ON THE SCENE
Covering EMS and Trauma in Colorado

A Publication of the Colorado Emergency Medical and Trauma Services Section

Fall 2010

Standardized (regional) Needs Assessment Project
EMS and Trauma in Colorado

Ken Riddle and Celeste White

The Colorado Department of Public Health and Environment and The Abaris Group would like to thank the regional coordinators/executive directors and council members as well as the EMS and trauma system stakeholders who participated in a three-year long comprehensive assessment endeavor of Colorado's 11 regions. Completion of this process ensures compliance with current statute and will provide a baseline of information that can be used at the local, regional and state levels to support the continued development of EMS and trauma care across Colorado.

The Standardized (regional) Needs Assessment Project began with a task force of representatives from each Regional Emergency Medical and Trauma Advisory Council (RETAC), the Colorado Rural Health Center and Colorado Counties, Inc., working with the department for nearly a year to adapt for statewide use the tool used by the Western RETAC in 2006. All RETAC boards submitted letters of support to the department committing their participation in the statutorily-mandated effort.

The assessment process consisted of on-site interviews with key stakeholders as well as two survey instruments: a benchmarking, indicators and scoring (BIS) tool and a problem ranking survey of 10 EMTS issues. The interview format and the content of the surveys are aligned with the 15 components of an EMTS system, as defined by Colorado statute. Notes from the interviews and scores from the two surveys were tabulated and analyzed and provided to each RETAC board and the department in a written report. Conclusions and recommendations for consideration by the RETAC members were offered. These reports are available at www.coems.info/retac, and the final report and executive summary will be made available this fall.

The BIS contained 45-60 questions on nearly 40 pages, and the time required to complete the BIS hindered the return of completed surveys. However, a good deal of valuable information may be gleaned as a result of the overall effort. Observations regarding some of the more common EMTS issues throughout Colorado among RETAC stakeholders include:

Volunteerism. The provision of emergency services, fire and EMS is primarily provided by dedicated citizen volunteers. Recruitment and retention continues to be a major issue in rural and frontier areas of Colorado.

800 MHz Digital Trunked Radios. Use of the DTR network varies between regions. Some have regional communications plans guiding the development and use of the system; others do not have the needed infrastructure. In all regions, occasional or infrequent users of the DTR system would benefit from additional and refresher training, especially in the hospital setting.

Regionalization. The approach to regionalization varies between RETACs. In some RETACs, there is a major effort to regionalize specific aspects and components of the EMTS system. In the geographically-large RETACs with primarily rural and frontier areas, regionalization is more challenging.

Hospital Staffing. The issue of filling specialty physician or nursing positions in the rural and frontier areas of the state can be a challenge.

Medical Direction. Overall, medical direction throughout the state is thought to be outstanding. Regionalization in this area appears to be more prevalent than with any other component.

continued on page 13

ON THE SCENE
AT A GLANCE

Fall 2010

Colorado Department of Public Health and Environment

ON THE SCENE is a quarterly publication of the Emergency Medical and Trauma Services Section of the Health Facilities and Emergency Medical Services Division at the Colorado Department of Public Health and Environment and serves the emergency medical services and trauma communities of Colorado.

4300 Cherry Creek Dr. S.
Denver, Colo. 80246
Main (303) 692-2980
(800) 866-7389 x2980
Fax (303) 691-7720
www.coems.info

Howard Roitman, Division Director
D. Randy Kuykendall, Section Chief
Jeanne-Marie Bakehouse, Editor
Rio Chowdhury, Layout Designer

The Chief's Corner
The EMTS Highway

D. Randy Kuykendall

One of the challenges I face each quarter when it's time for me to write this article is to identify a subject that is both timely and informative. Since the primary purpose of this newsletter is to inform the Colorado EMS and trauma community of what's going on throughout our statewide system, it seemed appropriate to identify the projects and initiatives that are presently under way at the state level and share a bit of the process our office follows to ensure quality service to our stakeholders. The projects described below are in addition to the daily responsibilities of the section in EMT certification, data collection, grants administration and trauma system regulation.

Although some of these initiatives have been generated as a result of the new resources provided through Senate Bill 09-002, others resulted from system needs and statutory mandates.

Two years ago, the Emergency Medical and Trauma Services Section adopted a project management system based on the identification of project goals/objectives, the individuals necessary to carry out the project and a timeline to guide the assigned team to project completion. As these projects and initiatives were developed and prioritized, the section began to refer to this part of our work as our "EMTS Highway" where some projects are fully under way and in various stages of completion, while others may be on the "on ramp" awaiting further development and/or resources. The current "EMTS Highway" of active projects and deadlines is illustrated below.

continued on page 4

EMTS Highway

	Mar 10	Apr 10	May 10	June 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Apr 11	May 11	Jun 11	Jul 11
EMT Certification Rules	Establish task force							Town hall meetings		AG informal review	SEMTAC approval	BOH hearing request		BOH hearing			Rules effective
Trauma Center Designation Fee Rules		4/20 start		Dept. invite letter		Establish task force	Staff draft			AG informal review	SEMTAC approval		BOH hearing request		BOH hearing		New fees effective
Emergency Medical Practice Advisory Council Implementation						Town halls, EMPAC solicitation	AG informal review	SEMTAC, CMO hearing	EMPAC orientation 18-19		Rules effective	EMPAC meeting		CMO hearing			Rules effective
Trauma Triage Algorithm Rules							AG informal review	SEMTAC approval	BOH hearing request		BOH hearing		Rules effective				
Statewide Data Collection Upgrade						Information collecting	RFP development	SEMTAC update, finalize RFP	RFP published	Vendor selection	Finalize selection process	Contract to vendor	Contract effective date	Yr2 funding request		Phase 1 complete	Project continues

The Chief's Corner
The EMTS Highway

continued from page 3

EMT Certification Rule Update Project. The goal of this effort is to update Colorado's regulations governing the certification of EMTs to bring our system into compliance with the new national scope of practice and education standards. The addition of the Advanced EMT level of certification will be included, and, in conjunction with this project, the scope of practice rules administered by the Emergency Medical Practice Advisory Council will be updated as well. This project will be completed by July 1, 2011, and will be consistent with changes presently being implemented by the National Registry of EMTs. Marilyn Bourn, Sean Caffrey, Art Kanowitz and Michelle Reese are leading this project.

Trauma Center Designation Fee Change Project. Stakeholder meetings are under way to develop new rules that will adjust the trauma center designation fee structure to ensure that the fund necessary to support this statutory activity continues to remain solvent. This is the first time that trauma center designation fees have been adjusted since the inception of the program in 1997. Lynne Keilman, Jean McMains, Margaret Mohan, Michelle Reese and Grace Sandeno are coordinating this project, which will be completed with rule promulgation to ensure implementation by July 2011.

Emergency Medical Practice Advisory Council Implementation Project. Processes have been underway to implement the requirements set forth by House Bill10-1260 that moved regulatory oversight of the EMS scope of practice, waivers to the scope of practice and requirements for EMS service medical directors from the Colorado Medical Board (formerly the Board of Medical Examiners) to the Colorado Department of Public Health and Environment. Draft rules have been developed and will be heard for promulgation on Oct. 26, 2010. The council membership is being identified by the Governor's office and is expected to be seated in early November. This initiative, managed by Art Kanowitz, Rick Leander, Michelle Reese and Celeste White, will be completed on schedule.

Trauma Triage Algorithm Rule Project. This project will be completed as scheduled with the State Emergency Medical and Trauma Services Advisory Council approving the technical rule change at its October meeting. The new algorithm has been completed and draft rules have been finalized and are being prepared for hearing before the Colorado Board of Health. Jean McMains, Margaret Mohan, Michelle Reese and Grace Sandeno are leading this project.

Statewide Data Collection Upgrade Project. This is the project recently recommended by the State Emergency Medical and Trauma Services Advisory Council to purchase a complete statewide prehospital database to replace the current system affectionately known as the "MATRIX." This project is being coordinated by Steve Boylls, Jesse Hawke, Holly Hedegaard, Lynne Keilman, Kris Kiburz, Rick Leander, Michelle Reese and Celeste White. Purchase of the software will be complete by June 30, 2011.

The "on-ramp" projects and initiatives are awaiting movement. These are important projects and, in conjunction with the State Emergency Medical and Trauma Services Advisory Council, RETACs and various stakeholder groups, we will engage these "projects in waiting" as soon as active projects are completed and reach sustainability. Some of the initiatives presently on the ramp include continuous quality improvement rule/process development, rewriting the Chapter 2 rules, developing rules governing the EMS account including the grant program rules, updating the data submission requirement rules, revising the ground ambulance rules and implementing the various sub-projects that will come from this ongoing work.

I have always regarded the opportunity to serve the EMS and trauma profession with value and respect. My purpose in this message is to share as much information as possible with the Colorado EMS and trauma community and acknowledge the energy and effort expended by many dedicated people to improve our ability to care for our patients. Please contact me at any time with questions or a need for additional information. ■

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
Preventable Deaths in EMS Providers

Art Kanowitz

On June 26, 2010, I attended the National EMS Memorial Service. This event celebrated 26 members of our EMS family throughout the United States who lost their lives in the line of duty. Having never been to such an event, I had a preconceived notion that the majority of EMS providers who lost their lives in the line of duty would have been from occurrences while on-scene, due to the inherent dangers of many field situations. In fact, seven people were killed in motor vehicle crashes responding to the scene; seven people were killed in aero-medical aviation accidents; one person was killed in an on-scene building collapse; one person died from complications of injuries sustained on-scene; and two people died of gunshot wounds. None of these surprised me. I was very surprised, however, to learn that 10 of the EMS providers who died in the line of duty died from heart attacks and strokes.

A study published in Annals of Emergency Medicine (December 2002 40:6) entitled *Occupational Fatalities in Emergency Medical Services: A Hidden Crisis*, looked at 114 EMTs and paramedics who were killed on the job. This is an estimated 12.7 fatalities per 100,000 EMS workers, making it close to the death rates for firefighters (16.5) and police (14.2). The national average for all workers is 5.0. Of the 114 deaths, 67 were from ground transportation accidents; 19 from aero-medical crashes; 13 from heart attacks and strokes; 10 from shootings; and 5 from other causes.

In another study published in the New England Journal of Medicine (N Engl J Med 2007;356:1207-15), researchers found the risk of heart attack in 449 firefighter deaths was highest when they were working at a fire scene, with increased odds ranging from 10 to 100 times the normal risk of heart attack. Although firefighters spend only 1 to 5 percent of their time putting out fires, 32 percent of firefighter deaths from heart attacks occur at fire scenes. However, the chances of a heart attack are significantly increased when firefighters are responding to an alarm, returning from an alarm or engaging in physical training. The authors hypothesized that the risk of dying from heart disease may increase during fire suppression because of the effects of strenuous exertion on firefighters who have underlying coronary heart disease and who may be overweight and lack adequate physical fitness. Stefanos Kales, the study's lead author and assistant professor at the Harvard School of Public Health stated, "We hope that our study will reinforce efforts in the firefighting community to improve their health and wellness programs."

What is being done to prevent death in the EMS worker? At basic EMT training, we teach scene safety. National Registry Certification Examination scenarios verbalize, "Is the scene safe?" The Emergency Vehicle Operators Course ensures the safe operation of emergency vehicles while responding to an emergency situation. Continuing education programs include safety-related issues. The first consideration as you arrive on scene typically is safety. In Colorado, we have an annual safety summit to explore and educate.

"What is being done to prevent death in the EMS worker?"

The fire service seems to be improving at encouraging good physical health by providing workout facilities and making physical agility tests part of the job requirements. National Fire Service organizations have numerous programs to promote good health and physical conditioning. For example, Safety, Health and Survival Week (Safety Week) is a collaborative program sponsored by the International Association of Fire Chiefs and the International Association of Fire Fighters. Fire departments are encouraged to suspend all non-emergency activity during Safety Week and focus entirely on safety, health and wellness-related training and education.

There are many activities designed to make an inherently unsafe profession safer, but we need to do more, especially in EMS. We need to include topics on health and wellness in our annual safety summit. We need our EMS agencies to make wellness and physical conditioning programs and equipment available through work. We, as individual EMS workers, need to make greater efforts toward better health: eat healthier, exercise more regularly and get yearly physical examinations. Overall, take better care of ourselves.

Let's raise a few tough questions. First, should yearly physical fitness testing be a job requirement? Second, what is the EMS medical director's role in promoting health and wellness? These topics are worthy of further exploration. As a community, we need to increase our efforts to improve health and wellness and decrease the preventable deaths among EMS workers. Please become involved. Work with your agencies to set up health, wellness and conditioning programs. But more importantly, take care of yourselves and be safe. ■

Dr. Arthur Kanowitz is the state EMTS medical director and can be reached at arthur.kanowitz@state.co.us.

Partnership for the People

Brighton's hospital-based paramedics now respond from fire stations

Thom Dick

This article is reprinted with permission from the EMS Responder magazine. It was originally published in the June 2010 issue.
www.emsresponder.com

People are so angry today. Angry at the president, angry at Congress, angry about the war, angry about their health insurance and angry about the economy. Worst of all, they're angry at each other. When you enter almost any blog about anything, you can't help noticing their unprecedented disrespect.

Of course, bloggers are like radio talk-show hosts. They know they can say (or misspell) just about anything they like without accepting responsibility for it. But talk to just about any EMSer from just about anywhere, and they'll tell you that kind of anger (and disrespect) has been common for many years between EMS agencies and fire departments—even where both functions are performed by the same agency. These are people who have been dying alongside one another for years, yet in so many ways they act like enemies—afraid of one another. What a shame.

Crews from the two departments participate in a recent mutual auto extrication drill. Platte Valley provides its crews with protective gear for use on all roadway incidents.

Brighton's a little town 20 miles north of Denver, where the absence of that kind of fear has had a powerful effect on the relationships between the town's BLS first responders and ALS transporters—and on their relationships with the public. You talk to chiefs or line workers on both sides, and the impression you'll get is, there don't seem to be any sides.

The Brighton Fire Protection District is a mostly paid, tight little organization with five current stations and a sixth one pending. Mark Bodane, formerly of the Carol Stream, IL, Fire Protection District, has led this department for the past three years. His style is casual, straightforward and respectful, and that's pretty much how his 70-some subordinates treat one another. More than that, they clearly care about the public. And, they're nice.

With half as many personnel as the fire district, Platte Valley Ambulance Service is Brighton's ALS transport provider. Chief Paramedic Carl Craigle oversees that service as a department of Platte Valley Medical Center, based on a contract with the fire district. His people also enjoy a relaxed environment, despite his use of military supervisory titles that parallel those of the fire department. Responding from four locations, they field two 24-hour crews and a 12-hour day crew seven days a week, along with a paramedic captain in a fly car. They keep six clean, ALS-stocked ambulances. If something big happens, like an incident at nearby Denver International Airport, they can split their crews and pair them with firefighters to double the number of available medic units.

Brighton's fire, ambulance and police departments use NIMS in their daily operations, and all three are dispatched (along with services from other municipalities) by ADCOM, the Adams County Communications Center. They're all capable of 800-Mhz communications with just about anybody they need to contact.

On-duty MT/paramedic crews from Platte Valley Ambulance have been "living" in Brighton's fire stations since September 1, 2009. That was Bodane's idea, and when he first proposed it, not everybody was thrilled. But when the EMS contract came up for renewal last year, he also proposed a 10-year term. The hospital read that as evidence he wasn't just trying to build an empire.

The reason for the move-in was that Brighton had been growing. Once a whistle-stop for farmers along the front range of the Rockies (the eastern side), the city's shape has changed from small and round to long and rectangular. The ambulance service's central "big-barn" deployment became

continued on page 7

Partnership for the People

Brighton's hospital-based paramedics now respond from fire stations

continued from page 6

obsolete enough that the hospital had to consider building not one but two new stations at once. Beset by a recession and transport collection rates of less than 33%, that seemed impossible.

Craigle worried that moving crews into fire stations would destroy his department's camaraderie and weaken its identity. Bodane had similar concerns on behalf of his own people. But the public's need was clear and growing, and the solution seemed inevitable.

People aren't perfect, and neither are departments. But eight months later it seems to be working. The ambulance service pays for its fair share of living supplies and goods. And people generally try to treat one another with respect. Of course, many were friends to begin with. For one thing, they had already shared a common schedule for years. For another, nobody was making a profit. Both agencies belong to the community.

Fire and ambulance personnel here train together six times a month on EMS topics chosen to match National Registry requirements. Skill competencies are assessed by means of annual refreshers mandated by a common medical director furnished by the hospital.

As a Colorado-certified Continuing Education Group, the ambulance service provides enough sanctioned CE so anybody in the system can maintain their National Registry levels, mostly while on duty. Their own EMTs and paramedics alike complete PALS and ACLS every two years, and are required to attend at least 30 additional hours of medical in-services besides. The ambulance service's education coordinator signs firefighters' recert apps and maintains the EMS training records for both departments. In addition, transport EMTs and paramedics are welcome to attend all fire department training, including specialized rescue classes on ice rescue, swiftwater rescue, auto extrication, hazmat, residential extrication and even fire suppression topics.

The ambulance service's turnover consistently runs about 10%, so paramedics and EMTs alike tend to be seasoned caregivers. They average no collisions, two service complaints and two critical vehicle failures a year. They stock fire and police units with all the medical equipment they need, and the fire district reciprocates with MDTs, tollway fares and numerous other concessions.

Medics and firefighters alike submit reports called PEAT reports—that stands for Physical Environment Assessment Tool—to focus attention on safety hazards, nutritional needs and social gaps they identify in people's homes. The ambulance service then conducts what they call Re-PEATS: return visits to check the welfare of people with special needs, and in some cases to physically install safety modifications at no charge to anyone.

"Fire and ambulance personnel here train together six times a month."

The collective commitment of these agencies to the people of Brighton is not lost on the public. Brighton is a town that likes its parades, and when emergency vehicles go by it's common for people to cheer not only for their firefighters and cops, but also the crews in their blue-and-white ambulances.

If all of this sounds like puffery, it's probably more like poor writing. But this story needs to be told somehow, and right now. There are no perfect systems, and this one demands constant hard work—especially from its leaders. There are countless evening meetings, weekend training sessions, public events, lectures and CPR classes just in this little town, not to mention the needs of surrounding jurisdictions. It never ends. You go home at the end of each day, and you're whipped. Then the phone rings to tell you there's something else to do.

If it seems like Craigle's just being naive, and the fire department's just planning to take over the system 10 years from now, you may be right. That could happen if he and his people don't stick to the knitting. But for now, they're all too busy doing what we all should be doing: Namely, focusing their energy on the needs of the people who own their stations, their equipment and their certificates. ■

Thom Dick is the quality care coordinator for Platte Valley Ambulance Service, a community-owned, hospital-based 9-1-1 provider in Brighton, CO. Thom is also a member of *EMS* Magazine's editorial advisory board. He can be reached at boxcar_414@yahoo.com.

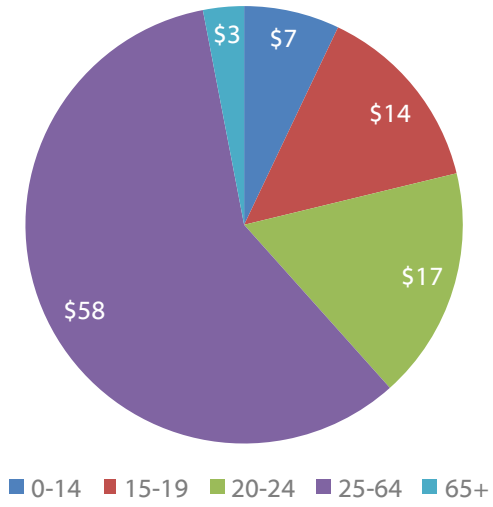
Injury Prevention

Sallie Thoreson

Motor vehicle crashes are costly, but preventable

According to a new Centers for Disease Control and Prevention study, motor vehicle crashes in 2005 cost more than $99 billion dollars for medical care and loss of productivity. That's an average of $500 a year for every licensed driver in the United States. People riding in motor vehicles accounted for $70 billion of those costs, with $12 billion for motorcyclists, $10 billion for pedestrians and $5 billion for bicyclists. The age group generating the most cost was adults 25 to 64 years of age, followed by young adults (ages 20-24) and teens (ages 15-19).

Annual Costs, in Billions, of Motor Vehicle-Related Fatal and Nonfatal Injuries, by Age Groups, 2005



Effective strategies to decrease motor vehicle crashes, injuries and costs include:

- Strong graduated licensing laws for teen drivers
- Child safety seat distribution and education programs
- Primary seat belt laws that allow law enforcement to stop and cite motorists if they are observed not wearing seat belts
- Seat belt enforcement programs such as Click It or Ticket
- Motorcycle and bicycle helmet laws
- Sobriety checkpoints

Are you involved in older adult fall prevention?

Falls are the most common cause of nonfatal injuries and hospital admissions for older adults in the United States. Each year 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.

Colorado now has an Adult Fall Prevention Coalition that has been working since September 2009 to identify existing programs and resources, promote best practice/evidence-based guidelines and raise awareness about fall prevention within the health care community and the public. Coalition members come from hospitals, EMS agencies, public health, exercise professionals and agencies that provide services to older adults.

As a initial step, the coalition developed an online survey to capture information on current programs throughout the state. If you are working on fall prevention for older adults, please go to http://fs8.formsite.com/cohealth/form418808509/index.html and fill out a short survey.

Members of the coalition will be asking partners in their communities and RETACS to help identify agencies and groups to complete the survey about their programs using the five building blocks of fall prevention: 1) education programs for older adults and their caregivers; 2) exercise programs to improve mobility, strength and balance; 3) medication review and management; 4) vision exams and vision improvement; and 5) home safety assessment and home modification.

continued on page 9

Injury Prevention

continued from page 8

EMS Providers Receive Suicide Prevention Education

In 2007, Colorado had the sixth highest suicide rate in the United States, 16.7 suicides per 100,000 persons, which is considerably higher than the suicide rate for the United States as a whole (11.5 suicides per 100,000 persons).

The Injury, Suicide and Violence Prevention Unit at the Colorado Department of Public Health and Environment used an EMTS provider grant award to develop an EMS provider training program around suicide prevention. As a first step, more than 100 Colorado EMS providers completed an online survey, with the following results.

- EMS professionals have a high degree of line-of-duty exposure to suicidal behaviors.
- EMS professionals have a high degree of exposure to suicide in their personal lives, with an expected greater emotional impact for these events.
- EMS professionals report varying levels of perceived comfort and competence in conducting suicide interventions or dealing with suicide events.

EMS professionals see their greatest area of support coming their work teams (44 percent) and family members (24 percent).

Building upon this information, the department engaged the QPR Institute to design an EMS suicide prevention training specifically for Colorado. The QPR Institute trained 39 people, from 10 of the 11 RETACs, to facilitate the newly-created EMS suicide prevention training. The training curriculum is currently being modified based on feedback from the EMS providers who attended the training, and the trained instructors will soon have updated materials to train other EMS providers in their communities. A few of the comments from the class attendees were:

“I feel more confident in approaching suicide and the issues around it."

"It approaches a subject no one really talks about. It will help me be a better paramedic, friend and loved one."

"I would recommend this training. Great information, needed for EMS." ■

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.

EMT Certification

In addition to these updates, detailed information and important notices on EMT certification is available at www.coems.info.

E-mail Reminder Notice

The EMTS Operations Program has implemented a new system to help prompt you to renew your EMT certification. Approximately 90 days prior to your expiration date, you will receive an e-mail reminding you of your upcoming certification expiration. If you don't renew following that 90-day reminder, you will be sent monthly reminders. In some cases, e-mail reminders may not reach you due to an incorrect or outdated e-mail address. Failure to receive an e-mail reminder will not extend the EMT certification period. Be sure your application has a current e-mail address, so we can notify you of this important renewal process. Plan ahead, and don't let your certification expire.

Applications for renewal can be found at www.coems.info.

Frequently Asked Questions on...

Provisional Certification

6 CCR 1015-3, Section 5.4

Q: Who qualifies for a provisional 90-day certificate?

A: The only basis for obtaining provisional certification is that the department has not yet received the applicant's fingerprint-based criminal history record check(s) from either the Colorado Bureau of Investigation or the Federal Bureau of Investigation. At the time you submit your application, you must have already sent your fingerprint card to the Colorado Bureau of Investigation to initiate the fingerprint-based criminal history record check(s). You must attest that you have done this on the application (items #35 and #36).

Q: Is there a special application for provisional EMT certification?

A: There is only one EMT certification application, which can be found on our website at www.cdphe.state.co.us/em/CertificationEducation/Certification/2010EMTApplication.pdf. If you are interested in and qualify for provisional certification, please check "yes" on question #6. If all of the required documents and information are included with your application, we may issue the 90-day provisional certificate.

Q: What additional documentation is needed for a provisional EMT certification?

A: A printed copy of a name-based criminal history record check is required for all provisional EMT applications. You must include the hard-copy results of name-based background check(s) from every state you've lived in the past three years. This includes Colorado if your application lists a Colorado address.

Q: Where do I get a name-based criminal history record check for Colorado or other states?

A: A name-based criminal history record check for Colorado can be obtained online from the Colorado Bureau of Investigation for $6.50 on its website at www.cbirecordscheck.com. Links to other states' name-based criminal history record checks can be found at www.cdphe.state.co.us/em/CertificationEducation/certification/StateBackgroundRecordList.pdf.

Q: If I have a provisional EMT certification, do I have to resubmit a "regular" application once the results of my fingerprint-based criminal history record check(s) have been received?

A: No…no additional application is necessary. Once the results of your fingerprint-based criminal history record check(s) have been received and approved, you will be issued a three-year certification.

Q: I sent a personal check with my application two weeks ago, but still haven't received my provisional certification. What's wrong?

A: You must include a certified check, cashier's check or money order in the amount of $23, made payable to the State of Colorado, with your request for provisional certification. Enclosing a personal check could delay the processing of your application for provisional certification.

continued on page 11

EMT Certification

continued from page 10

Six-Month Grace Period for Renewal

6 CCR 1015-3, Section 5.3

Q: I heard that there is a six-month grace period for expired certifications. What does that mean?

A: Certified EMTs who have let their certification expire for a period of less than six months may renew their certification. They must meet the recertification requirements and submit an application for renewal.

Q: Can I still work as an EMT during my six-month grace period?

A: No, you may not provide any patient care as an EMT once your Colorado certification has expired. You may perform non-patient care related duties such as driving or dispatching as allowed by your agency. No patient contact is allowed.

Q: I still have a current National Registry certification, but my Colorado certification is expired. Can I still work as an EMT?

A: No, you must be certified by the State of Colorado in order to provide patient care. You may not provide patient care under your National Registry certification. You may perform non-patient care related duties such as driving or dispatching as allowed by your agency. No patient contact is allowed.

Q: What happens once my Colorado certification is expired?

A: You have up to six months to submit your application for renewal. You can do so by going to www.cdphe.state.co.us/em/CertificationEducation/Certification/2010EMTApplication.pdf and printing the PDF application. The instruction guide provides answers to questions you may have about the application process. The same application is used for first time initial and renewal applicants.

Q: I just realized I am more than six months expired. Am I eligible to recertify?

A: Yes, you are eligible to recertify. You must hold a current National Registry certification. Information about National Registry can be found at www.nremt.org. You may then apply for Colorado certification by going to www.cdphe.state.co.us/em/CertificationEducation/Certification/2010EMTApplication.pdf and completing the recertification application process.

Criminal History Backgrounds

6 CCR 1015-3 Section 5
Emergency Medical and Trauma Services Section's Criminal Conviction Policy

Q: Are felony and misdemeanor convictions grounds for denial of my EMT application for certification?

A: Each application is reviewed on an individual basis. Please see the Criminal Conviction Policy on our website at www.cdphe.state.co.us/em/CertificationEducation/certification/CriminalConvictionPolicy.pdf. You are required to submit court documents for felony charges/convictions with your application.

Q: I am not sure if I have ever been arrested or charged with a misdemeanor (excluding traffic) or felony that may still be on my record...how should I answer?

A: While arrest records may be sealed, it is always best to answer all application questions truthfully and to the best of your knowledge. If you have ever been arrested or charged with an offense (excluding traffic), it is in your best interest to disclose this information prior to a background investigation being conducted.

Q: Do I have to report adverse disciplinary actions?

A: Yes. You are required to answer item #32 on the application for certification regarding prior disciplinary action taken against the applicant in connection with the performance of health care related activities. Additionally, disciplinary actions taken against an applicant (by any state licensing authority) are required to be reported to the Healthcare Integrity and Protection Data Bank, per Section 1921 of the Social Security Act. The background investigation may include a query of the Healthcare Integrity and Protection Data Bank by the Colorado Department of Public Health and Environment.

Additional questions regarding Colorado certification should be directed to:
Colorado Emergency Medical and Trauma Services Section
(303) 692-2980
cdphe.emtcert@state.co.us

Grant Opportunities

Sean Caffrey

While EMS and trauma service provider grantees begin their grant-funded project for the current fiscal year that began on July 1, the State Emergency Medical and Trauma Services Advisory Council's Public Policy and Finance Committee has been working with department staff to update and improve grant programs for upcoming years. All EMTS-related funding programs are authorized by Colorado Revised Statutes section 25-3.5-603(3) and include the following programs:

Program	Funding Goal/Yr
Provider Grants	$5,500,000
Statewide System Improvement	$650,000
CREATE EMTS Education Grants	$500,000
Emergency Grants	$100,000
Total	**$6,750,000**

New for fiscal year 2012 is the Statewide EMTS System Improvement Program. This program is an evolution of previous "special projects" programs that have been in use by our community for well over a decade. Funds in this category, often referred to as "603" funds since their authority is contained in C.R.S. Section 25-3.5-603(3)c, will be available for the direct and indirect costs of planning, developing, implementing, maintaining and improving the statewide EMS and trauma system. Projects in this category must be related to system-wide impact and eligible applicants can include EMS and trauma providers, local governments, RETACs, statewide associations and state agencies. Matching funds will not be required for this program and the funding target will remain at the historic level of 10 percent of grant funds that was previously allocated to special projects. Application materials for this program will be available in December and the request deadline will be in February 2011.

For fiscal year 2012, EMTS provider grants will include the same categories that have been historically available through that program. All grant categories will be structured to include a 50 percent match by the applicant as a baseline. The financial waiver process will still be available to allow for an applicant match as low as 10 percent based on financial need. All "priority" match programs used in past grant cycles that have automatically reduced the match for certain items or categories (i.e., safety equipment, pediatric items, recruitment and retention programs) will not be available in fiscal year 2012. While it is envisioned that a priority match program will return in the future, fiscal year 2012 will be used as a rebuilding year to better accommodate priority programs and calculations in the future. It is expected that all interested parties will be able to annually request priority funding consideration from the State Emergency Medical and Trauma Services Advisory Council at its April meeting. The provider grant application will be available in December and will have a February 2011 submission deadline.

The Colorado Resource for EMS and Trauma Education (CREATE) program is managed through a partnership with the Colorado Rural Health Center and will continue through fiscal year 2012. Minor process changes can be expected as this new program enters its second year. CREATE funds are available continuously and can be requested online at www.coruralhealth.org/programs/create/index.htm.

Finally, the Emergency Grant Program continues to be available for EMS and trauma organizations that suffer emergencies that may adversely affect the quality or accessibility of care locally. The emergency grant target funding level is established at $100,000 annually. Emergency grant requests are accepted anytime and can be found at www.coems.info/grants/emergencyinfo.html. ■

Sean Caffrey is the EMTS system development coordinator of the Emergency Medical and Trauma Services Section and can be reached at sean.caffrey@state.co.us.

Standardized (Regional) Needs Assessment Project
EMS and Trauma in Colorado

continued from page 1

Clinical Care. The quality of clinical care provided by EMTS personnel, paid and volunteer, is high. Modern, progressive treatment is being provided, and equipment used by the majority of stakeholders is up-to-date and in excellent condition.

Public Education and Injury/Illness Prevention. Grant funds from a variety of sources are largely responsible for the public education and injury or illness prevention programs that are provided regionally throughout the state.

RETAC Coordinators. RETAC coordinator/executive director job descriptions, roles and responsibilities, pay and benefit structures, and relationships with the RETAC board varies between regions. The coordinators/executive directors are very valuable resources to both the department and their regions because of the breadth of their knowledge of the system and players within it.

This assessment effort has required monumental support and time. The benefits will continue into the future as the data realized by this project are analyzed, evaluated and discussed in terms of making future policy and guideline decisions across the Colorado EMTS system. We encourage EMTS organizations and stakeholders to continue their support of and participation in the RETAC system and hope this regional needs assessment project will benefit planning efforts in the future. ■

Ken Riddle is the senior consultant at The Abaris Group and can be reached at kriddle@abarisgroup.com.

Celeste White is the boards and councils coordinator of the Emergency Medical and Trauma Services Section and can be reached at celeste.white@state.co.us.

Consolidated Communications Network of Colorado, Inc.
9008 No. U.S. Highway 85, Unit E
Littleton, Colorado 80125-9915

July 21, 2010

To The General Membership of the Consolidated Communications Network Of Colorado:

As you recall, the Consolidated Communications Network of Colorado (CCNC) Executive Board determined at its November 2, 2009 meeting that it was necessary to implement a temporary moratorium on the future addition of new talk groups or new radios, with a few exceptions, to the Digital Trunked Radio System (DTRS). The driving factors behind that decision were:

- System ID Capacity Issue: The DTRS has a known system ID capacity of 64,000 IDs per zone. While we were not at a point of reaching 64,000 IDs in a given zone at the time of the moratorium, we were approaching 71,000 IDs in total, and that number was growing rapidly. While the manufacturer advised us that the integrity of system reporting and statistical information could be impacted if we surpassed 80,000 IDs on the system, they also advised that call processing would not be affected. The CCNC, representing all users of the DTRS, was not willing to take any chance that call processing would be impacted in any way, or that system reporting would be negatively impacted.

  At this point, the CCNC Executive Board has received acceptable assurances that call processing will not be affected below 95,000 IDs, and that any impacts to system reporting will not have negative side effects.

- System Sustainability: In the October 21, 2009 letter to the general membership, the CCNC Executive Board noted that significant system sustainability and funding issues needed to be addressed. It noted that there was inequity in the support and maintenance of the infrastructure under the current model.

  While this issue has not been fully resolved, significant work is underway to identify the true cost of ownership and operation; a necessary task to achieve full completion. In parallel with this initiative, the CCNC continues to work toward establishment of a sustainable funding source.

- System Infrastructure Additions: As the DTRS grew, the addition of user agencies often occurred without the supporting infrastructure to handle the aggregated traffic load they contributed. Because of the continued growth, the CCNC needed to establish sufficient oversight to insure that unbridled growth did not negatively impact existing users.

  The diligent work of the Technical Committee in establishing a site impact study, and the attendant review process, will serve to fulfill this obligation.

Consolidated Communications Network of Colorado, Inc.

Consolidated Communications Network of Colorado, Inc.
9008 No. U.S. Highway 85, Unit E
Littleton, Colorado 80125-9915

Based upon all of the items noted above, the CCNC Executive Board voted at its July 14, 2010 meeting to immediately lift the temporary moratorium imposed on November 2, 2009. The Technical Committee has been tasked to review all of the applications that were tabled during the temporary moratorium and to identify and move forward those which were tabled for no reason other than the moratorium.

The Executive Board takes its responsibility to all users of the DTRS very seriously, and we thank all of the users for their patience and understanding during the moratorium.

Join your EMS cycling colleagues to ride in honor to the National EMS Memorial Service in Colorado Springs.*

REMEMBER the fallen

Riders will parade into the Springs and be served with an outdoor BBQ & ceremony at the destination.

**Even if you aren't riding, come take part in the service as we send the riders off!*

Friday, June 24, 2011
7:00am

Join the RIDE

National EMS Memorial Bike Ride

National EMS Memorial Service

Saturday, June 25, 2011
6:00pm

The year 2011 marks the second year for the NATIONAL EMS MEMORIAL SERVICE ceremony and surrounding activities in their new Colorado Springs, CO home. The climax and focus of the weekend is the NATIONAL EMS MEMORIAL SERVICE, and all EMS personnel are welcome and encouraged to attend to pay honor and respect to their colleagues who have lost their lives while in the line of duty.

If you plan on attending the SERVICE, please plan on arriving by 5:00pm - preferably in uniform - on the evening of Saturday, June 25, 2011 to First Presbyterian Church in Colorado Springs.

For more information about the weekend's activities, please visit nemsms.org.