

ACS Recommendations	Comments
<p>Philosophy of Trauma System Development: 12.b. Preserve the exemplary state-wide commitment to care of the injured patient, and assure that this commitment is guided by an inclusive, patient focused, trauma system plan (i.e. appropriate number, level and location of trauma centers).</p> <p>21.k Ensure representation of rural providers on all task forces, workgroups, and committees pertaining to trauma system development.</p>	<p>The department has always been committed to seeking rural representation on committees, task forces, etc. No one can ensure that there is rural representation at any given meeting; however, the department is committed to always inviting rural representatives to the table.</p>
In Progress	
<p>9.g Pursue appropriate federal funding streams to support trauma system development.</p>	<p>The EMTS staff has consistently applied for state, federal and private grant funding to support the costs of data linkage, trauma system development and special projects such as the ACS Trauma System Consultation. Staff will continue to apply for any funding that seems to be a reasonable adjunct to current fee funding.</p>
<p>1.c Continue the partnership with the Department of Transportation and share the trauma registry and MATRIX data so that data linkage with other important databases occurs routinely.</p>	<p>The Department has been funded by CDOT for the last 3 years to work on developing data linkages for the CDOT data warehouse. Trauma Registry data and MATRIX data linkages continue to be funded through 2010, with a reapplication process annually. Data linkages are not yet routine but are moving in that direction.</p>
<p>21.j Secure funding to provide prehospital trauma education (e.g. Prehospital Trauma Life Support and Basic Trauma Life Support) and RTTDC in rural communities.</p>	<p>This is ongoing. The funding for such projects can and has been secured from the EMTS grants program in the past. Now that additional funding is available through this funding source, the Department anticipates additional applications for expanded offerings to prehospital and facility-based providers. Concerns were expressed regarding number of PAs and NPs staffing rural Level IVs and Vs: until recently they haven't been able to get certified in ATLS training, but have been able to take the training at much discounted rate. They are now able to get certified, but will be charged full amount for the training. Need to look at funding training for rural NPs and PAs. Concerned that the people who should be taking it won't be taking it because of the cost. Make sure that this group of individuals would be eligible for funding for this. Do we have adequate ATLS courses that will accommodate these people? Current grant process DOES allow for this type of funding.</p>
<p>13.d Utilize the current national standards to update and modify the prehospital triage and hospital transfer guidelines. The Centers for Disease Control and the American College of Surgeons have established revised guidelines.</p>	<p>This process is also underway. The ACS and CDC guidelines have been used as the basis for the decisions by a state-convened task force. The task force is to make recommendations to the State Emergency Medical and Trauma Services Advisory Council and to the department regarding changes to the existing prehospital triage algorithm. SEMTAC will need to recommend the related rule changes to the Board of Health for promulgation. This process takes 6-9 months and does not begin until there is agreement on the rules being recommended.</p>
<p>16.c Hire a trauma program specialist with clinical expertise to educate and assist the RETACS and small rural facilities with the PI process.</p>	<p>This recommendation is close to being completed. The position was created in the funding provided by Senate Bill 02. The position description has been completed and the hiring process begun. The department has not found the right candidate yet; however, staff hope to have this position filled in the next 5-6 months.</p>

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<p>21.i Allow level IV and V trauma centers to apply for EMTS grant funds to support injury prevention programs within their communities.</p>	<p>Level IV and V trauma centers have always been eligible to apply for injury prevention grants. The staff believes that the consultation team did not understand this. The staff is working to make trauma centers more aware of the funding available through the current grant cycle to any qualified EMTS agency. Staff will continue to work to encourage injury prevention efforts at the local level whether they are funded by Highway User Tax Funds or any other funding source. RETAC coordinators help do this. State should encourage more and assist with this. This is part of the whole system, everyone should help with this.</p>
<p>11.d Standardize the pediatric age criteria (less than 15 years) for EMS protocols and triage and transport destination determination.</p>	<p>This process is in progress. The state rules for Level I and II trauma centers have already been modified to define individuals who are 14 and under as children. The Chapter Two rules, which currently define child as 12 and under, have many issues that require attention, and this will be addressed in a major rule change over the next few years.</p>
<p>1. f Modify the definition of trauma deaths for monitoring and reporting to exclude poisonings and drowning so that findings correspond to the patients treated by trauma centers</p>	<p>The state trauma data already exclude poisonings and drownings for the purpose of trauma analyses. However, drownings and poisonings are tracked for injury prevention purposes. The staff believes that the team misunderstood what data were available, in what format the data are available and what the data were used for.</p>
<p>Top 10 Priorities (MTAC first, others in alphabetic order)</p>	
<p>(General Topic: Creation and Implementation of MTAC) 4.a Create a Multidisciplinary Trauma Advisory Committee (MTAC) of State Emergency Medical and Trauma Advisory Committee (SEMTAC) to assist SEMTAC in addressing trauma system issues.</p> <p>4.b Task the MTAC to oversee all clinical components of the trauma system, including quality improvement and compliance with clinical care guidelines (e.g., trauma triage, interfacility transfer).</p>	<p>May need to do this first and then 4b and 4c will be resolved also. Important, pt and system may benefit. Been discussion at SEMTAC. Think that mechanisms are in place and would address that trauma community has lost a place to advocate for pts. Advise department and SEMTAC on trauma-related issues. Need to identify specific purpose and vision statement, roles and responsibilities, lines between SEMTAC and dept and committees. Can establish committee even without ability to review specific cases. Take small steps while building trust and changing culture. At SEMTAC meeting, Jan 28, there will be discussion of redesign of committee structure.</p> <p>Will group create and monitor standards? System may need to change also to reduce competition in front range area before this can be effective. In perfect world, what could group do? Should share info and provide better care info. Look at issues about triage and # of trauma centers. More like role of former Colorado Trauma Institute. Share mistakes and successes. Can this be done if the only data available are aggregate at state or regional level?</p>
<p>(General Topic: Assisting Rural Facilities in Providing Great Trauma Care.) 12.d Assist rural facilities with limited resources to achieve designation.</p> <p>21.f Allow hospitals applying for level IV and V trauma center designation to seek funding from the EMT and FLEX grant programs for resources needed to meet criteria.</p>	<p>Need to provide financial resources to do so. Requires money, personnel, computers. Many rural facilities struggle to maintain designation due to financial issues. Need to readjust resources. Need to really improve patient care, not just obtain the label of trauma center.</p> <p>Isn't this already in progress? Yes, facilities already can apply for things that support the development of a trauma program. Does this mean people could apply for \$ to pay for trauma designation fees? Probably not? Needs to be discussed at Public Policy and Finance Committee</p>

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<p>(General Topic: Critical Care Transport) 11.g Eliminate the discrepancy between EMS provider capabilities and the needs of the critically ill patient who requires transport between facilities.</p> <p>13.f Establish operational rules for critical care transport.</p> <p>23.b Develop a performance improvement program to monitor the care of seriously injured patients provided by advance practice EMT-Paramedics during long transports.</p>	<p>Recommendation not clear. <i>Add to recommendation:</i> Including a thorough gap analysis that looks at rural or transport resources and practice patterns and levels. Establish competency. Identify discrepancies. Could this be done with aggregate data? Really need to know details about both patient and provider to assess for appropriate transfer.</p> <p>Goes along with 11g. Problem is universal. Include all interfacility transport.</p> <p>What is a long transport? Subjective? May be worth considering all critical care transports...</p>
<p>(General Topic: Data Collection and Use) 16.f. Ensure the data collected from hospitals and EMS is complete, validated, consistent, and comprehensive to effectively conduct system PI.</p> <p>17.a Collect trauma registry data from all hospitals in order to conduct a complete and comprehensive assessment of trauma care in Colorado.</p> <p>1.d Move toward development of trauma datasets (trauma registry and MATRIX) that are population-based.</p>	<p>Difficult to ensure data is complete. Many different components. Only 75% of EMS agencies reporting; when data comes in, there is data clean up. Not collecting same data from Level IV and V as we are Level I – III. Grants program can help purchase software for small agencies. NOT low hanging fruit. Multifactorial. Make sure all agencies are submitting data; make sure data being submitted is complete and accurate. Tough to validate – can't tell if codes being used are correct.</p> <p>Yes, good idea. But very human resource intensive to get those data. If there is simple way to obtain, should investigate. What possibilities are there for data collection. Everyone agrees on value of data but is it worth losing trauma centers who can't comply. Traveling registrar? Collaboration with other registries. need to figure out how to best address those needs. Survey rural facilities to see how best to get this done. This also includes non-designated facilities. What impact on them? Requires both human resources and financial.</p> <p>Does priority #6 need to move up because it needs to be completed to implement a comprehensive PI process?</p>
<p>(General Topic: Development and Implementation of State Trauma Plan) 7.b Develop a plan for statewide trauma system implementation based on the needs assessment study, using the authority of the existing enabling legislation.</p> <p>21.d Clearly define roles and responsibilities of level IV and V trauma centers in the state trauma system plan.</p> <p>7.d Utilize the Multidisciplinary Trauma Advisory Committee to complete a trauma system plan.</p> <p>9.c Develop trauma system plan priorities and commit appropriate financial resources for the plan implementation.</p> <p>7.h Set a timeline and deadline to implementation of the state trauma system plan.</p>	<p>There was a discussion of how important this was or was not. Another item was whether a BIS should precede or follow a state planning process or both and whether a plan was necessary before a needs assessment can be undertaken.</p> <p>May need to address 7b first.</p>

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<p>(General Topic: Enforcement of Trauma Rules) 3.f Assure all hospitals being designated as trauma centers at levels I, II, and III meet the established criteria without waivers. 4.c Assure that SEMTAC supports the Lead agency’s efforts in dealing with trauma system issues (e.g. monitoring each phase of trauma care, the trauma center designation process, etc.) 6.c Enforce trauma system standards across the State in both hospital and prehospital phases of care. 7.g Create incentives and establish goals to reduce the number of trauma centers that do not meet criteria at the time of the redesignation application.</p>	<p>Part of problem is that rules are out-dated and no longer match what would be optimal patient care. Waivers have morphed into requests to not meet rules that are costly or inefficient. Need to re-do rules and take into account the shortage of care providers at many levels. Look at flexibility for rural facilities. Make sure that whatever we choose puts patients first. Different issue for urban/suburban centers. Why would rural centers need to be designated? Are there advantages to the patients? (Probably at every designation level.) This is of high importance with the current discussions at the DRC. I believe that it should be moved up to replace #3. Problem with giving waivers. Has waiver process weakened rules? Need to ensure that standards are really met.</p>
<p>(General Topic: Protection of Data) 16.b Assure the protection of the data and the trauma performance improvement process at local, regional, and state levels. 3.b Assure the protection of the data and the trauma quality improvement process at local, regional, and state levels. 17.b Assure the protection of the data and the trauma performance improvement process at local, regional, and state levels.</p>	<p><i>Definition:</i> Broader scope of data collection and analysis, including process improvement and performance improvement, at each level of care throughout the continuum of care. <i>What it would take:</i> ‘regulation’ is one piece; not sure what other pieces might be necessary.</p>
<p>(General Topic: Statewide Needs Assessment) 7.a Perform a patient-focused in-depth statewide needs assessment study to determine the appropriate level and geographic location of trauma centers for the state. 19.a Complete an in-depth statewide assessment of patient needs and resources available. 12.a Perform a patient-focused in-depth statewide needs assessment study to determine the appropriate level, number, and geographic location of trauma centers for the state. 18.d Conduct a statewide preventable mortality study that reports preventable, potentially preventable, and opportunities for improvement (regardless of preventability) across the system and all phases of care.</p>	<p>First question is what does this mean? Look at patient needs and decide where and what level of trauma centers there should be. Who performs this? Outside contracting agency to determine for region. Too much politics to be done locally. Clarification: is that looking at volume? population? outcomes? Where should certain index cases be sent? See guiding principle #2 - Better match the system resources and capabilities to patient need. Can pull out rural vs urban responses. May actually show that there is more need for higher level care in rural areas. Need to make sure that we have a more complex discussion than just population and geography. Where are and where aren't the resources that we really need. Must include gap analysis. Gaps and resources. Get very specific about specialties. However, this will be difficult if there is not protection for case-level data. Think this may even be more important than data protection. But needs buy-in from major players. Looking for how to make the patients the winners even if painful for some of the players. Must agree on what the parameters are before we get into an assessment. This is more patient-focused than some of the other recommendations. Ask for where this should go in priorities. Should be moved up to the top 5.</p>

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<p>(General Topic: Statewide Performance Improvement) 16.a. Develop a statewide trauma system performance improvement plan (PI) in collaboration with trauma system constituents within the next 12 months.</p> <p>4.g Fulfill the state mandate for system-wide quality improvement and positively influence public policy, through a collaborative effort involving the lead agency, with support of SEMTAC, and in concert with RETACs and other community leaders.</p> <p>7.f Set up monitoring and tracking data collection based on patient outcomes.</p> <p>16.d Establish system PI audit filters and measures that address process and outcomes.</p> <p>2.c Conduct repeated measures of key indicators to mark trauma system development progress over time.</p>	<p>Can't do the plan until we can protect it. Recommendation is clear. May require statute change, may require a regulation.</p> <p>Must be able to protect that information. Facility designation is every three years; this is done during trauma center designation, but is it often enough?</p>
<p>(General Topic: Triage and Transfer Guidelines) 3.g Assure compliance with the triage and transfer criteria for trauma patients on a continual basis and adjust the rule as necessary.</p> <p>16.i Monitor the triage and transfer guidelines and protocols for compliance routinely. Require plans of correction to address deviations, and trend deviations to determine a need for change in the protocol or guideline.</p> <p>13.c. Develop a mechanism and routinely monitor compliance with triage and transfer guideline rules.</p> <p>7.e Develop and enforce standardized protocols, triage, transfer guidelines and care plans.</p>	<p>Could this be done if the only data available are aggregated at the state or regional level? Really need to know which agencies are taking patients to what facility and why.</p> <p>Keep combined even though Prehospital triage is one issue; interfacility transport is another issue. Continuous monitoring of this being maintained. 3g assurance part; other 2 have to do with monitoring them, making sure there are protocols. RETACS established protocols, maybe they should be charged with monitoring. Interfacility transfer part is broken. Need to readdress Chapter 2 and 3 rules. Establish protocol, monitor compliance, and readjust as necessary to improve patient outcome. Monitoring part falls in realm of PI plan (16a).</p> <p>This is a need, but can it be done prior to a needs assessment or must it wait for that information?</p>
<p>All other recommendations (in no particular order)</p>	
<p>(General Topic: Benchmarks, Indicators and Scoring Process) 2.a Convene a group of 30-40 key stakeholders identified from trauma directors, trauma managers, rehabilitation personnel, prehospital personnel, select Regional Emergency Medical and Trauma Advisory Committee (RETAC) representatives, public health, public safety, emergency preparedness, and others and conduct a facilitated BIS evaluation</p> <p>2.b Incorporate the findings of the benchmarks, indicators and scoring (BIS) assessment into the formal trauma system plan.</p>	<p>Need to do this first in order to do the rest? Perhaps can do relatively quickly based on experience from other states. With SNAP project, ACS review, is this still a priority? How do we know what is or isn't working ... won't a BIS help us recognize that? Many states have used a BIS instead of an ACS consultative visit. An education session like this could be incorporated in the system plan development goal. Tool to evaluate where we are after we have made some changes.</p>

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16.j Ensure that the evaluation of the state trauma system is ultimately inclusive of the entire continuum of care (dispatch, prehospital, emergency department, trauma care, and rehabilitation) to fully assess impact of trauma care on mortality, as well as morbidity.	Definition clear. <i>What would it take</i> : take 16f to be done, 11g, 16a, 16b Could this be done if the only data available are aggregated at the state or regional level? Moved down in rank because may not be currently achievable.
21.g Encourage further implementation and utilization of telemedicine to increase accessibility of rural providers to education and patient consultation.	
17.g Develop a unique patient identification system to allow for patient tracking through all aspects of the trauma system from initial contact with EMS to disposition at rehabilitation.	May need this to happen before other data things can happen.
23.d Consider mechanisms (e.g., US Senate Bill 1066) to optimize funding for rural and frontier ambulance services and to provide for “surge” or “flex” capacity to perform long distance transfers between remote primary hospitals and distant tertiary centers.	
3.d Enforce 100% submission of EMS data by EMS agencies to the EMTS data collection system.	
3.e Dedicate a portion of the new grant funds for trauma system development.	May be able to make grants process work better for facilities to make sure that they are more competitive. But is there a desire to set aside funds for trauma system development? Maybe brainstorm what types of grants would qualify. May not want to dedicate a portion just for this but need to evaluate in context of other needs; look at relative value compared to other priorities.
13.h Secure funding to provide additional Rural Trauma Team Development Course (RTTDC), in conjunction with the Colorado Rural Health Center, to rural areas to encourage the appropriate stabilization and transfer of trauma patients.	See above. Important, but need to compare to other priorities. Resource issue may be about how the funding comes to facility or to Rural Health Center. Relates to 21.j. which is already in progress. In western Colo St. Mary's received grant to do in many locations. But is not required.
21.a Ensure that level I, II, and III trauma centers provide outreach education to level IV and V trauma centers and EMS agencies according to routine referral and transport patterns.	
17.d Convene the trauma managers and trauma directors to define the key data reports that need to be run on a quarterly and annual basis.	Important but could be covered under System Quality improvement task force efforts. Need to determine what is of value to the system, with a focus of improving patient outcomes. Need protection of data and universal reporting. PI plan should include what data elements will most benefit pts. Also can interpret narrowly...what can we do with the data that we have now. This may be a shorter term project to help advise the Department on what is useful to the community. And also identify data gaps to help tell what training needs to happen.

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<p>(General Topic: Consolidation of Oversight) 3.c Consolidate all regulatory oversight of emergency medical services (EMS) and trauma system functions within the Colorado Department of Public Health and Environment through the EMTS Section.</p> <p>20.b Convene a meeting of representatives from the counties, the Board of Medical Examiners and the Department of Public Safety to explore barriers and opportunities for a consolidated model of EMS regulation.</p> <p>11.a Transfer the responsibility for licensing EMS agencies and ground ambulances from county commissioners to the EMTS Section.</p> <p>6.b Consolidate all regulatory oversight of EMS and trauma system functions within the EMTS Section.</p> <p>20.c Seek legislative and rule change for the consolidated model if agreement is reached with other agencies and groups.</p> <p>20.d Plan the transition to the consolidated model if legislation and rule change is successful.</p>	<p>Two parts to this. Consolidation may not be best for all aspects. EG medical practice act could be fragmented by such a move. Also first responder under Fire Safety and ambulance licensing at county level. Some movement at consolidation as legislation will be introduced to move scope of practice and medical oversight. Also there are not good connections even in the Dept of Health. How important? Stays on table and addressed as issues come up.</p>
<p>4.d Provide guidance to the Regional Emergency Medical and Trauma Advisory Committees (RETACs), through the SEMTAC, regarding priority trauma system issues or projects.</p>	
<p>15.a Assure that input from the State Emergency Medicine and Trauma Advisory Committee (SEMTAC) and Regional Emergency Medicine and Trauma Advisory Committees (RETACs) is incorporated into state, regional, and local disaster plans and activities.</p>	
<p>9.d Solve the secondary transfer billing problem so that ambulance services can recover at least a portion of their operating costs for patient transfers.</p>	
<p>4.e Specify priority tasks in the RETAC contract in support of state trauma system development and hold them accountable for the accomplishment of those priorities.</p>	
<p>9.f Enhance the relationship between the State's emergency preparedness program and a trauma system to ensure that Assistant Secretary for Preparedness and Response (ASPR) grant funds help support trauma system development.</p>	

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13.e Ensure compliance with all specialty care transfer guidelines (traumatic brain injury, spinal cord injury, burns, pediatrics).	
16.k Build upon the best practice models of PI being promoted within individual RETACs and existing outreach programs.	
<p>(General Topic: Use of Media and Public Accountability)</p> <p>2.d Report progress to the trauma community, media, and legislators.</p> <p>9.b Provide an annual public report of the costs and benefits of the trauma system and trauma care in Colorado.</p> <p>21.h Engage community support through media campaigns.</p>	
16.e Provide educational opportunities to orient and train all trauma system stakeholders on the recommendation of issues to be investigated.	
16.h Provide access to data for the RETACs to facilitate regional PI under the leadership of the regional medical director.	
9.a Create a statewide picture of the costs and revenues associated with the provision of trauma care.	
11.e Require standardized education for EMS dispatchers.	
13.a Establish a statewide central communications system to coordinate and secure expeditious transports and interfacility transfers with one call.	This would include centralizing dispatch to try to better get the right patient to the right facility in the right amount of time. Need to help find the best place to go not just a place to go. Would assist with coordination of resources. Would this be looked at in the needs assessment? This probably should be moved up.
13.g Establish statewide EMS protocols that take into account variances due to time, distance, and personnel resources in rural areas of Colorado.	
13.i Create a system of seamless patient transport across county lines to the appropriate facilities under regionalized medical direction.	
17.e Produce and distribute reports on a quarterly and annual basis to all data contributing facilities and to personnel and committees charged with system oversight and quality improvement.	

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21.b Establish Memoranda of Understanding between level I, II and III facilities and level IV and V facilities to provide education, conduct performance improvement, and repatriate patients back to their communities.	
11.c Monitor and assure appropriate local EMS medical director performance.	
8.a Ensure that during the creation of a trauma plan the integration with EMS, mental health, social services, rehabilitation, emergency preparedness (MCI), and public health occurs.	
6.a Employ a 1.0 FTE physician state medical director to oversee the clinical aspects of the trauma and EMS system.	Hard time finding one person with all expertise needed. May just need to have focus on trauma without getting tied to the 1.0 FTE. Must need to define role and authority.
16.g Establish regional medical directors within the RETACS to support the implementation of regional PI.	
18.b Improve the accuracy and validity of the Colorado Trauma Registry and MATRIX data sets, or their successors, to support systems research.	
21.c Attend the Colorado Hospital Association meetings to educate the chief executive officers of rural hospitals about the benefits of trauma system participation and to gain input regarding rural EMS and trauma issues.	
1.e. Expand the focus of the trauma system's injury epidemiology to report on trauma patient outcomes for selected priority injury mechanisms in the state's injury strategic plan.	Not limited to the mechanisms in the state injury prevention plan.
12.e Focus pediatric trauma care at the regional pediatric trauma center (RPTC) as a regional resource.	
13.b Utilize new technology to support communications for consultations and transfer arrangements.	
<p>(General Topic: Limiting Number of Trauma Centers)</p> <p>19.c Develop a request for proposals (RFP) to identify potential level I and II trauma centers for the state. Clearly define the expectations of similar clinical care with expanded outreach, education, and clinical support expected of the level I trauma center or only level II trauma center in the region.</p> <p>19.b Obtain a revised statute or regulations permitting a limitation in the number of designated trauma centers based on the need of patients rather than institutional commitment.</p> <p>3.a Revise the statute to authorize limits on level and location of trauma centers commensurate with patient needs.</p> <p>12.c Develop a request for proposal process to identify potential level I and II trauma centers for the state.</p>	<p>Does this go with the needs assessment?</p> <p>Need to do 7a first before 3a.</p>

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21.e Conduct a cost benefit analysis for level IV and V trauma centers including possible revenue generated from UB04 trauma team activations.	
4.f Establish an infrastructure for RETACs to collaborate and regularly communicate with each other for exchange of programmatic issues, best clinical practices, prevention programs etc.	
<p>(General Topic: Coordination with Emergency Preparedness)</p> <p>8.b Utilize the new SEMTAC Multidisciplinary Trauma Advisory Committee (MTAC) to ensure trauma system integration with all emergency preparedness activities.</p> <p>15.b Mandate dialog between Emergency Preparedness and Response Division (EPRD) and the new Multidisciplinary Trauma Advisory Committee (MTAC) to optimize trauma system improvements for disaster response.</p>	
9.e Require all EMS agencies to charge for care and transportation at rates reflecting the cost of providing the service.	
14.d Develop process improvements regarding difficult placement issues, e.g., ventilator dependent patients and unfunded patients.	
22.c Ensure that new staff and other newly appointed leaders are provided with a specific historical orientation to trauma and EMS system development in Colorado. The overview provided the first night of the TSC visit serves as an excellent starting point for this task.	
23.a Develop an advanced practice EMT-Paramedic training program.	
23.c Develop a mechanism for “on call” or “stand by” resources to provide personnel and an ambulance for the performance of critical care interfacility transports.	All of these could be considered. What works in one part of the state may not work everywhere.
10.c Enhance communication and collaboration between the Injury Community Planning Group, trauma centers, and other partnering organizations to foster commitment for use of evidence-based injury prevention strategies recommended in the strategic plan.	
<p>(General Topic: Implementation of statewide EMS software)</p> <p>11.f Consider obtaining a NEMESIS-compliant (gold) commercial information system that allows for the selection of clinically relevant data elements.</p> <p>17.f Conduct a cost/benefit analysis and, if indicated, use a portion of the initial year’s Highway User’s Tax grant program funds, to purchase an “off the shelf”, NEMESIS compliant (Gold Level) program with multiple options for data input at the provider level and robust reporting at the state level.</p>	

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5.b Encourage trauma stakeholders to continue outreach to elected officials to increase the number of legislative champions.	
20.a Seek input from SEMTAC regarding a consolidated model of EMS regulation.	
17.c Work with other states using Clinical Data Management (CDM) software (e.g. Utah, Ohio, and North Dakota) to encourage the development of a CDM state-level capture and reporting module with routine reporting features included.	
22.a Support the development of an institutional memory by electronically archiving all documents of historical significance to EMS and trauma system development in Colorado and, as appropriate, nationally.	
10. a. Complete development of the injury prevention website to make prevention program resources more accessible to injury partners.	
6.d Reassess the roles and responsibilities of the EMTS Section personnel in light of the opportunity provided by the statewide trauma system needs assessment and planning initiative.	
5.a Ensure the involvement of the State American College of Surgeons Committee on Trauma and trauma center leadership in the Multidisciplinary Trauma Advisory Committee functions and activities.	The Colorado Chapter of the ACS has been invited to attend all meetings.
10.b. Integrate tertiary injury prevention into the planning of injury control priorities for the state.	
7.c Evaluate and consider refining Colorado's definition of an "inclusive system."	
14.b Assure rehabilitation representation on the Multidisciplinary Trauma Advisory Committee.	Easy once MTAC is developed.
18.c Partner with appropriate academic institutions and research agencies that can provide resources (personnel, research design knowledge, and financial support) to assist in the completion of the trauma system research agenda.	
22.b Create a mentor/mentee matching system with appropriate access to resources and support to offset the mentors' time.	

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5.c Expand the trauma stakeholders to include representation from mental health, rehabilitation, community organizations, the media, and the public.	
18.a Appoint a task group under the aegis of the Multidisciplinary Trauma Advisory Committee to develop a state trauma system research agenda that will encourage the systematic and scientific examination of all elements of trauma system performance.	Could this be combined with 77?
1.b Actively recruit other agencies, academic centers, institutions, the Colorado Injury Control Research Center, the Rocky Mountain injury institute, etc. to expand the injury epidemiology capabilities.	
14.c Assure rehabilitation specialist involvement in the systemwide needs assessment.	Move to section re: needs assessment?
8.c Consider including representation from other time-sensitive clinical conditions and system responses, such as stroke and ST elevation myocardial infarction (STEMI) when developing the trauma system plan.	
14.a. Collect data elements related to rehabilitation and utilize these data to inform the trauma system.	Include in PI process?
1.a Develop a relationship with the new school of public health and identify injury epidemiology projects for graduate students to increase the depth and breadth of injury data that can be analyzed.	
11.b Allow national accreditation of EMS agencies (Commission on Accreditation of Ambulance Services-CAAS) for eligibility for Colorado ground ambulance licensure.	