ON THE SCENE
Covering EMS and Trauma in Colorado

Colorado EMTS System Development
Next Steps

D. Randy Kuykendall

American College of Surgeons Consultative Visit
On May 17-20, 2009, a team of consultants from the American College of Surgeons came to Colorado to conduct a comprehensive review of our state's trauma and EMS system. The consultants worked from an extensive pre-review questionnaire prepared by Emergency Medical and Trauma Services Section staff with broad input from many stakeholders throughout Colorado. More than 150 interested individuals, representing almost every facet of the trauma and EMS system, attended the formal review meeting in Denver. On Aug. 27, the final report was released and is available at www.coems.info. The report is a comprehensive snapshot of our state's emergency care and trauma system as seen through the eyes of outside experts. Take time to download the report and digest the many comments and recommendations contained in the document.

The report is of interest to trauma and EMS providers alike. This is the first effort to evaluate the effectiveness and operation of Colorado's system since it was formally developed in 1995. This is a landmark moment in the overall development of our trauma system. We must move forward with purpose in evaluating the report's more than 100 recommendations and translating them into a plan that is both realistic and wide-ranging. To be successful in our next steps, the Statewide Emergency Medical and Trauma Services Advisory Council (SEMTAC) and the Colorado Department of Public Health and Environment developed the ACS Report Task Force to review, evaluate and make recommendations concerning the report.

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ON THE SCENE AT A GLANCE

Fall 2009

Colorado Department of Public Health and Environment

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In this Issue

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Colorado EMTS System Development
continued

from the cover page

This task force is made up of a broad spectrum of Colorado's trauma and EMS system stakeholders. It is currently reviewing the consultative visit report and prioritizing the recommendations. The task force will be providing direction to both the department and the SEMTAC that will become the basis for a system development plan. This is an important task and will drive our industry in Colorado for several years to come. There are many recommendations in the report and, although many recommendations are sensible, achievable and within the realm of possibility with our current resources, other recommendations contained within the report may be unachievable at the present time.

The challenge of fully understanding, evaluating and implementing the recommendations contained in the consultative visit report is an important process that will serve as the basis for our trauma system's development over the next decade. As the core model for our health care system's approach to caring for patients with time-sensitive acute syndromes, it is of the utmost importance that our trauma care system remains as efficient and effective as possible. All stakeholders with an interest in this important process are strongly encouraged to participate in the ACS Report Task Force. Meeting dates are posted at www.coems.info and inquiries regarding this project should be directed to Grace Sandeno, trauma program manager, at grace.sandeno@state.co.us.

EMTS Provider Grants Program

Efforts have begun to get funds made possible by the passage of Senate Bill 09-002 to trauma and EMS agencies throughout the state. The new funds started to accumulate on July 1, 2009, and a second grant cycle for fiscal year 2010 was initiated. The FY 2010 grant cycle II opened in August, and applications were accepted through Sept. 23, 2009. During the month of October, all 11 of Colorado's Regional Emergency Medical and Trauma Advisory Councils will complete their regional reviews. The State Emergency Medical and Trauma Services Advisory Council will conduct its review of the grant applications in November. We expect to award grants in December, with purchase orders and contracts following shortly thereafter.

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Colorado EMTS System Development
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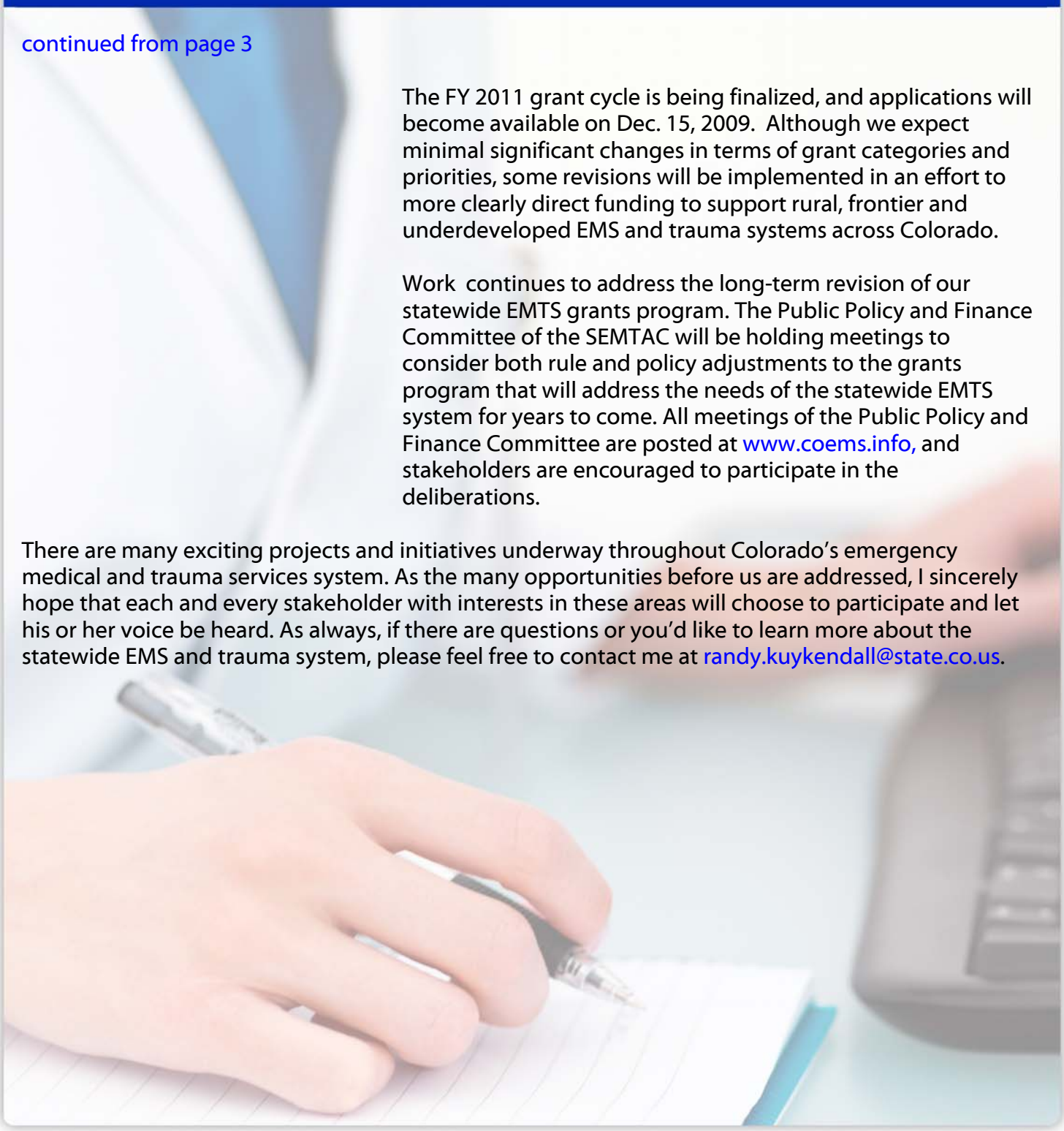
The FY 2011 grant cycle is being finalized, and applications will become available on Dec. 15, 2009. Although we expect minimal significant changes in terms of grant categories and priorities, some revisions will be implemented in an effort to more clearly direct funding to support rural, frontier and underdeveloped EMS and trauma systems across Colorado.

Work continues to address the long-term revision of our statewide EMTS grants program. The Public Policy and Finance Committee of the SEMTAC will be holding meetings to consider both rule and policy adjustments to the grants program that will address the needs of the statewide EMTS system for years to come. All meetings of the Public Policy and Finance Committee are posted at www.coems.info, and stakeholders are encouraged to participate in the deliberations.

There are many exciting projects and initiatives underway throughout Colorado's emergency medical and trauma services system. As the many opportunities before us are addressed, I sincerely hope that each and every stakeholder with interests in these areas will choose to participate and let his or her voice be heard. As always, if there are questions or you'd like to learn more about the statewide EMS and trauma system, please feel free to contact me at randy.kuykendall@state.co.us.



D. Randy Kuykendall, MLS, NREMT-P, is the chief of the Emergency Medical and Trauma Services Section and can be reached at randy.kuykendall@state.co.us.

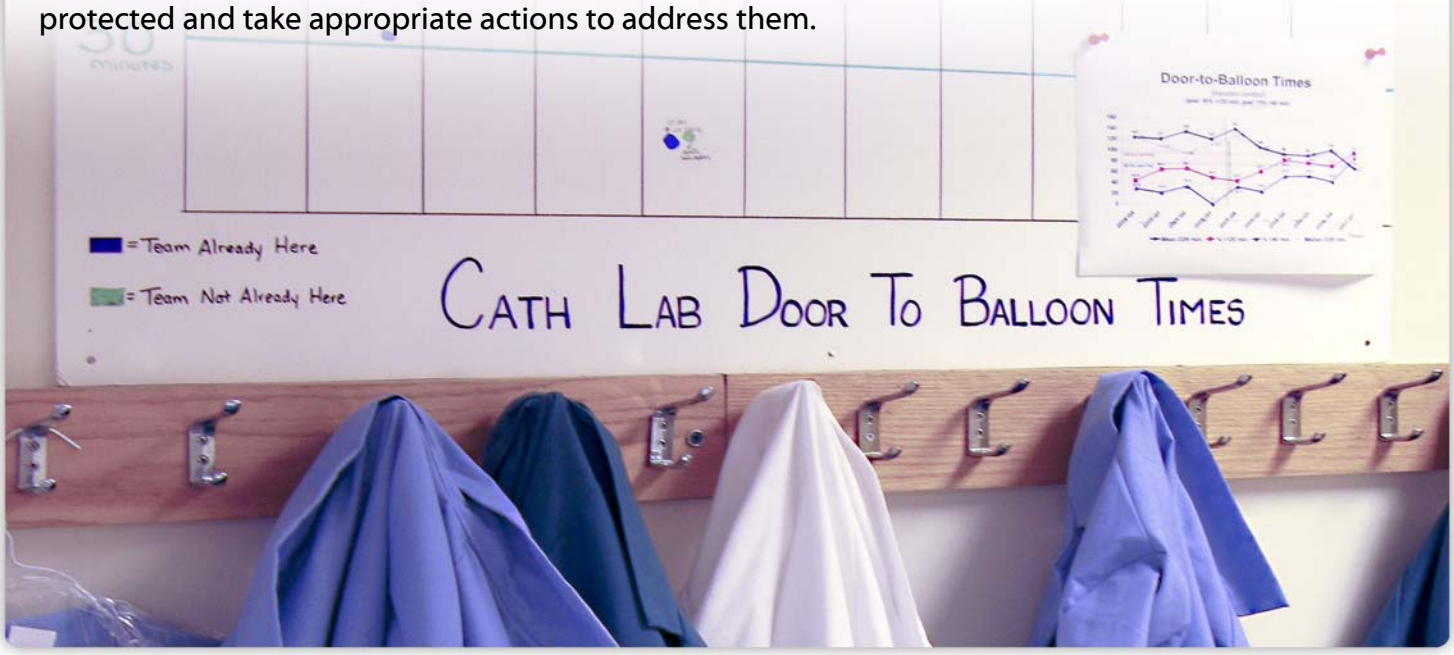
A Team In Touch

Statewide System Quality Improvement

Dr. Art Kanowitz

We are about to embark on a path that we have started many times before, but we never seem to get very far, let alone to our destination. That path is the development of a statewide system quality improvement program, and there are several reasons why we don't get to our destination. First of all, system quality improvement, just like any other quality improvement process, is not a destination, but a process. Secondly, when it comes to a regional or statewide quality improvement program, as opposed to agency or facility-specific quality improvement programs, we seem to rapidly hit a wall that stops our progress. If we are to be successful this time, we must identify what constitutes this wall and how can we either remove it or go around it.

A major portion of the wall is built on the fear of "discoverability." Discovery is a pre-trial procedure by which a party to a lawsuit gains information from another party. Thus, the concern is whether or not proceedings and records will be held in confidence and not be subject to discovery. Within the scope of a health care entity's professional (peer) review committee, Colorado law provides that records are not subject to discovery (C.R.S. § 12-36.5-104(10)). At the state level, data or information collected by the state for continuing quality improvement purposes also is not subject to discovery (C.R.S. § 25-3.5-704(2)(h)(II)). The concern is that the flow of information between entities, needed to perform regional and statewide continuous quality improvement, may not be protected. Example include information between hospitals and EMS agencies, EMS agencies and the RETACs, and hospitals and the RETACs. The truth is that it is not clear what is and what is not protected. There are a lot of myths, speculations and truths on what is discoverable. We need to obtain better clarity on discoverability at each level of information exchange and process. Do we give up the possibility of developing a statewide quality improvement program? Certainly not. We should go about designing an optimal system for managing quality and then determine the parts of the system that may not be protected and take appropriate actions to address them.



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Integrating EMS into Health Care
The Community Paramedic Model

Christopher Montera
Anne Robinson

Community medicine has been around for centuries. The Egyptians, Greeks and Romans all understood the need for prevention and health care in the home. In more recent times, a physician would arrive at your house with his black bag and care for the ill and injured. This idea of a doctor coming to your house and caring for you and your family is a concept that has gone by the wayside in the last 75 years. Today, we load up the kids or ill family members and drive them to a clinic to sit and possibly infect others while awaiting a visit from the busy doctor. One of the last health care entities to provide care at a patient's bedside in the home is emergency medical services (EMS). Generally, EMS arrives during times of urgent or emergent need, attending to the patient's immediate medical issue.

Colorado, like other states, faces challenges when it comes to providing primary care and public health in rural areas. Additionally, many rural areas of the state are hampered with the "Paramedic Paradox." The Paramedic Paradox is described as having too many paramedics in urban areas and not enough in rural areas where patients would benefit from the higher level of care a paramedic could provide.

For me, this paradox and the concurrent need for primary care and public health recently collided while I was part of a team evaluating the EMS system in the San Luis Valley. Last fall at the EMS Expo in Las Vegas, I benefited from the knowledge of Gary Wingrove from the Mayo Clinic when he presented the idea of creating community paramedic systems in the United States. At that time, I had no idea how it would fit into a small community in Western Eagle County. But in February, after that illuminating day in the San Luis Valley, our community paramedic model was born and the idea melded together for our community.

Personnel from the Nova Scotia Emergency Health Services, Western Eagle County Ambulance District, Eagle County Public Health and the Colorado Rural Health Center.

For the past two years, we have been trying to integrate with public health by partnering to provide more prevention and novel activities. The revelation from February promises to radically change how we provide EMS, provide funding for personnel, provide for a healthier community and partner with primary care and public health in our community.

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Narrowbanding
EMTS Communication Update

Bill Voges

On Jan. 1, 2013, radios in the VHF and UHF radio spectrum bands will be mandated to meet the Federal Communications Commission (FCC) narrowband requirements. Narrowbanding of radio frequencies means that the radio frequency spectrum will be divided in half to create more radio frequency capacity. This has been in the works for several years by the FCC. Currently, radio frequencies are spread with 25 kHz channel spacing between each other. In the future, Phase I will change the channel spacing technology requirement to 12.5 kHz, and Phase II will require 6.25 kHz channel spacing technology (Diagram A). You should plan now to cover this FCC mandate.

Affected radio spectrum bands:

- Very High Frequency (VHF) 150 MHz – 174 MHz
- Ultra High Frequency (UHF) 421 MHz to 512 MHz

There are two frequencies for paging that are not affected:

- 152.0075 MHz and 157.4500 MHz

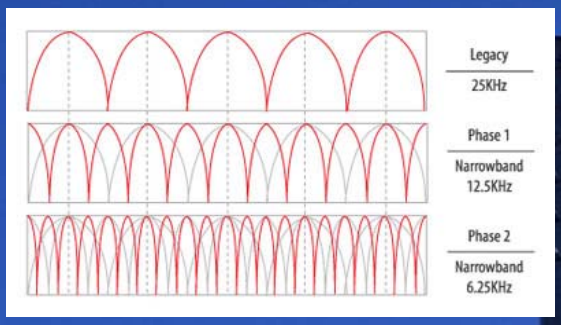

Diagram A

Agencies and facilities that will be affected by the mandate should consider these things:

- The narrowbanding mandate is not optional. You could incur possible FCC fines if you don't comply.
- Increasing interference may be an issue with equipment that has been narrowbanded. Interoperability may be negatively impacted by causing low and/or distorted receive audio.
- Coverage with the 12.5 kHz technology may not have the same transmit pattern as the 25 kHz channel spacing.
- After Jan. 1, 2011, the FCC will no longer accept modified or new license applications that exceed the narrowbanding guidelines.
- Agencies and facilities purchasing used communications equipment must make sure it will be in compliance with the FCC mandate and will operate in the 12.5 kHz and/or 6.25 kHz channel spacing.
- Most radio equipment purchased after 1997 can support narrowbanding simply by reprogramming.
- Consider using 700/800 MHz if VHF or UHF won't meet local agency or facility long-term goals.
- There are FCC fees for license modifications.
- You can decommission and surplus old radio equipment.

Bill Voges is the communications coordinator at the Emergency Medical and Trauma Services Section and can be reached at bill.voges@state.co.us.

Operation Cache Flow
Emergency Preparedness

Dr. Robin Koons

Last fall, Jennifer Trainer, the Strategic National Stockpile coordinator for Colorado, approached Cunningham Fire Protection District and asked if it was interested in assisting in the development of a state protocol for the field activation of CHEMPACK. CHEMPACK is a component of the Strategic National Stockpile that is pre-positioned in each state for response efforts involving exposures to organophosphates or other nerve agents. This federal cache contains nerve agent antidotes for both hospitals and first responders to support patient care. Jennifer felt developing procedures for the activation of this cache should occur with the input of those who would use the cache. So, with the assistance of 15 agencies, Operation Cache Flow took place on Aug. 5.

South Metro Fire crews sort through the chempacks

The exercise focused on a potential situation that could occur anywhere in Colorado: a pesticide truck involved in an automobile crash. As the scenario unfolded, the responders worked through a hazardous materials spill that not only exposed people in the cars involved in the accident, but also those sitting in cars downwind from the accident scene. The exercise simulated vapors from the spilled pesticide drifting into the ventilation system of a commercial building located near the intersection of the crash, resulting in additional victims. It quickly became clear that the fire fighters, hazardous materials specialists and EMS professionals were working a complex mass casualty scene.

The first objective was for first responders to recognize that the incident involved an organophosphate. Arapahoe County Sheriff's Office, Cunningham Fire and South Metro Fire's Hazardous Materials Team identified the agent category safely and gained control of the scene. It was the job of the paramedics to recognize the symptoms of the victims, the medication required for their care and assess their own agency's limitations in the supplies available to them. They recognized that the number of victims involved and the limitations in transport vehicles meant mutual aid was required and that CHEMPACK was necessary for this incident. As the scenario unfolded, EMS responders expanded their triage plan to address patient care for organophosphate exposure and the impending delay in patient movement from the scene.

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Injury Prevention
Program Updates

Sallie Thoreson

Booster Seat Usage
Booster seat use for 4- to 8-year-olds in Colorado remains at 50 percent, but not enough children 6-8 years of age are in boosters. Booster seats are for children who are too big for a car seat and not ready to be in an adult seat belt. A booster seat raises the child so the vehicle's lap-and-shoulder belt fits correctly across the child's chest and hips. Most children ages 4 to 8 should be riding in booster seats. We know that booster seats are much safer than seat belts. In a crash, seat belt use alone (without a booster) can cause serious injury to a child's abdomen, neck and back.

The Colorado Department of Public Health and Environment has conducted surveys with parents to determine how children ride in vehicles. In 2001, adults reported that 15 percent of the 4- to 8-year-olds used a booster seat. In 2004 and 2005, booster seat use increased to 45 percent. In 2007, booster seat use was at 50 percent. In the United States, booster seat use for 4- to 8- year-olds is about 40 percent.

Booster seat use for 4- to 5-year-olds in 2007 was 69 percent in Colorado. However, only 36 percent of 6- to 8-year-olds were using booster seats. Why the difference? Parents may look to the law for advice on how to keep their children safe. The current Colorado law states that children who weigh more than 40 pounds and are younger than 6 years old must be in a booster seat, unless they are over 55 inches tall. However, injury research shows us that children ages 6 to 8 are safer in crashes when they are using booster seats. Thirty-three states and the District of Columbia have booster seat laws for children who are 6, 7 or 8 years old. Safety experts say children should be in a booster until he/she is about 4 foot 9 inches tall, when the adult seat belt fits correctly.

For more survey results, information and fact sheets on child passenger safety, go to www.coinjuryprevention.org. Information also is available at www.carseatscolorado.com or www.usa.safekids.org.

EMS Takes Calls for Falls
Each year in the United States, one of every three adults age 65 and older is injured in a fall, and falls are the leading cause of injury death in this age group. An average of 297 older Coloradans die, and more than 9,000 are hospitalized from a fall-related injury each year. The Colorado EMS Ambulance Trip Report Information Exchange (MATRIX) database gives us a picture of the impact falls have on EMS transport agencies. In 2007, there were 65,936 calls involving patients age 65 +, and 12 percent of the calls (7,771) were for falls.

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RETAC Updates
Plains to Peaks and Mile-High Regions

Kim Schallenberger
Plains to Peaks RETAC

The Colorado Rural Health Center provided funding to the RETACs in an effort to develop a statewide EMT recruitment program. In this first year, a Web site has been developed at www.joinems.info to provide basic information about the world of emergency medical services in Colorado. In addition, a statewide advertising campaign is underway to direct potential recruits to the Web site and a toll free phone number. Some of the ads are being broadcast in Spanish. Data are being collected to track the traffic on the Web site and the toll free number. When a person solicits information from either, the regional coordinator for the RETAC selected by the person will make contact with the interested party to answer any questions he or she may have. Comments about the program can be directed to Kim Schallenberger at kschally@rebeltec.net or Mike Merrill at mike@secretac.com.

Shirley Terry
Mile-High RETAC

- The Mile-High RETAC hosted the RETAC forum in Denver Sept. 2-3, 2009.
- The Hospital Data Project has been validating data entry with Clinical Data Management over the past few months to ensure consistent data entry among the hospitals.
- The Mile-High RETAC will host the 2nd Annual EMS Safety Summit Oct. 8-9 at the Embassy Suites in Loveland. Thursday afternoon will consist of a black box training, and there will be a vendor reception that evening. Friday will have various topics and vendors with international speakers, as well as national and local presenters. The conference is free to Colorado residents. Out-of-state participants pay a small fee. There will be more than nine hours of continuing education credits offered. For additional information, visit www.milehighretac.org or contact Shirley Terry, executive director, Mile-High RETAC, at (303) 300-4704.

Betsy Stephens Joins the Division
Emergency Medical Certification Technician

The Emergency Medical and Trauma Services Section is pleased to announce that Betsy Stephens has been appointed as an emergency medical certification technician. She returned to Denver in 2003 following 20 years in Durango where she worked as a travel agent and special event planner. She most recently worked for a small Denver non-profit providing staff support in the areas of meeting planning, conference and travel coordination, project research, resource development and technical and administrative assistance.

Betsy has AAS degrees in criminal justice and liberal arts from Aims Community College. Her careers have taken her throughout the Western Hemisphere, and her interests include foreign travel, foreign film and small, furry animals.

Please join us in welcoming Betsy to the section!

Statewide System Quality Improvement
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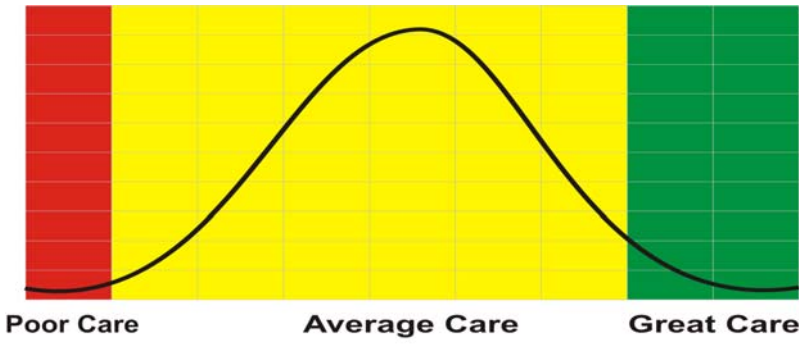
Because obtaining protection against discoverability is difficult at best and protection has been penetrated even when it was felt to be solid, consider an alternative that will encourage the flow of information and allow a statewide system to develop without the fear of discoverability.

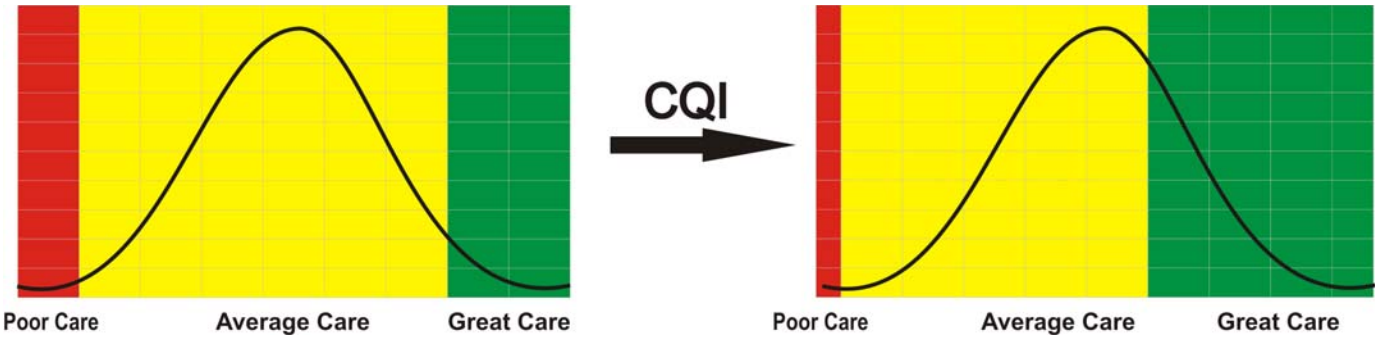
The quality of patient care is a spectrum from really great care to really poor care.



Quality Spectrum of Care

The concept of continuous quality improvement is to improve the entire spectrum of care, to erase preventable deaths, to make average care great care and to make great care even better.

All trauma centers under the direction of the trauma medical director and trauma nurse coordinator, as well as all EMS agencies under the direction of the EMS medical director and EMS coordinator, must have a continuous quality improvement process and are responsible for handling the "bad



cases." Within the facilities' peer review systems, those cases are protected and generally closely managed. Unfortunately, we frequently concentrate our efforts on the poor care end of the spectrum (for example, preventable deaths), and ignore the remainder of the spectrum. Although it is very important for us to have systems in place to eliminate preventable deaths, those make up a very small percentage of the spectrum of care.

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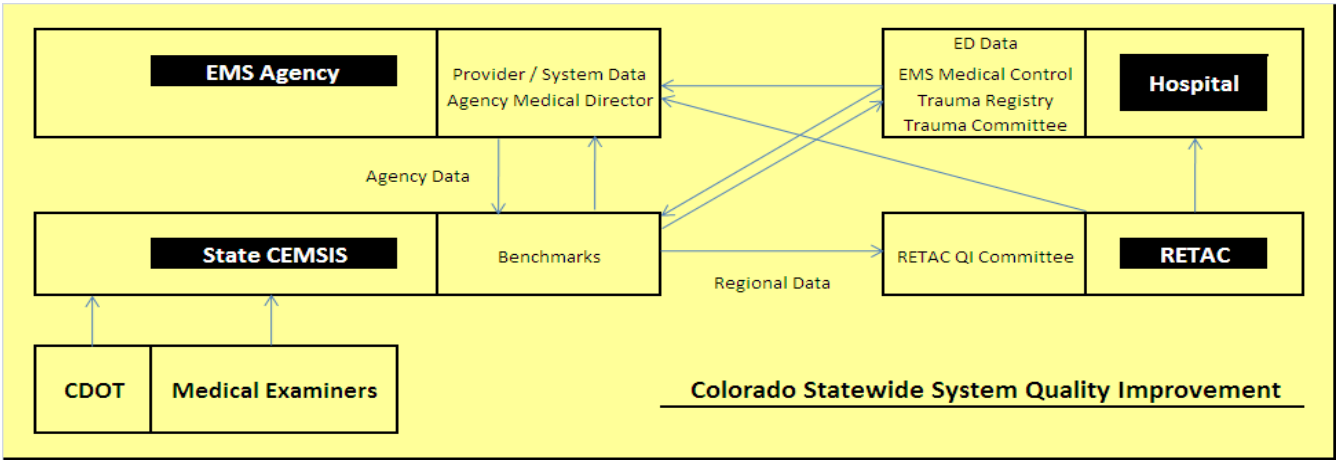
We may have a greater effect on improving care by dealing with the spectrum of care that is currently good and making it better, and dealing with the spectrum of care that is currently great and making it greater. We can improve.

Perhaps we should consider a dual system of oversight. One system would deal with the "bad cases," and one would deal with the remainder of the care spectrum or the "good cases." The "bad cases" would be handled under statutory oversight. Currently, on the trauma side, they are initially handled by the trauma program peer review process and later by the American College of Surgeons/state trauma center designation review process. On the EMS side, the "bad cases" typically are handled through the agency EMS medical director. Currently there is little regional or state system oversight of these cases, unless there is a complaint. The parallel system would deal with the "good cases." Because it would be dealing with only good cases, it might eliminate the concern for discoverability and thus eliminate the wall of fear.

As we design the statewide quality improvement program, we need to ensure that all aspects of the quality management cycle are in place:



1. **Set the target.** The optimal way to ensure goals are met is to clearly set the target that is expected. This can be done through clinical guidelines that clearly define optimal clinical care and key performance measures.
2. **Collect and evaluate data.** Data must collected and evaluated to measure fulfillment of the clinical guidelines.
3. **Close the loop.** It is of utmost importance to ensure that the information gained from data collection and evaluation is returned to the health care providers and shared with all in the system.

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Statewide System Quality Improvement
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4. **Educate.** The lessons learned from the data should form a platform from which further education is designed. The data will uncover both strengths and opportunities for improvement, and we need to share best practices.
5. **Reset target, if necessary.** Sometimes evaluation of the data over time leads to information that necessitates a change in the guidelines.
6. **Continue the cycle.**

Our statewide quality improvement system must include oversight of both the trauma system and the EMS system. Oversight of the trauma system includes all aspects of trauma care from the prehospital (EMS) handling of trauma patients, through the emergency department and surgical care, all the way through rehabilitation. Oversight of EMS includes not only the prehospital care of the trauma patient, but the prehospital care of all medical and trauma patients. Currently we have a better flow of information between facilities and EMS agencies on the trauma side. We need to develop better flow of information between the emergency department and EMS agencies, especially on the medical side.

A system of regional and statewide quality improvement requires the successful flow of information among many entities, including EMS agencies, hospitals, the 11 RETACs and the Colorado Department of Public Health and Environment .

A request to develop a statewide quality improvement plan and program was issued by the State Emergency Medical and Trauma Services Advisory Council (SEMTAC). The subcommittee formed to address this request held its first meeting in August and will hold meetings on the first Friday of every month from 9-11 a.m. at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Dr. S., Denver. These meetings are open, and I would encourage participation by anyone interested in quality management.

For more information, contact committee chairman Dr. David Ross at drdr0862@aol.com or Dr. Arthur Kanowitz, state EMTS medical director at arthur.kanowitz@state.co.us .

Integrating EMS into Health Care
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The Community Paramedic Pilot initiative is a partnership among Western Eagle County Ambulance District, Eagle County Public Health Department, Colorado Rural Health Center and the primary care providers in our community. The Community Paramedic Program has been successful for the past seven years in Nova Scotia, Canada. The paper, *Rural and Frontier EMS Agenda for the Future,* by Kevin McGinnis et. al., addressed the rural and frontier needs for EMS response and clearly outlined the need for future integration into the health care system. This paper was the basis for the current Community Paramedic programs and the generation of the International Roundtable on Community Paramedicine (www.ircp.info).

The Western Eagle County Ambulance District's model has developed over the past four months. Many meetings with community stakeholders and providers have taken place, and they culminated in a two-hour community meeting at the end of July. Anne Robinson and I have been the driving force for the implementation of this program, and here is a partial list of community members who have taken part in the conversations:

- Eagle Valley Medical Clinic – Dr. Werner
- Colorado Mountain Medical – Dr. Bock
- Vail Valley Medical Center/Home Health – Dr. Eck, Dr. Woodland, Doris Kirchner, Barb Firminger
- Valley View Medical Center – Nancy Frizell, Roxie Dean
- Eagle County Board of Commissioners – Jon Stavney, Sara Fisher, Peter Runyon
- Eagle County Government – Keith Montag, Suzanne Vitale, Sherri Almond
- Town of Eagle – Willie Powell
- Town of Gypsum – Jeff Shroll

The success of this program depended on buy-in from all of our community partners, but more importantly from the Board of Directors, staff at the Western Eagle County Ambulance District and the Board of County Commissioners. They have been instrumental in the process of creating this program.

The emphasis of our program is to ensure that all care is physician-driven and that the role of the paramedic is expanded, but not the scope. Thus, Western Eagle County Ambulance District has created two committees to help formulate the future of the program: a Community Paramedic Committee comprising of district staff and public health that will discuss the operational aspects of the program, and an Education Committee to partner with Colorado Mountain College and Hennepin College in Minnesota to bring the community paramedic college course to our area.

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Integrating EMS into Health Care
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Our goal is to create a program that will focus on four health needs in our community, based on the Eagle County Public Health *Healthy Eagle County 2010* health assessment:

1. Post-hospital discharge follow-up and linking patients back to primary care
2. Well child/neonatal checkups and child wellness and prevention, through age five
3. Chronic disease follow-up and prevention (diabetes, asthma, heart disease, high blood pressure, etc.)
4. Public health prevention programs through home safety inspections, immunizations of populations and cardiac screenings

Our goal is to have the program operational by August 2010 with a limited roll out next summer as our community paramedics complete clinical rotations. We want to ensure health care for our entire community at no charge to the patient while creating a lasting relationship with a "medical home" and primary care physician.

This will contribute to a healthier society, give our paramedics more hands-on skills and practice, reduce health care costs and create a sense of community medicine not seen since the 1800s.

Christopher Montera, NREMT-P, is the chief of Western Eagle County Ambulance District and can be reached at cmontera@wecadems.com.

Anne Robinson, RN, BSN, is the nurse manager and interim public health director for the Eagle County Department of Public Health and can be reached at anne.robinson@eaglecounty.us.

Injury Prevention
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The disposition of the calls is as follows:

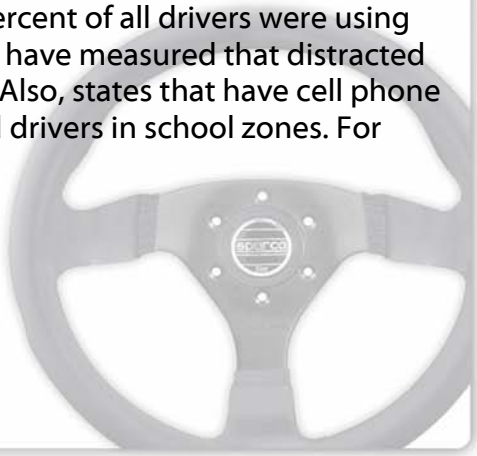
7,087 were treated and transported by EMS.
509 refused care.
83 were treated and released.
52 were treated and transferred care.
29 required no treatment.
11 were treated and transported by private vehicles.

For more background on older adult fall prevention, go to www.coinjuryprevention.org.

Eight Colorado Area Agencies on Aging have started implementing an evidence-based fall prevention program titled *A Matter of Balance*. This program is a group class that emphasizes practical strategies to reduce the fear of falling and increase physical and social activities. Participants learn that falls are preventable, set realistic goals to increase activity, change their environment to reduce the risk of falls and practice exercises to increase both strength and balance. For more information on *A Matter of Balance* in your area, contact Leighanna Konetski, program specialist, State Unit on Aging at (303) 866-3056.

Both Hands on the Steering Wheel, Please!
Effective Dec. 1, 2009, Colorado law prohibits drivers under 18 years of age from using a cell or mobile phone while driving unless it is to contact the police or fire department or it is an emergency. Drivers 18 and older may not use a cell or mobile telephone for text messaging while driving unless it is to contact the police or fire department or it is an emergency.

Multi-tasking while driving is a significant safety risk. A recent Safe Kids study found an astonishing one out of every six drivers in school zones is distracted. About 10 percent of all drivers were using handheld devices and either talking or texting while driving. Studies have measured that distracted drivers perform driving skills the same, or worse, than drunk drivers. Also, states that have cell phone or text messaging bans were 13 percent less likely to have distracted drivers in school zones. For more information on the study see, www.usa.safekids.org.



Sallie Thoreson, MS, is an injury prevention specialist at the Colorado Department of Public Health and Environment and can be reached at sallie.thoreson@state.co.us.

Operation Cache Flow
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A mock chemical spill setup is being investigated by the South Metro Fire crews. Teddy bears were used instead of volunteer victims.

Three separate dispatch centers were involved in activating Aurora Fire, Action Care and Rural Metro Ambulance to obtain additional EMS personnel and transport units. Dispatch was critical to the activation of CHEMPACK, which occurred successfully. The protocol developed last year with the assistance of Denver Health Paramedics Division was subsequently followed as the cache was loaded onto mutual aid ambulances and sent to the scene. Once CHEMPACK arrived, the EMS professionals once again had the daunting task of distributing the inventory to all the EMS personnel treating the victims. The final objective for the exercise was to determine if the EMS teams could develop a process for recording the administered drugs on the mass casualty tags.

The success of this exercise will be transferred to a protocol on the recognition, activation, movement and inventory management of CHEMPACK at the scene of an organophosphate/nerve agent incident.

Robin Koons, Ph.D., is the ESF #8 emergency response manager at the Colorado Department of Public Health and Environment and can be reached at robin.koons@state.co.us.

2009 Colorado State EMS Conference

Open Registration

We hope you will join us at the 2009 Colorado State EMS Conference to be held Nov. 5-8 at the Keystone Resort & Conference Center. This annual conference builds on its tradition of EMS education and offers nationally recognized speakers, pre-conference workshops, multiple breakout sessions, skills challenges and the region's largest exhibition of EMS products and service suppliers.

To register, visit www.emsac.org.

The Colorado State EMS Conference is brought to you by the Emergency Medical Services Association of Colorado (EMSAC) and the Emergency Medical and Trauma Services Section of the Colorado Department of Public Health and Environment.

FIGHT THE FLU!

Protect yourself from Flu, including novel H1N1

Wash your hands frequently with soap and water. Rub hands together for at least 20 seconds.

Use anti-bacterial hand sanitizers if soap and water are not available. Rub for 20 seconds until hands are dry.

Stay home if you are sick. Do not take children to daycare/school if they have a fever.

Avoid touching your eyes, nose and mouth.

Cover your cough or sneeze with a tissue or the crook of you arm.

Discard tissues and wash your hands after coughing or sneezing.

Sanitize common surfaces like doorknobs, keyboards, faucets, telephones and shopping cart handles.

Get your flu shots, including H1N1 when it becomes available to you.

Colorado HELP Line - 1-877-462-2911

http://www.colorado.gov/nofluforyou