or omissions performed," and the parent shall not incur any criminal charges for the relinquishment.

After a child is relinquished, the safe haven takes temporary physical custody of the child. Law enforcement then takes temporary custody of the child upon receipt of notice from the safe haven. Finally, the county department of social services then places the relinquished child with a potential adoptive parent as soon as possible and will proceed with a motion to terminate parental rights of the parent who relinquished the child as soon as lawfully possible.



If you have any questions about Colorado's Safe Haven Law please contact Scott Bates, program director of the Colorado Children's Trust Fund at scott.bates@state.co.us.

RETAC Roundup

There are 11 Regional Emergency Medical and Trauma Advisory Councils (RETACs) in Colorado. Learn more about the RETACs at www.cdphe.state.co.us/em/retac/index.html.

- The Colorado Springs Fire Department gave the **San Luis Valley RETAC** four pallets of fire hose, courtesy of Chief Bruce Long.

- The **Southeastern Colorado RETAC** was awarded a grant by the Colorado Rural Health Center Critical Access Hospital program for the development and implementation of a Web site. The successful bidder on this project was Mr. Chris Montera, whose expertise in EMS data systems, creativity and design credentials are expressed in the SECRETAC Web site at www.secretac.com. This Web site offers the standard menu, providing easy access to information and resources and some special features:
  - calendar with local, state and national events in one spot
  - media section with current and past media programs for both print and radio
  - vendors page with space and advertising available for EMTS agencies and organizations
  - forums for online blogging
  - donation capability with an online Pay Pal link for anyone who would like to show appreciation or donate to emergency medical and trauma services (tax deductable)

COLORADO'S 11 RETACs

On the Calendar

3rd Annual NWRETAC Leadership Conference
Glenwood Springs, Colo., April 17-18, 2008
Featuring Bob Waddell, Lois Todd, Karl Mecklenburg, Bob Marlin, Randy Kuykendall and Marilyn Bourn. For registration information go to www.nwretac.org or contact Danny Barela at (970) 255-2662.

7th Annual Plains to Peaks EMS/Trauma Conference
Burlington, Colo., April 26-27, 2008
Visit www.plainstopeaks.org for information on the schedule, online registration, conference instructors and staff, regional awards information and lodging.

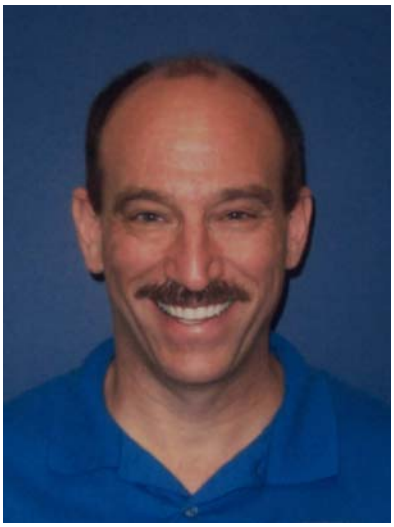
Colorado Medical Surge Seminars
Fort Collins, April 16; Sterling, April 24; Denver, May 15; Pueblo, May 29; Colorado Springs, June 11; and Grand Junction, June 25, 2008
Topics include surge capacity and alternate care facilities; demonstration of HCStandard as a situational awareness and resource request/tracking tool; Colorado's mobile medical caches; the Colorado Department of Public Health and Environment's draft "Guidance for alterations in the healthcare system during an influenza pandemic"; Colorado's Strategic National Stockpile program; Colorado's Health Emergency Line for the Public (COHELP); and Colorado Public Health Medical Volunteer System. Registration for each event is available at www.cotrain.org. For more information, please contact Ann Nedrow at ann.nedrow@state.co.us or visit the Colorado Rural Health Center's Web site at www.coruralhealth.org/crhc/events.

HealthONE EMS Educator Symposium
Denver, Colo., May 15-16, 2008
Join educators from around the region to explore the latest trends and development in providing effective education in our emergency medical services education program. For more information and reservations please call (303) 758-7000.

2008 EMS Summit at the Lake
Coeur d'Alene, Idaho, May 21-23, 2008
The Rural and Frontier EMS and Trauma Summit at the Lake will build on the success of the inaugural summit held in Big Sky, Mont. in 2006. The summit will have something for everyone, from federal and state policy makers to local EMS managers and hospital administrators to individual EMTs. More information is available at http://eu.montana.edu/summit.

Colorado's 2nd Annual EMS Data Conference
Radisson Hotel, Longmont, Colo., May 22-23, 2008
Conference highlights include selecting the right system, demonstrating the use of data in EMS agencies, small breakout sessions for individual attention and opportunities to network with other EMS agencies and software vendors. For more information please contact the Foothills RETAC at (970) 724-3870 or linda.u@msn.com.

Dr. Art Kanowitz Appointed State Medical Director



The Colorado Department of Public Health and Environment's Emergency Medical and Trauma Services Section is pleased to announce that Art Kanowitz, MD, FACEP, has been appointed to the position of state emergency medical and trauma services medical director.

Dr. Kanowitz comes to the department with significant experience and background in Colorado's emergency medical and trauma services community. He became an EMT in 1975 and later graduated from Dr. Gordon's (Cycle One) Paramedic Program. He worked for Denver Health Paramedic Division for five years before entering medical school at the University of Colorado. He completed an internship in internal medicine and a residency in emergency medicine before joining the staff at Lutheran Medical Center where he worked as an ED physician and their EMS medical director. Since leaving clinical practice, Dr. Kanowitz has served as medical director for Pridemark Paramedics and Mountain View Fire and founded a medical device research and development firm.

He has served Colorado's emergency medical and trauma services community on numerous councils and boards including the State Emergency Medical and Trauma Services Advisory Council, the Foothills Regional Emergency Medical and Trauma Advisory Council, the Emergency Medical Services Association of Colorado advisory board, Denver Metro Physician Advisors and Boulder County Physician Advisors. He also served as board member and president of the Colorado American College of Emergency Physicians (ACEP).

Nationally, Dr. Kanowitz has served on both the ACEP Trauma Committee and EMS Committee and is a member of the National Association of EMS Physicians. He has multiple publications in EM/EMS journals and books.

As a board-certified emergency physician with 33 years experience in EMS and as the only physician who has functioned as a full-time EMS medical director in Colorado, Dr. Kanowitz's experience and familiarity with Colorado issues will serve our community well in our collective efforts to improve the provision of prehospital care throughout the state.

Are You Prepared ?
continued

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During the week of March 1-9, 2008, the Emergency Preparedness and Response Division of the Colorado Department of Public Health and Environment encouraged the public to assemble emergency preparedness kits.

While there are many items that might seem essential for comfort, emergency preparedness kits should at least contain the very basic essentials for each person in your family, including bottled water, non-perishable food and medical supplies (including prescriptions). There are many items in your household already. Simply review the calculator and checklist at www.WhatIfColorado.com, determine which items you already have, and identify the items you still need.

- **Water**: Store 1 gallon of water per person per day for drinking and sanitation in clean plastic containers. In warmer months more water may be necessary.
- **Food**: Store food that won't expire quickly and does not have to be heated or cooked. Choose foods that your family will eat, including protein or fruit bars, dry cereal or granola, canned foods and juices, peanut butter, dried fruit, nuts, crackers and baby foods. Remember to pack a manual can opener, cups and eating utensils. And don't forget to include food and water for your family pets, too.
- **Warmth**: Colorado weather can change in a matter of minutes. It is important to think about warmth. It is possible that the power will be out and you will not have heat. Have warm clothing for each family member, including a jacket or coat, a long-sleeved shirt, sturdy shoes, a hat and gloves. Have a sleeping bag or warm blanket for each person.
- **Basic supplies**: Store a flashlight, battery-powered radio, extra batteries, a first aid kit, utility knife, local map, toilet paper, feminine hygiene products, soap, garbage bags and other sanitation supplies, plastic sheeting and duct tape, as well as extra cash and identification. Periodically rotate your extra batteries to be sure they work when you need them.
- **Special items**: Think about your family's unique needs. Include diapers, formula, bottles, prescription medications, eyeglasses, pet food, books, paper, pens, a deck of card or other forms of entertainment.
- Spread out the cost by buying a few items each time you shop.
- Start by collecting a three-day supply of items that are consumable, such as food, water and medication. Once you have gathered your three-day supply, start building a three-week supply.
- Keep your kit in a dry location that is easily accessible. For portability, store your items in a large plastic container or new trashcan with lid, suitcase, duffle bag, backpack or footlocker.
- Set up a schedule to evaluate, rotate and replenish your kit every six months.
- If space limitations are an issue, families should work closely with neighbors or friends to develop and store items together.

If you have questions about emergency preparedness in Colorado, please call your local public health official or local emergency manager. Their numbers are at www.cdphe.state.co.us.oll/locallist.html.

Chris Lindley is the director of the Emergency Preparedness and Response Division at the Colorado Department of Public Health and Environment and can be reached at chris.lindley@state.co.us.

Section Chief's Corner
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In my research for this article, I found that an Internet search for "EMS recruitment and retention" yielded approximately 350 hits, while a generic search for "recruitment and retention" yielded more than 1.3 million hits. The EMS and trauma community may be somewhat behind in researching this issue, but significant work already has been done in other industries that might provide some pathways for us to consider.

In Colorado, we have historically funded numerous recruitment and retention grant efforts. An entire category of the EMS grants program is dedicated to this effort. Additionally, funding from the Colorado Rural Health Center is available to local agencies that are most at-risk in terms of work force development. Both of these funding sources have been used by agencies over the years to provide resources that can aid communities in attracting and retaining qualified EMS providers. However, until we are able to better identify the barriers to attracting qualified EMTs and develop workable solutions to improve the trained workforce, I wonder how long many of our rural and frontier EMS agencies can continue to provide care and transportation across the state.

Several projects are underway to improve recruitment and retention. The Plains to Peaks RETAC, through a recruitment and retention grant, has been gathering information as to how many and why EMTs decide to leave the profession and developing strategies at the local level to improve personnel staffing. As this and other projects are completed, their results will be shared with the stakeholders. Additionally, if there are EMTS agencies that have developed successful programs to attract and retain EMS providers, we invite them to share their experiences with the Colorado EMTS community. This article is long in stating the problem and very short in offering answers, but it is my hope that we can collectively work to become more competitive in today's job market to provide quality emergency medical care and transportation that meets the ever-increasing demand. If there are success stories to share in this regard, please let us know and we'll be glad to share them. No single solution will fix this problem, but we must collectively address the crisis in recruitment and retention to move Colorado's emergency medical and trauma services system forward to meet the needs of our state's health care safety net.

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